



**TESTIMONY
OF THE
NEW YORK PUBLIC INTEREST RESEARCH GROUP
BEFORE THE
JOINT HEARING OF THE SENATE FINANCE AND ASSEMBLY WAYS & MEANS
COMMITTEES REGARDING THE
FISCAL YEAR 2020-2021 EXECUTIVE HEALTH BUDGET PROPOSAL
January 29, 2020
Albany, N.Y.**

Good afternoon, my name is Blair Horner and I am executive director of the New York Public Interest Research Group (NYPIRG). NYPIRG is a non-partisan, not-for-profit, research and advocacy organization. Consumer protection, environmental preservation, health care, higher education, and governmental reforms are our principal areas of concern. We appreciate the opportunity to testify on the governor's executive budget on health.

HEALTH CARE COSTS AND QUALITY

The state's looming budget deficit is driven by increasing health care costs – particularly in Medicaid. The governor has directed a Medicaid Redesign Team to review the health care system for find savings of about \$2.5 billion. In all the commentary that we have seen on this topic, an important “savings” that has not been discussed is that from improving the quality of medical care.

And the costs from substandard care are well-documented. In November 1999 the Institute of Medicine report, *To Err is Human: Building a Safer Health System*, was released. It documented a veritable epidemic of preventable deaths in United States hospitals. In September 2009, the director of the US Agency for Healthcare Research and Quality, wrote this about *To Err Is Human*: “Let me be clear: I am just as frustrated as my colleagues in the public and private sectors with our slow rate of progress in preventing and reducing medical errors.”¹ Then in 2013 a widely covered study published in the *Journal of Patient Safety* reported that nearly 400,000 U.S. hospital patient deaths each year were preventable.

The costs resulting from these patient injuries and deaths are large. According to one estimate, estimate that the annual cost of measurable medical errors that harm patients was \$17.1 billion.² Since New York State is approximately 7 percent of the nation's population – and if the quality of care was universally distributed – the state's additional costs could be roughly \$1 billion. However, there is compelling evidence that the quality of health care in New York is *worse* than the rest of the nation.

New York hospital perform poorly in health quality ranking issued by the federal government.

¹ Carolyn Clancy, MD, “Patient Safety: One Decade after To Err Is Human,” *Patient Safety & Quality Healthcare*, September/October 2009. In addition, in 2010 the *New England Journal of Medicine* stated that at U.S. hospitals there was “little evidence of widespread improvement.” See: <https://www.nejm.org/doi/full/10.1056/NEJMsa1004404>.

² Jill Van Den Bos, Karan Rustagi, Travis Gray, Michael Halford, Eva Ziemkiewicz, and Jonathan Shredoi: “The \$17.1 Billion Problem: The Annual Cost Of Measurable Medical Errors,” *Health Affairs*, April, 2011. 10.1377/hlthaff.2011.0084 HEALTH AFFAIRS 30, NO. 4 (2011): 596–60.

The U.S. Department of Health and Human Services publishes an annual *Medicare.gov/Hospital Compare*, which reports the quality of the nation’s hospitals to the public.³ It gives each hospital one, two, three, four, or five quality stars, with one star-hospitals being the worst and five stars-hospitals the best. New York overall had lower quality star ratings than all the 49 other states.

In a recent report⁴ released by NYPIRG, how New York’s hospitals stacked up against the rest of the nation found:

New York State ranked poorly when compared to 16 other major urbanized states.

In New York, 34 percent of hospitals were a quality one-star in 2019. In comparison, no hospital in Indiana had a quality one star and only one percent of hospitals in Ohio were in this category. Quality one-star hospitals made up four percent in Arizona, Michigan, Texas, Virginia and Washington State, seven percent in Massachusetts, nine percent in California and Pennsylvania, ten percent in Missouri, twelve percent in New Jersey, thirteen percent in Georgia and Maryland and twenty percent in Florida.⁵

All these states had at least six million in population and were at least 70 percent urbanized.

New York hospitals were much more likely to be ranked by Medicare as “Below the national average” of quality measures than hospitals in the rest of the US

The *Medicare.gov/Hospital Compare* National Average Comparison “shows how individual hospitals perform compared to all hospitals across the country for each of the seven groups or categories of quality measures that make up the Hospital Compare overall rating.”⁶ Each hospital is given a rating of “Same as the national average,” “Above the national average” or “Below the national average.” *National Average Comparison* is based on seven groups or categories of quality measures that make up the *Hospital Compare* overall rating. Four of these categories each represent 22 percent of the weight used in the calculations:

- **Safety of Care.** Sixty-nine percent of New York City hospitals, 60 percent of Nassau-Suffolk-Westchester counties’ hospitals and 41 percent of Upstate hospitals rated “Below the national average.”
- **Readmission.** Ninety-seven percent of New York City hospitals, 87 percent of Nassau-Suffolk-Westchester counties’ hospitals and 49 percent of Upstate hospitals were rated “Below the national average.”
- **Patient Experience.** Ninety-four percent of New York City hospitals 60 percent of the Nassau-Suffolk and Westchester counties’ hospitals and 60 percent of Upstate hospitals were “Below the national average.”
- **Mortality.** This is the only category in which New York hospitals ranked as well as other U.S. hospitals.

New York City hospitals had a disproportionate number of one-star rankings when compared with other US major cities.

When comparing all cities with a population of at least 300,000 in the northeastern and northcentral US: 66 percent of hospitals New York City, 44 percent in Chicago, 33 percent in Detroit, 25 percent in

³ According to Data.Medicare.gov, “Hospital Compare data was last updated on October 30, 2019.” See: <https://data.medicare.gov/data/hospital-compare>

⁴ NYPIRG, “Code Blue,” December 2019, https://www.nypirg.org/pubs/201912/Code_Blue_report.pdf.

⁵ Op. cit. See: <https://data.medicare.gov/data/hospital-compare>

⁶ See: <https://www.medicare.gov/hospitalcompare/details.html?msrCd=prnt9grp1&ID=330088>

Pittsburgh, 21 percent in Philadelphia, and 8 percent in Baltimore had only one quality star. There were no one-star hospitals in Indianapolis, Boston, Cleveland, Cincinnati, or Columbus.

When comparing all cities with a population of at least 750,000: 17 percent of hospitals in Jacksonville, 14 percent in Austin, 11 percent in San Francisco, 9 percent in San Antonio, 7 percent in Los Angeles, and 6 percent in Houston had one quality star. There were no one-star quality hospitals in Charlotte, Dallas, Fort Worth, Phoenix, San Diego, or Seattle.⁷

New York City, the suburbs (Nassau-Suffolk-Westchester counties) and Upstate all had comparatively high percentages of low-quality hospitals.

Seventy-eight percent of hospitals in New York City, 60 percent in the suburbs and 57 percent in Upstate had only one or two quality stars.

The Medicare.gov/Hospital Compare findings are consistent with those of other hospital reviews.

In Fall 2019 the nonprofit *Leapfrog Hospital Safety Grade* reported that only seven percent of New York hospitals received an “A” (out of an A, B, C, D or F) compared to 33 percent of US hospitals, and only four small states scored lower than New York. In 2019 *IBM Watson Health* “100 top-performing hospitals” did not include a New York hospital. *Healthgrades* reported in its 2019 “America’s 250 Best Hospitals” that New York had seven of these hospitals, but California had 41 and there were 25 in Ohio, 14 in Virginia, 11 in Illinois, 10 in North Carolina and Florida, nine in Maryland, and eight in Arizona and in Michigan.

Why do New York hospitals perform comparatively so much worse?

In July 2019 Erica Mobley, director of Leapfrog Group, explained what she knew about New York’s hospital safety:

“The system as a whole didn’t seem to have emphasized safety. We’ve seen other states work together and look at what’s working well at other states and implement it. It just doesn’t seem to be happening in New York. It has to be front of mind every single day in a hospital.”⁸

The NYPIRG report does not dig deeper into the federal quality ranking system to analyze hospital care in New York, but its findings do raise questions for policymakers who are responsible for protecting hospital patients as well as the public who foots the bill for the additional costs resulting from poor quality care.

- Why did New York State hospitals rank so poorly?
- What has the New York Department of Health done to respond to the national rankings that have consistently found poor quality in state hospitals?
- Should New York annually compile patient outcome data and ensure that all patients have access to it?
- What progress has New York State made in meeting its goal to reduce by half New York’s hospital patients’ injuries and deaths, a promise made nearly 20 years ago?
- Will state lawmakers – who have the oversight responsibility of the health care system – convene public hearings to explore New York’s stunningly poor performance in the national quality of care rankings?

⁷ Unlike these cities, 60 percent of San Jose hospitals had one-star.

⁸ See p 4: <https://www.cityandstateny.com/articles/policy/health-care/why-new-york-hospitals-have-terrible-federal-rankings.html>

- Twenty-five years ago, New York established the nation’s most advanced system of examining hospital quality with its Risk-Adjusted Cardiac Bypass Mortality program. Why has so little been done to modernize and expand that approach to other procedures, as well as provide “real time” performance information to patients?

CANCER CONTROL; TOBACCO AND VAPING

Virtually all New Yorkers have had an experience with cancer. According to the U.S. Centers for Disease Control and Prevention (CDC), cancer is the second leading cause of death in America.⁹ *As seen below, the top five cancer killers account for more than half of all the estimated cancer deaths.*

Estimated Number of New Cancer Cases and Cancer Deaths Exceeding 1,000, Calendar Year 2020 in New York¹⁰

Type of Cancer	New Cases	Deaths
<i>Total, all sites</i>	<i>117,910</i>	<i>34,710</i>
Lung & Bronchus	13,370	6,510
Colon & Rectum	8,910	2,950
Pancreas	3,750	2,890
Female Breast	17,540	2,430
Prostate	11,470	1,850
Liver & IBD	2,670	1,610
Leukemia	4,600	1,370
Non-Hodgkin Lymphoma	5,120	1,230
Urinary Bladder	5,590	1,080

Breast cancer is the leading form of cancer affecting women and the second biggest cancer killer of women. Yet, it is not the leading cause of cancer deaths for women. Prostate cancer is a leading cause of cancer in men, but it is not the leading cause of cancer deaths in men. *That terrible distinction belongs to lung cancer.*

As you see in the above chart, lung cancer is what drives cancer deaths in New York State: *One-quarter of all cancer deaths result from lung cancer.* It is a cancer that is deadly, and that afflicts men and women alike. It is also a cancer for which we know how to dramatically reduce its impact: by reducing the use of tobacco products.

The leading cause of lung cancer is tobacco use. Today nearly 9 out of 10 lung cancers are caused by smoking cigarettes.¹¹ Not only are smokers at risk, but even non-smokers can be afflicted by exposure to tobacco smoke. In the U.S., more than 7,300 nonsmoking lung cancer patients die each year from exposure to secondhand smoke alone.¹²

⁹ U.S. Centers for Disease Control and Prevention, “Leading Causes of Death,” <http://www.cdc.gov/nchs/fastats/leading-causes-of-death.htm>.

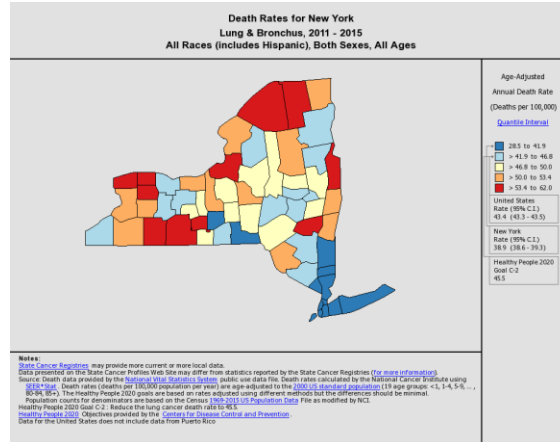
¹⁰ American Cancer Society, Cancer Facts & Figures, Supplemental Data, see: <http://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/annual-cancer-facts-and-figures/2020/estimated-number-of-new-cancer-cases-and-deaths-by-state-2020.pdf>.

¹¹ Smoking also causes cancers of the esophagus, larynx, mouth, throat, kidney, bladder, liver, pancreas, stomach, cervix, colon, and rectum, as well as [acute myeloid leukemia \(1-3\)](https://www.cancer.gov/about-cancer/causes-prevention/risk/tobacco/cessation-fact-sheet#q2). Source: National Cancer Institute, available at <https://www.cancer.gov/about-cancer/causes-prevention/risk/tobacco/cessation-fact-sheet#q2>.

¹² U.S. Centers for Disease Control and Prevention, “Secondhand Smoke Facts, 2015”: https://www.cdc.gov/tobacco/data_statistics/fact_sheets/secondhand_smoke/general_facts/index.htm.

Before we go into more detail about the governor’s failure to do anything to improve – much less meet – the scientifically-identified goals for how much money the state of New York should spend on fighting lung cancer, we reviewed the impact of lung cancer throughout New York State. As you can see below, lung cancer mortality rates tend to be higher in upstate counties.¹³

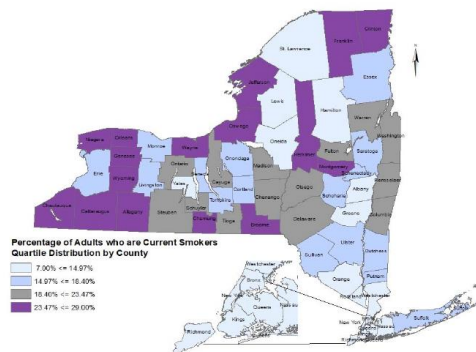
NEW YORK STATES COUNTIES’ LUNG CANCER MORTALITY RATES¹⁴



As seen below, given the causal relationship between lung cancer and smoking, it is not surprising that the smoking rates tend to be higher in upstate New York than downstate.

NEW YORK COUNTIES’ ADULT SMOKING RATES¹⁵

Prevalence of Current Smoking Among Adults in NY by County
NYS BRFSS 2016



Unfortunately, the governor’s executive budget is inadequate in how it combats the leading cause of cancer deaths. The executive budget adds no new revenues to the state’s program designed to combat tobacco use. Indeed, the state’s tobacco control program now has less than 50 percent of the funding it received a few

¹³ Cancer is not the only disease that can result from tobacco use, see: https://www.cdc.gov/tobacco/data_statistics/fact_sheets/health_effects/effects_cig_smoking/index.htm.

¹⁴ National Cancer Institute: <https://statecancerprofiles.cancer.gov/map/map.withimage.php?36&001&047&00&0&02&0&1&5&0#results>.

¹⁵ Source: New York State Department of Health, https://www.health.ny.gov/prevention/tobacco_control/reports/statshots/volume11/n4_current_adult_smoking_by_county.pdf.

years ago, and less than 20 percent of the amount recommended by the CDC.¹⁶ New York State has slashed its investment in the best way to reduce lung cancer incidence and mortality. *New York State, once ranked 5th in the nation in funding its anti-smoking efforts, has slipped to 23rd.*¹⁷ Indeed, when adjusted for inflation, New York State spends less now on its tobacco control program than at any other time.¹⁸

It is simply indefensible that the state’s response to the leading cause of cancer deaths among men and women has suffered drastic cuts. These funding reductions are even more inexcusable when examining the amount of money that tobacco use generates for the state’s coffers.

The money is available. In addition to the estimated \$1.1 billion raised in tobacco taxes, the state is now expecting new revenues from the state’s master settlement agreement (MSA). The MSA is an agreement to settle litigation between the nation’s largest cigarette companies and 46 states. The MSA requires those cigarette companies to, among other things, annually pay billions of dollars to the states as compensation for the health costs to their Medicaid programs resulting from tobacco use.

NYPIRG urges you to use that money to fully fund tobacco control and other cancer-prevention programs. The MSA revenues were promised to help curtail the carnage caused by tobacco use. Sadly, too little has been done. This budget provides you an opportunity to reverse New York’s years of neglect.

Banning flavored vaping and other restrictions

The governor proposes a number of measures to reduce the use of flavored vaping products and places other restrictions on minors’ access. Among the measures, there is a

- Prohibition of the sale of any flavored electronic cigarettes, liquid nicotine, or vapor products, except for tobacco flavored;
- Prohibition of the sale of tobacco products, herbal cigarettes, vapor product or electronic cigarettes in a pharmacy or in a retail establishment that contains a pharmacy;
- Prohibition of the acceptance of price reduction instruments for both tobacco products and e-cigarette;
- Prohibition of the display of tobacco products or electronic cigarettes in stores;
- Prohibition of vapor product advertisements targeted at youth; and
- Require manufacturers of vapor products to submit a list of ingredients to the Commissioner for publication.

According to the New York State Department of Health, 35,000 high school students smoke and the average age of beginning smokers is 13.¹⁹ Flavored tobacco products are widely considered to be “starter” products, establishing smoking habits that can lead to a lifetime of addiction, according to the U.S. Food and Drug

¹⁶ U.S. Centers for Disease Control and Prevention, “Best Practices for Tobacco Control Programs, 2014,” see: https://www.cdc.gov/tobacco/stateandcommunity/best_practices/pdfs/2014/comprehensive.pdf, p. 110.

¹⁷ Report issued jointly by the American Cancer Society, American Heart Association, American Lung Association and the Campaign for Tobacco Free Kids, et al, “Broken Promises to Our Children: A State-by-State Look at the 1998 State Tobacco Settlement Agreement, 20 Years Later,” 2018, see: <https://www.tobaccofreekids.org/what-we-do/us/statereport/new-york>.

¹⁸ For a more detailed examination of the state’s tobacco control program, see the report “Dissipated” at www.nypirg.org.

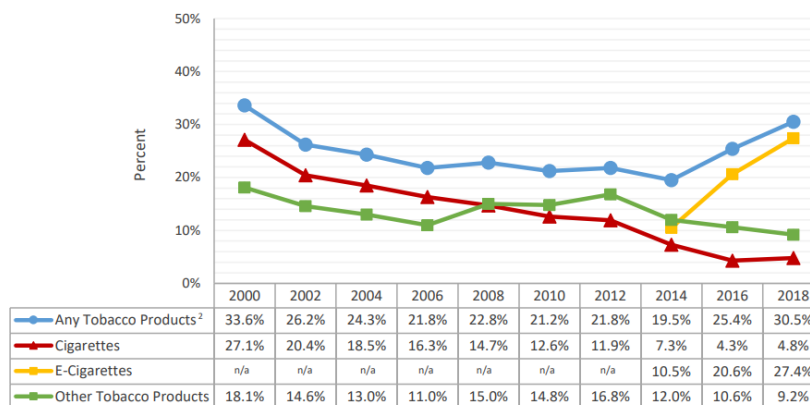
¹⁹ New York State Health Department, See https://www.health.ny.gov/prevention/tobacco_control/.

Administration (“FDA”).²⁰ That is why the FDA banned the sale of most – but not all – flavored cigarettes.²¹ It allows menthol flavors and continued to allow the sale of flavored non-cigarette tobacco products. The result has been the continued addiction of children to dangerous tobacco products. **As seen below, the Journal of the Medical Association has found that the overwhelming number of minors who start using tobacco do so by using a flavored product.**²²



And while it is true that flavored vaping products are a growing threat, as seen below, according to the New York State Department of Health a significant percentage of youth tobacco users rely on flavored products.²³

Trends in Any Tobacco Product Use among High School Students³ in NYS, 2000-2018



²⁰ The U.S. Food and Drug Administration, “Fact Sheet: Flavored Tobacco Products,” See <https://www.amadorgov.org/home/showdocument?id=6624>.

²¹ In 2009, Congress enacted the *Family Smoking Prevention and Tobacco Control Act*, which banned the use of flavors other than menthol in cigarettes. Other tobacco products, including “little cigars” (cigarettes wrapped in paper containing tobacco), snuff and other smokeless tobacco products were not included in the prohibition.

²² Ambrose, BK, et al., “Flavored Tobacco Product Use among US Youth Aged 12-17 Years, 2013-2014,” *Journal of the American Medical Association*, published online October 26, 2015.

²³ New York State Health Department, Bureau of Tobacco Control StatShot Vol. 11, No. 5/Oct 2018 Trends in Any Tobacco Product Use among High School Students in NYS, 2000-2018 Electronic Cigarette Use by Youth Increased 160% Between 2014 and 2018, See https://www.health.ny.gov/prevention/tobacco_control/reports/statshots/volume11/n5_e-cigarette_use_by_youth.pdf.

Historically, cigar manufacturers designed flavored cigars to serve as “starter” smokes for youth and young adults because the flavorings helped mask the harshness, making the products easier to smoke.²⁴ Recently, there has been an explosion of cheap, flavored cigars.²⁵

Menthol-flavored tobacco products have been particularly enticing. Flavors improve the taste and reduce the harshness of tobacco products, making them more appealing and easier for beginners to try the product and ultimately become addicted.²⁶ Menthol cools and numbs the throat, reducing the harshness of cigarette smoke, thereby making menthol cigarettes more appealing to youth who are initiating tobacco use.²⁷

This bill fills the gap left by the 2009 federal law and will add to New York’s strong record of youth tobacco use prevention. Moreover, this legislation would remove from the marketplace flavored varieties of tobacco products that have been found to be most appealing to children and appear to be targeting the illegal youth or “starter” market. New York must continue its efforts to combat smoking and tobacco use among minors and reduce the substantial risk that youthful experimentation will lead to a long-term, deadly habit for thousands of youngsters each year.

NYPIRG urges your support of the ban on flavored e-cigarettes. However, we urge that this ban be extended to all tobacco products. The dangers posed are the same.

CURBING THE GROWTH OF ANTIBIOTICS RESISTANCE

Antibiotics might rightfully be considered one of the medical miracles of the last century because of their powerful ability to fight illness and disease caused by bacteria. However, due to their overuse and misuse in humans and animals, many strains of bacteria have evolved resistance to medically important antibiotics, meaning they are not killed by the drugs. Instead, they survive, multiply, and spread. In fact, the more antibiotics are used, the faster antibiotic-resistant bacteria (aka “superbugs”) develop, putting more people around the world at increased risk of contracting an antibiotic-resistant infection. The spread of antibiotic resistance knows no geographic boundaries. And it is already compromising our ability to treat and prevent disease, especially in those who are typically more vulnerable – children, seniors, and those with compromised immune systems.

Antibiotic-resistant bacteria are most prevalent in environments associated with high antibiotic use: healthcare settings, the general community, and in livestock production. Antibiotic resistance can spread from person to person, from animal to person, via the natural environment or contaminated food and from bacteria to bacteria. Some bacteria have developed resistance to multiple antibiotics, making them especially difficult to treat, and thus very dangerous and sometimes deadly. Common infectious diseases such as tuberculosis, pneumonia, blood poisoning, food poisoning, and gonorrhea have already become harder and sometimes impossible to treat due to multidrug-resistant bacteria.

In recognition of the serious threat to public health posed by antibiotic-resistant infections, members of the U.N. General Assembly in 2016 committed to taking collaborative action.²⁸ The World Health Organization considers

²⁴ See e.g., Marketing Innovations, “Youth Cigarette - New Concepts,” Memo to Brown & Williamson, September 1972, Bates No. 170042014; R.J. Reynolds Tobacco Company, “Conference report #23,” June 5, 1974, Bates No. 500254578-4580; R.J. Reynolds Inter-office Memorandum, May 9, 1974, Bates No. 511244297-4298.

²⁵ Delnevo, CD, et al., “Changes in the mass-merchandise cigar market since the Tobacco Control Act,” *Tobacco Regulatory Science*, 3(2 Suppl 1): S8-S16, 2017. [In Press]

²⁶ HHS, Preventing Tobacco Use Among Youth and Young Adults, A Report of the Surgeon General, 2012.

²⁷ FDA, Preliminary Scientific Evaluation of the Possible Public Health Effects of Menthol versus Nonmenthol Cigarettes, 2013.

²⁸ United Nations, see: <https://digitallibrary.un.org/record/842813?ln=en>

it to be one of the biggest threats to global health, food security, and international development today.²⁹ The U.S. Centers for Disease Control and Prevention (CDC) has stated that fighting this threat is a public health priority and estimates that each year, **at least 2 million people in the U.S. become infected with antibiotic-resistant bacteria and as many as 162,000 of them die from it.**³⁰ A study commissioned by the U.K. government predicts that if action is not taken now to combat antibiotic resistance, **by 2050 the annual death toll will have risen to 10 million globally.**³¹ Most major medical and health groups in the U.S., including the American Medical Association, American Academy of Pediatrics, and Infectious Diseases Society of America, have recognized the urgency of the antibiotic resistance crisis.³²

Antibiotic Resistance and Food Safety

For almost 70 years we have been giving antibiotics to the animals we eat for food. To date, the U.S. Food and Drug Administration (FDA) has approved 41 antibiotics for use in food-producing animals, 31 of which are medically important for humans. According to FDA's 2017 data on domestic sales of medically important antibiotics, 65% of them are sold for use in livestock.³³ When antibiotics are given to food-producing animals, they kill most of the bacteria in them. The resistant bacteria, however, survive and can contaminate animal products during slaughtering and processing. They can also contaminate fruits and vegetables via contaminated soil or water, especially when animal manure is used as fertilizer. Antibiotic-resistant bacteria can contaminate food prepared on germ-filled surfaces and the environment via animal feces. According to the CDC, **approximately 1 in 5 antibiotic-resistant infections are caused by germs from food and animals.**³⁴ **Salmonella and Campylobacter—bacteria that commonly contaminate food—cause approximately 410,000 antibiotic-resistant infections in the U.S. each year.**³⁵

In 2013-14, one of the largest outbreaks of multidrug-resistant *Salmonella* infections—which sickened 634 people in 29 states and Puerto Rico—was traced back to consumption of a particular chicken brand that had been contaminated with the resistant bacteria.³⁶ A recent study of packaged chicken samples and patients with urinary tract infections (UTIs) in Flagstaff, Arizona, showed evidence that some of the patients had gotten their infections from *E. coli* that had originated in poultry. Moreover, these *E. coli* strains were more likely than others to be resistant to tetracycline and gentamicin, two of the antibiotics used in poultry production. This supports the observations of many previous studies that the use of antibiotics in food-producing animals creates antibiotic-resistant bacteria that can infect humans.³⁷

²⁹ World Health Organization, “Antibiotics Resistance,” see: <https://www.who.int/news-room/factsheets/detail/antibiotic-resistance>

³⁰ U.S. Centers for Disease Control and Prevention, “Antibiotic/Antimicrobial Resistance,” see: <https://www.cdc.gov/drugresistance/index.html>

Burnham JP, et al. (2019). “Re-estimating annual deaths due to multidrug-resistant organism infections,” *Infection Control & Hospital Epidemiology* 2019, 40, 112–113. doi: 10.1017/ice.2018.304, see: https://www.cambridge.org/core/services/aop-cambridge-core/content/view/C9B09A787FCCA1EA992AF45066F3FF7C/S0899823X18003045a.pdf/reestimating_annual_deaths_due_to_multidrugresistant_organism_infections.pdf.

³¹ World Health Organization, see: <https://www.who.int/bulletin/volumes/94/9/16-020916/en/>.

³² U.S. Centers for Disease Control and Prevention, “Joint Statement on Importance of Outpatient Antibiotic Stewardship,” see: <https://www.cdc.gov/getsmart/community/partners/joint-statement.html>

³³ Natural Resources Defense Council, “Livestock Antibiotic Sales See Big Drop, but Remain High,” see: www.nrdc.org/experts/avinash-kar/livestock-antibiotic-sales-drop-remain-very-high

³⁴ U.S. Centers for Disease Control and Prevention, see: <https://www.cdc.gov/foodsafety/pdfs/ar-infographic-508c.pdf>.

³⁵ U.S. Centers for Disease Control and Prevention, “Antibiotic Resistance Threats in the United States, 2013,” see: <https://www.cdc.gov/foodsafety/pdfs/ar-infographic-508c.pdf>.

³⁶ U.S. Centers for Disease Control and Prevention, “Multistate Outbreak of Multidrug-Resistant *Salmonella* Heidelberg Infections Linked to Foster Farms Brand Chicken,” see: <https://www.cdc.gov/salmonella/heidelberg-10-13/index.html>

³⁷ *Wired*, “The Hidden Link Between Farm Antibiotics and Human Illness,” see:

Antibiotic Resistance in New York State

In response to the emerging crisis, Governor Cuomo and New York State Department of Health launched the NYS Antimicrobial Resistance Prevention and Control Task Force, which released a report in November 2018 detailing the severity of the problem and recommending a series of solutions for the healthcare, veterinary, and agriculture communities.³⁸ The task force acknowledged that antibiotic resistance reduces quality of life, undermining ability to fight infectious disease and prevent complications related to surgeries and complex care such as chemotherapy, dialysis, and organ transplants. It also noted that antibiotic resistance is an economic burden, costing the U.S. up to \$20 billion in excess direct healthcare costs and costs of up to \$35 billion due to lost productivity. In addition to recommending that the State pursue policies that promote the highest standards of animal care and limit the inappropriate use of antibiotics in livestock, it also suggested a ban on over-the-counter sales of medically important antibiotics marketed for use in fish, since antibiotic use is currently not regulated in commercial aquaculture.³⁹

At its first summit, the Task Force identified limiting the use of medically important antibiotics in food-producing animals as one of the top three priorities for preventing the emergence of antibiotic resistance. It was also suggested that legislation be enacted to eliminate the use of medically important antibiotics in livestock production and that regulations be passed requiring all NYSDOH-licensed hospitals and SUNY facilities to purchase food sourced exclusively from animals raised without use of medically important antibiotics.⁴⁰

In order to respond to the antibiotics resistant “superbugs,” NYPIRG urges you to expand the governor’s proposal by including a response to the problem on farms – sites in which 20 percent of antibiotic resistance occurs.

First, place restrictions on the use of antibiotics in food-producing animals and create a regular reporting system. Require that medically important antimicrobials (those also used by humans) shall not be administered to a food-producing animal unless ordered through a prescription or a Veterinary Feed Directive given by a licensed veterinarian who has visited the farm operation within the previous 6 months. Prohibit the use of medically important antimicrobials in food-producing animals solely for growth promotion, improved feed efficiency, or feed prevention. Medically important microbials can be used only for the purpose and duration specified by a veterinarian.

Also, establish annual reporting requirements for veterinarians that prescribed, provided, or administered medically important antimicrobials to food-producing animals. It requires the New York State Board of Veterinary Medicine to develop antimicrobial stewardship guidelines and best management practices for veterinarians, livestock owners, and their employees. Moreover, require relevant New York State agencies to coordinate with federal agencies in antimicrobial resistance surveillance efforts.

DOCTOR DISCIPLINE

Require that all health facilities and physicians’ offices post information on how patients and other members of the public can access the physician profiles program. The public should have easy access to physicians’ background information. Such a requirement would allow consumers to have access to the website that would allow them to file a complaint against a doctor or other relevant health provider (http://www.health.ny.gov/professionals/doctors/conduct/file_a_complaint.htm), ensure that patients are aware of the state’s physician profiles resource (www.nydoctorprofiles.com), and provide access to the

<https://www.wired.com/story/farm-antibiotics-human-illness-hidden-link/>

³⁸ New York State Department of Health, “The NYS STop Antibiotic Resistance Roadmap (STARR),” see:

https://www.health.ny.gov/professionals/protocols_and_guidelines/antibiotic_resistance/docs/nys_starr.pdf.

³⁹ *Ibid.*

⁴⁰ NYS Department of Health, “New York State Antimicrobial Resistance Prevention and Control Task Force Summit, December 7, 2016,” see:

http://update.nyshfa.org/attachment/1003/mm16-492a.pdf?g_download=1

OPMC database of its actions against doctors and other providers (<http://www.health.state.ny.us/nysdoh/opmc/main.htm>). In addition, all patients of physicians who have had any limitation on their license must be notified in a timely manner.

Both the IoM and the State Health Department have recommended that physicians be recertified to assure that they continue to practice as competent professionals. Over time, physicians may see some of their skills erode and it is increasingly hard but critically important for them to keep current with the latest medical research and advances in technology. In an effort to identify physicians with eroding skills before a patient gets harmed, a system of recertification based on evaluating competency should be required as a condition of continued licensure.

HEALTH INSURANCE

Support a three-year extension for the New York State Health Exchange. As you know, the numbers of New Yorkers who lack health insurance is considerable. According to the Office of the State Comptroller, US Census Bureau, in 2017 4.9 percent of state residents were uninsured. This represents both the lowest percentage and number of New Yorkers who lacked health insurance since 1999.⁴¹

What has happened to drive down the number of uninsured? Nationally, until recent efforts to destabilized the Affordable Care Act, the percentage of Americans without health insurance was at the lowest since 2009,⁴² but given the fact that many states have been slow to embrace reforms, the national impact is hard to assess. However, the drop in the percentage of the uninsured has followed the timeline of the implementation of the federal health care law. Starting in the fall of 2010, coverage under the law started to kick in. Thus, it seems reasonable to conclude that the changes brought about by the Affordable Care Act (ACA) contributed to New York's decline.

The United States spends 17.9 percent of the Gross National Product on health care⁴³ yet ranks 27th of the 38 member Organisation for Economic Co-operation and Development (OECD member nations in life expectancy.⁴⁴ It is clear that American health care is expensive and yet doesn't deliver on its most basic mission, providing coverage to all those who need it. Public policy must ensure coverage for all residents.

Despite the demonstrable successes of the Affordable Care Act, many in need are left without health insurance. As mentioned earlier, 4.9 percent of New Yorkers still lack health insurance. And while this represents both the lowest percentage and number of New Yorkers who lacked health insurance since 1999, more must be done.

For those without health insurance, serious illnesses can be deadly. For example, cancer. Research suggests that nearly four percent of cancer patients are uninsured at the time of diagnosis.⁴⁵ Equally troubling, about one-third of cancer survivors report a loss of health insurance at some point in time since their diagnosis.⁴⁶

⁴¹ New York State Office of the State Comptroller, "7 Million and Counting; More New Yorkers Benefit from State Health Coverage," September 2018, see: <https://osc.state.ny.us/reports/health/state-health-coverage.pdf>.

⁴² Ibid.

⁴³ U.S. Center for Medicare and Medicaid Services, <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html>.

⁴⁴ Organisation of Economic Co-operation and Development, <http://www.oecdbetterlifeindex.org/topics/health/>.

⁴⁵ Thorpe KE, Howard D. "Health Insurance and Spending Among Cancer Patients" *Health Affairs* 2003. *W3*; 189-198.

⁴⁶ Indiana University, "Number of newly diagnosed cancer patients without insurance drops in first year of ACA," October 19, 2017, <https://news.iu.edu/stories/2017/10/iub/releases/19-cancer-affordable-care-act.html>.

For these individuals and their families, the cost of fighting cancer may mean choices that could lead to huge debts under the best of circumstances. The first concern of someone diagnosed with cancer is what are the chances of a recovery? For many, the cost of treatment will also become a top priority in surviving. According to the federal government, cancer is one of the five most costly medical conditions in the United States, forcing many patients to make decisions about their health based on their personal finances.⁴⁷

While some individuals diagnosed with cancer have meaningful and adequate health insurance to cover most of the cost of treatment, the uninsured and an increasing number of privately insured individuals face the prospect of crippling out-of-pocket costs. Financial barriers that delay treatment for cancer can mean the difference between life and death.

Cancer patients face deductibles, copayments, and other cost-sharing requirements, often compelling them to make difficult decisions in order to make ends meet. The burden is greater for cancer patients, who pay more out of pocket for care than those with other chronic illnesses. For example, 13 percent of nonelderly cancer patients spend at least 20 percent of their income on out-of-pocket expenses. Fifty percent of Medicare beneficiaries with cancer pay at least 10 percent of their income towards cancer treatment-related out-of-pocket costs.⁴⁸

Even with the expansion of coverage under the Affordable Care Act, many Americans still faced financial strains from medical costs. Even those with coverage face uncertainties, “roughly 20 percent of people under age 65 with health insurance nonetheless reported having problems paying their medical bills over the last year. By comparison, 53 percent of people without insurance said the same.”⁴⁹

Of course, the full-throated attack by the Trump Administration and its Congressional allies on the expansion of health insurance, makes it clear that states need to protect their gains. In the executive budget, the governor proposes to codify certain ACA provisions and state regulatory protections into law, including protections for people with preexisting conditions, a mandate for essential benefits, and putting into law the New York State of Health Marketplace.

Government must ensure coverage for all, including immigrants. We urge your support for the Affordable Care Act as well as your support for the creation of a **Commission on Universal Access to Healthcare**.

PRESCRIPTION DRUG PRICES

The problem of rising costs for prescription drugs is real and complicated. The executive budget proposes that the state comprehensively regulate Pharmaceutical Benefit Managers. NYPIRG agrees, but more should be done.

For example, for those who lack health insurance, or have inadequate pharmaceutical coverage, drugs costs can be excessive. New York State enacted a law that established a website to check the price of any one of

⁴⁷ U.S. Agency for Healthcare Research and Quality, “Statistical Brief #471: Top Five Most Costly Conditions among Adults Age 18 and Older, 2012: Estimates for the U.S. Civilian Noninstitutionalized Population,” https://meps.ahrq.gov/data_files/publications/st471/stat471.shtml.

⁴⁸ Zafar, S.Y., “Financial Toxicity of Cancer Care: It’s Time to Intervene,” The Journal of the National Cancer Institute, December 11, 2015, <https://academic.oup.com/jnci/article/108/5/djv370/2412415>.

⁴⁹ Sanger-Katz, M., “Even Insured Can Face Crushing Medical Debt, Study Finds,” The New York Times, January 5, 2016, <https://www.nytimes.com/2016/01/06/upshot/lost-jobs-houses-savings-even-insured-often-face-crushing-medical-debt.html>.

the 150 most prescribed drugs – in order to help them to shop for the lowest cost. In addition, the law required pharmacies to post a sign of the availability of that website.⁵⁰

In order to examine the price differences in each region of the state, NYPIRG searched the most current pricing information contained in the Department’s database as available on the state’s website. In addition, we “spot checked” pharmacies’ compliance with the requirement to publicize the website address.

We found that there were huge price differences by region. Our review shows surprisingly large ranges in the retail prices of drugs *within* geographic regions.

- In the city of **Albany**, the drug Advair Diskus had the greatest range in price, from a high of \$417.97 to a low of \$263.99 – a difference of \$153.98.
- In the city of **Binghamton**, the drug Advair Diskus had the greatest range in price, from a high of \$417.97 to a low of \$277.94 – a difference of \$140.03.
- In the city of **Buffalo**, Ventolin HFA Inhaler had the greatest range in price, from a high of \$177.17 to a low of \$44.59 – a difference of \$132.58.
- In the city of **Ithaca**, the drug Nexium had the greatest range in price, from a high of \$292.99 to a low of \$201.32 – a difference of \$91.67.
- In the city of **Rochester**, the drug Advair Diskus had the greatest range in price, from a high of \$389.99 to a low of \$230.99 – a difference of \$159.
- In the city of **Syracuse**, the drug Nexium had the greatest range in price, from a high of \$348.97 to a low of \$188.99 – a difference of \$159.98.
- In suburban counties surrounding New York City we examined three communities. In **Suffolk** County, in Commack the drug with the greatest range in price – Nexium, from a high of \$304.99 to a low of \$188.43 – a difference of \$116.56. In **Nassau** County, in Hempstead the drug with the greatest range in price was Advair Diskus, from a high of \$379.29 to a low of \$225 – a difference of \$154.29. In **Westchester** County, in White Plains the drug with the greatest range in price was Advair Diskus, from a high of \$411.50 to a low of \$253.32 – a difference of \$158.18.
- Within New York City we examined areas contained in or near zip codes in each borough.
In one area in the **Bronx** the drug with the greatest range in price was Advair Diskus, from a high of \$350.50 to a low of \$267.39 – a difference of \$83.11.
In one area in **Brooklyn** the drug with the greatest range in price was Advair Diskus, from a high of \$346.49 to a low of \$230.99 – a difference of \$115.50.
In one area in **Manhattan** the drug with the greatest range in price was Advair Diskus, from a high of \$467.75 to a low of \$260 – a difference of \$207.75.
In one area in **Queens** the drug with the greatest range in price was Lantus Solostar, from a high of \$188.05 to a low of \$123.72 – a difference of \$64.33.
In one area in **Staten Island** the drug with the greatest range in price was Advair Diskus, from a high of \$396.19 to a low of \$283.99 – a difference of \$112.20.

These price differences within the regions of New York underscore the financial threat posed to residents who lack prescription drug coverage. For those individuals, checking the state’s website can save a bundle. But that can only work if they know of the website’s existence.

NYPIRG’s review found many pharmacies appear to fail to display the drug price website address, as required by law. NYPIRG conducted a spot check of pharmacies across New York State, including in the

⁵⁰ New York State Education Department, Office of the Professions, [Questions and Answers About Pharmacists and Pharmacies](http://www.op.nysed.gov/prof/pharm/pharmqa703.htm), July 10, 2003, <http://www.op.nysed.gov/prof/pharm/pharmqa703.htm> and the New York State Department of Health, <https://apps.health.ny.gov/pdpw/Faq.action#Q1>.

regions of Albany, Buffalo, Manhattan, Nassau, Queens, Rochester, and Syracuse, to test whether consumers could easily find the required website posting as required under state law. We found 12 of 29 pharmacies that had signs displaying the state’s drug price website. In addition, when the web address was observed, it was difficult to understand the value of the site and the URL itself was difficult to remember.

Our “spot check” price check and review of compliance raises serious concerns about the program. Despite its existence for over a decade, wide price variations continue, and pharmacies appear to ignore the requirement that the web address for the state’s pricing website be posted at or near the checkout counter. Without that notice, New Yorkers simply cannot benefit from the price comparison law.

Moreover, we urge the New York State Education Department’s Board of Pharmacy to immediately review whether the anecdotal violations of the disclosure requirement are, in fact, widespread across the state.

REGULATE PHARMACEUTICAL MANAGERS

NYPIRG urges your support for the executive budget proposal to regulate Pharmaceutical Benefit Managers. Pharmacy Benefit Managers (PBMs), the pharmaceutical “middlemen,” arrange sales programs between drug manufacturers and health care plan providers (such as state health benefit programs, large businesses, and HMOs) seeking to reduce the cost of their prescription drug plans. PBMs provide pharmacy coverage to more than 266 million American consumers⁵¹; three PBMs— ExpressScripts, CVSHealth (also referred to as “CVS Caremark”) and OptumRx – controlling approximately 80% % of the lucrative market.⁵² Since 2003, the two largest PBMs—Express Scripts and CVS Caremark— have seen their profits increased by almost 600% from \$900 million to almost \$6 billion.⁵³ Despite the impact of PBMs on health care spending, tremendous secrecy surrounds how PBMs conduct business. Investigations by both the federal and state governments charge that PBMs exploit their ability to negotiate secret deals and increase their revenues without passing cost savings on to clients.

The problem with PBMs is that they are not the impartial third parties they present themselves as. Many PBMs have relationships with pharmaceutical companies that give them incentives to sell certain drugs in exchange for rebates. They are also perpetually looking to cut costs, often regardless of the effect such programs will have on the health of their customers. Regulation is needed to oversee these relationships.

PREVENT LEAD POISONING

Lead poisoning is a longstanding national problem with long-term health, social and economic effects, including developmental delays, cognitive damage, reproductive health problems, cardiovascular issues, reduced earning potential, greater social service costs and lifelong behavioral issues.

New York’s Childhood Lead Poisoning Epidemic. In New York, childhood lead poisoning is and has been at epidemic levels, with thousands of children newly identified each year as having dangerous levels of lead in their blood, indicating repeated exposure to lead in their lives. According to the CDC, New York has more children identified with elevated blood lead levels (EBLLs) than any other state, and it is estimated

⁵¹ Pharmaceutical Care Management Association (PCMA) (March 14, 2016), see: *That’s What PBMs Do*.

⁵² Testimony of David A. Balto “The State of Competition in the Pharmacy Benefits Manager and Pharmacy Marketplaces.” Before the House Judiciary Subcommittee on Regulatory Reform, Commercial and Antitrust Law November 17, 2015, see: <https://judiciary.house.gov/wp-content/uploads/2016/02/Balto-Testimony-1.pdf>.

⁵³ Ibid.

that over 100,000 children may have lead poisoning at EBLs of 5 ug/dL or greater, the current CDC reference level.⁵⁴

Substandard Housing is at the Root of the Epidemic. New York has the both the greatest number (3.3 million) and the highest percentage (43.1 percent) of its housing stock built before 1950, the houses most likely to contain lead paint, the greatest source of childhood lead poisoning.⁵⁵ Thus, New York’s children are at heightened risk for being exposed to lead in their homes, the most significant source of exposure.

Devastating Harms to Children. Children are the most vulnerable to the effects of lead contamination in their environment. Even seemingly miniscule increases in the concentration of lead in a child’s blood level can have significant cognitive impacts, with the greatest impact on IQ occurs at concentrations lower than 10 µg/dL. Studies have found that “children’s intellectual functioning at three and five years of age is inversely associated with blood lead concentrations, even when their peak concentrations remain below the CDC and WHO [2003] level of concern.”⁵⁶ Additional studies have used population statistics and public safety data to note the correlation between early childhood lead exposure and rates of criminal activity.⁵⁷ An article reviewing these studies found positive correlations between lead exposure and criminal activity in local, state and national surveys.⁵⁸

New York State is no longer at the vanguard of protection children’s health from lead poisoning. Three cities in New York made the national list for notably high levels in their sampling: Syracuse at 40.1 percent, Buffalo at 18.8 percent and Poughkeepsie at 14.9 percent.⁵⁹ These findings were correlated with lower income levels and environmental factors such as residing in housing that contains lead contaminated dust.⁶⁰

The Case for Early Intervention is Clear. Currently, New York’s Public Health Law requires mandatory blood lead testing for all children, with testing required twice by age three. Testing, however, is of limited benefit. Experts have confirmed the benefits of early intervention and primary prevention for lead poisoning cases. **It is critical to either remove/contain the source of the lead in the child’s life or remove the child from the exposure setting at the earliest possible point. Primary prevention approaches focus on removing or containing lead *before* a child is exposed.**

Advance primary prevention legislation in New York. Legislation that passed both houses in 2008 and was vetoed by former Governor Paterson should be updated to form the basis for a comprehensive legislative campaign to eliminate childhood lead poisoning in New York. The components for a primary prevention proposal include the following:

1. The state must commit to a robust “primary prevention” childhood lead poisoning prevention campaign to end this epidemic.

⁵⁴ Korfmacher, K., Benfer, E., Chachère, M., *Lead Laws and Environmental Justice in New York*, 39(1) NYSBA New York Environmental Lawyer 47-56 (2019).

⁵⁵ *Eliminating Childhood Lead Poisoning in New York State by 2010*, New York State Department of Health (2004), Table 3. <https://www.health.ny.gov/environmental/lead/exposure/childhood/finalplanscan.htm>.

⁵⁶ *Intellectual Impairment in Children with Blood Lead Concentrations below 10 mcg per Deciliter*, N Engl J Med 2003; 348: 1517-1526, April 17, 2003.

⁵⁷ Mielke, Howard W., and Zahran, Sammy, *The urban rise and fall of air lead (Pb) and the latent surge and retreat of societal violence*, Environmental International, 43 (2012) 48-55.

⁵⁸ Drum, Kevin, <http://www.motherjones.com/environment/2016/02/lead-exposure-gasoline-crime-increase-children-health/>, Feb. 11, 2016, last accessed, Aug. 7, 2017.

⁵⁹ Ibid.

⁶⁰ Lanphear, Bruce P. et.al, *The Contribution of Lead-Contaminated House Dust and Residential Soil to Children’s Blood Levels: A Pooled Analysis of 12 Epidemiologic Studies*, Environmental Research, Section, A 79. 51-68, 1998

2. New York must fund primary prevention from general fund sources, require contributions from the paint industry and tap other sources of funding, including economic and urban development streams.
3. Local health, housing and code enforcement agencies must play a critical role in preventing lead poisoning.
4. The state should take responsibility for the training, certification and supervision of contractors to ensure lead safe work practices are used home repairs and renovations.
5. The state should beef up the dust clearance standard to confirm that home contractors have been done safely.
6. The statutorily created Childhood Lead Poisoning Prevention Advisory Council must be strengthened to ensure that it plays a vigorous, central role in policy and includes the perspectives of parents, educators and public health advocates.
7. The lead poisoning liability waiver for rental housing insurance should be eliminated.
8. Provide support to qualifying rental property owners to make and maintain their properties as lead safe.
9. Require the state Department of Health to release an annual public report card detailing its progress in eliminating childhood lead poisoning.
10. Establish a state coordinated inter-agency Task Force on Childhood Lead Poisoning Prevention to ensure a multi-faceted response to the lead poisoning epidemic.

DOCTOR SUPPLY

New York has more doctors than ever before and that the rate of increase exceeds the growth in the state’s population. Despite some recent comments that New York’s supply of doctors is shrinking, new national data show that the state continues to be one rich in its physician supply. As seen below, New York ranks among the top states in physician supply:

Category	Physicians Per 100,000, 2016 ⁶¹	National Rank, 2016	National Average, 2016
Total physicians per 100,000 people	365.1	3	271.6
Active patient care physicians per 100,000	299.8	4	236.8
Active primary care physicians per 100,000	111.2	7	91.7
Active patient care primary physicians per 100,000	94.3	11	82.5
Active general surgeons per 100,000	10.2	7	7.8
Active patient care general surgeons per 100,000	7.6	15	6.7
Active physicians by age, under 40	17.8%		17%
Active physicians by age, over 60	33.4%		30.9%

As seen above, New York is ranked *third* in the total overall number of physicians per capita practicing in the state. Where major categories of specialty physicians are concerned, the state ranks well above the national averages. The data also suggests that New York remains an attractive place for younger physicians under 40 to practice, ranking above the national average. Moreover, the growth in the total number of physicians practicing in the state is expanding at a rate more than *four* times as great as is New York’s general population, roughly twice the difference nationally:

⁶¹ Data from AAMC “2017 State Physician Workforce Data Book,” see: <https://www.aamc.org/data/workforce/reports/484392/2017-state-physician-workforce-data-report.html>. Released November 2017.

	Total physician population ⁶²	Total general population ⁶³
New York, 2016	72,095	19.8 million
New York, 2008	67,545	19.5 million ⁶⁴
New York growth 2008-16	~6.7%	~1.8%
U.S., 2016	877,616	323 million
U.S., 2008	773,809	301 million ⁶⁵
U.S. growth 2008-16 ⁶⁶	~13.4%	~7.4%

As seen above, rate of the growth in the number of physicians practicing in the state exceeds rate of the growth in New York’s population. New York State has more physicians practicing now than at any other time.

Moreover, according to New York licensing data the state continues to add to its number of practicing physicians.

Licenses Issued, Past Seven Calendar Years⁶⁷

	2013	2014	2015	2016	2017	2018	2019
Number of physicians	5,223	4,644	4,575	4,589	4,776	4,970	5,342

There is no doubt, however, that certain communities within the state have more difficult access to physician care than others.⁶⁸ Yet, in the aggregate, New York’s physician supply continues to grow at a rate that far exceeds the growth of the state’s population.

In terms of statewide numbers, no shortage of physicians exists in New York.

LEGALIZE THE RECREATIONAL USE OF MARIJUANA

Allow the sale of recreational marijuana for adult use. The executive proposes language to allow the sale of marijuana and proposes regulations to oversee the sale and control of this product for some adults. NYPIRG urges your support for the idea.

The way New York State currently deals with cannabis causes harm. While personal possession of small amounts of cannabis was decriminalized in 1977, a loophole allows police officers to distinguish between what they consider personal or public possession. This has amounted to hundreds of thousands of arrests for possessing marijuana “in public view.” On average, over 60 people are arrested every day in New York

⁶² Data from AAMC “2017 State Physician Workforce Data Book,” see: <https://www.aamc.org/data/workforce/reports/484392/2017-state-physician-workforce-data-report.html>. Released November 2017.

⁶³ U.S. Census, 2016 estimates, see: <https://www.census.gov/programs-surveys/popest/data/data-sets.html>.

⁶⁴ New York State population, New York State Department of Health, “Table 2: Population, Land Area, and Population Density by County, New York State – 2008 see: https://www.health.ny.gov/statistics/vital_statistics/2008/table02.htm. According to the Health Department, the 2008 New York State population was 19,490,297.

⁶⁵ U.S. Census, “American Fact Finder, Total Population Universe: Total population, 2006-2008 American Community Survey 3-Year Estimates,” https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_08_3YR_B01003&prodTy pe=table. Total U.S. population was 301,237,703.

⁶⁶ Calculation, NYPIRG

⁶⁷ New York State Education Department, see: <http://www.op.nysed.gov/prof/med/medcounts.htm>.

⁶⁸ New York State Department of Education, “Regents: Designated Physician Shortage Areas in New York State,” see: <http://www.highered.nysed.gov/kiap/scholarships/documents/2015PLFShortageBulletin.pdf>.

State for marijuana possession.⁶⁹ While national statistics are stark in comparing arrest rates for marijuana offenses among racial groups, New York ranks particularly badly.

Despite data showing equal cannabis use among racial groups,⁷⁰ the New York State Division of Criminal Justice Services finds that 86 percent of the people arrested for marijuana possession in 2017 were people of color (48 percent were Black, and 38 percent were Hispanic, 9 percent were White.)⁷¹ Individuals with marijuana convictions can lose out on jobs, housing, and educational opportunities. As the New York State Department of Health states plainly:⁷² “The over-prosecution of marijuana has had significant negative economic, health, and safety impacts that have disproportionately affected low-income communities of color.”

Further, in addition to the growing evidence to support the benefits of cannabis for medical use to treat pain, epilepsy, and nausea, cannabis has been found to be an asset in the battle against the opioid epidemic. According to the U.S. Centers for Disease Control and Prevention (CDC), between 2010 and 2015, the number of lethal deaths from opioid overdose doubled in NYS and the number of lethal heroin overdoses increased more than five times.⁷³ Studies have shown that the availability of marijuana products significantly deters opioid related deaths.⁷⁴

The New York State Department of Health report, the *Assessment of The Potential Impact of Regulated Marijuana In New York State*,⁷⁵ found that: “Studies have found notable associations of reductions in opioid prescribing and opioid deaths with the availability of marijuana products. States with medical marijuana programs have been found to have lower rates of opioid overdose deaths than other states.”

Legalizing cannabis for adult use will reduce these harms.

Health and Safety Considerations: How will New York create a legal marijuana system for adult use that both reduces the harms that the current system creates and that considers public health and safety considerations? Below are a few proposals along those lines.

Driving Under the Influence: The National Highway Traffic Safety Administration (NHTSA) has reported that the number of drivers killed in crashes who tested positive for marijuana doubled from 2007 to 2015.⁷⁶

⁶⁹ New York State Division of Criminal Justice Services (2017, April). New York State Arrests for Marijuana Charges by year, Computerized Criminal History System.

⁷⁰ American Civil Liberties Union (2013). The War on Marijuana in Black and White. Retrieved from <https://www.aclu.org/files/assets/aclu-the-war-on-marijuana-re12.pdf>.

⁷¹ Cheney, B. (2018, Feb 13). Racial disparities persist in New York City marijuana arrests.” POLITICO. Retrieved from www.politico.com/states/new-york/cityhall/story/2018/02/13/racial-disparities-continue-in-new-york-city-marijuana-arrests-248896.

⁷² New York State Department of Health, Assessment of The Potential Impact Of Regulated Marijuana In New York State, July 2018, https://www.health.ny.gov/regulations/regulated_marijuana/docs/executive_summary_07-13-18.pdf.

⁷³ New York State Department of Health, New York State Opioid Annual Report, October, 2017, https://www.health.ny.gov/statistics/opioid/data/pdf/nys_opioid_annual_report_2017.pdf.

⁷⁴ Goldman, Henry. "New York Health Officials See Marijuana as an Alternative to Opioids." Bloomberg. July 13, 2018. <https://www.bloomberg.com/news/articles/2018-07-13/n-y-health-officials-see-marijuana-as-an-alternative-to-opioids>.

⁷⁵ New York State Department of Health, Assessment of The Potential Impact Of Regulated Marijuana In New York State, July 2018, https://www.health.ny.gov/regulations/regulated_marijuana/docs/executive_summary_07-13-18.pdf.

⁷⁶ National Conference of State Legislatures, Drugged Driving, Marijuana-Impaired Driving, September 13, 2018, <http://www.ncsl.org/research/transportation/drugged-driving-overview.aspx>.

However, state strategies to legislate around drugged driving note that more data, specifically as it relates to crash and citation information, is needed. Other hurdles have been identified in testing for drug impairment such as limitations of drug-testing technology and differing strategies for measuring and setting limits to determine impairment.

In crafting regulations, New York State should also be mindful of the criminal justice impact that imprecise regulations may have on racial profiling. New York should collect crash and citation data and then set drugged driving regulations based on data and best practices in other states which improves road safety as it relates specifically to drugged driving.

Maintain A Well-Funded Public Health Program: The state should create and maintain a robust public health program, similar to the Health Department's Tobacco Control Program, which would be funded with recurring revenues derived from taxing cannabis. Such a program would be tasked with ongoing public health research and public education campaigns; cessation efforts and drug treatment; and more. The Legislature and such a Public Health Program should also consider what pro-health messages or labels should be included on all cannabis sales containers, in the same way warning labels exist on tobacco packaging.

Clean Indoor Air Impact: New York should create rules for cannabis use in restaurants, workspaces, and other indoor locations that respects and mirrors current Clean Indoor Air Act laws for tobacco and e-cigarette use. Even if secondhand cannabis smoke has not been proven to cause cancer, being exposed to smoke is still being exposed to smoke which can trigger adverse reactions for people grappling with asthma and others who suffer from respiratory sensitivities.

Regulatory Structure: There will have to be robust discussion about how to regulate the sale of recreational cannabis. Models that currently exist in the state can provide a starting point for the conversation. One such model that has been introduced is the State Liquor Authority, which strictly separates production, distribution, and retails sales, with carve outs for craft brewers and small wineries.

Define Adults as Adults, 18 Years and Older: Eighteen-year olds can enlist in the armed services, sign contracts, vote for president, and serve on juries and decide death penalty cases. NYPIRG sees no valid reason to treat 18, 19, or 20-year-old adults differently than adults 21 or older.

Thank you for the opportunity to testify.