MMA Public Health Committee
June 11, 2014
4pm-6pm

Conference Call Dial in Number: 1-877-668-4493 **Note this is a new number**
Access Code: 23025386

AGENDA

(5 min) I. Welcome and Introductions – Drs. Lani Graham & Daniel Oppenheim

(5 min) II. Acceptance of April 2014 Minutes (attachment 1)

(5 min) III. Announcements

(75 min) IV. Priority Topics
1. Committee priorities for 2014-2015 (attachment 2 & 3)
2. Transition of staffing
    a. Meeting schedule
    b. Public Health Spotlight Article – volunteers?
    c. Other logistics
3. Resolution topic(s) for MMA Annual Session Sept 5-7

(15 min) V. Old Business & Brief Updates
1. Legislative Updates (attachment 4 – slide summary)
2. TSCA Reform (attachment 5)
3. Climate Change & Adaptation
4. Update on Domestic Violence Linkage Project (Dr. Postman)
5. Physician Wellness (Dr. Graham)

(15 min) VI. New Business
1. EPA Carbon Pollution Standards Sign on Request (attachment 6)
2. MeCDC representation
3. New Public Health Issues on the Horizon
4. Upcoming Events

MAINE MEDICAL ASSOCIATION - PUBLIC HEALTH COMMITTEE
MEETING MINUTES
April 9th, 2014

MEMBERS PRESENT: Co-Chair, Lani Graham, MD, Norma Dreyfus, MD (phone), Lawrence Mutty, MD (phone), Stephen Sears, MD, Edward Walworth, MD (with Bates College student guests – Patrick and Marilyn), James Maier, MD (phone), John Garofalo, MD (phone), Dora Mills, MD (phone).

OTHERS PRESENT: Guy Raymond, MD, MMA President (phone), Staff: Jessa Barnard, Ashley Bernier, Andy MacLean, Gordon Smith (phone).

TOPIC	DISCUSSION	ACTION/FOLLOWUP/RESULTS
	Before the meeting officially began, members decided they would write a letter to DHHS Commissioner Mary Mayhew concerning the vacant position for the State Epidemiologist, a position being vacated this spring by Stephen Sears, MD. This will ideally be a joint letter between MMA, MOA and the Maine Public Health Association. Members believe this position should be filled with an MD with much experience with public health.	**Ms. Barnard will draft a letter to Commissioner Mayhew.**
Welcome & Introductions	Introductions were made around the room and on the phone.	
Review of February 2014 Meeting Minutes (attachment 1)	Members reviewed the minutes. One name correction was made to correct the spelling of John Garofalo's name. Motion made to approve February 2014 minutes with the correction.	**Minutes were accepted.**
Announcements	Dr. Sears is stepping down from the MeCDC to become the Chief of Staff for the Maine VA. Members thanked Dr. Sears for his commitment to public health and serving the people of Maine and asked him to remain a member of the Public Health Committee.	

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Priority Topics & Guest Speakers **1. Committee priorities for 2014-2015 (attachments 2, 3 & 4)** **a. Review of Survey Monkey Results, discussion & voting**	Ms. Barnard sent out the Public Health Committee Priority survey a few weeks ago, and had 15 responses. Attachment 1 includes a bar graph and table of the results. The three top priorities were Access to Health Care (health coverage and access to preventive services), Integrating Public Health into Health Care Services and Physician Wellness. Members agreed that Access to Healthcare has always been a lead issue for MMA. If PHC makes it a priority, members thought it would be the same for any legislative activity with the committee being a source for potential speakers and advocates and a source of expertise for MMA. This would lend additional support to MMA. Members also discussed Physician Wellness. Mr. MacLean proposed that the PHC uses this topic and develop a curriculum for a CME program, conference or an online forum on the MMA website for physicians to access and use as a resource. An online forum would also be a good place to list resources for physician burn out. Others agreed that this is a topic that not many other associations or groups focus on, so MMA should take the lead. Some thought the MPHP Advisory Committee was working on a similar topic, so collaboration could be a possibility. Additionally, some members thought that instead of focusing on each of these three topics separately, they might be better accomplished as a whole, since there is overlap between them. With such big topics, there is some concern if the PHC would need to step back from other important topics. The PHC resolved to let Dr. Graham and Ms. Barnard frame a continuing discussion for the next meeting.	**The three top priorities in the survey were Access to Health Care (health coverage and access to preventive services), Integrating Public Health into Health Care Services and Physician Wellness. The PHC resolved to let Dr. Graham and Ms. Barnard put together a proposal for carrying these priorities forward for discussion at the next meeting.**

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Old Business and Brief Updates		
1. **Legislative Updates (Ms. Barnard, Mr. MacLean, Mr. Smith)**		
a. **LD 1578 & 1487, Medicaid Expansion**	LD 1487 was recently vetoed, and Mr. MacLean distributed the veto message. This veto was expected, but legislative members are hoping to override it. Mr. MacLean believes there is a small chance of this happening. It will start next in the Senate. LD 1578 is considered a "back-up" bill for LD 1487. LD 1578 amendments are currently being changed to appeal to Republicans. This bill would be a private Medicaid option (similar to New Hampshire's). This process will start on Monday (4/14).	**LD 1487 was vetoed. Small chance of this bill to be overridden. LD 1578 amendments are currently being drafted.**
b. **LD 1345, Single Payer**	After many hours in preparation, the Insurance Committee only managed to get 1 Republican vote after discussing their Single Payer study. Mr. MacLean stated it will most likely be vetoed by the Governor.	**LD 1345 will most likely be vetoed by the Governor.**
c. **LD 1699, HIV Education**	This bill would give $150,000 for teacher, peer and preventive education for HIV. This biggest issue with this bill will be funding, but it was passed unanimously by the Education Committee.	**LD 1699 is having funding issues.**
d. **LD 1719, FHM**	An amended version of this bill was approved by the	**Amended version of LD 1719 was**

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Funding	Appropriations Committee. It keeps $5 million of one-time tobacco settlement money going to the public health, but the money for family planning and head start was cut.	**passed, with money going to public health.**
e. **LD 1811, Drug Enforcement**	This is the Governor's bill which would increase the State's efforts in investigating, prosecuting and punishing for drug crimes. Law enforcement would be strengthened. Mr. MacLean believes this is likely not to pass due to the cost.	**LD 1811 is likely not to pass.**
f. **State Budget**	The Legislative committee reached a budget on April 9th to create a 2015 supplemental budget. One concern in the proposed budget that Mr. MacLean brought out was creating a 6 month time limit for Methadone and Suboxone – this was not included in the final version. The proposal for a tobacco tax was also not approved.	**2015 Supplemental budget has been created.**
g. **Safe Chemicals Act**	Mike Belliveau with Environmental Health Strategy Center testified to Congress two weeks ago concerning this bill, expressing how critical it is but that there are many issues with the current draft.	**Mr. Belliveau testified to Congress regarding the importance of this act.**
2. **Climate Change & Adaptation**	Physicians for Social Responsibility, that Dr. Graham is a part of, is revising their paper published in 2000, "Death by Degrees." The United Nations has also recently published a report on climate change. Ms. Barnard, along with Dr. Graham, will be presenting this topic in relation to public health at the next senior section meeting (April 30th). Dr. Joel Kase is also working on revising an article on this topic to include in the next edition of the MMA newsletter. Two members also spoke of a new book by Elizabeth Kolbert, titled the "Sixth Extinction," which analyzed this topic in	**Ms. Barnard and Dr. Graham will be giving a presentation on public health at the Senior Section meeting on April 30th.**

	great detail.	
3. Update on Domestic Violence Linkage Project (Dr. Postman)	Dr. Postman was not available to present on this topic.	
4. Updates from MeCDC (Dr. Sears)	May is Lyme disease awareness month, so the CDC will be giving community based presentations to educate people of the dangers of this disease and prevention. Due to this winter, it may be a little later till we see the ticks come back. The CDC is right in the middle of their budget season, so they are focusing on grant applications. One member asked about the recent letter in the Bangor Daily News concerning Public Health Nurses and their lack of appreciation. They were not cut from the recent budget, but they have many open positions that they can't seem to fill. This lack of support is making the PH nurses work harder. The PHC discussed the possibility of the committee raising awareness of this issue due to the importance of public health nursing.	**May is Lyme disease awareness month, so the CDC will be giving community based presentations to educate people of the dangers of this disease and prevention. The PHC discussed the possibility of the committee raising awareness of the need for public health nursing.**
5. Physician Wellness (Dr. Graham)	Not discussed at this time – discussed as part of prioritization.	
6. Carried over from February: Update on workplace Injuries/OSHA (attachment 5)	OSHA has launched a new website and kit focusing on healthcare workers safety, including violence and workplace injury. Members expressed that they were very happy for the attention to this ongoing issue.	**OSHA has launched a new website and kit focusing on healthcare workers safety.**

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7. **Update on Trigger Lock Campaign (Ms. Barnard/Dr. Walworth)**	The Maine Citizens against Handgun Violence last held a trigger lock campaign 10 years ago and Dr. Walworth expressed that it's time to revisit this issue. Ms. Barnard stated that the MMA has signed on to support the campaign. The American College of Surgeons is also supporting, and he is still awaiting responses from the Family Physicians and Emergency Physicians groups. One member recommended he send a letter to the MAPP, which Dr. Walworth agreed was a good idea. He has received endorsement but no donations at this time. Ms. Barnard stated when then MMET Trustees meet in May, the group will consider this.	**Dr. Walworth is continuing to seek support from specialty societies on this this campaign.**
New Business		
1. **New Public Health Issues on the Horizon**	MMA has signed on to the Lung Association's letter in support of the EPA's new smoke wood guidelines. Commissioner Aho has released a statement in opposition due to the impact on the wood industry and low income families. The Governor also wrote a recent piece about why this would be unacceptable.	**MMA has signed on to the Lung Association's campaign in support of the EPA's new smoke wood guidelines.**
2. **Upcoming Events**	Senior section meeting will be held on April 30th.	**Senior section meeting will be held on April 30th.**
Next Meetings: June 11, August 13, October 8, December 10, 4-6 pm, MMA Offices or by phone		**Meeting Adjourned**

MMA Public Health Committee 2014-2015 Priorities
- DRAFT June 2014 –

Top Priorities: PHC Should Lead the Effort

1. Access to Health Care (health coverage and access to preventive services)
    a. Proposed actions:
        i. MMA Public Health Committee convenes a work group to draft a resolution/position statement/brief white paper on health care reform – consider as an update to MMA's 2003 White Paper on Healthcare Reform in Maine "Providing Coverage to All" – See attached
        ii. White paper to reference/discuss other two priority issues –(1) the need to integrate public health into health care services and begin to provide population based care and (2) the need to ensure physician wellness/prevent burnout in the face of payment reform/health reform efforts and in order to ensure continued access to primary care services
    b. Other options:
        i. Standing or rotating PHC member participate in MMA Legislative Committee Calls and share appropriate updates/action alerts with members
        ii. PHC members participate in contacting legislators, writing LTEs, drafting testimony, as appropriate, on legislative initiatives
2. Integrating Public Health into Health Care Services
    a. Proposed actions:
        i. Address as subsection/paragraph in white paper, discussed above
    b. Other options:
        i. Standing or rotating PHC member participate in State Innovation Model Grant Delivery System Reform Subcommittee working on ACO, behavioral health integration, community health worker, diabetes prevention and health homes initiatives (http://www.maine.gov/dhhs/sim/strategies/delivery.shtml)
3. Physician Wellness
    a. Proposed actions
        i. Address as subsection/paragraph in white paper, discussed above
        ii. Consider addressing for all medical professionals, not just physicians
        iii. As resources and time allow, consider eventually drafting stand-alone white paper on scope of problem and possible action steps
        iv. PHC receive updates from Medical Professionals Health Program advisory committee via co-chair

Middle Priority: MMA/PHC Joins Coalition Efforts

On all issues: The Committee will only participate in/respond to legislative or other policy/regulatory initiatives when and if asked by the MMA legislative committee, coalition

partners or Committee members. The individual/entity requesting PHC support will have to provide sufficient background information and make the case at a Committee meeting and/or in an email request. The Committee is considered advisory to the MMA Legislative Committee. MMA staff may also participate in these issues and with coalition partners on behalf of the MMA/Legislative Committee and not wearing a PHC "hat."

1. Childhood immunizations
    a. Partners include: Maine Immunization Coalition (MMA staff actively participates), Universal program (physician members include Larry Losey, Sid Sewall)
2. Domestic Violence
    a. Partners include: Nellie's Web, Maine Coalition to End Domestic Violence
3. Environmental Toxins
    a. Partners include: Alliance for a Clean and Healthy Maine, PSR, Environmental Health Strategy Center
4. Health Effects of Climate Change
    a. Partners include: MeCDC Climate & Health Program, PSR, Environment Maine, Natural Resources Council of Maine
5. Preserving the Fund for a Healthy Maine
    a. Partners include: Friends of the Fund for a Healthy Maine, American Cancer Society, American Lung Association, American Heart Association
6. Public Health Infrastructure
    a. Partners include: Statewide Coordinating Council for Public Health (SCC) (MMA staff participate as Key Stakeholder, as time allows; physician representative is Joel Kase, DO)
7. Youth Health (childhood obesity & tobacco use)
    a. Partners include: Public Health Association Tobacco Policy Committee & Obesity Policy Committees (MMA staff participate, as time allows), American Cancer Society, American Lung Association, American Heart Association, Maine Osteopathic Association

Other: behavioral health, gun control, wood smoke, etc

    b. Proposed Actions
        i. Members bring opportunities for involvement to attention of Committee and MMA staff

May 1, 2003

"PROVIDING COVERAGE TO ALL"

MMA'S WHITE PAPER ON HEALTHCARE REFORM IN MAINE

Background

At its 2002 Annual Session, the Maine Medical Association considered a Resolution prepared by its Public Health Committee, which called for the Association to endorse the concept of universal healthcare coverage for all Mainers (See Resolution attached). During the discussion at the Annual Session, members referred the Resolution to the Executive Committee to consider more fully some of the more novel and complex issues noted in the Resolution. The Executive Committee appointed an Ad Hoc Committee on Health System Reform and charged it with writing a White Paper detailing the steps to be taken to achieve universal coverage in a manner consistent with the charge of building upon the existing system of public and private payors.

The Ad Hoc Committee (members are listed in appendix B) met on four occasions to devise a set of Guiding Principles and to develop a list of features of a universal coverage plan. This paper adds discussion and detail to the Committee's work.

We hope that this plan from Maine's largest physician professional organization will add to the very substantial dialogue taking place in Maine on health system reform. The Association acknowledges the substantial efforts by several other groups to offer similar plans, from which this Paper has drawn inspiration.

1. "Closing the Gap", Maine Hospital Association;
2. "Creating a Healthy Maine"; Anthem Blue Cross Blue Shield;
3. "White Paper on Principles for a Universal Health Care System for the State of Maine"; Portland Universal Health Care Work Group,
4. "The Health Care Challenge", Maine Health and other participating organizations.

In the preparation of this paper, the Ad Hoc Committee has also drawn upon several papers prepared by the American Medical Association, the American College of Physicians – American Society of Internal Medicine, and Governor Baldacci's Office of Health Policy & Finance and Health Action Team. Appendix C contains the agendas and minutes of the Ad Hoc Committee meetings, which contain a fuller description of the many resources considered by the Committee.

The Principles upon which a system of universal coverage should be built are as follows:

Guiding Principles

- Universal coverage, which ensures access. Mandate participation
- Emphasize prevention eg: recommendations of US Preventative Task Force
- Systematic support for healthier lifestyles, through incentives for identified health risk avoidance.
- Individual responsibility, including responsibilities for one's own behaviors affecting health and well-being.
- Eliminate cost shifting,
- Educate patients and providers as to the price of services, products, and valid quality outcome data.
- Hold all stakeholders accountable for working together to make our health care system better and health insurance more affordable.
- Maximize the percent of health care dollars that support direct provision of patient care.
- Provide patients with choice in the selection of physicians.
- Improve quality and minimize errors by relying upon evidence-based medicine, benchmarking, and outcome measures.
- Build organizational structure that provides ongoing quality improvement and support of quality initiatives.
- Provide ongoing stakeholder monitoring of governmental initiatives in universal coverage program.

Achieving Universal Access

More than 140,000 Maine people, approximately 12% of the state's population, are without health insurance.

While Maine's uninsured percentage is lower than the national average of 14%, the goal of achieving coverage for all Mainers is essential for the following reasons:

1. There is cogent evidence that persons without insurance wait too long to access necessary medical services and are less likely to avail themselves of preventive services.

2. When the uninsured do access services, they frequently are unable to pay the cost of those services which is then shifted to others. This notion of "cost-shifting" has become a major policy issue.

The Maine Hospital Association annually estimates the cost-shift represented by bad debt and charity care to be $145 million and that figure does not include the cost-shift that also affects physicians and other providers. Governor King's Blue

Ribbon Commission on Health Care Costs (2000) estimated the total cost–shift to be approximately $163 million in 1999.

While achieving universal access in a single state, without the full participation of the federal government, will be difficult, it is not impossible.

Any plan to cover the uninsured must take into consideration the diversity of the uninsured population. More than one-half of uninsured individuals are employed. A substantial number are eligible for public programs but have not enrolled. Still others are individuals who wish to purchase coverage but cannot afford, on their low salaries, to do so. A very small group of people make more than 300% of the federal poverty level, but choose not to obtain coverage.

We believe that universal coverage can only be achieved through a variety of diverse initiatives. Briefly stated, they are as follows:

1. Develop incentives for small businesses to offer health insurance to their employees. The former Maine Health Program, a pilot project in the late 1980's was a very good model, but the Legislature eliminated the Program during the budget crisis of the early 1990's.

   It may be possible to draw down federal Medicaid funds to assist in covering those employees currently eligible for Medicaid coverage. This approach has been discussed in the Governor's Health Action Team and may find its way into the Governor's package.

2. Raise income eligibility levels to the maximum permitted in Medicaid, as drawing down the additional federal dollars will always be a positive strategy for Maine, so long as Medicaid payments to physicians and other providers are increased to cover the cost of providing the care. Gradually, Medicaid reimbursement rates for individual practitioners should be increased to the level of Medicare. To expand access by increasing eligibility in the public programs will only exacerbate the cost-shift if the programs continue to inadequately reimburse physicians and other providers.

3. Continue efforts to reach out to and enroll those individuals who qualify for public plans, but have not enrolled. While DHS, hospitals, and consumer groups have initiated such outreach programs, thousands of eligible persons still are not enrolled. This problem becomes particularly unfortunate when children are involved, as they are dependent upon others to enroll them.

4. Private insurance must be reformed in order to lower premium costs and to offer products that are attractive to uninsured. For young,

healthy adults it is important to offer a product emphasizing preventive care and catastrophic coverage.

While the notion of a Basic Health Plan has been criticized by many, we believe that it is one option that should be included in our effort to pursue universal coverage. In Washington State, a Basic Health Plan exists for about 125,000 low-income residents who are ineligible for Medicaid. We envision a similar Plan with the following coverages:

- Two physician visits annually with co-pays of $10-$20. For pediatrics, coverage for well-child visits in accordance with the recommendations of the American Academy of Pediatrics.
- Up to $300 in preventive care costs per year
- Up to $500 for lab or imaging services
- Cap total out-of-pocket costs at $2,500
- Annual deductible of $1,000

As a rule, the current system could be stronger and more viable and certainly would be more equitable, if more people were covered for fewer services. The full tax deductibility of employer-paid health insurance encourages purchasing more health insurance than some people need. This over-insurance also impacts utilization, as people are not as discerning in their use of the health care system when they are insulated from its cost.

Bottom line. Less expensive policies must be developed if the "young immortals" are going to be motivated to purchase health insurance.

5. MMA supports the concept of Association Health Plans and other group purchasing collaboratives. While we are mindful of the problem of "cherry-picking" whereby such plans insure only the healthy leaving the chronically ill or disabled for high risk pools, this problem will be lessened in a system where all persons are insured.

Individual Mandate

Despite the five approaches endorsed above, it is the Association's considered opinion that universal coverage cannot be achieved without requiring everyone to maintain some basic coverage. For the same reason Maine requires motorists to buy auto insurance, the state should require the purchase of health insurance. This approach will not seem radical if several types of plans are accessible, some of which are basic plans with low cost. Some system of public subsidy will

be necessary for those individuals who do not qualify for a government health program and cannot afford individual or employer-sponsored coverage. Administratively, the individual mandate need not be difficult. At least one commentator has suggested requiring people to indicate on their annual tax form whether they are insured for health care. If they do not so indicate, they would be enrolled by default in a plan or either billed or subsidized accordingly. (Ted Halstead, New York Times article 1/31/03)

Such an approach would have several salutary effects, including:

1. People would be likely to have more opportunity than they do currently to select a policy and the level of insurance appropriate for them and their families. Continuity of coverage and of care would be more likely to be maintained.

2. A more vigorous and competitive market for health insurance would develop as the result of more customers. More choices of carriers and products would be available than the very limited choices available in Maine today.

3. People would be likely to seek preventive care earlier, thus improving the quality of their care.

4. Insurers would be more likely to invest in disease prevention because more people would stay with a single insurer for a longer period ensuring the carrier a better return on its investment.

State Subsidized Non-Profit Insurer

If the types of affordable insurance products contemplated by this Plan are not forthcoming, MMA is not opposed to the state chartering its own non-profit insurance company. In fact, at the time MMA opposed the sale of Blue Cross Blue Shield of Maine to Anthem, we noted that it might become necessary to "re-create" a similar company in the future, as a hedge against a lack of competition in the insurance market. This may be even more necessary today now that the three major health insurance companies are all for-profit, stock-based companies. In a relatively poor state such as Maine, we are skeptical about the ability of our patients to pay enough premium to pay for all the legitimate health care needs of the members, the administrative costs associated with those needs, and still have money left over to pay shareholders. The truly huge premium increases of the past 24 months are further evidence of this problem. Our MMA Group Health Plan has increased 67% in the past two years for our retired group and nearly 30% for our active members. It is a bit ironic when the physicians responsible for providing the hands-on care cannot afford coverage themselves!

Cost

Any plan to achieve universal coverage cannot ignore the fact that the high cost of health insurance is the greatest barrier to access. We cannot achieve universal coverage if premium costs continue their unrestrained increase. In addition, we acknowledge that health insurance premium increases are primarily the result of increasing health care costs. While many of the cost drivers are beyond the ability of government or society to control (aging population, new technology, patient demands, etc.), there are several concrete steps that can be taken to positively impact health care costs and premiums in Maine, including the following:

1. Eliminate geographical inequities in the Medicare funding formula. Maine's healthcare providers and institutions should not receive less pay for the same services that warrant up to 40% higher reimbursement in other states.

2. Provide incentives for electronic claims submission, electronic medical records, and other technological advances likely to make the delivery and finance system more efficient and to promote quality health care. Capitalize on new technology to develop care management systems to support the care of patients with chronic disease.

3. Establish a state health planning process that is independent, objective, and designed to ensure a rational building of additional capacity. Such a planning process should avoid duplication but should also encourage patient choice, including incentives for patients to receive care in the lowest cost setting where safe and appropriate. Ample data supports the case for allowing patients a choice of outpatient facilities rather than expanding existing monopolies. It may be possible to have different Certificate of Need rules apply in those areas where there is competition among providers versus those more rural areas where protection of the existing facilities may be a priority.

   Any state planning process should include specific goals for access, quality, and affordability.

4. Educate patients and providers as to the price of all health services and products, particularly the cost of prescription drugs. Encourage co-insurance rather than fixed co-payments to ensure that patients have a substantial personal investment in the medical care they seek.

5. Accept limits. No health care system can hope to cover all the services that patients want. Universal coverage cannot mean

unlimited care. Appropriate services based on evidence-based medicine, outcomes research and appropriate patient education should be covered. Appropriate end-of-life-care presents a unique opportunity to set limits, based on clear patient preference and appropriate ethical guidelines.

6. Professional Liability. Increasing medical liability premiums are a cost driver in the system and encourage the practice of defensive medicine. While Maine has an existing system of reforms, such as the pre-litigation screening panels, a reasonable cap on non-economic damages is necessary to reduce potential unlimited liability. We recommend $250,000.

Quality.

Most observers of our healthcare system now understand that good quality care saves costs. Medical errors and other examples of poor quality not only hurt patients physically, but also hurt all of us in the pocketbook. The MMA offers the following recommendations for improving quality.

1. Give physicians and other providers incentives to adopt new technologies such as electronic medical records and automated order entry and pharmacy monitoring in order to reduce medical errors.

2. Encourage conformance with professionally developed practice guidelines and protocols. Support establishment of a successor organization to the Maine Medical Assessment Foundation. Such a statewide quality improvement foundation could engage in a number of activities ultimately designed to improve quality such as small area variation analysis and standardized data analysis.

   Currently, many quality improvement initiatives exist throughout the state and all are well intentioned, but there is an acute need to coordinate and perhaps centralize these disparate and sometimes duplicative efforts.

   Both the Maine Hospital Association and the Maine Medical Association have quality committees working on these issues, but a state role may be necessary in order to assure broad-based funding and broad participation. We clearly need to build organizational structures that provide ongoing quality improvement and support of quality initiatives.

3. Quality can be enhanced by empowering patients to partner with their physicians in their health maintenance and care. The healthcare system needs to provide systemic support for healthier lifestyles through incentives for identified health risk avoidance.

Conclusion

Our final principle for reform provides that all stakeholders are accountable for working together to make our health care system better and health insurance more affordable. The Maine Medical Association stands ready and willing to work collaboratively with all other stakeholders, including state government, in order to address the very real crisis in health insurance coverage in our state.

Laws of Interest Enacted by the 126th Legislature

1st & 2nd Regular Sessions

Practice Education Seminar
June 18, 2014

1

Maine Medical Association

- Voluntary membership association of over 4,200 Maine physicians, residents, and medical students
- Formed in 1853
- Mission: to support Maine physicians, advance the quality of medicine in Maine, and promote the health of all Maine citizens

2

Maine Medical Association

- Activities:
  - Educational Programming/CME Credentialing
  - Peer Review Program
  - Medical Professionals Health Program
  - Manage specialty medical societies
  - Legal services
  - Legislative and regulatory advocacy

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Legislative and Regulatory Advocacy

- Advocates the interests of Maine physicians and their patients before the legislative and executive branches of federal and state government
- Advocacy team includes:
  - Gordon H. Smith, Esq., Executive Vice President
  - Andrew B. MacLean, Esq., Deputy Executive Vice President
  - Jessa Barnard, Esq., Associate General Counsel

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Legislative Advocacy - The Policy Makers

- 186 Legislators
  - 126th Legislature (2013-2014)
    - 19 D, 15 R, 1 U in Senate
    - 89 D, 58 R, 4 U in House
    - If 2/3 vote needed: 24 in Senate, 101 in House
- 151 members of the House of Representatives, each representing 8443 citizens
- 35 Senators, each representing 36,426 citizens
- All elected every 2 years for maximum of 4 consecutive terms
- Governor: elected every 4 years for maximum of 2 terms
- Find your legislators: http://www.maine.gov/legis/house/townlist.htm

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Physicians in 126th Legislature

- Rep. Linda Sanborn, M.D. (D), House District 130, parts of Buxton & Gorham
- Sen. Geoffrey Gratwick, M.D. (D), Senate District 32, Bangor & Hermon
- Rep. Ann Dorney, M.D. (D), House District 86, Madison, Norridgewock, & Solon
- Rep. Jane Pringle, M.D. (D), House District 111, part of Windham

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126th Legislature's Senate Leadership

- Senate President: Sen. Justin Alfond (D-Cumberland)
- Senate Majority Leader: Sen. Troy Jackson (Aroostook)
- Assistant Senate Majority Leader: Sen. Anne Haskell (D-Cumberland)
- Senate Minority Leader: Sen. Michael Thibodeau (R-Waldo)
- Assistant Senate Minority Leader: Sen. Roger Katz (R-Kennebec)

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126th Legislature's House Leadership

- Speaker of the House: Rep. Mark Eves (D-North Berwick)
- House Majority Leader: Rep. Seth Berry (D-Bowdoinham)
- Assistant House Majority Leader: Rep. Jeff McCabe (D-Skowhegan)
- House Minority Leader: Rep. Kenneth Fredette (R-Newport)
- Assistant House Minority Leader: Rep. Alexander Willette (R-Mapleton)

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Maine's Path of Legislation

- Idea developed
- Bill drafted (Legislative Request or LR)
- Bill introduced (Legislative Document or LD)
- Committee reference
- Committee action (public hearing/work session(s)/vote)
- First Reading (committee amendments)
- Second Reading (floor amendments)
- Next chamber, same process (must pass in identical form)
- Governor's action (10 days to sign or veto)
- Law (effective 90 days after adjournment, unless emergency or other specified date; citation is "Public Law" or "Resolve")

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Key Legislative Committees

- Joint Standing Committees on:
  - Appropriations & Financial Affairs
  - Taxation
  - Labor, Commerce, Research & Economic Development
  - Health & Human Services
  - Insurance & Financial Services
  - Judiciary
- Committee membership lists with contact info.: http://janus.state.me.us/house/jtcomlst.htm

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MMA Advocacy Activities

- MMA Legislative Committee
  - Monitor, Support, Oppose
- Committee Hearing & Work Session
  - Staff testifies, members testify, organize other specialty societies to testify, submit written comments, discuss with committee members, participate in work session
- Floor Action
  - Talk with members, draft floor materials, send action alerts to members

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Opportunities for Member Advocacy

- MMA Legislative Committee
  - Amy Madden, MD, Chair
- Regular communications through meetings, conference calls, *Maine Medicine*, & *Maine Medicine Weekly Update*
- Testifying in person, submitting written testimony, contact legislators, submit op-eds or letters to the editor
- Doctor of the Day Program
- Physicians' Day at the Legislature

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Tracking Maine Legislation

- Maine legislature's web site: http://www.maine.gov/legis
  - Bill status: L.D. #
  - Session laws: P.L. or Resolves Chapter
  - Statutes: 24 M.R.S.A. sec. 2851
- State agency rules online: http://www.maine.gov/sos/cec/rules/rules.html

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Governor's Contact Info.

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207-287-1034 Fax
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House Contact Info.

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Maine House of Representatives
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15

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The Honorable John/Jane Doe
The Maine Senate
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Laws Enacted with Day to Day Impact on your Practice

Went into effect Oct. 9, 2013 (1st session)
OR will go into effect Aug 1, 2014 (2nd session)
unless otherwise specified

New laws or changes from 2nd Session flagged with an asterisk

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Medical Records/ Confidentiality

- LD 23/LD 1500: Cost of Medical Records
  - Paper records: $5 for first page and $.45 per subsequent page with $250 ceiling.
  - Electronic records: "Reasonable actual costs of staff time" to create or copy record plus supplies and postage. Cannot include retrieval fee, costs of new technology, maintenance, data access or storage fees. $150 ceiling.

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Medical Records/ Confidentiality

- LD 882, Law Enforcement
  - Makes Maine law more consistent with federal law, allowing disclosure of health care information if, in good faith, disclosure is made to avert a serious threat to health or safety and is made to someone able to avert or lessen the threat

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Medical Records/ Confidentiality

- LD 534, Mental Health Services
  - Prior law: requires pt authorization for disclosure of health info outside of the office/facility if reflects mental health services provided by clinical nurse specialist, psychologist, social worker, LCPC or psychiatrist.
  - New law: allows disclosure without authorization to a health care practitioner, facility or payor for purposes of care management or coordination of care. Disclosure of psychotherapy notes remains governed by HIPAA. Shall make a reasonable effort to notify the individual of the disclosure.

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Health Care Costs

- * LD 990, replaced by LD 1642, Price list
  - Requires health care practitioners to maintain, inform patients of, and a price list (as billed without insurance) of services and procedures that they provided at least 50 times in the past year. Must include codes listed by current standard medical code or CPT code.
  - Do not need to provide entire list
  - Can list by practitioner, group of practitioners or facility
  - If don't render services directly to patients in an office setting, can post info on website
  - Must make information available about cost data on MHDO website
  - LD 990 effective 1/1/14. LD 1642 effective 8/1/14

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Health Care Costs

- * LD 1760, Cost Estimate for Encounter
  - On request of an uninsured patient, a health care entity, shall:
    - Provide within a reasonable time an estimate of the total price of medical services to be rendered directly by that health care entity during a single medical encounter
    - If unable to provide an accurate estimate because the amount of the medical service to be consumed is unknown in advance, the health care entity shall provide a brief description of the basis for determining the total price
    - If a single medical encounter will involve medical services to be rendered by one or more 3rd-party health care entities, the health care entity shall identify each 3rd-party health care entity
    - notify the uninsured patient of any charity care policy

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Scope of Practice/Licensing

- LD 198, Physician Delegation
  - Physician may now delegate activities to support staff (not just employees) and delegate without being present on the premises at the time the activities are performed.
- LD 727, Practitioner Transparency
  - Law requires full disclosure in advertising the license held (MD, DO, NP, etc); requires name badge in any face-to-face patient encounter; requires display of license
    - Note: license requirement not currently being enforced by OFPR pending further discussion BUT physicians already have requirement to publically display under 32 MRSA 3274

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Scope of Practice/Licensing

- LD 411, Drug and Alcohol Abuse Reporting
  - Updates language related to discipline for Dentists, Nurses, Osteopathic Physicians, Allopathic Physicians, Podiatrists from:
    - Habitual substance abuse that has resulted or is foreseeably likely to result in the licensee performing services in a manner that endangers the health or safety of patients
  - TO
    - Misuse of alcohol, drugs or other substances that has resulted or may result in the licensee performing services in a manner that endangers the health or safety of the licensee's patients

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Scope of Practice/Licensing

- LD 1437, BOLIM Clean Up Bill
  - Allows for licensing of dual trained oral & maxillofacial surgeon/MD
  - Allows discipline for: failure to produce documents on request to Board, failure to timely respond to complaint notification
  - Requires PAs to report PAs & physicians to Board for unprof. conduct
  - Allows Board-ordered evaluations to be done by someone other than physician

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Scope of Practice/Licensing

- LD 32, Pharmacist Vaccine Administration
  - A pharmacist may administer vaccines licensed by the FDA that are outside the guidelines recommended by the CDC/ACIP to an adult when stated on prescription (to allow shingles vaccine to those under 60)
- LD 1134, Pharmacist Collaborative Practice
  - Authorizes rulemaking allowing pharmacists to initiate, monitor & modify drug therapy under delegation of an "authorized practitioner." The pharmacist must be trained in the area of the collaboration and can only monitor for 3 months before allowing initiation, modification, discontinuation

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Scope of Practice/Licensing

- LD 198, Nurse Practitioners as School Health Advisor
  - Family or pediatric nurse practitioners can fill the role of school physicians
- LD 556, Physician Assistant Licensing
  - The law adds a PA to both the medical and osteopathic Boards; requires joint PA rules by the Boards (expected June 2014); authorizes delegation by PAs; repeals the law disallowing PA owned practice; and calls for a single PA license.

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Scope of Practice/Licensing

- * LD 1766, Delegating to Nurses
  - licensed nurse can now carry out tasks delegated by any legally authorized licensed professional acting within the scope of the licensed professional's authority to prescribe medications, substances or devices (not just physician, PA, podiatrists or dentist)
  - Effective Jan 1, 2015

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Liability

- LD 744, Certain Negligence Suits
  - The bill extends the statute of limitations for professional negligence actions against certain health care providers to 6 years when the action is based on a sexual act or sexual contact. Applies to psychiatrists, psychologists, social workers, professional counselors, pastoral counselors, marriage and family therapists and clinical professional counselors

29

Liability

- LD 1388, False Claims
  - This bill clarifies liability for conduct associated with false claims made to the Department of Health and Human Services. It changes the description of the statements, documents and records the making or submission of which incurs liability and adds provisions governing so-called reverse false claims, submission of false information to the department in order to avoid or decrease an obligation to pay or transmit money or property to the department.

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Prescription & Other Drugs

- * LD 1686, Access to Naloxone
  - Expands access to the anti-overdose drug, naloxone
  - May be prescribed to family members of an individual at risk of experiencing an opioid-related drug overdose
  - May be administered by law enforcement officers and municipal firefighters if they have received applicable medical training
  - Effective 4/29/14

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Prescription & Other Drugs

- * LD 388/1840, PMP Enrollment
  - Directs & Funds DHHS/PMP program to create automatic enrollment in PMP at the time of licensing or renewal of a license; effective immediately
- LD 171, Drug Importation
  - A licensed retail pharmacy located in Canada, the UK, Ireland Australia or New Zealand that meets its country's statutory and regulatory requirements may export prescription drugs by mail or carrier to a resident of Maine for personal use
  - Currently being challenged by federal lawsuit

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Prescription & Other Drugs

- LD 338, Atypical Antipsychotics in Children
  - Requires DHHS to adopt process regarding use of atypical antipsychotic medications by children covered by MaineCare under age 17
  - Will require prescribers to follow AACAP metabolic and neurologic monitoring standards for youth under age 17
  - Will be executed by Prior Authorization
  - Expect PA to be implemented summer or fall 2014

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Prescription & Other Drugs

- LD. 716, Stimulant Medications
  - Created a work group to review and make recommendations on appropriate prescribing of medications for children with ADHD
  - Recommendations include:
    - Develop measures to increase practice scores on 2 ADAD HEDIS measures (regarding time to follow up visits after initiating meds)
    - Institute a prior authorization for MaineCare kids under 5 to receive ADHD meds
    - Increase support for consultation/education regarding ADHD meds

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Prescription & Other Drugs

- Medical Marijuana
  - LD 1062: Adds to list of conditions for which patient may qualify:
    - Post-traumatic stress disorder
    - Inflammatory bowel disease
    - Dyskinetic and spastic movement disorders and other diseases causing severe and persistent muscle spasms
  - * LD 1739:
    - Adds nurse practitioners to list of those who can issue certificate
    - Clarifies certificate can be written for less than 1 year

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Public Health

- LD 597, Lyme Disease
  - Every health care provider that orders a laboratory test for the presence of Lyme disease shall provide the patient with a copy of the results of the test
  - Requires CDC to include additional information on its website about Lyme disease, including treatment alternatives

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Public Health

- LD 460, Screening for Heart Conditions
  - Requires hospitals, birthing centers and other birthing services to test newborn infants by means of appropriate technology for the presence of critical congenital heart disease; rulemaking may require reporting to DHHS; effective immediately

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Public Health

- LD 253, Fetal Death Certificates
  - This bill allows a fetal death certificate to be filed with the State Registrar of Vital Statistics and requires a hospital or an institution to prepare a fetal death certificate with medical information provided by a physician or other person in attendance.

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Public Health

- * LD 386, Tobacco Cessation Benefit
  - Restores & strengthens comprehensive tobacco cessation benefit in the MaineCare program
    - All pharmacotherapy that is approved by the FDA or recommended by USPHS; Group & individual counseling
    - No copayments, cost sharing, deductibles; no limits on numbers of attempts
    - Effective Aug 1, 2014

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Public Health

- * LD 1729, Epinephrine in Schools
  - Authorizes physicians & school health nurse practitioners to enter collaborative practice agreement with school nurse to delegate administration of epinephrine to non-licensed personnel
- * LD 1699/1679, HIV Education
  - Funds peer and teacher trainings for HIV prevention education in schools

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Mandatory Reporting

- LD 257, Prenatal Drug Exposure
  - Amends current law on reporting to DHHS by a health care provider involved in the delivery or care of an infant with prenatal exposure to drugs as follows:
    - changes "reports" to the department to "notifications" & repeals the requirement that the department investigate all reports
    - changes "suffering from withdrawal symptoms" to "demonstrating withdrawal symptoms that require medical monitoring or care beyond standard newborn care"
    - defines "fetal alcohol spectrum disorders" and adds it to the conditions of an infant that require notification to the department

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Mandatory Reporting

- LD 1024, Report to Licensing Board
  - DHHS will be required to make a report to the licensing board of a professional who appears to have violated the mandatory reporting law
- LD 1523, Additional Reports Required
  - Requires mandated reporters to report the following in any infant under 6 months or otherwise non ambulatory: fracture of a bone; substantial bruising or multiple bruises; subdural hematoma; burns; poisoning; or injury resulting in substantial bleeding, soft tissue swelling or impairment of an organ

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Insurance Coverage & Practices

- * LD 390, Ambulatory Surgical Centers
  - Restores MaineCare reimbursement for services provided in ambulatory surgical centers
  - Effective after emergency rules adopted
- * LD 627, Oral Chemotherapy
  - Requires carriers that cover intravenous chemotherapy to cover orally-administered
- * LD 347, Autism Spectrum Coverage
  - Expands coverage by private carriers for autism spectrum disorders to persons under 10

43

Insurance Coverage & Practices

- LD 1006, Insurance Profiling Programs
  - Requires that any cost metric used by insurance carriers in a provider profiling program be covered by existing transparency provisions in the health plan improvement laws. Also requires carriers to provide copies of the data and methodology used in the metric to affected providers.
- LD 1466, Preferred Provider Arrangements
  - Places certain requirements on contracts for preferred provider arrangements, such as requiring a carrier to include in the contract a fee schedule and any policies or procedures referred to in the contract to the provider

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Budget

- LD 1509, 2013-2015 State Budget
  - 10% cut to outpatient hospital services
  - Cut in "crossover payments" that cover Medicare Part B deductibles and copayments (still being resolved)
  - Study of equalizing payments to hospital-based and non-hospital based physicians (Part MMMM)
  - Avoided last minute proposal to cut rates to all Medicaid providers
  - Avoided proposed cut to critical access hospitals
  - No increase in the cigarette tax or tax on other tobacco products was included
  - Proposed cuts to Drugs for the Elderly and the Medicare Savings Program were avoided.

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Budget

- * 2013-2015 Supplemental Budgets
  - Adjustment in the timing of Medicaid payments to some providers (pushing 1 payment cycle into 2016)
  - Savings attributed to more intensive Medicaid RAC auditing

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Hospital Debt

- LD 1555
  - Uses future liquor revenue to pay outstanding $484M settlement debt
  - Attempt to tie to Medicaid coverage not successful

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Other Fiscal

- * LD 440, Tax Credits
  - Allows tax credit for up to 5 eligible primary care professionals each year working in primary care in an underserved area
- LD 645, Rural Medical Access Program
  - authorizes the Superintendent of Insurance to lower assessment rate on liability insurance premiums to fund the Rural Medical Access Program (providing malpractice premium assistance to qualified physicians who provide prenatal care and delivery services and practice at least 50% in underserved areas of the state)

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Medicaid Coverage & Reform

- MaineCare Expansion/Accepting Federal Funds
  - LD 1066 - failed to override veto in 2013
  - * LD 1487 - merged with Sen Katz managed care proposal - failed to override veto in 2014
  - * LD 1578 - amended to have private option like New Hampshire - failed to override veto in 2014

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Health Care & Payment Reform

- HP 1136, Health Exchange Implementation
  - Creates the Maine Health Exchange Advisory Committee to evaluate the implementation and operation of any health insurance exchange. MMA represented
- * LD 1345, Single Payer
  - Bill to study phasing in single payer system. Passed by legislature, failed to override Governor's veto

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Mental Health Services

- LD 1515, Availability of Services
  - Special session held in August 2013 passed bill on emergency basis
  - Authorizes transfer from a jail to a correctional facility of an adult inmate who the chief administrative officer of Riverview confirms is eligible for admission to a state mental health institute under Title 34-B, section 3863, but for whom no suitable bed is available, for the purpose of providing to the inmate mental health services in a mental health unit of a correctional facility

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Mental Health

- * LD 1738, Involuntary Commitment Process
  - Chief Justice shall convene a work group to review the situation for both individuals and hospitals when individuals present emergency psychiatric needs in hospital emergency departments and to develop recommendations for addressing immediate and long-term needs of individuals, hospitals, psychiatric hospitals and health care providers
  - Report due to Judiciary Committee by Dec 15, 2014

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Questions?

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TSCA Reform update

From : Mike Belliveau <mbelliveau@preventharm.org> Mon, Jun 09, 2014 10:32 AM

Subject : TSCA Reform update

To : Emma Halas-O'Connor <ehalasoc@preventharm.org>, Lily Swartz <lswartz@preventharm.org>, Jenny Rottmann <jrottmann@preventharm.org>, Emily Postman <epostman@preventharm.org>, Ryan Peabody <rpeabody@preventharm.org>

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FYI - the House bill has been "indefinitely postponed" - a partial victory! Mike

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ENVIRONMENT and ENERGY DAILY -- CHEMICALS:

With Democrats, GOP far apart on TSCA reform, industry groups focus on stalled Senate bill

Sam Pearson, E&E reporter
Published: Friday, June 6, 2014

Some industry groups are setting their sights on a stalled bipartisan Senate bill, the "Chemical Safety Improvement Act," as the preferred vehicle to reform the Toxic Substances Control Act as negotiations over a contentious House version have not progressed in the

face of united opposition from Democrats.

Ten state attorneys general wrote to the Senate Environment and Public Works Committee last week urging passage of the stalled "Chemical Safety Improvement Act," which was first introduced by the late Sen. Frank Lautenberg (D-N.J.) and Sen. David Vitter (R-La.) last year. That bill has been dormant for months as attention focused on whether a House discussion draft by Rep. John Shimkus (R-Ill.), known as the "Chemicals in Commerce Act," could gain traction.

The Senate legislation "balances States' needs to protect the health of their citizens and resources with the need to create a coherent and cohesive regulatory framework for chemical manufacturers," the attorneys general wrote.

The letter was signed by attorneys general from Alabama, Alaska, Arkansas, Arizona, Georgia, Michigan, North Dakota, Ohio, South Carolina and Utah. All but Arkansas Attorney General Dustin McDaniel are Republicans. Earlier this year, 13 Democratic state attorneys general wrote to Shimkus voicing strong opposition to his draft measure, saying it would prevent them from protecting residents from harmful chemicals by pre-empting popular state laws. They warned that the proposal would "eliminate the right of states to protect their citizens" (*E&ENews PM*, April 17).

The letter comes as the broader TSCA reform effort appears to be on precarious ground. The House is scheduled to meet for just 10 additional weeks prior to November's general election.

More than a month after Shimkus held the most recent of a series of hearings on his proposal, little progress is apparent, raising the prospect that the effort, unprecedented since TSCA was enacted in 1976, will fall victim to partisan disagreement.

Several iterations of Shimkus' measure have so far failed to win the support of any Democrats on the Energy and Commerce Committee. Public health and environmental groups have also criticized the proposal, with some calling it worse than the current legal system for evaluating the safety of chemicals that many feel is inadequate. The Senate version has faced many of the same criticisms.

Shimkus' proposal would require U.S. EPA to classify chemicals as high or low priorities and gather data from manufacturers to determine whether their use poses significant risks to consumers. Once the agency had determined a chemical was safe, states wouldn't be allowed to restrict its use. Unlike an earlier version of the bill, it wouldn't override existing state laws but would preclude future state restrictions.

In a statement, the American Chemistry Council said its members remained optimistic that a TSCA reform bill could clear Congress this year but put the burden on Democrats to offer "good-faith efforts."

Staff members were said to be meeting to resolve differences over Shimkus' proposal but so far have been unable to resolve long-standing policy differences in private talks. Democratic demands have echoed past policy proposals that failed to pass even when the House was

controlled by Democrats, said Bill Allmond, vice president of government and public relations for the Society of Chemical Manufacturers and Affiliates, an industry group.

Allmond said changes to the Shimkus draft proposed by Energy and Commerce Committee ranking member Henry Waxman (D-Calif.) mirrored language in the failed Democratic-led reform effort in 2010, which was known as the "Toxic Chemicals Safety Act." Waxman was "not acting in the interest of compromise when he's simply reintroducing the same bill he introduced some Congresses ago," Allmond said.

While the document itself remains behind closed doors, American Chemistry Council President Cal Dooley said in a statement that Democratic proposals would change Shimkus' legislation to "create an impractical and extremely cumbersome process to prioritize chemical reviews and would only amplify the challenges that the Environmental Protection Agency (EPA) currently faces in making a safety determination for chemicals."

Despite the discord, Richard Denison, a senior scientist at the Environmental Defense Fund, said there might be more common ground than is sometimes apparent.
"While it looks like the sides are miles and miles apart, sometimes, when you look at the competing proposals, there is a middle ground to be found," Denison said, "and I think the outlines of a lot of that middle ground actually are apparent to most of the players who have been at this for some time."

Waxman held a hearing on the 2010 bill, but the effort collapsed in the face of GOP and industry opposition. Less than four months later, Democrats lost their House majority.
A spokeswoman for Waxman declined to comment on his proposals.

Jordan Haverly, a spokesman for Shimkus, said there were no plans to hold a markup of the contentious legislation in the foreseeable future. Earlier this year, Shimkus said it could happen as soon as April and said he aimed to build a broad consensus for the plan (*E&E Daily*, Feb. 28).

"We're continuing to work toward a bipartisan solution that we can move forward," Haverly said. "Congressman Shimkus is committed to advancing chemical safety legislation that protects consumers and creates jobs, and his door remains open to any serious attempts to find common ground and move bipartisan TSCA reform through the House this year."

Advocacy push coming up short

Despite a boost in lobbying expenditures that has made the chemical industry one of the biggest spenders this year on Capitol Hill, the effort to reform TSCA has failed to overcome the objections of two prominent California Democrats with a track record of progressive views on the environment -- Sen. Barbara Boxer and Waxman, who is retiring after this term.

Chemical companies and their trade groups spent at least $63 million lobbying Congress last year, according to data from the Center for Responsive Politics that was analyzed by the Environmental Working Group last month. That marked a significant increase from the $49.7 million the groups spent on such expenses in 2010, the last midterm election year.

Boxer has signaled that she does not support the "Chemical Safety Improvement Act," and the two sides have been unable to agree on changes for months that would win her over and allow the bill to advance within the Environment and Public Works Committee, which she leads. Despite Boxer's opposition, 12 other Democrats have co-sponsored the bill. Industry officials have said they hoped to win the support of House Democrats but have grown frustrated that the members appear unwilling to publicly part ways with Waxman, a 20-term veteran. Some Democrats on the subcommittee who might be inclined toward moderation are effectively "held hostage" by Waxman, Allmond said.

Waxman earlier this year called for a "return to the drawing board" to focus on small-bore steps to boost chemical oversight (*E&E Daily*, April 30).

On the Senate front, the chemical industry is frustrated that Boxer "keeps moving the goalposts," Allmond said. But he said that based on its diverse array of co-sponsors, "I would think any objective observer would say that the Senate bill has the best chance of passing first."

Like the House bill, the Senate plan is months behind where some once predicted.

Sen. David Vitter (R-La.), one of the bill's co-sponsors, said earlier this year that he was hopeful the bill would progress. It's unclear how that will be possible, though, since the Senate bill has been criticized by health and safety groups for pre-empting state laws at an earlier stage than Shimkus' bill -- though Vitter has said the Senate bill has undergone changes that have not yet been unveiled. A Boxer spokeswoman didn't respond to a request for comment this week.

Current language "is not the bill that was initially introduced, and we have carefully listened to stakeholders to make measurable improvements," Vitter said earlier this year (*Greenwire*, Feb. 4).

Vitter and other Republicans on the Environment and Public Works Committee still hope to make progress on the "Chemical Safety Improvement Act" but have no timetable for doing so, Vitter spokesman Luke Bolar said.

Denison said regardless of this year's outcome, it was clear lawmakers were more aware of the need to fix TSCA than ever before.

"We have more momentum behind TSCA reform than we've ever had," Denison said. "We have both parties in both houses seriously talking about reforming this nearly 40-year-old law. We have proposals that are being put on the table and creating a lot of debate and dissension, but at least setting the table for finding a way forward. I really think that in both houses, we have a sizable number of members in both parties who really want to find a way to get this done."

Zimbra **jbarnard@mainemed.com**

Carbon pollution standards

From : Effie Craven <ecraven@lungne.org> Wed, Jun 04, 2014 05:29 PM
Sender : ecraven@lungne.org
Subject : Carbon pollution standards

Good afternoon,

Just wanted to give a quick update to our Healthy Air Coalition partners about the proposed standards for carbon pollution from existing power plants that were announced on Monday. The American Lung Association has been working on this issue for quite some time, and we have worked closely with EPA to let them know how important addressing carbon pollution is for people with lung disease and that climate change is a critical public health issue. Monday was an exciting day- we even got a chance to hear directly from President Obama!

The ALA press release can be found here. The New York Times included a photo of Monday's call with the President and also gives good background information on the proposed standards. This EPA website also has very useful state-specific information about these standards.

In the coming months, I will be asking our Healthy Air Coalition partners to sign a letter of support for these standards. I will also be collecting sign-ons for individual health professionals. Please begin the process now of asking your boards or leadership if your organization can sign on to this important letter. I will send a draft of the letters in the next few weeks.

Please feel free to contact me with any questions.

Thanks,
Effie

--
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AMERICAN LUNG ASSOCIATION.
Fighting for Air

American Lung Association Says Proposed Carbon Pollution Standards Would Protect Health of Millions of Americans

Contact
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Washington, D.C. (June 2, 2014)—In response to the introduction of first-ever carbon pollution limits for existing power plants, Harold P. Wimmer, National President and CEO of the American Lung Association issued the following statement:

"Power plant pollution makes people sick and cuts short lives. We are pleased to see significant health benefits from the U.S. Environmental Protection Agency's (EPA) proposed limits on carbon pollution from power plants, which would reduce the burden of air pollution in America, prevent up to 4,000 premature deaths and 100,000 asthma attacks in the first year they are in place, and prevent up to 6,600 premature deaths and 150,000 asthma attacks in 2030.

"EPA's proposed limits show serious commitment to addressing one of the most serious public health challenges of our day, climate change. Scientists say that warmer temperatures can enhance the conditions for lethal air pollutants, including ozone and particle pollution. Despite steps in place to curb these pollutants, evidence shows that climate change is likely to increase the risk of unhealthy air in large parts of the United States. More pollution means more childhood asthma attacks and complications for those with lung disease, including increased risk of premature death.

"Cleaning up carbon pollution will have an immediate, positive impact on public health; particularly for those who suffer from chronic diseases like asthma, heart disease or diabetes. Steps to clean up carbon pollution can reduce sulfur dioxide and nitrogen oxides, both poisonous emissions from coal-fired power plants that are also major precursors to lethal ozone and particulate matter pollution.

"We urge the EPA to set a final standard within a year and will work with health partners across the country to support the strongest limits on carbon pollution. Anything less shortchanges our future, our children and our health."

###

About the American Lung Association
Now in its second century, the American Lung Association is the leading organization working to save lives by improving lung health and preventing lung disease. With your generous support, the American Lung Association is "Fighting for Air" through research, education and advocacy. For more information about the American Lung Association, a holder of the Better Business Bureau Wise Giving Guide Seal, or to support the work it does, call 1-800-LUNG-USA (1-800-586-4872) or visit www.lung.org.

American Lung Association
55 W. Wacker Drive, Suite 1150
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EPA Carbon Pollution Standards

Excerpt from: http://cleanpowerplanmaps.epa.gov/CleanPowerPlan/

On June 2, 2014, the U.S. Environmental Protection Agency, under President Obama's Climate Action Plan, proposed a common sense plan to cut carbon pollution from power plants. The Clean Power Plan will maintain an affordable, reliable energy system, while cutting pollution and protecting our health and environment now and for future generations.

Clean Power Plan - States

The science shows that climate change is already posing risks to our health and our economy.

Nationwide by 2030, the Clean Power Plan will help cut carbon emissions from the power sector by 30 percent below 2005 levels.

The proposal also would cut pollution that leads to the formation of soot and smog by over 25 percent in 2030.

States, cities and businesses across our country are already taking action. They have set energy efficiency targets, increased their use of renewable energy, made agreements and implemented programs to cut carbon pollution.

Click on a state to learn more about climate change impacts, state action, and EPA's proposal for that state.

Maine

Climate change threatens our health and economy

Carbon pollution leads to long-lasting changes in our climate, such as rising global temperatures, rising sea level, and changes in weather and precipitation patterns. **The Third U. S. National Climate Assessment** outlines how climate change will impact states like **Maine**.

States are taking action

Before issuing this proposal, EPA heard from states, utilities, labor unions, nongovernmental organizations, consumer groups, industry and others to learn more about what programs are already working to reduce carbon pollution. We learned that states are leading the way– especially through programs that expand energy efficiency and renewable energy. **Maine** already has programs in place that could be part of its individual or regional plan to reduce carbon pollution, including:

- Participation in a greenhouse gas cap and trade program
- Energy efficiency standards or goals
- Demand-side energy efficiency programs that advance energy efficiency improvements for electricity use
- Renewable energy portfolio standards or goals

Proposed state goals build on state leadership

To set state-specific goals, EPA analyzed the practical and affordable strategies that states and utilities are already using to lower carbon pollution from the power sector. These include improving energy efficiency, improving power plant operations, and encouraging reliance on low-carbon and zero-emitting electricity generation. Together, these make up the best system for reducing carbon pollution. They achieve meaningful reductions at a lower cost.

The Agency applied these strategies consistently, but each state's energy mix ultimately leads to a different goal that is unique to the state.

In 2012, **Maine**'s power sector CO2 emissions were approximately **2** million metric tons from sources covered by the rule. The amount of energy produced by fossil-fuel fired plants, and certain low or zero emitting plants was approximately **8** terawatt hours (TWh)*. So, **Maine**'s 2012 emission rate was **437** pounds/megawatt hours (lb/MWh).

EPA is proposing that **Maine** develop a plan to lower its carbon pollution to meet its proposed emission rate goal of **378** lb/MWh in 2030.

**includes existing non-hydro renewable energy generation and approximately 6% of nuclear generation. The 2012 emission rate shown here has not been adjusted for any incremental end-use energy efficiency improvements that states may make as part of their plans to reach these state goals.*

States decide how to cut carbon pollution

The state goals are not requirements on individual electric generating units. **Maine** will choose how to meet the goal through whatever combination of measures reflects its particular circumstances and policy objectives. A state does not have to put in place the same mix of strategies that EPA used to set the goal.

Maine may work alone or in cooperation with other states to comply with the proposed rule. EPA estimates that states could achieve their goals most cost effectively if they work with others.

EPA encourages states to look broadly across their electricity system to identify strategies for their plans to reduce carbon pollution. Strategies can include:

- Demand-side energy efficiency programs
- Renewable energy standards
- Efficiency improvements at plants
- Dispatch changes
- Co-firing or switching to natural gas
- Construction of new Natural Gas Combined-Cycle plants
- Transmission efficiency improvements
- Energy storage technology
- Retirements
- Expanding renewables like wind and solar
- Expanding nuclear
- Market-based trading programs
- Energy conservation programs