NYPIRG NEW YORK PUBLIC INTEREST RESEARCH GROUP

**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 2025-2026 EXECUTIVE HEALTH BUDGET PROPOSAL**
**February 11, 2025**
**Albany, N.Y.**

The New York Public Interest Research Group (NYPIRG) is a non-partisan, non-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.

In the governor's executive budget, tens of billions of dollars will be spent on health care.[1] Yet, too little attention has been devoted to the quality of the medical care that the state, employers, and individuals pay for. There is considerable evidence that the quality of hospital care is too often substandard and it must be a priority of lawmakers to ensure that steps are taken to address the uneven quality of care as part of any final budget agreement.

Poor quality of care can drive higher costs. A key measure in assessing the quality of hospital care, for example, are "readmission rates."[2] Research from the Agency for Healthcare Research and Quality (AHRQ) shows that hospital readmission costs were higher than initial admission costs for about two-thirds of common diagnoses in 2016.[3] Thus, appropriately reducing hospital readmissions is not only providing better care, but is less costly.[4]

*NEW YORK HOSPITALS' POOR RANKING IN 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."[5] A widely-covered study reported that 400,000 U.S. hospital patients experienced some

[1] Governor Hochul's FY26 budget highlights, https://www.budget.ny.gov/pubs/archive/fy26/ex/book/healthcare.pdf.

[2] Healthcare.gov, "Readmission rates," https://www.healthcare.gov/glossary/hospital-readmissions/#:~:text=A%20situation%20where%20you%20were,30%2C%2060%20or%2090%20days.

[3] Agency for Healthcare Research and Quality, "Characteristics of 30-Day All-Cause Hospital Readmissions, 2010-2016," February 2019, Molly K. Bailey, M.S., Audrey J. Weiss, Ph.D., Marguerite L. Barrett, M.S., and H. Joanna Jiang, Ph.D., https://hcup-us.ahrq.gov/reports/statbriefs/sb248-Hospital-Readmissions-2010-2016.jsp.

[4] Beauvais B, Whitaker Z, Kim F, Anderson B. Is the Hospital Value-Based Purchasing Program Associated with Reduced Hospital Readmissions? J Multidiscip Healthc. 2022 May 12;15:1089-1099. doi: 10.2147/JMDH.S358733. PMID: 35592815; PMCID: PMC9113654, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9113654/.

[5] 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." https://www.nejm.org/doi/full/10.1056/NEJMsa1004404.

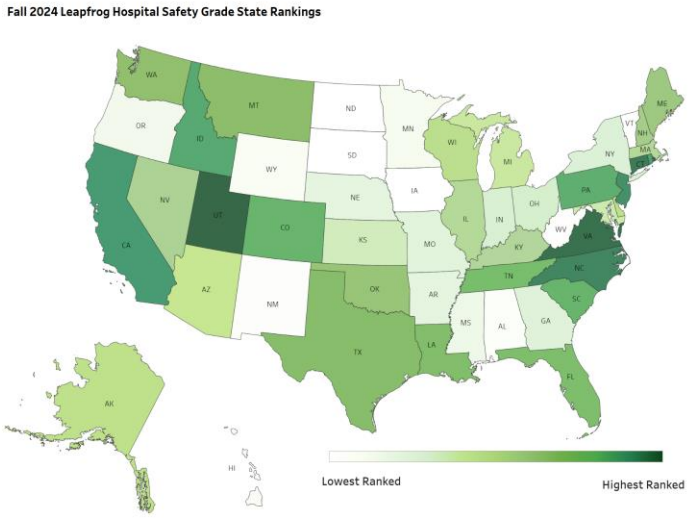
type of preventable harm each year.[6] The costs resulting from these patient injuries and deaths are enormous. According to one estimate, the annual cost of measurable medical errors that harm patients was $20 billion.[7] Since New York State is approximately 6 percent of the nation's population—and if the quality of care were universally distributed (which is not) — 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 rankings based on information provided by the federal government.**

The U.S. Department of Health and Human Services publishes an annual *Medicare.gov/Compare*, which reports the quality of the nation's hospitals and other providers to the public.[8] Researchers use that information to compare states. One notable organization, "The Leapfrog Group" (established by the nation's large employers in 2000 in order to measure "hospital performance, empowering purchasers to find the highest-value care and giving consumers the lifesaving information they need to make informed decisions"[9]) has issued annual reports on the quality of American hospital care for 25 years. *New York has been consistently ranked poorly.*

**A Recent Review Finds Problems in Hospital Quality**

The Leapfrog Group, issued a report last year looking at hospitals' quality of care nationwide. Unfortunately, as seen below, The Leapfrog Group found that New York State ranked 34th nationwide in terms of quality, with only 22 percent of hospitals receiving an "A" grade.[10]




[6] Rodziewicz TL, Houseman B, Hipskind JE. Medical Error Reduction and Prevention. 2023 May 2. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2023 Jan–. PMID: 29763131, https://pubmed.ncbi.nlm.nih.gov/29763131/.

[7] Ibid.

[8] Medicare.gov, "Find & compare providers near you." https://www.medicare.gov/care-compare/.

[9] Leapfrog Group, https://www.leapfroggroup.org/about.

[10] Leapfrog Hospital Safety Grade, "State Rankings," https://www.hospitalsafetygrade.org/your-hospitals-safety-grade/state-rankings.

**Why do New York hospitals perform comparatively so much worse?**
In July 2019 Erica Mobley, director of The 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 in 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. We've seen hospitals continually get As: They are embedding safety in their culture."[11]

Last year, New York State's "Commission on the Future of Health Care" was supposed to have submitted its report. Part of its charge is to "enable the delivery of accessible, equitable, high-quality care for all New Yorkers."[12] Did the Commission examine the important issue of the quality of care in New York hospitals?

Given the state's consistently subpar-quality ranking, we urge that you demand answers from the Administration to the following questions:

- 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 25 years ago?
- 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, or reputable third-parties.**

*MEDICAL DEBT*

Health care is too often unaffordable for New Yorkers. Many patients suffer serious financial harm as a result of needing medical care. In the past three years, New York has taken some steps to protect patients from the adverse impact of medical debt, including: prohibiting hospitals from garnishing wages and putting liens on property in pursuit of medical debt judgments; prohibiting medical debt from appearing on credit reports; requiring hospitals to utilize a uniform financial assistance application; and prohibiting medical debt lawsuits against New Yorkers under 400% of the federal poverty level. While these are laudable changes, more needs to be done to provide help to the 38 percent of New Yorkers who say they avoid

[11] See: https://www.cityandstateny.com/articles/policy/health-care/why-new-york-hospitals-have-terrible-federal-rankings.html.
[12] New York State Commission on the Future of Health Care, https://www.governor.ny.gov/programs/new-york-state-commission-future-health-care#:~:text=The%20Commission%20will%20provide%20ongoing,care%20for%20all%20New%20Yorkers.

necessary medical care because of costs or the 34 percent who say they have experienced serious financial harm due to medical bills (such as being unable to afford basic necessities or using up all of their savings).[13]

Over 53,000 patients were sued by hospitals between 2015 and 2020, and thousands had liens placed on their homes or had their wages garnished.[14] In 2022, New York recognized this problem and placed a prohibition on the practice of medical liens and wage garnishments. Despite this important change, some hospitals continue to be aggressive in initiating lawsuits – in particular, the State University of New York (SUNY) hospitals. One study found that these state-owned hospitals were responsible for three-quarters of all medical debt lawsuits filed in 2022.[15] The process of suing largely low-income patients is costly for the state and rarely recoups the expense involved in initiating such lawsuits, while it can be devastating for the low-income patients affected.

Last year, the state passed legislation prohibiting lawsuits against individuals below 400% of the federal poverty level. This proposal should be expanded to include the "Stop SUNY Suing" bill [S.359 (Rivera)/A.1356 (Paulin) of 2025], which would prohibit state hospitals from suing patients altogether, regardless of income. SUNY hospitals are the primary drivers of medical debt lawsuits in the state and prohibiting them from suing patients would go a long way towards protecting patients in New York from the adverse effects of medical debt.

**NYPIRG recommends that state hospitals be prohibited from suing patients altogether.**

*"SITE-NEUTRAL" PRICING*

Healthcare costs in New York have risen to a point that, according to one survey, about half of respondents said that they are not confident they can pay for routine care.[16] *Currently, the cost of care can depend as much on the physical setting as on the care itself.* A medical procedure performed in a hospital is often much more expensive than that same procedure done in a freestanding facility like a physician's office or a clinic.

However, as hospitals expand their networks and purchase non-hospital facilities, they often use hospital coding to determine prices in these non-hospital settings, such as private practices, clinics, labs, and imaging centers.[17] As a result, health care can cost more, both impacting the cost of insurance as well as the costs patients pay.

When acquired by a hospital, physician practices charge about 14 percent *more* than when they were independent.[18] More than half of physicians are now employed by hospitals and health systems as a result

[13] Amanda Dunker and Elisabeth Benjamin, "Financial Hardship, Avoiding Care: Results from Statewide Survey, Community Service Society of New York, March 10, 2022, https://www.cssny.org/news/entry/financial-hardship-avoiding-care-healthcare-affordability-survey.

[14] Amanda Dunker and Elisabeth Benjamin, "Discharged Into Debt: New York's Nonprofit Hospitals Garnish Patients' Wages," July 2022, https://www.cssny.org/publications/entry/discharged-into-debt-new-yorks-nonprofit-hospitals-garnish-patients-wages.

[15] Douglass Dowty, "How NY State, Upstate Medical Haul Thousands of Sick and Poor into Court for Little Gain," December 14, 2023, https://www.syracuse.com/health/2023/12/how-ny-state-upstate-medical-haul-thousands-of-sick-and-poor-into-court-for-little-gain.html

[16] "How New Yorkers Feel about Affordability and Healthcare Reform".2022 March;Robert Wood Johnson Foundation Affordability_NY_D4.pdf.

[17] MedPAC Report to Congress June 2022 "Medicare and the Health Care Delivery System" Ch.6 https://www.medpac.gov/wp-content/uploads/2022/06/Jun22_MedPAC_Report_to_Congress_v4_SEC.pdf

[18] Capps C, Dranove D, Ody C., "The effect of hospital acquisitions of physician practices on prices and spending," J Health Econ. 2018 May;59:139-152. doi: 10.1016/j.jhealeco.2018.04.001. Epub 2018 Apr 22. PMID: 29727744, https://pubmed.ncbi.nlm.nih.gov/29727744/.

of consolidation. Medicare and their beneficiaries pay twice as much for procedures done in hospital owned facilities than they would otherwise.[19]

"Site-Neutral Pricing", established in the "Fair Pricing Act" [S.705 (Krueger)/A.2140 (Jackson) of 2025], addresses this problem by capping prices for low complexity, routine, medical procedures at 150% of Medicare in order to lower health benefit expenses for payers while making healthcare more affordable for patients. By reducing the cost disparities between hospitals and independent facilities, patients won't be financially penalized for where they receive care, and employers and taxpayers will face less expense. For patients paying entirely out of pocket—like the uninsured or underinsured—this bill ensures they are not charged exorbitant hospital prices for basic services and instead benefit from fairer, standardized rates. Onerous facility fees, including any additional charges for routine office visits, basic diagnostic tests, or minor outpatient procedures that would potentially burden patients would also be prohibited under the bill. Transparency through data reporting and public availability of hospital pricing information will further ensure patients make informed decisions on healthcare for themselves and their families. Publicly accessible pricing data allows patients to compare the costs of procedures and services across hospitals, independent clinics, and other providers. This ensures they can choose care options that best fit their financial situation without compromising on quality.

The Fair Pricing Act also empowers the Department of Health with enforcement authority to assess administrative penalties for significant violations. Healthcare providers that fail to comply or violate policies of site-neutral pricing are subject to fines of $1,000 per claim improperly billed or a minimum statutory penalty of $100,000 per contract occurrence. The Department has the authority to request additional data reports from health care providers annually as needed to efficiently and fully report on pricing of applicable services as needed.

Every patient deserves fairly priced care and has the right to be protected for applicable medical services such as clinic visits, vaccines, and imaging procedures. These are among the many routine procedures New Yorkers experience every day that are threatened by unsustainable increases to healthcare costs. Site-neutral pricing ensures that patients will not be burdened by unsustainable pricing disparities. **NYPIRG urges your support for inclusion of this proposal in the final budget agreement.**

*CANCER PREVENTION AND 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.[20] The most recent cancer statistics from the American Cancer Society estimated that the top five cancer killers account for half of all the *estimated* cancer deaths in New York, with lung cancer far and away the biggest killer.[21]

[19]Actuarial Research Corporation, "Sizing Medicare Off-Campus Hospital Outpatient Department Site Neutrality Proposals," July 3, 2024 https://craftmediabucket.s3.amazonaws.com/uploads/Sizing-Medicare-Off-Campus-HOPD-Site-Neutrality-Proposals-2024.01.03.pdf.

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

[21] American Cancer Society, "Cancer Facts & Figures 2025," https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/annual-cancer-facts-and-figures/2025/sd3-21-cancers-by-state-2025.pdf.

| Type | Estimated Number of Cases | Estimated Number of Deaths |
|---|---|---|
| Total, NYS | 123,430 | 31,190 |
| Lung & Bronchus | 12,770 | 6,060 |
| Pancreas | 4,280 | 2,980 |
| Colon & Rectum | 8,920 | 2,610 |
| Female Breast | 19,170 | 1,920 |
| Prostate | 20,490 | 1,660 |

Two years ago, 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 $27 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 over $46 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 $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.

Despite its successes, New York State has so far 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.

At the same time the state has added responsibilities to the TCP monitor vaping use, it has failed to provide additional resources for these activities. This is true despite the availability of new revenues generated by a tax on vaping products. The resources are there, in September 2023, the state increased its cigarette tax.[23]

The problem cited most often about high tobacco tax rates is its impact on the sales of illegal products. Currently, the state relies on a tax stamp to ensure that tobacco products sold are legal and has its enforcement agents monitor compliance. The Commissioner of Taxation and Finance currently licenses agents to sell stamps for the payment of tax on cigarettes. The agent retains some of the revenues from the sale as commission according to guidelines established by the Tax Commissioner. The Commissioner is also authorized to prescribe a schedule of commissions, not exceeding five percent, to agents for buying and affixing stamps.

[22] For access to the NYPIRG report, https://www.nypirg.org/pubs/202302/Tobacco_Report_2023_Final.pdf.

[23] New York State Department of Taxation & Finance, https://www.tax.ny.gov/bus/cig/cigidx.htm#:~:text=The%20state%20excise%20tax%20rate,New%20York%20City%20to%20$6.85.

Currently, the state relies on a tax stamp system that uses four different colored, numbered, heat-transferred stamps. The stamps have security features including taggants, micro-imaging, stamp numbering, variable image and UV watermarking.[24]

The CDC recommends that states embrace cutting-edge technologies to limit illegal tobacco sales.[25] According to the CDC, "[e]vasion of tobacco excise taxes costs states millions of revenue dollars every year. After the switch to the new high-tech tax stamps, California collected an additional $110 million dollars in revenue, without raising the excise tax.[26]

The CDC cited three states (California, Massachusetts, and New Jersey) that require the stamp to have a hologram or encrypted image. Three states (California, Michigan, and New Jersey) require a barcode or other scannable code in the tax stamp. Within two years of passing legislation including encrypted tax stamps, California saw a 37% decline in cigarette tax evasion and increased tax revenue of $110 million.[27]

New York State should embrace these new technologies and use additional tobacco tax revenues to devote more resources to enforcement of its laws.

**NYPIRG recommends that the state stop shortchanging its tobacco control efforts and instead follow the science-based recommendations of the CDC.**

*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 (a/k/a "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 already become harder and sometimes impossible to treat due to multidrug-resistant bacteria.

In recognition of the serious threat to public health posed by antibiotic-resistant infections, members of the U.N. General Assembly in 2016 committed to taking collaborative action.[28] The World Health Organization considers it to be one of the biggest threats to global health, food security, and international development

[24] Federation of Tax Administrators, Tax Uniformity, "Tobacco Tax Information By State," Updated August 2019, p. 386.

[25] United States Centers for Disease Control and Prevention, "STATE System Tax Stamp Fact Sheet," https://www.cdc.gov/statesystem/factsheets/taxstamp/TaxStamp.html#anchor_1562859962.

[26] From CDC, Boonn A. The Case for High-tech Cigarette Tax Stamp, Campaign for Tobacco Free Kids. January 3, 2013. Accessed March 21, 2013.

[27] From the CDC, 5. McIntosh A. Tobacco tax cheating falls. Sacramento Bee. June 27, 2007.

[28] United Nations, https://digitallibrary.un.org/record/842813?ln=en

today.[29] 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.**[30] A study commissioned by the U.K. government predicts that if action is not taken now to combat antibiotic resistance, **by 2050 the annual death toll will have risen to 10 million globally.**[31] Most major medical and health groups in the U.S., including the American Medical Association, American Academy of Pediatrics, and Infectious Diseases Society of America, have recognized the urgency of the antibiotic resistance crisis.[32]

*Antibiotics Resistance and Food Safety*

For almost 70 years, we have been giving antibiotics to the animals we raise 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.[33] When antibiotics are given to food-producing animals, they kill most of the beneficial 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.**[34] ***Salmonella* and *Campylobacter*—bacteria that commonly contaminate food—are estimated to cause 410,000 antibiotic-resistant infections in the U.S. each year.**[35]

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

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[29] World Health Organization, "Antibiotics Resistance," https://www.who.int/news-room/fact-sheets/detail/antibiotic-resistance

[30] U.S. Centers for Disease Control and Prevention, "Antibiotic/Antimicrobial Resistance," https://www.cdc.gov/drugresistance/index.html.

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

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

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

[34] U.S. Centers for Disease Control and Prevention https://www.cdc.gov/foodsafety/pdfs/ar-infographic-508c.pdf. Link has been taken down. NYPIRG has original.

[35] 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.

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

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

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

*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.

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,[38] ensure that patients are aware of the state's physician profiles resource,[39] and provide access to the OPMC database of its actions against doctors and other providers.[40] 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 Medicine[41] and the State Health Department[42] 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 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 2021, nearly one million New York residents were uninsured (5 percent of the population).[43] 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. New York State, which implemented the ACA's reforms as state-based policies, has not seen an uptick in

[38] See http://www.health.ny.gov/professionals/doctors/conduct/file_a_complaint.htm.

[39] See www.nydoctorprofiles.com.

[40] See http://www.health.state.ny.us/nysdoh/opmc/main.htm.

[41] National Academy of Sciences' Institute of Medicine, To Err is Human: Building A Better Health Care System, November 1999, p. 10.

[42] 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.

[43] New York Office of the State Comptroller, "Health Insurance Coverage in New York State," August 2023, https://www.osc.ny.gov/files/reports/pdf/health-insurance-coverage-in-new-york-state.pdf.

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.[44] 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.[45]

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.[46]

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.[47]

**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

[44] Organisation of Economic Co-operation and Development, https://www.oecd.org/health/health-data.htm.

[45] 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.

[46] 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.

[47] 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.

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."[48]

The overwhelming case for universal health care modeled on Medicare has long been clear. Legislation proposed in New York, The New York Health Act, 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.

The New York Health Act 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.

*PREVENT LEAD POISONING*

**New York's long standing childhood lead poisoning epidemic merits close attention and a response commensurate with the size and scope of the problem. At a time when the Trump Administration is slashing funding and dismantling public health and environmental programs, regulations and standards, it is critically important that New York step forward. The Legislature must ensure that the state is finally making good on its decades-old promise to eliminate childhood lead poisoning.**

Despite the magnitude of this issue, the Department of Health has for decades failed to be transparent in how it operates its lead poisoning prevention programs and failed to be an aggressive protector of children's health in this area.[49] The Legislature should use the FY26 budget process to demand that the Health Department leadership detail in their budget testimony -- on the record -- how much it *actually has been spending* on childhood lead poisoning prevention programs and require the state's biggest agency to fully explain the governor's current childhood lead poisoning and safe housing programs in detail.[50]

Over the past two years, the governor proposed and the Legislature prioritized childhood lead poisoning prevention, requiring that housing in high-impact areas be designated by NYSDOH as "communities of concern" and those communities establish periodic rental property inspections and, where necessary, remediation.[51] A capital fund of $20 million was established. In addition to the $20 million in capital budget

[48] 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.

[49] For example, the latest childhood lead poisoning test data posted on the NYSDOH website is from 2020 – before the state adopted the more stringent action level of 5 ug/dL (half the previous level of 10 ug/dL). *See Childhood Blood Lead Testing and Elevated Incidence by Zip Code: Beginning 2000* accessed at https://health.data.ny.gov/Health/Childhood-Blood-Lead-Testing-and-Elevated-Incidenc/d54z-enu8/data_preview.

[50] The amount of state funds allocated in each budget and actually spent on childhood lead poisoning detection and prevention is opaque – at best. Advocates have been unable in recent years to determine these numbers—most importantly *how much is actually spent* by the state on prevention programs (not budgeted, but actually spent).

[51] NYSDOH has designated communities of concern for purposes of lead poisoning prevention since at least 2008. The communities contained in 19 counties outside of New York City (excluding Nassau and Suffolk Counties) were identified in the Housing Trust Fund Program notice of funding. Unfortunately, the $20 million allocated in the

funds allocated last year, the Legislature approved $39 million dollars for programs to prevent lead poisoning in 24 of the "hardest hit communities" in the state. The state also committed to creating a registry of pre 1980 rental housing outside of New York City to identify those properties mostly likely to contain lead paint.[52] The proposal created a regime whereby local inspections and lead safe certifications would occur on a triennial basis. The state is also encouraging contractors to become EPA certified in safe lead renovation, repair, and painting practices.

While these are welcome steps forward, the plans lacked the detail, adequate funding and long-range commitment to truly address the lead poisoning epidemic that continues to poison New York's children now 55 years after lead in paint was banned in the state.

**NYPIRG urges that the Legislature–led by the relevant health and financial committees–use the budget hearing process to ensure that the state and local health departments are aggressively working to eliminate childhood lead poisoning and that the state is actually spending at levels commensurate with this problem of epidemic proportions.**

**Childhood lead poisoning is at epidemic levels in New York.** Based on the recent 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.[53] Even if actual numbers are substantially less than upper-bound projections, 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."[54] Additional studies have used population statistics and public safety data to note the correlation between early childhood lead exposure

FY24 budget for rental property remediation in Communities of Concern has not been awarded as of the date of this testimony, https://hcr.ny.gov/leading-lead-prevention.

[52] NYSDOH staff have long mapped the state's housing stock and lead poisoning incidence. *See, e.g.*, Haley and Talbot, *Geographic Analysis of Blood Lead Levels in New York State Children Born 1994–1997* (2004), www.ncbi.nlm.nih.gov/pmc/articles/PMC1247624/.

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

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

and rates of criminal activity.[55] An article reviewing these studies found positive correlations between lead exposure and criminal activity in local, state and national surveys.[56]

**The previous Administration's track record on childhood lead poisoning was a huge disappointment**. The Cuomo administration advanced no new programs; it stalled funding;[57] 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.[58] *A clear indication of the Cuomo administration's disinterest in childhood lead poisoning was that his Department of Health had not posted lead testing data beyond 2014.*

Currently, it is 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.[59] 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. The Advisory Council did not meet in calendar year 2024 and was not consulted on the 2024 lead poisoning detection and prevention budget or briefed on its contents. Its last meeting–January 8, 2025–was *before* the 2026FY budget was released and the topic of programmatic budgets were not on the public agenda.[60]

**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 1950,[61] 41% of housing stock built pre 1950.[62] Housing stock built before 1950 are the most likely to contain lead paint, the greatest source of

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[55] 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.

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

[57] Again, responses to repeated requests by advocates to get a full picture of the state's programs and funding proved elusive.

[58] 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.

[59] 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. Lawmakers should use the 2026 budget hearing to clarify how much has been budgeted and how much actually spent on lead poisoning prevention programs over the past decade.

[60] New York State Advisory Council on Lead Poisoning Prevention Agenda, January 8, 2025 meeting. https://www.health.ny.gov/environmental/lead/advisory_council/.

[61] 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.

[62] *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, https://papers.ssrn.com/sol3/papers.cfm?abstract_id=3492119.

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.[63] 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 and the City of Rochester 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 an aggressive "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.[64] *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. State laboratories and independent contractor labs must have capacity to handle the lead dust tests expeditiously.
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 and policies when they are in the development process and stages.
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.

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[63] *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), https://www.jpeds.com/article/S0022-3476(1630206-2/fulltext.

[64] 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.

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 the government must step in to protect residents—including making lead-safe housing available when their safety cannot be assured during remediations.

Thank you for the opportunity to testify.