Biotechnology Innovation Organization
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February 3, 2025

Chair Michele Meyer
Chair Henry Ingwersen
Joint Committee on Health and Human Services
Maine House of Representatives

Dear Chairperson Meyer, Chairperson Ingwersen, and Members of the Committee:

The Biotechnology Innovation Organization and our members share the Committee's goal in increasing access to health care and public health programs and services, including vaccination. However, we write to express our **opposition to Maine LD 93**, which would expand the Universal Purchase (UP) program for vaccines to include adults in Maine. BIO is the world's largest trade association representing biotechnology companies, academic institutions, state biotechnology centers, and related organizations across the United States and in more than 30 other nations. BIO membership includes vaccine developers and manufacturers who have worked closely with the public health community to support policies that help ensure access to innovation and life-saving vaccines for all individuals.

Vaccines are one of the greatest success stories in public health. Routine childhood vaccinations have prevented hundreds of millions of cases of illness, millions of deaths, and have resulted in trillions of dollars of savings in societal costs in the US alone.[1] Vaccines against infectious diseases including measles, mumps, rubella, pertussis, diphtheria, tetanus, hepatitis B, and varicella have been administered for decades, preventing disease and illness in millions of individuals globally. As a result of successful and ongoing vaccination efforts measles, rubella, diphtheria, polio, and smallpox have been eliminated in the US.[2] However, progress in achieving high immunization rates for adults has seen much slower progress. We are supportive of efforts to increase access to vaccines, and consequently, increase immunization rates to protect people across the lifespan, but enacting UP for adults is not guaranteed to achieve this objective and could create additional challenges:

1. UP programs have not been shown to increase immunization rates consistently.
2. UP programs for adults take advantage of a Federal program designed for uninsured adults.
3. UP programs are duplicative of existing coverage and may limit access to vaccines for providers and patients.
4. UP programs do not eliminate administrative complexity.
5. UP programs may disrupt supply chains and safeguards against shortages.

[1] https://www.cdc.gov/mmwr/volumes/73/wr/mm7331a2.htm
[2] https://www.nejm.org/doi/10.1056/NEJMms1215400?url_ver=Z39.88-2003&rfr_id=ori:rid:crossref.org&rfr_dat=cr_pub%20%200pubmed

6. UP programs have resulted in immunization programs serving as a source of state funding for non-vaccine programs.

UP programs have not been shown to increase immunization rates consistently

Childhood UP programs have demonstrated that the use of assessments for vaccine purchasing does not necessarily drive us to our mutual goal of high immunization rates. Studies have found no association between the implementation of a UP program and an increase in vaccination coverage rates.[3] When the CDC researched increased coverage rates for the seven most improved programs from 2001 to 2004, none cited universal funding or the ability to provide free vaccines for all children as the reason for increased coverage.[4]

UP programs for adults take advantage of a Federal program designed for uninsured adults

As part of the funding that comes from Section 317 of the Public Health Services Act, the Centers for Disease Control and Prevention (CDC) is authorized to contract with vaccine manufacturers to negotiate prices for vaccines specifically for uninsured and underinsured adults. These federal contracts are designed in collaboration with industry to ensure that the most vulnerable have access to immunizations at a discount.

A distortion in the volume of vaccine under the 317 program could adversely impact the weight and composition of the rest of the vaccine market. As this occurs, the government's purchasing power could diminish, undermining its ability to obtain and maintain such favorable terms for procurements and to maintain adequate sources of supply.

UP programs are duplicative of existing coverage and may limit access to vaccines for providers and patients

Federal statute mandates that insurers cover vaccines recommended by the CDC's Advisory Committee on Immunization Practices (ACIP) at first dollar coverage for in-network providers.[5] Federal law requires first-dollar insurance coverage of all ACIP-recommended vaccines for enrollees in private insurance, Medicare, and Medicaid. The percent of insured individuals has been steadily increasing in Maine and was over 94% in 2023.[6] Individuals without insurance or who are underinsured can access vaccines at no cost through the Section 317 Program, which is specifically designed to address the needs of this population. Many vaccine manufacturers also offer patient assistance programs to eligible individuals.

Additionally, there are some UP programs that exclude products or limit choice in vaccine brands. This poses an additional challenge to access and innovation, as this can limit provider and patient access to products that otherwise would be available and covered. Every new vaccine that is developed, approved, and recommended provides us with a new tool to prevent certain illnesses or even death. Providers are best equipped to choose the right vaccine for their patients based on their medical information and needs, and research indicates that patients are

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[3] Mulligan K, Thornton Snider J, Arthur P, Frank G, Tebeka M, Walker A, Abrevaya J. Examination of Universal Purchase Programs as a Driver of Vaccine Uptake Among US States, 1995-2014. Vaccine. 2018 June 27;36(28):4032-4038. https://doi.org/10.1016/j.vaccine.2018.05.103

[4] CDC: http://www.cdc.gov/vaccines/vac-gen/policies/downloads/imz_rate_increases.ppt

[5] HHS, Preventive Care Benefits for Adults. https://www.healthcare.gov/preventive-care-adults/

[6] https://www.kff.org/other/state-indicator/total-population/?activeTab=graph&currentTimeframe=0&startTimeframe=14&selectedDistributions=uninsured&selectedRows=%7B%22states%22:%7B%22maine%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

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more likely to accept vaccination when given options.[7] Without protections in place to ensure access to all recommended vaccines, UP programs may hinder access.

UP programs do not eliminate administrative complexity

UP programs currently only have the ability to assess private insurers and TRICARE; there is currently no mechanism for programs to assess Medicare. In 2020 in Maine, the Medicare population totaled 345,205 people: 210,664 enrolled in traditional Medicare plans and 134,541 enrolled in Medicare Advantage plans.[8] The inability to assess Medicare would add complexity to hospital and physicians (i.e., family medicine, internal medicine) who will need to have a separate supply for providing vaccines to the Medicare population.

UP programs may disrupt supply chains and safeguards against shortages

Like most medicines, vaccines are vulnerable to shortages when there are fewer available products. Relying solely on UP programs may limit the diversification of vaccine suppliers. In the event of disruptions in the supply chain, such as manufacturing issues or sudden demand surges, the availability and distribution of vaccines could be compromised.

UP systems have resulted in immunization programs serving as a source of state funding for non-vaccine programs

In certain instances, the federal contract is being used for financial gain for the state, as assessments are being collected in excess of needed vaccine funding and administrative activities and then invested. While public health is underfunded in many states, vaccine assessments in excess of the cost of vaccine purchase should not be used as a stopgap for public health needs such as additional state health department staff or other public health programs. Vaccines should not be used as a cover for raising money for the state for other purposes.

Alternative solutions

There must be equity across populations with consideration given to factors such as geography (rural/urban), age, and demographic factors like race/ethnicity. Maine should undertake an examination of the factors impacting lower uptake of vaccines by certain populations and work to address specific issues in vaccine financing and access rather than implementing an overarching change to the system. Discussion of potential alternative solutions is included below.

- Raise the Medicaid vaccine administration fee to more fully compensate health care providers administering vaccines for their time and resources. Maine currently has

[7] Kutasi et al. Understanding hesitancy with revealed preferences across COVID-19 vaccine types. 2022. A
[8] Kaiser Family Foundation (2020), https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22maine%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

Medicaid fee-for-service vaccine administration fees that are just on par with the national median rate ($13.43 versus the median rate of $13.62), leaving room for improvement. UP programs do not address administration fees paid to private insurers or Medicaid.[9]

Additionally, a 2015 Alliance for Aging Research white paper, "Our Best Shot: Expanding Prevention through Vaccination in Older Adults," concluded that information and awareness of necessary vaccines and access to immunizing providers were just as significant issues as financial barriers to immunization.[10] Other states have undertaken processes to identify targeted solutions to vaccine education, access, and financing issues, which include:

- Training and education for providers on group purchasing options for lower-volume practices;
- Mentoring programs and centralized toolkits for providers;
- Development of buying group lists, optional centralized billing, credentialing, and contracting services for Local Public Health Agencies and other interested providers;
- Payer use of the CDC private sector cost list as reference for private payments;
- Improved reimbursement by payers for vaccine administration;
- Training on appropriate coding of vaccine type and administration;
- Investment and support for additional funding for the state IIS to support development of additional billing and inventory management infrastructure; and
- Innovative pilots that use technology solutions to address financing, billing and stocking of vaccines for providers.

Finally, we are concerned that this legislation is moving forward without the rigor necessary to understand the implications of such a policy shift. BIO urges you to first examine the challenges and acute solutions associated with them before enacting such sweeping changes to adult vaccine purchasing.

Thank you for the opportunity to comment. BIO and our members welcome the opportunity to discuss strategies for facilitating access to vaccines to improve adult immunization rates. Please do not hesitate to reach out if we can be a resource.

Sincerely,

Mark C. Gallagher
Drummond Woodsum

[9] Granade, Charleigh, et al. State Policies on Access to Vaccination Services for Low-Income Adults. April 27, 2020. JAMA Network Open. 2020;3(4):e203316. doi:10.1001/jamanetworkopen.2020.3316
[10] Alliance for Aging Research, "Our Best Shot: Expanding Prevention through Vaccination in Older Adults." https://www.agingresearch.org/app/uploads/2017/12/Our20Best20Shot.pdf