HEALTH CHOICE 4 ACTION

# FACT CHECKING THE "COMMUNITY IMMUNITY ACT" – S.2359/H.4096

## DO WE HAVE A PROBLEM IN MASSACHUSETTS?

Senator Rausch states that "multiple communities have fallen below medically established immunization rate thresholds necessary to protect the population from certain infectious diseases." She claims that exemptions are one of the fundamental drivers of this issue, and even published a map plotting exemptions across the Commonwealth, as "all the proof in the pudding" necessary to advance her bill. However, analysis of the school immunization data from the MA DPH tells a different story. While it's true that a minority of schools do not achieve herd immunity rates for every disease we vaccinate for, the number of MA schools falling below herd immunity for any infectious disease is declining, not rising. The percent of kindergartens falling below herd immunity for any immunization declined almost 60% over the last 6 years, from 26% (2013-2014) to 11% (2018-2019). In addition, 60% of these schools had 0% exemptions and 85% reported gap rates (defined as children attending school neither with the required vaccinations nor an exemption on file) that are larger than exemption rates[1]. If there is an area of concern at all, then it is the lack of enforcement of current vaccination and exemption requirements, which this bill does not substantially address.

## Are Exemptions a Concern? Facts at a Glance

- ✔ The top 10 kindergartens with the lowest rates of MMR vaccination have **0% exemptions.**
- ✔ 60% of kindergartens with any vaccination rate below herd immunity have **0% exemptions.** 85% have a gap larger than the exemption rate.
- ✔ There is a **lack of correlation** between the minimal rise in exemption rates, the number of measles cases and MMR vaccination rates in Massachusetts.
- ✔ The percent of schools below herd immunity has **declined 60%** over the last 6 years.

## What is the "Gap"?

The gap is defined as children attending school neither with the required vaccinations nor an exemption on file. The gap includes students who are missing records but are potentially vaccinated, students on catch up schedules and students who have proof of immunity without a vaccination record. It is also inclusive of a significant population of students who are simply attending school without a vaccination or an exemption. The largest gap populations are in Suffolk County, where barriers to vaccination access or lack of enforcement resources may be substantial contributing factors to lower vaccination rates.

[1] https://www.mass.gov/info-details/school-immunizations

***STATEMENT:* Recent outbreaks of measles in MA and at least 15 other states have been attributed to an absence of localized herd immunity.**

**FICTION -** Massachusetts has had 3 cases of measles thus far in 2019 and 6 cases total in the last 5 years. None of these cases were the result of secondary transmission from other cases in the Commonwealth and none of them spread to others via secondary transmission. All reported cases in 2019 have been attributed to international travel[2] as opposed to an absence of localized herd immunity. Additionally, data from the largest outbreaks in 2019, Rockland County and New York City, shows that 74% and 79% of measles cases, respectively[3], were not amongst K-12 populations. Herd immunity levels cannot be established in the non-school-aged population in these areas since adult immunization levels are not tracked. Outbreaks cannot accurately be attributed to a lack of localized herd immunity when the majority of cases were among a population with an unknown vaccination rate.

***STATEMENT:* The Community Immunity Act fixes the [systemic issues with our immunization requirements and exemption processes], and in doing so substantially reduces and hopefully fixes existing localized herd immunity problems.**

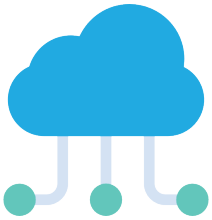
**FICTION -** Though the Community Immunity Act may seem worthwhile based on the sponsor's stated goals, the changes the bill actually makes are not supported by the data upon which the sponsor purports to rely. The "pocket" schools, referenced by the sponsor, are areas where vaccination rates fall below herd immunity levels. However, the majority of these schools are driven by the gap population rather than students claiming exemptions. In fact, the ten kindergartens that reported the lowest MMR rates in 2018-2019 reported 0% exemptions. Additionally, 90% of these "pocket" kindergartens are public schools[4]. The Community Immunity Act does not directly address the gap populations, which is a mere matter of enforcement of vaccination and exemption requirements under current law that can be easily remedied without this costly legislation. Instead, the largest changes the bill makes to current law are to add substantial restrictions to exemptions, allow minors to consent to preventive care including vaccinations and allow private programs to create their own stricter immunization policies.

[2] Mass DPH
[3] NY DPH, Michael Sussman Legal Brief, FF v State of New York 2019
[4] https://www.mass.gov/info-details/school-immunizations

***STATEMENT:* Since MA has no mandatory vaccination data reporting, hundreds of schools did not provide immunization exemption figures for the 2018-2019 school year, yielding incomplete statewide public health data.**

**FACT and FICTION -** 214 kindergartens (16%) and 203 (23%) of 7th grades failed to report immunization data for the 2018-2019 school year. However, this lower rate of reporting is new in the last two years and is directly correlated with the change in data collection systems introduced in 2016 and required in 2017. Prior to this change, kindergarten and 7th grade were reporting at 97% and 95% respectively (2015-2016), without mandated reporting [5]. The legislature and DPH should focus on removing barriers to reporting due to data collection changes, rather than imposing mandates and increasing the burden on schools. Additionally, the sponsor implies that the largest issue with voluntary reporting is that the State has incomplete exemption data. However, data shows that the overwhelming contributor to "a lack of localized herd immunity" is the gap population, not the exemption population. This is the data the State should be seeking to better understand.

***STATEMENT:* The Community Immunity Act will authorize the DPH to collect and publish immunization data.**



**FICTION -** The DPH is already authorized to collect and publish immunization data. All immunization data is available at https://www.mass.gov/info-details/school-immunizations, including current school by school data. The only thing the bill will do is force the DPH to publish the data of small schools, putting medically fragile children and religious minorities at greater risk for targeting and discrimination. As part of current DPH policy, records of schools with less than 30 students are not publicly available. The mandates in the Community Immunity Act would supersede this DPH policy and require these small schools to publish exemption rates, as the bill only cites applicable laws, not policies, as a means of protecting student privacy.

***STATEMENT:* The Community Immunity Act does not alter the availability of both medical and religious exemptions.**

**FICTION -** Although the Act does not remove medical and religious exemptions entirely, it imposes draconian and unjustified requirements for both exemptions that would drastically limit the amount of individuals who apply for or are approved for exemptions.

For example, the Community Immunity Act would require responsible adults to sign a form containing a statement that "refusing to immunize the participant may result in serious illness or death of the participant", which may constitute impermissible compelled speech, may conflict with the sincere religious beliefs of many families, and could potentially expose responsible adults signing the form to future legal action or liability.

[5] https://www.mass.gov/info-details/school-immunizations

***STATEMENT:* Private programs would retain the right to have stricter standards than those established by the DPH.**

**FICTION -** Current immunization law is applicable to both public and private programs in MA. Exemptions are required to be recognized by schools as part of this law, as stated in MGL c.76, § 15, 105 CMR 220.500 C(1), MGL c.15D, § 8E and 606 CMR 7.04 8(A). This bill would authorize private programs to create vaccination policies that differ from public schools, which would result in less standardization throughout the Commonwealth.

***STATEMENT:* The bill has a direct funding mechanism through the vaccination trust fund to provide the DPH with the resources it needs to implement this bill.**


**FICTION -** The bill alters MGL § 24N of Chapter 111, pertaining to the Vaccination Purchase Trust Fund, with the goal of allowing a portion of the funds to be used to administer the Community Immunity Act. However, this proposed amendment is a drastic alteration to the main purpose of this fund, which is to purchase vaccinations for guaranteeing universal access to childhood vaccines in the Commonwealth. Current law states that at least 90% of the fund must be used for the purchase of vaccinations and 10% or less can be allocated for storage and distribution of vaccines and maintenance of MIIS. A shift in this balance would decrease resources that ensure children of all backgrounds can receive vaccinations free of charge.

As of her last press conference, the sponsor failed to disclose a cost for the bill. However, the expenditure would be significant given the administrative resources needed within the DPH, including but not limited to, a department capable of processing 10K+ exemption applications each summer on an annual basis, a department to create educational resources and provide educational presentations to 100+ programs within a 45-day period, and undefined planning and enforcement resources. These administrative expenditures relating to management of exemptions and “elevated risk” schools do not align with the intent of the Vaccination Purchase Trust Fund and this questionable amendment to the Statute should be carefully considered.

The proposed amendment is a drastic alteration to the main purpose of this fund, which is to purchase vaccinations for guaranteeing universal access to childhood vaccines in the Commonwealth. A shift in this balance would decrease resources that ensure children of all backgrounds can receive vaccinations free of charge.

# FACT OR FICTION
# MARKETING MATERIALS FROM SPONSOR

***STATED ISSUE:*** ***Different programs for children and young adults are all subject to different immunization requirements.***

***THE BILL'S PROPOSED SOLUTION:*** ***Direct the DPH to create a standard schedule.***

**FICTION -** Currently, all programs are required to follow a standard immunization schedule, set forth by the DPH [6], and the DPH is already authorized and required to create and maintain this schedule. Regulations pertaining to adherence of the schedule for all programs are 105 CMR 220.00, 105 CMR 430.152 and 606 CMR 7.04(7)(A)13. Immunization requirements vary by grade/age by design, as certain vaccinations are targeted and authorized for certain age ranges. There is no need to create additional standardization as the sponsor asserts. Notably, this bill may actually result in less standardization, because private covered programs would be allowed to create more stringent and differing requirements.

***STATED ISSUE:*** ***Each school/program determines its own process for caregivers to obtain a medical or religious exemption.***

***THE BILL'S PROPOSED SOLUTION:*** ***All exemptions are standardized and supplied by the DPH.***

**FICTION -** The current law is clear with respect to medical and religious exemption requirements. The burden is currently on the family to obtain a medical exemption from a doctor or to create a written statement for a religious exemption, and then submit either document to the school.

***STATED ISSUE:*** ***Each individual school decides whether to approve or deny exemption requests, regardless of whether the school has medical staff.***

***THE BILL'S PROPOSED SOLUTION:*** ***All exemptions are tracked and approved or denied by the DPH.***

**FACT and FICTION -** Current law does not permit a school to deny a religious exemption. Any process or denial by a school is likely the result of a school not understanding the guidelines of the law or discrimination. Further, there is no requisite or necessity for school medical staff to evaluate religious exemptions. With regard to medical exemptions, the treating doctor, writing the exemption, should be trusted to provide the best medical guidance for their patients. In the rare event that a school disagrees with a medical exemption, there is already a process in place to escalate the exemption to the DPH for a decision. The DPH does not currently have the resources to process 10K+ exemption applications every summer, which is just one resource-intensive process this bill mandates. Additionally, the bill sponsor claims that processing exemptions through the DPH will reduce the burden on schools; yet, the process outlined in the bill still requires the school to process and handle immunization data and exemptions, and still report this data to the DPH, thus not reducing their burden.

[6] https://www.mass.gov/doc/immunization-requirements-for-school-entry-0/download

***STATED ISSUE:*** ***Medical exemptions must be renewed annually, but religious exemptions are "one and done," meaning they never require renewal.***

***THE BILL'S PROPOSED SOLUTION:*** ***Both types of exemptions must be renewed annually.***

**FICTION:** Current DPH published guidance on immunization requirements state that medical and religious exemptions should be renewed annually at the start of the school year [7].

***STATED ISSUE:*** ***Health care providers are not necessarily informed when parents/guardians request an exemption from immunization requirements.***

***THE BILL'S PROPOSED SOLUTION:*** ***Require providers to sign off on all exemption requests.***

**FACT and FICTION -** Current law requires a doctor to write a medical exemption, by default making that doctor aware of the exemption. This bill actually requires the primary care doctor to be the provider to write the exemption, when many medical conditions that contraindicate immunization can only be evaluated and determined by specialists. Furthermore, a provider signature should not be a requirement to obtain a religious exemption, as primary care providers will know their patients' immunization status. Additionally, all primary care providers currently have access to MIIS records, which provide up-to-date immunization information of their patients, making the provider's awareness of an exemption irrelevant.

***STATED ISSUE:*** ***There is insufficient guidance for health care providers about which conditions substantiate an exemption.***

***THE BILL'S PROPOSED SOLUTION:*** ***The community immunity act specifies that the Totality of a person's health circumstances, in addition to any cdc Contraindications, will justify a medical exemption.***

**FACT and FICTION -** The sponsor is correct that there is insufficient guidance and training for health care providers to allow them to write medical exemptions for many children that need them. However, the bill does not expand medical exemption options for these children. Instead, the bill places decision making authority with a DPH employee or "expert" provider who is neither the treating physician nor the best person to determine an exemption approval or denial for conditions outside of the narrow list of CDC contraindications. Whether a condition substantiates a medical exemption should be a matter left to the child's doctor or specialist and should not be subject to bureaucratic oversight.

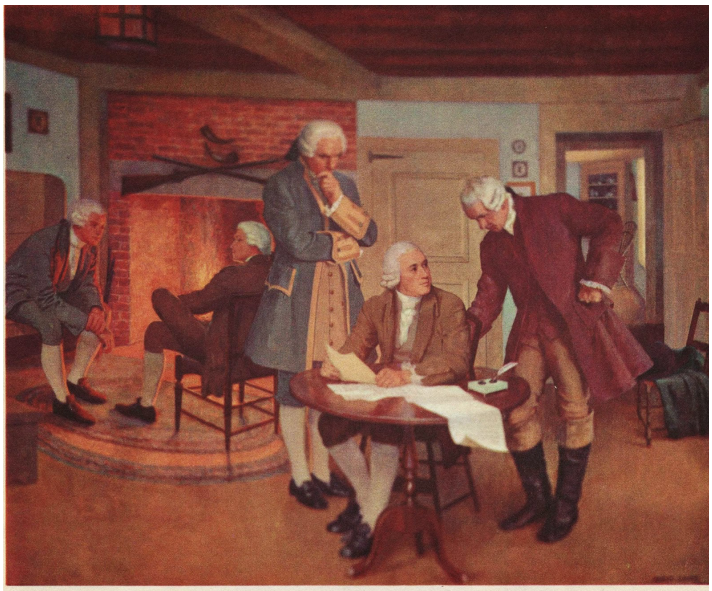
[7] https://www.mass.gov/doc/immunization-requirements-for-school-entry-0/download

***STATED ISSUE:** There is insufficient guidance for health care providers about the care they can provide to mature minors.*

***THE BILL'S PROPOSED SOLUTION:** The Act clarifies that mature minors can consent to preventive care.*

**FICTION -** Current statutory law permits minors who satisfy certain specified criteria indicating maturity to consent to emergency medical treatment. The common law in Massachusetts permits treatment of a minor where the minor is mature AND it is in the minor's best interest. However, this bill modifies existing law to permit providers to administer "preventive care" if the provider determines the child is mature outside of these classifications OR if the provider believes the care is in the child's best interest. The sponsor has inaccurately stated that this bill is a codification of existing law when, in actuality, the bill permits a provider to administer care to an immature minor, where the provider believes it in the minor's best interest, is a radical departure from current law. For instance, the bill would not require the minor be able to provide informed consent, be of a minimum age or have an established relationship with the administering provider.

***STATED ISSUE:** Few criteria are required for religious exemptions*



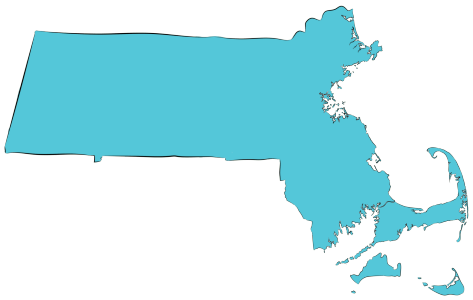
JOHN ADAMS, SAMUEL ADAMS AND JAMES BOWDOIN DRAFTING THE MASSACHUSETTS CONSTITUTION OF 1780.

**FACT -** Current requirements to obtain a religious exemption are in line with MA constitutional and religious rights. There should be no requirement, other than a statement of sincere religious belief, which is dictated by each individual's conscience, and the State should not be in the business of regulating matters of conscience or religion.

***STATED ISSUE:** Data reporting on immunization rates is not required in MA. Schools/programs report this data on a completely voluntary basis.*

***THE BILL'S PROPOSED SOLUTION:** Mandate that schools report data.*

**FACT -** Prior to data collection changes, implemented and mandated in 2016 and 2017, rates of non-reporting schools were consistently low at 3-5% [8]. Changes in this system yielded a sharp and immediate uptick in non-reporting schools.



***STATED ISSUE:** Parents may not know if their child's school or summer camp is below herd immunity rates for a disease.*

***THE BILL'S PROPOSED SOLUTION:** The DPH must send notices to families at schools deemed an 'elevated risk'.*

The sponsor makes no attempt to explain why children with communicable diseases are entitled to confidentiality protection but children who do not have communicable diseases, but are not immunized against them, are not.

**FACT and FICTION -** Families who are concerned about immunization rates currently have the ability to look up their school's rates on mass.gov. Mandating notification to parents of children in these schools will create unnecessary hysteria and fear and increase the likelihood of discrimination and bullying of medically fragile and religious minority children. The sponsor states that parents deserve to know if their children are exposed to "elevated risk." However, law dictates that parents often do not have a right to know. For instance, Section 504 of the Rehabilitation of Act of 1973 protects the confidentiality of and against discrimination toward students who are carriers of communicable diseases, such as HIV, Hepatitis B or tuberculosis. The Commonwealth and schools have at their disposal more than adequate quarantine and isolation protocols to protect against secondary transmission of infections.

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**Community Immunity Act (S.2359/H.4096)**

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