



**TESTIMONY
OF THE
NEW YORK PUBLIC INTEREST RESEARCH GROUP
BEFORE THE
JOINT HEARING OF THE SENATE FINANCE AND ASSEMBLY WAYS & MEANS
COMMITTEES REGARDING THE
FISCAL YEAR 2018-2019 EXECUTIVE HEALTH BUDGET PROPOSAL
February 12, 2018
Albany, N.Y.**

Good afternoon, my name is Blair Horner and I am executive director of the New York Public Interest Research Group (NYPIRG), with me today is Tammy Merlian, a policy associate with NYPIRG and a student at the College of Staten Island. NYPIRG is a non-partisan, not-for-profit, research and advocacy organization. Consumer protection, environmental preservation, health care, higher education, and governmental reforms are our principal areas of concern. We appreciate the opportunity to testify on the governor’s executive budget on health.

As you will see, we have reactions to a number of areas of the executive budget. However, the focus of our testimony is on the executive’s funding of important public health programs. First, the efforts to fight cancer.

As you know, the governor has made screening for breast cancer a top initiative. He rightly points out that breast cancer is the second largest cancer killer of women. He has advanced programs to boost screening.¹ Undoubtedly for women without adequate health insurance, such screening programs can have a positive impact. Below are the estimated numbers of new cancer cases in New York:

Estimated Number of New Cancer Cases and Cancer Deaths Exceeding 1,000, 2018²

Type of Cancer	New Cases	Deaths
<i>Total, all sites</i>	<i>110,800</i>	<i>35,350</i>
Lung & Bronchus	13,190	8,490
Colon & Rectum	9,080	2,970
Pancreas	3,590	2,760
Female Breast	17,890	2,390
Prostate	9,880	1,680
Leukemia	4,410	1,460
Liver & IBD	2,560	1,710
Non-Hodgkin Lymphoma	4,890	1,200
Urinary Bladder	5,440	1,060

¹ Governor Cuomo, “Governor Cuomo Announces \$37.7 Million Awarded to Improve Access to Breast Cancer Screening Across New York State,” February 1, 2018,” <https://www.governor.ny.gov/news/governor-cuomo-announces-377-million-awarded-improve-access-breast-cancer-screening-across-new-york>.

² American Cancer Society, Cancer Facts & Figures, Supplemental Data, see: <https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/annual-cancer-facts-and-figures/2018/estimated-number-of-new-cancer-cases-and-deaths-by-state-2018.pdf>.

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Virtually all New Yorkers have had an experience with cancer. According to the U.S. Centers for Disease Control and Prevention (CDC), cancer is the second leading cause of death in America.³ *As seen above, the top five cancer killers account for more than half of all the estimated cancer deaths.*

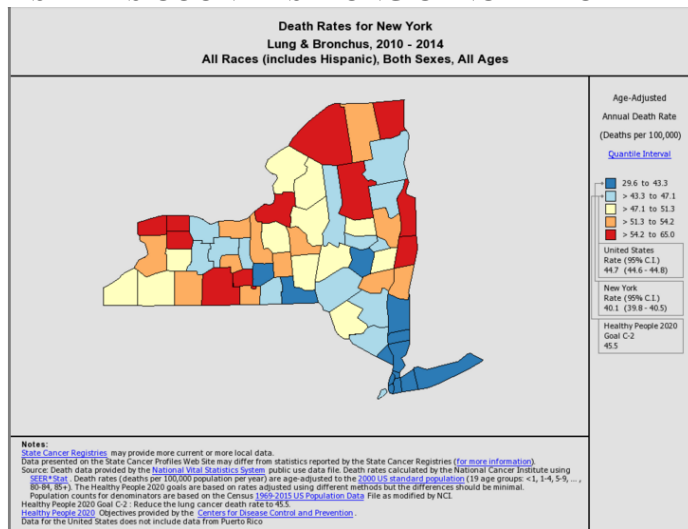
Breast cancer is the leading form of cancer affecting women and the second biggest killer. Yet, it is not the leading cause of cancer deaths for women. Prostate cancer is a leading cause of cancer in men, but it is not the leading cause of cancer deaths in men. *That terrible distinction belongs to lung cancer.*

As you see in the above chart, lung cancer is what drives cancer deaths in New York State: *One-quarter of all cancer deaths result from lung cancer.* It is a cancer that is deadly, and that afflicts men and women alike. It is also a cancer for which we know how to dramatically reduce its impact: by reducing the use of tobacco products.

1. The leading cause of lung cancer is tobacco use. Today nearly 9 out of 10 lung cancers are caused by smoking cigarettes.⁴ Not only are smokers at risk, but even non-smokers can be afflicted by exposure to tobacco smoke. In the U.S., more than 7,300 nonsmoking lung cancer patients die each year from exposure to secondhand smoke alone.⁵

Before we go into more detail about the governor's failure to do anything to improve – much less meet – the scientifically-identified goals for how much money the state of New York should spend on fighting lung cancer, we reviewed the impact of lung cancer throughout New York State. As you can see below, lung cancer mortality rates tend to be higher in upstate counties.⁶

NEW YORK STATES COUNTIES' LUNG CANCER MORTALITY RATES⁷



³ U.S. Centers for Disease Control and Prevention, “Leading Causes of Death,” <http://www.cdc.gov/nchs/fastats/leading-causes-of-death.htm>.

⁴ Smoking also causes cancers of the esophagus, larynx, mouth, throat, kidney, bladder, liver, pancreas, stomach, cervix, colon, and rectum, as well as acute myeloid leukemia (1-3). Source: National Cancer Institute, available at <https://www.cancer.gov/about-cancer/causes-prevention/risk/tobacco/cessation-fact-sheet#q2>.

⁵ U.S. Centers for Disease Control and Prevention, “Secondhand Smoke Facts, 2015”:
https://www.cdc.gov/tobacco/data_statistics/fact_sheets/secondhand_smoke/general_facts/index.htm.

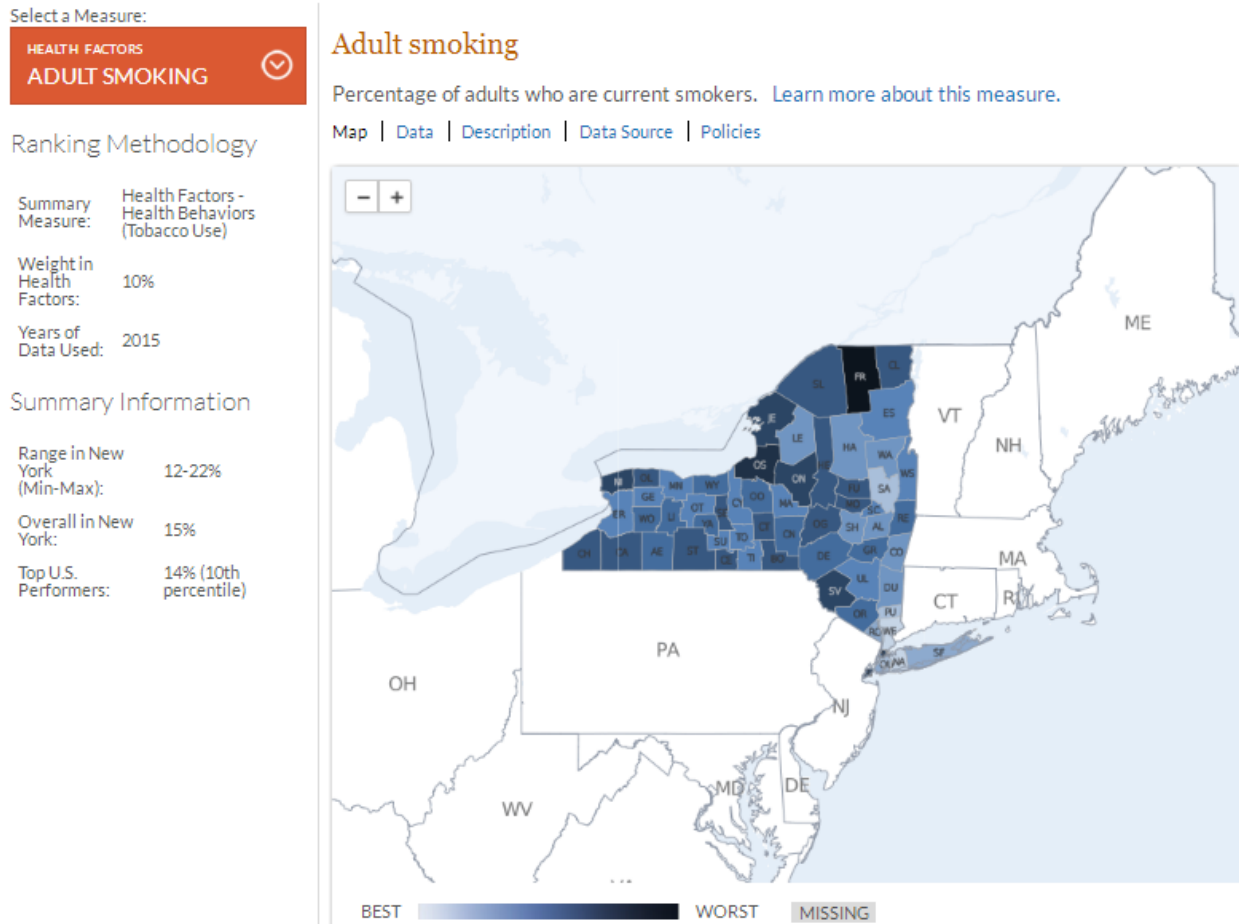
⁶ Cancer is not the only disease that can result from tobacco use, see:
https://www.cdc.gov/tobacco/data_statistics/fact_sheets/health_effects/effects_cig_smoking/index.htm.

⁷ National Cancer Institute:
<https://statecancerprofiles.cancer.gov/map/map.withimage.php?36&001&047&00&0&02&0&1&5&0#results>.

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As seen below, given the causal relationship between lung cancer and smoking, it is not surprising that the smoking rates tend to be higher in upstate New York than downstate.

NEW YORK COUNTIES' ADULT SMOKING RATES⁸



Unfortunately, the governor's executive budget does nothing new to combat the leading cause of cancer deaths in women and men.⁹ The executive budget adds no new revenues to the state's program designed to combat tobacco use. Indeed, the state's tobacco control program now has less than 50 percent of the funding it received a few years ago, and less than 20 percent of the amount recommended by the CDC.¹⁰ New York State has slashed its investment in the best way to reduce lung cancer incidence and mortality. *New York State, once ranked 5th in the nation in funding its anti-smoking efforts, has slipped to 22nd.*¹¹

⁸ Source: County Health Rankings, see:

<http://www.countyhealthrankings.org/app/new-york/2017/measure/factors/9/map>.

⁹ U.S. Centers for Disease Control and Prevention, for women see:

<https://www.cdc.gov/cancer/dcpc/data/women.htm>; for men, see: <https://www.cdc.gov/cancer/dcpc/data/men.htm>.

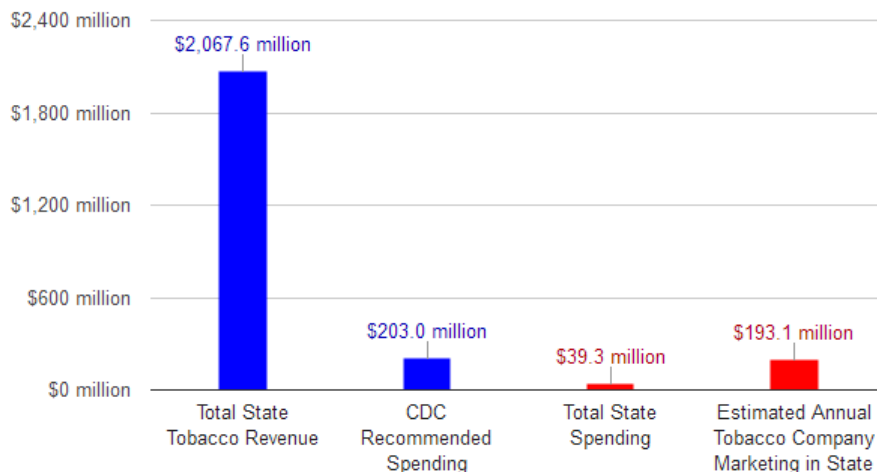
¹⁰ U.S. Centers for Disease Control and Prevention, "Best Practices for Tobacco Control Programs, 2014," see: https://www.cdc.gov/tobacco/stateandcommunity/best_practices/pdfs/2014/comprehensive.pdf, p. 110.

¹¹ Report issued jointly by the American Cancer Society, American Heart Association, American Lung Association and the Campaign for Tobacco Free Kids, et al, "Broken Promises to Our Children: A State-by-State Look at the 1998 State Tobacco Settlement Agreement, 19 Years Later," 2017, see: <https://www.tobaccofreekids.org/what-we-do/us/statereport/new-york>.

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As seen below, New York State's tobacco spending pales in comparison to the recommendations of CDC's experts and the estimated marketing expenditures of the tobacco industry.

NEW YORK'S TOBACCO REVENUE, CDC RECOMMENDED SPENDING, STATE SPENDING AND TOBACCO INDUSTRY MARKETING¹²



Not only has the state reduced its investment in the best way to reduce lung cancer incidence and mortality, relative to the other states, New York is still ranked in the middle.

It is simply indefensible that the state's response to the leading cause of cancer deaths among men and women has suffered drastic cuts. These funding reductions are even more inexcusable when examining the amount of money that tobacco use generates for the state's coffers.

The money is available. In addition to the estimated \$1.2 billion raised in tobacco taxes, the state is now expecting new revenues from the state's master settlement agreement (MSA). The MSA is an agreement to settle litigation between the nation's largest cigarette companies and 46 states. The MSA requires those cigarette companies to, among other things, annually pay billions of dollars to the states as compensation for the health costs to their Medicaid programs resulting from tobacco use. Bonds issued in 2003 that were secured by annual payments under the MSA with tobacco manufacturers will be fully retired. Last year, the executive stated that it expected that MSA payments of approximately \$400 million annually would be available for State purposes.¹³ In addition, the governor's proposed changes in taxing of cigar products adds an estimated \$23 million starting next fiscal year.¹⁴ These revenues can be used to enhance tobacco control as well.

NYPIRG urges you to use that money to fully fund tobacco control and other cancer-prevention programs. The MSA revenues were promised to help curtail the carnage caused by tobacco use. Sadly, too little has been done. This budget provides you an opportunity to reverse New York's years of neglect.

¹² Ibid.

¹³ New York State Division of the Budget, FY2018 Executive Briefing Book, p. 8.

¹⁴ New York State Division of the Budget, FY2019 Executive Briefing Book, p.22.

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After the MSA was signed in November 1998, many governors, state attorneys general, and other high-ranking state officials expressed strong support for investing substantial portions of the tobacco settlement payments in new efforts to prevent and reduce tobacco use in their states.

For example, Governor Thomas Carper, Chairman of the National Governors Association and Utah Governor Michael Leavitt, Vice Chair, wrote in a letter to U.S. Senate Minority Leader Daschle, March 5, 1998:

“The nation’s Governors are committed to spending a significant portion of the tobacco settlement funds on smoking cessation programs, health care, education, and programs benefiting children.”

Announcing the settlement, then-New York Attorney General Dennis Vacco released a statement on November 16, 1998, which stated:

“As a result, millions of children who are not yet smokers will be spared horrific diseases and suffering, *and millions of current smokers will get a real chance to quit and reclaim their good health.*” [Emphasis added]¹⁵

However, it was not just promises made by high-ranking public officials in press releases. The pledge to use the MSA revenues to curb tobacco use is found in the agreement itself. Most notably, the MSA begins with a series of “Whereas” clauses, including the following:

WHEREAS, the Settling States that have commenced litigation have sought to obtain equitable relief and damages under state laws, including consumer protection and/or antitrust laws, in order to further the Settling States’ policies regarding public health, including policies adopted to achieve a significant reduction in smoking by Youth . . .

WHEREAS, the Settling States and the Participating Manufacturers are committed to reducing underage tobacco use by discouraging such use and by preventing Youth access to Tobacco Products;

WHEREAS, the undersigned Settling State officials believe that entry into this Agreement and uniform consent decrees with the tobacco industry is necessary in order to further the Settling States’ policies designed to reduce Youth smoking, to promote the public health and to secure monetary payments to the Settling States; and

WHEREAS, the Settling States and the Participating Manufacturers . . . have agreed to settle their respective lawsuits and potential claims pursuant to terms which will achieve for the Settling States and their citizens significant funding for the advancement of public health, the implementation of important tobacco-related public health measures, including the enforcement of the mandates and restrictions related to such measures, as well as funding for a national foundation dedicated to significantly reducing the use of Tobacco Products by Youth.¹⁶

¹⁵ New York State Office of the Attorney General, News Release, “Vacco: \$200 Billion Tobacco Plan to Protect Health of Kids,” November 16, 1998.

¹⁶ *Master Settlement Agreement*, November 23, 1998, see: <http://www.naag.org/assets/redesign/files/msa-tobacco/MSA.pdf>.

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These excerpts clearly indicate that the states are obliged to use their MSA payments to advance public health and support tobacco-prevention efforts. Indeed, the last clause explicitly says just that, and also very clearly declares that the states are expected to use their MSA funding for tobacco-prevention and other public health efforts.

The money is now amply available; it is the commitment that is missing.

2. In addition to the erosion in state support for combating tobacco use, New York State has undermined support for other cancer services programs. *New York State offers a Cancer Services Program (CSP), which provides breast, cervical and colorectal cancer screenings and diagnostic services at no cost to women and men, typically those that lack health insurance. If the screening test finds something abnormal, diagnostic (testing) services are available for eligible women and men at no cost. The CSP will also provide a case manager who will guide someone with cancer through their follow-up diagnostic appointments.*

If breast, cervical or colorectal cancer is found, eligible women and men may be able to enroll in the special cancer treatment program to receive full Medicaid health insurance coverage for the entire time they are being treated for cancer.

But that program has never been adequately funded, with experts stating that it only historically offered help to 15 percent of the eligible population.¹⁷ Even with the expansion of health insurance under the Affordable Care Act, the CSP is still not adequately funded to meet the needs of the uninsured.

The governor's budget ignores that best scientific evidence behind cancer screening and instead has consistently tried to cut spending for this important program. Last year, CSP took a 20 percent reduction in funding. We urge that the program's spending be increased to meet the state's needs.

Ironically, cancer prevention experts will state that colon cancer screening is a much more scientifically useful cancer-fighting tool than other cancer screenings. The national experts at the federal government's U.S. Preventive Services Task Force regularly issue guidelines documenting the best available science to direct medical practice.

In the case of cancer screenings, they rank the efficacy of the effort with a letter grade, an "A" being the service that provides the most benefits with the smallest risks. According to the USPSTF, colon cancer screening ranks an "A," breast cancer screening is graded with a "B" and prostate cancer screening a "D."¹⁸ That does not mean that breast cancer screenings are untrustworthy; it means that the expert assessment is that there is less benefit and greater risks with that type of screening compared to colon cancer screenings.

Yet, unless the governor and Legislature agree, there will be no additional resources for colon cancer screenings. And, unless there is an agreement, there will be no additional funding for anti-smoking programs, which are the best ways to combat the biggest cancer killer. *There can be no doubt that the executive budget as drafted fails to support the best scientific evidence and as a result advances plans that leave more New Yorkers at risk of cancer.*

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¹⁷ New York State Department of Health, "RFA # 0707301113 Questions and Answers," see: https://www.health.ny.gov/funding/rfa/inactive/0707301113/questions_and_answers.pdf, p. 5. This is from FY 2007-08; we have not seen updated information.

¹⁸ For more information on the USPSTF and its rankings, see: <https://www.uspreventiveservicestaskforce.org/Page/Name/recommendations>.

3. Support Funding for the New York State Health Exchange. As you know, the numbers of New Yorkers who lack health insurance is considerable. According to the US Census Bureau, in 2016 roughly 1.2 million New York residents were uninsured (6.1 percent of the population). This represents both the lowest percentage and number of New Yorkers who lack health insurance since 1999.¹⁹

What has happened to drive down the number of uninsured? Nationally, until last year's efforts to destabilized the Affordable Care Act, the percentage of Americans without health insurance was at the lowest since 2009,²⁰ but given the fact that many states have been slow to embrace reforms, the national impact is hard to assess. However, the drop in the percentage of the uninsured has followed the timeline of the implementation of the federal health care law. Starting in the Fall of 2010, coverage under the law started to kick in. Thus, it seems reasonable to conclude that the changes brought about by the Affordable Care Act (ACA) contributed to New York's decline.

The United States spends 17.9 percent of the Gross National Product on health care²¹ yet ranks 27th of the 38 member Organisation for Economic Co-operation and Development (OECD member nations in life expectancy.²² It is clear that American health care is expensive and yet doesn't deliver on its most basic mission, providing coverage to all those who need it. Public policy must ensure coverage for all residents.

Despite the demonstrable successes of the Affordable Care Act, many in need are left without health insurance. As mentioned earlier, 6.1 percent of New Yorkers still lack health insurance. And while this represents both the lowest percentage and number of New Yorkers who lacked health insurance since 1999, more must be done.

For those without health insurance, serious illnesses can be deadly. For example, cancer. Research suggests that nearly four percent of cancer patients are uninsured at the time of diagnosis.²³ Equally troubling, about one-third of cancer survivors report a loss of health insurance at some point in time since their diagnosis.²⁴

For these individuals and their families, the cost of fighting cancer may mean choices that could lead to huge debts under the best of circumstances. The first concern of someone diagnosed with cancer is what are the chances of a recovery? For many, the cost of treatment will also become a top priority in surviving. According to the federal government, cancer is one of the five most costly medical conditions in the United States, forcing many patients to make decisions about their health based on their personal finances.²⁵

¹⁹ United State Census Bureau, "Health Coverage In The United States, 2016," <https://www.census.gov/library/publications/2017/demo/p60-260.html>, see: Table A-5, "Number of People Without Health Insurance Coverage by State: 2013 to 2016" and Table 6, "Percentage of People Without Health Insurance Coverage by State: 2013 to 2016."

²⁰ Ibid.

²¹ U.S. Center for Medicare and Medicaid Services, <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html>.

²² Organisation of Economic Co-operation and Development, <http://www.oecdbetterlifeindex.org/topics/health/>.

²³ Thorpe KE, Howard D. "Health Insurance and Spending Among Cancer Patients" *Health Affairs* 2003. W3; 189-198.

²⁴ Indiana University, "Number of newly diagnosed cancer patients without insurance drops in first year of ACA," October 19, 2017, <https://news.iu.edu/stories/2017/10/iub/releases/19-cancer-affordable-care-act.html>.

²⁵ U.S. Agency for Healthcare Research and Quality, "Statistical Brief #471: Top Five Most Costly Conditions among Adults Age 18 and Older, 2012: Estimates for the U.S. Civilian Noninstitutionalized Population," https://meps.ahrq.gov/data_files/publications/st471/stat471.shtml.

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While some individuals diagnosed with cancer have meaningful and adequate health insurance to cover most of the cost of treatment, the uninsured and an increasing number of privately insured individuals face the prospect of crippling out-of-pocket costs. Financial barriers that delay treatment for cancer can mean the difference between life and death.

Cancer patients face deductibles, copayments, and other cost-sharing requirements, often compelling them to make difficult decisions in order to make ends meet. The burden is greater for cancer patients, who pay more out of pocket for care than those with other chronic illnesses. For example, 13 percent of nonelderly cancer patients spend at least 20 percent of their income on out-of-pocket expenses. Fifty percent of Medicare beneficiaries with cancer pay at least 10 percent of their income towards cancer treatment-related out-of-pocket costs.²⁶

Even with the expansion of coverage under the Affordable Care Act, many Americans still faced financial strains from medical costs. Even those with coverage face uncertainties, “roughly 20 percent of people under age 65 with health insurance nonetheless reported having problems paying their medical bills over the last year. By comparison, 53 percent of people without insurance said the same.”²⁷

NYPIRG urges that you continue to support implementation of the ACA. However, as Washington considers changes to the ACA, it is more important than ever that the state explore its own options. Health insurance coverage is critical to the health and well-being of all New Yorkers.

In addition, as mentioned earlier, when it comes to important health programs for the uninsured, such as the Cancer Services Program, funding must be enhanced in order to provide services to those in need.

4. New York’s Heightened Lead Poisoning Problem. Lead poisoning is a national problem with long-term health effects, including developmental delays, brain damage and cardiovascular issues.

New York has the both the greatest number (3.3 million) and the highest percentage (43.1percent) of its housing stock built before 1950, the houses most likely to contain lead paint, the greatest source of childhood lead poisoning.²⁸ Thus, New York’s children are at heightened risk for being exposed to lead in their homes.

Children are the most vulnerable to the effects of lead contamination in their environment. Even seemingly incremental increases in the concentration of lead in a child’s blood level can have significant cognitive impacts. Research has shown that the greatest impact on IQ occurs at concentrations lower than 10 µg/dL for children. Studies have found that “children’s intellectual functioning at three and five years of age is inversely associated with blood lead concentrations, even when their peak concentrations remain below the CDC and WHO level of concern.”²⁹ Additional studies have used population statistics and public safety data to note the correlation between early childhood lead exposure and rates of criminal

²⁶ Zafar, S.Y., “Financial Toxicity of Cancer Care: It’s Time to Intervene,” The Journal of the National Cancer Institute, December 11, 2015, <https://academic.oup.com/jnci/article/108/5/djv370/2412415>.

²⁷ Sanger-Katz, M., “Even Insured Can Face Crushing Medical Debt, Study Finds,” The New York Times, January 5, 2016, <https://www.nytimes.com/2016/01/06/upshot/lost-jobs-houses-savings-even-insured-often-face-crushing-medical-debt.html>.

²⁸ *Eliminating Childhood Lead Poisoning in New York State by 2010*, New York State Department of Health (2004), Table 3. <https://www.health.ny.gov/environmental/lead/exposure/childhood/finalplanscan.htm>.

²⁹ *Intellectual Impairment in Children with Blood Lead Concentrations below 10 mcg per Deciliter*, N Engl J Med 2003; 348: 1517-1526, April 17, 2003.

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activity.³⁰ An article reviewing these studies found positive correlations between lead exposure and criminal activity in local, state and national surveys.³¹

In the past, New York State was at the vanguard of environmental protection, particularly in matters involving children's health. However, it continues to use an outdated standard. This is placing us behind national public health standards.³² New York must immediately revise its regulations to—at a minimum—match the CDC guideline of 5 µg/dL set in 2012. Some researchers report that even a blood lead level of 2 µg/dL can prove harmful to a child's health.³³

A study, “Blood Lead Levels in Young Children: US, 2009-2015,”³⁴ took a retrospective look at testing results across the country. The study looked at a sample of data from zip codes and regions and found that six regions had the highest percentages of children testing for very high levels of lead in their blood. Various cities in New York State are deeply affected by lead poisoning cases. **Three cities in New York made the list for notably high levels in their sampling: Syracuse at 40.1 percent, Buffalo at 18.8 percent and Poughkeepsie at 14.9 percent.**³⁵ These findings were correlated with lower income levels and environmental factors such as residing in housing that contains lead contaminated dust.³⁶

The Case for Early Intervention is Clear. Currently, New York's Public Health Law requires mandatory lead testing for all children, with testing required twice by age three. As you know, this is time window represents both a critical neural development window for children and the time that they are exploring their world at ground level and engaging in hand-to-mouth activities. The Department of Health has an action plan in place for health care providers and families depending on the levels of lead found in a child's blood. These include scheduling follow-up appointments, regular monitoring and investigations into the sources or areas where lead may be present in the child's environment. The goal is to identify and mitigate these sources as soon as possible. Currently, state law requires the child's care provider to begin providing risk reduction counseling if a child's blood lead level is 10 µg/dL or higher. National guidelines state that risk reduction counseling is much more effective if started when lower levels of lead are detected in the blood due to the harm that even smaller amounts of lead may have on a child's development. Earlier intervention would help eliminate a child's ongoing exposure to lead before the most serious damage is already done. Experts have confirmed the benefits of early intervention and primary prevention for lead poisoning cases.

Lower The Children's Blood Lead Threshold Action Level. The Department of Health should use existing authority to lower the blood lead “level of concern” for children—set more than 25 years ago—to trigger an investigation from the current standard of 10 ug/dL to 5 ug/dL, as was done by the U.S. Centers for Disease Control and Prevention (“CDC”) in 2012 and has been done in several jurisdictions. In

³⁰ Mielke, Howard W., and Zahran, Sammy, *The urban rise and fall of air lead (Pb) and the latent surge and retreat of societal violence*, Environmental International, 43 (2012) 48-55.

³¹ Drum, Kevin, <http://www.motherjones.com/environment/2016/02/lead-exposure-gasoline-crime-increase-children-health/>, Feb. 11, 2016, last accessed, Aug. 7, 2017.

³² The Department of Health's lead poisoning prevention action plan noted the steady march towards lower action levels, including the consideration of moving to the 5 ug/dL level in 2004—13 years ago. *Eliminating Childhood Lead Poisoning in New York State by 2010*, New York State Department of Health (2004), <https://www.health.ny.gov/environmental/lead/exposure/childhood/finalplanscan.htm>.

³³ Steven G. Gilbert, Bernard Weiss, *A rationale for lowering the blood lead action level from 10 to 2µg/dL*, *NeuroToxicology*, Volume 27, Issue 5, Pages 693-701, September 2006.

³⁴ McClure, Leland, F., Niles, Justin K., Kaufman, Harvey W., *Blood Lead Levels in Young Children: US, 2009-2015*, *The Journal of Pediatrics*, at 3.

³⁵ Ibid.

³⁶ Lanphear, Bruce P. et.al, *The Contribution of Lead-Contaminated House Dust and Residential Soil to Children's Blood Levels: A Pooled Analysis of 12 Epidemiologic Studies*, *Environmental Research*, Section, A 79. 51-68, 1998

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addition to the CDC, several states have taken the lead towards lowering the level of concern to 5 µg/dL, namely Connecticut³⁷, Idaho³⁸, Maine³⁹, Maryland⁴⁰, Minnesota⁴¹, New Jersey⁴² and Vermont.⁴³ All states cite their decision to move towards the lower CDC guidelines was based on the presence of evidence that supports early intervention as the primary way to prevent the serious health effects suffered by victims of lead poisoning.

Article 13 of the Public Health Law requires that the Department of Health establish a childhood lead poisoning prevention program and “exercise any and all authority which may be deemed necessary and appropriate” to effectuate the state’s policy of reducing lead poisoning. Public Health Law section 1370-a(1). Thus, the Department of Health is obliged by law to revise the policies and standards to implement the law by staying current with the latest medical science and lead poisoning prevention strategies. However, in 2018 the Department of Health is using an outdated standard of 10 µg/dL—last revised in 1992—which can still lead to significant health impairments and fails to capture the full extent of the lead poisoning epidemic in the state.⁴⁴

The current level was set 25 years ago and was based mainly on the effects of prenatal lead exposure.⁴⁵ The CDC revised its standard five years ago in light of evidence that early intervention mitigates the harmful effects of lead poisoning.⁴⁶ Changing the action level is an easily achievable task that would yield life-long benefits to millions of children across New York State.

Local governments have also adopted the CDC guidelines for their residents even though their states may still adhere to higher levels of concern. In New York, the City of Buffalo has codified the CDC’s current guidelines, stating that “[e]xcessive absorption of lead in the blood in concentrations defined as an “elevated blood lead level” in children by the Center of Disease Control (CDC) of the United States Department of Health and Human Services, as that definition may be revised in the future by the CDC.”⁴⁷

If the City of Buffalo has already made strides towards protecting its residents, the state must now take the opportunity to make this the universal standard for all New Yorkers.

While we note recent New York legislative activity in this area, we resolutely believe that state law and policy is clear that the Department of Health has the authority, history and obligation to act by regulating the action level through agency action.

³⁷ Conn Gen Stat Ann § 19a-110 [d]

³⁸ Idaho Admin Code 16.02.10.380 [01] [b]

³⁹ 10-144 Code of Me Rules Ch. 292, § 3 [Y]

⁴⁰ Code of Md Regulations § 10.11.04.02 [B] [8] [b]

⁴¹ Minn Stat Ann § 144.9504 Subd. 12

⁴² NJ Stat Ann 26:2-137.3

⁴³ Vt Stat Ann § 1751 [b] [7]

⁴⁴ Cognitive Deficits Associated with Blood Lead Concentrations < 10 µg/dL in US Children and Adolescents, Public Health Reports, Volume 115, 521-529, November/December 2000.

⁴⁵ Ibid at 522.

⁴⁶ Bellinger, David C., Chen, Aimin, Lanphear, Bruce, Establishing and Achieving National Goals for Preventing Lead Toxicity and Exposure in Children, JAMA Pediatrics, published online, May 15, 2017, explaining that “Children with a blood lead concentration of 5 µg/dL or greater will experience an average IQ score deficit of approximately 6 points. In 2012, the US National Toxicology Program

⁴⁷ Buffalo Code of Ordinances § 261-1

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Reduce the Lead Dust Clearance Level for Lead Clean Ups. In 1992, Congress directed the U.S. Environmental Protection Agency to reduce dust-lead hazards in residential housing.⁴⁸ EPA issued rules years behind the Congressionally-mandated schedule in 2001. The regulations were established in micrograms (a millionth of a gram) of lead per square foot or ug/ft²: 40 ug/ft² for floors and 250 ug/sf² for interior windowsills.⁴⁹ Presence of lead paint dust above these levels demonstrates the presence of a lead hazard or that a remediation effort has failed to achieve the minimum clean-up standard. The lead-dust standards were developed at the time when a child's blood lead level of 10 ug/dL was considered safe.⁵⁰

As stated earlier, the science is clearer now and it is universally the position of the U.S. regulators, toxicologists and pediatric health experts that there is no safe level of exposure to lead. Accordingly, to keep pace with the evidence-based understanding of the hazards posed by lead to children, the levels of lead dust on floors and window sills in residential settings should be lowered. EPA spent years developing a lower standard based on CDC's position, but it has dragged its feet on promulgating and implementing the lower standards.

While the United States Court of Appeals for the Ninth Circuit recently ordered EPA to put in place within a year the final rule unless EPA could show a modification was justified, New York should not wait. New York should adopt the stronger standard of 10 ug/ft² for floors and 100 ug/sf² for windowsills—levels that EPA explicitly found are technically and practically feasible.

Enact a Twenty-Five Cent Per Gallon of Paint Fee to Fund Lead Programs. New York should adopt a proposal advanced by then-governor Mario Cuomo in 1992 and subsequently enacted by the state of Maine to add a \$.25 per gallon surcharge at the corporate level for all paint sales in New York. Based on the success of Maine's program, New York would generate more than \$10 million each year for lead poisoning prevention and remediation programs.

As of July 1, 2006, the state of Maine began collecting a fee from paint manufacturers and wholesalers equal to \$.25/gallon of residential and commercial paint and coatings sold in the state.⁵¹ *These fees are not collected as a sales tax at the retail level.* Under Maine's law manufacturers and wholesalers are the only parties responsible for administering and paying the fees.

It is appropriate that the paint industry bear a small fraction of the costs for the toxic legacy of lead paint that plagues New York. Moreover, paint manufacturers will benefit from additional paint sales as lead paint hazards are remediated and older homes are properly maintained through more frequent painting.

⁴⁸ Residential Lead-Based Paint Hazard Reduction Act of 1992, Pub L. 102-550, 106 Stat. 3672.

⁴⁹ 40 C.F.R. section 745.65(b), <https://www.law.cornell.edu/cfr/text/40/745.65>.

⁵⁰ This was based on the science at that time, using a 1-5% probability of a child's developing a blood lead level of 10 ug/dL. See Identification of Dangerous Levels of Lead, 66 Fed. Reg. 1206, 1215 (Jan. 5, 2001). As noted above, the U.S. CDC now uses 5 ug/dL as the level of concern—50% lower than the level used to determine the 2001 floor and window sill lead-dust levels.

⁵¹ Chapter 403 of the Maine Statutes, http://www.maine.gov/dhhs/eohp/lead/documents/PL2005_C403.pdf.

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Administer the Lead Hazard Contractor Certification Program. New York should take over administration of the federal Renovation, Repair and Painting Program (“RRP”) worker training and certification program to ensure quality oversight of lead paint hazard remediation contractors in New York State. The RRP, currently run by USEPA, oversees the federal program designed to assure that firms disturbing lead-based paint in homes built before 1978 are trained, qualified and certified to perform the work in a way that protects public health and worker safety.⁵²

The program came in for significant criticism, including for a provision that required a dust wipe of surfaces and comparison of the wipe cloth to a color chart—instead of laboratory testing of dust samples—to demonstrate that lead hazards have been properly remediated. New York should take over this program, strengthen its requirements and set fees so that the program is revenue neutral.

Strengthen the State’s Childhood Lead Poisoning Prevention Advisory Council. The statutorily created New York State Advisory Council on Lead Poisoning Prevention (Public Health Law section 1370-b) should be strengthened to ensure that it plays a stronger role in the formulation of state childhood lead poisoning prevention policy, including the state budget, action levels, primary prevention efforts and public education. The Advisory Council’s involvement is often an afterthought or footnote, with no meaningful input into the state lead poisoning program budget or policy. For example, the Advisory Council has had no input into the budget and has not to date been briefed on the FY2019 budget in the area it is obliged to advise upon.

Require Residential Property Insurance Policies to Cover Lead Poisoning Insurance. In 1992, the State Insurance Department, forerunner to the Department of Financial Services (“DFS”), acting administratively began providing a waiver for lead poisoning liability coverage in property and casualty policies approved by the department for residential rental housing.⁵³ The state should eliminate the waiver for this coverage. The absence of liability coverage eliminates the positive role insurers can have in underwriting landlords who take lead hazards seriously; in pricing policies based on the risk of lead poisonings; and in ensuring that resources are available in the event a child is lead poisoned while residing in a rental property. Moreover, as a practical matter it means that poor families will have no recourse to the civil justice system if their children are harmed because there may be no resources to pursue as compensation. New York should remedy this situation and require lead poisoning prevention coverage for rental housing properties constructed prior to 1978.

Enact and Fully Fund the Governor’s Proposal for Local Code Enforcement. In the Article VII proposal,⁵⁴ the governor proposed that local code enforcement agencies inspect properties and enforce code violations related to lead paint hazards. The proposal would require municipalities that administer the New York State Uniform Fire Prevention and Building Code and have a lead poisoning designated high risk area to submit aggregate reports to DOH on outcomes of inspection and remediation.

In addition, the proposed legislation includes a presumption that all paint on any residential building constructed prior to 1978 is lead-based and an obligation that these older buildings be maintained in a condition such that the paint thereon does not become deteriorated paint, unless the deteriorated paint surfaces comprise a minimal surface area.

⁵² U.S. Environmental Protection Agency, “Renovation, Repair and Painting Program,” <https://www.epa.gov/lead/renovation-repair-and-painting-program>.

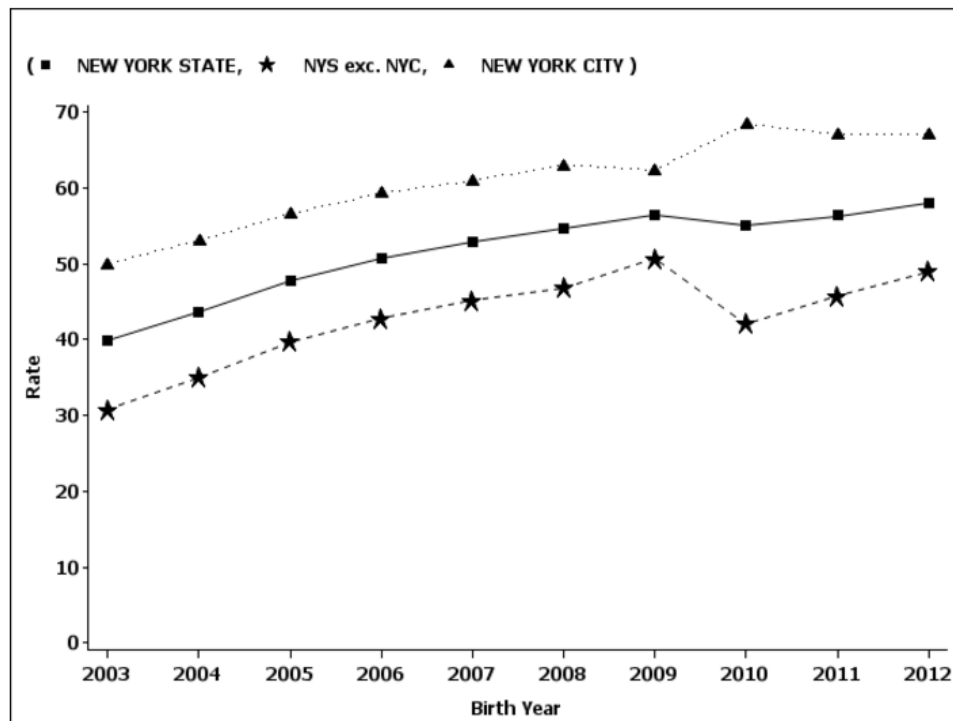
⁵³ *Insurers Avoid Lead Coverage*, Janet Aschkenasy, *Journal of Commerce*, October 24, 1993, https://www.joc.com/insurers-avoid-lead-coverage_19931024.html.

⁵⁴ Article VII, Health and Mental Hygiene, Section R.

These proposals deserve your enthusiastic support. However, they must come with a long-range commitment by the state to pay for these programs.

The Department of Health should update and upgrade the lead poisoning prevention information on its website. As seen below, the state’s public reporting (available on its website) is significantly out-of-date. It appears that the state is still not achieving the goal of universal lead screening for infants and young children, particularly outside of the city of New York.

NEW YORK STATE PERCENTAGE OF CHILDREN BORN IN 2003-2012 WITH AT LEAST TWO LEAD SCREENINGS BY 36 MONTHS⁵⁵



We urge that the Legislature hold hearings specifically on the state’s efforts to curb lead poisoning of children.

5. New York has more doctors than ever before and that the rate of increase exceeds the growth in the state’s population. Despite some recent comments that New York’s supply of doctors is shrinking, new national data show that the state continues to be one rich in its physician supply. As seen below, New York ranks among the top states in physician supply:

⁵⁵ New York State Department of Health, https://www.health.ny.gov/statistics/chac/general/g27_999.htm.

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Category	Physicians Per 100,000, 2016⁵⁶	National Rank, 2016	National Average, 2016
Total physicians per 100,000 people	365.1	3	271.6
Active patient care physicians per 100,000	299.8	4	236.8
Active primary care physicians per 100,000	111.2	7	91.7
Active patient care primary physicians per 100,000	94.3	11	82.5
Active general surgeons per 100,000	10.2	7	7.8
Active patient care general surgeons per 100,000	7.6	15	6.7
Active physicians by age, under 40	17.8%		17%
Active physicians by age, over 60	33.4%		30.9%

As seen above, New York is ranked *third* in the total overall number of physicians per capita practicing in the state. Where major categories of specialty physicians are concerned, the state ranks well above the national averages. The data also suggests that New York remains an attractive place for younger physicians under 40 to practice, ranking above the national average. Moreover, the growth in the total number of physicians practicing in the state is expanding at a rate more than *four* times as great as is New York’s general population, roughly twice the difference nationally:

	Total physician population⁵⁷	Total general population⁵⁸
New York, 2016	72,095	19.8 million
New York, 2008	67,545	19.5 million ⁵⁹
New York growth 2008-16	~6.7%	~1.8%
U.S., 2016	877,616	323 million
U.S., 2008	773,809	301 million ⁶⁰
U.S. growth 2008-16 ⁶¹	~13.4%	~7.4%

As seen above, rate of the growth in the number of physicians practicing in the state exceeds rate of the growth in New York’s population. New York State has more physicians practicing now than at any other time.

⁵⁶Data from AAMC “2017 State Physician Workforce Data Book,” see: <https://www.aamc.org/data/workforce/reports/484392/2017-state-physician-workforce-data-report.html>. Released November, 2017.

⁵⁷Data from AAMC “2017 State Physician Workforce Data Book,” see: <https://www.aamc.org/data/workforce/reports/484392/2017-state-physician-workforce-data-report.html>. Released November, 2017.

⁵⁸ U.S. Census, 2016 estimates, see: <https://www.census.gov/programs-surveys/popest/data/data-sets.html>.

⁵⁹ New York State population, New York State Department of Health, “Table 2: Population, Land Area, and Population Density by County, New York State – 2008 see: https://www.health.ny.gov/statistics/vital_statistics/2008/table02.htm. According to the Health Department, the 2008 New York State population was 19,490,297.

⁶⁰ U.S. Census, “American Fact Finder, Total Population Universe: Total population, 2006-2008 American Community Survey 3-Year Estimates,” https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_08_3YR_B01003&prodType=table. Total U.S. population was 301,237,703.

⁶¹ Calculation, NYPIRG

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Moreover, according to New York licensing data the state continues to add to its number of practicing physicians.

Licenses Issued, Past Six Calendar Years⁶²

	2012	2013	2014	2015	2016	2017
Number of physicians	4,272	5,223	4,644	4,575	4,589	4,776

There is no doubt, however, that certain communities within the state have more difficult access to physician care than others.⁶³ Yet, in the aggregate, New York's physician supply continues to grow at a rate that far exceeds the growth of the state's population.

In terms of statewide numbers, no shortage of physicians exists in New York.

Thank you.

⁶² New York State Education Department, see: <http://www.op.nysed.gov/prof/med/medcounts.htm>.

⁶³ New York State Department of Education, "Regents: Designated Physician Shortage Areas in New York State," see: <http://www.highered.nysed.gov/kiap/scholarships/documents/2015PLFShortageBulletin.pdf>.