Maryland Public Health Association

Mission: *To improve public health in Maryland through education and advocacy*

Vision: *Healthy Marylanders living in Healthy Communities*

The following nine issue briefs (in random order) represent a diverse collection of public health topics elected officials will be considering during the 2018 legislative session. Please help us by reviewing this information and voting for MdPHA's 2018 Legislative Priorities (ballot provided at our annual conference on October 6). We posed the following questions to our advocacy partners and the issue briefs include their answers. Please contact our Advocacy Chair, Rebecca Rehr, if you have questions about the issues, or the process. She can also put you in contact with the issue leads for any of the campaigns if you want to get more involved! Thank you!

Criteria for Selecting Advocacy Agenda

Last Revised: September 2016

- Is there significant impact on public health in Maryland? Describe.
- What are the major, most compelling reasons we want to support this issue?
- Please provide citations with the scientific evidence supporting the position.
- Is the current political climate conducive to moving this issue forward at this time?
- Would we have credible partners with whom to coalesce?
- Would there be parties working against us? What are their arguments? What are their resources?
- Is this the first time this bill will be introduced in Maryland?
- Is there significant support for this issue within MdPHA's membership?
    - Based on polling at our annual meeting
- Is there an MdPHA member who is willing to lead on this issue?

1. Maryland Community Health Worker Act

Please Support CHWs: frontline public health workers bringing the gap between communities and health systems by building trust and addressing the social determinants of health

History/Impact on Public Health

The 2014 legislatively mandated Maryland Workgroup on Workforce Development for Community Health Workers (WDCHW) agreed a CHW is a **frontline public health worker** who is trusted member of and/or has an unusually close understanding of the community they serve. A Community Health Worker (CHW) serves as a link between health/social services and the community. Maryland has one of the highest numbers of CHWs in the nation, with more than 1,460 CHWs employed in Maryland, however this is most likely under reported.[1] The workgroup agreed in 2015 recommendations to the General Assembly that Maryland must move towards certifying CHWs in the state, the purpose of the CHW Act.

Reasons to Support Maryland CHW Act/Supporting Evidence

- There is no oversight body of CHWs in Maryland or standardization of training
- Due to healthcare reform including the New All Payor Model more employers are hiring CHWs and there is uncertainty about their training; scope of practice; and role in healthcare teams
- CHWs have positive benefits as they relate to the Triple Aim of public health. Return on Investment in literature range from $1.80 - $28 for every $1 spent on CHWs [1]
- Cost savings as a result of CHWs have been shown in a range of approximately $95K to $2M annually and $181 - $2,245 per patient. [1]
- Maryland can receive a one percentage point (1%) increase in its federal medical assistance percentage (FMAP) to help pay for CHW services

Political Climate/Credible Partners

- MdPHA supported this bill in 2017 (HB1113/SB988). The legislation passed out of committee/and both chambers on first vote with no strong opposition or votes against
- CHW Member Association of Maryland; Local Health Departments; Maryland Area Health Education Center; Institute for Public Health Innovation all support
- Last year concerns from the Maryland Hospital Association and specific hospitals (employers) kept final vote and passage
- Primary sponsors (Senate Nathan Pulliam & Delegate Lam) have brought stakeholders together this summer to work on new draft legislation for 2018 Session

Areas That Need Consensus/Hindered 2016 Passage

- Voluntary vs Mandatory Certification (no other state mandates certification)
- CHW should not be viewed as a "licensed" role via a separate Board and just reflect a certification process of training or competencies
- The legislation created too many barriers for CHWs themselves
    - Background checks
    - Cost of certification
    - Clinical hours for grandfathering

1. Bureau of Labor Statistics, 2015., 2. Redding et al, 2014; Kangovi et. Al; 2014; Johnson et. Al, 2012; Whitley et al; 2006.,3.Johnson et al, 2012; Witley et al, 2006; Beckham et al, 2004

2. Lowering Maryland's blood lead action level for children

The Need: The science is clear that there is no safe level of lead in a child's body and the effects of lead poisoning are irreversible. All children poisoned with lead exposure deserve the same environmental intervention response and treatments and that response needs to occur at lower levels. Maryland can no longer be patient in waiting to adopt the CDC's standards that must be enacted now to advance prevention and reduce the health disparities that currently exist for lead poisoned children.

Is there significant impact on public health in Maryland? Describe.
Yes. Lead poisoning has a significant impact on public health in Maryland. The latest data available from 2015 Maryland Childhood Lead Registry finds that there were 2,144 children diagnosed with elevated blood levels (EBLs) of 5 ug/dl or higher in Maryland. Of the 2,144 children with EBLs across the state, **1,789** children have levels between 5 ug/dl and 9 ug/dl. One of the major reasons to lower the EBL action level to 5 ug/dl is to implement more aggressive prevention measures before a child suffers from a higher EBL and has to endure even more crippling effects of lead poisoning. Maryland must pursue more proactive primary preventive policies rather than reactive policies after a child has been lead poisoned. However, as part of a comprehensive lead poisoning elimination strategy, Maryland needs to improve its secondary prevention response protocols (such as inspection and case management services) to target resources at lower blood lead levels and reduce lead poisoning's public health impact.

What are the major, most compelling reasons we want to support this issue?
The CDC reviewed the substantial body of current research and determined that there is no safe level of lead in a child's body at which harm does not occur. Maryland must regain its position as the national leader in lead poisoning prevention by passage of legislation that will:

- Bring Maryland into line with the CDC standards and current research;
- State legislation is needed to mandate the lowering of the action level for environmental investigation and medical case management to 5 µg/dl as state agencies and local jurisdictions have been slow to adopt and implement the new standards;
- Lowering the blood lead action level in Maryland from 10 µg/dl to 5 µg/dl can better prevent higher level lead poisonings and the possible poisoning of siblings in pre-1978 rental properties by triggering the requirement for rental property owners to perform lead hazard reduction measures at lower blood lead levels;
- Maryland Department of the Environment's Lead Special Fund has increased substantially in the past several years and there are sufficient funds to cover any state or local expenditures needed to implement the law's change.

Several other states have realized that all children should receive immediate action at the lower lead levels. New Jersey is the latest state to lower the lead level for environmental investigation and case management by doing so in 2017. In 2015, the State of Maine determined to follow the new CDC guidance and lowered its blood lead action level to 5 µg/dl and provided funding to pay for additional environmental sanitarians.

Please provide citations with the scientific evidence supporting the position.
The effects of lead poisoning are well documented even at lower blood lead levels. Lead poisoning in children can cause learning disabilities, attention deficit disorder, hyperactivity, aggressive behavior, hearing loss, mental retardation and IQ reduction. Recent confirming studies have also proven the

direct correlation between childhood lead poisoning and increased rates for children in juvenile delinquency and criminal activity, clearly straining our limited judicial resources. The effects of lead poisoning are irreversible. Children poisoned by lead are 7 times more likely to drop out of school and 6 times more likely to end up in the criminal justice system than the population as a whole. From the fetus stage to adulthood, lead poisoning has a lifetime of impact. Adults who were lead poisoned have a 46% increased rate of early mortality. The ultimate tragedy of lead poisoning is that it is an entirely preventable disease.

American Academy of Pediatrics. Council on Environmental Health. Prevention of Childhood Lead Toxicity. *Pediatrics.* 2016, 138(1) e20161493.
Needleman, H. L., Riess, J. A., Tobin, M., Biesecker, G. & Greenhouse, J.B. "Bone Lead Levels and Delinquent Behavior," JAMA, vol 275 No 5. February 7, 1996.
"Childhood Exposure to Lead: A Common Cause of School Failure." Needleman HL. Phi Delta Kappan. September 1992.

Is the current political climate conducive to moving this issue forward at this time?
Yes, if MDE's increased annual, rental property registration revenue is captured to pay for additional lead inspection personnel at MDE or environmental sanitarians at local health departments to perform environmental investigations.

Would we have credible partners with whom to coalesce?
Yes. A number of health, housing and environmental groups will work to support this legislation. If we can implement mandatory environmental intervention, case management and education to families of children at levels of 5 ug/dl or higher, we can prevent lead levels from getting higher, address lead hazards in homes where siblings of EBL children reside and lower societal costs.

Would there be parties working against us? What are their arguments?
Yes. The landlord associations will work against this bill, as they think it will mean more lawsuits for them. Opponents will also argue the CDC standard is not a health-based standard, but a statistic based on the percentage of kids who are still poisoned. (They're right, but a health based standard would be ZERO, as we know there is no safe level of lead exposure). Finally, opponents will argue that they would prefer a "reference" level, rather than an "action" level.

What are their resources?
Technical, advocacy and other resources can be provided by organization such as GHHI and the Maryland Academy of Pediatrics among others.

Is this the first time this bill will be introduced in Maryland?
No. This bill was previously introduced during the 2016 and 2017 Maryland General Assembly legislative sessions.

3. Dental Therapy Licensure

Is there significant impact on public health in Maryland? Describe.
Yes. Despite recent progress on expanding access to health care, many Maryland residents still struggle to get dental care. Some cannot find a dentist who accepts public insurance, while others cannot get to a dental office due to mobility or transportation challenges. And many people, regardless of insurance status, are unable to afford the costly prices of dental services. 42% of children on Medicaid children – (274,000) – did not receive any dental care in 2015.[1] 37% of senior citizens had lost 6 or more teeth, and 46% of nursing home residents had untreated decay in 2013-2014.[1] More than 507,000 people live in areas designated by the federal government as having a shortage of dentists.[1] There were over 36,600 Emergency Department (ED) visits in 2013 for preventable dental conditions in Maryland, almost half of which were paid for by Medicaid (47%).[1] Using national per visit cost data, these visits represent a total estimated cost of nearly $28 million.[1] Only 33% of dentists were enrolled with the Maryland Healthy Smiles Dental Program in 2014 (Maryland's Medicaid dental program for children, pregnant women, and adults with certain high-cost chronic conditions), and only 25% billed at least $10,000.[1] Dental therapists are a common sense solution to increase access to dental care and improve the overall health of Maryland residents.

What are the major, most compelling reasons we want to support this issue?
Because despite important progress since the death of Deamonte Driver in 2007, Maryland still has chronic, persistent dental access gaps (listed above). Dental therapists, a type of midlevel dental professional, are a critical component because they can help dentists address the untreated decay of tens of thousands of residents. Many consequences of dental disease – pain, missed school and work days, unnecessary ED visits – are the result of untreated dental decay. Under the current state of the law, only dentists are authorized to drill and fill decayed teeth. Working under the general supervision of dentists, dental therapists are be able to provide preventive and basic restorative care, including filling cavities, placing temporary crowns, and extracting primary (baby) teeth and loose, diseased permanent teeth. Dental therapists can work in private and public practices to extend office hours to evenings and weekends without the physical presence of a dentist. They can bring care directly to patients in the community, including in schools, day care centers, and nursing homes. This flexibility allows practices to generate more revenue and serve more low-income patients.

Please provide citations with the scientific evidence supporting the position.
Dental therapists have practiced for nearly a century across the world and now work in more than 50 countries and are authorized to practice, in some form, in six states.[1] Dental therapists have practiced in Alaska since 2004, increasing access for over 40,000 Native Alaskans living in rural communities.[1] They have practiced in Minnesota since 2011; Maine authorized them in 2014, and Vermont followed suit in 2016.[1] The Swinomish Indian Tribal Community in Washington State and two local tribes in Oregon employ dental therapists.[1]

The legislation would allow dentists to expand their practices and serve more patients in more settings while increasing revenue. Dental therapists' lower salaries reduce the cost of delivering care to patients making it more feasible for dentists and dental practices to accept Medicaid payment rates. Studies find:

- One private practice in Minnesota that employs a dental therapist made an additional $24,000 in profit and served 500 Medicaid patients in the therapist's first year (despite Minnesota having the lowest pediatric dental reimbursement rate in the county).[1]
- One federally qualified health center in Minnesota that hired a dental therapist found that after the first year (2012) the dental therapist generated more than $30,000 in net revenue. The center hired a second dental therapist in July 2013.[1]

- In one analysis using 2014 dental clinic data from the Edward M. Kennedy Community Health Center in Massachusetts, the dental clinic could bring in an additional $60,000 a year over expenses by hiring a dental therapist.[1]
- A 2012 analysis found that dental therapists in Alaska produce an estimated $127,000 in net revenue for their dental teams.[1]

Is the current political climate conducive to moving this issue forward at this time?
Yes it is. We have two very strong bill sponsors, Sen. Joan Carter Conway (Chair of the Senate Education, Health and Environmental Affairs) and Del. Bonnie Cullison who are fiercely committed to this issue and legislation. Additionally, the current health policy climate is such that priorities with significant fiscal notes may be a challenge to enact. This approach, which would not incur direct costs to the state, may be seen as doable in the current climate. Finally, in every state that it is has been pursued, it enjoys strong bipartisan support from both progressive and center-right oriented organizations.

Would we have credible partners with whom to coalesce?
Yes. The legislation already has more than a dozen supportive organizations, including Advocates for Children and Youth, Maryland Family Network, Maryland Citizens' Health Initiative, Public Justice Center and the Maryland Developmental Disabilities Council, among others.

Would there be parties working against us? What are their arguments? What are their resources?
The only advocacy opponent is the Maryland State Dental Association. They argue that Maryland does not have a dental access problem, that there are other approaches to address the problem if there were, and that dental therapists are not safe nor proven enough to address the issue.

Is this the first time this bill will be introduced in Maryland?
No, this legislation was previously introduced in the 2016 legislative session by the same sponsors. It was modified in the Senate into a study bill that successfully passed the Senate but was not brought up in the House.

Is there significant support for this issue within MdPHA's membership? Based on polling at our annual meeting
MdPHA submitted a letter in support of the dental therapy bill last session, but as the issue was not brought before the membership for consideration as a priority, we do not know what kind of popular support it will enjoy this year.

4. Prescription Drug Affordability

Prescription drug spending accounted for over 22% of each health insurance premium dollar in 2014, and nearly a quarter of drugs in their deductible period were never picked up from the pharmacy, directly due to cost. The truth is, these cost increases are just the tip of the iceberg and nothing new. Prescription drug prices, and their associated impact on health care costs across the board are a huge burden on Marylanders

Prescription drugs continue to be consistently one of the largest, if not the single largest driver of health care costs, and if we cannot work on solutions to bend the cost curve. The incredible progress we have made over the last decade to insure our fellow family, friends, and neighbors could be in jeopardy if we do not take a serious approach towards affordability and out of pocket costs. Maryland needs to continue to address the cost of prescription drugs, building on the State's landmark 2017 legislation banning price gouging by manufacturers of generic and off-patent drugs.

Impact on Public Health
Major health coverage impact as has potential to address and reduce the largest driver of health care costs in an already burdened system, hence continuing affordability goals of Affordable Care Act.

Compelling reasons
No major cost containment initiative that seriously wants to address consumer affordability of coverage can exist without a deep look at prescription drugs. Maryland has also now made significant progress by passing a historic first step, and is primed to utilize momentum to make strides towards further addressing the problem.

Evidence and Call to Action
http://nashp.org/wp-content/uploads/2016/10/Rx-Paper.pdf

Credible partners
Besides the academic public health expertise of the Johns Hopkins Bloomberg School of Public Health, University of Maryland School of Pharmacy and other prominent national technical experts, we also plan on continuing to expand the broad based coalition of Maryland grassroots support including the health, labor, business, faith, and local communities. We will also work very closely this year for the first time with the National Academy for State Health Policy (NASHP) and Patients for Affordable Drugs.

Parties working against
Pharma and drug corporations that prefer the status quo of profits over patients and people

First time introduced
No on transparency, yes on rate setting and PBM drug pricing chain policy.

Support within MdPHA membership
Yes, and we hope to broaden the coalition of active members aggressively pursuing this measure.

5. The Maryland Clean Energy Jobs Initiative

Is there significant impact on public health in Maryland? What are the major, most compelling reasons we want to support this issue? Please provide citations with the scientific evidence supporting the position.

The Climate Crisis is an issue of public health. Global warming is contributing to the increasing severity and frequency of storms, lengthening allergy seasons, and worsening air quality. The American Public Health Association has declared 2017 the year of Climate and Health. Specifically, Maryland communities also facing extreme health consequences caused by fossil fuels and other dirty sources of energy. Chronic Obstructive Pulmonary Disease (COPD) is the 4th leading cause of death in Maryland. Emissions-related pollution can contribute to the development of heart disease, asthma, and different forms of Cancer (Andries, *Maryland Reporter*, 2013). The National Academy of Sciences states that climate-related health costs for the average Maryland household are at an average of $73 per month. In addition, climate-related illnesses disproportionately affect low-income families and people of color (Maryland Climate Coalition, 2016).

Not only do fossil fuels lead to chronic, expensive, lifelong health problems, they also lead to a disproportionate number of premature deaths. According to a 2013 study from MIT, there are around 113 deaths per year--deaths which are a direct result of ingesting pollution caused by transportation emissions and industrial incineration. Maryland holds the highest rate of emissions pollution related deaths in the US, and Baltimore specifically holds the highest rate of all large cities in the country, including New York, Los Angeles, and the DC metro area (Andries, *Maryland Reporter*, 2013).

But there are policy changes we can make now to reduce our reliance on fossil fuels, improving air quality and health outcomes. A 2017 Lawrence Berkeley National Laboratory Study posited that between 2005 and 2017, using more solar and wind energy in the US instead of fossil fuels helped to prevent between 3,000 and 12,700 premature deaths in the country (Rathi, *Quartz*, 2017). Across the country, an increased usage of renewable energy is directly related to climate-protecting laws. When states are forced to use more renewable electricity, their residents and communities prosper. The Maryland Clean Energy Jobs Act of 2016, the lifesaving bill which will hold the state to a mandate of 25% renewable electricity by the year 2020, will prevent between 25 and 50 premature deaths each year (Maryland Climate Coalition). We know that laws expanding renewable energy work, and we hope to push the current laws even further.

The Maryland Clean Energy Jobs Initiative seeks to double that percentage and hold Maryland to a standard of 50% renewable electricity by the year 2030. Importantly for public health, this initiative removes trash incineration from Tier 1 of Maryland's Renewable Portfolio Standard (RPS), the mechnism by which we incentivize renewable energy. While burning trash for energy deviates trash from landfills, it creates harmful byproducts, the burden of which is borne by people living near the incineration facilities. Our legislation combines the expansion of clean energy with investments in clean energy job training programs. Solar and wind both create at least three times more jobs per kilowatt hour of electricity than any fossil fuel source (Huntington, *USAEE Dialogue*, 2009). As a result, there is a growing number of $16/hour jobs installing solar panels on rooftops in Maryland, but a real shortage of workers trained to do those jobs (Baltimore Civic Works). This legislation will fund job training programs which will target economically distressed parts of the state, giving people access to those much needed jobs. We will also ensure that the clean energy economy is a future everyone can be a part of by

investing in clean energy businesses owned by women and people of color through the state's Small, Women, and Minority Owned Business Account (Video Lottery Terminal Fund).

The legislation advanced by the Maryland Clean Energy Jobs Initiative will improve the air quality in Maryland, reduce our contribution to climate change, and boost the state's economy all at once.

Is the current political climate conducive to moving this issue forward at this time? Would we have credible partners with whom to coalesce? Would there be parties working against us? What are their arguments? What are their resources? Is this the first time this bill will be introduced in Maryland?

Opinion Works conducted a poll (link below in the Works Cited) asking Marylanders whether they would support expanding renewable energy in Maryland to 50% by 2030, and found that 71% of Marylanders support the idea. When Maryland voters are told that the renewable energy expansion would be coupled with job training programs, support increases to 82%.

Not only do Maryland voters support this legislative package, they care about it enough to switch parties based on where candidates stand on the issue. If voters knew that the Republican candidate for a state office supported this proposal while a Democratic candidate opposed it, then the Republican candidate would win by 36 points. Likewise, if voters knew that the Democratic candidate supported this proposal while the Republican opposed it, then the Democrat would win by 43 points. Opinion Works told us that voters switched parties based this legislative package more than they had ever seen before. This high quality poll shows that Marylanders are overwhelmingly committed to this issue.

The Maryland Clean Energy Jobs Initiative informally launched the campaign this past February 2017, and already there is vast support for the legislation. The Maryland Climate Coalition has made this issue a priority campaign. The Chesapeake Climate Action Network, the League of Conservation Voters, Maryland Environmental Health Network, Interfaith Power and Light, and other members of the coalition have all committed to put institutional resources into passing this legislation. The Resolution which describes our proposed legislation (Link below in Works Cited) has already been endorsed by 317 groups from across Maryland, including faith-based and advocacy organizations, nonprofits, and businesses in the state.

The board chair of the Maryland Clean Energy Jobs Initiative is Vincent DeMarco. Vinny has spent a lifetime running successful grassroots campaigns to pass public health legislation in Maryland. He has followed a proven six step method (Link below in Works Cited) which has reduced gun violence, reduced teenage smoking rates, expanded healthcare, reduced rates of drunk driving, and made it harder for pharmaceutical companies to unconscionably raise their prices.

It is possible that large utility companies will work to oppose this legislation. These utilities have deep pockets and can afford a team of lobbyists in Annapolis, but lack a grassroots network and the ability to organize the people. Historically, there wasn't a strong opposition from utility companies during the campaign to pass 25% renewable electricity in Maryland.

Although we will work to convince Governor Hogan to support this legislation, he is likely to oppose it because he vetoed the 25% by 2020 legislation calling it a tax. Other politicians who are anti-tax and anti-government intervention will likely follow Governor Hogan's lead on this issue, potentially motivating their followers to oppose and work against the bill.

There are some environmental groups such as the Sierra Club and Food and Water Watch who will not endorse this proposal. They aren't opposing it, but they are also not endorsing it. Their argument is that the clean up of the RPS should include more than just trash incineration, such as burning black

liquor (an industrial by-product of paper manufacturing) and burning chicken litter for energy. Our analysis shows that black liquor plants or chicken feces burning plants will not be increased through the 50% mandate in the bill.

The proven six step model we are following involves leveraging an election cycle to pressure legislators into supporting the issue. We will introduce the legislation in 2018, and hopefully it will pass. If it doesn't pass in 2018, our plan is to make this an election issue in the 2018 election cycle. Leading up to the election we will ask every candidate if they support the legislation, and then we will publicize who has endorsed the proposal and who hasn't. We are confident that the pressure from the upcoming election coupled with the compelling polling data will convince a vast majority of state legislators to endorse 50% by 2030, and the legislation will pass in 2019.

Works Cited

Andries, Kate. "Maryland Deaths from Air Pollution Highest in U.S." *Maryland Reporter*, September 2013. <http://marylandreporter.com/2013/09/13/maryland-emissions-related-deaths-highest-in-u-s/>

Baltimore Civic Works. "Solar Installation Training." http://baltimoregreencareers.civicworks.com/for-applicants/solar-installation-training/

Huntington, Hillard G. "Creating Jobs with 'Green' Power Sources." USAEE Dialogue, 17(1). Stanford University. March, 2009. <https://web.stanford.edu/group/emf-research/docs/occasional_papers/OP64.pdf>

Maryland Climate Coalition. "Overriding Governor Hogan's Veto of Maryland Clean Energy Jobs Act of 2016." 2016. <http://marylandclimatecoalition.org/clean-energy/>

Rathi, Akshat. "One of the Biggest Criticisms Against Wind and Solar Energy has been Quashed" *Quartz*. August, 2017. <https://qz.com/1054992/renewable-subsidies-are-already-paying-for-themselves/>

For information and access to the Opinion Works Poll on the viability of a 50% bill in the state of Maryland, visit <https://www.cleanenergyjobs.org/wp-content/uploads/2017/04/Renewable-Energy-Poll-Memo-041817.pdf>

For access to the Resolution which describes our proposed legislation, visit <https://www.cleanenergyjobs.org/sign/>

For access to the Six Step Approach used by Vincent Demarco mentioned above, visit <https://www.cleanenergyjobs.org/about/>

For Information on the Video Lottery and Terminal Fund, please visit <http://commerce.maryland.gov/fund/programs-for-businesses/vlt>

6. Tobacco21: Increasing the Sale Age for Tobacco Products to 21

Increasing the minimum legal sale age for tobacco products will have a significant, positive impact on public health. It will reduce smoking, reduce cancer, heart disease and respiratory diseases, save lives and reduce health care expenditures. Already passed in Hawaii, California, New Jersey, Maine and Oregon as well as 260 localities throughout the country.

Is there significant impact on public health in Maryland? Describe.
Tobacco use remains the leading cause of preventable death, killing 7500 Marylanders annually. Passage of Tobacco21 will reduce smoking-caused deaths by 10%.

What are the major, most compelling reasons we want to support this issue?
1) Approximately 90% of adult smokers begin smoking before age 18, when the adolescent brain is still developing. Tobacco use during this time can affect brain development. The adolescent brain has a heightened susceptibility to the addictive qualities of nicotine; i.e., adolescents become addicted to nicotine more quickly than adults.
2) Tobacco use costs Maryland $2.7 billion in annual health care expenditures, including nearly $600 million in state Medicaid expenditures; productivity losses in Maryland account for an additional $2.22 billion in annual costs.

Please provide citations with the scientific evidence supporting the position.
1)Public Health Implications of Raising the Minimum Age of Legal Access to Tobacco Products, Institute of Medicine of the National Academies, Washington, DC; 2) The American Heart Association, Dallas Texas; 3)The Campaign for Tobacco Free Kids, Washington, DC

Is the current political climate conducive to moving this issue forward now?
Probably not, but with each election cycle it will be worse, so why wait?

Would we have credible partners with whom to coalesce?
We have an outstanding collection of partners in the Maryland Tobacco Control Coalition and we are continuing to recruit. Currently:
AHA, ACS, ALA, the March of Dimes, the Office of the Maryland Attorney General, the University of Maryland School of Law's Legal Resource Center, the Campaign for Tobacco Free Kids, GASP, Baltimore City Health Department, Healthy Montgomery, the Howard County Health Department, the Maryland Chapter of AACP and the University of Maryland School of Pharmacy.

Would there be parties working against us?
Absolutely: The tobacco industry and the convenience-store retailers including the Seven-Elevens and Royal Farms, and those located is gas stations such as Sunoco, Chevron, BP America and Sheetz.

What are their arguments?
They will say that their businesses will suffer from lost sales and they will have to lay off workers or maybe even close; they will say that lost revenue from reduced tobacco sales will result in diminished public services; they will say that kids under 21 will cross borders into states that have not passed such laws, further reducing revenues; they will say that the Government should not be telling industry how to run their businesses and laws such as this contribute to the reputation Maryland has of being "unfriendly to business."

What are their resources?
Substantial!

Is this the first time this bill will be introduced in Maryland?
This will be the third time that this bill will be introduced. In 2016 and 2017, the initiative was driven by the Maryland Association of County Health Officers (MACHO) and there was an unwillingness to include ACS and AHA model language and requirements. (As an example, the MACHO bills would have penalized the underage minor who purchased and/or used tobacco products as well as the distributer/seller; the model language of ACS and AHA only penalizes the distributer/seller.) Thus, our support was non-existent in 2016 and lukewarm in 2017. Now the bill is going forward as we wish it to, and the coalition is totally supportive. Also, similar laws have been passed recently in Hawaii, California, Washington, DC, Maine, New Jersey, Oregon

7. Styrofoam Ban

Is there significant impact on public health in Maryland? Describe.

- Styrene, a known carcinogen and component of polystyrene manufacturing, leaches into hot liquids, such as coffee, which is then consumed by humans[1].
- Polystyrene foam often ends up in our waterways because it floats and breaks into smaller pieces. Once in the water, polystyrene absorbs 10x more fertilizer, pesticides, and other petrochemicals than other types of plastic. These tiny pieces can be ingested by fish or picked up by people, exposing them to toxic chemicals[1].
- Litter is demonstrated to have negative effects on mental health and community well-being. Litter levels and other forms of blight tend to be disproportionately higher in economically distressed neighborhoods, compounding social inequity and opportunity disparity.

What are the major, most compelling reasons we want to support this issue?

- This is more than just an environmental issue. Support from MdPHA would bring in expertise demonstrating that polystyrene foam greatly impacts human health, too.
- APHA has prioritized environment-related legislation in the past[111], and a partnership with the environmental community includes access to their paid lobbyists and large grassroots base.

Please provide citations with the scientific evidence supporting the position.

- NTP (National Toxicology Program). 2016. Report on Carcinogens, Fourteenth Edition.; Research Triangle Park, NC: U.S. Department of Health and Human Services, Public Health Service. http://ntp.niehs.nih.gov/go/roc14/ (EndNote XML)
- Van, A., Rochman, C. M., Flores, E. M., Hill, K. L., Vargas, E., Vargas, S. A., & Hoh, E. (2012). Persistent organic pollutants in plastic marine debris found on beaches in San Diego, California. *Chemosphere*, *86*(3), 258-263.
- Preventing Environmental and Occupational Health Effects of Diesel Exha (Rep. No. 20147). (2014, November 18). Retrieved https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2015/01/28/12/14/preventing-health-effects-of-diesel-exhaust
- Reducing Flame Retardants in Building Insulation to Protect Public Health (Rep. No. 20156). (2015, November 3). Retrieved https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2016/01/05/18/39/reducing-flame-retardants-in-building-insulation-to-protect-public-health
- Reducing Human Exposure to Highly Fluorinated Chemicals to Protect Public Health (Rep. No. 20163). (2016, November 1). Retrieved https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2016/12/21/reducing-human-exposure-to-highly-fluorinated-chemicals

Is the current political climate conducive to moving this issue forward at this time?

- Maryland policymakers recognize the public health and environmental impacts of trash, litter, and plastic but have not taken action on other policy approaches to reduce litter due to perceived consumer impact. However, this ban imparts no fiscal impacts on consumers and minimal fiscal impact on businesses and state agencies; any change in practices will fall on businesses.
- Some businesses who have had to switch to non-foam containers have opened new locations since the legislation has taken effect, suggesting the ban had little fiscal impact[1].

- The proposal is often painted as additional burdens on business but it also presents an opportunity to increase local production of sustainable food packaging.

Would we have credible partners with whom to coalesce?

- The bill is expected to be a priority of the environmental community (Trash Free Maryland, Maryland League of Conservation Voters, Blue Water Baltimore, Chesapeake Bay Foundation, Surfrider Foundation, South River Federation, etc).
- Interfaith Partners for the Chesapeake is organizing in the faith community.
- Baltimore City school green teams will engage and the Young Activists Club in Takoma Park has extensive research and grassroots experience to lend.
- Various councilmembers on the Baltimore City Council have expressed interest and support of this type of ban.

Would there be parties working against us? What are their arguments? What are their resources?

- Foam manufacturers assert that foam is not a significant component of solid waste or litter. They commissioned a study of the Anacostia River to reevaluate trash loads and their methodology appeared to show little foam litter because the study focused on roads, not waterways[1].
- Small businesses express concerns about increase in costs. The bill includes affordability waivers if businesses find them necessary. Surveys in the DC Metro are currently collecting data on business experience with cost and implementation.
- Baltimore City and Howard County have foam recycling programs subsidized by Dart Container, the world's largest manufacturer of foam containers, and the industry will likely argue that these facilities are sufficient.

Is this the first time this bill will be introduced in Maryland?

- This will not be the first time this bill has been introduced in Maryland; it has been introduced as a statewide proposal and at the county level. Similar bans took effect in 2016 in Prince George's & Montgomery Counties, as well as in Washington, DC.
- Many cities and counties around the nation have passed similar bans.[1]
- Several Maryland jurisdictions and businesses have already enacted policies to require compostable or recyclable containers, and banning polystyrene will even the playing field statewide.

8. Placeholder for Protections on Health Insurance Coverage:

In June 2017, the Maryland Health Insurance Coverage Protection Commission was authorized (Chapter 17, Acts of 2017).

Changes and potential changes to the federal Patient Protection and Affordable Care Act, the *Maryland Children's Health Program*, Medicaid, Medicare, and the Maryland All-Payer Model will be monitored by the Commission. The impact of such changes will be assessed by the Commission, and recommendations made on how to ensure access to affordable health coverage for Maryland residents.

The Commission will undertake a study to include an assessment of the adverse effects on State residents, public health, and the economy resulting from the loss of health coverage through changes to the federal Patient Protection and Affordable Care Act. Further, the study will estimate the costs to Maryland and its residents, and examine measures to prevent or mitigate the adverse effects associated with changes to the Act, the *Maryland Children's Health Program*, Medicaid, Medicare, and the Maryland All-Payer Model.

Although at the time of the MdPHA Conference, we do not know what the legislative recommendation will be, we know we should leave space for improvements in health insurance coverage and healthcare delivery based on the recommendations of this Commission

9. Placeholder for Health in All Policies Commission Recommendation

In June 2017, the Work Group on Health in All Policies was established (Chapter 559, Acts of 2017).

Convened by the Maryland Center for Health Equity at the University of Maryland School of Public Health, in consultation with the Maryland Department of Health, the Work Group is to use a "Health in All Policies" framework, which is a public health framework where health considerations that collaboratively improve health outcomes and reduce health inequities drive policy decision-making across the public and private sectors.

The Work Group has several tasks. First, it will examine the current health status of Maryland citizens, and how State and local governments might collaborate to improve the health of Marylanders. The effect of the following factors on health are to be considered: access to safe and affordable housing; economic stability; educational opportunities; employment prospects; environmental factors; public safety issues; social justice; and workplace factors, such as inclusion, diversity, equity, and barriers to promotion and advancement.

Further, the Work Group will study and make recommendations on how health considerations can be incorporated into decisions by government agencies and entities that interact with them. Moreover, it will recommend how to foster collaboration between State and local governments in devising and implementing laws and policies that improve health and reduce health inequities.

Although at the time of the MdPHA Conference, we do not know what the legislative recommendation will be, we know we should leave space for Health in All Policies legislation based on the recommendations of this Commission.