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TESTIMONY
OF THE
AMERICAN CANCER SOCIETY
CANCER ACTION NETWORK
BEFORE THE
JOINT HEARING OF THE SENATE FINANCE AND
ASSEMBLY WAYS & MEANS COMMITTEES
REGARDING THE
2013-14 EXECUTIVE BUDGET
January 30, 2013
Albany, N.Y.

Good afternoon. My name is Blair Horner and I am the Vice President for Advocacy in NY & NJ for the American Cancer Society Cancer Action Network. With me today is Michael Burgess, our New York State Advocacy Director. We welcome the opportunity to comment on the governor's proposed health budget. We look forward to working with you to fashion a health budget that reduces in New York's cancer rate, helps identify cancers at the earliest – and often most treatable – phase, and ensures that cancer patients are adequately supported, both financially and physically, as they battle this terrible disease.

Our testimony is organized around those themes and we will comment on topics that cover each part.

Cancer is the name for many terrible diseases that have a profound impact on the lives of New Yorkers. As you will see, the number of cancer diagnoses and deaths is staggering. Some of these cancers lend themselves to policy interventions and others do not. However, what is clear is that policymaking should strive to achieve three goals:

1. Keep people from getting cancer. While that goal may be impossible for all cancers, policies can be put in place that in some cases protect people from cancer.
2. Help people to identify cancer in its earlier – and often most treatable – stage. There are some cancers in which early detection can make the difference between treatable and life-threatening patients' experiences.
3. Help patients to deal with the impact of cancer on their lives. Getting a cancer diagnosis is bad enough, but patients should not have to worry about the financial ramifications of their treatment, and their treatment should be as pain-free and comprehensive as possible.

The Impact of Cancer on New York

We will examine the budget proposal through the three goals mentioned above, but first a quick review of cancer in New York. Below is a listing of the most prevalent cancers and their impacts.

Estimated Number of Cancer Cases and Cancer Deaths in New York State, 2012

Type of Cancer	Estimated New Cases	Estimated Deaths
Total, all sites	**109,440**	**34,140**
Prostate	17,090	1,610
Female Breast	14,730	2,420
Lung & Bronchus	13,620	8,880
Colon & Rectum	9,390	3,090
Urinary Bladder	5,460	940
Melanoma	4,700	470
Non-Hodgkin Lymphoma	4,680	1,080
Kidney	3,830	710
Uterine Corpus	3,730	660
Pancreas	3,010	2,420
Leukemia	2,970	1,430
Oral Cavity	2,300	410
Liver	2,050	1,350
Stomach	1,840	790
Ovary	1,520	1,010
Brain and ONS	1,470	740
Myeloma	1,410	610
Esophagus	1,110	930
Uterine Cervix	850	290
Larynx	760	220

Keeping New Yorkers from Getting Cancer: Bolster the state's tobacco control program. Reject the governor's apparent cut.

As seen above, the number one cancer killer is lung cancer. Tobacco causes the overwhelming majority of lung cancers and one in four deaths from cancer. In order to significantly reduce overall cancer deaths, and from lung cancer in particular, New York must have a robust effort to reduce tobacco use.

In many ways, New York has been a leader in tackling the tobacco menace. New York has the highest cigarette excise tax in the nation (and the governor's loophole-closing will help further enhance the public health benefits of higher tax rates), and New York has one of the most expansive indoor smoking restriction policies in the nation. As a result, New York has seen a dramatic reduction in smoking and is among the national leaders in cutting the prevalence of tobacco use.

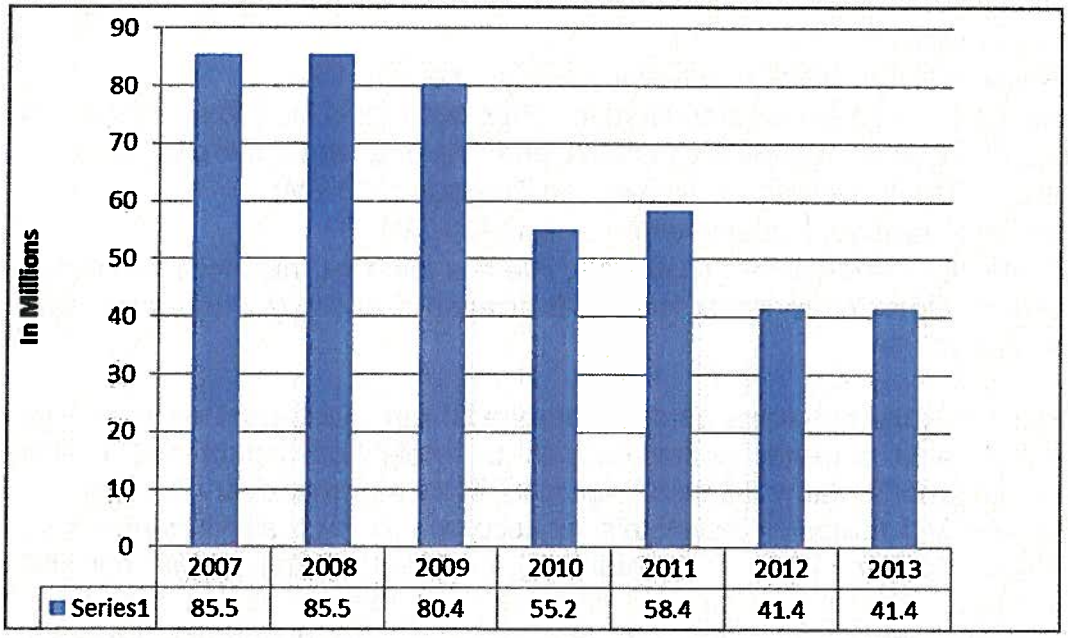
New York policymakers in general – and you in particular – deserve tremendous credit for these achievements. I believe that history will one day recognize these

accomplishments as one of the great public health efforts, on a par with occupational safety reforms following the Triangle Shirtwaist tragedy.

However, there is one glaring area in which New York, once a leader, has been slipping badly. That area is the funding of tobacco control programs that are designed to help smokers to quit and to keep kids from using tobacco.

Over the past four years, New York has slashed its tobacco control budget. The Center for Disease Control and Prevention recommends that New York spend $254 million annually.[1] Since 2007, state funding has been cut by more than half. During that time, New York has dropped from 5th to 21st among states' per capita spending on tobacco control.[2] This year we believe that the governor is proposing another cut. The state must reverse this decline. And the money is there. The state collects over $2 billion in tobacco revenues.[3]

New York State Spending on Tobacco Control 2007-2013



As seen above, there has been a dramatic 50 percent decline in state spending on tobacco control since Fiscal Year 2006-2007.

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[1] U.S. Centers for Disease Control and Prevention (CDC), "Best Practices for Comprehensive Tobacco Control Programs – 2007, October 2007, p. 90 (NY). See: http://www.cdc.gov/tobacco/stateandcommunity/best_practices/pdfs/2007/BestPractices_Complete.pdf.

[2] American Cancer Society Cancer Action Network, Campaign for Tobacco-Free Kids, American Heart Association, American Lung Association, Robert Wood Johnson Foundation and Americans for Nonsmokers' Rights, "A Broken Promise to Our Children: The 1998 State Tobacco Settlement, 14 Years Later," see: http://www.acscan.org/content/wp-content/uploads/2012/12/2012-State-Tobacco-Report.pdf.

[3] New York State Division of the Budget. New York State Enacted Budget Financial Plan for Fiscal Year 2012. April, 2012.

The governor's budget plan lacks specificity and most likely means another deep cut in the state's tobacco control efforts.
The reason that I can't give you a specific number on the magnitude of the governor's apparent cut is the result of the way that the executive's budget has been presented.

Instead of clearly disclosing his budget proposals in an item-by-item basis, the governor instead allocates those public health programs into six area and allows the Health Department to award grants from that pool on a competitive basis, based on the achievement of outcomes in six areas or "buckets" which used to comprise 89 programs at a total funding level of $395 million. The total funding allocation for the 89 programs for 2013-14 has been reduced by about 10% to $355.2 million.

The six areas are as follows with funding in the Aid to Localities budget:[4]

- Chronic Disease Prevention and Treatment ($63M): We are told that this includes anti-tobacco, cancer services and diabetes & obesity funding and other programs.
- Environmental Health and Infectious Disease ($19.8M)
- Maternal, Child Health and Nutrition Program ($114.8M): We are told that this includes School-Based Health Center funding and other programs.
- HIV, STD and Hepatitis C Prevention Program ($90.7M)
- Health Quality and Outcomes Program ($30.7M)
- Workforce Development ($36.2 M): We are told that this includes Doctors Across New York, Area Health Education Center (AHEC) and other programs.

We estimate that the programs contained in the Chronic Disease Prevention and Treatment area is currently somewhere in the neighborhood of $75 million. Thus, the governor's plan proposes huge cuts in those programs. Roughly $37 million[5] of the $41 million in the state's tobacco control program is contained in the Chronic Disease fund. In addition, another $27 million is currently appropriated for the state's Cancer Services Program (more on that later). Those two programs alone are the equivalent of the governor's proposed allocation.

Obviously, the governor's proposal contemplates cuts to these already woefully underfunded programs.

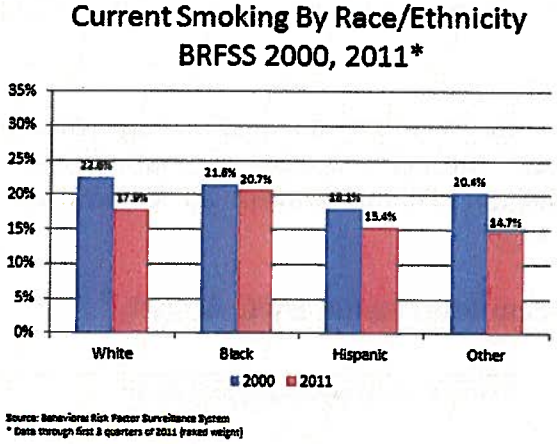
Limited funding prevents – and the governor's proposal will further exacerbate – the Tobacco Use Prevention and Control Program from reaching the most vulnerable populations with the highest rates of smoking – those with the lowest

[4] See Aid to Localities Budget Bill, page 392, starting on line 29 and Health and Mental Hygiene Article VII Legislation, section 42.
[5] The total amount currently appropriated for tobacco control is $41.4 million. In The governor's budget two lines in the State Operations Budget are maintained, those two lines total roughly $4 million.

incomes. As a result, the burden of tobacco taxes and tobacco-caused disease increasingly falls most heavily on those least able to pay.

New York's tobacco control program, combined with policy measures including a high tobacco excise tax and public smoking restrictions, has fostered a decline in the rate of tobacco use among both children and adults. Between 2000 and 2010, the prevalence of smoking among high school students fell steadily from 27.1 percent to 12.6 percent, a significantly faster rate than observed in the rest of the country.[6]

Similarly, the adult smoking rate in New York has also fallen faster than in the U.S. as a whole, dropping from 21.6% in 2000 to 17.7% in 2011.[7] The decline in smoking has occurred about equally across all ethnic groups. There is now little significant difference among New York's major racial/ethnic groups in the adult prevalence of smoking.

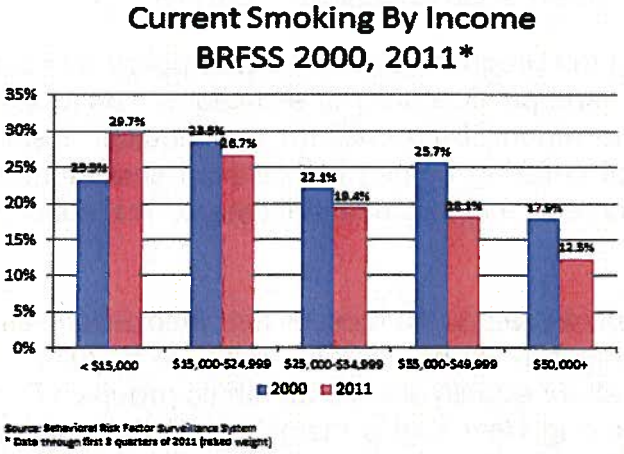


However, a closer look at the data identifies one disturbing trend: The decline in smoking has not occurred among the poor – those least able to afford the cost of cigarettes and the consequences of addiction.

Since 2000, smoking cessation rates have been greater, and smoking prevalence is now lowest, among New Yorkers with household incomes over $50,000 a year. Among this group, which constitutes a bit over 50 percent of the population, the prevalence of adult smoking is 12 percent. But among the less affluent half, the smoking rate is 20 percent, and increases as you go down the income ladder. Those with incomes below $25,000 have the highest smoking rates, and smoking prevalence among the very poorest one-sixth of our state's people (those with income under $15,000 a year) has increased in ten years.

[6] Information from New York State Department of Health, Tobacco Use Prevention and Control Program.
[7] Behavioral Risk Factor Surveillance System.

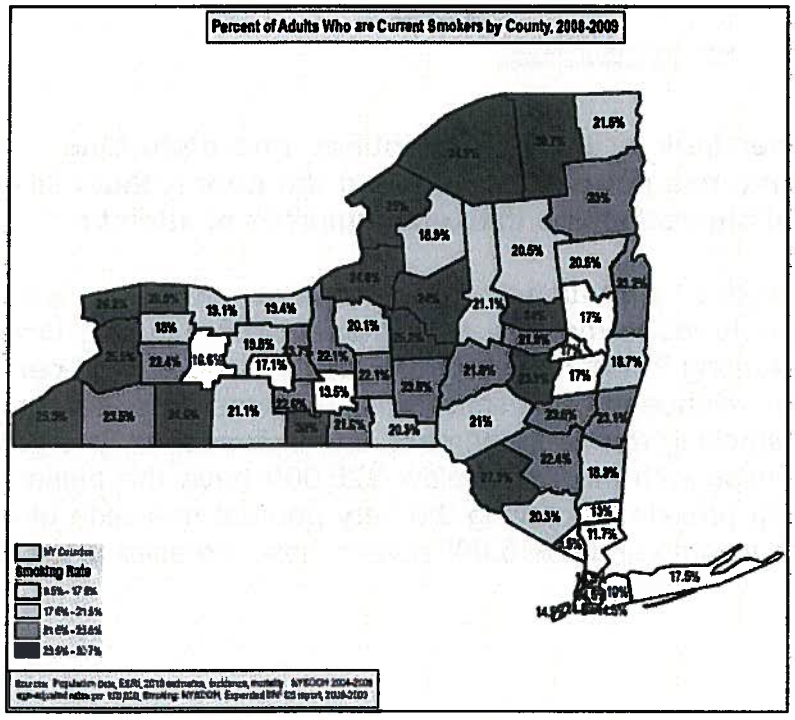
Adult Prevalence of Smoking by Income, 2000-2011



Poorer, less educated individuals live throughout New York. In urban, rural and suburban areas of the state, low income individuals struggle not only with extremely tight finances, but with the financial and health consequences of this powerful addiction as well.

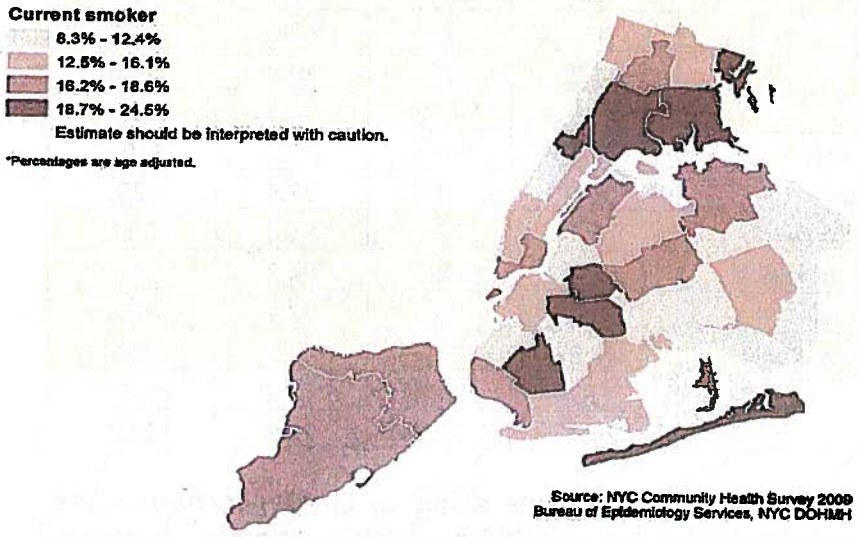
Upstate, rural counties tend to have adult smoking rates higher than the statewide average, especially the Adirondacks and central New York, as well as the Buffalo-Niagara Falls region. All these areas exhibit lower household income and higher rates of poverty.

Smoking Rates By County[8]



[8] New York State Department of Health, Behavioral Risk Factor Survey, 2010.

While downstate counties' smoking rates are low, they mask significant differences within the counties. New York City's overall smoking rate is nearly 24 percent lower than upstate regions, (13.2% vs. 17.2%),[9] yet (as seen below) within New York City, certain areas with high poverty rates, including South Bronx, Central Harlem, Morningside Heights, Central Brooklyn and Rockaway, have much higher rates than the rest of the New York City.[10]



Lung Cancer Rates in New York – A Tale of Two States

As a result of these higher smoking rates, upstate New York suffers from higher than national average lung cancer rates – rates that are noticeable when compared to three other most frequently diagnosed cancers (breast, colon, prostate and lung – as seen earlier – represent roughly half of all cancer diagnoses as well as half of all cancer deaths).

[9] 2010 Behavioral Risk Factor Surveillance System.
[10] New York City Community Health Survey Atlas, 2009.

Annual Cancer Incidence and Mortality Rates, 2004-2008[11]
(# of cases per 100,000 population)

	US	NYS	Not NYC	NYC
All cancer incidence male	541	569.3	598	521.8
All cancer incidence female	411.6	431	460.3	388.8
All cancer mortality male	225.4	202.7	214.3	183.3
All cancer mortality female	155.4	146.2	156.6	130.9
Colorectal incidence male	55	56.7	57.1	56.2
Colorectal incidence female	41	43	43.6	41.9
Colorectal mortality male	21.2	20	19.9	20.2
Colorectal mortality female	14.9	14.3	14.3	14.2
Breast cancer incidence female	124	124.3	133.5	110.9
Breast cancer mortality female	24	22.9	22.8	23
Lung & bronchus incidence male	75.2	77.3	84.3	65.8
Lung & bronchus incidence female	52.3	54.8	64.2	41
Lung & bronchus mortality male	68.8	56.3	62.1	46.9
Lung & bronchus mortality female	40.6	36.2	42.9	26.2
Prostate incidence	156	166.9	172.6	157.2
Prostate mortality	24.7	22.7	22.3	23.4

As seen in the above chart, New York State has a higher cancer *incidence* rate (annual number of new cancer cases per 100,000 population) than the nation as a whole. However, New York has a lower cancer *mortality* rate (number of deaths due to cancer per 100,000 population). **The state's lower mortality rate is largely driven by a reduced incidence of lung cancer**, one of the deadliest forms of the disease, and that reduction is due to significantly lower rates of lung and other tobacco-caused cancers in New York City. **New York City's significantly lower lung cancer incidence and mortality rates (almost one-fifth lower than the national average) drives down the state's overall cancer mortality rate.**

Given the strong link between tobacco use and lung cancer, we examined county-level smoking rates. As seen above, smoking rates – which correlate with lung cancer incidence rates – are much higher in most upstate counties.

The City of New York (and some of its suburban neighbors) has a long history of aggressively implementing policies to curb tobacco use. New York City has instituted its own tobacco tax; led the state in prohibiting smoking in business and public settings; and focused on strong enforcement of laws that curb children's access to tobacco products.

All of these efforts have helped dramatically reduce the smoking rate in the City and helped reduce lung cancer incidence rates and deaths.

[11] American Cancer Society, Source: New York State Department of Health, State Cancer Registry, 2011.

Men living in the counties of Cayuga, Chemung, Clinton, Cortland, Franklin, Greene, Jefferson, Niagara, Oswego, Rensselaer, St. Lawrence, Schuyler, Steuben, and Washington have lung cancer rates higher than the state average. By contrast, men residing in Bronx, Brooklyn, Manhattan, Nassau, Queens, Rockland, and Westchester have rates below the state average.[12]

Women residing in Chemung, Clinton, Fulton, Greene, Jefferson, Madison, Niagara, Oneida, Onondaga, Oswego, Putnam, Rensselaer, St. Lawrence, Seneca, Sullivan, Warren, and Washington experience the highest rates of lung cancer. Women living in Bronx, Brooklyn, Manhattan, and Queens have the lowest lung cancer rates.

Tobacco use and all its consequences disproportionately impact the most vulnerable members of our society. Poor smokers spend a large share of their household income on tobacco products, with half the cost going to state government. Yet they receive little help from the state when they want to quit smoking.

Tobacco's Impact on Medicaid

Annual Medicaid expenditures to cover the illnesses caused by smoking are estimated to be $5.47 billion in New York State. Of that total, roughly half of the cost is absorbed by state taxpayers.[13]

Not surprisingly, given the earlier discussion that smoking rates tend to be higher among those with lower incomes, the Medicaid population has higher smoking rates than the general population.

As seen below, while the smoking rate among adult Medicaid beneficiaries has dropped from 39 percent in 2003 to 27 percent in 2011, that smoking rate is significantly higher than the overall smoking rate in New York State of 18 percent.

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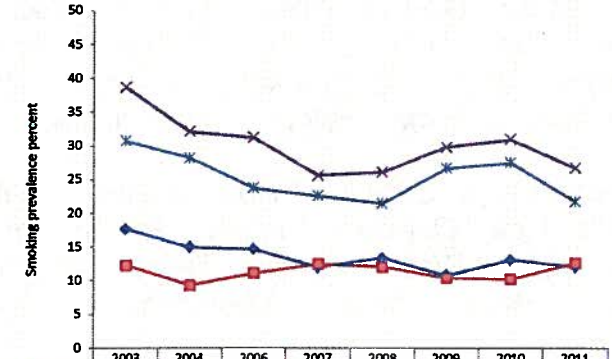
[12] New York State Cancer Registry. Regional variation is smoking rates, and certain occupational exposures may explain these differences.

[13] U.S. Centers for Disease Control and Prevention, "Best Practices for Comprehensive Tobacco Control Programs – 2007, October 2007, p. 90 (NY). See: http://www.cdc.gov/tobacco/stateandcommunity/best_practices/pdfs/2007/BestPractices_Complete.pdf.

Smoking Rates in New York by Type of Health Insurance[14]



	2003	2004	2006	2007	2008	2009	2010	2011
Private	17.7	15.0	14.7	12.0	13.4	10.8	13.1	12.1
Medicare	12.2	9.3	11.1	12.4	12.0	10.4	10.2	12.6
Medicaid	38.6	32.1	31.2	25.6	26.1	29.8	30.9	26.7
None	30.7	28.2	23.8	22.6	21.5	26.7	27.5	21.8

Of course, the impact of smoking on Medicaid expenditures is not unique to New York. According to the CDC, "Medicaid recipients are disproportionately affected by tobacco-related disease because their smoking rate is approximately 53% greater than that of the overall U.S. adult population."[15] Clearly, targeting tobacco control programs to lower-income populations will not only benefit public health, but help drive down state Medicaid expenses.

Tobacco Control Programs Work

In a 2007 publication, *Ending the Tobacco Problem: A Blueprint for the Nation*, the prestigious Institute of Medicine of the National Academy of Science concluded,

> "The evidence ... shows that comprehensive state programs have achieved substantial reductions in the rates of tobacco use ... this is particularly true ... when states aggressively funded and implemented their tobacco control programs."[16]

A 2006 study published in the *American Journal of Health Promotion* provides evidence of the effectiveness of comprehensive tobacco control programs and tobacco control policies. The study's findings suggest that well-funded tobacco control programs combined with strong tobacco control policies increase cessation rates. Quit rates in communities that experienced both policy and programmatic interventions were higher than quit rates in communities that had only experienced policy interventions (excise tax increases or secondhand smoke regulations).

These savings are not only over the long haul. Tobacco control can have immediate benefits. A 2012 George Washington University study found that

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[14] New York State Department of Health, Tobacco Control Program, "No Change in Smoking Rates Among Adults in New York with Medicare," StatShot Vol.5, No. 9/November, 2012.

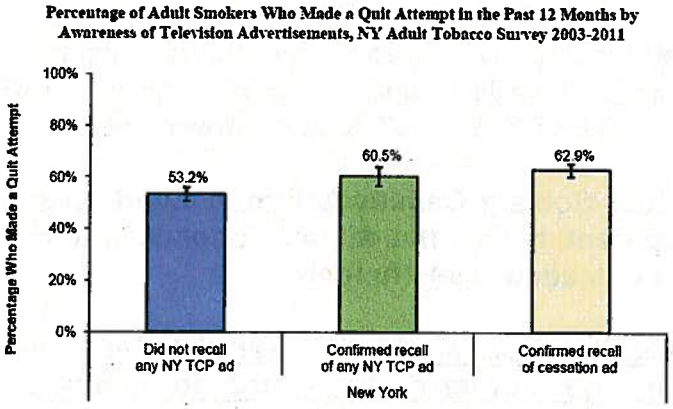
[15] U.S. Centers for Disease Control and Prevention, "State-Level Medicaid Expenditures Attributable to Smoking," Preventing Chronic Disease: Public Health Research, Practice and Policy, Volume 6: No. 3, A84, July 2009.

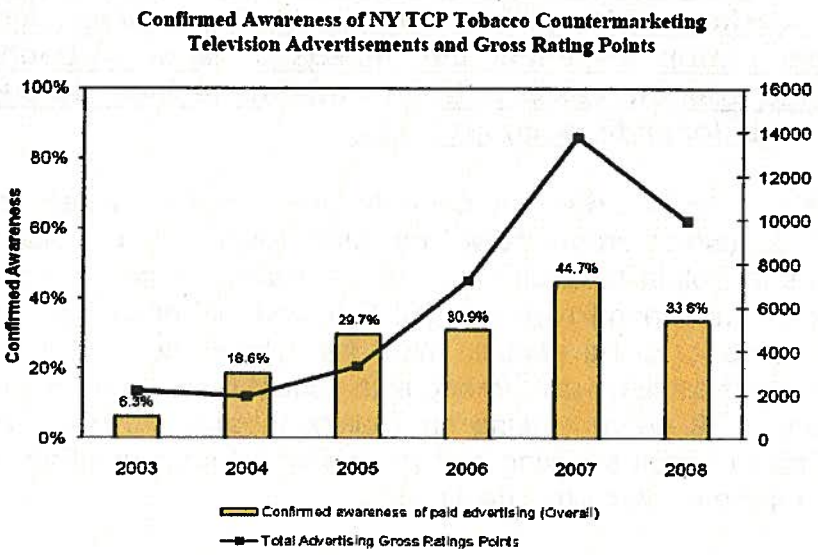
[16] Institute of Medicine of the National Academies, "Ending the Tobacco Problem: A Blueprint for the Nation," Washington, D.C., The National Academies Press, p. 171.

when the Massachusetts Medicaid program covered a comprehensive smoking cessation benefit, the state saw a $3 in health care savings for $1 invested in only a year-and-a-half.[17]

This finding supports the claim that state-based tobacco control programs can accelerate adult cessation rates in the population and have an effect beyond that predicted by tobacco-control policies alone.[18]

Research also shows a clear connection between tobacco control advertising efforts and attempts by smokers to quit. Below is evidence of the connections between tobacco control advertising and quit attempts.





It is in this area that the most devastating budget cuts have occurred. As a result, fewer smokers are likely to be attempting to quit and New York's health costs could see an increase that may not have occurred if the program was adequately funded.

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[17] Richard, P., West, K., and Ku, L., "The Return on Investment of a Medicaid Tobacco Cessation Program in Massachusetts," PLoS One, January 6, 2012, 7(1).

[18] Hyland, A, et al., "State and Community Tobacco-Control Programs and Smoking - Cessation Rates Among Adult Smokers: What Can We Learn From the COMMIT Intervention Cohort?" *American Journal of Health Promotion* 20(4):272, April/March 2006.

A report by the Tobacco Control Program's independent evaluator concluded:

> "..sizeable budget reductions [since 2009] limit the Program's ability to reach a significant proportion of New Yorkers with the wide range of evidence-based interventions that have been developed over many years. This limited budget also constrains the Program's ability to address stubbornly high smoking rates among historically disadvantaged populations." [19]

It recommended:

> "Increas(ing) NY TCP funding to a minimum of one-third of CDC's recommended funding level for New York ($254 million) to $85 million per year for FY 2012–2013 and to $127 million (50% of CDC's recommendation) for FY 2013–2014 and following years."[20]

The American Cancer Society Cancer Action Network urges you to reject the governor's apparent cut in the state's tobacco control program and instead ensure that it is adequately funded.

Support the governor's proposals to (1) Allow the Department of Taxation and Finance (DTF) the authority to refuse to issue a certificate of registration to retailers with unpaid tax delinquencies; and (2) Increase the penalty for possessing unstamped or illegally stamped cigarettes from $150 to $600 per carton to reflect the increased value of bootlegged cigarettes resulting from increases to the tax rate since 2000. In addition, require tax rate parity for all tobacco products.

There is evidence that this tax disparity not only allows some smokers to avoid higher taxed products (which erodes New York State revenues), but also makes it easier for minors to obtain tobacco products. A recent report from the U.S. centers for Disease Control and Prevention (CDC) found that despite a decline in cigarette smoking among young people, there have been high rates of cigar smoking and smokeless tobacco use among high school boys, with 15.7 percent smoking cigars and 12.9 percent using smokeless tobacco. Among all high school students, rates of cigar smoking and smokeless tobacco use have stayed steady even as cigarette smoking has declined.[21]

The national advocacy group, the Campaign for Tobacco-Free Kids, suggests that to deter tobacco use among children, it is important to raise tax rates on *all* tobacco products to prevent switching to a lower taxes and lower priced product and prevent initiation into these other tobacco products. Tobacco tax increases are one of the most effective ways to reduce smoking and other tobacco use.

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[19] RTI International, "2011 Independent Evaluation Report of the New York Tobacco Control Program," Prepared for the New York State Department of Health, November 2011, p. ES-1.
[20] *Id,* p. ES-3.
[21] U.S. Centers for Disease Control and Prevention, "Consumption of Cigarettes and Combustible Tobacco — United States, 2000–2011," MMWR 2012;61: 565-569, August 3, 2012.

Every 10% increase in cigarette prices reduces youth smoking by about 6.5% and total cigarette consumption by about 4%.[22]

Finally, the U.S. Surgeon General report found that "use of smokeless tobacco and cigars declined in the late 1990s, but the declines seem to have stalled in the past five years. The latest data show the use of smokeless tobacco is increasing among white high school males, and cigar smoking may be increasing among black high school females."[23]

Clearly, the lower tax rates on these tobacco products make it more affordable for high school students. Parity in tax rates should help reduce youth access to tobacco products. Increasing the tax rates will have a public health benefit, but using the additional revenues to fund tobacco control programs would enhance the benefit.

During last year's budget debate, the governor proposed to have the "roll you own" loophole closed, thus generating additional revenues for the state.[24] That proposal, despite apparent legislative support, fell out of the final budget agreement.

The American Cancer Society Cancer Action Network urges you to ensure tax parity among all tobacco products and use any additional revenues to bolster the state's tobacco control program.

Identifying Cancers Early: Support funding of the state's Cancer Services Program (CSP) and reject the governor's apparent cut.

In recent fiscal years, the CSP received as much as $29 million to conduct outreach and screenings for cancer. Combined cuts to the CSP have reduced overall spending for this lifesaving screening to $26.7 million in FY 2012-13, of which about $19 million directly supports the screening services. Although we understand that these are difficult economic times, the need for CSP is critically important to the nearly 2.5 million uninsured New Yorkers.[25]

As mentioned above, the governor's vague budget plans do not itemize his proposed spending levels for public health programs. The same is true for CSP.

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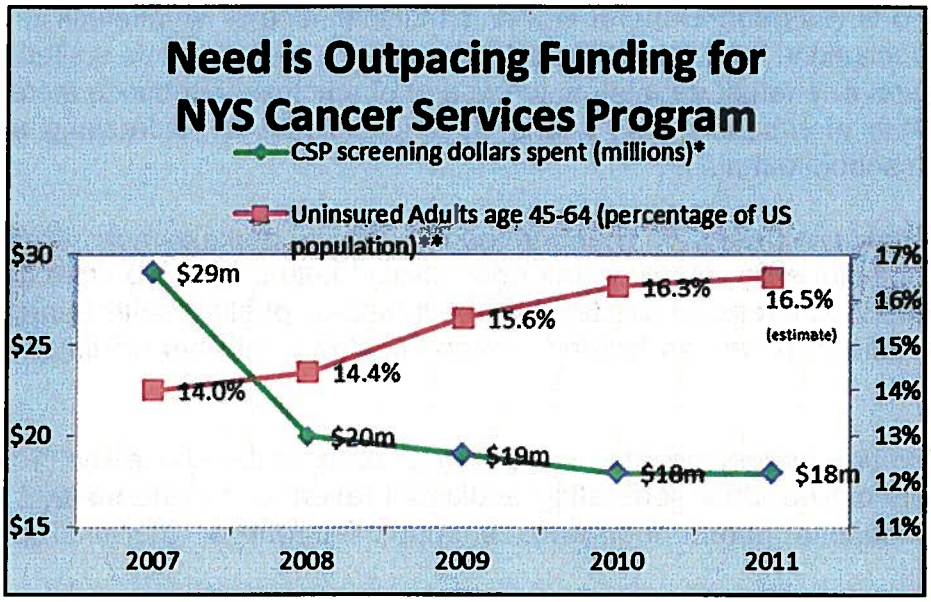
[22] Robert Wood Johnson Foundation, "Strategic Thinking on State Tobacco Tax Increases," see: http://www.rwjf.org/content/dam/supplementary-assets/2006/09/SLSTobaccoTax.pdf. p.1.

[23] U.S. Surgeon General, "Preventing Tobacco Use Among Youth and Young Adults, A Report of the Surgeon General, Executive Summary," U.S. Department of Health and Human Services, 2012, see: http://www.surgeongeneral.gov/library/reports/preventing-youth-tobacco-use/exec-summary.pdf.

[24] New York State Division of the Budget, "2012-13 Executive Budget Economic and Revenue Outlook," http://publications.budget.ny.gov/eBudget1213/economicRevenueOutlook/economicRevenueOutlook.pdf, see p. 222.

[25] United State Census Bureau, see: http://www.census.gov/hhes/www/hlthins/data/historical/HIB_tables.html, accessed 11/12/12, Table HIB-4, "Health Insurance coverage Status & Type of Coverage by State All People: 1999 to 2011.

We assume that CSP would be included in the Chronic Illnesses budget pool and thus subject to the governor's deep cut in that appropriation.



The CSP has worked diligently in every community across the state to provide screening and early detection of breast, cervical and colorectal cancer to women and men who are under- and uninsured for more than twenty years.

For those who qualify, the CSP provides clinical breast exams, mammograms, pap tests, pelvic examinations, colorectal cancer screening, surgical consultation and diagnostic testing to people without health coverage in every county of New York State. And while the program has screened tens of thousands of people, at current funding levels for example, the New York State Cancer Services Program is able to help fewer than 20% of the women who don't have insurance and can't afford a mammogram.[26]

Cancer screening saves lives. Detecting cancer early increases the chances of successful treatment, improves survival rates, and saves New York in overall medical costs. For example, research shows that the earlier breast cancer is detected and treated, the better the survival rate. When breast cancer is diagnosed when the tumor is localized and has not spread the 5-year survival rate is 99%.[27] Yet, uninsured patients are less likely to get recommended cancer screenings and are more likely to be diagnosed with cancer at later stages.[28] For example, uninsured women diagnosed with breast cancer are 2.5 times more

[26] New York State Department of Health, "Breast and Cervical Cancer Early Detection Program Report," Program Year 2008-2009, see: http://www.health.ny.gov/diseases/cancer/cervical/resources/docs/2008-2009_early_detection_report.pdf.

[27] American Cancer Society, "Cancer Treatment and Survivorship: Fact and Figures, 2012-2013," p. 4.

[28] Halpern MT, Bian J, Ward EM, Schrag NM, Chen AY. "Insurance status and stage of cancer at diagnosis among women with breast cancer." *Cancer* 2007; 110: 403-11.

likely to have a late stage diagnosis than women enrolled in private health insurance.[29]

Published research on the success of the National Breast and Cervical Cancer Early Detection Program, which partially funds and guides the state screening program, demonstrates a substantial impact on reducing mortality from breast cancer in medically uninsured, low income women.[30]

These evidence-based findings justify the state's investment in the early detection of breast cancer. In 2009, the State Department of Health estimated that the cost of the Cancer Services Program was offset by $46 million in savings due to early detection.

Even with the enactment of the Affordable Care Act, a significant number of New Yorkers will remain uninsured.[31] For individuals that remain uninsured, access to CSP's screening and early detection programs can be lifesaving. In addition, there are many program aspects that continue to be necessary in order for New Yorkers to benefit from critical, potentially life-saving cancer screening services:

- Recruitment, public and provider education, quality assurance, and data collection.
- Patient navigation and coordination of care.
- Language and cultural barriers, transportation barriers, knowledge and attitude barriers to preventive medicine will continue to exist and, even with insurance, men and women will need assistance to fully access these services.

Lastly, the CSP provides a direct entry to Medicaid for those diagnosed thanks to the Medicaid Cancer Treatment Program. This federal law allows New Yorkers diagnosed through the program to receive immediate Medicaid coverage. It behooves the Medicaid program to simultaneously consider the important role this program plays in optimizing federal dollars to care for New Yorkers diagnosed with cancer. Those who continue to fall through the cracks are not only diagnosed with later-stage cancers, they often come into the Medicaid Program through a more traditional door, relying on state funding to finance their care.

The American Cancer Society Cancer Action Network recommends that the apparent budget cut proposed by the governor be rejected and that CSP funding be maintained at $26.7 million so that local program can adequately serve their existing clients and outreach to the eligible

[29] Kaiser Commission on Medicaid and the Uninsured. "The Uninsured: A Primer. Key Facts About Americans Without Health Insurance," January 2006.
[30] Hoerger, Thomas J., PhD, et al. Estimated Effects of the National Breast and Cervical Cancer Early Detection Program on Breast Cancer Mortality. Am J Prev Med 2011;40(4):397– 404.
[31] New York State Health Foundation, "Implementing Federal Health Care Reform: A Roadmap For New York State," p. 3. The report estimated that as many as 1.2 million New Yorkers will become newly insured when the federal law is fully phased in. see: http://www.healthcarereform.ny.gov/research_and_resources/docs/roadmap_for_nys.pdf.

population to the extent possible. Your support, through the budgetary process, can mean the difference between life and death for New Yorkers impacted by cancer.

Helping Cancer Patients: Support the governor's proposal to fund New York's health insurance exchange. However, we urge that additional steps be taken to keep health insurance affordable.

According to the US Census, New York State has nearly 2.5 million uninsured. In addition, research suggests that approximately 10 percent of cancer patients are uninsured at the time of diagnosis. More troubling, about one-third of cancer survivors report a loss of health insurance at some point in time since their diagnosis.

Uninsured patients are less likely to get recommended cancer screenings and are more likely to be diagnosed with cancer at later stages. For example, uninsured women diagnosed with breast cancer are 2.5 times more likely to have a late stage diagnosis than women enrolled in private health insurance.

For those who have insurance coverage, usually through their employer, the cost keeps rising. Small businesses especially struggle with the rapidly escalating costs of health insurance. Over the past decade, small-business owners nationwide have watched their health insurance premiums rise 133 percent—the same kind of premium growth large businesses have experienced. But because of their smaller scale and thinner margins, they are less able than larger businesses to absorb these increasing costs

Consequently, the percentage of small businesses offering coverage fell from 68 percent in 2000 to 59 percent in 2009. Fifty-four percent of businesses with three to nine employees offered coverage in 2000 and only 46 percent offered coverage in 2009. Because of high costs, many employees at these businesses do not take the benefits offered. A recent Urban Institute study estimates that implementation of the Affordable Care Act will save New York businesses $2.5 billion a year.

Based on its successes in Massachusetts, the American Cancer Society Cancer Action Network has supported creation of a Health Insurance Exchange that will help ensure that cancer patients have unrestricted access to high quality, affordable and adequate insurance coverage that is simple to navigate and easy to understand. **The American Cancer Society urges your support for ACA implementation.**

Medicaid expansion and smoking cessation

An estimated 93,000 New Yorkers with cancer rely on Medicaid for their medical treatment. This is nearly 20 percent of all people in the state with cancer. More

than half the cancer patients receiving Medicaid benefits are under age 65, including more than 1,700 children.[32]

Medicaid provides a critical safety net not only for low-income people, but also for middle-income individuals who have spent their life savings paying for medical expenses such as crucial cancer care. Cancer patients in Medicaid generally become eligible for the program in one of three ways:

1. By receiving a qualified cancer screening and diagnosis through the Cancer Services Program.
2. Being declared disabled or qualifying for disability through the compassionate care disabled list.
3. By qualifying as medically needy because high treatment costs mean that they meet the state's income eligibility threshold.

Medicaid beneficiaries have better access to health care than do the uninsured. If they get cancer, it's more likely to be discovered at an early stage and, compared to the uninsured; they have better access to outpatient and hospital care and prescription drugs. Unfortunately, many do not sign up for Medicaid until they are sick and need medical care. Ensuring that more eligible individuals participated in Medicaid, saw a doctor regularly, and got screening tests such as pap smears and mammograms, would enhance the likelihood of detecting cancer at an earlier, more curable stage. They would also have access to preventive services, such as smoking cessation. There is evidence that patients who enrolled in Medicaid prior to their diagnosis have better survival rates than those who enrolled after their diagnosis.

- Michigan residents enrolled in Medicaid 12 months prior to their diagnosis of cancer had higher 8-year survival rates relative to residents who enrolled in Medicaid after a diagnosis of cancer.[33]
- For Michigan residents with cervical, colorectal or lung cancer, individuals who enrolled in Medicaid after a cancer diagnosis were approximately 2 to 3 times more likely to have late-stage disease compared with individuals who were enrolled before the month of diagnosis.[34]
- In Georgia, breast and cervical cancer patients who were enrolled in Medicaid, had better survival compared to the uninsured.[35]

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[32] "Medicaid's Impact in New York: Helping People with Serious Health Care Needs," American Cancer Society Cancer Action Network, American Diabetes Association, American Lung Association, Families USA, September 2011, available at: http://www.acscan.org/pdf/medicaid/medicaid-report-NY.pdf. p. 3.

[33] Bradley, C. et al. "Late Stage Cancer in a Medicaid-Insured Population." Medical Care 41 (6): 722-728 June 2003.

[34] *Id.*

[35] Adams EK, Chien LN, Florence CS, Raskind-Hood C. The Breast and Cervical Cancer Prevention and Treatment Act in Georgia: effects on time to Medicaid enrollment. Cancer. 2009 Mar 15;115(6):1300-9.

Health care costs are a contributing factor in nearly two-thirds of individual bankruptcies.[36] Even people with health insurance may find they are overwhelmed by the costs of cancer care because their insurance is inadequate or they lose a job and the insurance that goes with it. And it is often impossible for a low income senior with cancer to afford all the premiums, cost-sharing, and deductibles that are associated with Medicare without the help of Medicaid.

Affordable Care Act Implementation

Under the Affordable Care Act (ACA), Medicaid eligibility will expand to cover thousands of additional cancer patients. The ACA improves access to timely, continuous care in Medicaid by removing eligibility restrictions that keep poverty-stricken adults without children from qualifying from the program, requiring administrative simplicity to make enrollment easier and consistent, and providing extra federal funding for cancer screenings and cessation treatments.

- The ACA removes Medicaid eligibility restrictions on non-elderly, low-income adults and provides states with extra money to cover all adults below 133 percent of the federal poverty level beginning in 2014.
- The ACA streamlines the Medicaid enrollment process. Through automatic verification, simple enrollment forms and 12-month continuous eligibility, patients will be able to receive easier and timelier access to early detection and treatment options.
- The ACA increases the coverage of preventive services for Medicaid beneficiaries. The law gives states the option to receive extra money for including preventive services such as cancer screenings graded "A" or "B" by the U.S. Preventive Services Task Force in their Medicaid programs beginning in 2013. It also requires states to cover cessation services for pregnant women. These services became available without co-pays or deductibles beginning in 2010. In addition, coverage is required for prescription cessation treatments and FDA-approved over-the-counter cessation tools if the pharmaceutical company has a drug rebate agreement with the federal government.
- The ACA encourages greater primary care physician participation through higher reimbursement rates. The law increases the reimbursement rates for Medicaid providers from 2011-2016 to match the rates of Medicare providers to ensure physicians and hospitals accept Medicaid payments and patients.

New York has already adopted virtually all of the changes required under the ACA. Given that adoption of the Medicaid expansion will increase federal reimbursement and reduce Medicaid expenditures by $2 billion, policymakers must embrace this expansion.[37]

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[36] Himmelstein, D., Thorne, D., et al, "Medical Bankruptcy in the United States, 2007: Results of a National Study," *The American Journal of Medicine,* 2009, available at: http://www.pnhp.org/new_bankruptcy_study/Bankruptcy-2009.pdf.

[37] Blavin, F., Blumber, L., Buettgens, M., Roth, J., "The Coverage and Cost Effects of Implementation of

Smoking Cessation

Increasing access to tobacco cessation treatment is key to reducing death from cancer and other chronic diseases related to tobacco use. The most successful treatment is based on the same principles of care applied to the management of chronic disease. It recognizes that ongoing care, including continued provider counseling, proactive telephone counseling, and the extended and/or combined use of Nicotine Replacement Therapy and other pharmaceuticals, increases long-term abstinence. Minimizing barriers to access, such as cost-sharing and preapproval, and heavily promoting to Medicaid clients the availability of the support will increase utilization and result in greater cost savings, sooner.

By providing Medicaid beneficiaries and participants in substance abuse treatment programs with access to affordable tobacco cessation services, including pharmacotherapy and counseling services, New York can improve the health of its residents while also reducing the rising costs of treating tobacco-related illness and disease.

The American Cancer Society Cancer Action Network urges your support for the governor's proposed ACA implementation and Medicaid expansion.

Thank you for the opportunity to testify.

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the Affordable Care Act in New York State," Urban Institute, Health Policy Center, March 2012, p. 7.