Senate Executive

Chair Senator Mattie Hunter

January 9, 2021

Dear Honorable Committee Members,

The American Cancer Society Cancer Action Network is grateful for the work of the Illinois Legislative Black Caucus to address health disparities.

Despite the fact that US cancer death rates have decreased by 26 percent from 1991 to 2015, not all Americans have benefited equally from the advances in prevention, early detection, and treatments that have helped achieve these lower rates. Significant differences persist in cancer incidence, survival, morbidity, and mortality among specific populations in the US. Research shows that racial/ethnic minorities, individuals of lower socioeconomic status, and other medically underserved groups continue to have higher cancer rates and are less likely to be diagnosed early or receive optimal treatment compared to other groups.

The underlying causes of disparities in cancer care are complex and include interrelated social, economic, cultural, environmental, and health system factors. Geographic location (e.g. rural versus urban areas or northern states versus southern states) also contributes to disparities in cancer care.

Public policy interventions are an important strategy for substantially reducing, and ultimately eliminating, cancer disparities. In order to address gaps in health outcomes, a multi-prong approach must include enhanced prevention and early detection, increased access to coverage and treatment across all populations; and delivery of care in a culturally and linguistically competent manner. Continued research – particularly on ways to collect disparities data, implement public health interventions, and better prevent, detect, and cure many cancers that disproportionately affect medically underserved populations – is also critical.

We support the following provisions within HB3840:

- Implicit bias and racial training
- Expansion of sick leave provisions
- Increased access to primary care physicians and federal qualified health centers
- State health assessment and improvement plan additions

Implicit Bias & Racial Training:

Implicit bias and racial training seek to improve healthcare disparities by implementing the American Medical Association recommendation for healthcare staff to be trained in implicit bias. Implicit bias

training that is designed to expose people to their unconscious biases, provide tools to adjust automatic patterns of thinking, and ultimately eliminate discriminatory behaviors.

Training healthcare workers in implicit bias will not only be better for patient/provider relationships but can also help to improve patient health outcomes.

Citation:

Zhao J, Miller KD, Islami F, Zheng Z, Han X, Ma J, Jemal A, and Yabroff KR (2020). Racial/Ethnic Disparities in Lost Earnings from Cancer Deaths in the United States. JNCI Cancer Spectrum DOI: 10.1093/jncics/pkaa038

Expansion of Sick Leave Provisions:

An estimated 1.8 million cases of cancer will be diagnosed in 2020.[1] Cancer strikes at any age but for many types - including testicular (81 percent under the age of 65), thyroid (63 percent), uterine cervix (52 percent), leukemia (51 percent), and melanoma of the skin (46 percent)[2] -the median age of diagnosis is during peak employment years. Fortunately, almost 17 billion Americans are now living beyond a cancer diagnosis,[3] and nearly 40 percent of cancer survivors in the U.S. are of working age.[4] Access to health care coverage for these cancer patients and survivors is key. But to reap those benefits, people with cancer and survivors need the time necessary for treatment, recovery and follow-up.

The National Health Interview Survey (NHIS) indicates just over 6 million people with a cancer history were employed in the U.S. in 2018.[5] These individuals want to be productive employees during treatment and survivorship for many reasons – not the least of which are that working brings much needed income and often health insurance coverage. But cancer treatment is time consuming. Flexibility to balance cancer treatment and employment is essential. A 2015 study of colorectal cancer patients showed that having paid sick leave was correlated with higher rates of job retention and lower rates of financial burden.[6] A more recent study also of colorectal cancer patients confirmed that paid sick leave was significantly associated with job retention, after adjusting for socio-demographic, clinical, geographic and job characteristics.[7] Yet not all cancer patients and survivors who work have access to paid leave. NHIS data show that only 58 percent of individuals with a cancer history over the age of 18 have access to paid sick leave[8] - similar rates to previously published numbers.[9]

Paid family and medical leave is equally important to employees who care for family members with cancer. About 43.5 million Americans provide unpaid care to a loved one with a serious disability or illness like cancer.[10] Caregivers are especially important to consider in this discussion given that some paid sick day or leave options, like short-term disability insurance, are not available to employees caring for someone else. The Family and Medical Leave Act (FMLA) provides valuable help to cancer patients, survivors and caregivers by ensuring flexibility in meeting the competing needs of treatment, caregiving and employment.

But the FMLA only applies to employers with 50 or more employees and only guarantees unpaid leave.[11] Without access to paid medical leave millions of Americans in active cancer treatment, survivors and caregivers risk losing employment or not getting the care they need.

The American Cancer Society and the American Cancer Society Cancer Action Network (ACS CAN) believes and will advocate for paid family and medical leave public policies that recognize the unique needs of cancer patients, survivors and caregivers. 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.

Citation:

[1] American Cancer Society. Cancer Facts & Figures 2020. Atlanta: American Cancer Society; 2020.

[2] American Cancer Society. Cancer Treatment & Survivorship. Facts & Figures 2019-2021. Atlanta: American Cancer Society; 2019.

[3] Ibid.

[4] Zheng Z, et. al. Employer provided health benefits among cancer survivors in the United States. DOI: 10.1200/JCO.2019.37.27_suppl.155 Journal of Clinical Oncology37, no. 27_suppl(September 20, 2019)155-155. https://ascopubs.org/doi/abs/10.1200/JCO.2019.37.27_suppl.155

[5] National Center for Health Statistics. Survey Description (https://www.cdc.gov/nchs/nhis/data-questionnairesdocumentation.htm), 2018 National Health Interview Survey Public Use Data Release. Hyattsville, Maryland. Analysis performed by American Cancer Society Intramural Research team, April 7, 2020.

[6] Veenstra CM, Regenbogen SE, Hawley ST, Abrahamse P, Banerjee M, Morris AM. Association of Paid Sick Leave With Job Retention and Financial Burden Among Working Patients With Colorectal Cancer. JAMA. 2015 Dec 22 29;314(24):2688-90. doi: 10.1001/jama.2015.12383. PubMed PMID: 26717032.

[7] Veenstra, C.M., Abrahamse, P., Wagner, T.H., Hawley, S.T., Banerjee, M. & Morris, A.M. (2018). Employment Benefits and Job Retention: Evidence Among Patients With Colorectal Cancer. Cancer Med. 2018 Mar; 7(3): 736– 745. doi: 10.1002/cam4.1371.

[8] National Center for Health Statistics Ibid.

[9] Zhiyuan Zheng, Xuesong Han, Matthew P. Banegas, Jingxuan Zhao, Ashish Rai, Reginald Tucker-Seeley, Ahmedin Jemal, and K Robin Yabroff. Employer provided health benefits among cancer survivors in the United States. Journal of Clinical Oncology37, no. 27_suppl(September 20, 2019)155-155. https://ascopubs.org/doi/abs/10.1200/JCO.2019.37.27_suppl.155

[10] Family Caregiver Alliance. Caregiver Statistics: Demographics. April 17, 2019. https://www.caregiver.org/caregiver-statistics-demographics

[11] U.S. Department of Labor. Family and Medical Leave Act, Overview. Accessed April 1, 2020. https://www.dol.gov/agencies/whd/fmla

Increased access to primary care physicians and federal qualified health centers:

Primary care physicians and federal qualified health centers are the front lines of cancer prevention. Early detection of cancer through screening can improve survival and reduce mortality by detecting cancer at an early stage when treatment is more effective. Effective screening tests are available for cancers of the colon and rectum, breast, uterine cervix, and lung. In addition to early detection of cancer, screening for colorectal or cervical cancers can identify and result in the removal of precancerous abnormalities, preventing cancer altogether.

The COVID-19 pandemic has created new and worsened existing challenges to getting individuals screened for cancer. These challenges include the fact that COVID-19 rules for businesses vary by locality, so it is difficult to say whether an individual will have an easy or more difficult time accessing screening. Health care providers and facilities have limited capacity because of the stress on resources caused by the pandemic. The implementation of new safety protocols in health care facilities can further reduce capacity. In addition, there is very real fear, reluctance, and confusion among both patients and providers as to whether it is safe to access cancer screenings. Action will be needed to ensure health care providers and facilities to have the capacity and processes in place to address the unprecedented backlog of cancer screenings and address patients' concerns.

Individuals who do not have health insurance are less likely to be screened for cancer.[1] The COVID-19 pandemic has caused a staggering loss of employment and an associated loss in employer-sponsored health insurance. According to an Urban Institute study, 3.3 million non-elderly adults in the United

States lost employer-sponsored health insurance over the summer of 2020, and researchers estimate 1.9 million adults became newly uninsured from late April through mid-July.[2] In addition, a recent Avalere study found that the COVID-19 pandemic is exacerbating existing economic and health care inequalities between racial groups in the U.S., and that millions of Black, Asian, and Hispanic workers are likely to lose their employer-sponsored health insurance in 2020.[3] Efforts to insure these individuals and increase cancer screenings must reduce, not worsen, these inequities.

Citation:
[1] American Cancer Society. Cancer Prevention & Early Detection Facts & Figures 2019-2020. Atlanta: American Cancer Society; 2019.
[2] The Urban Institute. As COVID-19 Recession Extended Into Summer 2020, More Than 3 Million Lost Employer-Sponsored Health Insurance Coverage and 2 Million Became Uninsured Evidence from the Household Pulse Survey, April 23,2020–July 21, 2020. September 2020. https://www.rwjf.org/en/library/research/2020/09/as-covid-19-recessionextended-into-summer-2020-more-than-3-million-lost-employer-sponsored-healthinsurance.html
[3] Avalere. COVID-19 Projected to Worsen Racial Disparities in Health Coverage. September 2020. https://avalere.com/press-releases/covid-19-projected-to-worsen-racial-disparities-inhealth-coverage

State health assessment and improvement plan additions:

Research shows that while overall cancer mortality rates in the U.S. are dropping, populations that have been marginalized are bearing a disproportionate burden of preventable death and disease. Despite notable advances in cancer prevention, screening, and treatment, not all individuals benefit equitably from this important progress.

For example we know:

- People with lower socioeconomic status (SES) have higher cancer death rates and a higher likelihood of advanced-stage cancer diagnosis and a lower likelihood of receiving standard treatment than those with higher SES.
- Black females have 40% higher breast cancer death rates than non-Hispanic white females despite similar incidence rates.
- Death rates from lung cancer are highest in the South and parts of Appalachia for both males and females. People from the LGBTQ community may face barriers accessing culturally competent cancer care.

Health equity in cancer care means that everyone has a fair and just opportunity to prevent, find, treat, and survive cancer regardless of race, ethnicity, gender, age, sexual orientation, SES, or zip code. Addressing health equity in cancer starts with timely, complete, and accurate data on populations and demographics that are facing cancer disparities.

Cancer registries are data systems designed for the collection, management and analysis of data that can inform policy at the local, state, and national levels. However, these data are often not readily accessible, and the structure, data collection, and data sharing polices can vary from state to state. One notable gap includes a two-year delay between data collection and reporting from the Centers for Disease Control and Prevention.

ACS CAN supports funding and policies to promote timely collection and publication of demographic data that aid researchers and policymakers in identifying disparities to improve health equity in cancer prevention, detection, and treatment.

Citations:
[1] American Cancer Society. Cancer Facts and Figures, 2020. Accessed at https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/annual-cancer-factsand-figures/2020/cancer-facts-and-figures-2020.pdf
[2] American Cancer Society Cancer Action Network. Cancer Disparities: A Chartbook. Accessed at https://www.fightcancer.org/sites/default/files/National%20Documents/Disparities-inCancer-Chartbook.pdf.
[3] American Cancer Society. Lesbian, Gay, Bisexual, Transgender, Queer (LGBTQ) People with Cancer Fact Sheet. Accessed at https://www.cancer.org/content/dam/cancer-org/cancercontrol/en/booklets-flyers/lgbtq-people-with-cancer-fact-sheet.pdf.
[4] Freeman, M., Wilson, R. J., & Ryerson, B. (2017). Examination of Preliminary Cancer Surveillance Data from the National Program of Cancer Registries, Diagnosis Year 2012. Journal of registry management, 44(2), 62–68.

For more information about any of these policies, please do not hesitate to reach out at 309.645.6909 or shana.crews@cancer.org.

Respectfully submitted,

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