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 2017-2018 EXECUTIVE HEALTH BUDGET PROPOSAL

February 16, 2017
Albany, N.Y.

Good afternoon, my name is Blair Horner and I am executive director of the New York Public Interest Research Group (NYPIRG), with me today is Smitha Varghese, a policy associate with NYPIRG and a student at Queens College. 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.

As you will see, we have reactions to a number of areas of the executive budget. However, the focus of our testimony is on the executive's funding of programs to fight cancer.

As you know, the governor has made screening for breast cancer a top initiative. He rightly points out that breast cancer is the second largest cancer killer of women. He has advanced programs to boost screening.[1] Undoubtedly for women without adequate health insurance, such screening programs can have a positive impact. Below are the estimated number of new cancer cases in New York:

Estimated Number of New Cancer Cases and Deaths Exceeding 1,000, 2017[2]

Type of Cancer	New Cases	Deaths
Total, all sites	*107,530*	*35,960*
Lung & Bronchus	12,700	8,660
Colon & Rectum	8,490	2,870
Pancreas	3,490	2,750
Female Breast	16,310	2,410
Prostate	10,060	1,560
Leukemia	4,320	1,460
Liver & IBD	2,520	1,680
Non-Hodgkin Lymphoma	4,760	1,210
Urinary Bladder	5,410	1,050

[1] Governor Cuomo, "Get Screened, No Excuses," see: https://www.ny.gov/programs/get-screened-no-excuses.
[2] American Cancer Society, Cancer Facts & Figures, Supplemental Data, see: https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/annual-cancer-facts-and-figures/2017/estimated-deaths-for-selected-cancers-by-state-us-2017.pdf.

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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.[3] *As seen above, the top five cancer killers account for more than half of all the estimated cancer deaths.*

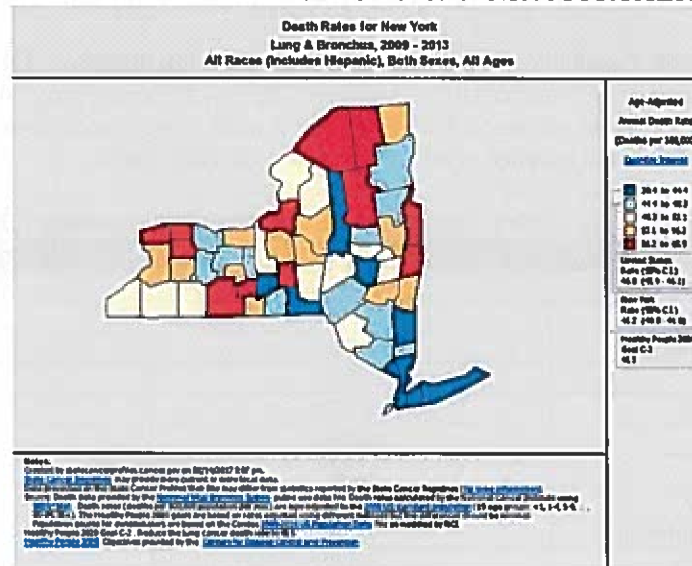
Breast cancer is the leading form of cancer affecting women and the second biggest killer. Yet, it is not the leading cause of cancer deaths for women. Prostate cancer is a leading cause of cancer in men, but it is not the leading cause of cancer deaths in men. *That terrible distinction belongs to lung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

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

The leading cause of lung cancer is tobacco use. Today nearly 9 out of 10 lung cancers are caused by smoking cigarettes.[4] Not only are smokers at risk, but even non-smokers can be afflicted by exposure to tobacco smoke. In the U.S., more than 7,300 nonsmoking lung cancer patients die each year from exposure to secondhand smoke alone.[5]

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

NEW YORK STATES COUNTIES' LUNG CANCER MORTALITY RATES[6]



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

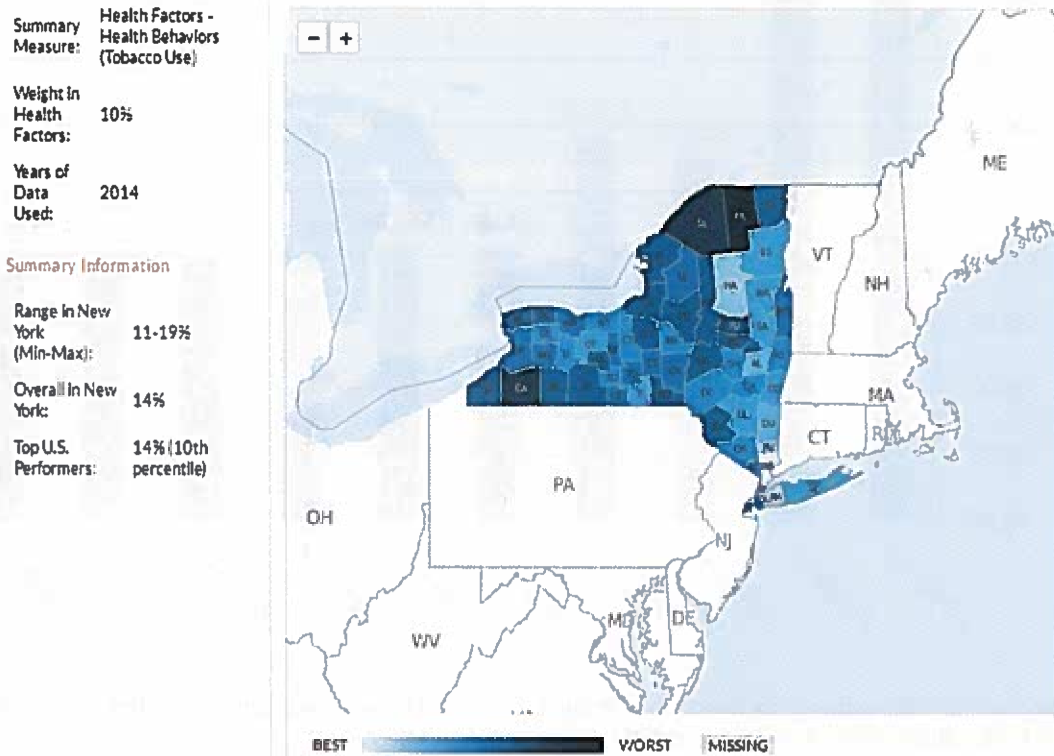
[4] Smoking also causes cancers of the esophagus, larynx, mouth, throat, kidney, bladder, liver, pancreas, stomach, cervix, colon, and rectum, as well as acute myeloid leukemia (1-3). Source: National Cancer Institute, available at https://www.cancer.gov/about-cancer/causes-prevention/risk/tobacco/cessation-fact-sheet#q2.

[5] U.S. Centers for Disease Control and Prevention, "Secondhand Smoke Facts, 2015" see: https://www.cdc.gov/tobacco/data_statistics/fact_sheets/secondhand_smoke/general_facts/index.htm.

[6] National Cancer Institute, see: https://statecancerprofiles.cancer.gov/map/map.withimage.php?36&001&047&00&0&02&0&1&5&0#results.

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

NEW YORK COUNTIES' ADULT SMOKING RATES[7]



Unfortunately, the governor's executive budget does nothing new to combat the leading cause of cancer deaths in women – and men.[8] 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 CDC.[9] 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.*[10]

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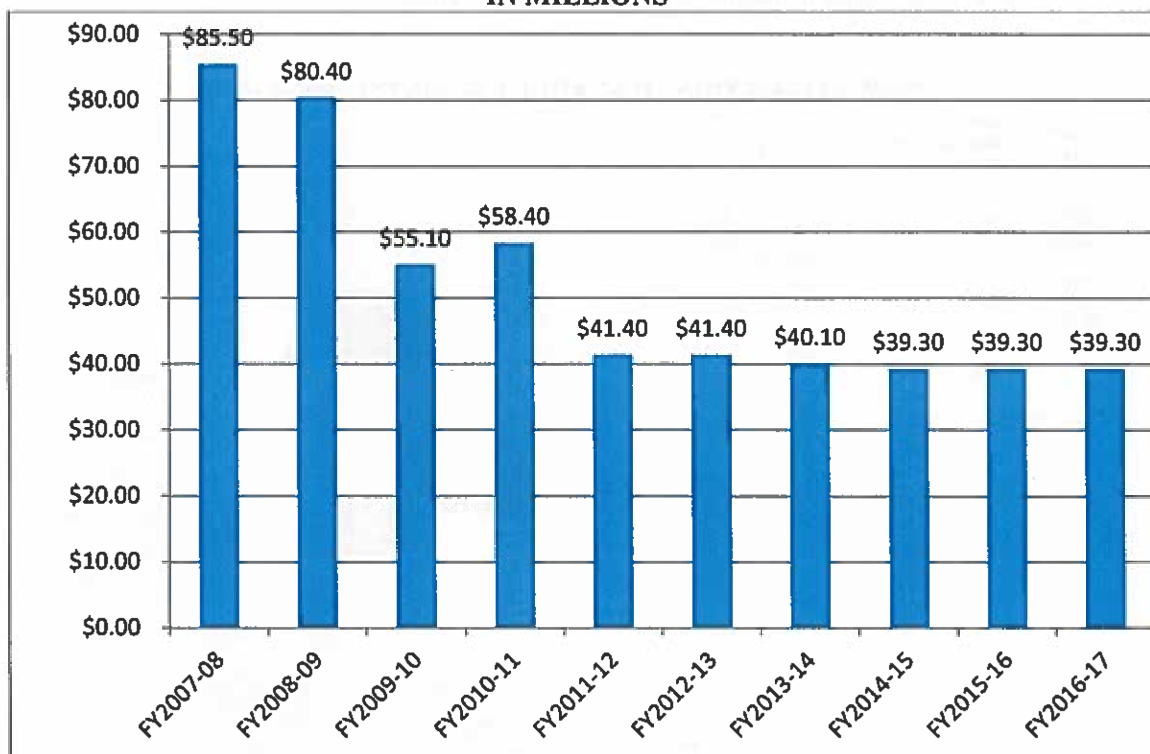
[7] Source: County Health Rankings, see: http://www.countyhealthrankings.org/app/new-york/2016/measure/factors/9/map.

[8] U.S. Centers for Disease Control and Prevention, for women see: https://www.cdc.gov/cancer/dcpc/data/women.htm; for men, see: https://www.cdc.gov/cancer/dcpc/data/men.htm.

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

[10] Report issued jointly by the American Cancer Society, American Heart Association, American Lung Association and the Campaign for Tobacco Free Kids, et al, "Broken Promises to Our Children: A State-by-State Look at the 1998 State Tobacco Settlement Agreement, 18 Years Later," 2016, see: http://www.tobaccofreekids.org/microsites/statereport2017/pdf/3_FY2017_Rankings_Funding_Prevention_Programs.pdf.



Not only has the state reduced its investment in the best way to reduce lung cancer incidence and mortality, relative to the other states, New York is still ranked in the middle.

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

The money is available. In addition to the estimated $1.2 billion raised in tobacco taxes, the state is now expecting new revenues from the state's master settlement agreement (MSA). The MSA is an agreement to settle litigation between the nation's largest cigarette companies and 46 states. The MSA requires those cigarette companies to, among other things, annually pay billions of dollars to the states as compensation for the health costs to their Medicaid programs resulting from tobacco use. Bonds issued in 2003 that were secured by annual payments under the MSA with tobacco manufacturers will be fully retired. The executive budget expects that MSA payments of approximately $125 million in FY 2018, and $400 million annually thereafter, will be available for State purposes.

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[11] New York State Department of Health, "2014 Independent Evaluation Report of the New York Tobacco Control Program," see:
https://www.health.ny.gov/prevention/tobacco_control/docs/2014_independent_evaluation_report.pdf, p. 4. The two most recent fiscal years' totals are from the enacted budgets.

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

The revenue is generated from New York's MSA, an agreement to settle litigation between the nation's largest cigarette companies and 46 states. The MSA requires those cigarette companies to, among other things, annually pay billions of dollars to the states as compensation for the health costs to their Medicaid programs resulting from tobacco use.

After the MSA was signed in November 1998, many governors, state attorneys general, and other high-ranking state officials expressed strong support for investing substantial portions of the tobacco settlement payments in new efforts to prevent and reduce tobacco use in their states.

For example, Governor Thomas Carper, Chairman of the National Governors Association and Utah Governor Michael Leavitt, Vice Chair, wrote in a letter to U.S. Senate Minority Leader Daschle, March 5, 1998:

> "The nation's Governors are committed to spending a significant portion of the tobacco settlement funds on smoking cessation programs, health care, education, and programs benefiting children."

Announcing the settlement, then-New York Attorney General Dennis Vacco released a statement on November 16, 1998, which stated:

> "As a result, millions of children who are not yet smokers will be spared horrific diseases and suffering, *and millions of current smokers will get a real chance to quit and reclaim their good health.*" [Emphasis added] [12]

However, it was not just promises made by high-ranking public officials in press releases. The pledge to use the MSA revenues to curb tobacco use is found in the agreement itself. Most notably, the MSA begins with a series of "Whereas" clauses, including the following:

> WHEREAS, the Settling States that have commenced litigation have sought to obtain equitable relief and damages under state laws, including consumer protection and/or antitrust laws, in order to further the Settling States' policies regarding public health, including policies adopted to achieve a significant reduction in smoking by Youth . . .
>
> WHEREAS, the Settling States and the Participating Manufacturers are committed to reducing underage tobacco use by discouraging such use and by preventing Youth access to Tobacco Products;
>
> WHEREAS, the undersigned Settling State officials believe that entry into this Agreement and uniform consent decrees with the tobacco industry is necessary in order to further the Settling States' policies designed to reduce Youth smoking, to promote the public health and to secure monetary payments to the Settling States; and

[12] New York State Office of the Attorney General, News Release, "Vacco: $200 Billion Tobacco Plan to Protect Health of Kids," November 16, 1998.

> WHEREAS, the Settling States and the Participating Manufacturers . . . have agreed to settle their respective lawsuits and potential claims pursuant to terms which will achieve for the Settling States and their citizens significant funding for the advancement of public health, the implementation of important tobacco-related public health measures, including the enforcement of the mandates and restrictions related to such measures, as well as funding for a national foundation dedicated to significantly reducing the use of Tobacco Products by Youth.[13]

These excerpts clearly indicate that the states are obliged to use their MSA payments to advance public health and support tobacco-prevention efforts. Indeed, the last clause explicitly says just that, and also very clearly declares that the states are expected to use their MSA funding for tobacco-prevention and other public health efforts.

The money is now amply available; it is the commitment that is missing.

In addition to the erosion in state support for combating tobacco use, there have been proposals that have put at risk other cancer services programs.

New York State offers a Cancer Services Program (CSP), which provides breast, cervical and colorectal cancer screenings and diagnostic services at no cost to women and men, typically those that lack health insurance. If the screening test finds something abnormal, diagnostic (testing) services are available for eligible women and men at no cost. The CSP will also provide a case manager who will guide someone with cancer through their follow-up diagnostic appointments.

If breast, cervical or colorectal cancer is found, eligible women and men may be able to enroll in the special cancer treatment program to receive full Medicaid health insurance coverage for the entire time they are being treated for cancer.

But that program has never been adequately funded, with experts stating that it only historically offered help to 15 percent of the eligible population.[14] Even with the expansion of health insurance under the Affordable Care Act, the CSP is still not adequately funded to meet the needs of the uninsured. In his executive budget, the governor proposes to cut funding for this vital program.

The governor's budget ignores that best scientific evidence behind cancer screening and instead proposes to consolidate 39 public health appropriations into four pools, and reduce overall spending by 20 percent, or $24.59 million, with cuts to "evidence-based cancer services" taking the biggest hit – nearly $5 million.

Ironically, cancer prevention experts will state that colon cancer screening is a much more scientifically useful cancer-fighting tool than other cancer screenings. The national experts at the federal government's U.S. Preventive Services Task Force regularly issue guidelines documenting the best available science to direct medical practice.

In the case of cancer screenings, they rank the efficacy of the effort with a letter grade, an "A" being the service that provides the most benefits with the smallest risks. According to the USPSTF, colon cancer

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[13] *Master Settlement Agreement*, November 23, 1998, see: http://www.naag.org/assets/redesign/files/msa-tobacco/MSA.pdf.

[14] New York State Department of Health, "RFA # 0707301113 Questions and Answers," see: https://www.health.ny.gov/funding/rfa/inactive/0707301113/questions_and_answers.pdf, p. 5. This is from FY 2007-08, we have not seen updated information.

screening ranks an "A," breast cancer screening is graded with a "B" and prostate cancer screening a "D."[15] *That does not mean that breast cancer screenings are untrustworthy; it means that the expert assessment is that there is less benefit and greater risks with that type of screening compared to colon cancer screenings.*

Yet, unless the governor and Legislature agree, there will be no additional resources for colon cancer screenings. And, unless there is an agreement, there will be no additional funding for anti-smoking programs, which are the best ways to combat the biggest cancer killer.

There can be no doubt that the executive budget as drafted ignores the best scientific evidence and as a result advances plans that leave more New Yorkers at risk of cancer.

Support Funding for The New York State Health Exchange. As you know, the numbers of New Yorkers who lack health insurance is considerable. According to the US Census Bureau, in 2015 roughly 1.4 million New York residents were uninsured (7.1 percent of the population). This represents both the lowest percentage and number of New Yorkers who lack health insurance since 1999.[16]

What has happened to drive down the number of uninsured? Nationally, the percentage of Americans without health insurance is at the lowest since 2009,[17] but given the fact that many states have been slow to embrace reforms, the national impact is hard to assess. However, the drop in the percentage of the uninsured has followed the timeline of the implementation of the federal health care law. Starting in the Fall of 2010, coverage under the law started to kick in. Thus, it seems reasonable to conclude that the changes brought about by the Affordable Care Act (ACA) contributed to New York's decline.

The United States spends 17.1% of the Gross National Product on health care[18] yet ranks 27th of the 38 member Organisation for Economic Co-operation and Development (OECD member nations in life expectancy.[19] It is clear that American health care is expensive and yet doesn't deliver on its most basic mission, providing coverage to all those who need it. Public policy must ensure coverage for all residents.

Despite the demonstrable successes of the Affordable Care Act, many in need are left without health insurance. As mentioned above, 7.1% of New Yorkers still lack health insurance.[20] And while this represents both the lowest percentage and number of New Yorkers who lacked health insurance since 1999, more must be done.

NYPIRG urges that you continue to support implementation of the ACA. However, as Washington begins its consideration of changes to the ACA, it is more important than ever that the state explore its own options. Health insurance coverage is critical to the health and well-being of all New Yorkers.

In addition, as mentioned earlier, when it comes to important health programs for the uninsured, such as the Cancer Services Program, funding must be enhanced in order to provide services to those in need.

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[15] For more information on the USPSTF and its rankings, see: http://www.uspreventiveservicestaskforce.org/Page/Name/recommendations.

[16] United State Census Bureau, see: https://www.census.gov/content/dam/Census/library/publications/2016/demo/p60-257.pdf accessed 1/18/17, Table A-1, "Population Without Health Insurance Coverage by State: 2013 to 2015."

[17] *Ibid.*

[18] World Bank, "Health expenditure, total (% of GDP)," see: http://data.worldbank.org/indicator/SH.XPD.TOTL.ZS.

[19] Organisation of Economic Co-operation and Development, see: http://www.oecdbetterlifeindex.org/topics/health/.

[20] U.S. Census Bureau, Table A-1, see: http://www.census.gov/data/tables/2016/demo/health-insurance/p60-257.html.

Support Enhanced Testing and Monitoring of Public Drinking Water. The governor proposes the establishment of the Emerging Contaminant Monitoring Act, which would require all public water systems to test drinking water for the presence of emerging contaminants once every three years and report their findings. The governor's plan requires water systems to test drinking water for emerging contaminants and unregulated contaminants monitored under the Federal Safe Drinking Water Act and it requires every public water system test to be conducted by a New York State Department of Health-certified laboratory.

Support Testing of Private Wells. Currently, only public drinking water supplies in New York are tested regularly for contamination. It is estimated that nearly two million New Yorkers rely on private wells for their drinking water.[21] These residents may unknowingly be drinking water that is not safe for human consumption. Groundwater can be contaminated by leaking fuel tanks, chemical spills, agricultural run-off, industrial activities, and other sources, both manmade and naturally-occurring.[22]

The governor's budget requires testing of individual water systems (wells) prior to, and as a condition of, a residential real estate sale; following the completion of the drilling of any new water well; and at least once every five years for rental properties.

It is important that future residents of a property know what is in their drinking water to enable them to take precautions, as necessary, to protect their health. In addition, it will provide valuable data to state and local agencies concerning potential environmental threats that could be occurring in the vicinity of the well. This will enable state and local agencies to warn neighboring properties that their drinking water may also be at risk, and to identify and remediate potential sources of contamination.

Support Enhanced Regulation of Pharmaceutical Benefit Managers. Pharmacy Benefit Managers (PBMs), the pharmaceutical "middlemen," arrange sales programs between drug manufacturers and health care plan providers (such as state health benefit programs, large businesses, and HMOs) seeking to reduce the cost of their prescription drug plans. PBMs provide pharmacy coverage to more than 266 million American consumers[23]; three PBMs— ExpressScripts, CVSHealth (also referred to as "CVS Caremark") and OptumRx – control approximately 80% of the lucrative market.[24] Since 2003, the two largest PBMs— Express Scripts and CVS Caremark— have seen their profits increase by almost 600%, from $900 million to almost $6 billion.[25] Despite the impact of PBMs on health care spending, tremendous secrecy surrounds how PBMs conduct business. Investigations by both the federal and state governments charge that PBMs exploit their ability to negotiate secret deals and increase their revenues without passing cost savings on to clients.

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

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[21] Cornell Cooperative Extension, "Private Wells, Groundwater, and Public Water Supply Systems," see: http://waterquality.cce.cornell.edu/supply.htm.

[22] United States Department of the Interior, U.S. Geological Survey, "Contamination in US Private Wells," see: http://water.usgs.gov/edu/gw-well-contamination.html.

[23] Pharmaceutical Care Management Association (PCMA) (March 14, 2016), see: *That's What PBMs Do*.

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

[25] *Ibid.*

Support safe staffing ratios for nurses. We urge that you add additional patient protections to the budget in the area of staffing ratios. There is a serious problem of needless patient injuries and deaths due to substandard medical care in hospitals. According to numerous expert panels, the number of deaths in hospitals is staggering. Patient deaths resulting from medical mistakes in hospitals are either the third or fourth leading cause of death in America.[26]

The findings of the above-referenced report build on previous studies that estimated huge numbers of patient injuries and deaths due to medical errors. Most notably, the National Academy of Sciences' Institute of Medicine's (IoM) report, *To Err Is Human*, estimated that there were as many as 98,000 patient deaths in hospitals each year due to substandard care.[27] The IoM report noted that estimates of injury and cost are considered by many experts to be low because these types of reports do not look at medical errors occurring outside of hospitals, for example, in outpatient clinics, physicians' offices and retail pharmacies.

In addition to this mortality rate estimate, healthcare-related infections (HAI) are a common occurrence. One out of 25 hospital patients contract HAIs, translating to over 720,000 infection cases in 2011 alone.[28]

To Err is Human argued that the nation must set a goal of reducing by half the number of deaths by the year 2005. Soon after the Institute of Medicine called for a 50% reduction of medical errors within five years, the then-New York State Health Commissioner pledged to meet the IoM goal.[29]

California has had a law setting nurse-to-patient ratios for over a decade and research has concluded that the law has helped improve the quality of hospital care. One such review concluded, "Hospital nurse staffing ratios mandated in California are associated with lower mortality and nurse outcomes predictive of better nurse retention."[30]

In addition, the federal government's agency responsible for monitoring patient safety concluded, "Hospitals with low nurse staffing levels tend to have higher rates of poor patient outcomes such as pneumonia, shock, cardiac arrest, and urinary tract infections."[31]

After a thorough review of the nation's experience and the need to improve patient safety, the Institute of Medicine concluded, "Hospitals and nursing homes should employ nurse staffing practices that identify needed nurse staffing for each patient care unit per shift."[32] We urge that the final budget agreement follow the conclusions of such expert analysis.

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[26] James, J., "A New, Evidence-based Estimate of Patient Harms Associated with Hospital Care," *J Patient Safety*, 9(3):122-128 (Sept. 2013).

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

[28] U.S. Centers for Disease Control and Prevention, Healthcare-associated Infections (HAIs). (2015). See: http://www.cdc.gov/HAI/surveillance/index.html.

[29] New York State Health Department, "NYPORTS News & Alert," Issue No. 14, January 2004.

[30] Aiken, L., Sloane, D., et al, "Implications of the California Nurse Staffing Mandate for Other States," *Health Services Research*, Health Research and Educational Trust, DOI: 10.1111/j.1475-6773.2010.01114.x.

[31] Stanton MW, Rutherford MK. "Hospital nurse staffing and quality of care," Rockville (MD): Agency for Healthcare Research and Quality; 2004, *Research in Action* Issue 14. AHRQ Pub. No. 04-0029.

[32] Institute of Medicine, Committee on the Work Environment for Nurses and Patient Safety Board on Health Care Services Ann Page, Editor, "*Keeping Patients Safe: Transforming the Work Environment of Nurses*."

Support Childhood Lead Poisoning Prevention Funding. When it comes to the critically important programs addressing childhood lead poisoning prevention we are troubled by the further consolidation of 39 public health programs into just four "buckets" and the proposed 20% cut to these programs—representing $24.6 million in reductions.

However, due to the way the budget information is presented, it's impossible for us to discern the funding levels and programs related to childhood lead poisoning. Despite the fact that lead poisoning from substandard housing is still at epidemic proportions, the executive budget does not break out numbers for the programs in this area. This makes it impossible for legislators, advocacy groups and the public to comment on the proposals. Indeed, when Department of Health staff were asked about lead poisoning prevention funding during a January 27, 2017 budget briefing, they could not provide responses and did not subsequently furnish the requested information.

Further, it's not just the public that is left guessing about funding for the lead poisoning prevention budget. The statutorily created Advisory Council on Lead Poisoning Prevention[33] has made numerous requests to the Department for timely and detailed information on proposed funding in this area and as of February 15, 2017, close of business had not received that information.

Accordingly, we urge that the Legislature resist consolidation of programs that makes the budget process more opaque and urge that you demand detailed information on the lead poisoning prevention budget 2017-18 and on actual program spending in this area for the previous five years, and share such information with the Advisory Council and the public so that we all may make an informed assessment.

Our review of the data on the number of practicing physicians in New York State as well as their medical malpractice payments over time.

It has been often reported that the number of physicians in some rural (and even in poor urban) areas have declined due to shrinking populations and economic/social factors. Below we review existing data to demonstrate that New York has an abundance of doctors, including specialty doctors, and that the number of doctors is increasing statewide. New York has a very high per capita ratio of doctors practicing in "high risk" specialties.[34] New York State had the fourth highest number of practicing physicians per capita in 2013 (the latest year of national data that we reviewed). The per capita number of New York doctors practicing in obstetrics and gynecology is fifth highest in the nation. New York has 18 OB/GYNs per 100,000 population. The national average is 13 per 100,000. The per capita number of New York general surgeons is third highest and the per capita number of internal medicine specialists is also the third highest in the nation.[35]

According to the U.S. Census, in 2015 it estimated that New York State had nearly 19.8 million residents.[36] The Department of Health has estimated that the state had 19.2 million residents in 2004.[37] Thus, the state's population has increased slightly, at a *3%* increase.

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[33] The council was created by Public Health Law section 1370-b. see: https://www.health.ny.gov/environmental/lead/advisory_council/.

[34] We chose these three specialties because those are the specialties often highlighted due to their malpractice premiums.

[35] American Medical Association, "Physician Characteristics and Distribution in the U.S.," 2016 edition.

[36] Source for 2015 New York State population estimate: U.S. Census Bureau, "State and County Quickfacts: New York" http://quickfacts.census.gov/qfd/states/36000.html. Source for 2004 population estimate: New York State Department of Health, "Table 1: Estimated Population by Sex, Age and Region," see: http://www.health.ny.gov/statistics/vital_statistics/2004/table01.htm.

[37] New York State Department of Health, Vital Statistics, see: https://www.health.ny.gov/statistics/vital_statistics/2004/table01.htm, Table 1.

According to the State Education Department, there has been a significant increase in the number of licensed doctors in New York. In 2003, there were over 61,000. In July of this year, the state had nearly 75,000 licensed doctors.[38] That's an increase of over *21%.*

Despite a stagnant statewide population – and a loss in population in many upstate areas – in only fifteen counties out of New York State's 62 counties was there a decline in the number of physicians.[39]

Often it is asserted that medical malpractice payments have risen at a ruinous rate. Yet, a careful review of the amount physicians have paid out over time, shows that – even in a state like New York – malpractice payments have changed little over time. In fact, when adjusted for inflation, payments have *decreased.*

As seen below, this becomes clear by tracking malpractice payout information over time. As is well known, actuarial estimates drive insurance premiums and this report examines the trend of doctors' payouts over a longer period of time. The National Practitioner Data Bank (NPDB) has been collecting payout information since its first full year of operation in 1991. While the NPDB has undergone changes over the years, we felt that it was appropriate to examine the 20-year trend using the only publicly-available information.

Our over-time analysis examined the actual payout information collected by the NPDB, the annual estimated increase in those payouts if the Consumer Price Index inflation factor was used, and the amount paid per doctor in the most recent year.

The chart[40] below shows the changes over time:

[38] New York State Education Department, "License Statistics," see: http://www.op.nysed.gov/prof/med/medcounts.htm, 2003 numbers are unavailable online, NYPIRG has a copy of that document on file.

[39] We compared county data provided by the New York State Education Department for those two years. The most recent statistics can be found at http://www.op.nysed.gov/prof/med/medcounts.htm.

[40] National Practitioner Data Bank, data downloaded, see: https://www.npdb.hrsa.gov/resources/publicData.jsp.

Year	Number of physicians paying a malpractice award	Total malpractice payments
1994	2,419	$563,085,050
1995	2,010	$421,001,500
1996	2,125	$464,168,800
1997	2,194	$496,561,550
1998	2,319	$546,708,850
1999	2,370	$578,117,500
2000	2,631	$662,860,200
2001	2,678	$712,512,300
2002	2,257	$668,996,350
2003	2,390	$747,286,950
2004	2,373	$820,067,250
2005	2,213	$733,012,400
2006	2,416	$822,807,150
2007	2,027	$753,592,950
2008	1,878	$741,440,050
2009	1,803	$735,370,300
2010	1,770	$717,529,100
2011	1,745	$678,176,050
2012	1,779	$762,738,250
2013	1,704	$687,845,300
2014	1,801	$713,842,500

The overall trend is quite clear: the *number* of malpractice payments have *dropped* significantly over time, while the aggregate amount paid out has increased. A straight CPI adjustment from 1994 through 2014 would have resulted in nearly $900 million in medical malpractice payments. As seen in the chart above, the actual amount fell far short.[41]

Thank you.

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[41] National Practitioner Data Bank. For the "projected" category, using the 1994 actual figures as a base, we calculated how inflation would have increased the 1994 costs through 2014. The NPDB recommends using the inflation rate for the consumer price index. The NPDB recommends that adjustment since medical malpractice payments cover a wide range of services. Inflation source: Bureau of Labor Statistics, Consumer Price Index for All Urban Consumers 1994 – 2014. Calculations by NYPIRG. Totals rounded off to the nearest dollar.