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HOUSE OF REPRESENTATIVES

COUNCIL FOR HEALTHY COMMUNITIES
ANALYSIS

BILL #: CS/CS/HB 871

RELATING TO: Meningitis Immunization/Schools

SPONSOR(S): Council for Healthy Communities, Committee on Colleges & Universities, and Representative Hogan

TIED BILL(S): None.

ORIGINATING COMMITTEE(S)/COUNCIL(S)/COMMITTEE(S) OF REFERENCE:

(1) HEALTH REGULATION YEAS 9 NAYS 0
(2) COLLEGES & UNIVERSITIES YEAS 11 NAYS 0
(3) COUNCIL FOR HEALTHY COMMUNITIES YEAS 16 NAYS 0
(4)
(5)

I. SUMMARY:

THIS DOCUMENT IS NOT INTENDED TO BE USED FOR THE PURPOSE OF CONSTRUING STATUTES, OR TO BE CONSTRUED AS AFFECTING, DEFINING, LIMITING, CONTROLLING, SPECIFYING, CLARIFYING, OR MODIFYING ANY LEGISLATION OR STATUTE.

CS/CS/HB 871 requires postsecondary educational institutions to provide information regarding the risks of: meningococcal meningitis, diphtheria, tetanus, and hepatitis B; as well, information regarding the availability, effectiveness, and known contraindications of any required or recommended vaccinations against such diseases. This information must be provided to every student, or parent of a minor student, who has been accepted for admission to the institution.

CS/CS/HB 871 requires individuals enrolled in a postsecondary educational institution that reside in on-campus housing to be vaccinated against meningococcal meningitis, diphtheria, tetanus, and hepatitis B. An individual may be exempted from the vaccination requirement if the individual, or the individual's parent if the individual is under 18, signs a waiver form stating that the information provided by the institution has been received and reviewed and the individual chooses not to be vaccinated.

CS/CS/HB 871 does not provide for the costs of the vaccine or its administration, nor does it include any provision that would help offset the cost to the private sector by requiring that immunization be covered through health insurance benefits; managed care; indemnity health care plans; or Medicaid. The cost to postsecondary educational institutions of providing the required information or obtaining the required documentation or waivers is unknown at this time.

Postsecondary education in Florida is provided by 48 school district vocational-technical centers; 39 public community colleges, colleges, and universities; over 100 private colleges and universities; and over 500 private career schools. Information regarding the number of students accepted for admission by these institutions or the extent to which these institutions provide on-campus housing and the number of persons residing in such housing was not available at the time this analysis was prepared.

The bill provides an effective date of July 1, 2002**.**

II. SUBSTANTIVE ANALYSIS:

A. DOES THE BILL SUPPORT THE FOLLOWING PRINCIPLES:

1.	Less Government	Yes []	No [x]	N/A []
2.	Lower Taxes	Yes []	No []	N/A [x]
3.	Individual Freedom	Yes [X]	No []	N/A []
4.	Personal Responsibility	Yes []	No []	N/A [x]
5.	Family Empowerment	Yes []	No []	N/A [x]

For any principal that received a "no" above, please explain.

This bill expands government regulation of postsecondary educational institutions in the state.

B. PRESENT SITUATION:

Postsecondary Education

Postsecondary education in Florida is provided by 48 school district vocational-technical centers; 39 public community colleges, colleges, and universities; over 100 private colleges universities; and over 500 private career schools. Nearly two million students are enrolled in various institutions of postsecondary education in this state.[1] The number of students accepted for admission by these institutions each year is not known.

The extent to which postsecondary educational institutions provide on-campus housing is not known. For the year 2000, institutions of the State University System reported their residence hall capacities as follows[2]:

- Florida A&M University 2,942
- Florida Atlantic University 1,500
- Florida Gulf Coast University 250
- Florida International University 1,500
- Florida State University 4,315
- University of Central Florida 1,637
- University of Florida 6,791
- University of North Florida 1,604
- University of South Florida 2,679
- University of West Florida 867

The types of additional housing that may fall under the "on-campus housing" provision of the bill is unknown. It is unknown how many independent colleges and universities in the state provide student-housing facilities. Few, if any, vocational-technical centers or career schools provide on-campus housing.

Some postsecondary educational institutions already require students to provide certain health information. Rule 6C-6.001, Florida Administrative Code, requires each student who is accepted for admission by an institution of the State University System to submit, before registration, a medical

[1] Higher Education Resource Document, Committee on Colleges & Universities, Florida House of Representatives, January 2001
[2] State University System 2000 Legislative Briefing Book

history signed by the student including proof of immunization for measles and rubella. Additionally, some state universities reportedly request information in the admissions application about vaccinations for meningitis and other infectious diseases. The Department of Education (DOE) states that some independent colleges and universities also require documented proof of immunization against measles and rubella. It is not known at this time how many independent colleges and universities currently require students to provide such proof.

Florida law currently places certain requirements on public postsecondary educational institutions to provide educational and informational materials to students regarding communicable diseases. Section 240.2097(4), F.S., provides that members of the State University System must develop a policy that addresses the instruction, information, and activities regarding human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS). Such instruction, information, or activities should emphasize the known modes of transmission of HIV/AIDS, the signs and symptoms, the risk factors associated with the diseases, and methods of controlling the spread of such diseases. Section 240.3192, F.S., provides that public community colleges must develop programs similar to those required for state universities for awareness and control of HIV/AIDS.

Meningococcal Meningitis

Meningococcal meningitis is a rare but potentially fatal infection, which can occur in either a viral or bacterial form. The viral form is generally not regarded as a life-threatening disease and the body will usually fight off the viral form through its own defense mechanisms. The bacterial form is regarded as being more dangerous. Meningococcal meningitis is an attack on the brain and spinal cord, which occurs through the cerebrospinal fluid. It can result in permanent brain damage, hearing loss, learning disability, organ failure, loss of limbs, or death.[3] There are five subtypes (or Serogroups) of the bacterium that cause meningococcal meningitis (Serogroups A, B, C, Y, and W-135). The Center for Disease Control (CDC) recommends that students consider getting the Menomune vaccine, which stimulates protective antibodies for all but Serogroup B. In the past, Serogroup B accounted for approximately 50 percent of the cases of meningococcal meningitis in the United States, but more recently, it has decreased to about 27 percent or less. The vaccine lasts three to five years[4].

The Department of Health (DOH) does not regulate postsecondary educational institution immunization requirements, but supports the recommendations of the U.S. Public Health Service Advisory Committee on Immunization Practices (ACIP) that "recommends providing information on meningococcal meningitis to college students, particularly those planning to live in dormitory on-campus housing." The ACIP recommends that college freshmen wanting to reduce their risk for meningococcal meningitis should receive the vaccine from a doctor's office or student health service or be directed to a site where the vaccine is available. DOE staff states that the cost of a meningococcal meningitis vaccination is approximately $70. It is unknown how many Florida residents have already been vaccinated against meningococcal meningitis or if such vaccinations are readily available to the public at large.

Diphtheria

Diphtheria was once one of the most common causes of death in children. Since the introduction and widespread use of diphtheria vaccine, diphtheria has been rare in the United States. Between 1980 and 1995, 41 cases of diphtheria were reported to health authorities. According to the Centers for Disease Control, it is reported that approximately 0.001 cases per 100,000 population in

[3] Meningitis Foundation of America
[4] Florida State University Health Alert

the U.S. since 1980; before the introduction of vaccine in the 1920s incidence was 100-200 cases per 100,000 population. Diphtheria remains endemic in developing countries.

Diphtheria is still common in many other parts of the world, including the Caribbean and Latin America. During the last few years, large epidemics of diphtheria have occurred in the former Soviet republics. Outbreaks have also been reported in Algeria, China, and Ecuador. The majority of cases in many of these epidemics have been in adults and adolescents. Diphtheria has re-emerged in the newly independent states of the former Soviet Union and in some other parts of the world at near-epidemic levels. The increases have generally been the result of failed public health and immunization programs in areas weakened by economic and social turmoil.

In the United States, the diphtheria threat is shifting from children to adults and adolescents. Cases are occurring in persons who have not been immunized or in vaccinated persons who did not receive periodic booster doses to maintain their immunity

Diphtheria is caused by Corynebacterium diphtheriae, a bacterium. The bacterium produces a toxin (poison) that is carried in the bloodstream. It is a highly contagious bacterial disease that is transmitted from person to person through close physical and respiratory contact. It can cause large epidemics in areas of low vaccination coverage. Bacteria that are found in the mouth, throat and nose of an infected person cause diphtheria. Diphtheria can cause a membrane to grow around the inside of the throat, which can lead to difficulty in swallowing, breathlessness, and suffocation. A powerful poison (toxin) is produced by the diphtheria bacteria and may spread throughout the body. The toxin may cause serious complications such as paralysis and heart failure. About 7% of people who contract diphtheria, die from it.

The diphtheria vaccination should be administered in combination with one against tetanus, and in the case of children with one against tetanus and whooping cough.

Tetanus

Tetanus is a dangerous nerve ailment caused by the toxin of a common bacterium, Clostridium tetani. Bacterial spores are found in soil, most frequently in cultivated soil, least frequently in virgin soil. They also exist in environments as diverse as animal excrement, house dust, operating rooms, contaminated heroin, and the human colon. If the spores enter a wound that penetrates the skin and extends deeper than oxygen can reach, they germinate and produce a toxin that enters the bloodstream.

This toxin, tetanospasmin, ranks with botulism toxin as the most potent known microbial poison. It is taken up from the blood by the outermost nerves and moves inward toward the spine at a rate of about 10 inches a day. After 7 to 21 days, it begins to short-circuit nerve signals and block the relaxation of muscles. This results in sustained muscle contractions, notably the lockjaw for which tetanus is nicknamed.

Spasms of the jaw or facial muscles may follow, spreading to the hands, arms, legs, and back and blocking the ability to breathe. Spasms are often precipitated by noise or touch. Once tetanus has spread, the mortality rate is approximately 40%, even in modern medical facilities.

An estimated 1 million infants die of tetanus in developing countries each year because of poor hygiene. Since childhood immunization laws were passed in the United States in the 1970s, only about 50 cases a year are reported in this country; about three-quarters are elderly people or people who have never been immunized.

Hepatitis B

Most cases of hepatitis are caused by viruses that attack the liver, defined by the letters A through G. It should be noted that the cause of hepatitis is sometimes unexplained, indicating that additional viruses have not yet been discovered.

The virus for hepatitis B, formerly called serum hepatitis, is found in semen, blood, and saliva. It is usually spread by blood transfusions, contaminated needles, and sexual contact. Blood screening has reduced the risk from transfusions. The virus does not kill cells directly, but seems to activate cells in the immune system, which cause inflammation and damage in the liver. Hepatitis D virus can replicate only by attaching to hepatitis B and therefore cannot exist without the B virus being present. Between 1% and 10% of hepatitis B patients go on to develop chronic hepatitis and hepatitis B can become chronic without an acute stage.

Hepatitis B, the most widespread of the hepatitis viruses, infects an estimated 300,000 people every year in the United States. The virus can pass from mother to child at birth or soon afterward; the disease organism can also travel between adults and children to infect whole families. Hepatitis B can also spread through sexual contact, blood transfusions and needle-sharing by intravenous-drug users. In a third of all hepatitis B cases the source cannot be identified.

The majority of hepatitis B patients recover completely, but a small percentage don't recover and may develop chronic hepatitis and possibly cirrhosis. People with chronic hepatitis become carriers, meaning they can transmit the disease to others even when their own symptoms have vanished. About 25 percent of chronic hepatitis B patients die prematurely from the disease as a result of cirrhosis or liver cancer.

According to the National Digestive Diseases Information Clearinghouse, people at high risk for getting hepatitis B disease are:

- People with multiple sex partners and those who have been recently diagnosed with a sexually transmitted disease;
- Sex partners and household contacts of HBV carriers;
- Men who have sex with men;
- Adoptees from countries with endemic hepatitis B;
- Injection drug users;
- Travelers to countries with high HBV rates (staying longer than 6 months);
- People with occupational exposure to blood or body fluids;
- Clients and staff in institutions for the developmentally disabled;
- Patients with chronic renal failure;
- Patients receiving clotting factor concentrates; and
- Inmates of long-term correctional facilities.

Research indicates that:

- 90-95% of all hepatitis B cases recover completely after 3 to 4 weeks of nausea, fatigue, headache, arthritis, jaundice and tender liver.[5]
- Up to 17 % of all hepatitis B vaccinations are followed by reports of fatigue and weakness, headache, arthritis and fever of more than 100 F.[6]

[5] Harrison's Principles of Internal Medicine, 1994.

- The vaccine can cause death, according to a 1994 Institute of Medicine report.[7]
- In 1996, there were 10,637 cases of hepatitis B reported in the U.S. and the CDC stated, "Hepatitis B continues to decline in most states, primarily because of a decrease in the number of cases among injecting drug users and, to a lesser extent, among both homosexual and heterosexuals of both sexes." [8]

An historic report in 1994 published by the Institute of Medicine, National Academy of Sciences, reviewed the medical literature for evidence that vaccines, including hepatitis B vaccine, can cause a variety of immune and neurological health problems. An independent committee of physician experts concluded that there were no case controlled observational studies or controlled clinical trials conducted on hepatitis B vaccine either before or after licensure to scientifically evaluate persistent reports that hepatitis B vaccine can cause sudden infant death syndrome; Guillain-Barre syndrome (GBS) and other central demyelinating diseases including transverse myelitis, optic neuritis, and multiple sclerosis; and immune system dysfunction including chronic arthritis.
The IOM report concluded: "The lack of adequate data regarding many of the adverse events under study was of major concern to the committee...the committee encountered many gaps and limitations in knowledge bearing directly or indirectly on the safety of vaccines. These include inadequate understanding of the biologic mechanisms underlying adverse events following natural infection or immunization, insufficient or inconsistent information from case reports and case series, inadequate size or length of follow-up of many population-based epidemiological studies...."

The fifth meeting of the Institute of Medicine's Immunization Safety Review Committee will be held March 11-13, 2002 in Washington, DC. The topic of this meeting is the possible association between hepatitis B vaccine and neurological disorders.

Current Immunization Schedules:

The American Academy of Pediatrics issues the Year 2002 Immunization Schedule:

"1. **Hepatitis B vaccine (Hep B).** All infants should receive the first dose of hepatitis B vaccine soon after birth and before hospital discharge; the first dose may also be given by age 2 months if the infant's mother is HBsAg-negative. Only monovalent hepatitis B vaccine can be used for the birth dose. Monovalent or combination vaccine containing Hep B may be used to complete the series; four doses of vaccine may be administered if combination vaccine is used. The second dose should be given at least 4 weeks after the first dose, except for Hib-containing vaccine, which cannot be administered before age 6 weeks. The third dose should be given at least 16 weeks after the first dose and at least 8 weeks after the second dose. The last dose in the vaccination series (third or fourth dose) should not be administered before age 6 months.

Infants born to HBsAg-positive mothers should receive hepatitis B vaccine and 0.5 mL hepatitis B immune globulin (HBIG) within 12 hours of birth at separate sites. The second dose is recommended at age 1-2 months and the vaccination series should be completed (third or fourth dose) at age 6 months.

Infants born to mothers whose HBsAg status is unknown should receive the first dose of the hepatitis B vaccine series within 12 hours of birth. Maternal blood should be drawn at the time of delivery to determine the mother's HBsAg status; if the HBsAg test is positive, the infant should receive HBIG as soon as possible (no later than age 1 week).

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[6] Merck & Co. Hepatitis B Vaccine product insert, 1993.
[7] OMI, Adverse Events Associated with Childhood Vaccines,1994.
[8] OMI, Adverse Events Associated with Childhood Vaccines, 1994.

2. **Diphtheria and tetanus** toxoids and acellular pertussis vaccine (DTaP). The fourth dose of DTaP may be administered as early as age 12 months, provided 6 months have elapsed since the third dose and the child is unlikely to return at age 15-18 months. Tetanus and diphtheria toxoids (Td) is recommended at age 11-12 years if at least 5 years have elapsed since the last dose of tetanus and diphtheria toxoid-containing vaccine. Subsequent routine Td boosters are recommended every 10 years.

3. Haemophilus influenzae type b (Hib) conjugate vaccine. Three Hib conjugate vaccines are licensed for infant use. If PRP-OMP (PedvaxHIB ® or ComVax ® [Merck]) is administered at ages 2 and 4 months, a dose at age 6 months is not required. DTaP/Hib combination products should not be used for primary immunization in infants at ages 2, 4 or 6 months, but can be used as boosters following any Hib vaccine.

4. Inactivated polio vaccine (IPV). An all-IPV schedule is recommended for routine childhood polio vaccination in the United States. All children should receive four doses of IPV at ages 2 months, 4 months, 6-18 months, and 4-6 years.

5. Measles, mumps, and rubella vaccine (MMR). The second dose of MMR is recommended routinely at age 4-6 years but may be administered during any visit, provided at least 4 weeks have elapsed since the first dose and that both doses are administered beginning at or after age 12 months. Those who have not previously received the second dose should complete the schedule by the 11-12 year old visit.

6. Varicella vaccine. Varicella vaccine is recommended at any visit at or after age 12 months for susceptible children, i.e. those who lack a reliable history of chickenpox. Susceptible persons aged >13 years should receive two doses, given at least 4 weeks apart.

7. Pneumococcal vaccine. The heptavalent pneumococcal conjugate vaccine (PCV) is recommended for all children age 2-23 months. It is also recommended for certain children age 24-59 months. Pneumococcal polysaccharide vaccine (PPV) is recommended in addition to PCV for certain high-risk groups. See MMWR. 2000;49(RR-9):1-35.

8. Hepatitis A vaccine. Hepatitis A vaccine is recommended for use in selected states and regions, and for certain high-risk groups; consult your local public health authority. See MMWR. 1999;48(RR-12):1-37.

9. Influenza vaccine. Influenza vaccine is recommended annually for children age > 6 months with certain risk factors (including but not limited to asthma, cardiac disease, sickle cell disease, HIV, diabetes; see MMWR. 2001;50(RR-4):1- 44), and can be administered to all others wishing to obtain immunity. Children aged <12 years should receive vaccine in a dosage appropriate for their age (0.25 mL if age 6-35 months or 0.5 mL if age >3 years). Children aged <8 years who are receiving influenza vaccine for the first time should receive two doses separated by at least 4 weeks."

Concerns Regarding Mass Vaccination

On November 6, 1995, the Institute of Medicine's Vaccine Safety Forum convened a workshop on detecting and responding to adverse events following vaccination. Workshop speakers and participants discussed the difficulties in detecting adverse events, current adverse events detection and response methods and procedures, suggestions for improving the means of detecting and responding to adverse events following vaccination, and future areas of research. This document represents a summary of that workshop.

The detection of adverse events following vaccination includes a range of activities. At one extreme it involves the realization that a specific event might be associated with vaccination and the reporting of that case to appropriate authorities. At the other extreme, detection of adverse events includes the assessment of a statistical pattern that suggests that a particular adverse event might be associated with or caused by a particular vaccine. A number of factors make it difficult to detect adverse events associated with vaccination and to determine whether the event is causally associated with the administration of a vaccine: (1) the need to study multiple exposures and multiple outcomes, (2) the lack of unique vaccine-associated syndromes, making it difficult to establish causality, (3) the need for large sample sizes and lack of large computerized immunization databases with individual level data including vaccine lot number, (4) brief exposure periods for each individual, (5) high vaccination coverage makes unvaccinated individuals highly selected.

Adverse events associated with vaccines are currently detected through the Public Health Service's Vaccine Adverse Event Reporting System (VAERS), the Centers for Disease Control and Prevention's (CDC's) Large Linked Data Base (LLDB), and through surveillance measures undertaken by vaccine manufacturers. The federal agencies primarily responsible for responding to the adverse events associated with vaccines are the Food and Drug Administration (FDA) and CDC. The efforts made by CDC, FDA, and vaccine manufacturers to detect and respond to adverse events following vaccination have been effective in many cases, but there are limits to the detection and response systems currently in use. Workshop participants expressed a wide diversity of opinions on priorities for change and improvements and on the scientific basis for some of the suggestions presented. Participants suggested that efforts can be made to improve the quantity, quality, accessibility, and usefulness of VAERS reports. Routine, systematic screening of data, as well as other procedures, can be developed to make LLDB data more useful. The use of larger and better-designed clinical trials conducted both before and after a vaccine's licensure for general use could also be considered to improve the rate of detection of rare adverse events. Such trials could be designed to help separate out the effects of vaccines used in combination and to determine whether certain vaccine combinations pose more risk than vaccines given separately. Vaccine recall procedures could be improved as well.

The Institute of Medicine's Vaccine Safety Forum reported that more research could be done on potential long-term adverse effects from vaccines as well as the potential of vaccines to induce or worsen immune disorders. Research also could usefully address such questions as whether age is a factor in the adverse events experienced following vaccination and whether some groups of individuals are more prone to such adverse effects than others.

During the past two decades, the Institute of Medicine (IOM), National Academy of Sciences, has assembled committees to examine vaccine research, policy and safety issues. The Institute of Medicine was chartered in 1970 by the National Academy of Sciences to “enlist distinguished members of the appropriate professions in the examination of policy matters pertaining to the health of the public.” The IOM acts under the Academy’s 1863 congressional charter responsibility to be an adviser to the federal government and initiate the identification of issues of medical care, research and education.

Congress Asks IOM To Look At Vaccine Safety: The National Vaccine Information Center, (NVIC) founded by parents of vaccine injured children in 1982, supported a provision in the 1986 National Childhood Vaccine Injury Act in which Congress asked the IOM to assemble independent physician committees to review the medical literature for scientific evidence for a causal relationship between childhood vaccines and immune and neurological dysfunction. NVIC assisted the IOM committees in the early 1990’s by providing information about vaccine reactions. Four landmark reports were published by IOM in 1991 and 1994, including Adverse Effects of Pertussis and Rubella Vaccines; Adverse Events Associated with Childhood Vaccines; DPT Vaccine and Chronic Nervous System

Dysfunction: A New Analysis; and Research Strategies for Assessing Adverse Events Associated with Vaccines.

IOM Creates Vaccine Safety Forum: In 1995, the IOM established a Vaccine Safety Forum to examine critical issues relevant to the safety of vaccines used in the U.S. and to discuss methods for improving the safety of vaccines and vaccination programs. The IOM Vaccine Safety Forum held five public workshops on vaccine safety and published three reports: Options for Poliomyelitis Vaccination in the United States; Summaries of Two Workshops ("Detecting and Responding to Adverse Events Following Vaccination" and "Research to Identify Risks for Adverse Events

New IOM Immunization Safety Review Committee Appointed: In 2000, the Centers for Disease Control (CDC) and the National Institutes of Health (NIH) asked the Institute of Medicine (IOM), National Academy of Sciences, to assemble a physician committee to review hypotheses about existing and emerging vaccine safety concerns. The committee will assess evidence of causality; the biologic plausibility of the adverse event hypothesis; the likelihood of competing hypotheses; and the societal perspective, including level of public concern. Based on the assessment of these factors, the committee will recommend appropriate action for the federal government to take to address identified vaccine safety issues. A meeting is scheduled in Washington D.C, to discuss this issue in March 2002.

However, even with the aforementioned expressed concerns regarding mass vaccination, the CDC maintains that failure to immunize can lead to new outbreaks of disease. For example, in 1989-91, a measles epidemic resulted in more than 55,000 reported cases, 11,000 hospitalizations, and more than 120 deaths. According to the CDC, vaccines are cost-effective. More than $13 are saved for every $1 spent on measles/mumps/rubella vaccine; more than $29 are saved for every $1 spent on diphtheria/tetanus/pertussis vaccine; more than $6 are saved for every $1 spent on polio vaccine; and more than $5 are saved for every $1 spent on varicella vaccine. At the time of this analysis, data were not available regarding any cost savings associated with the vaccination for meningococcal meningitis.

Other States:

The following states have current provisions requiring vaccination at postsecondary educational level:

California: hepatitis b;
Colorado: measles, mumps, rubella;
Massachusetts: diphtheria, tetanus, measles, mumps, rubella;
Vermont: measles.

C. EFFECT OF PROPOSED CHANGES:

CS/CS/HB 871 creates s. 381.0421, F.S., relating to vaccination against meningococcal meningitis.

CS/CS/HB 871 requires each postsecondary educational institution to provide detailed information on the risks associated with meningococcal meningitis, diphtheria, tetanus, and hepatitis B and the availability, effectiveness, and known adverse reactions of any required or recommended vaccine to every individual, or parent of individuals under the age of 18, who has been accepted for admission to the institution. The bill does not address the potential for overlap of administrative costs where a student is admitted to multiple postsecondary institutions of education in the state and each institution must provide the student with identical information. The costs of providing the required information to every student accepted for admission is unknown at this time.

CS/CS/HB 871 requires individuals who are enrolled in a postsecondary educational institution and who will be residing in on-campus housing to provide documented proof of vaccination against meningococcal meningitis, diphtheria, tetanus, and hepatitis B. The bill also provides that individuals, or the parent of individuals under 18 years of age, may sign a vaccination waiver provided by the institution. The waiver should state that the individual has received and reviewed the information provided by the institution regarding the recommended vaccinations and has chosen not to be vaccinated. The administrative cost of collecting the documentation or waiver is unknown at this time.

CS/CS/HB 871 does not require the postsecondary educational institutions to provide or pay for the required vaccinations.

D. SECTION-BY-SECTION ANALYSIS:

See above.

III. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT:

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

See Fiscal Comments.

2. Expenditures:

See Fiscal Comments.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

See Fiscal Comments.

2. Expenditures:

See Fiscal Comments.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The fiscal impact on the private sector is indeterminable. The vaccination is estimated to cost approximately $70. This may be an undue burden on some individuals. According to the DOE, the CDC reports 45 cases of meningitis by dormitory residents from September 1998-August 1999. This is a rate of 2.2 cases per 100,000 individuals.

CS/CS/HB 871 does not provide for the costs of the vaccines or its administration, nor does it provide any provision that would help offset the cost to the private sector by requiring that immunization for meningococcal meningitis be covered through health insurance benefits; managed care, chapter 641, F.S.; indemnity health care plans, chapter 627, F.S.; or Medicaid, chapter 409, F.S.

The cost to private postsecondary educational institutions of determining compliance with the vaccination requirement or providing the required information and distributing and collecting the waiver forms for students seeking an exemption from the required vaccination is unknown.

D. FISCAL COMMENTS:

The fiscal impact of CS/CS/HB 871 is indeterminate.

According to the DOE, postsecondary institutions will have the burden of the administrative and educational support involved with the program. The costs to the institutions of determining compliance with the vaccination requirement or providing the required information and distributing and collecting the waiver forms for students seeking an exemption from the required vaccination is unknown.

According to the DOH, if routine vaccination for meningococcal meningitis were offered to all college students residing on-campus, then the costs of the vaccine and its administration need to be addressed so that the potential burden to county health departments from referrals for vaccinations is reduced.

IV. CONSEQUENCES OF ARTICLE VII, SECTION 18 OF THE FLORIDA CONSTITUTION:

A. APPLICABILITY OF THE MANDATES PROVISION:

This bill does not appear to require a city or county to expend funds or to take any action requiring the expenditure of funds.

B. REDUCTION OF REVENUE RAISING AUTHORITY:

This bill does not appear to reduce the authority that municipalities or counties have to raise revenues in the aggregate.

C. REDUCTION OF STATE TAX SHARED WITH COUNTIES AND MUNICIPALITIES:

This bill does not reduce the percentage of a state tax shared with counties or municipalities.

V. COMMENTS:

A. CONSTITUTIONAL ISSUES:

This bill does not appear to violate any constitutional provisions.

B. RULE-MAKING AUTHORITY:

The bill does not appear to provide any rule-making authority.

C. OTHER COMMENTS:

The DOH supports the ACIP recommendation for vaccination against meningococcal disease for college students.

VI. AMENDMENTS OR COMMITTEE SUBSTITUTE CHANGES:

On February 7, 2002, the Committee on Health Regulation adopted a "strike everything" amendment. The bill was reported favorably as amended.

The "strike everything" amendment provides that:

- Students accepted for admission by a postsecondary educational institution must be provided detailed information on the risks associated with meningococcal meningitis and the vaccine;
- Students living in on-campus housing will be required to show proof of vaccination or sign a waiver; and
- Nothing in this section of law shall be construed to require a postsecondary educational institution to provide or pay for the vaccine.

On February 19, 2002, the Committee on Colleges & Universities passed HB 871 as a committee substitute. CS/HB 871 engrosses the language of the strike-all amendment that was traveling with the original bill. CS/HB 871 provides that postsecondary educational institutions must provide admitted students with information packets on meningococcal meningitis. Students living in on-campus housing must either provide documented proof of vaccination against meningococcal meningitis or sign a vaccination waiver form. CS/HB 871 does not require postsecondary educational institutions to provide or pay for meningococcal meningitis vaccinations.

On February 26, 2002, the Council for Healthy Communities adopted a "strike everything" amendment and reported the bill favorably as a Council Substitute. The CS/CS/HB 871 differs from the CS/HB 871 in that the provisions regarding vaccination for meningcoccal meningitis are now expanded to include the same provision for diphtheria, tetanus, and hepatitis B.

VII. SIGNATURES:

COMMITTEE ON HEALTH REGULATION:

Prepared by:	Staff Director:
Lisa Rawlins Maurer, Legislative Analyst	Lucretia Shaw Collins

AS REVISED BY THE COMMITTEE ON COLLEGES & UNIVERSITIES:

Prepared by:	Staff Director:
Steven Henderson	Betty Tilton, Ph.D.

AS REVISED BY THE COUNCIL FOR HEALTHY COMMUNITIES:

Prepared by:	Council Director:
Lisa Rawlins Maurer, Legislative Analyst	David De La Paz