

Chicago Board of Health
Meeting Summary March 15, 2017
DePaul Center, 333 South State Street

Roll Call

Board Members Present

Carolyn C. Lopez, M.D., President
Melanie Dreher, RN, PhD.
Caswell A. Evans, Jr., D.D.S., .P.H
Victor M. Gonzalez
Steven K. Rothschild, M.D.
Joseph B. Starshak

Board Members Absent

Adele Joy Cobbs, M.D.
Horace E. Smith, M.D.

For the Department

Julie Morita, M.D., Commissioner

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Call to Order: The meeting was called to order at 9:06 a.m. by Dr. Lopez, Board President.

Approval of Minutes: The February 2017 minutes were approved unanimously.

Commissioner's Update: Dr. Morita reported the following:

- Dr. Morita commended Dave Graham, Assistant Commissioner of Environmental Permitting and Inspections and his team on their and ongoing efforts on the southeast Side, where a recent report indicated the possibility of manganese in the air. Manganese is an element essential to our health and well-being, but can be dangerous in elevated amounts. Dave's team is launching a multi-pronged approach to determine the level of concern and his presentation today will address that approach.
- Dr. Morita thanked the board for their work on passing the immigration resolution last month. CDPH was able to share the information with various audiences including providers and the media, resulting in coverage on Univision and others about the definitive stand the department and board is taking to welcome all people regardless of their status. Next week, CDPH will host a webinar with our partners at the Illinois Coalition for Immigrant and Refugee Rights and the Shriver Center for providers, reminding them of their legal rights, and those of residents. CDPH will also discuss best practices around data collection and how providers can ensure their space is welcoming to immigrants.
- Next, Dr. Morita reported the following: (1) Earlier this month, she joined our partners at the Office of Emergency Management and Communications and the Chicago Police Department to announce that all City dispatch operators have now completed comprehensive mental health and de-escalation training. This is a first for the city and one she's especially proud of as it fills a key goal of Healthy Chicago 2.0 and expands our Health in All Policies framework, ensuring our sister agencies approach their work from a health lens. With this training, city's dispatch operators will be better equipped to identify mental health crises and route the more appropriately to help ensure a more appropriate response on the part of the city. This is also a big step forward in our effort to ensure Chicago is a trauma-informed city. (2) Earlier this month Mayor Emanuel and the Department of Planning and Development announced an investment of \$16 million to invest in eight communities in greatest need to strengthen retail corridors. The program provides \$250,000 grants to new and existing retailers in the area to rehabilitate commercial buildings. These investments would not only increase economic activity, but in turn will decrease violence and improve overall health outcomes.
- In addition, Dr. Morita reported the following update: She traveled to Washington, DC for a meeting with the Big City Health Coalition, which brings together the leaders of the nation's 20 largest local public Health agencies. The focus of our conversation was the Affordable Care Act and the devastating impact would have on all of our cities. She met with seven members of our congressional delegation while in DC and shared the local impact repeal would have on Chicago.

Comments by the Board President: Dr. Lopez welcomed all the students and a member of the public. Dr. Lopez provided an overview of the board's history and explained the board's advisory role in matters of infectious disease and health issues affecting public health.

Policy Update: Jesse Lava reported on the American Health Care Act:

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Parts of the ACA kept in the proposed bill:

- You can stay on your parents' insurance until age 26.
- Insurance would be required to cover pre-existing conditions.
- Insurance companies couldn't set lifetime limits on reimbursements.
- Some form of tax credits, though limited, would supplement people's premium payments.
- Grandfathering in people who are currently on Medicaid expansion.

Differences from the ACA:

- Using cuts in coverage to pay for big tax cuts for the wealthy. These cuts include a repeal of Medicare taxes on high-income people, along with fees on drug companies, insurers, and others that helped fund greater coverage. The cost of the tax cuts would be hundreds of billions over 10 years.
- Premium subsidies would come through tax credits and be a lot lower. The funding would be capped—and the cap would be based not on the cost of care, but on inflation. The projected growth rate of the costs is higher than inflation. So the real value of the subsidies would erode over time.
- Premium subsidies, though tax credits, would be based on age, not income. So people who are young but have had health problems and work in jobs where insurance isn't provided would likely be unable to afford insurance. But older folks would still be worse off if they are low income—and could now be charged five times as much as what a young person is charged, an increase from the ACA's ratio of three times as much.
- There would be higher premiums on the marketplace if you have a gap in insurance. If you leave the insurance pool and then come back to it, insurance companies could charge you a 30% premium on top of what you'd already be paying. Theoretically that's an incentive to keep people from going without insurance, but it's weaker than the current mandate—and indeed may have the opposite effect by deterring people from buying insurance. That could lead to an adverse selection problem, also called a death spiral, where healthier people leave the market and don't return, making the insurance pool older and sicker and thus more expensive—pushing more healthy people out of the market and exacerbating the problem.
- ACA opponents have said that co-pays and deductibles were too high, but this bill would likely lead to even higher ones by allowing higher deductibles and co-pays.
- Medicaid expansion would begin to disappear, starting in 2020. That year, for any patient who wasn't already enrolled in Medicaid, the state would be reimbursed at just 50% (or for some states up to 75%) by the federal government as opposed to the 90% today. Most states wouldn't be able to afford that. Patients who are already enrolled in Medicaid but leave for a month or more because they got a job would be unable to return to Medicaid at the old federal reimbursement rate. Since most Medicaid enrollees use the program for short periods, there would be a sharp drop-off in enrollment starting in 2020, and then by attrition, Medicaid expansion would be at risk of gradually ending altogether.

Example: Opioids

- The opioid epidemic has grown, and federal coverage of treatment has grown with it to meet the need. But under the House plan, with the per capita cap, states would have to cover the full cost of increased need, and more. That means more addiction. If states allocated dollars to treating addiction, they would have to weaken Medicaid coverage for others, leading to an increase in other health problems.

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CBO Report:

- The report estimates that 24 million would lose coverage under the new plan by 2026. This would break a promise made by bill advocates that no one would lose coverage under the plan. 14 million would lose coverage in 2018, mostly people on the individual market, due to repealing the mandate. After that, the drops would come from the freeze Medicaid in expansion in 2020.
- It's also estimated that the bill would sharply raise premiums for older, poorer Americans. A 64 year-old making \$26,500, for instance, would see a 750% increase in premiums—leading the person to pay more than half their annual income for premiums alone. And that's before paying any co-pays, deductibles, or additional costs.
- While some claim that that the CBO's estimates can't be trusted, it was fairly accurate on the ACA. In 2012, before the bill took effect but after the Supreme Court ruling that compromised Medicaid expansion, the CBO predicted that 89% of the nonelderly would have coverage by 2016. The number ended up being 89.7%. These figures belie the White House's claim that the CBO's estimates were "way, way off."

Prevention and Public Health Fund (PPHF):

- Through the ACA's Prevention and Public Health Fund (PPHF), Chicago has been able to strengthen our public health capacity in key health areas, helping prevent the spread of deadly disease. CDPH has received \$12.8 million via the PPHF since 2012. Indeed, PPHF funding now makes up more than 12% of total CDC funding, showing how critical it has become to the overall public health infrastructure. Programs funded by these dollars including immunization distribution, lead poisoning prevention and communicable disease surveillance and response would lose funding. Examples of how this funding has helped Chicago:
 - In Chicago, the number of young people receiving the HPV vaccine went up 20 percentage points between 2013 and 2014 following direct investments from the PPHF for a comprehensive citywide HPV campaign including provider education and public outreach.
 - Enhanced surveillance and testing through PPHF helped CDPH detect and respond to an outbreak of meningitis among Chicago-area gay and bisexual men in 2015-2016. CDPH was able to launch a citywide vaccination campaign, distributing nearly 23,000 doses of the vaccine and administering nearly 20,000 directly—preventing the outbreak from spreading further.
 - Following new funding from PPHF, CDPH nearly tripled the number of food outbreaks that were identified, from approximately six/year between 2009-2013 to 10 in 2014 and 16 in 2015.
 - CDPH increased community outreach and education around lead poisoning prevention, connecting 2,408 residents including pregnant women and new mothers to a variety of interventions including visual lead inspections and in-home education.

Presentation: CDPH's Environmental Program: Progress and New Challenges - Dave Graham, Assistant Commissioner for Environmental Protection

Old Business: None.

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New Business: None.

Public Comment: Dr. Carl Bell explained the effects of fetal alcohol exposure on the brain and motor function and his finding on choline supplements improving brain function and memory. He also mentioned choline deficiency may also play a part in age-related cognitive decline, including memory loss and Alzheimer's disease. He requested BOH members to consider a resolution suggesting choline dosage be increased to 500 mg for pregnant women.

Adjourn: The meeting adjourned at 10:30 a.m.

Next Board Meeting: April 19, 2017, 9:00 a.m.