

**Testimony before the Joint Standing Committee on  
Appropriations & Financial Affairs &  
The Joint Standing Committee on Health and Human Services**

**Re: LD 353, The Governor's Proposed Biennial Budget for SFY 2010-2011**

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February 18, 2009**

The Maine Primary Care Association appreciates this opportunity to present testimony regarding the Governor's proposed biennial budget, LD 353. MPCA represents the state's safety net of Federally Qualified Health Centers that are delivering care among the state's underserved and shortage areas to more than 200,000 patients. Attached is a fact sheet that conveys the role and value of Maine's FQHCs among their communities and service areas to provide greater access to comprehensive primary care, high quality health outcomes, and reduced overall health care costs.

More specifically, I am here to testify in support of the state's investment in childhood vaccine as sound public policy for it is a necessary element to restoring universal access to childhood vaccine in Maine. At the start of this year, Maine lost universal access due to: 1) a growing schedule and increased costs of vaccine; 2) reduced federal funding; 3) insufficient contributions from private insurance; and 4) lack of any state funding for the program. Universal access reduces barriers to vaccine administration for patients and providers alike. Universal access will result in higher rates of vaccination, increased federal funding, and lower costs to insurance premium payers than our current fractionated approach.

This allocation of state funding in support of universal access to childhood vaccine represents the second part of a three-pronged approach to restoring universal access, with the first, and principal source being our federal funding (Vaccine for Children funding and Public Health Service 317 funds). In order to achieve universal access, there should be an equitable pooling of resources that also includes private insurance contributions as the third source of funding. Private insurance contributions should be in proportion to their share of covered lives and will represent a lower total cost to private insurers than the existing chaos which places a greater burden on patient, provider and insurer.

Before describing how we arrived at this point in our approach to childhood vaccine, it is worth noting that federal HR 1, the American Recovery and Reinvestment Act, includes \$300 million for "the section 317 immunization program." This 0.04% of the stimulus package is welcome relief to states around the country for the purpose of vaccine funding. It provides us greater flexibility in the interim to adhere to our public health goals while we hopefully get out from this budget crisis. Maine's allocation of this stimulus funding might be enough to bring our section 317 funds back to previous 2005 levels. However, it won't be enough to singlehandedly support universal access. If nothing else is done, once we get beyond the funding horizon of the stimulus package, we will be right back at this point. While enjoying the stimulus relief, we shouldn't miss the opportunity to put in place a method of assuring a universal vaccine program that fully leverages the purchasing power of our combined resources – federal, state and private contributions – to achieve the highest rates of childhood vaccination at lowest cost to any participant, patients and providers included.

Central to the arguments of this approach to universal vaccine is the understanding that next to clean drinking water, childhood vaccine is arguably the greatest public health intervention available to society and the reason for dramatically reduced morbidity and mortality in the last century for both children and adults alike. Moreover, impact studies of vaccine have shown a 15 to 1 return on the investment.

On January 1, 2009, Maine lost universal immunization coverage from our public health infrastructure. Universal immunization coverage has meant in the past that Maine children and their parents – regardless of insurance coverage status or type – had the reassurance that they would be able to be fully immunized against childhood disease that once routinely crippled and killed in generations past. This change has repercussions for vaccine rates, health plan costs, and most importantly – the health of our state’s children.

Where Maine once led the nation in our childhood rates of vaccination, we now rank worse than a majority of states. Maine’s HEDIS scores for childhood immunizations are below the national average at just 68.80% compared with the average of 72.00%. The factors that have unraveled Maine’s universal status were mentioned above. This loss of universal status has meant:

- Reduced access to vaccine which will likely further contribute to a decline in Maine’s childhood vaccination rates, and in turn further reduce VFC funding for Maine.
- Increased costs of vaccination passed along to premium payers as the CDC pricing is no longer available to health plans. Currently this discount averages 27%.
- Increased administrative hurdles and loss of productive time for primary care clinicians who must navigate much greater complexity rather than manage a single seamless system.
- A tremendous financial burden on primary care clinicians who are already beleaguered. Primary care practices must now purchase vaccine inventory upfront without assurance that the benefits package of their patients will provide sufficient reimbursement for this cash outlay. This particularly hurts FQHCs and private practices with scant margins for error.

The public health response should be a public-private partnership to restore a universal vaccine program in Maine. The Maine Primary Care Association calls for:

1. Participation by both health plans and self-insured plans to cover vaccine purchase and administration. This private participation should be in keeping with each plan’s share of covered lives, and should be capped at no more than they would otherwise pay in the absence of a universal program. Programmatic language to effect this change is available and draws heavily on the successful program in existence in New Hampshire.
2. State funding for the immunization program – including the necessary overhead to properly staff the program. Even with the short-term stimulus funding that might temporarily restore federal 317 program funds to Maine’s previous levels, there is still a need to devise a structure now that includes considerations for state investment in this model given the tremendous benefits from a universal approach. Funds only designated for vaccine purchase will place the state at a federal audit risk or unfairly impose the associated overhead costs on private payers. Cuts to federal 317 funding also eliminated from our public health programs adult vaccination including tetanus, pertussis, and Hepatitis B. Such efforts are the only source of vaccination for the homeless and other at-risk populations.

The childhood immunization program is the bedrock of our public health infrastructure, and without a strong program we stand to lose ground not only in our vaccination rates, but also in our rates of infant mortality. Please support the state’s investment in childhood vaccine.