

The Future of the Section 317 Program

Melinda Wharton, MD, MPH

*Acting Director, Immunization Services Division
National Center for Immunization & Respiratory Diseases*

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History of the 317 Immunization Program

- ❑ **1955: Polio Vaccination Assistance Act**
- ❑ **1962: Vaccination Assistance Act**
 - *Allowed CDC to support mass immunization campaigns and support ongoing immunization activities*
 - *Provided vaccine and personnel to State and Local Health Departments*
- ❑ **1963: First grants, authorized under Section 317 of the Public Health Service Act**
- ❑ **1992: Funding to support direct delivery of immunization services**

Section 317 Vaccine Funding: Past

- ❑ Focus evolved over time but provided a safety net**
- ❑ Vaccines were fewer and not so expensive**
- ❑ If a family could not afford vaccines, the provider could refer them to the health department**

The Measles Epidemic

The Problems, Barriers, and Recommendations

The National Vaccine Advisory Committee

The nation has experienced a marked increase in measles cases during 1989 and 1990. Almost one half of all cases have occurred in unvaccinated preschool children, mostly minorities. The principal cause for the epidemic is failure to provide vaccine to vulnerable children on schedule. Major reasons for the low vaccine coverage exist within the health care system itself, which creates barriers to obtaining immunization and fails to take advantage of many opportunities to provide vaccines to children. Ideally, immunizations should be given as part of a comprehensive child health care program. However, immunization cannot await the development of such an ideal system. Essential changes can and should be made now. Specific recommendations include improved availability of immunization; improved management of immunization services; improved capacity to measure childhood immunization status; implementation of the two-dose measles vaccine strategy; and laboratory, epidemiologic, and operational studies to further define the determinants of decreased vaccine coverage and to develop new combinations of vaccines that can be administered earlier in life. The measles epidemic may be a warning flag of problems with our system of primary health care.

(*JAMA*. 1991;266:1547-1552)

school- and college-age students who had not been vaccinated or who had been vaccinated unsuccessfully. Because vaccine failure remains a problem, beginning in 1989, a second dose of vaccine was recommended to be administered at the time of enrollment in either primary school or middle or junior high school.^{2,3} Since this is a long-term solution requiring 7 to 13 years to reap the full benefits, aggressive revaccination during school-based outbreaks will be needed in the interim.

Studies reveal no change in the effectiveness of the vaccine during recent years (G. E. King, MD, unpublished data, 1991). The vaccine, licensed and in use since 1963, protects about 95% of those who receive it. About three fourths of those with measles during

Vaccines for Children Program (VFC)

- ❑ **Created by the 1993 Omnibus Budget Reconciliation Act, operational since October 1994**
- ❑ **Eligible children (through age 18 yrs): Medicaid eligible, uninsured, American Indian/Alaska native, underinsured in Federally-Qualified Health Centers or Rural Health Centers**
- ❑ **Legislation gives the Advisory Committee on Immunization Practices the authority to determine the vaccines that will be provided in the VFC Program**
- ❑ **VFC is a federal entitlement program**

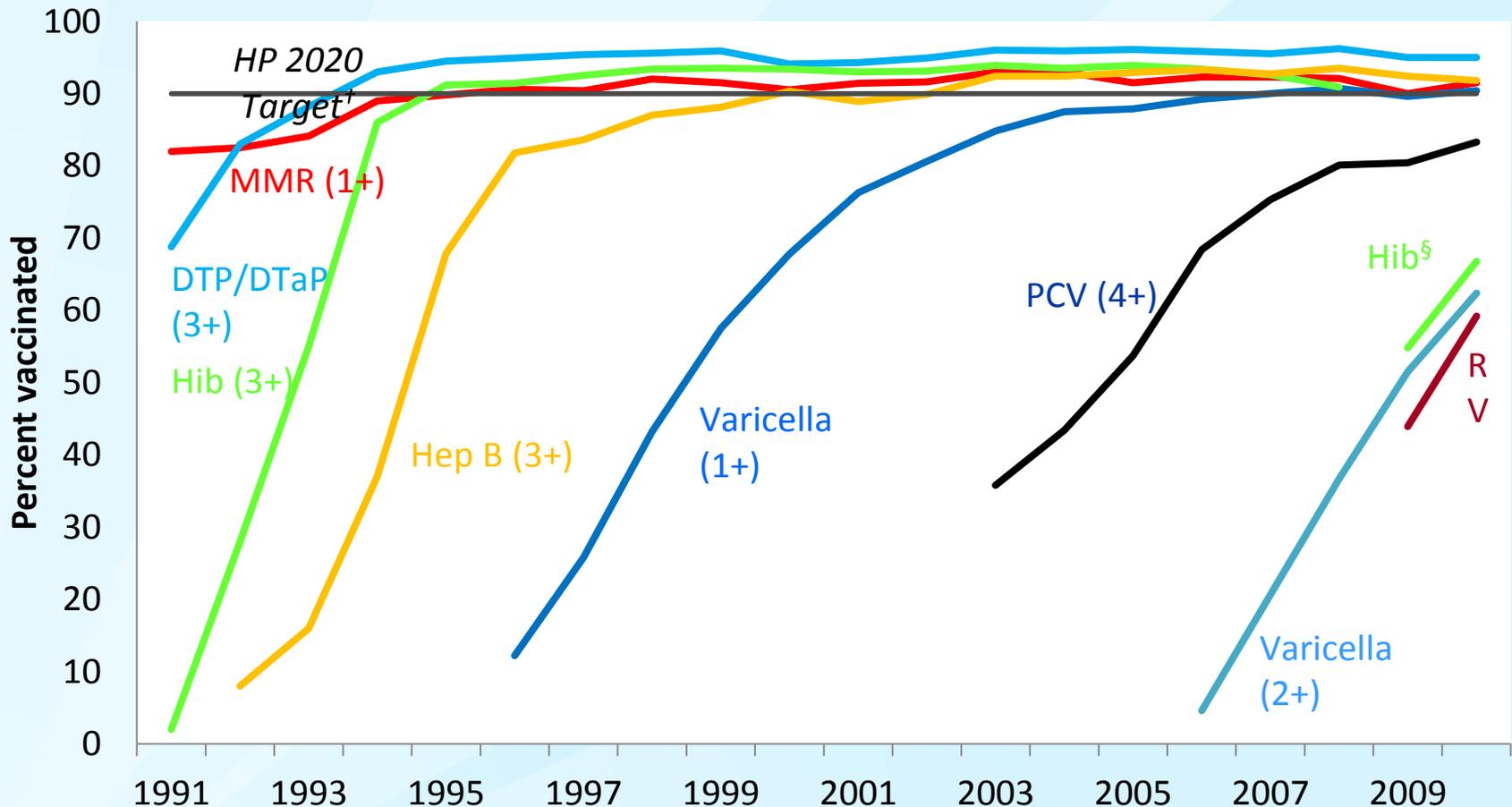
<http://www.cdc.gov/vaccines/programs/vfc/default.htm>

<http://www.cdc.gov/vaccines/programs/vfc/providers/acip-what-is.htm>

FIGURE 1: Recommended immunization schedule for persons aged 0 through 6 years—United States, 2012 (for those who fall behind or start late, see the catch-up schedule [Figure 3])

Vaccine ▼	Age ►	Birth	1 month	2 months	4 months	6 months	9 months	12 months	15 months	18 months	19–23 months	2–3 years	4–6 years	
Hepatitis B ¹	Hep B	Hep B	Hep B			Hep B								Range of recommended ages for all children
Rotavirus ²				RV	RV	RV ²								
Diphtheria, tetanus, pertussis ³				DTaP	DTaP	DTaP	<i>see footnote³</i>	DTaP					DTaP	
<i>Haemophilus influenzae</i> type b ⁴				Hib	Hib	Hib ⁴		Hib						Range of recommended ages for certain high-risk groups
Pneumococcal ⁵				PCV	PCV	PCV		PCV				PPSV		
Inactivated poliovirus ⁶				IPV	IPV	IPV						IPV		
Influenza ⁷						Influenza (Yearly)								
Measles, mumps, rubella ⁸								MMR		<i>see footnote⁸</i>			MMR	Range of recommended ages for all children and certain high-risk groups
Varicella ⁹								Varicella		<i>see footnote⁹</i>			Varicella	
Hepatitis A ¹⁰								Dose 1 ¹⁰			HepA Series			
Meningococcal ¹¹								MCV4 — <i>see footnote¹¹</i>						

Estimated Vaccination Coverage, among Children 19-35 Months of Age, 1991-2010*



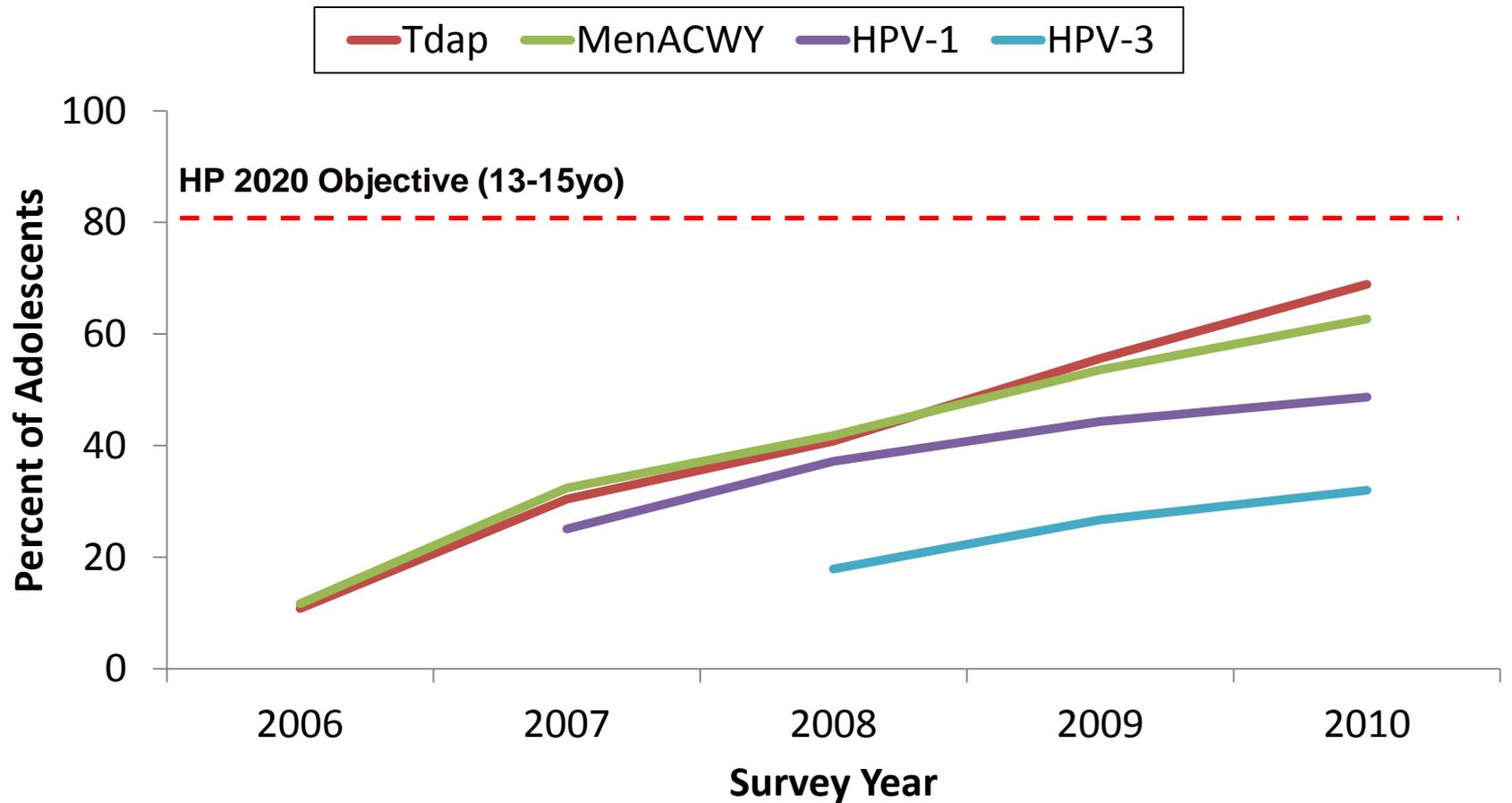
* Source: NHIS (1991-1993); NIS (1994-2010) children 19-35 months and NIS-Teen (2006-2010) teens 13-15 years

† Target is 80 percent for Rotavirus, Tdap (1+), MCV4 (1+), HPV (3+) and 90% for varicella (2+)

§ Full series Hib (≥3 or ≥4 doses, depending on product type received). Brand of Hib vaccine received was not collected on the NIS prior to 2009.

¶ Among females

Estimated Vaccination Coverage among Adolescents Aged 13-17 Years – NIS-Teen 2006-2010



**2006: HPV-1 was not reported; 2007: HPV-3 was not reported*

Estimated Vaccine Coverage Among Adults, 2010

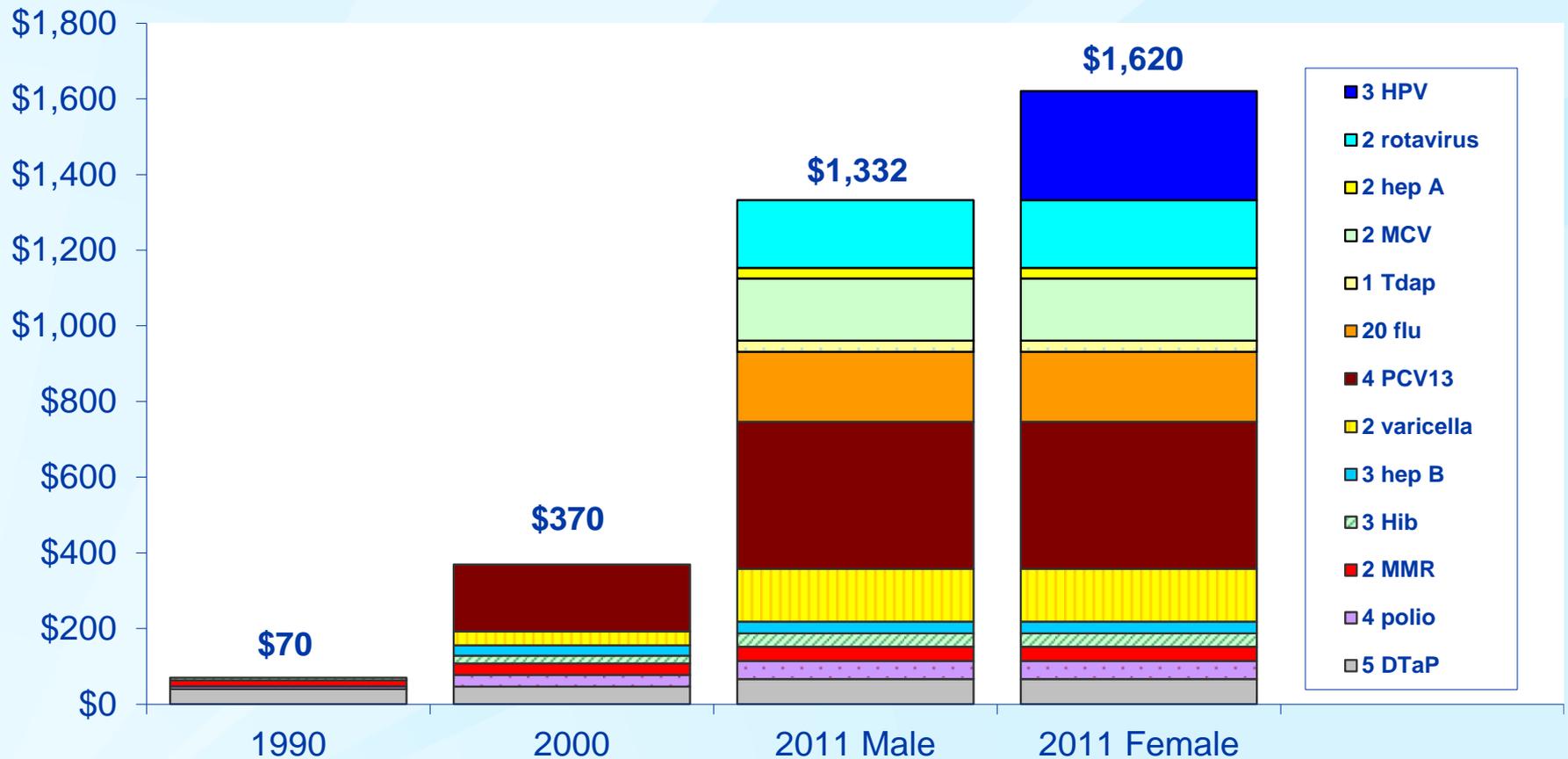
- ❑ **Pneumococcal vaccine ≥ 65 years – 59.7%**
- ❑ **Tdap, past 5 years, 19-64 years – 8.2%**
- ❑ **Hepatitis B vaccine, 19-49 years, high risk – 42.0%**
- ❑ **Herpes zoster vaccine, ever, ≥ 60 years – 14.4%**
- ❑ **HPV vaccine, ≥ 1 dose females 19-26 years – 20.7%**
- ❑ **Influenza vaccine, ≥ 65 years, 2010-2011 season – 66.6%**
- ❑ **Healthcare personnel**
 - *Tdap (<65 years, last 5 years) – 20.3%*
 - *Hepatitis B vaccine (≥ 19 years, ≥ 3 doses) – 63.2%*
 - *Influenza (2010-11 season) – 63.5%*

National Health Interview Survey, 2010, MMWR 2012;61:66-72

http://www.cdc.gov/flu/professionals/vaccination/coverage_1011estimates.htm

Lindley M et al, <http://www.cdc.gov/flu/professionals/vaccination/health-care-personnel.htm>

Cost to Vaccinate One Child with Vaccines Universally Recommended from Birth Through 18 Years of Age: 1990, 2000, and 2011



2011 represents minimum cost to vaccinate a child (birth through 18); exception is no preservative influenza vaccine, which is included for children 6-47 months of age.

HPV excluded for boys because it is not routinely recommended by the ACIP.

Federal contract prices as of February 1, 1990, September 27, 2000, and April 1, 2011.

Challenges for Private & Public Sectors

❑ Private immunization providers:

- *Up front investment to stock more expensive vaccines*
- *Reimbursement uncertain or inadequate to cover costs*

❑ Public sector:

- *VFC grew as the need grew, but Section 317 funding did not*
- *More complex and more expensive program needed*
 - *New providers and new age groups*
 - *New surveillance systems*
 - *New coverage assessments*
 - *New professional education needs*
 - *New communication issues*

The Problem of the Underinsured

- ❑ **Children who are covered by private insurance that does not cover all the costs of all recommended vaccines are considered underinsured**
 - *Some insurance plans do not cover ACIP-recommended vaccines*
 - *Parents or guardians may be responsible for some or all of the cost of vaccination because of high deductibles and/or co-payments*
- ❑ **Many families can and do pay these out-of-pocket costs, but for some they are a financial burden and an economic barrier to vaccination**
- ❑ **Some underinsured children are ineligible for VFC vaccine except at FQHCs and RHCs (~3000 clinics)**

Section 317 Vaccine Funding: Present

- Underinsured children**
- Insured children**
- Outbreak control**
- Adults**

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The Affordable Care Act (ACA), 2010

- ❑ New health insurance plans must provide coverage for ACIP recommended vaccines without deductibles or co-pays, when delivered by an in-network provider**
- ❑ As the new plans are written and existing plans lose their grandfathered status, the number of underinsured children and adults should be decreasing**
- ❑ Although some uncertainties around the ACA remain, with full implementation over the next several years expect that the problem of the underinsured should largely be solved**

Federal Budget Realities

- ❑ **Great pressure to decrease Federal spending**
- ❑ **Expectation that the need for Section 317 vaccine purchase will decrease as health insurance coverage expands**

The Challenge of An In-Network Provider for Every Person with Insurance

- ❑ **Not all primary care providers provide all ACIP-recommended vaccines**
 - *Investment needed to become a vaccinator*
 - *Small number of eligible patients in practice*
 - *Reimbursement rates inadequate*
- ❑ **In some communities, health department immunization services are seen as convenient and more accessible than an in network provider**
- ❑ **Health departments that provide immunization services to insured persons need to identify funds other than 317 vaccine funding for vaccine purchase**

An In-Network Provider for Every Person with Insurance: A Shared Responsibility

- ❑ In-network providers need to be accessible in every community**
- ❑ In-network providers need to provide all recommended vaccines**
- ❑ Medical organizations need to help providers learn to become immunizers**
- ❑ Industry needs to help providers obtain initial vaccine stocks**
- ❑ Public health departments that serve insured people need to do so as in-network providers**
- ❑ Policymakers need to establish policies that facilitate these steps**

Where We Should End Up

- ❑ **Continued shared responsibility between public and private sectors**
- ❑ **For the insured, insurance should assure access to ACIP-recommended vaccines for both children and adults**
- ❑ **VFC will continue to provide vaccines for uninsured children, children eligible for Medicaid, and American Indian/Alaska Native children**
- ❑ **Section 317 vaccine funding should be able to help meet remaining needs**
 - *Uninsured adults*
 - *Maintain or improve our ability to respond to outbreaks*
 - *Support preparedness*

Section 317 Operations Funding

- ❑ **These funds provide critical support for the people and systems that make immunization programs work**
 - *Recruiting immunization providers*
 - *Quality assurance and provider education*
 - *Surveillance of vaccine-preventable diseases*
 - *Response to outbreaks of vaccine-preventable diseases*
 - *Immunization information systems*
 - *Assessment of immunization coverage*
 - *Vaccine safety monitoring*
- ❑ **317 operations funding is critical for the implementation of the Vaccines for Children Program.**

Vaccine Storage and Handling: Three Critical Components

❑ **Reliable and appropriate equipment**

- *Vaccine storage unit*
- *Temperature monitoring equipment*

❑ **Knowledgeable staff**

- *Designated person to handle storage and handling*
- *Train all staff on vaccine storage and handling*

❑ **Written storage and handling plans**

- *Routine storage and handling of vaccines*
 - *Ordering and accepting vaccine deliveries*
 - *Storing and handling vaccines*
 - *Managing inventory*
 - *Managing potentially compromised vaccines*
- *Emergency vaccine retrieval and storage*

Response to Outbreaks of Vaccine- Preventable Diseases

- ❑ **Epidemiologic investigation**
 - *Case identification and investigation*
 - *Settings of exposure and transmission*
 - *Vaccine failure or failure to vaccinate*
- ❑ **Control measures**
 - *Isolation and quarantine*
 - *Vaccination*
 - *Antimicrobial prophylaxis*
- ❑ **Resource-intensive efforts, and most carried out by state and local public health**
- ❑ **Importance of laboratory support**

Where We Want to End Up

- ❑ Protecting our communities from vaccine-preventable diseases**
- ❑ Maintaining or improving our capacity to respond to public health threats**
- ❑ Protecting the most vulnerable in our communities**

For more information please contact Centers for Disease Control and Prevention

1600 Clifton Road NE, Atlanta, GA 30333

Telephone, 1-800-CDC-INFO (232-4636)/TTY: 1-888-232-6348

E-mail: cdcinfo@cdc.gov Web: www.cdc.gov

The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.

National Center for Immunization & Respiratory Diseases

Immunization Services Division



Modernizing Immunization Programs

- ❑ **Information technology initiatives**
 - *“Meaningful use” and interoperability of immunization information systems with electronic health records*
 - *Barcoding to more accurately capture vaccine type, manufacturer, lot number, and expiration date*
 - *Modernizing vaccine ordering and inventory management at the provider and program level*
- ❑ **Using immunization information systems, electronic health records, and other technology to improve coverage**
- ❑ **Billing for vaccines administered to fully insured persons in public health clinics**