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Editorial Comment: Changing the Rules in Vaccine Coverage for Vulnerable Populations

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Abstract

Increasing life expectancy through decreasing vaccine preventable deaths is a hallmark of modern public health in the United States (1). Two federal vaccine programs help insure coverage for vulnerable populations. The Vaccines for Children (VFC) Program provides vaccines to eligible children[1] at no cost, removing financial barriers to vaccinations. Close to half of US children and 30 percent of adolescents are vaccinated through the VFC program yearly (2). The federal Section 317 Immunization Grant Program (Section 317) complements VFC by supporting the national immunization infrastructure, primarily immunization workforce, delivery systems, and emergency response, as well as by providing vaccines for non-VFC eligible financially vulnerable populations.

Increasing life expectancy through decreasing vaccine preventable deaths is a hallmark of modern public health in the United States (1). Two federal vaccine programs help insure coverage for vulnerable populations. The Vaccines for Children (VFC) Program provides vaccines to eligible children[i] at no cost, removing financial barriers to vaccinations. Close to half of US children and 30 percent of adolescents are vaccinated through the VFC program yearly (2). The federal Section 317 Immunization Grant Program (Section 317) complements VFC by supporting the national immunization infrastructure, primarily immunization workforce, delivery systems, and emergency response, as well as by providing vaccines for non-VFC eligible financially vulnerable populations.

Before the new policy took effect on October 1 2012, states could use Section 317 funds at their discretion and immunize any child, regardless of insurance status, at no cost. With the policy change, states can no longer use Section 317 vaccine for insured individuals with vaccine coverage (3). The CDC maintains that gaps in vaccine coverage will exist only for underinsured children not vaccinated at a Federally Qualified Health Center (FQHC) or Rural Health Center (RHC) and uninsured adults. The resulting savings are intended to strengthen the national immunization infrastructure (2).

Knight et. al use immunization data from Eastern Tennessee to determine if changes in Section 317 rules had a significant effect on vaccine uptake, comparing pre- (FY12) and post- (FY13) policy change median monthly vaccine counts for each of seven vaccine types required by the State of Tennessee for admission to school plus Hepatitis A. Analyses were conducted by age group: birth – 5 and 6 – 18. Results indicate significant differences in vaccine uptake only for 0 – 5 year olds and only for two vaccines; monthly uptake decreased for Hepatitis A&B, while uptake for *H. influenza* type B increased. Although these results are idiosyncratic, they suggest that changes to Section 317 have not had a substantial or immediate effect on uptake.

This study is important, as it examines the nuanced impact of changes brought about by ACA on a fundamental public health service. There is reason to suspect that changes to Section 317 might have unintended, negative consequences. Recent work in Colorado (4) has raised concerns that insured individuals with vaccine coverage might seek vaccines outside their provider network for a number of reasons. These include geographic or financial barriers that limit client mobility or access, client confusion or lack of awareness regarding access, and providers who do not stock all of the recommended vaccines. These issues are likely of particular concern in more rural, medically underserved areas. Results from the Tennessee study do not appear to support these concerns.

Not known is the degree to which local health departments complied with the recent changes to policy and since vaccines delivered by payor type is not examined in this study, it

[i] Ages 0-18 – Medicaid-eligible, uninsured, American Indian or Alaska native, or underinsured when receiving care at a FQHC or RHC.

is not known if cost savings envisioned for the Section 317 program were achieved. Consequently, it will be important to monitor vaccine uptake over time, as the new guidance becomes routine.

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