



# Building Emergency Response Capacity for New York State: *Protecting the Public Health Workforce During the COVID-19 Pandemic*



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# NYSACHO 2021-2022 State Budget Proposal Overview

## **Background: Who We Are and What We Do**

- NYSACHO represents New York State's Commissioners and Directors of public health and the 58 local health departments they lead.
- Local health departments are at the forefront of public health issues and serve as the first line of defense against all new and widespread public health crises.
- LHD's are organized under Article 3 of Public Health Law and are reimbursed for core public health services through Article 6 of Public Health Law.

## **Health Positive Revenue Proposals**

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.

***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.***

***POTENTIAL TOTAL REVENUE EARNED: \$40M (20M State/20M County Escrow) and reductions in administrative costs to providers and insurers.***

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

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

***3. Increase taxes on tobacco 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***

***POSSIBLE TOTAL REVENUE: \$30-40M in Revenue plus a statewide reduction in health care costs related to tobacco use.***

***4. Adopt revenue producing proposals that will fund the work needed to implement the lowered elevated blood lead level policy passed during the 2019 legislative session***

***POSSIBLE TOTAL REVENUE: Varies by proposal, potentially to fully fund expansion of lead poisoning prevention to children with elevated blood lead levels of 5µg/dL or higher, with potential long-term health care, public health, education, and related cost savings.***

<b>FUNDING OPTIONS</b>	<b>ESTIMATED REVENUE</b>
<b>(1) Lead poisoning prevention fee on paint*</b>	
Fee set at- \$0.50 per gallon	\$19,500,000
\$0.75 per gallon	\$29,250,000
\$1.0 per gallon	\$39,000,000
<b>(2) Surcharge fee on Homeowners' Insurance and Renters' Insurance*</b>	\$56,500,000
<b>(3) Other: Utilizing Health Care Reform Act (HCRA) Resources</b>	Dependent on state budget allocation
<b>(4) Other: Utilizing Master Settlement Agreement (MSA) funds for secondary and tertiary prevention*</b>	Dependent on state budget allocation

*\*Lead Poisoning Prevention Funding Options used in other states*

**2021-2022 NYSACHO STATE BUDGET ASKS:**

1. ENHANCE FUNDING TO ARTICLE 6 STATE AID: NYSACHO respectfully requests the following funding allocated in the State Budget 2020-2021:

Allocate \$13.1 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)
2. CURRENTLY, FRINGE BENEFIT EXPENSES ARE AN INELIGIBLE EXPENSE UNDER ARTICLE 6 STATE AID. MODIFY THIS TO ALLOW COUNTIES TO USE ARTICLE 6 TO COVER FRINGE EXPENSES.
  3. DO NOT CUT FUNDING TO LOCAL HEALTH DEPARTMENTS OR PUBLIC HEALTH PROGRAMS IN THE MIDST OF A PANDEMIC RESPONSE.
  4. NYSACHO STRONGLY OPPOSES LEGALIZATION OF ADULT USE CANNABIS. PLEASE CONSIDER HOW SUCH A POLICY WILL FURTHER STRAIN THE ALREADY TAXED PUBLIC HEALTH WORKFORCE, AND RESULT IN ADDITIONAL NEGATIVE HEALTH OUTCOMES AND ASSOCIATED COSTS.
  5. PASS THE ABOVE REVENUE PRODUCING PROPOSALS AND ALLOCATE FIRST TO ARTICLE SIX STATE AID, THEN PUBLIC HEALTH PROGRAMMING AND FINALLY, NON-HEALTH SERVICES AND POLICIES THAT ADDRESS THE SOCIAL DETERMINANTS OF HEALTH.

## LOCAL HEALTH DEPARTMENTS ARE ACTIVELY RESPONDING TO THE COVID-19 PANDEMIC

This proposal includes the following components:

1. An overview of the important role of Local Health Departments in protecting public health, *including pandemic response*;
2. NYSACHO's revenue-generating budget proposal which will generate monetary gain for the state with portions being allocated to protect NYS's local public health infrastructure;
3. Data supporting revenue proposals and data to demonstrate the need for protecting local health departments from future budget cuts.

## WHAT DO LOCAL HEALTH DEPARTMENTS DO AND HOW DO THEY DO IT?

New York's local health departments (LHDs) lead the way to promote and protect public health in our communities. LHD staff serve as the first line of defense against all new, existing, and potentially wide-spread public health crises. LHDs are New York State's partners and operational extensions - implementing public health policies and interventions in their communities to address public health hazards and protect communities and residents.

New York State Public Health Law (PHL) Article Six outlines core public health services as those that address **family health, communicable disease, chronic disease, emergency preparedness/response, community health assessment, and environmental health.**

LHDs are organized under the statutory authority of PHL Article 3 and article 6 of PHL is the primary statutory mechanism through which the state partially reimburses core public health services provided by LHDs. LHDs are also responsible for the enforcement and delivery of services related to many other areas of PHL.

Through LHDs, counties provide essential, population-based health services that promote and protect the health of all who live, work, and play in counties throughout New York.

Over time, LHDs have responded to an increase in emerging issues\* such as:

- Threats to water quality: harmful algal blooms, presence of PFOA/PFOS, and other water contaminants;
- Opioid overdose deaths;
- Vector borne diseases: rabies and tick-borne illnesses;
- Communicable disease outbreaks: Ebola virus, Zika virus, and the re-emergence of vaccine-preventable diseases such as measles and mumps;
- Environmental hazards: lead in housing stock, cooling tower regulations to monitor for Legionella, harmful algal blooms, and natural disasters such as hurricanes or flooding.

*\*These are examples and do not encompass all emerging crises that LHD's respond to.*

## UNREIMBURSED FRINGE/INDIRECT COSTS ARE A BURDEN ON LOCAL TAXPAYERS

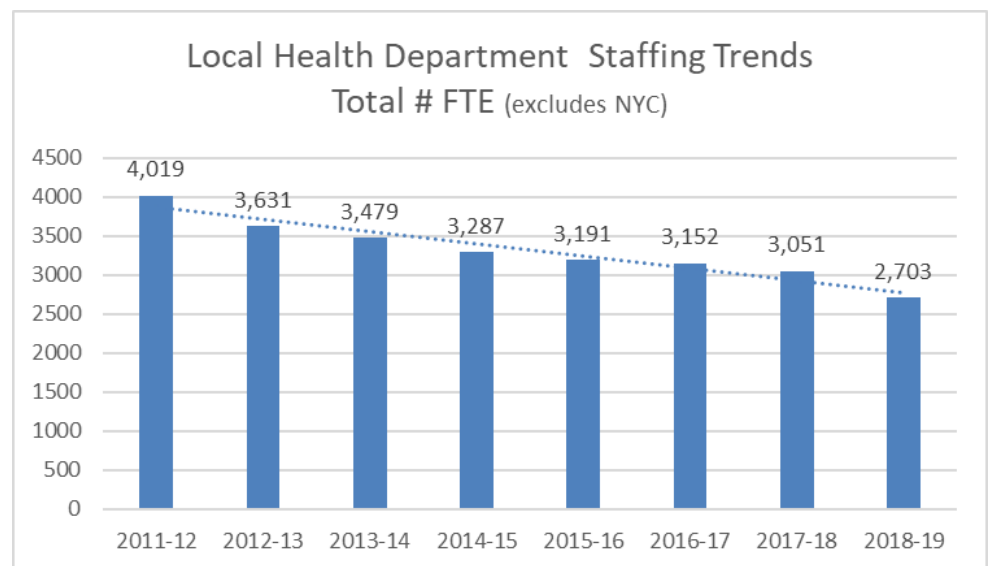
Inconsistent with ongoing and new public health threats and new state-level public health policies, LHDs have not received an increase in state aid in more than six years, nor have they received adequate compensation to respond to emerging public health crises. Despite the stated intent of property tax 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 COUNTIES TO USE ARTICLE 6 TO COVER FRINGE EXPENSES.**

## TO END THIS PANDEMIC, WE MUST ACT NOW TO REVERSE THE EROSION OF LOCAL PUBLIC HEALTH SERVICES

Public health infrastructure is built on people – local health officials, preparedness coordinators, epidemiologists, public health nurses, sanitarians, public health educators, fiscal and support staff. Emergency response to public health crises are possible because of the daily public health work, preparedness, and experience of the public health workforce and are critical when we are faced with a threat such as COVID-19.

The skilled experts central to public health response have

received stagnant and non-competitive salaries for decades, due to stagnant state aid, the property tax caps, funding eligibility restrictions, and other administrative barriers. Combined, these actions have eroded our local public health infrastructure, the one our communities expect to be there in emergencies. **As a result, our public health workforce outside of New York City decreased by one-third between 2011 and 2018. It has placed New York in the position of needing to rebuild and backfill their local** a public health workforce in the midst of responding to the COVID-19 pandemic.



Further cuts will not just undermine current and future emergency public health response, they put the entire public health infrastructure at risk. Crippling public health funding in the midst of a pandemic will result in even more illness and death and place an even greater strain on state and local resources as they try to fill the gaps left in these essential services.

## **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.

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.

In 2018 providers submitted claims to commercial insurers totaling \$76,498,012.57, but insurers paid just \$12,034,496.61, or approximately 16% of total claims. In contrast, through Medicaid, governmental payers reimburse between 70-80% of claims submitted annually. EI is a vital program with a steep growth curve: the cost of services and numbers of children enrolled have grown exponentially since the program began in 1993. EI consumes a large and growing percentage of most local public health budgets, with the cost of EI often dominating that of any other single public health program, despite serving a small percentage of the population. Without the intended contribution of commercial insurers, the viability of the EI program, as well as other public health services, are threatened and places an undue and unnecessary burden on state and local taxpayers.

In addition to the direct fiscal costs of third-party insurance claim denials, the current system poses an administrative burden on both providers and the insurers themselves. Third party billing challenges have contributed to provider capacity problems, causing existing providers to no longer be willing to serve the EI population, and serving as a disincentive to new providers. A covered lives assessment

will provide relief to both providers and insurers in submitting, reviewing, and adjudicating denied 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 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.<sup>1</sup> 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.”<sup>2,3,4,5</sup>

In youth, higher intake of SSBs is most often found among boys, adolescents, non-Hispanic blacks, and youth living in low-income families. <sup>6,8</sup> In the adult population, higher SSB intake is primarily found among males, young adults, low-income adults, non-Hispanic blacks, and Mexican American adults. <sup>7,8</sup> African American, Hispanic, and other low-income minorities face higher burdens of heart disease, stroke, type 2 diabetes, and other chronic illnesses.<sup>9</sup>

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.

Taxing sugary drinks for volume has been the most frequently used method of SSB tax, but taxing based on added sugar content broadens the potential impact by targeting a wider range of beverage options. Implementation of the tax can be done flexibly by setting up tiers of added sugar levels or taxing distributors of sugary drinks, similar to how some states already tax wines and spirits. 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

Taxing sugar content is seen as having the best chance to reduce consumption of SSBs based on studies that have shown this method would be more selective in targeting drinks that have higher sugar content, compared to other methods. Excise taxes on manufacturers and/or at value added points in the supply chain are the most frequently used tax internationally, with 35 countries using a specific excise tax (based on volume/sugar content) or an ad valorem tax (% of wholesale or retail price). Of the 40 countries with SSB taxes, 10 used a tiered tax approach.

A 2020 review by the World Bank<sup>10</sup> 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

Results from some Localities/Countries that have passed SSB taxes:

- *Berkeley, CA* – Generated 1.5 million dollars in revenue which went to the city school district and other health related programs.
- *Philadelphia, PA* – Generated more than 200 million dollars in tax revenue since 2017. Funding was used to build parks and support healthy initiatives. Philadelphia saw a 38% decrease in soda sales throughout the city.
- *Cook County, Illinois* – From August 2017 to November 2017, 62 million dollars in tax revenue was raised and the county saw a 21% percent decline in consumption. The tax was repealed a few months later.
- *Hungary* – 200 million euros were raised in the first four years after implementing SSB taxes. These funds were used to for a 25% wage increase for nearly 95,000 healthcare workers. Healthcare workers in turn continued to advocate and promote the significance of a healthy diet.
- *Mexico* – Implemented a one peso per liter sugary drink tax in 2014 and saw an average reduction of 7.6% in purchases per year for taxed beverages. They also saw a 2.1% increase for the purchase of water in lower income areas.

**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***

Smoking is a proven risk factor for cancer, chronic obstructive pulmonary disease (COPD) and heart disease, which put people at increased risk for severe illness from COVID-19.

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.

- An estimated 22,290 deaths every year are attributed to smoking in New York.
- Approximately 12.8% of New York adults are still smoking.
- Tobacco use remains the leading preventable cause of death and a significant contributing factor to heart disease, and stroke, that nation's number one, and number five cause of mortality.
- Lung cancer is the leading cause of cancer death in both men and women in New York.
- After years of downward trends in New York, the smoking rate among high school students increased from 4.3% to 4.8%.
- Disparities in smoking rates persist, most notably by race, mental health, income, and education, thanks in part to Big Tobacco's targeted marketing and advertising in these communities.

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. The projected health care saving of increasing the cigarette tax by \$1.00 per pack in New York include:

- 5-Year health care cost savings from fewer smoking-caused lung cancer cases: \$12.05 million
- 5-Year health care cost savings from fewer smoking-affected pregnancies and births: \$16.10 million

- 5-Year health care cost savings from fewer smoking-caused heart attacks & strokes: \$26.01 million
- 5-Year Medicaid program savings for the state: \$46.11 million
- Long-term health care cost savings from adult & youth smoking declines: \$1.86 billion.

Increasing tobacco taxes saves on long term healthcare expenditures and will also generate new revenue for New York as we face a \$14.5 billion budget deficit. For New York, an increase in the cigarette tax by \$1.00 per pack is estimated to generate \$30-40 million in new annual state revenue

In addition, this projection does not account for the additional revenue raised from an increase in taxes on other tobacco products (OTPs). Raising state tax rates on OTPs, including e-cigarettes, to parallel the increased cigarette tax rate will bring the state additional revenue, public health benefits, and cost savings (and promote tax equity). With unequal rates, the state loses revenue each time a cigarette smoker switches to other tobacco products taxed at a lower rate.

**POSSIBLE TOTAL REVENUE:** \$30-40M in Revenue plus a statewide reduction in health care cost.

***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 has proven time and again it is committed to safeguarding its children, and have shown that its legislature and the governor, representing all of New York, take action based on scientific research.

New York State Department of Health estimates 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 \$36.6 million or 80% of the costs to be paid by local governments.*

A survey conducted by NYSACHO of Local health Departments regarding the budget impact and resource needs related to the statute identified additional personnel costs including nursing and environmental health staff, health educators, clerical/support staff and staff recruitment and training costs. Non personal expenses noted in the survey included lab-testing, equipment (XRF machine, desks, file cabinets, computer etc.), additional workspace and supplies including dust wipes and cleaning supplies to assist families.

Additionally, reimbursement under Article 6 of the Public Health Law does not cover fringe benefits and indirect costs. Therefore, it is imperative, in order to support the implementation, these additional costs be covered in full by the state through a grant mechanism to allow the needed flexibility to hire at the discretion of the Local health Departments.

*Sources of lead that make children sick*

Sources of lead include paint (in older homes, old toys, furniture and crafts), dust, soil, drinking water, air, folk medicine and numerous others [2]. However, according to the New York State Department of Health, the most common cause of lead poisoning is dust and chips from old paint [2]. Even though lead-based paints were banned for use in housing in 1978, all houses built prior to 1978 are likely to contain some lead-based paint [3].

#### *Lead-based paint hazards in New York*

According to the United States Census Bureau's Population Estimates Program, 78% of housing structures in New York State were built prior to 1979 [5] and 42.9% of total housing units were built before 1950 [6]. Given lead-based paints were only banned in 1978, it can be estimated that more than three quarters of all housing units in New York State have lead paint.

#### *Why children are at higher risk*

Children under the age of 6 years are at particular risk because they are growing rapidly and because they tend to put their hands or other objects, which may be contaminated with lead dust into their mouths [3]. Children living at or below the poverty line who live in older housing are at the greatest risk because this housing is most likely to both contain old lead paint and be poorly maintained, resulting in active lead hazards. Some studies have found that children of some racial and ethnic groups living in older housing are disproportionately affected by lead.

#### *Associated Role and Responsibilities of Local Health Departments*

The roles and responsibilities of local health departments (LHDs) regarding identification and coordination of follow-up services for children with elevated blood lead levels (EBLLs) are defined in NYCRR Title 10 Subpart 67-1 [4]. As defined in 67-1.6, local health departments shall:

- Provide blood lead screening or arrange for blood lead screening for each child who requires screening and whose parent or guardian is unable to obtain a lead test for their child because the child is uninsured, or the child's insurance does not cover lead screening [4].
- Establish a sliding fee schedule for blood lead screening of children from families with incomes in excess of 200% of the federal poverty level, pursuant to Section 606 of the Public Health Law, and collect fees for blood lead testing from third party payers, when available [4].
- Provide environmental management for children with confirmed blood lead levels (BLLs)  $\geq 15$   $\mu\text{g}/\text{dL}$ . (Note: On May 6, 2009, the NYS Code of Rule and Regulations Part 67-1 was revised to lower the blood lead level requiring environmental management and other specified follow-up services from 20 to 15  $\mu\text{g}/\text{dL}$ , and to clarify that follow-up services are required for all children aged birth to 18 years with elevated blood lead levels. These changes became effective on June 20, 2009.) [4].
- Provide data to identify exposure patterns and high-risk populations for strategic planning for lead poisoning prevention at the state and local levels [4].
- Institute measures to identify and track children with elevated blood lead levels (EBLLs) to assure appropriate follow-up [4].

- Local health departments who serve as a child's primary health care provider shall carry out activities in accordance with paragraphs (1) through (9) of section 67-1.2(a). (See Appendix C, D, E) [4].

LHD lead programs are responsible for tracking all children with BLLs  $\geq 5$   $\mu\text{g}/\text{dL}$  to assure that appropriate follow-up services are provided [4]. Current New York State regulations define “follow-up” as actions by LHDs and health care providers which, depending on the child’s blood lead level and exposure history, include as appropriate [4].

- Confirmatory and follow-up blood lead testing;
- Risk reduction education;
- Nutritional counseling;
- Diagnostic evaluation which includes a detailed lead exposure assessment, a nutritional assessment including iron status, and developmental screening;
- Medical treatment, if necessary;
- Environmental management; and
- Case management.

To meet their responsibilities, LHD lead programs work in coordination with other team members, who may include the child’s parent(s) or guardian(s), the child’s health care provider(s), other LHD program staff and LHD or NYSDOH District Office (DO) environmental health staff, and other health professionals as needed [4].

## ***EBLL REVENUE GENERATING PROPOSALS***

### ***(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]. The following suggestions related to the Lead Poisoning Prevention Fee are listed based on a review of literature including legislation related to the fee imposed in Maine.

#### **Lead Poisoning Prevention Fee**

- a. The fee will be imposed on companies owning the brand name or private label of paint sold in New York State. If paint is imported for sale in New York State, the fee will be imposed on the importer.

- b. At the discretion of the New York State legislature, the fee can be waived for smaller companies that sell less than a certain amount of paint per year (in Maine, the fee was waived for companies which sold less than 1,800 gallons a paint in a calendar year).
- c. The paint subject to the fee should include architectural coatings (interior and exterior paint, primers, stains and lacquers), product finishes for equipment manufacturers (vehicles appliances, metals and furniture) and special-purpose coatings (traffic marking paint and vehicle refinishing paints) [7].
- d. New York residents purchase over 39 million gallons of paint each year [8]. A paint fee per gallon would raise revenues, which would be used to fund the extra workload that falls on Local Health Departments in New York State. We encourage the manufacturers to bear this fee and not charge it to the consumer.
- e. Any fee collected could then be designated for the Lead Poisoning Prevention Program budget to be disbursed to Local Health Departments to help fund the expanded mandate. We encourage this to be deemed as grant funding to give flexibility to Local Health Departments to utilize funds for additional personnel hiring and associated fringe benefits.

<b>Paint fee per gallon</b>	<b>Revenue</b>
\$0.50	\$19,500,000
\$0.75	\$29,250,000
\$1	\$39,000,000

If the 'Lead poisoning prevention fee on paint 'was set at \$0.50 per gallon, the revenue raised will amount to approximately \$19,500,000 per year. If the fee was \$1 per gallon of paint, the revenue from the fee will amount to approximately \$39,000,000.

If the fee is set at less than \$1 per gallon of paint, we propose the legislature and governor utilize any of our other proposed funding options to help fund the balance amount that is required to help fund the existing expanded mandate.

***(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.

Of the 3.9 million owner-occupied units in New York State, 61.9% of housing units have a mortgage. As homeowners 'insurance is required when getting a mortgage, we can extrapolate there are approximately 2.4 million owner-occupied housing units that have homeowners 'insurance. Since 78% of housing units in New York State were built before 1979, we can estimate that there are approximately 1.88 million owner occupied housing units in New York State that have homeowners '

insurance that were built prior to 1979. Adding a surcharge of \$25 per year for these 1.88 million housing units will raise approximately \$47 million.

According to United States Census Bureau data, of the 7.3 million occupied housing units in New York State, over 3.3 million, or 46% of occupied housing units are renter-occupied [5]. A study conducted by ORC International reported that only approximately 37% of renters have renters' insurance [10]. 37% of the 3.3 million renter-occupied units in New York State, is 1.2 million. Based on census data we can determine that there are approximately 950,000 renter-occupied housing units in New York State that have renters' insurance that were built prior to 1979. A \$10 surcharge on these units will raise \$9.5 million.

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.

#### ***OTHER: (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.

#### ***OTHER: (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. The language states that:

‘Notwithstanding any other provision of article 6 of the public health law, a county may obtain reimbursement pursuant to this act, only after the county chief financial officer certifies, in the state aid application, that county tax levies used to fund services carried out by the county health department have not been added to or supplanted directly or indirectly by any funds obtained by the county pursuant to the Master Settlement Agreement entered into on November 23, 1998 by the state and leading United States tobacco product manufacturers, except in the case of a public health emergency, as determined by the commissioner of health.’

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 from the 2020-2021 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.

**Utilizing the options provided in this proposal will help raise enough revenue to help fund the current existing expanded mandate.**

We hope the options presented in this paper are utilized to help fund the mandate, thereby heralding New York State as a leader in lead paint remediation efforts in our nation.

## **CONCLUSION:**

### **2021-2022 NYSACHO STATE BUDGET ASKS:**

- 1. DO NOT CUT FUNDING TO LOCAL HEALTH DEPARTMENTS OR PUBLIC HEALTH PROGRAMS IN THE MIDST OF A PANDEMIC RESPONSE.**
- 2. NYSACHO STRONGLY OPPOSES LEGALIZATION OF ADULT USE CANNABIS. PLEASE CONSIDER HOW SUCH A POLICY WILL FURTHER STRAIN THE ALREADY TAXED PUBLIC HEALTH**

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.

WORKFORCE, AND RESULT IN ADDITIONAL NEGATIVE HEALTH OUTCOMES AND ASSOCIATED COSTS. *PLEASE REFER TO NYSACHO'S CANNABIS REGULATION PRINCIPLES DOCUMENT FOR MORE INFORMATION.*

**3. PASS THE ABOVE HEALTH POSITIVE REVENUE PRODUCING PROPOSALS AND ALLOCATE FIRST TO ARTICLE SIX STATE AID, THEN**

**PUBLIC HEALTH PROGRAMMING AND FINALLY, NON-HEALTH SERVICES AND POLICIES THAT ADDRESS THE SOCIAL DETERMINANTS OF HEALTH.**

**4. ENHANCE FUNDING TO ARTICLE 6 STATE AID: NYSACHO respectfully requests the following funding allocated in the State Budget 2020-2021:**

Allocate \$13.1 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)

**1. CURRENTLY, FRINGE BENEFIT EXPENSES ARE AN INELIGIBLE EXPENSE UNDER ARTICLE 6 STATE AID. MODIFY THIS TO ALLOW COUNTIES TO USE ARTICLE 6 TO COVER FRINGE EXPENSES.**

Meeting these budget requests 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!

Adopting the health positive revenue producing proposals outlined within this paper will not only improve the health and wellness of communities in NYS but will also generate needed revenue to support the State and local reserves during this critical time.

**Thank you** for the opportunity to present our needs and ideas for collaboration. We look forward to continuing our work with the Governor's Executive Office to better serve the essential public health needs of the people of New York State.



### **Sugar Sweetened Beverage Tax Resources:**

1. [https://health.gov/dietaryguidelines/2015/resources/2015-2020\\_Dietary\\_Guidelines.pdf](https://health.gov/dietaryguidelines/2015/resources/2015-2020_Dietary_Guidelines.pdf)
2. Malik V, Popkin B, Bray G, Desprs J-P, Hu F. Sugar-sweetened beverages, obesity, type 2 diabetes mellitus, and cardiovascular disease risk. *Circulation*. 2010;121(11):1356-1364.
3. Malik VS, Hu FB. Fructose and Cardiometabolic Health: What the Evidence From Sugar-Sweetened Beverages Tells Us. *J Am Coll Cardiol*. 2015;66(14):1615-1624.
4. Bomback A, Derebail V, Shoham D, et al. Sugar-sweetened soda consumption, hyperuricemia, and kidney disease. *Kidney International*. 2010;77(7):609-616.
5. Bernabe E, Vehkalahti MM, Sheiham A, Aromaa A, Suominen AL. Sugar-sweetened beverages and dental caries in adults: a 4-year prospective study. *J Dent*. 2014;42(8):952-958.
2. 6.. Rosinger A, Herrick K, Gahche J, Park S. Sugar-sweetened beverage consumption among U.S. youth, 2011–2014. NCHS Data Brief. No 271. Hyattsville, MD: National Center for Health Statistics. 2017.
6. Rosinger A, Herrick K, Gahche J, Park S. Sugar-sweetened beverage consumption among U.S. adults, 2011–2014. NCHS Data Brief. No 270. Hyattsville, MD: National Center for Health Statistics. 2017.
7. Ogden CL, Kit BK, Carroll MD, Park S. Consumption of sugar drinks in the United States, 2005-2008. NCHS Data Brief. 2011(71):1-8.
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9. “World Bank. 2020. Taxes on Sugar-Sweetened Beverages: Summary of International Evidence and Experiences. World Bank, Washington, DC. © World Bank.  
<https://openknowledge.worldbank.org/handle/10986/33969> License: CC BY 3.0 IGO.”

### **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>.

#### **EBLL Revenue Proposal Resources:**

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2. New York State Department of Health, 'Sources of Lead' 2018. Retrieved from <https://www.health.ny.gov/environmental/lead/sources.htm>. Accessed on July 11<sup>th</sup>, 2019.
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12. City of Portland website 2019. Lead Safe Housing and Healthy Homes. Retrieved from <https://www.portlandmaine.gov/1902/Lead-Safe-Housing>. Accessed on July 20<sup>th</sup>.

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