

**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 2021-2022 EXECUTIVE HEALTH BUDGET PROPOSAL  
February 25, 2021  
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*

As we know from the recent Attorney General's report, the quality of nursing home care can be inadequate, putting residents at risk. The Attorney General's report found nursing home compliance with infection controls lacking. In the report "Nursing Home Response to COVID-19 Pandemic," the Attorney General specifically found that *"nursing homes' lack of compliance with infection control protocols put residents at increased risk of harm."* Actions must be taken, and that New York should do all it can to help consumers of nursing home services.

The federal government, through the CMS, has established a five-star rating system, in which nursing home ratings can be easily and readily understood. The Attorney General's identified that *"nursing homes that entered the pandemic with low U.S. Centers for Medicaid and Medicare Services (CMS) Staffing ratings had higher COVID-19 fatality rates."*

The report also found that *"pre-existing, insufficient staffing levels put residents and staff at increased risk of harm during the pandemic."*<sup>1</sup>

**Use of federal data to identify nursing homes that perform poorly raises the question as to why the Health Department did not use that tool in advance of the pandemic? Moreover, a similar program exists for hospitals as well. A review of the CMS data – pre-pandemic – finds that New York's hospitals perform poorly in that regard too.**

**How is the Department using this data?**

*NEW YORK HOSPITALS' POOR RANKING IN CMS QUALITY OF CARE RANKINGS.*

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

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<sup>1</sup> Office of the Attorney General, "Nursing Home Response to COVID-19 Pandemic," <https://ag.ny.gov/sites/default/files/2021-nursinghomesreport.pdf>.

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.”<sup>2</sup> 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, the annual cost of measurable medical errors that harm patients was \$17.1 billion.<sup>3</sup> Since New York State is approximately 7 percent of the nation’s population—and if the quality of care were 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 hospitals perform poorly in health quality ranking issued by the federal government.**

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.<sup>4</sup> 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.

A recent NYPIRG report<sup>5</sup> on 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.<sup>6</sup>

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.”<sup>7</sup> Each hospital is given a rating of “Above the national average,” “Same as the national average,” or “Below the national average.”

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 regions of the US: 66 percent of hospitals in New York City, 44 percent in Chicago, 33 percent in Detroit, 25

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<sup>2</sup> 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>.

<sup>3</sup> Jill Van Den Bos, Karan Rustagi, Travis Gray, Michael Halford, Eva Ziemkiewicz, and Jonathan Shrevdoid: “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.

<sup>4</sup> According to Data.Medicare.gov, “Hospital Compare data was last updated on October 30, 2019.” See: <https://data.medicare.gov/data/hospital-compare>.

<sup>5</sup> NYPIRG, “Code Blue,” December 2019, [https://www.nypirg.org/pubs/201912/Code\\_Blue\\_report.pdf](https://www.nypirg.org/pubs/201912/Code_Blue_report.pdf).

<sup>6</sup> Op. cit. See: <https://data.medicare.gov/data/hospital-compare>.

<sup>7</sup> See: <https://www.medicare.gov/hospitalcompare/details.html?msrCd=prnt9grp1&ID=330088>

percent in 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.<sup>8</sup>

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’s* “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.”<sup>9</sup>

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?
- 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?

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<sup>8</sup> Unlike these cities, 60 percent of San Jose hospitals had one-star.

<sup>9</sup> See: <https://www.cityandstateny.com/articles/policy/health-care/why-new-york-hospitals-have-terrible-federal-rankings.html>.

## *NURSE STAFFING RATIOS IN BOTH NURSING HOMES AND HOSPITALS.*

As mentioned earlier, the Attorney General's report on nursing homes found that "*pre-existing, insufficient staffing levels put residents and staff at increased risk of harm during the pandemic.*"<sup>10</sup>

The Attorney General's findings have an all-too-familiar ring to those of us working to protect patients from substandard health care. The findings should not be a shock to anyone who has paid attention to the quality of care and governmental oversight problems that plague the state. The state should establish safe staff to patient ratios in hospitals and nursing homes and to ensure a minimum number of resident hours of care per day.

Two decades ago, the landmark report, *To Err is Human*, released by the National Academy of Sciences' the Institute of Medicine concluded, "Hospitals and nursing homes should employ nurse staffing practices that identify needed nurse staffing for each patient care unit per shift."<sup>11</sup>

Hospitals with lower nurse staffing levels have higher rates of pneumonia, shock, cardiac arrest, urinary tract infections and upper gastrointestinal bleeds; all leading to longer hospital stays, increased postsurgical 30-day mortality rates and increased rates of failure-to-rescue, *i.e.*, death of a surgical patient following a hospital-acquired complication.<sup>12</sup>

In nursing homes, safe staffing standards have a positive impact on both facility processes and on resident outcomes, for example, fewer facility deficiencies for poor quality and improved functional status of the residents.<sup>1</sup>

Had these studies and warnings been heeded, patient care in nursing homes (and hospitals) would have been improved. And as mentioned above, the Attorney General report identified inadequate staffing as a significant contributing problem. **Follow the conclusions of such expert analysis by requiring adequate staffing on both hospitals and nursing homes.**

## *INFECTION CONTROL AND ANTIBIOTIC 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 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

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<sup>10</sup> Office of the Attorney General, "Nursing Home Response to COVID-19 Pandemic," <https://ag.ny.gov/sites/default/files/2021-nursinghomesreport.pdf>.

<sup>11</sup> Institute of Medicine, Committee on the Work Environment for Nurses and Patient Safety Board on Health Care Services Ann Page, Editor, "Keeping Patients Safe: Transforming the Work Environment of Nurses."

<sup>12</sup> Agency for Healthcare Research and Quality Pub. No. 04- 0029, 2004.

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 become harder and often impossible to treat due to multidrug-resistant bacteria.

The World Health Organization considers antibiotic resistance to be one of the biggest threats to global health, food security, and international development today.<sup>2</sup> The CDC has stated that fighting this threat is a public health priority and estimates that each year, **at least 2.8 million people get an antibiotic-resistant infection, and more than 35,000 people die.**<sup>3</sup> 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.<sup>4</sup>

### **New York's stewardship performance**

The CDC offers a “Core Elements of Hospital Antibiotic Stewardship” to provide a framework for implementation of antibiotic stewardship programs. According to the CDC, New York State has 94 percent of its hospitals meeting all 7 Core Elements in 2019.<sup>5</sup> As mentioned earlier, however, the recent report issued by the New York State Office of the Attorney General found nursing home compliance with infection controls lacking. In “Nursing Home Response to COVID-19 Pandemic,” the Attorney General specifically found that “nursing homes’ lack of compliance with infection control protocols put residents at increased risk of harm.”<sup>6</sup>

## *CURBING THE GROWTH OF ANTIBIOTICS RESISTANCE*

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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.<sup>13</sup> The World Health Organization considers it to be one of the biggest threats to global health, food security, and international development today.<sup>14</sup> 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 2.8 million people get an antibiotic-resistant**

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<sup>13</sup> United Nations, see: <https://digitallibrary.un.org/record/842813?ln=en>

<sup>14</sup> World Health Organization, “Antibiotics Resistance,” see: <https://www.who.int/news-room/fact-sheets/detail/antibiotic-resistance>



**infection, and more than 35,000 people die.**<sup>15</sup> 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.**<sup>16</sup> 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.<sup>17</sup>

### **Antibiotics 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, and 31 of them are medically important for humans. According to FDA's most recent data on domestic sales of medically important antibiotics, 65% of them are sold for use in livestock.<sup>18</sup> When antibiotics are given to food-producing animals, they kill most of the bacteria in the animals. 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 they can contaminate the environment via animal feces. According to the CDC, **approximately 1 in 5 antibiotic-resistant infections are caused by germs from food and animals.**<sup>19</sup> *Salmonella* and *Campylobacter* – bacteria that commonly contaminate food – are estimated to cause 410,000 antibiotic-resistant infections in the U.S. each year.<sup>20</sup>

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.<sup>21</sup> 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.<sup>22</sup>

### ***OVERSIGHT OF NURSING HOMES***

In the summer of 2020, we reviewed actions taken against nursing homes by the Department of Health.<sup>23</sup> Our review found that during the last six to seven years the number of DOH fines issued against nursing homes declined sharply in New York City and Westchester while remaining at the same levels in Nassau,

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<sup>15</sup> U.S. Centers for Disease Control and Prevention, “Antibiotic/Antimicrobial Resistance,” see:

<https://www.cdc.gov/drugresistance/index.html>.

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

<sup>17</sup> 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>.

<sup>18</sup> 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](http://www.nrdc.org/experts/avinash-kar/livestock-antibiotic-sales-drop-remain-very-high)

<sup>19</sup> U.S. Centers for Disease Control and Prevention see: <https://www.cdc.gov/foodsafety/pdfs/ar-infographic-508c.pdf>. Link has been taken down. NYPIRG has original.

<sup>20</sup> U.S. Centers for Disease Control and Prevention, “Antibiotic Resistance Threats In The United States 2019,” p. 17, <https://www.cdc.gov/drugresistance/pdf/threats-report/2019-ar-threats-report-508.pdf>.

<sup>21</sup> 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>.

<sup>22</sup> *Wired*, “The Hidden Link Between Farm Antibiotics and Human Illness,” <https://www.wired.com/story/farm-antibiotics-human-illness-hidden-link/>.

<sup>23</sup> For access to our full review, [https://www.nypirg.org/pubs/202007/Final\\_Letter\\_Final.pdf](https://www.nypirg.org/pubs/202007/Final_Letter_Final.pdf).

Suffolk, and the seven major Upstate counties reviewed. The review also found that the total nursing home payments for fines were significantly higher in Upstate than Downstate nursing homes overall. Did the New York City and Westchester nursing homes improve their qualities so much that DOH was correct in finding almost no new fines? Was the DOH correct when it continued issuing the Upstate nursing home fines as high as before?

### *CANCER CONTROL*

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.<sup>24</sup> The top five cancer killers account for more than half of all the estimated cancer deaths.

Shocked by the rapid growth in the number of underage youths using electronic cigarettes, New York State approved legislation ending the sale of flavored vaping products. As part of that agreement, the new plan included increased public educational efforts to deter people from using vaping products as well as educating young people on the dangers of electronic cigarettes.

The vaping industry has increasingly become dominated by big tobacco companies, an industry that has spent decades fighting public health measures. Traditional combustible tobacco products continue to entice minors into a dangerous addiction. Electronic cigarettes, on the other hand, have been surreptitiously marketed as benign and trendy and have seen a skyrocketing use.

In 2020, NYPIRG released a report examining the state's tobacco control program.<sup>25</sup> That report reviewed the science behind tobacco control, the recommendations of the nation's experts on how to run a pro-health tobacco control program, and the new threats posed by vaping and flavored tobacco products. In addition, the report examined the responsibilities of the Tobacco Control Program (TCP) and shows how, despite massive available revenues, New York has starved its health efforts and the TCP is now falling short.

As we found in our report, New York has collected over \$24 billion in tobacco taxes and fees since 1999, the year the national Master Settlement Agreement (MSA) went into effect. Coupled with tobacco revenues from the MSA, New York has collected nearly \$41 billion since 1999.

Despite this windfall, New York spends less today (adjusted for inflation) on its state tobacco control program than it has over the past twenty years. New York has spent less than \$1 billion on tobacco control since the MSA, despite promises to use the money to combat tobacco addiction.

While it appears that the state does follow expert guidance on how to implement a tobacco control program, independent audits have repeatedly identified the state's lack of resources as a major flaw.

At the same time the state has added responsibilities to monitor vaping use, it has failed to provide additional resources for these activities. Despite the availability of new revenues generated by a tax on vaping products.

Flavored tobacco products, like their vaping cousins, are designed to entice youth to a deadly addiction. A loophole in federal law allows the sale of menthol flavored cigarettes and the current federal restriction does not cover flavored cigarillos, chewing, and cigar tobacco products. **While New York now prohibits the sale of flavored vaping products, it has not banned the sale of flavored tobacco.**

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<sup>24</sup> U.S. Centers for Disease Control and Prevention, "Leading Causes of Death," <http://www.cdc.gov/nchs/fastats/leading-causes-of-death.htm>.

<sup>25</sup> For access to the NYPIRG report, [https://www.nypirg.org/pubs/202008/Falling\\_Short\\_Report\\_Complete.pdf](https://www.nypirg.org/pubs/202008/Falling_Short_Report_Complete.pdf).

**New York should increase its commitment to tobacco control efforts by following the recommendations of the U.S. Centers for Disease Control and Prevention (CDC), which recommends the state spend up to \$203 million annually.**

Given its added responsibilities, additional resources (beyond the amount recommended by the CDC), should be added to ensure adequacy in achieving its new vaping public educational efforts.

The state's cigarette and little cigar tax should be raised \$1 and other tobacco products should be taxed at equivalent rates. The state should embrace new tax stamp technologies and bolster tax enforcement efforts.

Despite its successes, New York State has undermined its efforts to curb tobacco use. It has the resources, the science on how to best approach the problem, and even a plan to implement it. Unfortunately, the state's leadership has starved this important program of necessary resources. Based on the total revenue from tobacco taxes since its implementation, New York can, and should be investing more into its tobacco control program. This means expanding public education and treatment efforts, as well as extending taxation to flavored tobacco products.

Moreover, the public health benefits of tobacco taxes have eroded over the past decade. Boosting those taxes will not only keep kids from starting this addiction, add revenues to the state, but also add additional resources to programs designed to help tobacco users to quit.

#### *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](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](http://www.nydoctorprofiles.com)), and provide access to the 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.

**We agree with the creation of a system of periodic recertification of physicians.** Both the National Academy of Sciences' Institute of Medicine<sup>26</sup> and the State Health Department<sup>27</sup> 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*

As the Covid-19 pandemic has clearly illustrated, failing to have access to adequate health care can be deadly. Yet, the number of New Yorkers who currently lack health insurance is considerable. In 2019,

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<sup>26</sup> National Academy of Sciences' Institute of Medicine, *To Err is Human: Building A Better Health Care System*, November 1999, p. 10.

<sup>27</sup> New York State Department of Health, *Report of the New York State Advisory Committee on Physician Recredentialing: Phase One General Principles, Proposed Process, Recommendations*, January 1988.



nearly 1 million New York residents were uninsured (5 percent of the population).<sup>28</sup> However, this represents both the lowest percentage and number of New Yorkers who lack health insurance in years. What has happened to drive down the number of uninsured? Nationally, until recent efforts to destabilize the Affordable Care Act, the percentage of Americans without health insurance was shrinking. Since the efforts to destabilize the Affordable Care Act (ACA) began in the Trump Administration, that trend has reversed. Since 2016, the percentage of Americans who lack health insurance has ticked upwards. The policies of the Trump Administration and its allies in Congress have resulted in over one million additional uninsured people.<sup>29</sup> By contrast, New York State, which implemented the ACA's reforms as state-based policies, has not seen an uptick in uninsured. In fact, the rate has remained low. Thus, it seems reasonable to conclude that the changes brought about by the ACA as implemented by state policymakers contributed to New York's decline in the uninsured rate.

The United States spends 17 percent of its Gross National Product on health care (pre-pandemic) yet ranks 28<sup>th</sup> of the 37 Organisation for Economic Co-operation and Development (OECD) member nations in life expectancy.<sup>30</sup> It is clear that American health care is expensive and does not 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, 5 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 about one-third of cancer survivors report a loss of health insurance at some point in time since their diagnosis.<sup>31</sup>

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. While the primary concerns of someone facing a cancer diagnosis would be the likelihood of survival, the next immediate concern in far too many cases is their ability to afford needed treatments. 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.<sup>32</sup>

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<sup>28</sup> Kaiser Family Foundation, "Health Insurance Coverage of the Total Population; New York," 2019, <https://www.kff.org/other/state-indicator/total-population/?dataView=1&currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22new-york%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.

<sup>29</sup> Kaiser Family Foundation, "Health Insurance Coverage of the Total Population," 2019, <https://www.kff.org/other/state-indicator/total-population/?dataView=1&activeTab=graph&currentTimeframe=1&startTimeframe=11&selectedDistributions=uninsured&selectedRows=%7B%22wrapups%22:%7B%22united-states%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.

<sup>30</sup> Organisation of Economic Co-operation and Development, <https://www.oecd.org/health/health-data.htm>.

<sup>31</sup> 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>.

<sup>32</sup> 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](https://meps.ahrq.gov/data_files/publications/st471/stat471.shtml).

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 financial burden is greater for cancer patients, who pay more out of pocket for care than many of 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.<sup>33</sup>

**Even with the expansion of coverage under the ACA, 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.”<sup>34</sup>

A new Biden Administration will be looking for ways to restore the ACA and to broaden it. However, as Washington considers changes to the ACA, it is more important than ever that the state explore its own options. Health insurance coverage is critical to the health and well-being of all New Yorkers. Make sure that all New Yorkers are covered.

### *PRESCRIPTION DRUG PRICES*

The rising cost of prescription drugs is not felt only by those consumers who lack health insurance coverage; businesses that provide insurance for their workers must either absorb drug price hikes, shift the cost to employees through higher deductibles or co-pays, or drop coverage altogether. Taxpayers also feel the impact as higher prescription drug costs drive up payments to government-provided insurance programs such as Medicaid, Family Health Plus, Child Health Plus, EPIC, as well as costs for public employees’ coverage.

New York State posts drug pricing information online for 150 of the widely prescribed prescriptions. Each pharmacy is required to post the web address for this service.<sup>35</sup>

In 2020, NYPIRG reviewed prescription drug prices in the largest counties in New York State. Our review showed surprisingly large ranges in the retail prices of drugs *within* geographic regions. For example, in the borough of Manhattan, which had 684 pharmacies listed, the drug Spiriva had the greatest range in price, from a high of \$698.72 to a low of \$265.17 – a difference of \$433.55.

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.

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<sup>33</sup> 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>.

<sup>34</sup> 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>.

<sup>35</sup> New York State Education Law, section 6826

The current limit of only posting the prices for the 150 most widely prescribed drugs is anachronistic. The website could use a considerable amount of modernization, but the number of drugs listed should be expanded. The state collects retail prices for hundreds (if not thousands) of drugs; the state should post them *all*.

While clearer signage would help consumers, having an easy-to-remember website address (*For example, [www.NYSRxPriceShop.gov](http://www.NYSRxPriceShop.gov)*) would as well.

The New York State Department of Education should audit pharmacies to ensure that they are complying with regulations requiring that pharmacies conspicuously display information on the existence of the New York State Department of Health website and its Internet address. The current law requires that pharmacies alert consumers to the existence of the state's prescription drug price website address. In previous reviews of the state law, we have found many instances in which the required signage was not easily seen by customers. The state must ensure that pharmacies are posting the prescription drug website address as required; comparing prescription drug prices can help consumers save money quickly and easily.

### *REGULATE PHARMACEUTICAL MANAGERS*

**NYPIRG urges your support for regulation of 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 consumers<sup>36</sup>; three PBMs— ExpressScripts, CVSHealth (also referred to as “CVS Caremark”) and OptumRx – controlling approximately 80% % of the lucrative market.<sup>37</sup> 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.<sup>38</sup> 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*

New York is in the middle of a childhood lead poisoning epidemic. Epidemic is the accurate term when thousands of children are newly identified as lead poisoned each year, indicating repeated exposure to lead in their environments. According to the CDC, New York has more children identified with elevated blood lead levels (EBLLs) than any other state, and it is estimated that over 100,000 children may have lead poisoning at EBLLs of 5 ug/dL or greater, the current CDC reference level.

This is tragic because of the human toll, the lost potential, and the staggering additional costs to New York for healthcare, education, criminal justice, and social services. But the tragedy is magnified because childhood lead poisoning is a *man-made problem*: Lead poisoning is overwhelmingly caused by

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<sup>36</sup> Pharmaceutical Care Management Association (PCMA) (March 14, 2016), see: *That's What PBMs Do*.

<sup>37</sup> 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>.

<sup>38</sup> Ibid.

deteriorating paint that was applied more than a half a century ago in housing that is poorly maintained. Thus, childhood lead poisoning is *entirely preventable* through effective public policy interventions. Unfortunately, New York has failed to fully address the root causes of childhood lead poisoning.

**The Problem: New York’s Old Housing Stock and the Lack of Effective Primary Prevention.** Among the states, New York has both the greatest number (3.3 million) and the highest percentage (43.1 percent) of housing stock built before 1950, the houses most likely to contain lead paint, the greatest source of childhood lead poisoning. New York banned the use of lead-based paint in residential dwellings, childcare facilities, and kindergartens in 1970. Fifty years later New York’s children remain at heightened risk for being exposed to lead in their homes.

New York’s Public Health Law requires mandatory blood lead testing at least twice for all children by age three. Testing, however, is of limited benefit. Because the effects of lead ingestion are both severe and generally irreversible, it has long been the consensus among public health experts and policy makers that primary prevention— *i.e.*, identifying and removing environmental lead hazards before children are affected— is key. While New York City has had primary prevention laws in place since 1982, and Rochester since 2005, there is essentially no primary prevention law covering the remainder of the state, leaving vulnerable children and their families without viable and effective remedies, particularly in rental housing.

**New York State is no longer at the vanguard of protecting children’s health from lead poisoning.** Then-Governor David Paterson vetoed primary prevention legislation that passed both houses in 2008. The vetoed bill would have required the state to target communities with high levels of lead-poisoned children for prevention approaches to remove or contain lead hazards before children are poisoned. Paterson instead established an interagency Task Force on the Prevention of Childhood Lead Poisoning. Although the Task Force made a number of recommendations for integrating primary prevention, few have been implemented.

This was a veto with tragic consequences: A 2016 analysis of nationwide blood lead levels, among the six cities with the highest percentages of EBLLs, three of them were in New York: Syracuse at 40.1%, Buffalo at 18.8 %, and Poughkeepsie at 14.9 %. Elevated blood lead levels are correlated with lower income levels and environmental factors such as residing in housing that contains lead contaminated dust. Shockingly, New York took seven years to adopt the more stringent action level for children exposed to lead as recommended by U.S. Centers for Disease Control and Prevention in 2012. While many states have taken over enforcement of the federal EPA’s Renovation, Remodeling and Painting Rule (“RRP”) to further the use of safe work practices, New York has not. New York must move aggressively forward to address the lead poisoning epidemic.

### **New York Must Finally Eliminate Prevent Childhood Lead Poisoning**

For New York to eliminate childhood lead poisoning, the state must undertake an aggressive, well-funded primary prevention campaign that attacks lead at its sources, with an emphasis on inspecting, monitoring, and remediating lead paint in older housing in lower income communities. The 2008 Legislation that passed both houses could form the basis for a comprehensive legislative campaign to eliminate childhood lead poisoning in New York. The principles for a primary prevention proposal must include the following:

- The state must commit to and fund a robust “primary prevention” childhood lead poisoning prevention campaign to end the childhood lead poisoning epidemic, including, at a minimum, enforceable housing standards that require rental housing to be free of lead-based paint hazards; mechanisms for pre-rental and ongoing inspections, and mechanisms to enable a registry of housing where lead-based paint has been identified and disclosure of the same to tenants, as well as measures to ensure point-of-sale identification of lead-based paint in pre-1978 dwellings.

- Local health, housing and code enforcement agencies must play a critical frontline role in preventing lead poisoning. Silos between involved agencies and governments should be eliminated through enhanced data sharing. Tenants in rental property must have access to remedies to prevent and remediate lead-based paint hazards, including injunctive remedies, and protections against retaliation.
- 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.
- The lead poisoning liability waiver for rental housing insurance should be eliminated.
- NYS should take responsibility for enforcement of the federal RRP program to assure that the training, certification, and supervision of persons performing work in pre-1978 housing use lead safe work practices and mandate the use of dust clearance tests. Dust clearance standards and other lead hazard standards should be updated to accord with current research.
- Enhance secondary prevention (i.e., response to an EBL child), including inspection of all units in buildings where an EBL child is identified, enhanced case management and services, such as neuropsychological evaluations, early intervention and other screenings of affected children.
- The state should make available to qualified residential rental property owners' access to financial and other resources to make and keep their rental housing lead safe, with adequate safeguards to assure that such resources are not enabling gentrification and displacement.
- The statutorily created Advisory Council on Lead Poisoning Prevention must be strengthened to ensure that it plays a vigorous, central role in policy and includes the perspectives of parents, educators, housing, and public health advocates. In addition, establish a state coordinated inter-agency Task Force on Childhood Lead Poisoning Prevention to ensure state and local government provides a multi-faceted response to the lead poisoning epidemic.
- Set specific empirical goals for the reduction and elimination of childhood lead poisoning and the elimination of lead-based paint hazards; require the state Department of Health to release an annual public report card detailing its progress in eliminating childhood lead poisoning, and to make specific recommendations for further measures if targets are not met.
- Address other contributing sources of lead poisoning, such as lead in residential and school drinking water, lead-based paint hazards in schools, and child-care facilities.

Fully funding lead poisoning prevention programs could finally place New York on the road to eliminating childhood lead poisoning, upgrading its housing stock, saving money on programs dealing the problems caused by the epidemic, and prevent children from having their futures stolen before they enter pre-school.

#### *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 State for marijuana possession.<sup>39</sup> While national statistics are stark in comparing arrest rates for marijuana offenses among racial groups, New York ranks particularly badly.

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<sup>39</sup> New York State Division of Criminal Justice Services (2017, April). New York State Arrests for Marijuana Charges by year, Computerized Criminal History System.

Despite data showing equal cannabis use among racial groups,<sup>40</sup> 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.)<sup>41</sup> Individuals with marijuana convictions can lose out on jobs, housing, and educational opportunities. As the New York State Department of Health states plainly:<sup>42</sup> “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.<sup>43</sup> Studies have shown that the availability of marijuana products significantly deters opioid related deaths.<sup>44</sup>

The New York State Department of Health report, the *Assessment of The Potential Impact of Regulated Marijuana In New York State*,<sup>45</sup> 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.<sup>46</sup> 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.

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<sup>40</sup> American Civil Liberties Union (2013). The War on Marijuana in Black and White. Retrieved from <https://www.aclu.org/files/assets/aclu-thewaronmarijuanarel2.pdf>.

<sup>41</sup> 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](http://www.politico.com/states/new-york/cityhall/story/2018/02/13/racial-disparities-continue-in-new-york-city-marijuana-arrests-248896).

<sup>42</sup> 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](https://www.health.ny.gov/regulations/regulated_marijuana/docs/executive_summary_07-13-18.pdf).

<sup>43</sup> 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](https://www.health.ny.gov/statistics/opioid/data/pdf/nys_opioid_annual_report_2017.pdf).

<sup>44</sup> 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>.

<sup>45</sup> 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](https://www.health.ny.gov/regulations/regulated_marijuana/docs/executive_summary_07-13-18.pdf).

<sup>46</sup> National Conference of State Legislatures, Drugged Driving, Marijuana-Impaired Driving, September 13, 2018, <http://www.ncsl.org/research/transportation/drugged-driving-overview.aspx>.



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 retail 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.

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<sup>1</sup> Health Services Research, 2012.

<sup>2</sup> World Health Organization, "Antibiotics Resistance," <https://www.who.int/news-room/fact-sheets/detail/antibiotic-resistance>

<sup>3</sup> U.S. Centers for Disease Control and Prevention, "Antibiotic/Antimicrobial Resistance," <https://www.cdc.gov/drugresistance/index.html>.

<sup>4</sup> U.S. Centers for Disease Control and Prevention, "Joint Statement on Importance of Outpatient Antibiotic Stewardship," <https://www.cdc.gov/getsmart/community/partners/joint-statement.html>.

<sup>5</sup> U.S. Centers for Disease Control and Prevention, Antibiotic Resistance, "Current Report," <https://www.cdc.gov/antibiotic-use/stewardship-report/current.html>.

<sup>6</sup> Office of the Attorney General, "Nursing Home Response to COVID-19 Pandemic," <https://ag.ny.gov/sites/default/files/2021-nursinghomesreport.pdf>.