2025 New York State Spring Cancer Action Day
Legislative Requests

1) **S172 / A84** will improve access to NY's paid medical leave system. All working cancer patients, survivors, and caregivers should have access to paid family and medical leave that allows them to take time off work to attend to their own or a loved one's care without losing their job or income. **Will you co-sponsor this legislation and ask your conference leader to support A84 and pass it right away?**

2) **S2000 / A1195** will improve access to lung cancer screening by eliminating patient cost-sharing for follow up screening. Out-of-pocket costs for individuals lead to delayed or missed lung cancer screenings. Delayed or missed screenings can lead to delays in follow-up testing and treatment, which ultimately impacts a patient's survival. **Will you co-sponsor this legislation and ask your conference leader to support A1195 and pass it right away?**

3) **S5565 / A6586** will improve care for individuals who are eligible for screening, follow-up, or treatment by expanding access to patient navigation services. By requiring all state regulated health plans in New York State, including Medicaid, to reimburse for patient navigation services New York State can improve patient outcomes and reduce overall health care spending. **Will you co-sponsor the legislation?**

ACS CAN is making cancer a top priority for public officials and candidates at the federal, state, and local levels. ACS CAN empowers advocates across the country to make their voices heard and influence evidence-based public policy change as well as legislative and regulatory solutions that will reduce the cancer burden. As the American Cancer Society's nonprofit, nonpartisan advocacy affiliate, ACS CAN is critical to the fight for a world without cancer.

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ACS CAN SUPPORTS

S2000 / A1195: Eliminating Cost Sharing for Lung Cancer Screening and Follow-up Tests

Despite the effectiveness of lung cancer screening, uptake has been low, with only about 19.5% of high risk New Yorkers getting screened in 2024.[1] Research shows that required cost sharing – including co-pays, co-insurance, and deductibles – can be a significant barrier for individuals who need preventive services.[2] [3] This can be especially true among people with limited incomes for whom these payments can represent a significant percentage of their income.

The ability to detect lung cancer early can have a dramatic effect on survival. For non-small cell lung cancer, the most common lung cancer, the 5-year survival rate is 65% when found at a localized stage but only 9% when found at a distant stage. 70% of lung cancers detected through screening are found at an early stage. Unfortunately, in New York, only 31.0% of cases are caught at an early stage with significant differences between racial and ethnic groups.

Twenty-four percent of lung cancer cases are diagnosed at an early stage among Black individuals in New York and 27.4% of lung cancer cases are diagnosed at an early stage among Latino individuals in New York—both significantly lower than the rate of 32.2% among white individuals in New York.[4]

Meanwhile, treating cancer at a late stage is also significantly more expensive than treating it at an early stage. Treating lung cancer at Stage 4 is 254% more expensive than treating Lung Cancer at Stage.

The Importance of Screening

In New York State., lung cancer is the **#1** cause of cancer death. More than **14,000** New Yorkers will be **diagnosed** and **6,000** will **die** from lung cancer in 2025.[11] Clinical trials on the effectiveness of lung cancer screening resulted in a significant reduction in lung cancer mortality.[12]

Out-of-pocket costs for individuals lead to delayed or missed lung cancer screenings. Delayed or missed screenings can lead to delays in follow-up testing and treatment, which ultimately impacts a person's survival. The ability to detect lung cancer early can have a dramatic effect on survival. For non-small cell lung cancer, the most common lung cancer, the 5-year survival rate is 65% when found at a localized stage but only 9% when found at a distant stage.[5]

Removing cost sharing for preventive services has proven to increase the use of these lifesaving services. For example, research shows that the Affordable Care Act provisions that remove cost sharing for preventive services increased utilization of these services. [6] Federal law requires all Affordable Care Act compliant private insurance plans to cover recommended lung cancer screening services for high-risk individuals without cost sharing, removing a key barrier to these services – especially for individuals with limited incomes. This provision of the federal law has increased access and utilization of these life-saving services. [7]

While the law is clear that cost sharing should not apply to preventive services, without federal or state laws defining what constitutes screening, payers are determining what is or is not a no-cost preventive service. As a result, individuals are being charged when additional screening tests are recommended, such as after an abnormal screening or if supplemental screening is recommended for people who are above average risk.

For a person being screened for lung cancer, this can include a charge for testing after an initial abnormal scan, such as needle biopsy, cytology, or bronchoscopy. One study found that the out-of-pocket costs for follow-up screening tests among individuals whose insurance covered lung cancer screening averaged $424.05 per individual with a range of $0 to $7,498.74.[8] The costs associated with follow-up testing as part of screening undermine the benefit of screening in reducing death from lung cancer, leaving people unscreened for cancer, having the potential to delay a diagnosis of cancer.

ACS CAN Supports S2000 / A1195

ACS CAN believes that cancer screening is a continuum of testing rather than a single recommended screening test, and that irrespective of individual risk, screening is a process **that includes a recommended screening test and all follow-up screening and diagnostic tests** described as diagnostic and judged to be integral and necessary to resolve the question of whether an adult undergoing screening has cancer.

ACS CAN supports **S2000 / A1195** which ensures comprehensive insurance coverage and the elimination of cost sharing for recommended lung cancer screening and follow-up screening and diagnostic tests for asymptomatic individuals by all payers in New York, including Medicaid.

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WE SUPPORT S.2000 / A.1195

REMOVING BARRIERS TO LUNG CANCER SCREENING

Memorial Sloan Kettering Cancer Center

Roswell Park Comprehensive Cancer Center

Weill Cornell Medicine

American Cancer Society Cancer Action Network

NYU Langone Health

New York State Public Health Association

GO2 Foundation for Lung Cancer

Montefiore Health System, Inc.

Mount Sinai Tisch Cancer Center

Northwell Health

LUNGevity Transforming Lung Cancer

Stony Brook Cancer Center

UR Medicine Wilmot Cancer Institute

NewYork-Presbyterian

NYSARH New York State Association for Rural Health

American Lung Association

Columbia University Herbert Irving Comprehensive Cancer Center

Brooklyn College Cancer Center

Lung cancer is the #1 cause of cancer deaths in New York with over 6,000 people expected to die from the disease. S.2000 /A.1195 will ensure comprehensive insurance coverage and the elimination of cost sharing for recommended lung cancer screening and follow-up screening and diagnostic tests for asymptomatic individuals by all payers in New York, including Medicaid.

List in formation as of 3.31.25

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ACS CAN SUPPORTS

A84/S172: Improving NY's Paid Family and Medical Leave Programs

Battling cancer is hard. Continuing to work full or even part time while undergoing cancer treatment is almost impossible. **Nearly 3 out of 4 cancer patients and survivors say they missed work due to their illness and 2 out of 3 missed more than a month of work.** Making matters worse, more than a third of those who missed work did not receive any pay for the time missed.

Studies show that cancer patients who have paid leave have higher rates of job retention and lower rates of financial burden. Yet not all cancer patients, survivors and caregivers who work have access to paid leave, and without it they risk losing employment or not getting the care they need.

New York made history when it enacted the Paid Family Leave program in 2016. The program was built on the state's decades-old temporary disability leave program. Together, paid family leave (PFL) and temporary disability insurance (TDI) constitute New York's paid family and medical leave program. While PFL is used to bond with a new child, care for a seriously ill loved one, or address the impact of military deployment, TDI is the program New Yorkers rely on when they need to take care of their own serious health needs.

When **PFL** was passed in 2016, it guaranteed New Yorkers 12 weeks of paid, job-protected leave at 67% of their wages -- up to **$1,151.16 per week** in 2024. But **TDI** remained untouched, languishing at a benefit level unchanged since 1989 -- a maximum of just **$170 per week**.

New York's paid leave program is woefully inadequate for those workers who need time off to care for themselves, not just their loved ones.

Making matters worse, is the inability for workers to take time off intermittently to care for themselves or a loved one. While New York's Paid Family Leave (PFL) and Temporary Disability Insurance (TDI) programs ensure that a patient can take time for theirs or a loved one's treatment, the shortest duration that a patient may take time under PFL is one day at a time, and **TDI does not cover any intermittent leave.**

For many cancer patients this is problematic. Conditions like cancer (or treatment of cancer) are often sporadic or intermittent lasting weeks or months. That's why it is so important to give employees the right to take a few hours or days of leave at a time, if necessary, for their own serious health conditions or to care for family members with serious health conditions.

A nationwide survey of cancer patients showed that of those cancer patients who had to take unpaid leave from work during their treatment **37% took either hours or days at a time, which is considered intermittent**, and 11% had a mix of increments of time taken. For those who benefitted from paid medical leave, 30% took time in increments of hours or days.

ACS CAN Supports A84/S172 continued

All working cancer patients, survivors, and caregivers should have access to paid family and medical leave that allows them to take time off work, including intermittently, to attend to their own or a loved one's care without losing their job or income.

A84/S172 contains the reforms needed to make these programs work for all New Yorkers. To give New Yorkers the paid medical leave they need, the program must include all the reforms included in A84/S172**:**

- Remove the $170/week cap on benefits for one's serious health condition and increase that cap to 67% of the State's average weekly wage by 2029;
- Provide intermittent leave;
- Protect workers' jobs and health insurance during medical leave;

These reforms are affordable. Paid family leave is entirely employee-funded, and temporary disability insurance is a shared employer-employee cost; the program's updates can be funded with only a small adjustment to current costs to employers and employees. A84/S172

A84/S172 would transform New York's paid medical leave program into one on par with modern paid family and medical leave programs across the country. And it would make a profound difference in the lives of New Yorkers, especially those already living paycheck to paycheck.

ACS CAN Supports A84/S172.

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ACS CAN SUPPORTS

S5565 / A6586 would require state-regulated health plans in New York to reimburse for patient navigation services

Navigating the health care system can be confusing and complicated. Making decisions after receiving a complex medical diagnosis such as cancer is challenging for anyone. Patient navigation is the individualized assistance that helps a patient overcome health care system barriers from prevention and early detection of disease to accessing necessary access to quality health and psychosocial care. Patient navigation extends across the full care continuum, beginning with screening and early detection, and extends through diagnosis, treatment, survivorship, and end-of-life. Access to patient navigation services can help patients and survivors get the care they need.

Improving Patient Outcomes and Reducing Health Care Costs

- Patient navigation services can help eliminate health disparities and reduce costs across the care continuum by addressing the needs of people who have been historically marginalized and excluded as well as those living in under resourced rural and urban communities.

- Patient navigation services help increase cancer screenings rates, help patients better understand treatment options after diagnosis and help ensure patients receive the post treatment care they need in survivorship;

- Patient navigation services have a proven return on investment by helping identify and diagnose disease at earlier stages when less invasive and less costly treatment options are available to patients, often resulting in better outcomes.

- Multiple studies have shown that patient navigation services can reduce overall health care costs.
    - In one study costs to Medicare declined significantly for navigated patients compared with non-navigated patients, with total costs reduced by $781.29 more per quarter per navigated patient for an estimated $19 million decline per year across the network compared to the non-navigated group.[1]

    - In another study a patient navigation program for patients with breast cancer led to a reduction in medical costs by $511 to $2080 per patient and a similar program for patients with colorectal cancer led to a reduction in medical costs by $1192 to $9708 per patient.[2]

    - A third study of a citywide patient navigation program for breast cancer found that the potential costs savings from averted hospitalizations and emergency room visits for 63 additional patients who received timely treatment is estimated at $21,798-$30,429 and $2536-$5692 per patient, respectively, compared to treatment as usual.[3]

Despite the record of success, patient navigation services are still absent or limited in many cancer programs and hospital settings due to a lack of clinical reimbursement. A recent survey of cancer patients by the American Cancer Society showed that while nearly all (91%) of patients surveyed agree that it is important for cancer patients to have access to a patient navigator, only fifty-five percent say their primary oncology provider has a patient navigator available on staff.

Sustainable funding through reimbursement is needed

Throughout the U.S., a patchwork of coverage exists depending on the where patients live and the type of insurance coverage they have and is not continuous throughout the cancer care continuum due to a lack of insurance reimbursement. **S5565 / A6586** will require all state regulated health plans in New York State, including Medicaid, to reimburse for patient navigation services provided to patients to improve access to care for individuals who are eligible for **screening, follow-up, or treatment services related to serious illnesses like, but not limited to, cancer.** The definitions of eligibility, covered services, and qualifications are consistent with Medicare's rules for reimbursable patient navigation services.

Eligibility: Eligibility for patient navigation services coverage under S5565 / A6586 includes individuals with a serious condition that is expected to last at least three months and places the individual at high risk for one or more of the following:

- Hospitalization;
- Nursing home placement;
- A sudden worsening of preexisting symptoms;
- Physical or mental decline; or
- Death.

Covered services: Patient navigation reimbursable services shall include but not be limited to:

- Screening for nonclinical and social needs that do not require a licensed healthcare provider to complete such as referrals and follow-up to connect individuals to services including, but not limited to transportation, employment, job training, food insecurity, childcare, housing, language or health literacy support;
- Help with enrollment or maintaining enrollment in government programs or other assistance programs;
- Arranging for and accompaniment to in-person and virtual healthcare visits; or
- Other prevention, screening and treatment health education, health navigation, health advocacy, or individual supports including transition of care supports.

Qualifications: To qualify for reimbursement for patient navigation services, the provider must:

- Be trained and have completed a national patient navigation certification or credentialing program, or other certification or training program approved by the state department of health;
- Be employed by or in consultation with article twenty-eight facilities, diagnostic and treatment centers, federally qualified health centers, clinics, physicians or other licensed healthcare providers, to provide patient navigation services; or
- Be authorized to provide patient navigation services under the general supervision of a licensed physician or other licensed healthcare provider.

S5565 / A6586 will improve access to quality care among communities that have been under-resourced by extending the reach of navigation services and ensuring that these services can be paid for over the long term. Therefore, **ACS CAN Supports S5565/A6586.**

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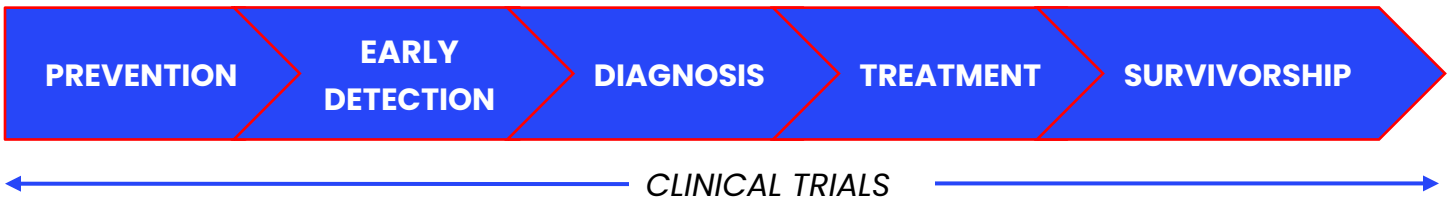
What is Patient Navigation?

In 2024, the projected number of new cancer diagnosis in the U.S. will top 2 million for the first time. This number is equivalent to about 5,480 diagnoses each day.[i] Navigating the health care system can be confusing and complicated. Making decisions after receiving a complex medical diagnosis such as cancer is challenging for anyone, but particularly for populations that have been historically marginalized. **Access to patient navigation services could help cancer patients and survivors get the care they need.**

> Patient navigation is the individualized assistance that helps a patient overcome health care system barriers from prevention and early detection of disease to accessing necessary access to quality health and psychosocial care.

The American Cancer Society (ACS) and the American Cancer Society Cancer Action Network (ACS CAN) are united in the goal of achieving health equity and access to quality care across the cancer continuum through effective patient navigation, beginning with preventive screening and early detection, and extending through diagnosis, treatment, survivorship, and end-of-life.



Why is Patient Navigation Critical?

Patient navigation can help to eliminate health disparities and reduce costs across the cancer care continuum by addressing the needs of people who have been historically marginalized and excluded as well as those living in under resourced communities. For example, one study showed that women in the patient navigation intervention group had significantly higher likelihood of being up to date on their mammography screening at the end of the follow-up period compared to women in the control group who did not receive these services, with the largest impact among African American Medicare beneficiaries living in urban areas who were previously not up to date on their breast cancer screenings.[ii] Other benefits of patient navigation include:

Access Across Cancer Care Continuum

Patient navigators have been shown to help increase cancer screenings rates, help patients better understand treatment options after diagnosis and help ensure patients receive the post treatment care they need in survivorship.[iii,iv]

Cost Savings & Treatment Adherence

Patient navigator programs help identify diagnosis at earlier stages when less invasive and less costly treatment options are available to patients, often resulting in better outcomes and reduced overall costs.[v,vi]

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Advances Health Equity

Culturally appropriate patient navigation services can improve health outcomes for diverse populations through community outreach and targeted care coordination. [ii,vii]

Patient & Provider Satisfaction

Patient navigation offers tailored patient-centered cancer care and the opportunity to prioritize unique patient needs. Patient navigation has also been shown to increase patient retention and reduce provider administrative burdens.[v]

Evidence Supporting Patient Navigation's Return on Investment

Patient navigation services have become increasingly recognized for reducing cancer costs for both patients and the health care system by:

- Increasing adherence to treatment regimens by helping patients better understand their treatment options;[vi,v]
- Reducing unnecessary resource utilization, such as costly emergency department visits and hospitalizations;[v]
- Reducing burdens on oncology providers by potentially reducing workforce burnout, provider errors, and costly staff turnover through expanding capacity to support the patient during their treatment;[v] and
- Decreasing patients moving to other health facilities for care, improving patient satisfaction, and increasing patient retention.[v]

Prior to the creation of Medicare's new Principal Illness Navigation codes, one Centers for Medicare and Medicaid demonstration project showed that costs to Medicare declined significantly for navigated patients compared with matched comparison patients, with total costs reduced by $781.29 more per quarter per navigated patient for an estimated $19 million decline per year across the network compared to the non-navigated group.[viii]

Increasing Access to Patient Navigation Services

ACS CAN has been a long-standing advocate in making patient navigation services available for everyone at risk of cancer, those diagnosed with cancer, and cancer survivors. Yet to date, patient navigation services are still absent or limited in many cancer programs and hospital settings due to cost concerns and lack of clinical reimbursement. Throughout the U.S., a patchwork of coverage exists depending on the where patients live and the type of insurance coverage they have and is not continuous throughout the cancer care continuum. Ensuring access to patient navigation services will only be achieved by ensuring payment for patient navigation services is available across both public and private payers.

Medicare's reimbursement for non-clinical navigation, which took effect on January 1, 2024, was a first step. The final 2024 Medicare Physician Fee Schedule rule created the new Principal Illness Navigation reimbursement codes for patient navigation services for Medicare enrollees diagnosed with high-risk conditions, including cancer.

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ACS CAN's Position

ACS CAN is advocating for state and federal legislation and policies to increase access to patient navigation for people with cancer, prioritizing policies that create sustainable funding to ensure patient access to patient navigation services across the cancer continuum.

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