



County Health Officials of New York
Leading the Way to Healthier Communities

2021 Joint Legislative Budget Hearing

New York State Association of County Health Officials (NYSACHO) Testimony on Executive Budget Proposal

NYSACHO's MISSION:

NYSACHO supports, advocates for, and empowers local health departments in their work to promote health and wellness and prevent disease, disability and injury throughout New York State.

NYSACHO is incorporated as a not-for-profit, non-partisan charitable organization with 501(c)(3) tax exempt status.

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Introduction

The mission of the New York State Association of County Health Officials (NYSACHO) is to support, advocate for, and empower the 58 local health departments (LHDs) in their work to prevent disease, disability and injury and promote health and wellness throughout New York State. LHDs are your partners and operational extensions, working in the forefront of communities as chief health strategists, addressing public health issues and serving as the first line of defense against all public health crises.

New York State continues to confront a growing number of monumental public health challenges. Using just the past three years as an example, recent public health threats included: in 2018, vaping related lung illness and death; 2019, a massive measles outbreak hit the city and Hudson valley region; and in 2020 the first global pandemic in recent history from a previously unknown virus. Continuing into 2021, we continue to respond to the most significant public health crisis of our generation with the worldwide COVID-19 pandemic. All these events coincide with ongoing public health issues, such as an increase in rates of sexually transmitted infection; Hepatitis A outbreaks; opioid overdose and deaths; suicide fatalities; an increase in reports of children with elevated blood lead levels due to a change in public health law and other severe public health crises. Currently, local health departments are vaccinating thousands of New Yorkers at points of dispensing (POD) events in order to achieve the level of herd immunity needed to stop this virus.

Notwithstanding our best efforts and the tireless work of our front-line staff, the ever-increasing public health mission we face is quickly exhausting the resources necessary to meet incoming threats and sustain the core public health services provided in each jurisdiction. Year after year, we see decreasing appropriations proposed within the Article 6 funding line for local health departments, due to administrative actions, the local property tax cap, and in some cases, cuts in reimbursement such as the one proposed for New York City. Local health departments have not received an increase in core public health aid in more than six years, nor have they received additional state funding support needed to respond to emerging health issues. In fact, State Budget appropriations for public health spending have either been flat-funded or reduced year after year. Short-term funding streams for emergency response

activities are frequently accompanied with stringent federal spending or supplanting restrictions, which restricts how funds can be utilized and reduces flexibility to respond to local community need. Short-term emergency funding, while necessary and appreciated, also allows both the state and federal government to ignore infrastructure needs until the next crisis. We ask the legislature to consider the recommendations we provide within this testimony which will stabilize and start to rebuild the public health infrastructure throughout the state.

Activities led by New York's LHDs are paramount to our collective ability to achieve Prevention Agenda goals, address health disparities, improve health outcomes and ensure community safety and stability.

We ask you, New York's respected lawmakers, to initiate a call to action for a reinvestment of resources into the public health infrastructure in New York State through increased funding of Article 6 support for general public health work. By doing so, you will be demonstrating your commitment to the foundational services that underpin the public health preparedness and safety measures needed to protect residents in New York State. NYSACHO's testimony provides a background on services provided by local health departments as well as a description of the Article 6 claiming process.

On behalf of the 58 local health departments in New York State, it is an honor to submit budget testimony to the joint legislative committees on Health and Finance and Ways and Means. LHDs implement state public health policy in each of your counties, through the provision of core public health services. As new threats emerge, local health departments are your public health first responders.

Local Health Departments Role in Emergency Response

Public health emergency preparedness and response includes planning, training, and maintaining readiness for public health. Prior to COVID-19, the threat of a global pandemic was theoretical to most - but not to local health departments. LHDs have been responding to public health emergencies for over a century, and starting in 2002, they began to formalize their emergency response processes. Through learning and adapting emergency management tools,

LHDs integrated public health into broader county all-hazards emergency plans. LHDs successfully deployed pandemic response plans during the 2009 H1N1 Influenza pandemic. LHDs also maintain continuity of operations plans, conduct drills and exercises with staff and partners, and use core public health activities, such as annual flu vaccination clinics, to test and improve their ability to deliver medical countermeasures.

Communicable disease control is where public health began. LHDs work daily to mitigate the spread of infectious diseases. Public health activities include disease surveillance and epidemiological programs to detect diseases in their early stages, immunizations, investigation and prevention of transmission through contact tracing, and isolation or quarantine, when needed. Contact tracing is the “who, how, why, when and where” of disease control that LHDs conduct daily to identify individuals infected with or exposed to emerging diseases, vaccine-preventable diseases and sexually transmitted infections. Isolation and quarantine measures were most recently used during the 2019 Measles Outbreak. These were among the first public health defenses employed by New York’s LHDs as federal recommendations to identify travelers at risk of having COVID-19 were put in place.

Professionals employed by local health departments are on the front lines of this pandemic, working to protect communities from exposure to COVID-19. Since the start of the pandemic, they have provided oversight of the following responsibilities:

1. Activating and mobilizing emergency preparedness plans during local emergency or outbreak response;
2. Serving as communicable disease experts. During disease outbreaks, epidemiological experts conduct investigations, contract tracing, monitor suspected cases, enforce isolation and quarantine protocols and set up mass clinics;
3. Assisting and connecting vulnerable or under resourced individuals to life-sustaining resources like housing, nutritious meals, utilities and health or mental health services;
4. Supporting community partners and working hand in hand with the New York State Department of Health and the Centers for Disease Control and Prevention. They also serve as a lynchpin for community partnerships with hospitals, clinicians, colleges, schools, businesses, community-based organizations and volunteer groups;

5. Upholding state and local laws. Public Health law grants authority to local health officials to respond to disease threats. **New York’s local health departments are the only boots-on-the-ground entities legally responsible for the control of communicable diseases;**
6. Keeping community members informed by answering questions, providing up-to-date information about the outbreak and the local community impact, and recommendations for how best to protect your family from exposure.

2021-2022 State Budget Requests & Legislative Priorities

CORE LHD FUNDING

1. Protect funding to local health departments and public health programs from cuts while we are in the midst of pandemic response.
2. Restore proposed cut to NYC Department of Health and Mental Hygiene and improve funding to Article 6 state aid:
Allocate \$12.6 million to LHDs for expanded capacity and ability to provide core public health services AND respond to emerging issues via a Strike Force funding stream.
 - a. \$100,000 for each full-service local health departments (31)
 - b. \$50,000 for each partial service local health departments (21)
 - c. Per capita increase for the 6 largest LHDs from \$0.65 to \$1.30 (8.9M)
3. Make incremental steps toward inclusion of fringe benefit as an eligible expense under Article 6 to support the public health workforce. Implementation of such an allowance will take time, but will achieve lifesaving outcomes for New York State.

HEALTH POSITIVE REVENUE PROPOSALS

4. Pass health positive revenue producing proposals outlined within this testimony and allocate revenue first to core public health services under article 6 state aid, then targeted public health programming and finally, non-health services and policies that address the social determinants of health.
5. Enact the following health-positive proposals included in the Executive Budget:
 - a. Expand and improve access to telehealth services;
 - b. Broaden the scope of practice of pharmacists to allow administration of all ACIP recommended adult vaccines to improve access and increase vaccination rates;

- c. Support technical changes regarding revocation and suspension of tobacco retailer licenses that will assure that sales of products do not continue after license revocation or suspension by requiring the removal of all tobacco products from the location.

OTHER

- 6. Include Local Health Departments During Establishment of NYS Public Health Corps
- 7. Increase Flexibility to Support Emergency Response with Amendments to Aid to Localities Appropriations Bill
- 8. Restore Cut to Rabies Funding and Include Amendments to Public Health Law to Control Costs
- 9. Permanently Allow EMS Professionals to Administer Vaccines at Mass Vaccination Clinics
- 10. Consider how an adult-use regulated cannabis policy will further strain the already taxed public health workforce, and result in negative health outcomes and associated cost. *REFER TO NYSACHO'S CANNABIS REGULATION PRINCIPLES DOCUMENT FOR RECCOMENDATIONS- Appendix II.*

Meeting these recommendations will increase public health and safety infrastructure throughout the state, allowing LHDs to build capacity, hire new staff, and continue local response to the COVID-19 pandemic to ensure our communities are protected, healthy, and safe!

Public Health's Successes Rely on Local Health Department Infrastructure

Public Health is the great success story of the 20th century. The Centers for Disease Control and Prevention (CDC) looked at the monumental gains in life expectancy realized in the 20th century. After reviewing the data, they estimated that 25 of the 30 years of increased life expectancy – over 83% - can be directly attributed to the core public health interventions that led to reductions in child mortality, such as expanded immunization coverage, clean water, sanitation, and other child-survival measures.

Those additional years of life expectancy, and the strong public health policies you enact to support them, came about by addressing health threats at the population level. They came about because we, as communities, states and nations invested in public health. To sustain the work needed to support our public health system, we hope to partner with you to protect these

public health policies and demonstrate continued commitment to mitigating threats to public health infrastructure.

Emergency responses to public health crises rely on the daily public health work of prepared and experienced staff who are most valuable when faced with a threat such as COVID-19. Our public health infrastructure is built on people – local health officials, preparedness coordinators, epidemiologists, public health nurses, sanitarians public health educators and support staff. These skilled experts have received stagnant and non-competitive salaries for decades, due to stagnant state aid, tax caps, funding eligibility restrictions and other administrative barriers which combine to undermine the local public health foundation we all rely on and assume will be there in emergencies. *As a result, our public health workforce outside of New York City decreased by one-third between 2011 and 2018.*

Further cuts will not just undermine the current and future emergency public health response. They put the entire public health system at risk of being unable to respond. Cutting public health in the midst of a pandemic response will result in more illness and death and place an even greater strain on state and local resources to try and fill the gaps left in these essential services in every community in New York State.

Reducing public health funding now, at any level, is like cutting the hose while trying to put out the fire. You still have part of a hose, but it is not likely to reach the flames in time. We respectfully ask our state leaders reject the proposed cut to New York City and bolster the existing public health workforce statewide by increasing Article 6 reimbursement rates and base grants. This will allow counties to protect their public health workforce working on the front lines of this pandemic from furloughs and layoffs.

Article 6 Claiming Process and State Aid and Why This Matters in the Context of Continued Cuts to New York City Department of Health and Mental Hygiene

Funding to local health departments comes from a variety of sources including: the county property tax levy and/or sales tax revenues; fees, fines or reimbursement for services (i.e.,

restaurant permit fees, civil penalties for failure to comply with Public Health Law, etc.); state aid for general public health work (Article 6 funding); and state, federal and private grants.

Article 6 of the Public Health Law provides statutory authority for state aid for general public health work. The program provides reimbursement for expenses incurred by LHDs for core public health areas as defined in law. Counties are eligible to receive a flat base grant of \$650,000 or a per capita rate of 65 cents per person, whichever is higher. Currently, this means that counties with populations of 1,000,000 or less receive the flat base of \$650,000. Counties with more than 1,000,000 residents receive the per capita rate of 65 cents per person.

The flat base grant ensures that even our least populated counties receive enough state aid to support their core public health work. If municipalities with populations of 75,000 or less received the current per capita rate, most could barely afford a single full-time employee. In our least populous counties, the flat base grant might cover a majority, or in a few instances all, of the eligible public health expenses. The per capita rate is intended to assure that the most populous counties also receive an equitable base grant, but in practice, the tying of the per capita rate to the flat base grant results in the largest counties receiving far less per capita funding at 100% reimbursement than their less populous counterparts.

Eligible expenses are reimbursed 100% by the state up to the amount of the base grant. Once a county exceeds its base grant reimbursement funding, LHDs receive 36% reimbursement from the state, and pay the remaining 64%, plus 100% of the costs associated with services that are ineligible for reimbursement, such as employee benefits. Reimbursement through Article 6 is provided based on the net expenses of each LHD. The net expenses are determined by subtracting revenues obtained from third party reimbursement, fees/fines and grants from a county's gross expenditures for public health services. The remaining balance is what a LHD can submit for reimbursement for core services. Please refer to appendix document I for more information on the Article 6 claiming process.

During the 2019-2020 Budget Process, a 16% cut in reimbursement to New York City Department of Health and Mental Hygiene was enacted. This translated to a loss of \$59 million

less revenue to support essential public health programs to New York City residents. On the heels of the 2019-20 reduction of state aid for General Public health Work to NYC, the 2021-22 Executive Budget proposal would further reduce New York City's current reimbursement above the base grant from 20% down to 10%. The appropriation reflects this proposed cut and projects a \$38.5 million loss in funding to NYC when fully annualized.

The rationale for the reduction in funding to New York City is that they receive direct federal funding for a number of core public health services. While this is true for New York and other big cities nationally, under New York's Article Six claiming process, prior to submitting a claim, those federal grants must be considered revenue and applied against the city's eligible expenditures – that is, NYC has already accounted for this additional funding and reduced their “bill” for state aid accordingly. The proposed cut, therefore, is in no way addressed or filled by federal funds. It is simply a loss in core public health funding to address the public health needs of 8.1 million New Yorkers.

Cuts to Article 6 threaten the State's public health infrastructure and have a negative impact upon the important essential public health programs led by local health departments. During this time of extreme need for public health awareness and intervention, it is imperative that the State provide flexible and sustained funding to local health departments. With additional funding, programs that protect communities will be strengthened and yield in a substantial cost-savings to the state.

Unreimbursed Fringe and Indirect Costs are a Burden on Local Taxpayers

Inconsistent with ongoing and new public health threats and new state-level public health policies, LHDs have not received an increase in state aid in more than six years, nor have they received adequate compensation to respond to emerging public health crises. Despite the stated intent of property tax relief through the state cap, unreimbursed Fringe/Indirect costs place a significant fiscal burden on the local tax levy. Ineligible local fringe costs alone exceed the total state aid reimbursement for core public health expenses. This is exclusive of the \$427,012,107 local share of eligible expenses. Other local departments, such as mental hygiene and social services, receive state reimbursement for their fringe/indirect personnel expense.

Thus, the unreimbursed fringe burden on the local property tax levy places local health departments at the front of the line for staff reductions for counties trying to stay within the state-imposed property tax cap. The results of this structural funding inequity were laid bare in 2020 when our public health workforce, much reduced from the 2009 H1N1 pandemic response levels, struggled to protect our communities. While the costs of adding fringe as an eligible expense would be substantial, it would also remove the inherent conflict between the reimbursement formula and the property tax cap. *CURRENTLY, FRINGE BENEFIT EXPENSES ARE AN INELIGIBLE EXPENSE UNDER ARTICLE 6 STATE AID. WE RECOMMEND THIS IS MODIFIED TO ALLOW ARTICLE 6 TO COVER FRINGE EXPENSES.*

Enact Health Positive Revenue Generating Proposals Supported by County Health Officials

Revenue solutions to the COVID-19 pandemic fiscal crisis must acknowledge that this is a public health crisis and reflect a health across all policies approach. The state should adopt as a guiding principle, that any new revenue options and related policy changes be health-positive or health-neutral. Any revenue option that has the potential to exacerbate or cause negative health consequences - that will, in effect, add to public health and health care costs – should be off the table and at the very least, must be the option of last resort. A guiding principle we recommend the state adopts is: revenue proposals should not require substantial state investment (i.e. expansion of state workforce, capital investment) to implement.

1. Enact a Covered Lives Assessment for the Early Intervention Program, with a Year 1 \$40M, revenue estimate, will recoup lost revenue for both the state and localities.

The New York State Association of County Health Officials (NYSACHO) supports the enactment of a covered lives assessment on third party commercial insurance payers for the purpose of assuring that commercial health insurance plans contribute a proportionate share of the payment for Early Intervention (EI) services provided to infants and toddlers with special needs and their families. Currently, third party reimbursement for services to this vulnerable population is far lower than the insurers' legal obligation and far less than Medicaid reimburses for these services.

The enabling legislation for Early Intervention intended for Commercial insurance to help finance these services and is included in state and local budgetary assumptions. Despite numerous legislative and administrative actions designed to improve commercial insurance payments for eligible EI services, insurance companies continue to reject reimbursement claims submitted for EI services provided to insurance plan beneficiaries under the state's Part C program of federal IDEA, shifting this responsibility to state and local taxpayers, and placing undue administrative burdens on EI providers and the state fiscal agent in pursuing claims.

NYSACHO believes that a covered lives assessment will provide significant cost savings to the state and is requisite to responsible stewardship of public dollars. If accomplished, it will support and improve the provision of appropriate, high quality services to this fragile population. NYSACHO recommends that a covered lives assessment should ideally match the Medicaid rate of reimbursement, and minimally cover the equivalent of 50% of eligible claims based on number of enrolled children with third party coverage (\$40M).

It is imperative that commercial health insurers pay their share of costs for EI services. Given current state and local fiscal stressors, and more importantly, provider capacity challenges, the need to access all available revenue sources has never been more urgent. NYSACHO urges you to act now to ensure that this important funding stream helps support this critical program for infants and toddlers with developmental delays and disabilities.

POTENTIAL TOTAL REVENUE EARNED: \$40M (20M State/20M County Escrow)

2. Set a sugar-sweetened beverage tax and direct a portion of generated revenue to public health programs and Article 6 funding. Chronic Disease prevention is a core public health service under Article 6 law.

Sugar sweetened beverages (SSB) contribute to rising obesity and diabetes incidence. These drinks are a leading source of added sugars in the American diet.¹ According to the Centers for Disease Control and Prevention (CDC), "Frequently drinking sugar-sweetened beverages is associated with weight gain/obesity, type 2 diabetes, heart disease, kidney diseases, non-

alcoholic liver disease, tooth decay and cavities, and gout, a type of arthritis. Limiting the amount of sugar-sweetened beverage (SSB) intake can help individuals maintain a healthy weight and have a healthy diet.”^{2,3,4,5}

A potential solution to this health disparity is a sweetened beverage tax, which may reduce the consumption of sugary drinks in vulnerable populations. In recent years, 40 countries, including France, Hungary, Mexico, and the United Kingdom, as well as some localities in the US, have adopted sugary drink taxes. This tax has helped raise revenues to support public health initiatives and workers.

Different approaches law makers can take include:

- Taxing drinks based on amount sugar content. (Tiers) Hungary and the United Kingdom both passed sugary drink taxes with this approach
- Taxing all sugary drinks to raise revenue for other community programs that help to promote health in various ways. -The approach taken by some U.S cities (Philadelphia, Berkeley)
- Only taxing sugary drinks that have the highest sugar content to reduce economic burden - This strategy was mentioned to reduce the economic impact on lower income families

A 2020 review by the World bank¹⁰ on the effectiveness of SSB taxes found that overall, taxes work in reducing consumption and improving population health by:

- Deterring purchases of SSBs due to price increases;
- Raising public awareness;
- Incentivizing industry responses such as product reformulation or other responses that reduce sugar intake; and
- Generating revenue which may be directed towards programs that improve health

POTENTIAL TOTAL REVENUE EARNED: \$368-841 million a year*, plus live-saving public health benefit and reduced burden of chronic disease for New Yorkers.

**Range based on <http://www.uconnruddcenter.org/revenue-calculator-for-sugary-drink-taxes>, using a range from .5 cents to 3.00 cents, 100% pass through to the consumer, and assumption of a 75% compliance rate.*

3. Increase taxes on tobacco and vaping products in NYS with product parity and dedicate a portion of this revenue to support public health programming and Article 6 funding. This policy will have a positive impact on priority health outcomes in NYS and will generate revenue that can be used to support state and local public health services

Despite the well documented benefits of tobacco tax increases, New York has not increased most tobacco taxes in over a decade. Tobacco tax increases are a win-win-win; they improve public health, reduce healthcare costs, and generate revenue. NYSACHO and other public health partners support a cigarette tax increase of at least \$1.00 per pack and the establishment of tax parity with other tobacco products be included in your FY 2021-2022 Executive Budget.

There is no better time to act. Once at the forefront of cigarette taxes in the nation, New York's cigarette tax is now surpassed by the District of Columbia, Puerto Rico, and numerous other municipalities across the country.

A significant increase in tobacco taxes will have a positive impact on the number of people who smoke, especially youth who are price sensitive. The projected health benefits of increasing the cigarette tax by \$1.00 per pack in New York include:

- Youth under age 18 kept from becoming adult smokers: 29,500
- Reduction in young adult (18-24 years old) smokers: 6,500
- Current adult smokers who would quit: 61,800
- Premature smoking-caused deaths prevented: 24,400
- 5-Year reduction in the number of smoking-affected pregnancies and births: 6,000

An increase in New York's tobacco taxes is a good public health policy and an investment in the future. It will also reduce health care costs. In addition to the public health benefits, a tobacco

tax is essential to help make a dent in the \$9.7 billion New York spends annually on tobacco-related healthcare costs.

POTENTIAL TOTAL REVENUE EARNED: \$30-40M per year, plus a statewide reduction in health care costs.

4. Adopt revenue producing proposals enumerated below that will fund the work needed to implement the lowered EBLL level policy passed during the 2019 legislative session

During the 2019 legislative session, New York State passed into law a bill lowering the level of lead in a child's blood requiring action under the Childhood Lead Poisoning Prevention Program from 10 micrograms of lead per deciliter ($\mu\text{g}/\text{dL}$) of whole blood to 5 $\mu\text{g}/\text{dL}$ following the level set by the CDC in 2012.

New York State Department of Health estimated that the lowering of the blood lead level (BLL) will result in an estimated 17,046 additional cases, which is a six-fold increase from current statistics. *The states investment of \$9.4 million for local health departments, by Article 6 funding, leaves approximately \$30.3 million of the costs to be paid by local governments.*

Utilizing the options provided in this proposal will help raise enough revenue to help fund the existing expanded mandate. See appendix section III for details.

30-Day Budget Amendment Recommendations:

Inclusion of Local Health Department Expertise During Establishment of NYS Public Health Corps

NYSACHO welcomes the concept of the creation of a public health corps to support response during extraordinary public health emergencies. We request an opportunity to provide input on local health department needs, and to assure that the creation of a volunteer corps, be an enhancement, not a substitute, for state investment in the long-term, highly trained, local public health staff needed. As a planning group is established, we request a seat at the table to help inform the development of this important state initiative. We look forward to partnering

with the State on this new initiative and stand ready and willing to leverage our collective expertise.

Restore Proposed Cuts to Article 6 Funding and Increase Statewide Appropriation

New York City, like all eligible municipalities, must, through the Article Six claiming process, apply grant revenue - including any direct federal public health revenue - received against their eligible expenditures and reduce their claims for state aid accordingly. The proposed change to reimbursement for general public health work to New York City is not a shift of state costs onto federal dollars; rather it is a shift of state costs onto the local taxpayers.

To reduce core public health support to the agency that protects the health of 8.4 million New Yorkers, and that has borne the brunt of the human cost of this pandemic, put all other jurisdictions in New York State at risk. If COVID-19 has taught nothing else, it has taught everyone that communicable disease does not stop at jurisdictional boundaries.

While we recognize the fiscal constraints set upon the State of New York, it is imperative to include an increase to Article 6 state aid to all municipalities which will allow us to continue to respond to COVID-19 and strengthen our ability to respond to future public health emergencies in this year's budget. We request allocation of \$13.1M to Article 6 state aid, with an increase of 100,000 for each full-service local health department and \$50,000 for each partial service and a per capita increase for the 6 largest LHDs from .65 to 1.30 (8.9M). We submitted revenue proposals last fall to the Department of Budget that if enacted, could cover this increase in funding. Because public health response capacity is contingent upon our ability to hire and secure skilled public health workers, we request an amendment to allow fringe benefits to be covered under Article 6 state aid.

Honor Commitments to Progressive Tobacco Control and Enforcement

The 2020 COVID-19 pandemic has also brought into sharp relief the interconnectedness of public health and personal health behaviors and outcomes. Diseases where tobacco is a major contributing factor, e.g., COPD, ischemic heart disease, cancers, and diabetes, were identified early in the pandemic as significant risks/health conditions that contributed to a poor prognosis in those infected with COVID-19.

In sharp contrast to the public health threat presented by COVID-19 and to the strong statutes enacted in the 2020-21 State Budget, the 2021-22 Executive Budget proposal offers not a strengthening of public health efforts in this area, but instead proposes 25% cuts– that is a full quarter reduction – to the aid to localities funding for tobacco enforcement and education, and tobacco use prevention and control.

Cuts to this funding make no sense from both a public health and a fiscal standpoint. According to the New York State Department of Health: “In addition to the human costs, every year smoking costs NYS: \$10.4 billion in health care, of which more than a third (\$3.3 billion) is paid for by Medicaid. Billions of dollars more in lost workplace productivity.”

Now is the time to recognize the risks that chronic disease conditions related to tobacco use and other lifestyle factors often increase vulnerability to communicable diseases. Restore funding for these public health positive programs to honor the state’s commitment to implementing its own tobacco control policies and to protecting people from COVID-19.

Support and Enact Health Positive Revenue Proposals

NYSACHO is concerned that some of the current proposed revenue options in the Executive Budget proposal, particularly the legalization of adult-use recreational cannabis, are health negative revenue proposals – that is, that the costs associated with addressing the health, economic and social impacts that will result from increased access and use will negate at least some, if not all, of the revenue realized. We urge the Executive to be open to instead putting forward health positive revenue options, such as the implementation of a sugar-sweetened beverage tax, and an increase to tobacco taxes, as well as imposition of a standard tax rate on all tobacco products. Both of these options raise revenue for the state and produce health benefits through providing economic incentives to individuals to change unhealthy behaviors, ultimately reducing health care costs. Minimally, adult recreational use cannabis legalization must put public health and health equity as its first and primary tenet, if New York is to mitigate the negative health impacts associated with recreational use. While we caution such a policy will result in health negative consequences, if enacted, a portion of revenue from legalized adult-use cannabis program must be allocated directly to local health departments to cover the

cost of necessary local education programs and enforcement activities, tasks of which will surely fall to local health officials. See appendix document II for health-positive cannabis principles.

Increase Flexibility with Amendments to Aid to Localities Appropriations Bill

Lessons learned from current and previous public health emergency response efforts indicate the need for flexibility to ensure statewide capacity for local efforts. NYSACHO requests an amendment to the Aid to Localities appropriations bill to allow flexibility and maximization of state funding to local health agencies during a public health emergency. Such an amendment will strengthen our ability to work collaboratively as we implement state-level directives at the local level during emergencies. Please refer to part 1 of the attached appendix document IV for recommended language.

Restore Cut to Rabies Funding and Include Amendments to Public Health Law to Control Cost

County health authority is responsible, in accordance with public health law, for the services necessary to remediate cases of human rabies, a deadly zoonotic disease with a 99.9% fatality rate if left untreated. Communities and localities depend on this state funding to ensure the cost of post-exposure prophylaxis is covered. We request restoration of the proposed elimination of this funding in 30-day amendments. To control the cost of post-exposure prophylaxis, we recommend amendments to public health law regarding rabies expenses, that would remove barriers related to third-party reimbursement by allowing local health authority approval to be sufficient prior approval for insurers and equalize treatment charges for individuals exposed to rabies who require post-exposure prophylaxis by requiring that providers accept rates set by the Commissioner of Health. Please refer to part 2 of the attached appendix document IV for recommended language.

Permanently Allow EMS Professionals to Administer Vaccines at Mass Vaccination Clinics

Local health departments have been prepared and trained to host mass vaccination clinics as needed for decades, most recently with H1N1 and currently, COVID-19 clinics. The need to ensure capacity in our ability to identify eligible vaccinators to assist with such an effort couldn't be more critical at this time. County health officials therefore recommend an amendment that will expand of the definition of emergency medical treatment to permanently

allow emergency medical professionals to administer certain vaccines as part of state or local health department run or authorized mass vaccination clinics. Please refer to part 3 of the attached appendix IV document for recommended language.

Conclusion

This is a critical time in the history of our great state. The COVID-19 pandemic has ravaged our vulnerable populations, public health system, healthcare workers and economic viability. As we continue to recover from this devastating public health crisis, we have a responsibility as state leaders to start engaging in discussion around investing in our current public health infrastructure. Local health departments cannot continue to vaccinate, support those in quarantine/isolation, contact trace, make decisions about reopening businesses while facing additional withholdings and program cuts at the state level. Funding to local health departments must be restored and bolstered now, so that we can emerge from the current pandemic and prepare for the next.

Emergency response is not the only service provided by local health departments. LHDs follow a complex regulatory framework which mandates they address a multitude of other public health needs of communities. Through this framework they address maternal child health; chronic disease; environmental health services; communicable disease; community health needs assessments. In New York State, LHDs coordinate Early Intervention services for children and families with special health care needs. Each service they provide is underpinned by a commitment to assure health equity and protect the most vulnerable populations in our communities.

On top of these life-protecting requirements, LHDs are continuously subject to cuts, restrictions in how funding is spent, and new underfunded state mandates. With each new state mandated public health policy, we grapple with legal, fiscal and ethical choices. Do we cut back on restaurant inspections to monitor cooling towers for legionella? Will we have to delay lead remediation interventions for a child with elevated blood lead levels because the mandated costs of the Early Intervention program have forced us to eliminate or leave public health positions unfilled? Will we reduce or eliminate our maternal-child health home visits because

we need our public health nurses to address communicable disease outbreaks? These are real life decisions that can have long-term, life-altering, and potentially deadly consequences. We must engage in frank assessments of what is best for our citizens in terms of progressive public health policy, including both local and state resource availability and needs, if the state is committed to achieving our public health goals.

We hope the recommendations presented in this paper are utilized to help fund the mandate, thereby heralding New York State as a leader in commitment to public health infrastructure advancements in our nation. We believe that you are so committed, and we ask for your support to ensure we are provided with the state resources necessary to fulfill our many critical missions. Furthermore, we ask that you call on us to help inform your state-level priorities. Please do not hesitate to let us know, *what you need from us to help you effectively and appropriately resource our local public health infrastructure?*

Resources

1. Monitoring health concerns related to marijuana in Colorado, 2015: changes in marijuana use patterns, systematic literature review, and possible marijuana-related health effects. Colorado Department of Public Health and Environment, Retail Marijuana Public Health Advisory Committee-2017.

2. Bertrand KA, Hanan NJ, Honerkamp-Smith G, et al. Marijuana Use by Breastfeeding Mothers and Cannabinoid Concentrations in Breast Milk. *Pediatrics*. 2018; 142(3):e20181076.
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Tobacco Tax Resources:

1. Projected numbers of youth prevented from smoking and dying are based on all youth ages 17 and under alive today. Projected reduction in young adult smokers refers to young adults ages 18-24 who would not start smoking or would quit as a result of the tax increase.
2. Savings to state Medicaid programs include estimated changes in enrollment resulting from federal laws in effect as of January 1, 2020 and state decisions regarding Medicaid expansion. Long-term cost savings accrue over the lifetimes of persons who stop smoking or never start because of the tax rate increase. All cost savings are in 2020 dollars. The state Medicaid cost savings projections, when available, are based on enrollment and cost estimates by Matt Broaddus at the Center on Budget and Policy Priorities using data from the Centers for Medicare and Medicaid Services
3. Projections are based on research findings that nationally, each 10% increase in the retail price of cigarettes reduces youth smoking by 6.5%, young adult prevalence by 3.25%, adult prevalence by 2%, and total cigarette consumption by about 4% (adjusted down to account for tax evasion effects.). The projections were generated using an economic model developed jointly by the Campaign for Tobacco-Free Kids and the American Cancer Society Cancer Action Network and are updated annually. The projections are based on economic modeling by researchers with Tobacconomics: Frank Chaloupka, Ph.D., and John Tauras, Ph.D., at the Institute for Health Research and Policy

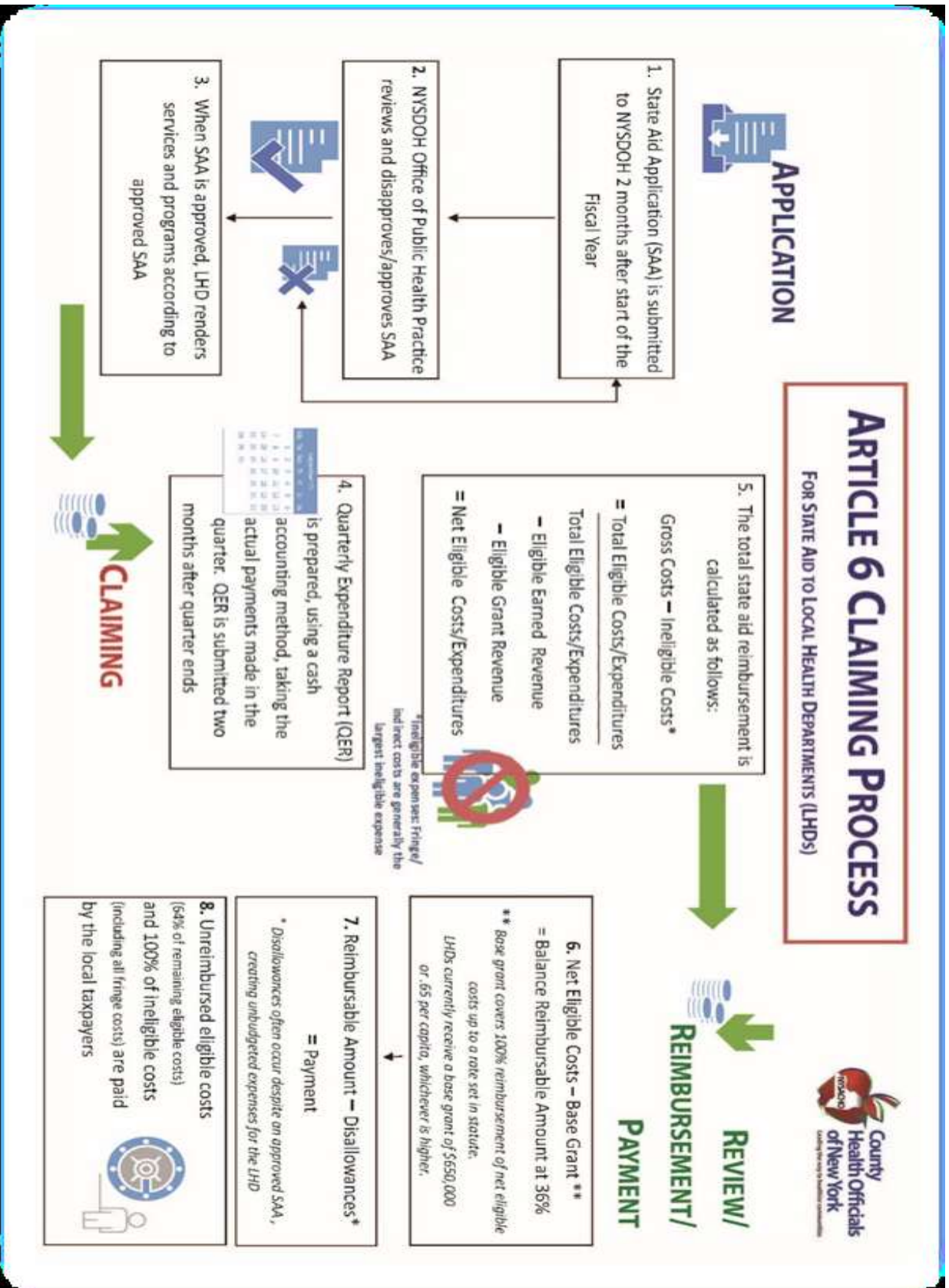
at the University of Illinois at Chicago, and Jidong Huang, Ph.D., and Michael Pesko, Ph.D., at Georgia State University. The projections also incorporate the effect of ongoing background smoking declines, population distribution, and the continued impact of any recent state cigarette tax increases or other changes in cigarette tax policies on prices, smoking levels, and pack sales. These projections are fiscally conservative because they include a generous adjustment for lost state pack sales (and lower net new revenues) from possible new smuggling and tax evasion after the rate increase and from fewer sales to smokers or smugglers from other states, including sales on tribal lands. For ways that the state can protect and increase its tobacco tax revenues and prevent and reduce contraband trafficking and other tobacco tax evasion, see the Campaign for Tobacco-Free Kids (CTFK) factsheet, State Options to Prevent and Reduce Cigarette Smuggling and to Block Other Illegal State Tobacco Tax Evasion, <https://www.tobaccofreekids.org/assets/factsheets/0274.pdf>.

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Appendix II



NEW YORK'S LOCAL HEALTH OFFICIALS REMAIN STRONGLY OPPOSED TO REGULATED RECREATIONAL ADULT USE OF CANNABIS.

New York has supported the use of cannabis for medical purposes and moved to rectify past inequities with decriminalization and expungement measures. Broader access risks serious population harms, including neurological harms on developing brains, for women who are pregnant, and increased automobile crashes, that are not easily mitigated once the product becomes widely available.

Overall, there is a lack of substantive research on the use of marijuana and associated health outcomes, and a limited time period of data on the experience of states who have chosen to legalize recreational use of cannabis. In addition, legalization threatens to undermine New York's strong tobacco control statutory protections by introducing and renormalizing smoking and vaping through the use of the smoked and vaped versions of this dangerous product.

POTENTIAL NEGATIVE HEALTH IMPACTS INCLUDE:

1. Confirmed increases in substance use disorders
2. Established negative cognitive and academic effects
3. Documented association with serious mental illness among a narrow slice of the population, but disproportionately among adolescents
4. Adverse cardiac and respiratory effects
5. Increased unintentional poisonings in children
6. Growth in motor vehicle crashes

THE LEGALIZATION OF ADULT-USE RECREATIONAL CANNABIS IS ALSO A HEALTH NEGATIVE REVENUE PROPOSAL

in that the costs related to preventing its harmful effects reduce, and potentially outweigh, any economic benefit to the state. A 2018 report based on research conducted by the independent research firm QREM, found that for every \$1.00 of revenue gained from legalized cannabis, Colorado spent \$4.50 in mitigating the negative effects related to legalization. While the Colorado report is only one assessment, it highlights the reality that, compared to health positive revenue options, such as taxing sugar-sweetened beverages, legalized adult-use cannabis, as a revenue source, brings with it both economic and societal costs.

NYSACHO recognizes that despite serious population harms, recreational use has its proponents who defend legalization measures from a perspective of presumed safety rather than impending harm. Should adult use cannabis legislation move forward in New York State, NYSACHO believes that policy-makers must approach legalization from the perspective of presumed harm. Thus, in keeping with Governor's efforts to promote a health across all policies approach, public health and health equity need to be the first policy issues addressed, and should underpin all decision-making related to cannabis sales and use, both recreational and medical.

Adapted from www.gettingitrightfromthestart.org

Cannabis, like alcohol and tobacco, is a potentially addictive substance that has known population harms; it is not an ordinary commodity. From the start of the regulatory process, New York State must place public health authorities in leadership roles (something that took centuries for tobacco). The basic philosophy underlying the following principles is that, if New York's elected officials choose to move forward with legalizing adult-use cannabis, it should be implemented cautiously to reduce the social harm of illegality, and that cannabis sale and consumption should not be normalized.

NYSACHO RECOMMENDS THE FOLLOWING:

GET IT RIGHT FROM THE START

- **Allow local governments the flexibility to be more restrictive regarding cannabis sales/use.** Much of New York's strong tobacco control policies grew out of local government policies. Continue to allow local governments to serve as innovators and test cases for public health policy by rejecting any industry efforts to insert preemption language into statute or regulation.
- **Put the following key infrastructure components in place before sales begin.** These components should be considered the necessary basic components applicable to the legalization and use of any drug, alcohol, tobacco or other product that may cause similar harm.
 - **Prevention infrastructure:** Including public health education campaigns for the general public, and high-risk populations, such as children, adolescents, pregnant women, and the elderly.
 - **Evidence-based treatment programs:** Assure that evidence-based treatment training is available to both treatment providers and the broader medical community, and that adequate capacity to meet treatment needs is in place before recreational cannabis sales begin.
 - **Robust surveillance systems:** The impacts of legalized adult-use recreational cannabis can only be assessed and addressed through a robust public health surveillance system. The New York State Department of Health should lead surveillance activities, gathering data collected through multiple agencies, to monitor for any negative public health impacts among the general population and specific high risk groups, and any public health trends related to usage. Additionally, they should establish baseline datasets to effectively monitor the impact of future policy changes on public health.
 - **Strong and comprehensive regulatory structure:** From the start of the regulatory process, place public health authorities in leadership roles (something that took centuries for tobacco). Regulations should be in place in advance of sales, with appropriate testing of infrastructure and critical staff onboarding completed.
- **Ensure that county health departments and local mental health and substance abuse agencies receive flexible funding** to expand workforce capacity in community education, prevention, intervention, enforcement and treatment. Public health is a major pillar in the success of a regulated marijuana program and must be sufficiently funded to ensure harm reduction.



Adapted from www.gettingitrightfromthestart.org



FIRST, ENACT A BROAD BASED INFRASTRUCTURE

- **Direct all state agencies** involved in legalization to keep protecting the public's health as the underlying tenet of all regulation, policy, guidance, and directives issued by their agency.
- **Assure that enforcement activities related to cannabis use by individuals are focused on harm reduction**, rather than punitive measures.

ADDRESS THE FOLLOWING SPECIFIC ISSUES RELATED TO PRODUCT SAFETY, HARM REDUCTION, PREDATORY BUSINESS PRACTICES, AND ENVIRONMENTAL PROTECTION:

• ENSURE APPROPRIATE REGULATION OF PRODUCTS AND USE

- **Formulate edible safety regulations** including child-resistant packaging and restrictions on products which may be enticing to children.
- **Fully fund enforcement and oversight.** Enforcement regulations related to restaurant and environmental inspections must mirror inflation and industry growth.
- **Standardize and test packaging and potency.** Strict THC concentration regulations, particularly those relating to packaging, labeling, and testing, must be in place before implementation.
- **Set a blood level operating limit for THC.** An active-THC blood level limit for operating a motor vehicle must be based on the best available evidence.
- **Prohibit misleading/unsubstantiated/anecdotal health claims** in all advertising and promotion of cannabis products.
- **Limit advertising** online and prohibit child focused advertising.

• MINIMIZE HARM AND INFORM THE PUBLIC

- **Minimize cannabis dependency and attendant health and social harms** by limiting potency of allowed products and aggressive marketing.
- **Require warning labels on any advertising & prominent graphic warnings on packages.** Prohibit therapeutic health claims for recreational cannabis products.
- **Use a specialized business model (no food or other product sales) to reduce normalization.** Require prominent health warnings in stores and to consumers.
- **Extend smoke-free and vape-free air restrictions** to include cannabis.

• PREVENT THE EMERGENCE OF A NEW TOBACCO-LIKE INDUSTRY

- **Avoid transferring control to outside investors** by favoring worker cooperatives/non-profits or similar structures.
- **Preserve local control** so communities can be more stringent (except as regards incarceration), up to and including, bans on all commercial activities.
- **Prohibit conflicts of interest** in regulatory bodies, advisory commissions, and for regulators and prescribers.

Adapted from www.gettingitrightfromthestart.org

PROVIDE SPECIAL PROTECTIONS FOR CHILDREN, YOUTH, PREGNANT AND BREASTFEEDING WOMEN, & DRIVERS AND PEDESTRIANS

- **Prohibit any products, packaging or marketing attractive to children or youth**, such as cannabis-infused beverages, flavored combustibles, vaping products, or wrappers, and products that resemble candy.
- **Limit the number of dispensaries to fewer than 1:15,000 people** to reduce exposure and social normalization while allowing access.
- **Require buffer zones** around schools, colleges, and other youth-serving facilities.
- **Enact protections for pregnant and breastfeeding women** through education about the potential harms related to cannabis use for themselves and the potentially harmful effects on the developing brain of fetuses and infants.
- **Prevent marketing to pregnant women** regarding unsubstantiated health claims related to relief of pregnancy-related symptoms, such as morning sickness.
- **Create standards, using objective technology**, for determining cannabis-impaired operation of motor vehicles and other heavy machinery.
- **Provide support, training, technology, and tools to law enforcement** to mitigate the impact of increased use of cannabis on driving impairment and related motor vehicle crashes in the general population.



PROMOTE ECONOMIC & SOCIAL JUSTICE



- **Prioritize equity in licensing applicants** using best practices emerging from pioneering municipalities (for example, residents of communities impacted by high drug incarceration rates).
- **Direct economic benefits** from cannabis legalization to communities most negatively affected by the “war on drugs.”
- **Assure that that past cannabis convictions**, which have affected the lives of so many men and women from black and Latino communities, not be a barrier to moving into the legal market.
- **Revenue should fund health.** Invest tax revenue gained from legalized recreational cannabis in public health, prevention, substance abuse treatment, mitigating negative social impacts of the war on drugs, improved access to health care, and public education campaigns.

Adapted from www.gettingitrightfromthestart.org

DO NOT WORSEN HEALTH INEQUITY

- **Avoid exacerbating existing health inequity** such as low birth weight, poor mental health outcomes, or lower high school graduation rates.
- **Inform vulnerable groups of the risks of use**, such as during pregnancy, mental health effects, and immigration risks (Ex: 69% of cannabis dispensaries in Denver recommended cannabis for pregnancy-related morning sickness).
- **Enact density caps on cannabis related commercial activities** to prevent concentration in low-income neighborhoods and to avoid perpetuating past discriminatory policies.



AVOID ENVIRONMENTAL DEGRADATION

- **Establish water usage limits and protections for surface and ground water** in the growing of cannabis to protect drinking water quality.
- **Require growers** to submit and implement air quality protection plans.
- **Regularly assess energy usage and emissions from cannabis cultivation** to assure that it does not negatively impact New York's Climate Leadership and Community Protection Act goals.
- **Increase monitoring and enforcement of illegal growing operations on public lands** to reduce the risk of environmental damage to wildlife and water from illegal pesticide use.
- **Monitor and establish restrictions on the conversion of agricultural farmland from food crops to cannabis cultivation** to assure legalization does not threaten food security.



ADVANCE EVIDENCE BASED SCIENCE

- **Fund surveillance and research efforts**, through dedicated academic research centers, to closely monitor potential benefits, risks, type of use, frequency of use, and potency of marijuana used by all New Yorkers.
- **Encourage and fund the scientific study of health effects** among New Yorkers who use marijuana.
- **Establish a cannabis research review committee on the Public Health and Health Planning Council** that regularly assesses new evidence from other states and makes appropriate regulatory and statutory recommendations to assure that public health protections address any emerging public health threats related to cannabis sale or use.



Adapted from www.gettingitrightfromthestart.org

Appendix III

Options for EBLL Revenue Generating Proposals

FUNDING OPTIONS	ESTIMATED REVENUE
(1) Lead poisoning prevention fee on paint*	
Fee set at- \$0.50 per gallon	\$19,500,000
\$0.75 per gallon	\$29,250,000
\$1.0 per gallon	\$39,000,000

(2) Surcharge fee on Homeowners' Insurance and Renters' Insurance*	\$56,500,000
(3) Other: Utilizing Health Care Reform Act (HCRA) Resources	Dependent on state budget allocation
(4) Other: Utilizing Master Settlement Agreement (MSA) funds for secondary and tertiary prevention*	Dependent on state budget allocation

(1) Introducing a Lead Poisoning Prevention Fee on Paint

We propose the NYS Senate and Assembly introduce and pass into law a 'Lead Poisoning Prevention Fee' that will act as a per-gallon fee imposed on the sale of paint in New York State and have the revenue collected from the fee be deposited in the Lead Poisoning Prevention Program budget that can be disbursed to Local Health Departments to help fund the expanded mandate.

A similar fee has been imposed in Maine since 2006, and the fee is imposed on the manufacturer or wholesaler level in the amount of 25 cents per gallon of paint estimates to have been sold in the state during the prior year [7][8].

(2) Surcharge fee on Homeowners' Insurance and Renters' Insurance

Another option to consider is adding a \$25 per year surcharge on homeowners' insurance and \$10 per year surcharge on renters' insurance for housing units built prior to 1979.

Adding a Surcharge Fee on Homeowners' Insurance and Renters' Insurance for housing units built prior to 1979 will yield a total of \$56.5 million in revenue.

While we propose this surcharge, we encourage the legislature to include language that will enable landlords and renters to have this fee waived, if they can prove their housing units are lead safe and/or have undergone lead abatement. Another alternative would be to create a "disappearing" fee, which could go down proportionally based on a reduction in the number or percentage of children with elevated blood lead levels.

(3) Utilizing Health Care Reform Act Resources

The New York Health Care Reform Act of 2000 (HCRA 2000), signed into law at the end of 1999, created a new framework for health care finance in New York State. By extending and expanding legislation enacted in 1996, HCRA 2000 addresses a broad range of issues, including mechanisms for hospital reimbursement, graduate medical education finance, and subsidies for care provided to the uninsured [20]. The new legislation enacts a number of major changes to increase funding for health care and attempts to increase access to health insurance [20].

As per the Senate-Assembly Budget bill of 2019, among the appropriations made, HCRA resources funding has been allocated for Children's Health Insurance Account (p.359), Elderly Pharmaceutical Insurance Coverage Program Account(p.359), New York State of Health Account (p.386), Medicaid Fraud Hotline and Medicaid Administration (p.389), Emergency Medical Services Account (p.392), Health Care Delivery Administration Account (p.393), Health Occupation Development and Workplace Demo Account (p.394), Primary Care Initiatives Account (p.395), Cigarette Strike Task Force Account (p.654) and Tobacco Control and Cancer Services Account (p.349) [21].

HCRA resources have been appropriated for public health, health care coverage, and primary health initiatives. Given the significant annual and life-time costs to the taxpayers from children with elevated blood lead levels, the state should consider investing HCRA resources to fund the expanded mandate.

(4) Utilizing Master Settlement Agreement (MSA) funds for secondary and tertiary prevention

Disbursements of the MSA funds are at the discretion of the states, which are responsible for deciding how the money is spent [11]. Between 1998 and 2017, the settling states received over \$126 billion in payments; however, less than 1 percent of these funds were earmarked for state tobacco prevention programs [11].

In 2007, the United States Government Accountability Office, GAO, reported before the Committee on Health, education, Labor, and Pensions, U.S. Senate that from 2000 through 2005, states allocated the largest portion of their payments to health care, \$16.8 Billion or 20 percent, which includes Medicaid, health insurance, hospitals, medical technology and research. States allocated the second largest portion to cover budget shortfalls, about \$12.8

billion or about 22.9 percent [13]. Other categories to which states allocated their tobacco settlement payments were for debt service on securitized funds, education, infrastructure and general purposes. United States GAO reported that 11.9% of the payments were unallocated [13].

New York State will receive over \$600 million in 2019 [14][15], inclusive of state and county shares. While New York State has devoted much of its portion of MSA funding to health care related costs, most counties securitized their MSA funds and used funding to address county expenses outside of public health.

A key component directing county use of MSA funds away from public health services is specific statutory language included in annual state budget appropriation bills that specifically prohibits the use of county master settlement funds to support core public health activities. T Given the growing number of public health mandates, coupled with shrinking state resources and the property tax cap, we recommend that this language be removed permanently from the 2021-22 State Budget, and future budgets, to allow counties that did not securitize master settlement payments to use MSA funds, where available, to support local expenditures related to the delivery of core public health services mandates, including the implementation of the lower EBLL.

Appendix IV

APPENDIX

Recommendations to Governor and Legislature for 2021-22 SFY Budget (language recommendations in bold underline)

1. In Aid to Localities appropriation legislation, add the following language to the general authorizing language at the start of the Aid to Localities legislation to provide flexibility to use state funding to local health agencies to meet public health response needs during a declared public health emergency.

For all appropriations for grants from the amounts appropriated within and provided therefor to local health agencies, when a public health emergency exists, as declared by the counties or the commissioner of the department of health, or a state of emergency as declared by the Governor, some, or all of such funding may be redirected to public health emergency response, with approval by the commissioner of the department of health, and so long as the emergency declaration is in effect, or a period of time designated by the commissioner. If the period of time designated by the commissioner extends beyond the end date of the emergency declaration, such extension shall be subject to the approval of the director of budget. This provision shall further apply retroactively to all response activities undertaken by local health agencies in response to the COVID-19 pandemic during the 2020-21 state fiscal year.

2. In HMH Article VII bill, amend Section 2145 of the public health law to remove barriers to recoupment/management of costs associated with human post exposure prophylaxis as follows:

Section § 2145 (3) of the public health law is amended as follows: Rabies; services and expenses of suppression.

3. Human post exposure treatment specifically authorized by the county health authority shall be rendered by the provider or providers selected by the county health authority, located within the county or the vicinity thereof, **and shall be considered sufficient authorization for pre-approval** by the person's health insurance carrier or managed care plan. **[if] No additional** pre-approval **[is] shall be** required by the health insurance carrier or managed care plan.

(a) any person may, at his or her option, be treated at his or her own expense by the health care provider of his or her choice, **without approval by the county health authority;**

(b) the county health authority may, at its option, assume financial responsibility for necessary treatment rendered by a health care provider chosen by the person; **provided, however, that the county health authority is not obligated to assume financial responsibility if notified after the completion of treatment. If evidence of approval of the county health authority has not been provided, health care providers must report initiation of rabies post exposure prophylaxis within 24 hours of the first treatment.**

(c) the county shall authorize initial treatment from a provider or providers geographically accessible to the location of the exposed person at the time that treatment is determined to be necessary, and

(d) the county shall authorize post-initial treatment from a provider or providers geographically accessible to the exposed person's residence if the person returns to his or her residence during the course of treatment.

4. Consent by any person to human post exposure treatment authorized by the county health authority shall constitute assignment of any third party health benefits to the county health authority and permission for the person's health care and insurance providers to release medical and financial information regarding the treatment to the county health authority.

5. Health care and insurance providers shall comply with any requests by the county health authority for information regarding human post exposure treatment rendered to an enrollee whose treatment was authorized by the county health authority.

6. Health care providers shall accept payments by the county health authority for human post exposure treatment at a rate set by the commissioner of health; provided that such reimbursement shall be no less than the Medicaid rate.

[6] **7.** Under the terms of this title, the county health authority is not responsible for:

(a) services and expenses of human post exposure treatment that were not specifically authorized by the county health authority, except for completion of treatment for their residents exposed and started on rabies treatment in New York city or elsewhere outside of New York state. **Treatment started in New York City shall be confirmed as necessary treatment by the New York City Department of Health and Mental Hygiene, or the New York State Department of Health.**

(b) services and expenses of medical treatment unrelated to the prevention of rabies infection such as wound suturing and measures to control bacterial infection of bite wounds, and

(c) expenses of preexposure rabies vaccination.

[7] **8.** A clinic for rabies vaccination for dogs, cats and domesticated ferrets of persons with local residence shall be conducted at least every four months within the county under the direction of the county government, by the health officials of the county and the several local health districts within a county. Donations may be requested but not required at the clinics. Any listing of costs in clinic announcements or advertisements must indicate that vaccinations are available free of charge, and that donations are optional. Counties may at their option provide vaccination clinic services to persons without county residence, and may require a fee based on cost from these persons.

[8] **9.** Claims for services and expenses, approved by the county shall be paid by the fiscal officer of the county from funds in his or her custody upon presentation of such claim, without further or other audit or may be paid pursuant to the local finance law.

3. Amend section 3001 of the Public Health Law to allow emergency responders to administer vaccinations

§ 3001. Definitions. As used in this article, unless the context otherwise requires:

1. "Emergency medical service" means initial emergency medical assistance including, but not limited to, the treatment of trauma, burns, respiratory, circulatory and obstetrical emergencies, **and all vaccinations as designated and approved by the commissioner of health, provided that vaccinations may only be administered pursuant to a non-patient specific order at sites overseen or approved by the New York State Department of Health or local health departments and operated under the medical supervision of licensed physicians, licensed physician assistants, or certified nurse practitioners, unless otherwise authorized by the Commissioner of Health.**

Appendix V

Reversing the Erosion of Local Public Health Services...[read more here.](#)

Function of Local health Departments...[read more here.](#)

Tobacco-Product Tax Increase and Parity...[read more here.](#)

Social Determinants of health...[read more here.](#)

Sugar Sweetened Beverages Tax: Health Positive Revenue...[read more here.](#)

Honor Commitments to Progressive tobacco Control and Enforcement ...[read more here.](#)