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HEALTH POLICY BULLETIN

FOCUS: MEDICAL WASTE

According to *Medical Waste News* the "best opportunity for growth in the '90s for hazardous waste is in infectious medical waste." In Michigan by 1995 about 840,000 tons of infectious medical waste will be generated, and by the year 2000 the amount will be 1.1 million tons; 90 percent of this waste is estimated to come from hospitals and nursing homes. What is Michigan doing to handle this problem?

Larry Chadzyinski, Administrator, Special Programs and Projects, Office of the Director, Michigan Department of Public Health, thinks the state is doing a lot. "Michigan has demonstrated leadership in this area," he says and points with pride to the fact that the state received a $120,000 grant from the federal Environmental Protection Agency (EPA) to conduct a survey of small-quantity generators (facilities or practices that have only small amounts of waste as opposed to hospitals and nursing homes) to determine who generates medical waste and how much is generated by site and discipline; 43,000 possible sites, ranging from pharmacies, physician and dental offices, and veterinary practices to tattoo parlors, will be surveyed in the next few months.

Chadzyinski hopes that the survey will provide good national data on medical waste and how it is handled. To date no one knows how much of the medical waste stream comes from small-quantity generators; all that is known is that some small-quantity generators appear to handle their medical waste carelessly simply because they do not feel they have enough to justify the costs of appropriate disposal.

Two methods of disposing of medical waste exist—incineration and landfill. Both have drawbacks. Landfill sites are being filled, and finding new sites is proving to be next to impossible because of the "not-in-my-backyard" (nimby) syndrome. Older incinerators are having to shut down because they do not meet standards for emissions of gases; sites for new incinerators are also subject to the "nimby" syndrome. Chadzyinski feels the level of public anxiety over landfills and incinerators reflects the fact that "we haven't done a very good job of communicating information about incinerator and landfill design and technology." If no one wants an incinerator or landfill in their backyard, he asks, "where is the waste going to go?"

There are two examples of cooperation that he thinks Michigan should look at. In New York's Suffolk and Nassau counties a new incinerator is being built that requires the participants to practice waste minimization—recyclable materials must be recycled rather than incinerated, and other materials must be reduced (1) in volume through microwaving (literally melting them down) or (2) in infectious characteristics through autoclaving (a high temperature steam sterilization process). In Baltimore, Maryland, a consortium of twenty hospitals built an incinerator that has public support; it is allowing the hospitals to dispose of their waste at a lower cost (15 cents per pound versus one dollar and up per pound for landfills), and the facility is profitable.

Bruce Marsh, plant manager, Michigan Hospital Association Service Corporation, says that each hospital in the state handles waste differently. He notes, for example, that when his organization surveyed hospitals in an attempt to find out how much of their waste was infectious, the answers ranged from a low of 3 percent for a major teaching facility to highs of 70 to 80 percent in some smaller hospitals. Obviously, how much infectious medical waste is out there depends to some extent on how seriously a facility applies universal precautions to every patient and how the waste generated in patient care is categorized (infectious or noninfectious). Marsh observes that incineration makes a great deal of sense, although siting is very difficult. "It is not the most popular thing to build," he observed wryly.

Currently, according to Marsh, landfill disposal is usually less expensive; however, landfill space and the number of landfills that are willing to take infectious medical waste are declining. In fact, the declining availability of landfill space makes serious consideration of incineration a necessity. Given the trends, Marsh thinks that incineration will have a significant cost advantage in about three years.

Another factor complicating the use of incinerators is the fact that when existing rules governing the use of incinerators were promulgated by the Air Quality Control Commission in the 1960s they were more concerned with particulate rather than gaseous and heavy metal emissions. (Incinerators emit all three.) The Michigan Department of Natural Resources is forced to extrapolate from those rules in deciding permit approvals and denials, an arduous process that subjects the department to the wrath of nimby groups.

Public Sector Consultants, Inc.
Knapp's Centre • 300 S. Washington Square
Suite 401 • Lansing, MI 48933 • (517) 484-4954

Fortunately, new rules for incinerators are being developed. Paul Schleusener, Senior Permit Engineer, Air Quality Division, Michigan Department of Natural Resources, is working on the new rules and feels certain that under proper circumstances "the regulations will allow . . . some facilities to incinerate some medical waste." According to him, the modern medical waste stream has several characteristics that his department needs to consider. For example, he notes that "the presence of chlorine in plastics made from polyvinyl chloride (PVC) increases the amount of hydrochloric acid in the air, and organic materials, when incinerated, give off substances that, combined with the plastics, form compounds that we know are cancer-causing in low concentrations." Another concern is metals such as arsenic, cadmium, chromium, and mercury. Schleusener observed that while "there will be hurdles, we will permit incinerators."

What is the current status of the rules process? About six months behind schedule, says Schleusener. While the original timetable called for draft rules to be ready by July 1992, they are more likely to be ready in January 1993. This backs up the deadlines for facilities to have their proposals ready for the DNR to examine to 1995 and to have projects completed to 1997.

All are confident that there will be no conflicts with the federal rules due in 1992. Schleusener explained that the federal Clean Water and Air Act is not preemptive legislation; some Michigan requirements may be more stringent than the federal rules, while others may be more lenient. In his view, facilities do not have to worry about conflicts since they will be required to meet both the state and federal requirements to receive a permit.

FOCUS: HEALTH INSURANCE REFORM

A key battleground for the 1992 federal elections is health insurance reform. Three major federal proposals currently exist.

Senator Jay Rockefeller (D-WV) introduced Senate Bill 1177, which would require employers with 100 or more workers to insure their employees and their dependents or pay a payroll tax. The payroll tax would be used to establish a new public insurance program replacing Medicaid; this program would be available to small employers. Insurers would not be permitted to select risks and would be required to guarantee coverage and minimum benefits; premiums would be based on community rating.

The big gain for insurers would be freedom from state-mandated benefits. Employers would receive more favorable tax treatment; self-employed persons and unincorporated businesses (partnerships and sole proprietors) would be able to deduct the entire cost of health insurance premiums, while companies with fewer than 25 workers and an average annual payroll of less than $18,000 per worker would receive a five-year subsidy of 40 percent of the cost of the premiums. Small firms would be allowed to require their insurers to pay providers according to Medicare rules, a provision that is likely to face stiff opposition from provider groups.

A second Democratic proposal being sponsored by senators George Mitchell (D-ME), Edward Kennedy (D-MA), and Donald Riegle (D-MI) but not yet introduced would give firms five years to insure their employees and their dependents. An 8 percent payroll tax would go into effect for all firms not providing insurance at the end of the five years. The proposal would also create a government commission to recommend an annual spending target for health; subtargets would be created for each provider group. Insurers, businesses, and consumer groups in each state or other locality would be able to negotiate with providers. This plan appears to borrow heavily from the Medicare volume targets and would allow reductions in payments to providers in the years succeeding a year in which the spending targets were exceeded.

A Republican proposal introduced by representatives Ray Chandler (R-WA) and Nancy Johnson (R-CT) would remove state-mandated benefits, state-imposed taxes on health insurance premium income, and state restrictions on the use of managed care. The tax deduction for health insurance premiums for self-employed persons would be increased from 25 percent to 100 percent of the premium. This plan appears to be weighted heavily in favor of the insurance companies and is not viewed as likely to succeed on its own merits.

OF INTEREST

In the next 30 days look for the

- House Committee on Public Health to report out SB 243 (repeal of the school notification requirement in the parental consent law) and SB 295 (reimbursement of physician assistants by Blue Cross and Blue Shield of Michigan) and
- House Committee on Public Health possibly to take up HB 4407 (optometric scope of practice).

The Senate Committee on Health Policy will not meet again until the fall.

The House will adjourn June 27 and return for two one-day sessions on July 11 and July 25; the Senate will adjourn on June 20 and will return on June 27 for one day, and thereafter every two weeks for one day through the middle of September.

—Frances L. Faverman, Editor

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