



Optimizing Adult Immunizations in the U.S. – Building on Recent Coverage Expansions

U.S. Vaccine Coverage 2023

Introduction

Vaccine policy is at a defining moment in the United States with the expansion of coverage for vaccines for adults under the Inflation Reduction Act of 2022 (IRA) and heightened awareness of the importance of getting immunized against communicable diseases since the onset of the COVID-19 pandemic. Yet, challenges to improving immunization rates persist, especially for adults. Vaccination rates for adults in the U.S. remain low—with significant declines during the COVID-19 pandemic—resulting in higher levels of vaccine preventable diseases (VPDs) and deaths annually^{1,2,3} VPDs also lead to significant health care costs and socioeconomic impacts in the U.S. One estimate projects that four VPDs in adults over the age of 50 contribute to annual costs of about \$26.5 billion in the U.S.⁴ Further, older adults (age 65 years or older) may be particularly susceptible to more serious infections or complications from VPDs due to immune system decline or the presence of chronic conditions.⁵ As the number of older adults in the U.S. continues to grow, additional focus is needed to ensure recommended vaccines are received.⁶

Factors impacting adult immunization rates are well-documented and complex.^{7,8,9,10,11} To immunize more adults, federal policies should be harmonized to align agencies' efforts toward meaningful actions that ensure greater accountability for population health. This paper explores three immediate, actionable steps to boost adult immunization rates:

1. Address Seasonality and Operationalize the Adult Immunization Schedule
2. Ensure “No Wrong Door” to Vaccine Receipt—Making Access Easier
3. Embed an Equity Focus Across Adult Immunization Efforts

Coverage Expansions for Adult Vaccines under the IRA

The IRA closed longstanding gaps in adult vaccine coverage in the U.S. and strengthened access for more than 60 million adults in Medicare and Medicaid (Exhibit 1).^{12,13} Specific improvements were the elimination of cost sharing for Medicare Part D covered vaccines and, for adults in Medicaid, the requirement to cover all vaccines recommended by the Centers for Disease Control and Prevention’s (CDC’s) Advisory Committee on Immunization Practices (ACIP) without cost sharing.¹⁴ These policy changes result in 90% of Americans having coverage for vaccines recommended by the CDC’s ACIP without cost sharing.¹⁵

Exhibit 1. Impact of IRA on Adult Vaccine Coverage in U.S.

Program	Pre IRA	IRA Change	Estimated Impact
Medicare	Part D. Cost sharing permitted for vaccines (e.g., shingles)	Part D. Eliminated cost sharing	51.3 million Part D- enrolled beneficiaries ¹⁶
	Part B. No cost sharing for covered vaccines (e.g., flu, pneumonia, COVID-19)	Effective: January 2023	
Medicaid	Non-ACA Expansion Adults. Vaccine coverage not required, state variation in both coverage of vaccines and cost sharing	Non-ACA Expansion Adults. Expanded coverage to all ACIP-recommended vaccines without cost sharing	12.8 million non-ACA expansion, non-disabled adults ages 21-64 ^{17*}
	ACA Expansion Adults. Coverage for ACIP-recommended vaccines with no cost sharing	Effective: October 2023	

Affordable Care Act (ACA)

* This estimate excludes beneficiaries who are dually eligible for Medicare and Medicaid because they receive vaccine coverage through Medicare. Some disabled Medicaid adults not included in this estimate may also be impacted by the IRA provision. This estimate does not include adults ages 19-20 who have vaccine coverage through Medicaid.

Source: CapView Strategies Analysis

Current U.S. Vaccine Coverage Across the Life Course

While most Americans will now have insurance coverage for recommended vaccines without cost sharing, children had near universal coverage, even if uninsured, before passage of the IRA. This is largely due to the successful Vaccines for Children (VFC) program.¹⁸ VFC covers both children in Medicaid and those who are uninsured, although access may still be a challenge.¹⁹ Broad coverage of vaccines for children—augmented by well-established immunization schedules, a robust well-child visit calendar, and school vaccination requirements—has yielded a better than 90% vaccination rate among school-age children.^{20,21,22}

While most adults will now have coverage for recommended vaccines without cost sharing, some in the U.S. remain without full coverage. Nearly 25 million adults lacked coverage for recommended vaccines (excluding vaccines for COVID-19) in 2021 due to being uninsured.^{23,24} Further, some underinsured adults (e.g., those with short-term duration and grandfathered health plans that are exempt from ACA-mandated vaccine coverage) may lack coverage for all recommended vaccines with no cost sharing.²⁵ Also, approximately 12% of Medicare beneficiaries are not enrolled in a Part D plan and lack other sources of creditable drug coverage.²⁶ These beneficiaries are only covered for vaccines paid for by Part B.

Some funds are available for vaccines for uninsured or underinsured adults under Section 317 of the Public Health Service Act, and some states offer programs with limited vaccine access.²⁷ Otherwise, no national safety net program exists that ensures uniform access to vaccines for all uninsured or underinsured adults. Recently, there have been proposals, including in the Administration’s proposed FY2023 and FY2024 budgets, to create a Vaccines for Adults program, which is conceptually similar to VFC, for uninsured or underinsured adults.^{28,29} However, such a program will require Congressional action.

Exhibit 2. Coverage of Vaccines in the U.S. Across the Life Course

Coverage Type	Covered Vaccines	Cost Sharing Requirements
Commercial-Employer/Marketplaces*	All ACIP-recommended	No cost sharing
Medicare Part B	Covers statutorily specified vaccines including: <ul style="list-style-type: none"> • COVID-19 • pneumococcal • influenza (flu) • hepatitis B for adults at increased risk • vaccines directly related to the treatment of an injury or exposure 	No cost sharing
Medicare Part D**	All ACIP-recommended not covered under Medicare Part B	No cost sharing
Medicaid/CHIP***	All ACIP-recommended	No cost sharing
Uninsured/Underinsured Children (Through VFC)	All ACIP-recommended	No cost sharing
Uninsured Adults	Variable	Variable

* Excludes enrollment in short-term duration health plans or other grandfathered health coverage that does not include ACA provisions for vaccine coverage at no cost sharing.

** Not all Medicare beneficiaries are enrolled in Part D plans or have other prescription drug coverage.

*** Begins October 2023 for non-ACA expansion adults.

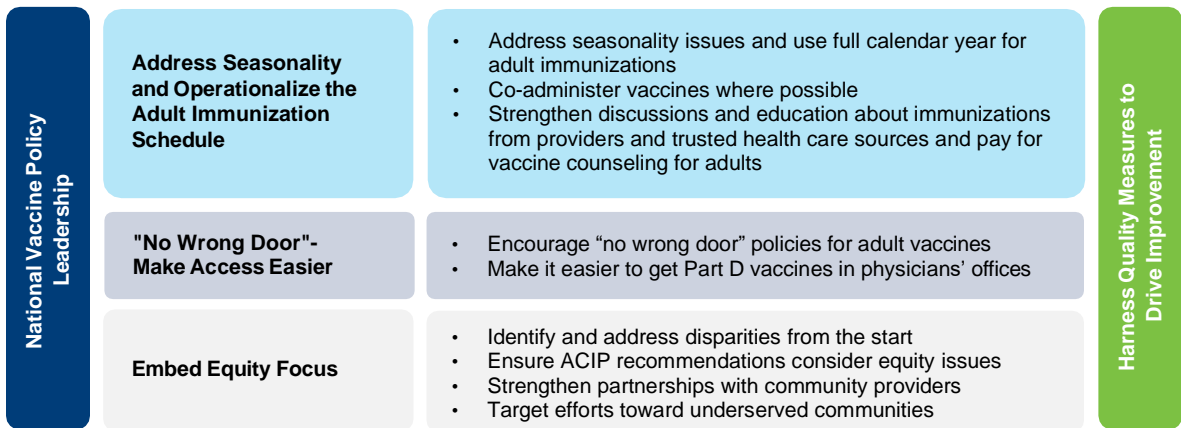
Source: CapView Strategies Analysis; Avalere Health, *Vaccine Coverage Requirements in the U.S.*, October 18, 2017.

Building on Coverage Expansions to Increase Adult Vaccine Uptake

The IRA’s expansion of coverage for adults and the spotlight on vaccines generated by the pandemic present opportunities to raise persistently low immunization rates.³⁰ Improvement is not assured, however. Addressing these issues and making important headway on adult vaccine uptake will require concerted federal leadership. Harmonizing federal immunization activities toward clear policy objectives and strengthening coordination across the Department of Health and Human Services (HHS) are essential for addressing longstanding issues. Policymakers should emphasize breaking down barriers to vaccination, especially for vulnerable groups, to support public health preparedness and pandemic response in the future.

Optimizing the receipt of vaccines included on the existing adult immunization schedule, maximizing access across more settings, and addressing equity will raise adult vaccine use. This will not only align stakeholders on actionable policy measures but will also increase accountability. Such actions will be pivotal as the Centers for Medicare and Medicaid Services (CMS) works to implement provisions of the IRA that expand coverage and access to Medicare and Medicaid beneficiaries. Finally, quality measures specific to adult immunizations, like the adult immunization status (AIS) measure, should be implemented broadly across programs to increase focus and efforts, and to better identify disparities in immunization rates (see Box 2).

Exhibit 3. Recommendations for Advancing Access to Adult Immunizations in U.S.



Source: CapView Strategies Analysis

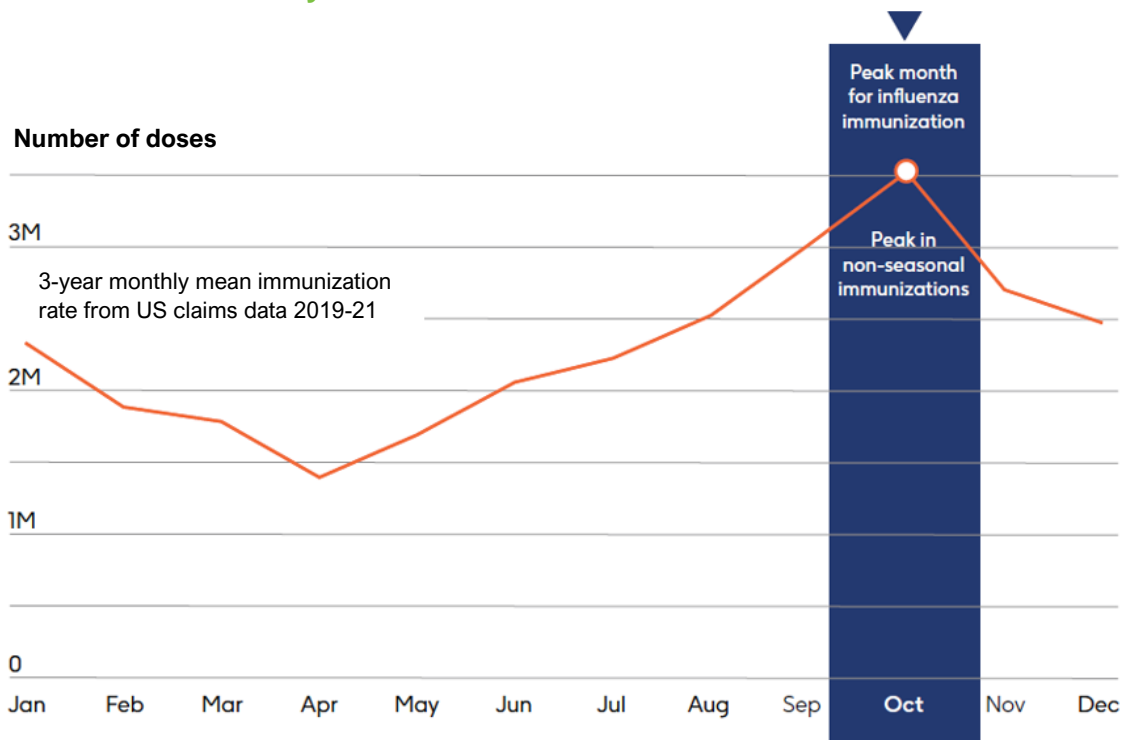
1. Address Seasonality and Operationalize the Adult Immunization Schedule

One challenge for adult immunization efforts is that the period when people usually receive recommended vaccines is concentrated in the fall and winter months of the year. This so-called “vaccine seasonality” may impact overall routine immunization rates if there are competing vaccine priorities during that narrow window.

Certain vaccines, such as influenza, need to be delivered during specified periods when there is a higher incidence of the disease.³¹ Other recommended vaccines can be delivered at different points throughout the year.

Challenges with seasonality arise because the adult vaccine schedule is becoming increasingly complex. The CDC compiles a complete list of ACIP-recommended vaccines for adults (persons age 19 and older) as part of the adult immunization schedule, which includes information on recommended use.³² There are currently nine age-based vaccines on the adult schedule. More vaccines, such as for respiratory syncytial virus (RSV) for adults, are expected to be added to the schedule in the near future. Further, some future pipeline vaccines may have more complex recommendations related to use and administration across populations.³³

Exhibit 4. Seasonality of U.S. Adult Vaccinations*



* Includes adults ages 19 years and older.
Source: IQVIA analysis of adult vaccine claims data available in Vaccine Track at www.vaccinetrack.com

It is important that vaccination efforts utilize the full calendar year to avoid competing with seasonal immunization peaks and to increase uptake of recommended vaccines. Further, as potentially more vaccines are recommended for the adult vaccination schedule, medical and public health practitioners will need to work with patients to clarify and prioritize timing to improve the receipt of all recommended vaccines. Such clarity will also help reduce vaccine burnout/fatigue.³⁴ Opportunities for co-administration should be encouraged so that patients receive multiple vaccines at the same time to reduce burden and optimize each vaccination session.

2. Ensure “No Wrong Door” to Vaccine Receipt—Making Access Easier

To improve vaccination uptake among adults, it is imperative to assure that vaccines are available in settings where patients are most likely to receive them—a “no wrong door” approach. For people who are mobile, physician offices, pharmacies, and community clinics are important sites. For those with limited mobility, vaccinations must be accessible to them, whether in long-term care settings or at home for homebound individuals.

To boost uptake of vaccines may require addressing structural barriers, such as expanding programs that support access for beneficiaries that may not be able to travel to traditional sites for immunization services. Operational barriers for providers may also need to be addressed, such as making it easier for physicians to bill for Medicare Part D vaccines delivered in their offices.

Box 1. Medicare’s Split Coverage for Vaccines – A Challenge for Administration in Physicians’ Offices

One barrier for some Medicare patients may be in receiving Medicare Part D vaccines in physician offices—resulting from billing challenges between physicians and Part D plans. Part D plans do not contract with physicians. They contract with pharmacies to provide prescription drug benefits. Physicians who administer Part D vaccines must bill those plans as out-of-network providers. Many physician practices, seeing this as an undue burden, may not provide Part D vaccines in their offices. A patient already at their physician’s office may find additional steps inconvenient and the likelihood that they will follow through with the vaccination may lessen. More than a few beneficiaries no doubt miss out on full vaccination as a result.

Exhibit 5. Medicare Coverage and Billing for Vaccines

Covered Vaccines	Medicare Billing
<p>Medicare Part B</p> <ul style="list-style-type: none"> • COVID-19 • pneumococcal • influenza • hepatitis B for adults at increased risk • vaccines directly related to the treatment of an injury or exposure 	<ul style="list-style-type: none"> • Physicians and other Medicare enrolled health professionals can bill across Part B settings (e.g., offices, hospitals) • Pharmacists are able to roster bill
<p>Medicare Part D</p> <ul style="list-style-type: none"> • All other ACIP-recommended vaccines (e.g., shingles and RSV, when available) 	<ul style="list-style-type: none"> • Pharmacists bill as Part D providers • Physicians bill Part D plans as out-of-network providers

Source: CapView Strategies Analysis; Hughes, Richard, "CMS Can Fix Medicare Vaccine Coverage to Protect Seniors From RSV," Health Affairs Forefront, March 30, 2023.

3. Embed an Equity Focus Across Adult Immunization Efforts

The COVID-19 pandemic highlighted historic disparities in health care access and outcomes and underscored inequities in vaccine access and uptake. Research on adult immunization rates reveals persistent disparities due to sociodemographic factors, coverage type, and geography.³⁵ Further, having access to a regular provider and routine preventive care is a key driver of vaccination rates and lack of regular care worsens disparities.^{36,37}

Data from the coronavirus experience shows outreach and other efforts to promote uptake of the primary series of COVID-19 vaccinations likely contributed to closing longstanding gaps in vaccination rates.³⁸ For instance, the COVID-19 response demonstrated the importance of engagement and partnership across key stakeholders, including community providers and pharmacists as well as targeted outreach to underserved or hard-to-reach populations. Lessons learned from these efforts should be applied more broadly for all vaccines across all populations to address equity more holistically.

As new ACIP-recommended vaccines become available, policymakers and other stakeholders must address equity from the start. It is not too early to factor equity goals into the process of making vaccine recommendations. ACIP recommendations should be clear and simple for all covered groups and should promote appropriate use among all populations. This includes recognizing that ACIP recommendations “with shared clinical decision-making” may inadvertently result in more limited vaccine use for patients lacking regular access to care or a regular provider.

Furthermore, all vaccine education and dissemination strategies must explicitly speak to overcoming the barriers—whether physical, financial, cultural, or attitudinal—that impede immunization equity. Importantly, partnering with trusted leaders and providers in underserved communities, for both outreach and opportunities to improve access, remains essential.

Box 2. Use of Quality Measures to Drive Immunizations and Promote Equity

Adoption of quality measures focused on immunizations would promote and incentivize improvements in vaccine use, and foster better monitoring and reporting of vaccinations, particularly if the measures are used in value-based payment programs.^{39,40,41} For adult immunizations, both the Prenatal Immunization Status (PRS) measure and the Adult Immunization Status (AIS) measure are composite measures that evaluate multiple immunizations recommended for adults.⁴²

The AIS measure includes several age-recommended vaccines including influenza, tetanus, and diphtheria (Td) or tetanus, diphtheria, and acellular pertussis (Tdap), zoster, and pneumococcal. Despite stakeholder interest in using the AIS measure more broadly to increase adult immunization rates, it has not been widely applied across programs to systematically assess vaccination performance.^{43,44,45}

CMS recently proposed to include the AIS measure in a core set of quality measures to use across programs, called the Universal Foundation measure set. Doing so will encourage greater vaccine use, reporting and monitoring.⁴⁶ Further, with the implementation of the Universal Foundation of quality measures, more consistent measure stratification affords an opportunity for CMS to track demographic and social factors to address disparities in coverage and care across all CMS programs.

Conclusion

At this crucial juncture, U.S. policymakers, advocates and other stakeholders must commit to leveraging the momentum of the IRA and the impact of the pandemic to improve adult immunization rates. They must advance policies and programming to overcome persistent challenges with vaccination rates, especially for adults. Addressing these challenges requires a commitment to create a national strategy with a focus on three key issues—seasonality, making vaccine access easier, and addressing equity.

Endnotes

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