

**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 2022-2023 EXECUTIVE HEALTH BUDGET PROPOSAL
February 8, 2022
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

In her executive budget, Governor Hochul proposes a \$10 billion, multi-year investment in healthcare, including billions of dollars to support wages and bonuses for healthcare workers. Her plan is in response to the highly-negative impact that the COVID pandemic has had on the healthcare workforce. The governor states that her plan would grow the healthcare workforce by 20 percent over the next five years.

In addition, the governor's executive budget authorizes a fourth round of grants for the Statewide Health Care Facility Transformation Program. The Program was initiated in 2016 with an eye toward providing financial support for projects designed to improve facility infrastructure and patient care.

Yet, the executive budget fails to adequately respond to an ongoing health care crisis in New York: the apparent substandard quality of hospital medical care.

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 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 enormous. According to one estimate, 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 were universally distributed—

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 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.³ It gives each hospital one, two, three, four, or five quality stars, with one-star hospitals being the worst and five-star hospitals the best. New York overall had lower quality star ratings than all the 49 other states.

A 2019 **pre-pandemic** NYPIRG report⁴ 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.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 “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 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.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.

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>

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

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.”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 that foots the bill for the additional costs resulting from poor quality care. The questions raised by NYPIRG’s report include:

- 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?

NYPIRG recommends that you support additional funding to bolster the state’s beleaguered medical community. However, we recommend that such funding be tied to annual reporting on the quality of care offered in hospitals – quality evaluations published by federal (or state) government, not magazines or other non-government outlets.

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

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

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 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.⁹ The U.S. Centers for Disease Control and Prevention (CDC) has stated that fighting this threat is a public health priority. 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.¹⁰

CURBING THE GROWTH OF ANTIBIOTICS RESISTANCE

Due to the overuse and misuse of antibiotics 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.

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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.¹¹ The World Health Organization considers it to be one of the biggest threats to global health, food security, and international development today.¹² The CDC has stated that fighting this threat is a public health priority and estimates that each year,

⁹ World Health Organization, “Antibiotics Resistance,” <https://www.who.int/news-room/fact-sheets/detail/antibiotic-resistance>

¹⁰ 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>.

¹¹ United Nations, see: <https://digitallibrary.un.org/record/842813?ln=en>

¹² World Health Organization, “Antibiotics Resistance,” see: <https://www.who.int/news-room/fact-sheets/detail/antibiotic-resistance>

at least 2.8 million people get an antibiotic-resistant infection, and more than 35,000 people die.¹³ 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.**¹⁴ 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.¹⁵

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.¹⁶ 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.**¹⁷ ***Salmonella* and *Campylobacter* – bacteria that commonly contaminate food – are estimated to cause 410,000 antibiotic-resistant infections in the U.S. each year.**¹⁸

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.¹⁹ 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.²⁰

Unfortunately, there is no meaningful recommendation in the budget to coordinate this growing public health menace. NYPIRG urges the establishment of a unit within the DOH to centralization and coordinate the state's response to this threat.

¹³ U.S. Centers for Disease Control and Prevention, "Antibiotic/Antimicrobial Resistance," see: <https://www.cdc.gov/drugresistance/index.html>.

¹⁴ World Health Organization see: <https://www.who.int/bulletin/volumes/94/9/16-020916/en/>.

¹⁵ 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>.

¹⁶ 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

¹⁷ 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.

¹⁸ 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>.

¹⁹ 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>.

²⁰ *Wired*, "The Hidden Link Between Farm Antibiotics and Human Illness," <https://www.wired.com/story/farm-antibiotics-human-illness-hidden-link/>.

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.²¹ The top five cancer killers account for more than half of all the estimated cancer deaths.

In 2020, NYPIRG released a report examining the state's tobacco control program.²² 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. 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.

²¹ U.S. Centers for Disease Control and Prevention, "Leading Causes of Death," <http://www.cdc.gov/nchs/fastats/leading-causes-of-death.htm>.

²² For access to the NYPIRG report, https://www.nypirg.org/pubs/202008/Falling_Short_Report_Complete.pdf.

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.

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 years ago, and less than 20 percent of the amount recommended by the U.S. CDC. 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 22nd.*²³ **Such historic funding reductions were indefensible considering the amount of money that tobacco use generates for the state’s coffers. NYPIRG urges you to fully fund tobacco control and other cancer-prevention programs.**

DOCTOR DISCIPLINE

The executive budget proposes to allow New York to join an interstate commission to facilitate the licensing of physicians and nurses in other member states to practice in New York. According to the governor’s plan, eligible physicians and nurses would go through a licensing and registration process. Yet, the office that oversees medical discipline in New York – the Office of Professional Medical Conduct – needs to be strengthened.

For example, any legislation action in this area should 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,²⁴ ensure that patients are aware of the state’s physician profiles resource,²⁵ and provide access to the OPMC database of its actions against doctors and other providers.²⁶ In addition, all patients of physicians who have had any limitation on their license must be notified in a timely manner.

In addition, the governor’s plan should require a system of periodic recertification of physicians. Both the National Academy of Sciences’ Institute of Medicine²⁷ and the State Health Department²⁸ 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,

²³ Campaign for Tobacco-Free Kids, “A State-by-State Look at the 1998 Tobacco Settlement 23 Years Later,” 2022, <https://www.tobaccofreekids.org/what-we-do/us/statereport/>.

²⁴ See http://www.health.ny.gov/professionals/doctors/conduct/file_a_complaint.htm.

²⁵ See www.nydoctorprofiles.com.

²⁶ See <http://www.health.state.ny.us/nysdoh/opmc/main.htm>.

²⁷ National Academy of Sciences’ Institute of Medicine, *To Err is Human: Building A Better Health Care System*, November 1999, p. 10.

²⁸ 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).²⁹ 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.³⁰ 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 28th of the 37 Organisation for Economic Co-operation and Development (OECD) member nations in life expectancy.³¹ 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.³²

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.³³

²⁹ Kaiser Family Foundation, "Health Insurance Coverage of the Total Population; New York," 2019, <https://www.kff.org/other/state-indicator/total-population/?dataView=1¤tTimeframe=0&selectedRows=%7B%22states%22:%7B%22new-york%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.

³⁰ Kaiser Family Foundation, "Health Insurance Coverage of the Total Population," 2019, <https://www.kff.org/other/state-indicator/total-population/?dataView=1&activeTab=graph¤tTimeframe=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>.

³¹ Organisation of Economic Co-operation and Development, <https://www.oecd.org/health/health-data.htm>.

³² 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>.

³³ 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.

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.³⁴

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.”³⁵

The governor’s budget plan takes additional steps to expand New York State’s health coverage. She proposes to expand eligibility for the state’s Essential Plan Reforms (subject to federal approval). The executive budget expanded eligibility by raising the Federal Poverty Limit (FPL) cap from 200 percent to 250 percent, expanding coverage for non-citizens with incomes at or below 233 percent FPL, covering pregnant people for one year after the end of pregnancy without regard to changes in income. Her plan also expands Child Health Insurance Plan services.

Yet, the executive’s plan falls short of providing full, comprehensive health coverage. The overwhelming case for universal health care modeled on Medicare has long been clear. Legislation proposed in New York, NY Health, would end the cruel and needless rationing of health care that defines the current system. Instead, it would establish, simply, that health care is a right and that all New Yorkers have access to care. Regardless of ability to pay. Regardless of race or ethnicity. Regardless of whether they live in a city or rural area. Regardless of employment status.

NY Health should improve health care as well. New Yorkers would have better insurance – with broader coverage, including for long-term care – than they do now. Doctors and nurses would be freed to provide care rather than spend their time on billing. This new system would also be vastly more efficient than the current system.

Amid the worst acute public health crisis in generations, the current insurance system failed massively. People lost their health insurance. Hospitals and providers, operating with just-in-time systems and investments oriented to expensive treatments rather than public health, were less well equipped to absorb the pandemic demands than they should have been.

PRESCRIPTION DRUG PRICES

³⁴ 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>.

³⁵ 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 governor's proposed budget proposes to expand the scope of practice, yet ignores their failures to ensure that consumers have easy access to drug pricing information as required by current New York State law.

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.³⁶

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.

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*) 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.

PREVENT LEAD POISONING

Based on the latest data from the state, researchers with the Mailman School of Public Health at Columbia University estimate that as many as “108,000 young children in the state may have lead poisoning at levels of or over 5 ug/dL.” This is the level at which intervention is required and colloquially children are considered lead poisoned.³⁷ Even if actual numbers are substantially less than upper-bound projections,

³⁶ New York State Education Law, section 6826

³⁷ This is an upper bound projected limit using 2014 data, the latest data the state Department of Health makes available – a problem in and of itself. The 2014 data confirmed more than 10,000 screened children had elevated blood lead levels as confirmed through blood tests. *Eliminating Lead Poisoning in New York: A National Survey of Strategies to Protect Children*, Columbia Law School Health Justice Advocacy Clinic, October 2019. Accessed at

without doubt *thousands of children* are newly poisoned by exposure to lead in their environments in New York *each year*. While there may be multiple sources of lead exposure, in the overwhelming number of cases, it is lead from poorly maintained paint in their homes that creates the elevated blood lead levels. And most of these children are poor and live in communities of color.

Lead is devastating for children. Even seemingly miniscule increases in the concentration of lead in a child's blood can have significant cognitive consequences, 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.”³⁸ Additional studies have used population statistics and public safety data to note the correlation between early childhood lead exposure and rates of criminal activity.³⁹ An article reviewing these studies found positive correlations between lead exposure and criminal activity in local, state and national surveys.⁴⁰

The previous Administration’s track record on childhood lead poisoning was a huge disappointment. The Cuomo administration advanced no new programs; it stalled funding;⁴¹ further reduced the role of the Childhood Lead Poisoning Prevention Advisory Council; was less transparent on lead poisoning than his predecessors; and *failed for seven years* to take regulatory action to lower the lead exposure action level to have New York match to the U.S. Centers for Disease Control and Prevention (“CDC”) level adopted in 2012.⁴² *A clear indication of the Cuomo administration’s disinterest in childhood lead poisoning is that the Department of Health has not posted lead testing data beyond 2014.*⁴³

Currently, it was very difficult to determine the actual amount of the state’s spending on lead screening and primary prevention programs. A NYSDOH September 2017 presentation to the New York State Advisory Council on Lead Poisoning Prevention pegs the “primary prevention” budget for 2017-2018 at \$9.8 million with \$7.1 million for “lead poisoning prevention program,” for a total of \$16.9 million.⁴⁴ Members of the Advisory Council requested a briefing on the FY 2023 budget and were told the next meeting would be in April, after the budget is likely to have been approved.

https://web.law.columbia.edu/sites/default/files/microsites/clinics/health-advocacy/final_lead_poisoning_prevention_best_practices_report_october_2019_final.pdf.

³⁸ Intellectual Impairment in Children with Blood Lead Concentrations below 10 mcg per Deciliter, N Engl J Med 2003; 348: 1517-1526, April 17, 2003.

³⁹ 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.

⁴⁰ Drum, Kevin, <http://www.motherjones.com/environment/2016/02/lead-exposure-gasoline-crime-increase-children-health/>, Feb. 11, 2016, last accessed, Aug. 7, 2017.

⁴¹ Again, responses to repeated requests by advocates to get a full picture of the state’s programs and funding proved elusive.

⁴² Ultimately it was up to the Legislature to act – despite clear and ample authority of the New York State Department of Health to reduce the action level on its own. After the Assembly passed legislation in March 2019 [A.5779 (Ryan)], the Public Health Law was amended in the budget to reduce the action level from 10 ug/dL to 5 ug/dL. See Budget Bill S.1507-C/A.2007-C (Part P), Chapter 57 Laws of 2019.

⁴³ The NYSDOH surely has more recent data. For example, it included 2015 blood test data in the September 28, 2017 Powerpoint presentation to the Advisory Council, showing 9,300 confirmed children’s tests at 5 ug/dL or above.

⁴⁴ New York State Department of Health Powerpoint presentation to New York State Advisory Council on Lead Poisoning Prevention (September 28, 2017). It is not entirely clear that these two figures are combined or if the smaller is a part of the larger. If it is the larger combined figure, this amount is similar to Governor Paterson’s budget of a decade earlier. An August 2019 presentation to the Advisory Council by NYSDOH staff cites a “new investment” of \$13.8 million for the 2019-2020 budget, which coincides with significant workload increase as a result of implementation of the then new lower elevated lead level threshold and requirement for environmental intervention. Again, hopefully the hearing will clarify how much has been budgeted and how much actually spent on lead poisoning prevention programs over the past decade.

New York’s oldest-in-the nation housing stock is the root of the problem. Although the application of lead-based paint in residential dwellings, child care facilities, and kindergartens was banned by the Board of Health in New York City in 1960 and through legislation in New York in 1970, New York has the oldest housing stock in the nation, with more than 3 million units built before 1950⁴⁵, 41% of housing stock built pre 1950.⁴⁶ Housing stock built before 1950 are the most likely to contain lead paint, the greatest source of childhood lead poisoning. Thus, New York’s children are at heightened risk for being exposed to lead in their homes.

Three cities in New York made a national list for notably high levels in a review of more than 4 million blood test results of young children tested for lead across the country: Syracuse at 40.1 percent, Buffalo at 18.8 percent and Poughkeepsie at 14.9 percent.⁴⁷ These findings were correlated with lower income levels and environmental factors such as residing in housing that contains lead contaminated dust.

Eliminate Childhood Lead Poisoning by Prioritizing Safe Housing and Primary Prevention

The track record of New York City in reducing childhood lead poisoning over the past two decades points the way for a state approach. The components for an effective primary prevention proposal include the following:

1. The state must enact a robust “primary prevention” childhood lead poisoning prevention law to end this epidemic; prevention should be prioritized over screening.
2. Provide long term, consistent and robust funding for primary prevention programs from general fund sources, contributions from the paint industry and by tapping other sources of funding, including economic and urban development streams. A program similar to Maine’s program of charging paint manufacturers \$.25 per gallon of paint sold at the corporate level would generate \$12 million in New York.⁴⁸ *New York should double that amount to \$.50 per gallon equivalent.*
3. Rental property owners must be subject to clear, enforceable maintenance standards and obliged to periodically inspect rental premises to ensure there are no lead hazards and use only trained, certified personnel and methods to paint, repair and renovate older properties.
4. Local health, housing and code enforcement agencies must play a critical role in preventing lead poisoning, including inspecting properties regularly.
5. The state should take responsibility for the training, certification and supervision of contractors to ensure lead safe work practices are used for home repairs and renovations that could disturb lead paint.
6. The state should beef up the dust clearance standard to confirm that home contractors have done their work properly and safely.

⁴⁵ 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>.

⁴⁶ *Lead Laws and Environmental Justice in New York*, Katrina Smith Korfmacher, Emily A. Benfer, and Matthew J. Chachere, *The New York Environmental Lawyer*, New York State Bar Association, Fall/Winter 2019, Vol. 39, No. 1. Accessed at https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3492119.

⁴⁷ *Blood Lead Levels in Young Children: US, 2009-2015*, Leland F. McClure, PhD, Justin K. Niles, MA, and Harvey W. Kaufman, MD, *The Journal of Pediatrics* (2016). Accessed at [https://www.jpeds.com/article/S0022-3476\(1630206-2/fulltext](https://www.jpeds.com/article/S0022-3476(1630206-2/fulltext).

⁴⁸ Beginning on July 1, 2006, the state of Maine began collecting a \$.25/gallon fee on paint sold in the state. Companies were given two options; track the volume of paint sold in Maine or assume Maine's sales represent 0.45% of the company's national paint sales and pay the fee based on 0.45% of the company's national paint sales. Any company selling less than 1,800 gallons of paint per calendar year would be exempted from paying this fee.

7. 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; the Advisory Council should have a timely opportunity to review and comment on proposed lead poisoning prevention budgets.
8. The lead poisoning liability waiver for rental housing insurance should be eliminated.
9. Provide support to qualifying rental property owners to make and maintain their properties as lead safe.
10. Require the state Department of Health to release an annual public report card detailing its progress in eliminating childhood lead poisoning, including the number of local inspections, findings and actions taken; lead screening program participation and test results.
11. Establish a statewide lead-in-housing hotline number and website portal so that New Yorkers outside New York City have a central point of contact to follow up on their concerns about lead hazards in housing and get their housing promptly inspected.
12. Establish a permanent state coordinated inter-agency Task Force on Childhood Lead Poisoning Prevention to ensure a multi-faceted response to the lead poisoning epidemic.
13. Ensure that lead hazard violations are addressed swiftly and effectively; if property owners fail to make required repairs, then government must step in to protect residents.

Thank you for the opportunity to testify.