Principles on Section 317 Vaccine Purchase Funding Allocation

Background

Section 317 of the Public Health Services Act authorizes funds for state immunization grants to support the reduction of vaccine-preventable disease through the maintenance of high immunization coverage rates. Grants to states come in two forms: (1) Direct Assistance (DA), which is for the purchase of vaccines, and (2) Financial Assistance (FA) which states can use for various programmatic activities like outreach, surveillance and outbreak control.

Section 317 vaccine purchase (DA) grants are intended to allow grantees to provide vaccine for populations at greatest risk for undervaccination and disease. The emphasis has historically been placed on children whose health insurance does not cover immunizations, but the program is authorized to support vaccine purchase for children and adults.

Funding for Section 317 vaccine purchase has not kept pace with need, and is inadequate to support vaccine purchase for all children and adults who are without other private or public immunization coverage. According to the Institute of Medicine, 14.5% of children aged 0-17 are underinsured for immunization[1] and half of all adults aged 18-64 lack immunization coverage, with 32% of this population (29 million adults) considered to be at high risk for contracting vaccine-preventable disease and/or its complications.[2] Despite the tremendous need, Section 317 vaccine purchase grants serve only 11% of the childhood population and less than 5% of 317 vaccine purchase funding is spent on adults.

Allocation of Section 317 vaccine purchase funds varies tremendously by state, with some states receiving more than two dollars per capita and others receiving less than a quarter. Public vaccine program eligibility and health insurance coverage also vary tremendously by state: some states require health insurance to cover immunization and some don't; state laws don't apply to self-insured or multi-state plans; and some states are able to provide vaccine for underinsured children at public health facilities while some are not.

Principles

- The 317 DA program should be adequately funded in order to support vaccine purchase for children and adults not covered for immunization by private insurance or other programs.

- Section 317 resources should be allocated uniformly in a predictable, defensible, equitable fashion based on safety net need. Allocation methods should be clearly defined.

- Transition to a uniform allocation method should take place over time and ideally, with additional funding. If additional funding is not available, grantee funding reductions should be phased in with grantees annually receiving at least 95% of their previous year's funding.

- Grantees should be given flexibility to spend Section 317 vaccine purchase funding in a way that supports their state and local immunization goals.

- In the event that grantees do not receive funding to meet the full scope of their needs, grantees should prioritize limited funding to support underserved children in their medical home.

- All stakeholders of immunization throughout the lifespan should work collaboratively to raise awareness of the need for vaccine in underserved populations and to increase funding support for Section 317.

- Where applicable, state and federal policies and laws should be pursued to require all health insurance plans to cover immunization and to uniformly provide vaccine to those without insurance coverage.

[1] Institute of Medicine: *Financing Vaccines in the 21st Century: Assuring Access and Availability*. The National Academies Press, Washington, D.C., 2004; p. 64.

[2] Ibid., p. 89.