MCHC
The Consumer Connection
... linking consumers with health care news and information

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The Consumer Connection is a publication of the Michigan Consumer Health Care Coalition with the Michigan League for Human Services

Secondhand Smoke: Health Impacts and Smoke-Free Laws

Cigarette smoking is the leading preventable cause of death in this country. In addition, nonsmokers exposed to environmental tobacco smoke (ETS) are experiencing higher death rates from cardiovascular disease than nonsmokers who are not exposed to ETS. A newly released report, "Smoke-Free Workplaces: The Impact of House Bill 4163 on the Restaurant and Bar Industry in Michigan" (Public Sector Consultants Inc., Lansing, Michigan, 2008), summarizes the effects of secondhand smoke in general and the efforts in Michigan to ban smoking in public places as Michigan attempts to join the ranks of states that are banning smoking in the workplace.

Surgeon General Reports

The 1986 Surgeon General's report, *The Health Consequences of Involuntary Smoking*, issued by Dr. C. Everett Koop (U.S. Department of Health and Human Services, 1986), was the first Surgeon General's report to focus on the issue of secondhand smoke. This national report was among the first to provide a comprehensive review of the scientific literature regarding secondhand smoke. Its conclusions include the following:

- Involuntary smoking causes disease, including lung cancer, in healthy nonsmokers.
- The children of parents who smoke, compared with the children on nonsmoking parents, have an increased frequency of respiratory infections and respiratory symptoms, and slightly lower rates of increase in lung function as the lung matures.
- The simple separation of smokers and nonsmokers within the same air space may reduce, but does not eliminate, the exposure of nonsmokers to environmental tobacco smoke.

As a result of this report, political jurisdictions at both the state and local levels moved to prohibit smoking in public indoor areas (other jurisdictions had already passed smoke-free ordinances prior to the 1986 report). The goal of these laws was to protect nonsmokers who work in and frequent public places. Between 1986 and 2006, 20 states passed smoke-free workplace legislation.

The 2006 Surgeon General's report *The Health Consequences of Involuntary Exposure to Tobacco Smoke* (U.S. Department of Health and Human Services, 2006), reaffirmed and strengthened the findings of the 1986 report, and came to some significant new conclusions:

- Children exposed to secondhand smoke are at an increased risk for sudden infant death syndrome (SIDS), acute respiratory infections, ear problems, and more severe asthma. Smoking by parents causes respiratory symptoms and slows lung growth in their children.

HEALTH CARE BY THE NUMBERS

Toll of Tobacco in Michigan

14,500	Adults who die each year from their own smoking
930-2,610	Adult nonsmokers who die each year from exposure to secondhand smoke
716,000	Kids exposed to secondhand smoke at home

Source: The Toll of Tobacco in Michigan, Campaign for Tobacco-Free Kids, 2005.

May 2008
vol. 8 no. 3

From the consumers' perspective...

We measure what we care about...and what gets measured improves.

Measuring plus public reporting works even better.

In the state of New York, in just the three years after public reporting (by hospital and surgeon) of data on deaths following coronary bypass grafts, the death rate fell by 41 percent.

The National Partnership for Women and Families points out that each year, two million of us will pick up infections in U.S. hospitals that are supposed to make us well; and that when we enter we stand only a fifty-fifty chance of getting the right care.

Despite these facts, and in the midst of a large legislative battle surrounding the passage of a Blue Cross bill to reform the organization's governance and its rating practices, patient safety in Michigan has been sidelined as a public health issue.

The multi-year effort of the Michigan State Commission on Patient Safety's and the priority recommendation in its final report (http://www.mihealthandsafety.org/statecommission/barefoot/final_report.html) for error reporting through a collaborative reporting system that is independent, free-standing, voluntary, peer protected, provider friendly, and non-punitive has been put in limbo in favor of an internal process by the providers' trade association.

In Michigan, it is still easier for a consumer to find the safety record of a car than the safety record of a hospital.

Beverley McDonald, Chair
Michigan Consumer Health Care Coalition

- Exposure of adults to secondhand smoke has immediate adverse effects on the cardiovascular system and causes coronary heart disease and lung cancer.
- Many millions of Americans, both children and adults, are still exposed to secondhand smoke in their homes and workplaces despite substantial progress in tobacco control.
- Eliminating smoking in indoor areas is the only way to fully protect nonsmokers from exposure to secondhand smoke. Scientific evidence indicates that there is no risk-free level of exposure to secondhand smoke and separating smokers from nonsmokers, cleaning the air, and ventilating buildings cannot eliminate exposures of nonsmokers to secondhand smoke.

Earlier Surgeon Generals' reports on smoking and ETS focused on lung cancer and respiratory health problems. The 2006 report expanded the health concerns to include heart and cardiovascular problems. it also made clear that only a complete elimination of smoking from indoor areas fully protects nonsmokers.

The Workplace and Secondhand Smoke

Effects of secondhand smoke on employees:

- Secondhand smoke causes approximately 3,400 lung cancer deaths annually, as well as exacerbation of lung disease in non-smoking adults and respiratory problems in children. Secondhand smoke also causes approximately 46,000 heart disease deaths in adult nonsmokers in the United States each year.
- Restaurant employees are far less likely than other workers to be protected by smokefree workplace policies, more likely than other workers to have these policies violated where they do exist, and are more likely to be exposed to high levels of secondhand smoke on the job.
- People exposed to smoke in the workplace were 17 percent more likely to develop lung cancer than those who were not exposed.

Effects of secondhand smoke on employers:

- The 2005 estimated total cost of secondhand smoke exposure in the United States is about $10 billion annually, $5 billion in direct medical costs, and $5 billion in indirect costs such as lost productivity.
- Workers have been awarded unemployment, disability, and worker's compensation benefits for illness and loss of work due to exposure to secondhand smoke.
- The U.S. Environmental Protection Agency (EPA) estimates that $4 billion to $8 billion in building operations and maintenance costs would be saved if policies prohibiting smoking in workplaces were adopted nationwide.

Source: Smoking Policies in the Workplace Fact Sheet, September 2007, American Lung Association

Economic Impact of Smoking in Michigan

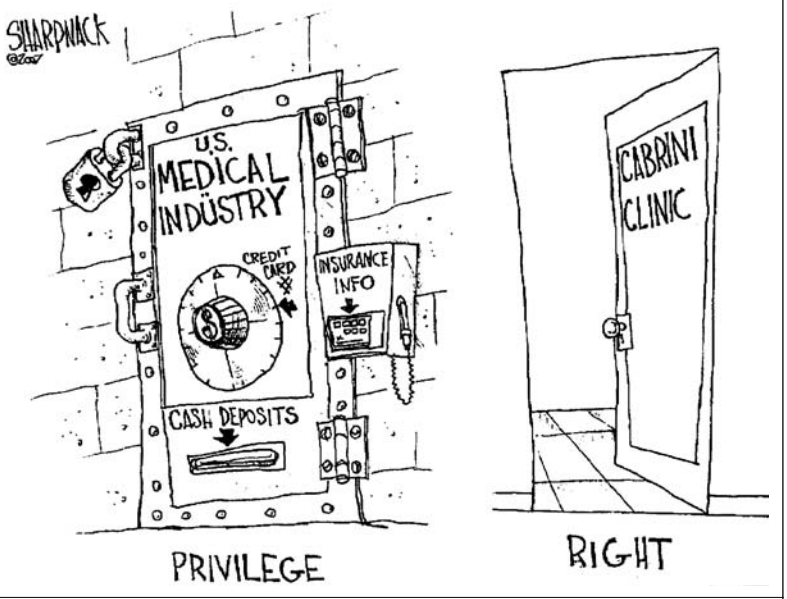
Smoking burns a hole in Michigan's economy. According to the Campaign for Tobacco-Free Kids, billions of tax dollars are spent on smoking-related costs.

- Annual health care costs in Michigan directly caused by smoking — $3.4 billion
  - — Portion covered by the state Medicaid program — $1.1 billion
- Residents' state and federal tax burden from smoking-caused government expenditures — $637 per household
- Smoking-caused productivity losses in Michigan — $3.8 billion

Note: These amounts do not include health costs caused by exposure to secondhand smoke, use of chewing tobacco, or cigar and pipe smoking.

Other non-health costs from tobacco use include residential and commercial property losses from smoking-caused fires (more than $500 million per year nationwide); extra cleaning and maintenance costs made necessary by tobacco smoke and litter; and additional productivity losses from smoking-caused work absences, smoking breaks, and on-the-job performance declines and early termination of employment caused by smoking-caused disability or illness (the dollar amount listed above is just from productive work lives shortened by smoking-caused death).

Source: The Toll of Tobacco in Michigan, Campaign for Tobacco-Free Kids, 2005.



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Smoke-Free Laws

With the release of the 2006 Surgeon General's report, the scientific evidence was clear: Secondhand smoke is a proven cause of serious diseases and premature death. Within 21 months following the release of the report, 11 states and 120 local units of government enacted comprehensive smoke-free laws. A growing number of cities, states, and countries are enacting laws that require all workplaces and public places to be smoke-free.

In the United States today:

- 24 states, Washington, D.C., and Puerto Rico have passed smoke free laws that cover restaurants and bars. The states are Arizona, California, Colorado, Connecticut, Delaware, Hawaii, Illinois, Iowa (effective July 1, 2008), Maine, Maryland, Massachusetts, Minnesota, Montana (extends to bars Sept. 1, 2009), Nebraska (June 1, 2009), New Hampshire, New Jersey, New Mexico, New York, Ohio, Oregon (Jan. 1, 2009), Vermont, and Washington.
- Four other states—Florida, Idaho, Louisiana, and Nevada—have smoke-free laws that cover restaurants but exempt stand-alone bars.
- Hundreds of cities and counties across the country have also taken action.

Source: Special Report Smoke-Free Laws: Protecting Our Right to Breathe Clean Air, Campaign for Tobacco-Free Kids, www.tobaccofreekids.org.

Michigan Legislation Moves on Smoke-Free Workplaces

Since the recodification of the Public Health Code in 1978 (MCL 333.1101 et seq.), many attempts have been made to clarify the law's provisions dealing with smoking in public places, including restaurants and bars. For almost 30 years, state lawmakers have attempted to define where smoking is acceptable and how much smoking should be permitted in both public places and private businesses. The majority of

these proposals have come in the form of amendments to The *Food Service Sanitation Act* and *Clean Indoor Air Act* sections of the Michigan Public Health Code. Also, a 1992 Executive Order and a 2001 Michigan Court of Appeals decision provide guidance.

In January 2007, HB 4163 was introduced in the Michigan House. This bill amends Part 126 (Smoking in Public Places) and Part 129 (Food Service Establishments) of the Public Health Code (MCL 333.12601 et al.), to prohibit smoking in public places, in places of employment, and in food service establishments (such as restaurants, cafeterias, and bars). House Bill 4163 expands Michigan's smoke-free workplace law to all workplaces, including restaurants and bars, by changing the definition of public place to incorporate a "place of employment." The House bill includes exemptions for cigar bars, tobacco specialty stores, bingo halls, casinos, and horse race tracks. The House passed this legislation in December 2007.

In May 2008, the Senate approved substitute language that strengthened the legislation by eliminating exemptions for casinos in Detroit, cigar bars, and bingo halls. Indian casinos, because of tribal sovereignty, likely would not be part of the ban. The Senate bill was then approved on a bipartisan vote. HB 4163 now returns to the House for a concurrence vote on the Senate changes.

An estimated 80 children try their first cigarette in Michigan every day, surveys show, and another 50 become daily smokers. About17 percent of Michigan's high school students smoke.

Source: Blue Cross Blue Shield of Michigan, *Living Healthy*, Spring 2008

Pennsylvania Authority Releases 2007 Patient Safety Report

The Pennsylvania Patient Safety Authority, an independent state agency, was established by Act 13 of 2002, "The Medical Care Availability and Reduction of Error (Mcare) Act." It is charged with taking steps to reduce and eliminate medical errors by identifying problems and recommending solutions that promote patient safety in hospitals, ambulatory surgical facilities, birthing centers and certain abortion providers. Its role is non-regulatory and non-punitive.

Under Act 13, when a Serious Event (one that harms a patient) happens in a facility, the patient who suffered from the event must receive written notification from the facility explaining what happened.

Reports of Serious Events and Incidents (including near misses) are received through PA-PSRS, the Pennsylvania Patient Safety Reporting System. Statewide mandatory reporting began in June 2004 and does not include patient or provider names. The reports are confidential and non-discoverable in a legal action.

Under Act 52 of 2007, the Authority—in conjunction with the Department of Health, the state regulator of reporting—has been determining reportable care-associated infection events for hospitals and nursing homes. The use of *Patient Safety Advisories* is the major guidance tool for facilities; consumer tip sheets are also available.

Following an extensive strategic planning process, 11 initiatives will be implemented over the next several years, primarily addressed to education of providers, boards of trustees, and patients; improved reporting consistency and recommendations; data collaboration; and nursing home data analysis.

The Authority works as a collaborative with the Governor's Office of Healthcare Reform, the Pennsylvania Healthcare Cost Containment Council, the U.S. Centers for Disease Control and Prevention, and, in the private sector, with the Hospital and Health System Association of Pennsylvania and the American Hospital Association.

More background information on the Authority and a complete copy of the 2007 report are available at www.psa.state.pa.us

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The Health Care Happenings...

In Washington…

New Safety Program: Monitoring Medicare Prescription Drug Use

Federal health officials will begin monitoring prescription drug usage by Medicare participants in an effort to identify potential safety problems.

New regulations announced by the U.S. Department of Health and Human Services (HHS) will enable the Food and Drug Administration (FDA), individual states, and academic researchers to screen the Medicare claims data. Under the regulations, the Medicare data can be made available in 30 days. The Institute of Medicine recommended creation of such a surveillance system in 2006. Officials stated that personally identifying information will not be available to the FDA or other agencies.

Medicare beneficiaries use an average of 28 prescriptions a year, and those who consider themselves in poor health use an average of 45 prescriptions annually, giving investigators a huge database of health records to tap into.

The FDA relies primarily on physicians and patients to report suspected adverse events. Often, it takes a number of cases before someone at the agency detects a pattern that is worth investigating. At that point the agency conducts an investigation to determine whether the side effects were caused by the drug. With these new regulations the FDA will be able to query databases involving tens of millions of patients at the first hint of trouble. It will be able to see the medications used, whether or not a patient had lab work, and whether the patient had to be hospitalized.

HHS Secretary Mike Leavitt said that the first batch of records to which the agency will have access comes from 25 million Medicare beneficiaries. At some later point, private companies will also contribute medical data.

Officials provided only general details about the cost of enacting what the FDA has labeled the Sentinel Initiative. The agency is hiring more staff, but it won't need a large new computer system because agencies such as the Centers for Medicare and Medicaid Services will use their own computer systems to do the data-mining. The FDA will simply provide the questions while Medicare's computers supply the answer.

Medicare officials said the program could end up reducing the government's health costs if it can cut down on adverse drug events. The cost of treating preventable adverse events in Medicare comes to about $900 million a year. This program will also allow the FDA to determine when a drug is being inappropriately dispensed to treat certain conditions. Agency officials hope that by promoting best practices in therapy management, they can see a reduction in unnecessary prescription bills.

Source: New Safety Program to Monitor Medicare Drug Use, Kevin Freking, Associated Press, May 22, 2008.

We want to hear from you— suggestions for improvements and topics, questions, even encouragement!

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President Bush's 2009 Budget Cuts

The President's cuts to the FY 2009 federal budget would slash Medicaid expenditures by $18.2 billion over five years. It would also cut $15 billion from hospitals in annual funding for patient care and cut an additional $25 billion from hospitals that primarily serve the poor.

While Congress was not able to override two presidential vetoes and reauthorize the State Children's Health Insurance Program (SCHIP) during 2007, the President's budget does include $19.7 billion in funding for the SCHIP program through fiscal year 2013. This amount represents an increase, but falls far short of the $35 billion included in the reauthorization bills passed by Congress; it will not be sufficient to allow states to cover more uninsured children, millions of whom are eligible for SCHIP and Medicaid but not enrolled.

In 2007, the Centers for Medicare and Medicaid Services (CMS) issued several new regulations, which were neither mandated nor reviewed by Congress, and could result in an estimated $12 billion cutback in federal Medicaid spending over the next five years. The Bush administration states that each of these regulations is essential for the overall welfare of the Medicaid program. Members of Congress, beneficiaries, the states, and providers have expressed outrage about the proposed reductions. These

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regulations are inconsistent with Medicaid policies enacted by Congress and could have extremely negative consequences. In November 2007, Congress placed moratoriums on implementation of these regulations. Bipartisan efforts are currently under way in Congress to extend the moratoriums through March 2009. Federal legislation (HR 5613 or S 2819) to extend for one year the moratoriums on the seven CMS Medicaid regulations is in progress. HR 5613, sponsored by Rep. John Dingell (D-Dearborn), was unanimously approved in April by the health subcommittee of the House Committee on Energy and Commerce and later passed by a veto-proof margin in the House. S. 2819 has been introduced, but not passed, in the Senate. Immediate action is needed, as several of the current moratoriums expire in May/June 2008.

With many states experiencing fiscal crises themselves, it is unlikely that they would be able to cover the lost federal revenues with state resources, should these regulations be implemented. A new study from the Center on Budget and Policy Priorities identifies 20 states facing total budget shortfalls of at least $34 billion in 2009.

In Michigan…

Michigan facing $700 million in federal cuts this year

Michigan stands to lose $3.9 billion over the next five years in federal Medicaid dollars if regulatory changes by the Bush administration go into effect.

This fiscal year alone, Michigan would lose more the $700 million, according to a report from the U.S. House Committee on Oversight and Government Reform. Among the cuts would be services to children and adults with disabilities through new restrictions on physical and occupational therapies. Medicaid spending for school transportation for Medicaid-eligible children would be ended, as would dollars that go to hospitals to train new doctors. Michigan's Medicaid program serves more than 1.5 million needy children and their parents, people with disabilities, and seniors.

Source: Michigan League for Human Services, April 10, 2008 press release.