



**TESTIMONY OF DAVID RICH,
SENIOR VICE PRESIDENT, GOVERNMENT & PUBLIC AFFAIRS,
GREATER NEW YORK HOSPITAL ASSOCIATION
ON MEDICAL MALPRACTICE REFORM**

**AT A JOINT FEDERAL/STATE INVESTIGATION INTO THE
ACCESS AND EQUALITY OF NYS MEDICAL MALPRACTICE INSURANCE**

**BROOKLYN BOROUGH HALL
CEREMONIAL COURTROOM**

AUGUST 15, 2007

Good morning Congressman Towns and other distinguished members of the New York Congressional delegation, State legislators, and City officials.

My name is David Rich. I am the Senior Vice President for Government and Public Affairs at the Greater New York Hospital Association. GNYHA is the principal trade association for nearly 300 not-for-profit and public hospitals and continuing care facilities in the New York metropolitan area and throughout New York State, as well as in New Jersey, Connecticut, and Rhode Island.

GNYHA applauds you for holding this hearing today to address the increasingly crippling costs of medical malpractice insurance for physicians and hospitals. Rising medical malpractice premiums are of the utmost importance, not only to the critical health care providers who bear the brunt of the costs, but for New Yorkers whose access to quality health care is threatened by the costs of a tort system that is inefficient, poorly designed, and, therefore, unnecessarily time-consuming and costly.

Your keen interest in this issue gives us hope for the first time in many years that a true, reasoned debate may lead to action. We also applaud Governor Spitzer for his leadership in tasking New York State Insurance Superintendent Eric Dinallo with creating a task force to make recommendations by the end of the year for legislative changes. We expect the task force to begin its deliberations next month, and will be working closely with the task force and State legislators on solutions that enhance quality and reduce costs for all New Yorkers.

PRINCIPLES FOR REFORM

We believe that all parties to this reform discussion should agree at the outset that legislative solutions must meet the following test: they must 1) improve the efficacy and efficiency of New York's medical malpractice claims system for patients and providers alike; 2) reduce costs; or 3) both. GNYHA strongly believes that everyone who pursues a claim for injuries caused by actual negligent medical care should be fairly compensated in a timely manner. If a proposal does not improve the system by either 1) creating efficiencies and streamlining the process or 2) reducing costs while providing fair compensation for claimants who are truly suffering from negligent medical care, it should not be considered "reform" and should not be part of this debate.

With this in mind, I would like to first discuss the problem and then discuss potential solutions.

RISING MEDICAL MALPRACTICE INSURANCE COSTS ARE HURTING AN ALREADY STRUGGLING HEALTH CARE COMMUNITY

Physicians in New York are struggling mightily with the high cost of medical malpractice insurance, compounded recently by the approval of a 14% increase in medical malpractice premiums effective July 1, 2007. The Medical Society of the State of New York and the Medical Society of the County of Kings are both testifying at this hearing on the impact of medical malpractice costs on physicians. We are extremely concerned about this given that physicians are of such paramount importance to our hospitals and the provision of quality health care. Indeed, when it comes to physicians actually employed by our hospitals, the hospitals are often the ones

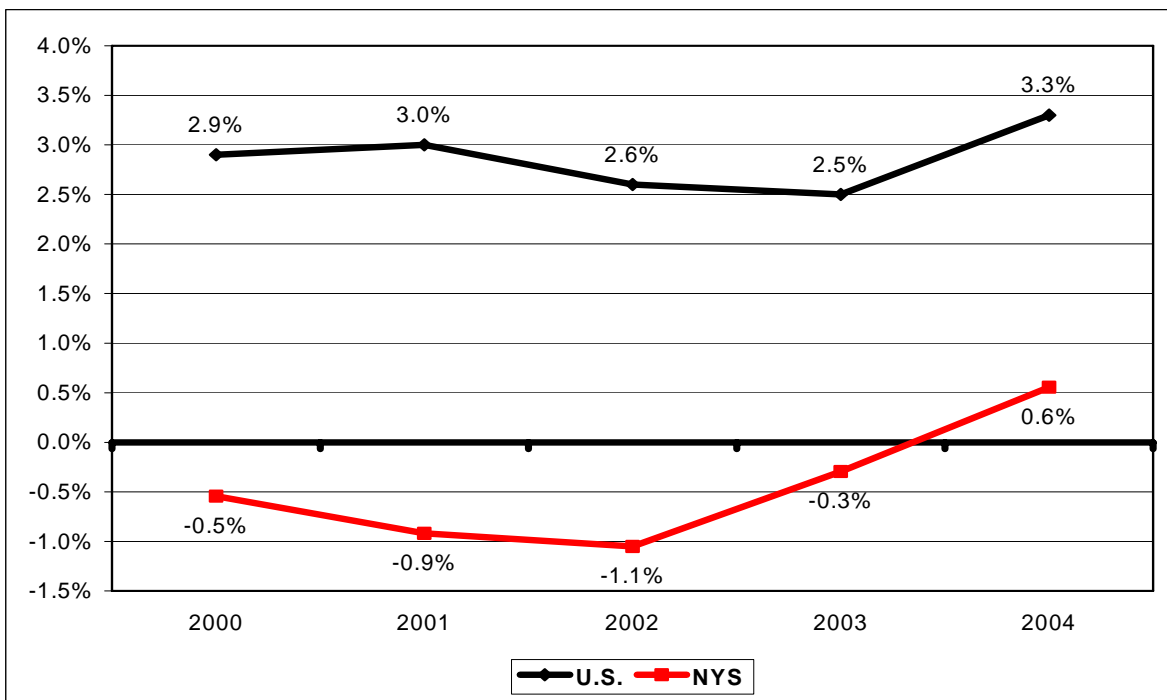
responsible for the medical malpractice insurance costs of individual physicians. I would like to strongly associate GNYHA with the testimony of the medical societies testifying today and look forward to working with them on reforms in the coming months.

Having said that, I would like to focus the rest of my testimony on the medical malpractice insurance crisis affecting New York's hospitals.

Hospitals in New York continue to struggle financially, especially when compared to their counterparts nationally. The hospital community's financial health and stability are something we should all work for because financial stability translates into better patient care and improved quality and patient safety. Financial health also allows institutions to make needed financial and human capital investments to be able to practice 21st century medicine.

Unfortunately, financial health is a goal that continues to elude us. As seen in Figure 1 below, while hospitals nationally enjoyed a 3.3% gain on their bottom line, New York's hospitals were essentially breakeven after years of losses.

Figure 1. Hospital Bottom Line Margins, New York State and U.S.

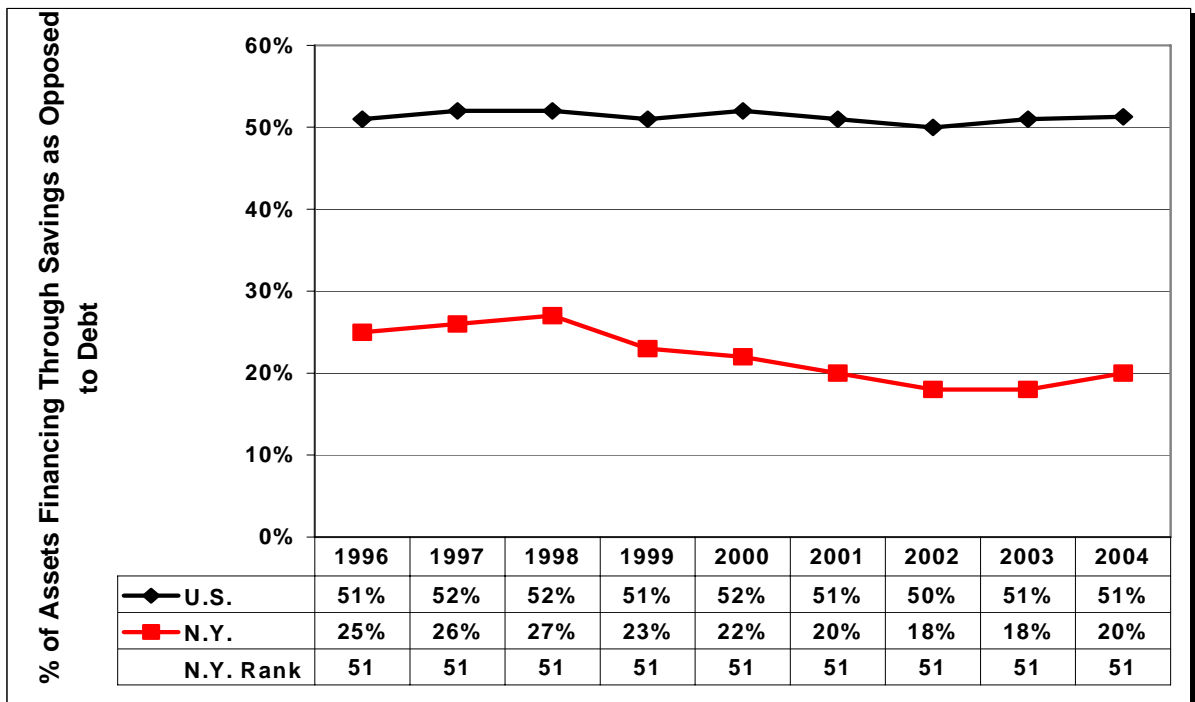


Source: GNYHA analysis of Medicare cost reports.

The lack of a positive “bottom line” directly undermines hospitals’ ability to make capital investments for the future, a fundamental principle of survival for any organization whether it is a publicly traded corporation, a museum, a college, a library, or a school system. For a hospital, investing in the future means maintaining and doing routine upgrades to the physical plant,

implementing new information technology, expanding operating rooms to accommodate modern medical equipment, building state-of-the-art surgical suites, and the like, including eventual replacement of an old hospital building. In 2004, while hospitals nationally financed 51% of their capital investments with equity, or surpluses accumulated through positive financial performance over the years, New York’s hospitals were only able to finance 20% of their investments with equity and had to rely on debt for the balance (see Figure 2). The poor profitability represented by the graph above means that hospitals do not have the funds they need to pay for basic re-investment in their infrastructures. Our hospitals’ reliance on debt places us at grave risk of not being able to make needed capital investments, particularly if financial performance suffers as a result of additional losses and lenders become unwilling to extend more credit. Indeed, the inability to reinvest in the capital infrastructure has resulted in New York hospitals having *the oldest* physical plants and equipment in the country.¹

Figure 2. Equity Financing Ratios, New York State and the U.S.



Source: GNYHA analysis of Medicare cost reports.

There are many reasons for the financial distress of our hospital community. These include a highly regulated system for several decades during which the State set all hospital reimbursement rates—even rates paid by private insurers—at levels designed to ensure that hospitals barely broke even. This was followed by rate deregulation in 1996, right at the time that HMOs gained a prominent position in the New York marketplace, meaning that deregulation pushed already inadequate reimbursement rates down even lower. On top of that, punishing

¹ Source: 2007 Almanac of Hospital Financial and Operating Indicators, Ingenix Analysis of Medicare cost reports.

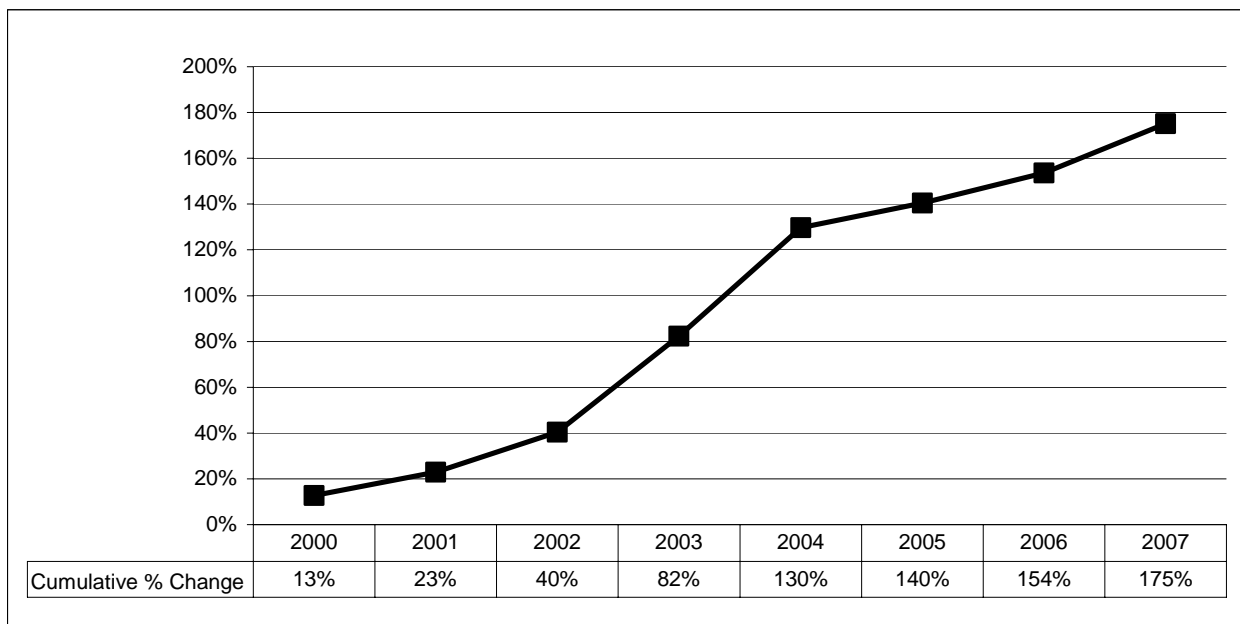
Medicare reimbursement rate cuts beginning in 1997, coupled with Medicaid reimbursement rate cuts at the State level, have kept reimbursement down while costs have risen dramatically.

In this context, increased costs for *anything* contributes to financial difficulties. And it is in this context that we must discuss the huge increase in hospital medical malpractice insurance costs.

Based on a review of hospital institutional cost reports (ICRs), GNYHA estimates that New York hospitals now collectively spend more than **\$1.3 billion annually** on medical malpractice insurance premiums, up from \$800 million in 2000. Even worse, a recent GNYHA member hospital survey of not-for-profit hospitals in the downstate area (31 respondents) found that, from 2000 to 2007, medical malpractice insurance premiums increased 175%. These 31 downstate hospitals alone paid hundreds of millions more in medical malpractice premiums in 2007 than in 2000.

Over that same time period, GNYHA estimates that hospitals' total revenue (Medicare, Medicaid, private insurance, etc.) grew by only 56%, far slower than the increase in the cost of medical malpractice premiums.

Figure 3. Cumulative % Change in Hospital Medical Malpractice Premiums



Source: GNYHA survey of member hospitals malpractice premium expenses.

According to our statistics, ***hospitals in New York State are paying half a billion dollars more per year today than they were paying at the beginning of the decade*** for medical malpractice insurance. To put this amount in context:

- \$500 million is more than the State of New York spends on the Family Health Plus program, which covers 500,000 low-income adults across the State (\$490 million);

- \$500 million is more than New York State spends on Child Health Plus, which covers 400,000 low-income children across the State (\$349 million);
- \$500 million is more than New York State spends on the Elderly Pharmaceutical Insurance Coverage Program, or EPIC, which covers prescription drug costs for thousands of New York’s seniors (\$471 million); and
- \$500 million is ten times the amount that New York will spend next year on stem cell research (\$50 million).²

These costs might be at least somewhat justifiable if most of the premium went to compensating patients for actual negligence. However, as I stated earlier, New York unfortunately has a tort system that is inefficient and poorly designed to provide fair compensation for those who bring claims and are actually suffering from injuries due to negligent medical care.

Studies evaluating the rates of adverse events in hospitals versus malpractice claims suggest that the two are poorly correlated. Most studies have found that less than half, and by some estimates as few as 17%, of malpractice claims involve negligence.³ In the latest such study, published in the *New England Journal of Medicine* just last year, 40% of medical malpractice claims involved neither verifiable medical injuries (3%) nor medical errors of any kind (37%).⁴ Further, the authors found that for every dollar spent on compensation, **54 cents went to administrative expenses** (including those involving lawyers, experts, and courts). And, many cases of actual negligence result in no compensation at all. Clearly, a huge amount of resources are expended that never make their way to an injured patient. Instead, the majority of the tort system’s costs are for overhead expenses.

This inefficiency and the resulting costs are having a negative impact on patient care, particularly for high-risk specialties like obstetrics. We understand that a full 40% of hospital medical malpractice costs are related to obstetrical care. Subsequently, in recent years, a number of hospitals in New York State announced their intention to discontinue the provision of maternity services altogether.

For instance, in December 2004, Interfaith Medical Center here in Brooklyn and The Hospital in rural Sidney, New York, announced that they were discontinuing obstetrical services. Since then, The Hospital closed its doors altogether. In addition, prior to announcing that it would close its doors in late 2005, one of the major cost-saving initiatives instituted by St. Mary’s Hospital (again, here in Brooklyn) was to discontinue delivering babies because of high malpractice costs and low reimbursements. This pattern continues a trend that was illustrated in dramatic fashion in 2003 when two New York City birthing centers closed as a result of high malpractice insurance costs. In August 2003, the Brooklyn Birthing Center closed when its medical malpractice insurer ceased to provide malpractice insurance for midwives. In September 2003,

² New York State Division of the Budget, *2007-08 New York State Financial Plan First Quarterly Update*, July 30, 2007, p. 54.

³ David M. Studdert, et al., “Medical Malpractice,” *New England Journal of Medicine*, January 15, 2004; M. White, “The Value of Liability in Medical Malpractice,” *Health Affairs*, Fall 1994; Eric J. Thomas, et al., “Incidence and Types of Adverse Events and Negligent Care in Utah and Colorado,” *Medical Care* 38, No. 3, March 2000.

⁴ David M. Studdert, et al., “Claims, Errors, and Medical Malpractice Compensation Payments in Medical Malpractice Litigation,” *New England Journal of Medicine*, May 11, 2006.

Elizabeth Seton Birthing Center closed its Manhattan location when its carrier raised premiums by 400%.

To find out just how unaffordable the provision of maternity services has become for hospitals in New York City, two years ago GNYHA conducted an in-depth analysis of hospital cost reports to determine whether hospitals were losing money providing maternity services. Strikingly, GNYHA learned from this analysis that virtually all—86%—of hospitals in New York City that provide maternity services lost money on those services in 2003. The aggregate losses amounted to \$195 million annually. If it were not for the ability to cross-subsidize from other, better-reimbursed services, hospitals would not be able to provide maternity care at all, leaving their communities without vital health services. The skyrocketing cost of medical malpractice insurance, therefore, is creating a potential access crisis, particularly in the case of obstetrics.

Other organizations have reported similar, alarming trends. For instance, the American College of Obstetricians and Gynecologists (ACOG) has reported that seven upstate New York counties have no OB/GYNs. According to ACOG, since 2003, 8.7% of OB/GYNs in New York have stopped performing obstetrics and 12.6% have cut back on the number of deliveries they perform due to high medical malpractice costs. Further, 92% of New York OB/GYNs report that they have been sued at least once, with 44% reporting that they have been sued at least four times, compared with 30% nationwide. A full 51% report having been sued during their residencies at teaching hospitals, compared to 37% nationwide.

Clearly, we have a crisis. The question, then, is what to do about it.

THE HEALTH CARE COMMUNITY'S COMMITMENT TO QUALITY

Before I discuss some of the potential solutions to the medical malpractice cost crisis, I would like to make clear that GNYHA and its members are committed to quality patient care and are committed to improving our operations so that we reduce, as much as humanly possible, the incidents of errors causing patient harm or injury. We are not just looking for relief from a medical malpractice tort system we view as inefficient and costly; we are also searching on a daily basis for ways to improve our operations and our patients' outcomes.

To that end, our members have instituted—and continue to develop—new programs and protocols, both individually and collectively, designed to reduce errors, infections, and other adverse events. In addition to each hospital's discrete, individual efforts to improve quality, many of our hospitals are working with their medical malpractice insurers and physicians on ways to reduce risks to patients. We at GNYHA are also working with our members on a number of major initiatives, which include:

Infection Control

GNYHA has been working intensively with its members to eliminate a number of different types of infections and has had a major initiative in place since 2005 to eliminate central line-associated bloodstream (CLABs) infections. The CLABs collaborative has resulted in significant

reductions in these infections in our members' intensive care units. Other projects include initiatives involving front line workers to improve hand hygiene and environmental safety.

Critical Care Leadership Network

GNYHA has created a Critical Care Leadership Network, whose aim is to identify opportunities to standardize and improve care in hospital critical care areas, thereby saving lives, reducing costs, and promoting efficiencies.

Rapid Response Systems Collaborative

GNYHA is currently sponsoring a collaborative that helps members develop rapid response systems. These systems are designed to identify early symptoms of potential respiratory or cardiac distress in order to avoid respiratory and cardiac arrest and reduce mortality rates. Through the use of specially trained rapid response teams, hospitals are better able to identify high-risk patients, respond to early signs of deterioration, and bring critical care expertise to the bedside.

Medication Safety Programs

GNYHA has an active Medication Safety Workgroup, which has developed guides and educational materials for reducing reliance on abbreviations, reducing the risk associated with high-risk medications, and improving medication reconciliation.

Quality Measures

GNYHA has developed a Quality Coach Fellowship program, which is designed to train front line staff in GNYHA member hospitals to draw a clearer connection between their day-to-day activities and their facility's performance under various quality measures.

Root Cause Analysis Training

GNYHA offers members training in undertaking a root cause analysis as to why and how errors occur in order to avoid their recurrence. The training also focuses on failure mode and effects analysis, which is a proactive risk-assessment process used to design safer systems and processes by identifying the sources of potential problems before they occur.

Communication Skills Training

GNYHA provides members with communication skills training, which is premised on the idea that better communication leads to improved patient outcomes of care and, ultimately, to improved patient satisfaction. The training focuses heavily on the skills needed to disclose to patients and their families when an adverse event has occurred, to apologize, and when appropriate, to offer compensation.

Certificate Program on Re-engineering Health Care Systems for Quality Outcomes

GNYHA has worked with Baruch College to develop a new certificate program on skills needed to re-engineer systems to improve quality, patient outcomes and satisfaction, and efficiencies, while at the same time reducing risks and costs. This new certificate program is scheduled to begin in October 2007.

Nursing Workforce Programs

GNYHA has developed what it calls the “Gap Program,” which is designed to bridge the gap between nursing school academic settings and the clinical setting. The program trains nurse managers in GNYHA members to be adjunct clinical faculty, thereby helping to address the shortage of nursing school faculty and to retain those nurses who attain faculty status. In turn, these in-house faculty members become strong mentors of nursing students and recent graduates of nursing schools, thus improving the skills of new nurses and promoting their retention in the long run.

Perinatal Safety Collaborative

GNYHA will be kicking off a perinatal safety collaborative in October 2007, which is designed to assist members in improving the quality of their obstetrical and perinatal care processes and to reduce the incidence of perinatal and maternal injuries. This clinical collaborative will include the development of clinical practice guidelines for certain high risk areas of practice as well as multidisciplinary team training, including simulation training, in the areas of communication, fetal monitoring strip interpretation, and responding to emergency clinical situations. The obstetrical and perinatal experts from the participating institutions will identify the areas of clinical focus. An "expert-on-call" system will be developed as part of the collaborative to provide ongoing resources to the participating institutions. A "kick off" training session conducted by national experts in the areas of patient safety and human factors teamwork will be hosted by GNYHA to help introduce the participants to the collaborative approach to patient safety and quality improvement.

POTENTIAL SOLUTIONS: ENHANCE EFFICIENCY, REDUCE COSTS

In New York State, a number of legislative proposals have been put forward to try to deal with the escalating costs of medical malpractice insurance. These include comprehensive tort reform bills; a proposal to launch a “health courts” pilot; bills to create an “impaired infant compensation fund”; a proposal to create a “medical indemnity fund”; a variety of quality improvement and tort reform initiatives; and a bill that would protect peer review activities from disclosure. I have summarized below many of these proposals.

GNYHA supports all of these approaches. As mentioned earlier, we believe that all proposals must be viewed through a prism of enhanced efficiency and reduced costs for patients and providers alike. If proposals do not improve the system by enhancing efficiency while providing fair compensation for those claimants truly suffering from negligent medical care, they should not be considered a part of the reform debate.

One proposal that has received the most attention in the past is a fixed dollar cap on the amount of non-economic damages—i.e., damages for “pain and suffering”—that can be collected by a plaintiff. A number of other states, including California and Texas, have placed such caps on awards. Obviously, a cap on a portion of the award, by definition, reduces costs; however, the concept of caps on awards has become controversial, despite adoption by other states. This controversy has often been the reason given for the lack of consensus and, therefore, the lack of meaningful reform in New York. GNYHA would be willing to forego caps—but only in the context of a comprehensive solution that truly reduces costs. Absent real proposals that provide real relief for our hospitals and physicians, we believe caps will still need to be part of the discussion.

The Schimminger-Hannon Bill: Medical Liability Reform Act

In 2007, Assemblyman Robin Schimminger and Senator Kemp Hannon sponsored a bill (A. 3139 / S. 2144) that takes a comprehensive approach to tort reform. This bill has been introduced in every Legislature since 2003. The bill’s major provisions include the reforms described below.

- Currently in New York State, no affidavit from a physician is required to accompany the plaintiff’s certificate of merit asserting that there is a reasonable basis for the commencement of a malpractice lawsuit. This bill would require the plaintiff’s lawyer to obtain a signed affidavit from a physician to accompany the certificate of merit.
- New York is the only state that explicitly allows the identity of expert witnesses to be kept secret in medical malpractice cases prior to trial. This proposal includes a requirement that lawyers reveal the names of expert witnesses to be called at trial and that the opposing counsel is afforded the opportunity to orally depose expert witnesses who will be called.
- Currently, all defendants are liable for all economic damages regardless of their level of culpability. For non-economic damages, defendants are only liable for damages in relationship to their proportion of the culpability, but only if the relative culpability of a defendant is less than 50% of the total liability. The Schimminger-Hannon bill provides for a “Fair Share Rule” under which all defendants are liable for economic and non-economic damages only in proportion to their relative culpability.
- The proposed bill would impose a cap on non-economic damages, such as pain and suffering, emotional distress, and so forth, of \$250,000.

The Towns-Volker Bill: Health Courts Pilot

Earlier this year Assemblyman Darryl Towns and Senator Dale Volker proposed a bill (A. 8066A / S. 4149) to launch a pilot program that would test a new approach to the medical malpractice tort system. Specifically, the bill authorizes the Office of Court Administration to select up to five counties, each in a different judicial district of the State, to establish specialized health courts. The health courts would have exclusive jurisdiction over any medical, dental, or podiatric malpractice lawsuits brought within the supreme court of the county. The courts would be characterized by a judicial training program and the use of medical experts. Specifically:

- **Training:** Each supreme court judge chosen to preside over a health court would be required to complete a judicial training program on the law and science of medicine to prepare for cases that might be brought before the judge in health court. A committee would develop the training curriculum, which would include classroom clinical education as well as internship experience in health care settings, with equal representation from the Medical Society of the State of New York and the State Bar Association.
- **Medical Experts:** The health court would maintain a list of qualified, court-appointed medical experts to advise the judge on medical issues, as necessary. The experts would be required to hold an active license in the same profession as the defendant; be trained and experienced in the same discipline as the defendant and have experience in the diagnosis and treatment of the condition or injury that is the subject matter of the lawsuit; have no financial ties or conflicts of interest that would call into question the expert's independence; and have no *ex parte* communication with either party to the lawsuit, except as permitted by the court.

In addition to the health courts pilot, the Towns-Volker bill would amend the Education Law to make it a violation of medical conduct to provide expert witness testimony that is false or completely without any medical foundation (that is, without foundation in accepted peer-reviewed, science-based medical research). Like the Schimminger-Hannon bill outlined above, the Towns-Volker bill would also require lawyers to divulge the names of expert witnesses and make them available for oral deposition by opposing counsel.

The Golden Bill: Impaired Infant Compensation Fund

Introduced in each Legislature since 2004, Senator Martin Golden's bill (S.157) would, among other things, create an impaired infant compensation fund to help pay the cost of medical malpractice awards for OB/GYNs and nurse midwives. Specifically, the State would create a fund to compensate plaintiffs for award amounts in excess of \$250,000. A board comprising nine members appointed by the Governor and State legislative leaders would administer the compensation fund. At least six of the members of the board would be OB/GYNs who are board-certified and licensed to practice in New York State. If the board found that a case for which it is providing compensation involved a physician who, in their judgment, had acted in a particularly egregious manner, the board would not agree to provide funding for future claims against that physician, and the physician would have no cap on liability. Physicians participating in the fund would, in effect, have their liability capped at \$250,000 and have personal assets valued in excess of \$250,000 protected.

In addition to the impaired infant compensation fund, the Golden bill would create a medical care and assistance program for impaired infants, under which medical and custodial care expenses would be paid for the rest of an impaired infant's life through the State Medicaid program. Juries would be instructed not to include amounts for medical expenses that will be covered by the medical assistance program in the jury award.

The Golden bill would also reform the tort system by providing that a physician who provides expert witness testimony that fails to meet professional clinical standards acceptable to the State

Office of Professional Medical Conduct may be fined no less than \$50,000 or have his or her license to practice medicine revoked.

Medical Indemnity Fund

In the late 1980s and early 1990s, the State Legislature debated a bill a number of times—which passed the State Senate but not the Assembly—that would create a State fund to pay the actual medical expenses of neurologically impaired individuals as those expenses are incurred, as opposed to including an often-inflated estimate of future medical expenses in a medical malpractice award. The fund would be administered by the State Insurance Department. The NYS Department of Health would resolve disputes about the medical necessity of a claim against the fund. In addition, to ensure that the fund was the secondary payer, or payer of last resort, private health insurers would be prohibited from placing liens on awards and would be required to pay for any medical expenses for which they were liable. The fund would be financed through broad-based assessments, thus spreading the cost of medical expenses for impaired individuals from the relatively small universe of physicians, hospitals, and medical malpractice insurers to a much larger tax base.

Quality Improvement and Tort Reform

As a way to get beyond the usual debate in which health care providers blame trial lawyers and trial lawyers blame poor quality for all of the ills of the medical malpractice system, GNYHA has in the past proposed a possible solution: a program whereby, in exchange for engaging in a rigorous State quality improvement program and meeting certain quality improvement benchmarks, participating hospitals and physicians would benefit from tort reform. Non-participants, or participants that did not achieve quality goals, would operate under the current system. Specifically, hospitals and physicians would gain a certification from the State for meeting quality improvement goals (for example, achieving thresholds on measures promulgated by the Centers for Medicare & Medicaid Services), participating in quality improvement activities (for example, activities under the Institute for Healthcare Improvement's *5 Million Lives Campaign*), and conducting a program of early disclosure and compensation for so-called adverse events.

The certification would grant providers a presumption in court that they were creating a culture of safety within their institutions or physician practices, and, thus, would afford them protections such as:

- a cap on non-economic damages;
- prohibition on liens placed on damage awards by providers of collateral source benefits, including private insurers and the State Medicaid program;
- an exemption from Medicaid income and asset tests of the dollar amount of the award so that Medicaid-eligible plaintiffs may remain covered by the Medicaid program in the future for their health care needs;
- a Fair Share Rule under which defendants are liable only for their share of economic and non-economic damages in direct proportion to their responsibility for damage done to the plaintiff;

- a requirement that expert witnesses at trial be chosen from a neutral list of experts;
- protection against disclosure in court of statements, including statements of remorse, made during pre-claim negotiations and as part of an early disclosure and offer of compensation program; and
- protection for statements made by all parties participating in peer review committees and other quality improvement activities.

These protections would not apply to actions brought against physicians or hospitals related to adverse events that should never occur. Such “never events” are defined as the following three events: surgery performed on the wrong body part, surgery performed on the wrong patient, and the wrong surgical procedure performed on a patient.

Protection of Peer Review Activities from Disclosure

Bill S. 4642 / A. 6723, introduced in every Legislature since 2003, is sponsored by Assemblyman Richard Gottfried and Senator Kemp Hannon. The bill would encourage health care providers to participate in hospital peer review and quality improvement committees and proceedings by protecting from discovery a provider’s statements at a peer review or quality assurance meeting if he or she is party to an action or proceeding that is being reviewed at that meeting. The bill would also make it a violation of medical conduct to refuse to cooperate with and participate in quality assurance and peer review activities that are protected by State confidentiality statutes.

CONCLUSION

In conclusion, I would like to once again commend you for holding this hearing on the critical issue of rising malpractice insurance costs. GNYHA looks forward to working with you to solve this important issue for all New Yorkers and the health care system upon which they rely. Thank you for your consideration.