

March 4, 2014

Mr. Chairman and Committee members, my name is Rosalyn Singleton. I am a pediatrician representing myself and other Alaska providers and I am here to respond to written concerns about Senate Bill 169 submitted by Phyllis Arthur from the Biotechnology Industry Organization (BIO)

First of all, we look forward to having BIO's support going forward since we pursue the same goal of increasing immunization rates among people of all ages.

I would like to address 3 concerns brought up by BIO:

- 1. Universal Purchase (UP) programs have not actually helped to increase immunization rates;**
 - a. Only a handful of states have universal purchase programs. If 3 are in the top 10% for childhood immunizations, that's actually pretty impressive! I believe the three in the bottom 10% are Alaska, Vermont, and Idaho. Each of those states has unique challenges for vaccine delivery. The universal purchase programs certainly haven't *hurt* immunization rates there.
 - b. New Hampshire has had a vaccine association for over 10 years, and it has consistently been a leader in childhood immunizations. According to the recent CDC survey, NH has an immunization rate of 80.1%, which is second in the country only to Hawaii's 80.2%.
 - c. Maine lost its universal status and saw a decrease in immunization coverage. However, it re-gained universal status and between 2010 and 2012, it jumped from 41st to 14th in the nation.
 - d. Washington also saw a jump in immunization rates. It went from 45th in 2005, to 29th in 2010, to 18th in 2012.
 - e. There are many reasons for low immunization rates in Alaska, among them access to vaccines - In 2012 Alaska did have low rates among 19-35 month olds who would have received vaccines during 2009-2012 when Alaska was experiencing decreases in universal access. Alaska's low rates should spur us to look at all means (reminder recall, parent education, reduced barriers to providers, and increased access to vaccines for parents) to improve immunization rates.
- 2. The Affordable Care Act (ACA) has addressed many of the financial barriers to immunization affecting patients by requiring private insurers to cover ACIP-recommended vaccines for children, adolescents and adults with no out-of-pocket expense and no deductible.**
 - a. The ACA doesn't solve the issues for PROVIDERS. They still have to purchase vaccines up front and await repayment from insurers, often at discounted rates. Under the Affordable care Act providers would still need to keep separate stocks of vaccine
 - b. The ACA does not address insurance payment levels to providers for vaccine purchase and administration
- 3. The ability of the state to assess all types of insurance plans in the state is unclear and may not be allowed under federal law. This may result in a multi-tiered immunization system where providers still must access the private sector for some patients or specific vaccines but with smaller volumes.**
 - a. The model would allow an opt-in for uninsured adults but would cover all children and all insured adults. This would still be a significant improvement from the current system which requires separate private and public stocks of vaccine for childhood as well as adult vaccines.
 - b. If this is an ERISA preemption argument, it is misguided. In fact, no preemption claim has yet been asserted in states with similar models. If it were, the ERISA argument should fail because these vaccine programs should not burden the plans; they should provide a benefit because they lower healthcare costs.
 - c. In addition, based upon the ERISA statute, ERISA trustees may actually have a legal obligation to participate because they have a fiduciary duty to serve their beneficiaries. Lower healthcare costs through participation would be more consistent with trustees' legal duties than resisting programs such as that proposed which will lower their costs.

4. **UP programs often burden state health departments with the additional administrative costs of managing the vaccine supply for the entire state, such as warehousing and shipping doses to multiple sites.**
 - a. The State already has recent experience with a universal program and under the current two-tiered system still manages much of the vaccine supply
 - b. The administrative costs are minimal compared to the public health benefits. Healthier people make less work for the Health Departments.
5. **In addition providers will still be required to screen patients for eligibility, stock private sector doses for children and adults whose insurance plan is not paying into the assessment pool, submit for reimbursement and track use of these doses.**
 - a. By requiring all insurers and TPAs to participate, the separate stock issue is eliminated.
6. **This type of UP program, tax assessments and insurance pools, create a pass through of a federal discount intended for vulnerable populations. Vaccine costs are not a high or significant cost for insurers as a portion of insurance premiums. In fact a 2009 HHS study showed that vaccine coverage accounts for only 0.8% of family premiums.**
 - a. The study cited is from 2009 and cost of vaccinating a child through 18 years has been increasing significantly in the past 30 years, from \$50 in the 80s to \$2250 in 2012. In a recent survey 10% of physicians had seriously considered discontinuing providing all childhood vaccines to privately insured patients because of cost issues. For private pediatric offices the cost of vaccines has gone from a minor consideration in the overhead in the 1980s to one of the top overhead expenses – magnifying the risks of uncompensated expenses. (Pediatrics 2014;133:367).
7. **America’s vaccine manufacturers are continuously investing in both existing and new vaccines for children, adolescents and adults. This is only possible when there is a sustained, viable market for these vital public health products.**
 - a. Universal purchase programs seek to ENLARGE the market. They strive to increase vaccine usage. They also provide a reliable source of funding so that financing risk is eliminated. Adult vaccination rates are very low in the U.S. – for instance, only 14.2% of US adults ≥ 19 years have received Tdap vaccine recommended for all adults, and only 20.1% of adults ≥ 60 years old have received a Zoster vaccine. Universal access to vaccine for adults could dramatically increase these rates.
8. **Providing private insurers access to federally discounted vaccine intended for disadvantaged children runs counter to the original intent of the VFC program and provides a pass through to insurers at the expense of vaccine companies.**

The VFC statute specifically allows states to purchase vaccines for insured children at the federal contract rate. Congress’s intent was to improve childhood health generally and to help states improve childhood immunization rates.

See 42 U.S.C. § 1396s(d)(4)(B):

(B) each State, at the option of the State, shall be permitted to obtain additional quantities of pediatric vaccines (subject to amounts specified to the Secretary by the State in advance of negotiations) through purchasing the vaccines from the manufacturers at the applicable price negotiated by the Secretary consistent with paragraph (3), if

(i) the State agrees that the vaccines will be used to provide immunizations only for children who are not federally vaccine-eligible children and

(ii) the State provides to the Secretary such information (at a time and manner specified by the Secretary, including in advance of negotiations under paragraph (1)) as the Secretary determines to be necessary, to provide for quantities of pediatric vaccines for the State to purchase pursuant to this subsection and to determine annually the percentage of the vaccine market that is purchased pursuant to this section and this subparagraph.

Sincerely,

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