Biotechnology Innovation Organization

May 4, 2021

Senator Ned Claxton
Chair, Joint Committee on Health and Human Services
Maine Legislature
100 State House Station
Augusta, ME 04333

Representative Michele Meyer
Chair, Joint Committee on Health and Human Services
Maine Legislature
100 State House Station
Augusta, ME 04333

Chair Claxton, Chair Meyer, and Members of the Committee,

I am writing today on behalf of the Biotechnology Innovation Organization (BIO), a national trade association for the biotechnology industry, representing over 900 companies and academic institutions involved in the research and development of innovative healthcare, agriculture, industrial, and environmental biotechnology products. 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.

BIO and our member companies share the Committee's goal of increasing access to health care and public health programs and services, including vaccination. However, we would **oppose LD 745 / HP 550** if it includes any proposal to expand vaccine purchasing under the Maine Vaccine Board or any other Universal Purchase arrangement.

Immunizations are a triumph of public health. Over the past century, high childhood immunization rates have led to millions of lives saved, cases averted, and costs to the health care system saved. Progress in achieving high immunization rates for adults has seen much slower progress. While we are supportive of efforts to increase access to vaccines and, consequently, increase immunization rates to protect people throughout the lifespan from the negative impacts of serious infectious diseases, we do not believe that a Universal

1201 Maryland Avenue SW
Suite 900
Washington DC 20024
202.962.9200 P
202.488.6301 F
bio.org

Purchase (UP) program is the best mechanism for doing so due to the following reasons:

1. UP programs erode the benefits of a valuable Federal entitlement program.
2. UP programs have not been shown to increase immunization rates consistently.
3. UP programs are duplicative of existing coverage for vaccines.
4. UP programs do not eliminate administrative complexity.
5. UP systems have resulted in immunization programs serving as a source of state funding for non-vaccine programs.

UP programs erode the benefits of a valuable Federal entitlement program

As part of the Vaccines for Children (VFC) program, the Centers for Disease Control and Prevention (CDC) is authorized to contract with vaccine manufacturers. These federal contracts are designed in collaboration with industry to ensure that the most vulnerable[1,2] have access to immunizations at a discount and that each state has a sufficient quantity of vaccine for specified groups in VFC. The CDC has clearly declared that states should transition to an infrastructure where dose level accountability is provided to ensure vaccines purchased off federal contracts are only administered to VFC-eligible children. Purchase of vaccines for adults is not the intention of the VFC contract. To illustrate this point, please see the enclosed piece from the Centers for Disease Control & Prevention outlining eligibility guidelines for appropriate utilization of the VFC contract.

A distortion in the volume of vaccine under the VFC 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[3] and to maintain adequate sources of supply. Therefore, use of the VFC contract to purchase vaccine doses for adults undermines the CDC's ability to administer this critical public health program.

---

[1] Children are eligible for the VFC program if they are younger than age 19 years and either: Medicaid-eligible; uninsured; underinsured; or American Indian or Alaskan Native.
[2] CDC, VFC Eligibility: https://www.cdc.gov/vaccines/programs/vfc/about/index.html#eligibility
[3] Urban Institute, Universal Purchasing of Childhood Vaccines in New York State: A Feasibility Assessment:
http://www.urban.org/uploadedpdf/412235-Universal-Purchasing.pdf

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. A recent study found no association between the implementation of a UP program and an increase in rates.[4] 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.[5]

UP programs are duplicative of existing coverage for vaccines

The federal Patient Protection & Affordable Care Act (ACA) mandates that insurers cover vaccines recommended by the CDC's Advisory Committee on Immunization Practices (ACIP) at first dollar coverage for in-network providers.[6] Vaccines for insured adults age 19-64 years are therefore already covered at no cost to patients, making a UP model administratively redundant. Some vaccines are also covered with no cost-sharing under Medicare.[7]

A proposed expansion of the Maine Vaccine Board to adult populations would also have no impact on access to a COVID-19 vaccine. As with previous pandemics, the federal government is procuring and distributing vaccines to the public at no cost during the declared pandemic. The U.S. Congress has already expanded access to COVID-19 vaccines through emergency legislative packages enacted since the pandemic began. As discussed, most people already get vaccines for free or low cost under existing law, but these additional measures will ensure COVID-19 vaccines are available to most populations with no cost-sharing in the event that the vaccine becomes recommended for seasonal use beyond the pandemic.

UP programs do not eliminate administrative complexity

Universal Purchase programs currently only have the ability to assess private insurers and TRICARE; there is currently no mechanism for programs to assess

---

[4] 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
[5] CDC: http://www.cdc.gov/vaccines/vac-gen/policies/downloads/imz_rate_increases.ppt
[6] HHS, Preventive Care Benefits for Adults. https://www.healthcare.gov/preventive-care-adults/
[7] AARP, Which Vaccines Does Medicare Cover? https://www.aarpmedicareplans.com/medicare-articles/which-vaccines-does-medicare-cover.html

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

In certain instances, the VFC 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.

- Ensure low or no-cost sharing for vaccines for Medicaid-eligible and uninsured adults. Medicaid cost-sharing varies from state-to-state and is a gap where privately insured and Medicare-eligible adults have no cost-sharing for vaccines. Rather than implementing a duplicative assessment system that violates a federal contract when most populations already have coverage, efforts should focus on fixing this gap.
- Raise the Medicaid vaccine administration fee to more fully compensate health care providers administering vaccines for their time and resources. Maine currently has Medicaid fee-for-service vaccine administration fees that are just on par with the national median rate ($13.43 versus the

[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

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.

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 BIO can be a resource.

Sincerely,

Benjamin Chandhok

---

[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

Ben Chandhok
State Government Affairs Director, Eastern Region
Biotechnology Innovation Organization
bchandhok@bio.org

Cc: Senator Joseph Baldacci
Senator Marianne Moore
Representative Jon Connor
Representative Margaret Craven
Representative Abigail Griffin
Representative Kathy Javner
Representative Michael Lemelin
Representative Colleen Madigan
Representative Anne Perry
Representative Holly Stover
Representative Sam Zager
Ms. Kerri Withee, Committee Clerk

Attachments:

1. Centers for Disease Control and Prevention. Vaccines for Children Program (VFC): VFC Eligibility Criteria.