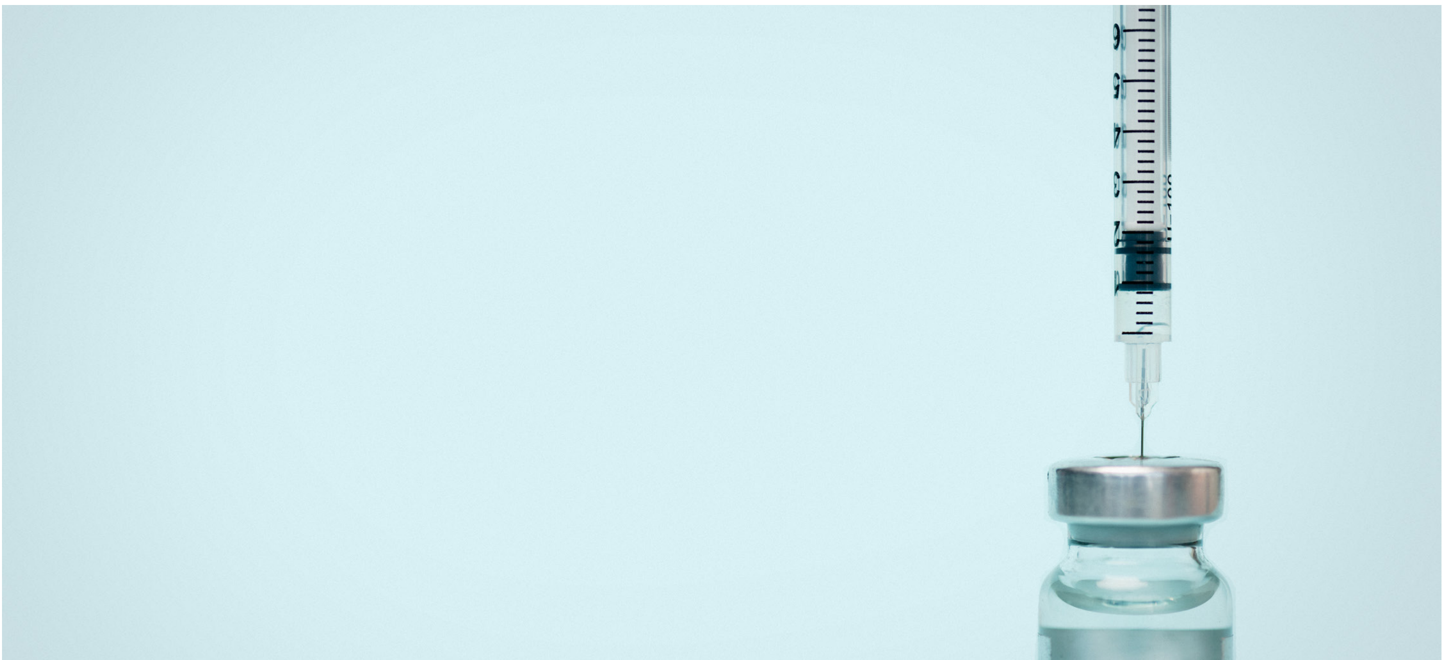
Should Medicare Eliminate Cost Sharing for Preventive Vaccines?

By Doug Badger



GALEN INSTITUTE

February 2022

P.O. Box 130

Paeonian Springs, VA 20129

galen.org

(703) 687-4665

galen@galen.org

https://galen.org/assets/Should-Medicare-Eliminate-Cost-Sharing-for-Preventive-Vaccines.pdf

Should Medicare Eliminate Cost Sharing for Preventive Vaccines?

By Doug Badger
Senior Fellow at the Galen Institute

OVERVIEW

Medicare coverage of preventive vaccines is balkanized. Part B covers some preventive vaccines, while Part D covers others. Beneficiaries are not responsible for cost sharing for Part B vaccines. Most Part D plans require cost sharing, with amounts varying by plan and product.

Cost-sharing requirements are among the factors that affect vaccine uptake. Since seniors are generally more susceptible to severe illness from vaccine-preventable diseases, it has been proposed that Medicare make preventive vaccines free at the point of service. This policy would increase immunization rates, thereby diminishing the risk of serious disease among beneficiaries and reducing the amount the program spends to treat preventable diseases. On balance, such proposals would increase Medicare spending, but experts disagree over the size of the increase and the extent to which the added costs would be offset by reducing the incidence of illness that vaccines prevent.

Proposals to eliminate cost sharing for preventive vaccines take various approaches. Legislation passed by the House in 2021 includes a provision that would reduce cost sharing for vaccines covered under Part D to $0.[1] Alternatively, the Medicare Payment Advisory Committee (MedPAC) has recommended moving coverage of all preventive vaccines to Part B, which does not require cost sharing for immunizations.[2]

This paper examines the pros and cons of eliminating Medicare cost-sharing requirements for preventive vaccines.

[1] House Committee Print 117-18, Rules Committee Print 117-18, Text of H.R. 5376, Build Back Better Act, section 139402. https://www.congress.gov/committee-print/117th-congress/house-committee-print/46234 Rep. Ann Kuster (D-NH) and Larry Bucshon (R-IN) introduced H.R. 1978, a bill to eliminate Medicare cost-sharing for preventive vaccines, on March 17, 2021. As of January 22, 2022, the bill had 49 cosponsors, including 16 Republicans and 33 Democrats. https://www.congress.gov/bill/117th-congress/house-bill/1978?s=2&r=9 Companion legislation was introduced in the Senate by Mazie Hirono (D-HI) on March 23, 2021. https://www.congress.gov/bill/117th-congress/senate-bill/912

[2] *Report to the Congress: Medicare and the Health Delivery System*, Medicare Payment Advisory Committee (MedPAC), June 2021, chapter 7, pp. 241-276. https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun21_medpac_report_to_congress_sec.pdf Chapter 7.

Background: Medicare Coverage of Preventive Vaccines

Section 1862 of the Social Security Act stipulates that Medicare Part B only covers medical items and services that are "reasonable and necessary for the diagnosis or treatment of illness or injury."[3] Preventive vaccines do not meet this criterion.[4] Congress has carved out exceptions, providing for Medicare Part B coverage of vaccines to prevent pneumonia and influenza and, for certain high-risk patients, hepatitis B.[5] Medicare covers 100% of the cost of these products.[6]

Part D covers other preventive vaccines, including any that might be developed in the future. Beneficiaries choose among competing private Part D plans to receive their prescription drug coverage. These plans use formularies, which vary cost sharing by product, including preventive vaccines. CMS has encouraged plans to create a preventive vaccine tier with no cost sharing. But MedPAC estimates that all enrollees in free-standing prescription drug plans and 90% of beneficiaries enrolled in Medicare Advantage plans that include drug coverage must meet cost-sharing requirements for preventive vaccines.[7]

These cost-sharing requirements can be considerable. MedPAC found that the median cost sharing for a shingles vaccine in 2019 was $47 per dose, with 10% of plans requiring out-of-pocket payments exceeding $172 per dose.[8] Patients require two doses of the shingles vaccine, making the cost-sharing requirement extremely burdensome for many seniors.[9]

---

[3] Section 1862(a)(1)(A) of the Social Security Act.

[4] There are certain vaccines that can be used both for prevention and treatment of diseases. These include vaccines for hepatitis A, rabies, tetanus/diphtheria and tetanus/diphtheria/pertussis. Part D covers these products when they are administered as part of a preventive regimen. Part B covers them when they are used as a treatment (e.g., a rabies shot after an animal bite).

[5] 1861(s)(10).

[6] Congress has provided that Medicare will pay for the administration of COVID-19 vaccines. The government has paid for the vaccines themselves outside the Medicare program. Beneficiaries are not responsible for cost sharing for these products.

[7] MedPAC, June 2021, p. 245.

[8] MedPAC, June 2021, p. 255.

[9] "Recommended Adult Immunization Schedule for Ages 19 or Older, United States, 2021," Centers for Disease Control and Prevention, undated. https://www.cdc.gov/vaccines/schedules/hcp/imz/adult.html#note-zoster (accessed January 22, 2022).

Prescription drug plans negotiate reimbursement for vaccines with manufacturers. Under Part B, Medicare pays 95% of the average wholesale price (AWP) in most settings for the product and a separate fee to the provider for administering the injection.[10] When vaccines are provided in institutional settings (e.g., hospitals, skilled nursing facilities, dialysis centers and federally funded clinics), Medicare pays the facility's "reasonable cost."[11]

Medicare is Unique in Requiring Cost Sharing for Preventive Vaccines

In recent years, Congress has adopted a series of policies to encourage preventive care by eliminating cost sharing. Medicare provides an array of free preventive services, including an initial wellness visit,[12] regular screenings for various diseases,[13] and services, such as diabetes prevention and intensive behavioral therapy for obesity, that receive an A or B grade from the United States Preventive Services Task Force.[14]

Congress has placed a similar requirement on non-grandfathered commercial plans.[15] In addition, the government requires these commercial plans to cover immunizations recommended by the Centers for Disease Control and Prevention's (CDC) Advisory Committee on Immunization Practices (ACIP) without cost sharing.[16]

Medicare Part D is thus an outlier in requiring beneficiaries to pay a portion of the costs of preventive vaccines. This policy is especially anomalous since the same private pharmacy benefit managers who provide free vaccine coverage

---

[10] MedPAC, June 2021, p. 255.

[11] MedPAC, June 2021, p. 255.

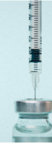
[12] Section 1861(ww).

[13] Section 1861(s)(2).

[14] Section 1861(ddd)(1). CMS has provided a list of covered preventive services on its website. "Medicare Preventive Services," CMS (undated). https://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/medicare-preventive-services/MPS-QuickReferenceChart-1.html (accessed January 22, 2022).

[15] Section 2713(a) of the Public Health Service Act. Nongrandfathered plans refers to certain policies that were in effect on December 31, 2013, the day before many ACA regulatory requirements took effect. Some plans have retained that status. These nongrandfathered plans are not required to provide preventive services at no cost sharing.

[16] Section 2713(a)(2) of the Public Health Service Act.



for enrollees in their commercial policies require cost sharing in Part D plans they sponsor.

There is no obvious policy rationale for this policy. Seniors are generally at elevated risk of severe sickness from vaccine-preventable diseases. Indeed, the CDC recommends some vaccines only for older adults, so it makes sense for Congress to consider rationalizing these policy inconsistencies.

For example, CDC recommends a two-dose vaccine against shingles only for adults aged 50 and older.[17] The agency estimates that half the people who live to age 85 will contract shingles.[18] Symptoms typically involve blistering and painful rashes, but older adults may also suffer vision loss, stroke, dementia, long-term nerve pain in the affected area (post-herpetic neuralgia, a significant cause of disability among older people) and, in rare cases, death.[19]

Weakened immune responses in older adults make them more susceptible to these adverse outcomes, which is why CDC recommends that they be immunized.

Medicare policy does not track with these recommendations. A 64-year-old with employer-sponsored private insurance can get free shingles vaccines, but a 65-year-old on Medicare may have to pay more than $350 for a two-dose course.

Cost-Sharing Requirements Depress Vaccine Utilization Rates

These Medicare requirements can discourage immunization among the population that would most benefit from it.

---

[17] "Recommended Adult Immunization Schedule," Table 1.

[18] "CDC Recommends Shingles Vaccine," Centers for Disease Control and Prevention, May 15, 2008. https://www.cdc.gov/media/pressrel/2008/r080515.htm

[19] James Roland, "Why Is Shingles More Serious in Older Adults?" Healthline, May 17, 2021. https://www.healthline.com/health/senior-health/shingles-elderly

Several studies have found that cost-sharing requirements reduce vaccine uptake among adults. For example, a 2011 GAO study found that Part D cost sharing was a deterrent to seniors getting the shingles vaccine.[20]

A study by Avalere Health found a 40% to 60% higher uptake from 2012 to 2016 for the shingles vaccine among enrollees in Part D plans that offered $0 cost sharing.[21] The authors estimated that in 2016, 95% of seniors had Part D coverage that required cost sharing for that product.

A 2018 study published in the Journal of Current Medical Research and Opinion found that high patient copays were a barrier to Tdap (tetanus/diphtheria/pertussis) and shingles vaccinations for Medicare Part D patients.[22]

These findings are consistent with those of a body of peer-reviewed literature confirming that cost sharing reduces the use of preventive services. A review of 19 studies conducted during the 1990s found strong evidence of the effectiveness of reducing out-of-pocket expenses in increasing vaccination rates.[23]

MedPAC examined take-up rates for vaccinations between pneumococcal vaccines—which are free to beneficiaries under Part B—and shingles vaccines, which require copayments under Part D. It found that 59% of seniors had received the pneumococcal vaccine in 2017 or earlier.[24] By contrast, only 32% of beneficiaries received shingles shots between 2010 and 2018.[25] In 2018, just 4% of beneficiaries got shingles shots, although MedPAC concluded that

---

[20] "Many Factors, Including Administrative Challenges, Affect Access to Part D Vaccinations," Government Accountability Office, December 15, 2011. https://www.gao.gov/products/gao-12-61 At the time GAO did the analysis, there were other complicating factors. For example, the earlier version of the shingles vaccine had just become available. Also, doctors did not have an established protocol for billing Part D plans, creating logistical challenges that have since been obviated.

[21] Loren Baker, Nick Diamond, Richard Hughes IV and Haile Dagney, "Fewer Seniors Get Vaccinated as Their Out-of-Pocket Costs Rise," Avalere Health, July 19, 2018. https://avalere.com/insights/fewer-seniors-get-vaccinated-as-their-out-of-pocket-costs-increase

[22] S. Yan, M. DerSarkissian, R.H. Bhak, P. Lefebvre, M.S. Duh and G. Krishnarajah,"Relationship Between Patient Copayments in Medicare Part D and Vaccination Claim Status for Herpes Zoster and Tetanus-Diphtheria-Acellular Pertussis," *Current Medical Research Opinion*, July 2018, pp. 1261-69. https://pubmed.ncbi.nlm.nih.gov/29231748/ (accessed January 22, 2022).

[23] P.A. Briss, et al., *Reviews of Evidence Regarding Interventions to Improve Vaccination Coverage in Children, Adolescents and Adults*, review published in 2000. https://www.ncbi.nlm.nih.gov/books/NBK68159/ (accessed January 22, 2022).

[24] MedPAC, June 2021, Table 7-3, p. 249.

[25] MedPAC, June 2021, Figure 7-1, p. 252.

factors unrelated to cost sharing, such as race and ethnicity, accounted for much of the disparity in immunization rates.[26]

Insurers use cost sharing to discourage excessive and inappropriate utilization of medical care and steer beneficiaries to more efficient providers. Requiring Medicare beneficiaries to have "skin in the game" for vaccinations is different. There is little risk that patients will over-vaccinate. Pharmacists, doctors and other providers generally adhere to CDC recommendations in administering vaccines. Medicare only covers vaccines that are consistent with these recommendations. Once a beneficiary gets two doses of the shingles vaccine, the course is completed. Medicare wouldn't cover a third dose unless CDC revises its recommended vaccine schedule.

Medicare's cost-sharing requirements thus do not discourage overuse but do discourage appropriate use of preventive vaccines.

The Cost of Eliminating Medicare Cost Sharing for Preventive Vaccines

If Medicare's cost-sharing requirements reduce the vaccination rate among beneficiaries, eliminating those requirements will increase utilization. Immunizing more beneficiaries would impose costs on the program, but reduced incidence of vaccine-preventable illness would offset some of these costs. Removing cost-sharing requirements also would provide the benefit of avoiding serious illness for those who are vaccinated, with the intangible but very real benefit of a longer or greater quality of life.

Estimates of the net costs to Medicare of eliminating cost sharing vary. Avalere Health examined the costs of eliminating cost sharing for preventive vaccines under Part D along with the savings associated with lower medical bills for immunized beneficiaries.[27] They concluded that, over the ten years from 2020-2029, Medicare would spend roughly $5.5 billion more on Part D vaccines and realize savings of around $5.1 billion in Part A and Part B due to reduced spending to treat illnesses that the vaccines prevent. That rounds to about $300 million in net new Medicare spending over a decade.

[26] MedPAC, June 2021, p. 254.

[27] Christine Liow, et al., "Impact of Removing Part D Vaccine Cost-Sharing on the Federal Budget," Avalere Health, September 10, 2021. https://avalere.com/insights/impact-of-removing-part-d-vaccine-cost-sharing-on-the-federal-budget (accessed January 22, 2022).

In 2021, the Congressional Budget Office estimated the ten-year cost of a legislative provision to eliminate Medicare cost sharing for preventive vaccines at $3.3 billion.[28] CBO did not explain whether this estimate considered offsetting savings to the Medicare program from reduced incidence of preventable illnesses. If it does not account for these savings, then the CBO and Avalere estimates may not be as far apart as they appear to be.

As discussed below, MedPAC has advanced an alternative way to eliminate cost sharing for preventive vaccines: moving Medicare coverage of all such vaccines to Part B, with no cost-sharing requirements. MedPAC reports that CBO estimated the cost of this proposal at between $1 billion and $5 billion over five years.[29] The midpoint of this estimate would put the price at around $6 billion over ten years, or nearly twice the cost of eliminating cost sharing under Part D.

All these estimates carry additional uncertainty since they are based on currently available preventive vaccines. Should new preventive vaccines be developed and recommended for seniors, Medicare would incur costs not included in these estimates, since the statute requires Part D plans to cover any future preventive vaccine that ACIP recommends for seniors. These new costs would be higher if plans were prohibited from imposing cost-sharing requirements, although they would be offset at least in part by the reduced cost of treating preventable conditions.

Eliminating cost sharing for preventive vaccines would reduce the incidence of serious illness caused by diseases that vaccines prevent. While that would be a better outcome for beneficiaries, it would produce a net increase in Medicare spending. Analysts differ over the magnitude of that increase, but they agree on its direction.

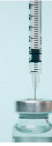
Given the perilous state of Medicare financing, any expansion of coverage of preventive vaccines should include broader Medicare reform provisions to offset those costs.[30]

---

[28] "Estimated Budgetary Effects of Title XIII, Committee on Ways and Means, H.R. 5376, the Build Back Better Act," November 18, 2021. https://www.cbo.gov/publication/57626 (accessed January 22, 2022).

[29] MedPAC, June 2021, p. 264.

[30] "The estimated depletion date for the HI trust fund is 2026, the same as last year's report. As in past years, the trustees have determined that the fund is not adequately financed over the next ten years." *2021 Annual Report of the Boards of Trustees of the Federal Hospital Insurance Fund and Federal Supplemental Medical Insurance Trust Funds,"* August 31, 2021, p. 8. https://www.cms.gov/files/document/2021-medicare-trustees-report.pdf (accessed January 22, 2022).



Policy Options for Eliminating Medicare Cost Sharing for Preventive Vaccines

There are two broad policy pathways for eliminating Medicare cost sharing for vaccines: Move all vaccine coverage to Part B or require Part D plans to cover preventive vaccines without cost sharing.

Option 1: Eliminate Medicare Part D Cost Sharing for Preventive Vaccines

H.R. 1978, the "Protecting Seniors Through Immunization Act," would prohibit Part D plans from collecting any cost sharing—including deductibles and coinsurance—for any vaccine approved by CDC's vaccine advisory committee (ACIP).[31]

Pros

- Increases immunization rates, thereby reducing the disease burden on beneficiaries.
- Pharmacy Benefit Managers (PBMs) already cover preventive vaccines with no cost sharing in the non-Medicare private market, so extending this practice to their Medicare book of business should be feasible.
- Rates negotiated by PBMs are likely to be lower than Part B reimbursement, especially if Part B continues to pay "average wholesale price" and "reasonable cost." (See discussion of Option 2 below.)
- Would likely result in only a minimal increase in Part D premiums.[32]

[31] Section 3 of H.R. 1978 would add a new paragraph (8) to section 1860D-2(b) of the Social Security Act.

[32] This assumes that CBO's $3.3 billion estimate discussed above is the gross Part D cost to the federal government of eliminating cost sharing. That comes to $330 million annually. The federal government finances 74.5% of the Part D program, with premiums covering the rest. That means that the total average annual cost of the enhanced vaccine benefit would be around $443 million ($330 million/.745). Annual Part D premiums would have to rise by $113 million ($443 million - $330 million). Since this would be spread over 48.8 million enrollees, annual premiums would rise by around $2.32, translating to a monthly premium increase of around 20 cents. This is only a back-of-the envelope estimate and not the product of actuarial analysis.

GALEN INSTITUTE

Cons

- Increases net Medicare spending by $3.3 billion over ten years.
- Maintains Medicare's bifurcated approach, with some immunizations covered under Part B and others under Part D.
- Benefits fewer seniors than moving vaccine coverage to Part B since more are enrolled in Part B than Part D.[33]

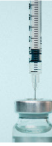
Option 2: Cover Preventive Vaccines Under Part B, rather than Part D

MedPAC has proposed that Congress move coverage of preventive vaccines into Part B. They also have recommended that the program alter its reimbursement methodology. Currently, Part B pays the "average wholesale price" (AWP) for vaccines administered in non-institutional settings. This so-called "list" price is notoriously inflated and does not reflect acquisition costs paid by doctors and pharmacies. Medicare Part B pays hospitals, skilled nursing facilities and other institutional providers "reasonable costs," which also are highly inflated. MedPAC proposes that Part B reimburse all institutional and non-institutional providers based on wholesale acquisition cost (WAC), which is the amount wholesalers pay without accounting for manufacturer discounts or other price incentives. They also recommend that CMS explore the feasibility of transitioning to reimbursement based on "average sales price" (ASP), which accounts for rebates, discounts and other price concessions and is the methodology Medicare generally uses for Part B drug reimbursement.

Pros

- Increases immunization rates, thereby reducing the disease burden on beneficiaries.
- Rationalizes Medicare policy by covering all vaccines under Part B, rather than dividing coverage between Parts B and D.
- Covers more seniors than Option 1.

[33] In 2020, 57.3 million beneficiaries were enrolled in Part B, compared with 48.8 million in Part D. MedPAC, June 2021, p. 258.



Cons

- Increases Medicare costs because Part B covers more beneficiaries and reimburses at inflated rates. Congress could reduce this cost differential by requiring Part B reimbursement based on WAC or ASP.

- Shifts the cost of some drug coverage from retiree health plans to Medicare. Some Medicare beneficiaries receive coverage from sources other than Part D (e.g., former employers that enroll their retirees in Part D). These costs would move from private payors in Part D to the federal government in Part B.

Conclusion

Medicare policy toward preventive services is inconsistent. In some respects, it encourages prevention to improve beneficiary well-being and reduce avoidable high-cost medical interventions. Its policy toward preventive vaccines is discordant with this overall direction. By requiring cost sharing for these products, Medicare deters some beneficiaries from getting recommended immunizations.

Cost sharing does not discourage the *overuse* of preventive vaccines, but it does discourage their *proper use*.

Reforming this policy—whether by requiring Part D plans to eliminate cost sharing for preventive vaccines or moving coverage of such products to Part B—would reduce the risk of serious illness among a vulnerable population.

Such a policy would place additional burdens on a program bordering on insolvency and come at some increased cost to taxpayers. Congress should improve coverage of vaccines and include provisions to achieve Medicare savings through broader reforms across the Medicare program sufficient to offset the cost of these improvements.

Doug Badger is a Senior Fellow at the Galen Institute. During his career spanning more than three decades, he has advised elected officials at the White House, in Congress, and at the Department of Health and Human Services on a broad range of public policy issues, with an emphasis on healthcare policy.

GALEN INSTITUTE