



Uninsured and Not Immune — Closing the Vaccine-Coverage Gap for Adults

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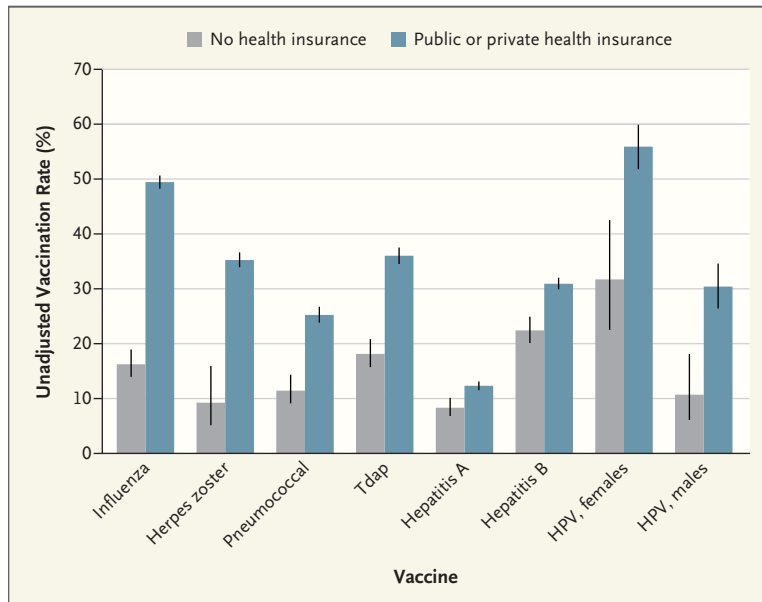
The U.S. Covid-19 vaccination strategy was simple: get safe and effective vaccines into arms as quickly as possible by making them free and accessible. This strategy worked: more

than 670 million Covid-19 vaccine doses had been administered to more than 270 million Americans by the end of the national public health emergency. As we look toward the fall, Covid-19 vaccines — the most effective tool for preventing severe disease — will largely be moving to the commercial market, where access to vaccines is often limited for adults without health insurance.

In keeping with its pandemic-long goal of promoting equitable access to Covid-19 vaccines, the Biden administration in April 2023 introduced the Health and Human Services Bridge Access Program for Covid-19 Vaccines and Treatments to cover Covid-19 vaccines for uninsured people through 2024. Conceived of as a tempo-

rary solution until a more comprehensive vaccine-access plan can be authorized and funded by Congress, the program would utilize more than \$1 billion of Covid-19 funds to distribute Covid-19 vaccines to state and local health departments and associated providers, clinics supported by the Health Resources and Services Administration (HRSA), and pharmacies. The fact that this program had to be created from scratch — with funding identified, contracts modified, and timelines and end points designated — speaks to the need for a sustainable, comprehensive vaccine program for uninsured adults, to provide protection against vaccine-preventable diseases for both eligible participants and the general public.

A federal Vaccines for Adults (VFA) program was proposed in President Joe Biden's fiscal year 2023 budget but wasn't funded and has been proposed again for fiscal year 2024. Building on the framework of the U.S. Vaccines for Children (VFC) program, now in its 30th year, the VFA program would purchase vaccines for uninsured adults at discounted prices and then work with state and local health departments to distribute them to enrolled providers. When fully implemented, the program would offer free access to the 14 routine vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) for roughly 23 million uninsured adults between 19 and 64 years of age (about 12% of working-age adults in the United States). It would also be a vehicle for enhancing coverage of vaccines that may be recommended in the



Unadjusted Vaccination Rates for Selected ACIP-Recommended Vaccines for Adults, by Health Insurance Status.

Data are from the National Health Interview Survey and are from 2018.³ Vaccines include the influenza vaccine (one dose during the 2017–2018 influenza season among adults ≥ 19 years of age); the herpes zoster vaccine (at least one dose of live or recombinant vaccine among adults ≥ 60 years of age); the pneumococcal vaccine (at least one dose of any type of the vaccine among adults 19 to 64 years of age with risk factors); the tetanus, diphtheria, and pertussis (Tdap) vaccine (one dose during the preceding 10 years among adults 19 to 64 years of age); the hepatitis A vaccine (two doses among adults ≥ 19 years of age); the hepatitis B vaccine (three doses among adults ≥ 19 years of age); and the human papillomavirus (HPV) vaccine (at least one dose among adults 19 to 26 years of age). Error bars indicate 95% confidence intervals of the estimated unadjusted vaccination rates. ACIP denotes Advisory Committee on Immunization Practices.

future, such as those for respiratory syncytial virus, and could support responses to outbreaks of both known pathogens, such as meningococcal meningitis or hepatitis A, and unknown pathogens.

To be recommended by the ACIP, vaccines must undergo a comprehensive review process, which includes examination of safety, efficacy, and cost-effectiveness data. Even before the Covid-19 pandemic, lack of vaccination was associated with substantial costs; estimated health care costs and productivity losses associated with vaccine-preventable diseases among unvaccinated adults totaled \$7.1 billion in 2015, for example, much of which was related to influenza.¹ Covid-19 vaccines were estimated to have

saved more than \$1 trillion in medical costs in the first 2 years² — nearly 30 times the U.S. government’s investment in Covid-19 mRNA vaccine research, production, and purchase through that period, as estimated by the Kaiser Family Foundation. Despite the public health and cost-related benefits of vaccination, coverage rates for recommended routine immunizations for adults are low, especially among uninsured people (see graph).³ Given that the United States spends \$4.3 trillion per year on health care, we believe it should be an easy decision to spend less than \$2 billion per year on reducing the vaccine-coverage gap between insured and uninsured adults by improving access to safe, effective, and cost-effec-

tive — if not cost-saving — vaccines.

The recent expansion of Medicare and Medicaid reimbursement to include all ACIP-recommended routine vaccines for adults under the Inflation Reduction Act, which ensures coverage without cost sharing for approximately 100 million people, represents a major step toward universal access. Although this expansion dramatically reduces the number of people without access to routine vaccines, it doesn’t address coverage for uninsured adults. Currently, uninsured adults have limited access to routine immunizations without cost sharing, as part of patient-assistance programs sponsored by pharmaceutical companies and through local and state health departments and HRSA-supported clinics. The administrative hurdles imposed in patient-assistance programs — which often involve requirements that both the eligible patient and the provider submit applications for each vaccine dose — and annual quotas for health facilities limit the reach of these programs. The CDC divides approximately \$70 million (11% of its discretionary immunization funding) among state and local health departments for purchasing and administering adult immunizations, which is insufficient to meet the current need. Because of this limited budget, higher-cost vaccines, such as the shingles vaccine, may not be provided at all in some states.

The success of the VFC program highlights the potential impact of a program focused on adult immunization. Adopted to address barriers to pediatric vaccine uptake after a national measles resurgence resulted in 11,000 hospitalizations and 123 deaths among children between 1989 and

1991, the VFC program has supplied and helped deliver more than 1.3 billion vaccine doses since it was implemented in 1994. After the CDC purchases discounted ACIP-recommended childhood vaccines using VFC program funds, it distributes them through state and local health departments to more than 44,000 participating providers. The program covers children who are uninsured or underinsured, eligible for Medicaid, or members of American Indian or Alaska Native communities. Although vaccination rates transiently decreased during the Covid-19 pandemic, increases in vaccination rates for all children and reductions in disparities between White children and children from historically marginalized racial and ethnic groups have endured since the program's implementation. For example, in 1993, rates of measles vaccine coverage among children between 19 and 35 months of age were 86% for White children and 77% for Black children⁴; in 2021, such rates by 24 months of age were 93% and 88%, respectively.⁵

Vaccine costs are a well-recognized barrier to access, are often highest for uninsured people, and contribute to disparities in adult vaccination rates by insurance status. But the national free-to-patients Covid-19 vaccination program demonstrated that out-of-pocket costs aren't the only impediment to vaccination; limited numbers of vaccination sites in rural settings and areas with low concentrations of primary care providers and failure to disseminate straightforward, trusted information about vaccines also hinder uptake among adults. To address some of the challenges that disproportionately affect vaccine access among adults, the VFA program could reimburse various

providers — including pharmacies in medically underserved areas — for vaccine administration to defray costs and encourage participation. The program could also facilitate the availability of discretionary funds for activities by community-based organizations and other partners aimed at achieving vaccine equity and boosting public confidence in vaccination.

A postpandemic VFA program that was congressionally authorized and funded by means of appropriations could also benefit from recent advances in public health infrastructure. During the pandemic, the CDC supported the development of new vaccine-delivery systems to better serve adults' needs, which included expanding access to vaccines in pharmacies and through other new vaccine providers. The need to monitor and report rates of Covid-19 vaccine coverage gave the CDC and public health partners the opportunity to further modernize and standardize immunization information systems. These vaccine-coverage data were used by the CDC and jurisdictions to inform public health actions. Recognizing the associated benefits, nearly all jurisdictions plan to continue sharing Covid-19 vaccination data with the CDC; some jurisdictions have also begun sharing data on other vaccines for adults. Having data on vaccine coverage among adults would be key to a successful VFA program, since it would allow the agency to swiftly identify areas with limited vaccine access, such as some rural or urban areas with lower access to primary care services, and to address related challenges.

The United States made enormous investments in vaccine development and distribution and in secure data collection during

the Covid-19 pandemic. If we continue to move forward without access to vaccines, including long-term access to Covid-19 vaccines, for uninsured adults, we will neglect an important opportunity for advancing health and economic benefits in this population, which includes many essential workers, caregivers, recent college graduates, and others. Building on the success of the VFC program and associated discretionary funding supporting immunization infrastructure, the VFA program has the potential to be a low-cost, high-reward initiative that could help achieve the essential goal of ensuring vaccine availability throughout the life span.

Disclosure forms provided by the authors are available at NEJM.org.

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1. Ozawa S, Portnoy A, Getaneh H, et al. Modeling the economic burden of adult vaccine-preventable diseases in the United States. *Health Aff (Millwood)* 2016;35:2124-32.
2. Fitzpatrick MC, Moghadas SM, Pandey A, Galvani AP. Two years of U.S. COVID-19 vaccines have prevented millions of hospitalizations and deaths. *To The Point (blog)*. New York: Commonwealth Fund, December 13, 2022 (<https://www.commonwealthfund.org/blog/2022/two-years-covid-vaccines-prevented-millions-deaths-hospitalizations>).
3. Lu P-J, Hung M-C, Srivastav A, et al. Surveillance of vaccination coverage among adult populations — United States, 2018. *MMWR Surveill Summ* 2021;70:1-26.
4. Centers for Disease Control and Prevention. Vaccination coverage of 2-year-old children — United States, 1993. *MMWR Morb Mortal Wkly Rep* 1994;43:705-9.
5. Hill HA, Chen M, Elam-Evans LD, Yankey D, Singleton JA. Vaccination coverage by age 24 months among children born during 2018–2019 — National Immunization Survey-Child, United States, 2019–2021. *MMWR Morb Mortal Wkly Rep* 2023;72:33-8.

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