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Davis Area LWVC Health Care Committee
Institute for Public Science & Art
Davis California USA

Unpacking the LWV New York Healthcare Concurrence Proposal
Encourage LWVUS to include This Position for Delegates to the National Convention
LWV Colorado
Saturday, February 5, 2022

Linda Mahan: Thank you. I am Linda Mahan, a member of he League of Larimer County in Colorado and also of the League of Colorado's Healthcare Committee and on there behalf I want to welcome you to our discussion today about a very important concurrence that is being proposed.

First, a little bit about the Healthcare Committee. Our League Healthcare Committee in Colorado was begun actually last month, to engage members across the state to take action to improve Healthcare laws, policies and systems in alignment with our League positions. It will coordinate education and advocacy with Local Leagues and other organizations. For those of you from Colorado, if you would like to join that committee, we will be meeting this coming Tuesday at 2 o'clock, February 8th. You can sign up fro that on our League web calendar.

Our focus today for our education will revolve around our national position and proposed addition to that. We are very pleased to have over 68 people who have registered for this. We hope you will enjoy the discussion

We are going to begin with a presentation by two Leaguers. Then that will be followed by a question and answer period. During their presentation, if you want to put questions in the chat, my colleague Barb Dungey will monitoring that, and we will be asking those questions after they finish.

Also, there will be time, if you want to unmute, you can raise your hands and we will call on you and you can ask your question in person. We are recording this today. This is going to be on our YouTube channel for League of Colorado.

I will go ahead and introduce our two speakers joining us from New York.

Barb Thomas first joined the League in Billings Montana, and has been active since the 1980s in the Local League now of Saratoga County New York, where she has been President for over 20 years at some point in that period. She has also been a member of

the Board of the New York State League, and serves as the Issues Specialist for Equality Opportunity and for Medical Aid and Dying. She has a Masters Degree Elementary Education and Social Studies, and was the Executive Director of a 4 County Planned Parenthood Affiliate. She co-chaired the Healthcare Update Committee that developed the new New York State Healthcare positions.

The second speaker, her partner, is **Dr. Judith Esterquest**, a member of the Long Island New York League for five years where she has served as the Healthcare Chair and supported Voter Services forums and Diversity Inclusion and Equity initiatives. Judith has recently been appointed the New York specialist position for healthcare, and she holds a Ph.D. in English from Harvard where she taught for a decade before spending the rest of her decades long career in management consulting with global responsibilities. She was an active member of the New York State Healthcare Update Committee. Thank you, and welcome to you all. I am going to turn it over to you now, Judy and Barb.

Barb Thomas: Thank you so much. I am so pleased to see so many people participating today. I certainly want to officially thank the League of Colorado, and especially Linda Mahan for hosting this event. As Linda said, I am Barb Thomas from Saratoga County, and my co-presenter is Judy Esterquest from Port Washington-Manhasset which is on Long Island. We were both members of the Healthcare Update Committee that developed the New York State League New Healthcare Positions.

AGENDA:

- What are Leagues being asked to do?
- What is the LWV concurrence process?
- LWV health care: Why update?
- How did LWVNY update its Healthcare positions?
- What does the concurrence add?
- What are the effects of inequitable access?
- What would universal access mean?
- Where to learn more

5. What exactly are we asking you to do?

- Ask US LWV Board to make this concurrence a recommended item for program consideration at Convention: **"Adding language excerpted from the 2021 LWVNYS Positions on Healthcare and Financing Healthcare"**
- Include this Recommendation on LL Program Planning Report Form (online survey, due March 1st)
- Note: If enough Leagues recommend this Concurrence, it will be brought to the floor of the Convention for discussion and a vote

Mainly, we are asking you to recommend this Concurrence for consideration at the Convention. By putting it on your League's Program Planning Survey Response. Doing that does not commit you or your delegates to vote for the Concurrence at Convention. But naturally, we hope that your delegates have some sense of the way your members feel about the issue, and do vote for the Concurrence.

Concurrence materials are now on line and will be there for the next 5 months. The url to access them is "pwm.tempurl.host/hc-concurrence/". We will circle back to any specific questions that you have at the end of the presentation.

6. Concurrence Process:
   - The wording of a proposed concurrence cannot be changed (no wordsmithing)
   - Some trusted League entity must have conducted a study and reached consensus on a position
   - The study materials from the study should be available to League delegates considering the concurrence
   - Once adopted, the League Board will incorporate the new wording into the existing position (if there is one). Otherwise, it becomes a new position
   - Concurrences done at Convention save Leagues time and resources

Concurrence is a very specific League process. It depends on some League entity doing a study and reaching a position. Other Leagues can then agree or concur with that position. That is why the wording cannot be changed. Concurring with another League's position allows you to have a position without spending the time and resources to conduct a study.

7. Current LWVUS Position on Healthcare
   - Was adopted in 1993 and updated, by concurrence in 2016, by adding a section on Behavioral Health
   - Needs updating due to changes in our healthcare system over the past 29 years
   - Can be updated (using the concurrence process) by adding excerpts from the LWVNYS 2021 Healthcare Positions

A lot has changed since the main part of the national healthcare position was adopted in 1993. The New York League has two positions: one on health care in general and one on the financing of healthcare which were based on studies and updates from 1985 and were last revised in 1991, except for a section on advance directives that was added in 1999.

The easy way to update the national position is to concur at Convention with a position in this case with the excerpts from the 2021 New York State Positions. We cannot change the language of the existing national position without a study; through concurrence we can add to it.

How has healthcare delivery changed since 1993?

8. What has changed since 1993?
   - Fewer Americans with affordable access
     - Healthcare increasingly expensive for families;
     - Healthcare increasingly expensive for taxpayers
   - Public health worsening
     - US outcomes lagging peer countries
     - Disparities among marginalized Americans worse

There have been great advances in medical care, pharmacological treatments have become more effective in curing, treating or delaying the onset of many serious conditions, even making previously lethal chronic diseases manageable. Complicated surgeries have become more successful. Think heart transplants, and now-routine joint replacements.

But costs have exploded, creating inequities in access. Families spend way more on health care than they did in the 1990s. And many employers no longer offer health insurance for their employees. Others require increased employee contributions and offer plans with lower premiums, narrower networks, increasing cost-sharing, all of which reduce access for even middle class Americans.

Taxpayers are paying more for healthcare too. Providing healthcare for government employees, the indigent, the incarcerated. And, with pricier privatized care for seniors, long term dialysis patients, veterans and others, Americans are now paying twice as much for healthcare per capita as Europeans. We are paying more in taxes for healthcare than Europeans pay for all of their healthcare. And they cover everyone. In 1990, healthcare expenditures were 12% of our county's GDP. Now healthcare expenditures are 20%.

But on important measures, we are not getting healthier. Access now depends much more on where you live, how much you make, and what kind of work you do.

Today, fewer Americans can afford access to healthcare.

Judy Esterquest: Thank you Barb.

9. Insurance premiums continue o rise
Average Annual Worker and Employee Contributions to Premiums and Total Premiums for Family Coverage, 1999-2018
Kaiser Family Foundation

1999: $4,247 + $1,543 = $5,791
2018: $14,069 + $5,547 = $19,616

The cost of health insurance premiums has tripled over the past 20 years, from an average cost of just under $6,000 to over $19,000 per year, with bigger shares paid by workers. Employers are also choosing plans with greater cost sharing.

10. Employers shift costs to workers: deductibles are up 4 times faster than premiums, 8 times faster than wages
Kaiser Family Foundation

Deductibles: increased 162%; Family Premiums increased 54%; Workers' Earnings increased 26%; Overall Inflation increased 20%.

Healthcare has become prohibitively expensive. The bottom blue and black lines, inflation and wages, have gone up 26%. The green line is premiums, up twice that. And the orange line is cost sharing, which has increased 162%, eight times faster than wages. This orange line, deductibles and co-pays and everything you pay after you pay premiums, plays a huge role in reducing American access to healthcare. It is a cost control method lauded in the 1980s and 1990s which raises total health costs, and reduces public health. It is why the concurrence seeks to add "evidence-based cost controls" to the national League position.

But doesn't job-based insurance offer equitable access?

11. Job-based insurance disproportionately benefits better off – only 40% of private-sector employees covered: Lower-income families and workers are much less likely to be covered by an employee plan: Percent of non-elderly population expected in Employee-sponsored coverage by household poverty level, 2018

Total Non-Elder Population/Fulltime Workers
FPL: Federal Poverty Level

Under 100% FPL: 11%/24%;
100% FPL – 250% FPL: 34%/48%
250% FPL – 400% FPL: 69%/74%
400% + FPL: 85%/88%
Total All Households: 58%/73%

More high wage workers get benefits than lower wage workers. Let me use some New York State examples to illustrate what "Federal Poverty Level" means on this chart. In New York State, 90% of families making under $50,000 a year get no health benefits, but 85% of families earning more than $200,000 do get benefits. Is this equitable access?

Why do we believe Americans depend on worker health benefits? In 1991, when the national League was studying healthcare, more than 77% of private sector jobs had healthcare benefits; now, 40% do, about half. It is dropping every year. Newly hired workers don't get health benefits. Nor do gig workers, Uber, Lyft, Grubhub, Instacart are all speeding this trend. Healthcare access today is far less equitable than it was 30 years ago.

What's happened in Public Health?

12. U.S. Life Expectancy trails peers, with flattening growth relative to peers since 1993: Life expectancy vs. health expenditure, 1993-2015

74 years rising to 82 years by $1,000 to $4,000 for Japan, Spain, Israel, Canada, Sweden, Germany
U.S.: 74 years rising to 77 years with costs rising from $4,000 to approaching $9,000.

This slide is complicated. Just note that the red line of the United States is lower and flatter than the other lines. The red line shows the U.S. as an outlier. It is flatter because American life expectancy has lengthened 3 years over the last quarter century. Meanwhile, peers with universal healthcare with all the other colors live four and a half years to six years longer, with healthcare costing half as much.

Treating healthcare like a market harms Public Health.

13. Between 2005 and 2020: 166 rural hospitals closed; 2021: 40% of the nation's rural hospitals are at risk: Cumulative rural hospital closures since 2005

900 rural hospitals (40%) at risk of closing

One hundred and sixty-six rural hospitals have closed over the past 15 years. 47 filed for bankruptcy just in 2020. Forty percent of the rest are in dire straits. In the map at the bottom, purple means that more than half of that state's rural hospitals could close soon. Fuchsia means 20% to 50% are at risk.

Here is even worse news: hospitals that are staying open are cutting services, like behavioral health, like substance abuse, like maternity wards.

When maternity wards close, obstetricians and midwives relocate.

14. 2004-2014: US counties with hospital obstetric services saw even more close or curtail services

On this map, the ninety counties in black show where hospitals have closed. The blue counties show where hospitals have shut down obstetric services. Note that they are still open, but no maternity wards, no obstetricians, no midwives.

What happens when Americans live 40 to 200 miles from the nearest OB/GYN facility?

15. Maternal Mortality is decreasing outside the US – but rising in the US for 2 decades
Maternal Deaths per 100,000 live births:
13 countries 3.8 deaths to 9.2 deaths
US 26.4 deaths

The red line shows the US trend. The black lines show a dozen peers. But, according to the World Health Organization, out of 183 countries, 157 decreased their maternal mortality between 2000 and 2013, when the US rose sharply. 157 black lines went the other direction.

Of the 31 OECD countries, only Mexico has worse maternal mortality. Our Black mothers die at 3 or more times the rate of White mothers. Rural areas are two to three times worse than urban areas. Our urban areas are two to three times worse than Europe's.

Thirty years ago, too many American mothers died of pregnancy related reasons. Since then, many countries have halved their death rates. Ours have almost doubled.

16. Primary Care Doctor Shortage by County
None of county is shortage
Part of county is shortage
Whole county is shortage

Primary Care isn't profitable. It is reimbursed at lower rates. Medical schools discourage students from entering primary care. If the family doctor who knows you and your medical history is the backbone of good care, or was 30 years ago, across the 3,000 US counties, only the pale blue counties have enough family doctors. Look for the pale blue counties. And note that much of rural America lacks broadband, so telemedicine is not an option. This is why we are asking supporters of our healthcare concurrence to also support digital equity concurrence.

Now that we have set the stage for why a health care position that was adopted 30 years ago might need updating, let's discuss the New York State study and the proposed Concurrence.

17. How did LWVNYS update its Healthcare and Healthcare Financing Positions?
- LWVNYS Convention 2019 gave charge to update it Financing of Healthcare position
- Healthcare Update Committee (HCUC), formed in Fall of 2019, began meeting
- HCUC decided that it made sense to also update the Healthcare Position
- By Fall of 2020 the HCUC had developed extensive study materials and drafted new Positions, and distributed to Local Leagues for their consensus
- New Positions adopted, nearly unanimous, March 2021

Barb Thomas: In 2019, there was much public discussion about adopting a New York State single-payer system. So the New York State Board recommended that the 2019 Convention update our position on financing of healthcare. The Board wanted member understanding of the existing position and its consequences.

By the Fall of 2019, a committee was formed consisting of 7 members from various regions of New York state, including 3 Ph.D.s, and 4 with experience in the delivery of health care. We compiled and summarized health policy sources, and then culled them down to 50 foot-noted pages of study materials, which included the two re-written positions.

By late Fall of 2020, we sent the Positions and Study Materials to Local Leagues for concurrence by March of 2021. Of the 31 Leagues who reported their discussions, all concurred with the Healthcare Position and all but one concurred with the Healthcare Financing Position.

18. Current LWVUS Goals for Healthcare
- Universal – Equitable Access
    - "For all U.S. residents"
    - No rationing by income, gender, race/ethnicity, pre-existing conditions, where you live…
- Equitable Quality
    - Equitable treatment, including prevention of disease, health promotion and education
    - Equitable distribution of services
- Affordable (and Feasible)
    - For all: patients, taxpayers, providers…
    - "Financed through general taxes" [progressive] not "individual insurance premiums" [regressive]

In deciding which language from the New York State Positions to include in the Concurrence Statement, our Healthcare Update Committee, which is the group bringing this Concurrence forward, looked at what was important to add to the US position, removing redundant and state specific language from what is being offered. When we look at the goals in the national position, they call for every resident of the US to have access to a basic level of quality care, distributed equitably, at reasonable cost to patients, individuals and taxpayers. As we go through the points, we have put national League's wording in green, and New York's in purple, so you can clearly what we have [proposed to add.

19. Highlights of Proposed Additions from NYS
1. Protecting the vulnerable – and public health
2. Expanding delivery options (e.g. telemedicine) while providing "standard of care" tests and treatment
3. Separating healthcare access from employment status
4. "Safe Staffing" – for staff and patient safety
5. Patients, families and providers decide health care
6. Cost-controls require evidence of reduced total costs and not exacerbate disparities in outcomes
7. Single-payer concept as viable, desirable for achieving LWV goals: affordable, equitable, universal healthcare
8. States can enact universal healthcare until Congress does
9. Regular assessment and transparent administration

Here is what we want to add:
Protecting the vulnerable, and by doing that, protecting public health. The pandemic has certainly shown us that we need to add telemedicine and other innovative delivery settings to our repertoire, and that we need to separate healthcare access from employment status. We add safe staffing, which is defined as a minimum number of staff with specified training required to care for a specific number of patients at specified risk, and needing particular kinds of care, to keep patients safe and to keep staff safe. We spell out the right for patients to make their own decisions in consultation with whomever

they choose. We call for cost controls to be evidence based, to show that they actually reduce cost for the whole system, and that they don't increase disparities of outcome. We specifically add that the single-payer concept is viable and desirable for achieving the League's national goals of achieving affordable, equitable, universal healthcare. States can act as laboratories of democracy by piloting state-based programs of universal healthcare until such time as a federal program is enacted. Additionally, we also call for regular assessment and transparent administration of the healthcare system.

20. US Current Position: Goals
GOALS: The League of Women Voters of the United States believes that a basic level of quality health care at an affordable cost should be available to all U.S. residents. Other U.S. health care policy goals should include the equitable distribution of services, efficient and economical delivery of care, advancement of medical research and technology, and a reasonable total national expenditure level for health care.

This slide shows you the actual work of the Goals of the existing healthcare position, which will not change.

21. Proposed NYS Additions: Goals
New (purple) Language:
The League supports regulatory incentives to encourage the development of cost-effective alternative ways of delivering and paying for healthcare. [Expand delivery options:] Delivery programs may take place in a variety of settings, including the home and online, and must provide quality care, meaning consistent with "standard of care" guidelines, by trained and licensed personnel, [Safe staffing:] staffed adequately to ensure their own and patient safety.

As public health crises increasingly reveal, a health program should [Protect the vulnerable to protect all:] protect the health of its most vulnerable populations, urban and rural, in order to protect the health of everyone. In addition, all programs should be evaluated regularly.

[Who makes decisions:] Decisions on medical procedures that would prolong life should be made jointly by patient, family and physician. Patient decisions, including those made prior to need, should be respected.

This slide shows you the current wording of the language in the New York State League's Position that will be added to the existing national position. It will be up to the LWV national Board to decide where to add this language.

22. US Current Position: Financing and Administration
[Implicit single-payer:] The League favors a national health insurance plan financed through general taxes in place of individual insurance premiums.

As the United States moves toward a national health insurance plan, an [Job-based interim step:] employer-based system healthcare reform that provides universal access is

acceptable to the League. The League supports administration of the U.S. health care system either by a combination of the private and public sectors by [Multi-level administration:] a combination of federal, state and/or regional government agencies.

The League is opposed to a strictly private market-based model of financing the health care system. The League also is [Oppose private-sector alone or state alone:] opposed to the administration of the health care system solely by the private sector or the states.

This slide shows the current wording of the national position as it relates to the financing of healthcare. You will note that the current wording does not actually use the term single-payer, although by calling for a national health insurance system financed through general taxes that provide universal access, it implicitly supports single-payer.

And the call for a transition from an employment-based insurance to universal access is a call for the unemployed, the disabled, the young, and those whose employers do not provide health insurance to all of them have access to health care.

23. Proposed NYS Additions: FINANCING AND ADMINISTRATION
New (purple) Language:
The League [Explicit single-payer:] supports the single-payer concept as a viable and desirable approach to implementing League positions on equitable access, affordability, and financial feasibility. In any proposed healthcare financing system, the League favors health [Separating insurance access from employment:] insurance access independent of employment status.

Although the League prefers a healthcare financing system that includes all citizens of the United States, [Until federal healthcare program is enacted, support State healthcare programs:] in the absence of a federal program that achieves the goals of universal, affordable access to essential health services, the League supports healthcare programs financed by the states which include continuation of federal funding and comply with League principles.

This shows financing excerpts from the New York State financing positions that would be added to the national one. The new position would make support for single-payer system more explicit and provide rationale. It would strengthen the concept of separating health coverage from employment. We all recognize that Americans enjoy their mobility; optimally, you would have the same universal healthcare access regardless of the state you live in, with no gaps or waiting periods after you move.

This section recognizes the role that individual states have traditionally played in piloting critical legislation, from seat belts to gay marriage, from drug laws to environmental protections. It also recognizes the role that Canadian Province of Saskatchewan played in 1962, demonstrating the feasibility of its single-payer healthcare, and prompting all of Canada to follow within a decade.

It also calls for continued federal funding as a necessary part of the funding mix before the League will support any state bill.

24. US Current Position: COST CONTROL
The League believes that efficient and economical delivery of care can be enhanced by such cost control methods as:

- the reduction of administrative costs,
- regional planning for the allocation of personnel, facilities, and equipment.
- The establishment of maximum levels of public reimbursement of providers,
- Malpractice reform,
- The use of managed care,
- Utilization review of treatment,
- Mandatory second opinions before extensive surgery or extensive treatment,
- Consumer accountability through deductibles and copayments.

Some of the cost control methods listed in the League position, like mandatory second opinions and cost sharing, have raised total systems costs. Remember, a concurrence cannot revise the wording of an existing position; it can add wording that is not in opposition. Everything in the New York State position was reviewed with this in mind.

25. Proposed NYS Additions: COST CONTROL
New (purple) Language:
Specific cost control methods should reflect the most credible, evidence-based research available on how healthcare financing policy affects [Evidence of equitable access, quality, less cost:]

- equitable access to healthcare,
- overall quality of care for individuals and populations,
- and total system costs of healthcare and its administration.

Methods used should not exacerbate disparities in health outcomes among marginalized residents. [Shall not exacerbate disparities in outcomes:]

- [Up to 30% less costs:] Reduction of administrative costs – both for the insurance program and for providers.
- [Up to 30% - 60% savings:] Negotiated volume discounts for pharmaceuticals and durable medical equipment to bring prices closer to international levels – or importing of same to reduce costs.
- Evidence-based treatment protocols and drug formularies that include cost/benefit assessments of medical value.

This slide and the next one would add to the national position on cost control. Given the much faster than inflation increase in healthcare costs since 1993, when he national position on healthcare was adopted, we in New York State recommended that specific cost control methods should reflect the most credible evidence based research available on how healthcare financing policy affects equitable access to healthcare, the overall quality of care for individuals and populations, the total systems costs and its

administration, and that methods used should not exacerbate disparities in health outcomes among marginalized residents.

The League has always called for universal access to healthcare but our recent emphasis on diversity, equity and inclusion requires us to pay more attention to the way that certain cost control measures unfairly impact marginalized communities. By that, we mean rural residents, those living in urban healthcare deserts, people who identify as non-binary or LBGTQ, non-English speakers, the incarcerated, the undocumented, as well as people of color and specific ethnicities.

Reduction of administrative costs is a key benefit in a single payer system, since it eliminates the need for providers to employ a brigade of billers and coders to keep up with the requirements of multiple insurance, just as it eliminates the brigade of insurance administrators whose jobs depend on denying or delaying care.

We have the experience of single payer systems like the Veteran's Administration and Medicare, where administrative costs are less than 3% of total costs, not the 15% to 20%, or even 30% for some private for profit insurance.

Negotiating volume discounts with pharmaceutical companies would likely achieve the 50% savings achieved by the Veteran's Administration for its six million patients.

26. Proposed NYS Additions: COST CONTROL continued
New (purple) Language:

- Malpractice reforms designed both to compensate patients for [Reduce Errors, Tort costs, Premiums:] medical errors and to avoid future errors by encouraging robust quality improvement processes (at individual and systemic levels) and open communications with patients
- Investment in [Well-care saves $ over disease-care:] well-care – such as prevention, family planning, patient education, primary care – to increase health and reduce preventable adverse health events and expenditures
- Investment in maternal/infant care, chronic disease management, and behavioral healthcare
- [Better outcomes, fewer costs:] Provision for short-term and long-term home-care services to reduce institutionalization

These cost control methods reduce the overall costs of healthcare by reducing harm, such as reducing malpractice errors by systemic quality improvements. Or, preventing serious disease with early intervention and regular health education. Today, preventive care is not profitable for private insurance. Paying for preventive care for patients who change insurers represents costs but no savings. When everyone is in the same state insurance pool, preventive care reduces the total costs for that person and reduces the overall systems costs.

Similarly, people who need assistance with daily tasks prefer to remain in their own home if possible. And paying for short term and long term healthcare is usually less

expensive than institutionalization because the patient continues to pay for their own housing and food.

27. Proposed NYS Additions: PUBLIC PARTICIPATION
Current US Position: [silent]
New (purple) Language:
The League supports public input as integral to the process [Wider range of perspectives informs better decisions:] for determining healthcare coverage and funding. To participate in public discussion of health policy decisions, residents must be provided with [Transparency:] information on the healthcare system and on implications of health policy decisions.

This requirement for public participation in healthcare policy just makes explicit the League's longstanding support for public input into all government decisions.

28. Highlights of Proposed Additions from NYS
New (purple) Language:

1. Protecting the vulnerable – and public health
2. Expanding delivery options (e.g. telemedicine) while providing "standard of care" tests and treatment
3. Separating healthcare access from employment status
4. "Safe staffing" – for staff and patient safety
5. Patients, family, providers decide health care
6. Cost-controls require evidence of reduced total costs and not exacerbate disparities in outcomes
7. Single-payer concept as viable, desirable for achieving LWV goals: affordable, equitable, universal healthcare
8. States can enact universal healthcare until Congress does
9. Regular assessment and transparent administration

Judy Esterquest: This is the same page you saw before.

Legislation that encompasses these additions, just one of them in a bill, or many of them in a bill, will allow the League to advocate for reduced costs, improved public health and making both access and outcomes more equitable.

What has the pandemic taught us about our public health?

29. 2019: Marginalized Americans (of color, rural, poor) got less healthcare, died 7-9 years younger than other G7 Countries before the pandemic:
G7 Average: 81.9 years
White, non-Hispanic: 78.5 years
Black: 74.9 years
Native Americans: 71.8 years

The U.S.'s six peer countries outlived even white Americans by 3.5 years; and Whites out live Blacks by more than 3.5 years, who out lived Native Americans by yet another 3 years.

The pandemic has worsened our health disparities.

30. Pandemic: US healthcare inequities became more visible and exacerbated relative to peer countries: the gap worsened by 50% in 2020:
2010: 1.88
2018: 3.05
2020: 4.69

These columns show the worsening gap in American longevity: we die two years younger than peers in 2010, and three years younger in 2018. 2020, the gap rose 50% to over 4.5 years. On the average, this is bad. For the marginal amongst us, it has been catastrophic.

Covid sharply reduced Latinx (3 years) and Black (2.9 years) Life Expectancy -- White Americans lost (1.2 years)
Hispanic: 81.8 years to 78.8 years
White: 78.8 years to 77.6 years
Black: 74.7 to 71.8 years

Life expectancy in France fell seven months; in Germany, three months; American Whites lost 14 months; but, Latinx lost three years; so did Blacks – American Blacks die almost 10 years younger than G6 residents. Harlem, the South Bronx, the East Bronx lost one half percent to one percent of their residents. It is like having 3.3 million Americans die.

Covid has killed Black and Indigenous People at three to five times the rates of Whites, and at earlier ages.

What caused most deaths before Covid?

32. The Five Leading Causes of Death (All Americans)
Heart Disease, Cancer, Unintended Injuries (not homicide or suicide), Lower Respiratory Diseases, Strokes

The five leading causes of death are he same for all Americans, urban and rural, Black and White.

33. Black Americans have higher rates of PREVENTABLE DEATH from the five leading causes of death
Heart Disease: 30% more: 15 months
Cancer: 70% more: 8.6 months
Unintended Injuries (not homicide or suicide): 65% more

Lower Respiratory Diseases: triple
Strokes: 70% more: 5.7 months

But more Black Americans die and die faster, at triple the rates for Whites for respiratory diseases and 70% higher for cancer and strokes.

34. Black and Rural Americans have higher rates of PREVENTABLE DEATH from five leading causes:
Blacks/Rural:
Heart Disease: 30% more: 15 months/2.5 times
Cancer: 70% more: 8.6 months/Quadruple
Unintended Injuries (not homicide or suicide): 65% more/50% more
Lower Respiratory Diseases: Triple/Triple
Strokes: 70% more: 5.7 months/Double

More rural Americans die and die faster. For cancer, it is four times the rate, yet 86% of these deaths are preventable. 86%. These are people's lives, Americans. Americans are not getting what people in peer countries get routinely. Prevention, treatment, affordable care. Americans don't have family doctors. They live too far. And they fear getting sick because it costs too much. Two-thirds of bankruptcies are caused by medical debt. I find these differences astonishing. And tragic.

36. Life Expectancy correlates with ZIP code (by county, colors show a 12 year difference, 2018: red below the Mason-Dixon line, except for the southern half of Florida, and the southern half of Texas

For Americans, your ZIP code predicts how long you live. As we have seen rural Americans have less access to healthcare, fewer hospitals, fewer primary care doctors, less insurance, and are more likely to die of preventable deaths. Lack of access to healthcare kills. Ditto for Black and Indigenous Americans. And ditto to no access even with telemedicine. Add in people who do essential jobs who must interact daily with the public. Essential workers with no sick leave and no healthcare, and no choices. This is why the American College of Physicians recommended rolling out vaccinations by ZIP code not age.

Before we end, I would like to add that Covid taught us about viruses riding subways, and planes, and inevitably reaching even remote Alaskan villages. Notice how much of Alaska has among the worst death rates.

Ease of travel is one obvious reason why the US has experienced more epidemics over the past decade than anywhere else globally. But the World Health Organization which has documented about 200 epidemics per year recently notes another reason: the US, despite its wealth, is seeing such devastation: the most difficult to control epidemics occur in countries with poor public health, among populations without equitable access to primary care.

The League of Women Voters and the World Health Organization have similar goals, but our League needs to become more explicit in our advocacy. Hence the need for the Concurrence process in support of the New York State Resolution.

I would like to end with a quote from the 2018 World Health Organization Handbook on Epidemics.

37. Pandemics: to reduce them, to end them:
Universal Health Coverage and health security are two sides of the same coin. Ultimately the absence of universal health coverage [for the most vulnerable people] is the greatest threat to health security [for everyone]. Dr. Tedros Adhanom Ghebreyesus, Director-General, World Health Organization

The League's advocacy for equitable access to healthcare certainly will benefit marginalized Americans. But it will equally benefit vulnerable Americans, which means every one of us.

38. Learn more: LWV Healthcare Concurrence URL:
<pmw.tempurl.host/hc-concurrence/>

- Health Care Concurrence Statement
- Memo on Concurrence
- Leagues that support the Concurrence
- How to support the Concurrence on the LWV ProgPlan online survey
- LWVNYS HCUS Study Materials
- Pro/Con's
- US Position & NYS Positions and More
- Link to Digital Equity Concurrence (on LWVNM website)

This power point will be made available on request. All of our concurrence materials will be on line for the next five months, being updated as we go. You will find directions for filling out the national program committee's online survey with links to the survey so that your League can support getting this resolution and others discussed at convention.

While of course we hope your delegates will vote to support for adopting our resolution, your support on the survey does not commit them in any way.

You will also find a link to the digital equity concurrence materials, and an up-to-date list of Leagues who have already signed on. Right now, it is 39 Leagues from 13 states, about 5% of the Leagues in the United States. We would really like to get it to 10%.

Before I say thank you, I would like to just add, when you go to the online Concurrence page, it is long, but part of what you will see is the specific request we are asking Leagues to make. Get on your League's agenda and ask for their support. If your League decides to support this, please refer to the Program Planning report (there is a link right below this) which explains exactly how to fill it out. We are asking you to put the

EXACT LANGUAGE THAT IS IN THE BOX into the question box so there is no confusion about what we are doing.

40. What are Leagues being asked to do has the form.
39. Thank you. Questions?

Linda Mahan: Thank you very much Barb and Judy. This was very informative and as you can see in the chat, many people would like to have your slide deck. If it is alright with you, in a followup email we can send that out.

We have got some very good questions that I would like to put out to you. One of the first ones had to do with the big difference in maternal death rate; they are wondering what other countries do that we don't do that makes ours twice as high?

Barb Thomas: First of all, most of the European countries have a long period of post partum care. Mothers generally have six months to a year of paid family leave when they have a birth, so – besides having the healthcare – they have visits from someone like a public health nurse to actually see what is happening and to reassure or tell people that yeah, really that their experience is a problem and they need to go and be treated for something.

Linda Mahan: Thank you. Following along in that same vein of public health, a question came in when you referenced the regular assessment of public health metrics and coverage and funding, you know around the country we have seen a lot of public health departments coming under fire during the pandemic and public health directors resigning. Do you think the position should be strengthened more with regard to public health or do you think that some of the arguments that you included really started to give us more legs to stand on in our advocacy for public health?

Judy Esterquest: Both. It is my belief, and I don't have a degree in public health and I have not spent a lot of time studying public health, I was in comparative literature.

Our public health suffers both because the public does not have access to the doctors and it suffers because it does not have enough funding. When you don't have a population that understands what public health departments do, or why they exist, it is very hard for them to survive something like the pandemic. It is my personal belief, and I saw one article mention this and I have been chasing the reporter and haven't been able to reach the reporter, it is my belief that when people do not have family doctors that they trust, and they go to clinics and it is a different doctor all the time, or they have employee-based insurance and the network keeps shifting so you keep shifting your policy and your doctor, if you don't have a doctor you trust – why should you trust doctors?

Linda Mahan: That relationship with their primary care.

Judy Esterquest: Yes.

Linda Mahan: As you pointed out in other countries, that is the real emphasis of their system, rather than on medical specialists which you see once or twice.

Judy Esterquest: To refer to something that Barb said, our infant mortality is astonishing and awful, and infant mortality is most effected by regular, skilled pre-natal care and regular, skilled post-natal care, because when you take care of the mother and the mother is monitored and is taken care of, she takes care of her baby.

It probably helps that there is subsidized or free day care in most of these countries so that if I have a two year old or a three year old or a four year old, I can focus on my infant. And not have multiple children all demanding my time.

Linda Mahan: How to deal with the battle of the ideology of "socialized medicine" in America? This is something all of the single payer people have worked for years around the messaging.

Barb Thomas: The messaging is difficult because people with a real stake in the profit system that our insurers have like to sling that word of "socialized," but I think we have to say that it is universal care, that is supported by everybody, all the taxpayers pay in. It really is to the advantage of everybody. I mean, we have seen that in the pandemic. That if you are in contact with other people, you need them to be healthy too.

Judy Esterquest: Two of our legislators in the New York Assembly did a short video which we should send to Linda to send out. This is about New York Health Act, not anything else. It is two firefighters, two Assembly people who are dressed up like firefighters, talk about what "privatized, capitalistic, good market economy" firefighting would be like – rather than terrible, socialized firefighting. "Not that building. You don't have insurance, so we are not going to fight your fire."

The way I pick up the socialized medicine is: you know, we have socialized police, and socialized schools, and socialized firefighters, we have a socialized military, and we have socialized medicine effectively for all of these groups.

So you are saying is the only people who shouldn't get socialized good like this are people who actually work for a living in the private sector. In fact, Medicare is socialized, the Veteran's Administration is socialized.

When it is around the public good, and cheaper and more efficient because it is no a market – healthcare is not a market. When I get sick, I go to a doctor and I trust the doctor to tell me what is wrong with me. That is not how I buy a car. I do not go to the dealership and say "Hey, I think I might need a car. What do you think? What kind of a car, an expensive one or a cheap one? The most expensive one with all of the highest stuff? Oh, OK, I trust you because you are the expert. That isn't how car dealerships work.

Linda Mahan: Thank you. How does the League support putting two Concurrences into the form? Would you review that again?

Judy Esterquest: It is our understanding that there are two boxes that can take suggestions from a local or state League as to what else they would like to see on the program for the Convention. So what we are talking about the recommended program is essentially the AGENDA to be discussed and voted on. Each of those boxes ill hold 300 words. Each of the concurrences for healthcare and digital equity is under 120 words. So you can drop in two of them and have room for another few sentences in another box. And then you have room for as much as you can say in the second box.

My League will also be supporting three concurrences, two in one box and one in the other.

Linda Mahan: Are there any people who would like to unmute and ask a question directly? I have been pulling questions from the chat, but it occurs to me that maybe some of you would actually like to speak. Barbara, will you help me look to see if there are hands raised.

Barbara Dungey: Yes I will.

Linda Mahan: Another question has to do with the tremendous amount of money that is already floating around in our health care system. Do you have any ideas in how the League and other activists can combat this large amount of money of the vested interests?

Judy Esterquest: I have been exchanging emails this morning about the legislation in New York. We have a majority of sponsors in each of the two chambers, and it is not clear that we have a majority of the votes. What I try to say is: as of now, corporations don't vote. They can give campaign donations, and Political Action Committees (PACs) can give donations but they cannot vote.

Healthcare is part of the conversation because of the pandemic. Most people realize how disastrous our response has been. They don't realize that the United States has lost more people per hundred thousand than any country other than Russia. There are countries in Europe where the population grew during the pandemic.

We lost people and the reason for that is the pandemic is around us and people care about talking about healthcare. So if you can get voters to realize what they could do about it, I think you could get voters' elected representatives to vote properly. But only if there is a mobilized groundswell.

Carol Mattoon, you have your hand up?

Carol Mattoon: Someone wrote that they would like the script as well. Will that be available?

Judy Esterquest: Probably.

Barb Thomas: If you have the slide deck, there are notes that are at the bottom that are most of the script.

Judy Esterquest: That is true; good save, Barb.

I see a question that says how do we respond to people who say we have to be loyal to the Affordable Care Act, to Obamacare?

My reaction to that is legislation isn't loyalty to one bill over loyalty to another bill. For the League, what we are looking for is legislation that will serve the public good. I don't know how much activity we should spend on healthcare at the Congressional level right now. I would think it is very important to spend our activity at the state and local level, so that local communities and states think about how they can save costs and improve healthcare across their populations. I think that there are very few states that are not worried at least a little about it. Regardless of what their Governors say.

Linda Mahan: there is a question here about ways that single payer would be paid for. We don't usually go into that in our positions other than our original position says "would be paid for by taxes." Did you look at that any further in your study, Judy and Barb?

Judy Esterquest: We did not show a slide that shows that the United States, although Barb did say it. The rest of the world has a certain amount they pay in healthcare total per capita – you take the total healthcare expenditure for the country and divide it by the population and that is how much they spend for healthcare, either in taxes or out of pocket.

In the United States, if you take the amount that we spend on taxes for healthcare right now, it is more than those countries are spending for all of their healthcare – plus we spend another $5,000 out of our own pockets.

Karen Sheek: If someone would like to support the New York State League position, that they wait to do that until they see the outcome of our position so that they can include both when they have the documents.

Judy Esterquest: I would second that. It is not clear to me. This may not be politically correct, but it seems to me, if there are two or three or four activities that are happening, coming up from the grassroots, that we should be able to support more of them rather than fewer of them.

Barb Thomas: And we have six hundred words of space to put suggestions in, so it is not impossible to do that. You just have to be aware of that. Also, I would like to point out that the form isn't really due until March 1st. I don't advise you to wait until the last day,

because you might encounter some problems with the online form. But you don't have to do it tomorrow.

Linda Mahan: Beth DeHaven, you do have your hand up.

Beth DeHaven: I have a general question about Concurrence. I understand the difference with concurrence, you add to a position, you are not changing it. If you were changing the US position, you would have to go through a study, but looking at what you are wanting to add, it seems like quite a bit. What is the decision factor when it comes to whether you are going to change it, because I feel like adding on. I guess I have to see the whole position, but it seems like you are adding to a huge document after a while if you keep adding on. Just some commentary on that would be helpful to me.

Judy Esterquest: It is 500 words.

Barb Thomas: I think you are right in terms that it does make it a lengthier position, but it is a position where like the part on safe staffing. That allows you, and any League throughout the country to then support that kind of a law. It is not a whole package that everybody has to use all in one. It has those components and that is what makes it helpful to a lot of Leagues. I think a lot of Leagues don't have their own healthcare position.

When we look at this, we know that national League, because it is something that we all agree on, is that voting rights and access to the polls are absolutely core issues. We do not want to take resources from that to conduct a study. And don't forget, for those of you who are just recent members of the League, it often takes two years and quite a lot of resources and national staff time in order to conduct a study.

Judy Esterquest: I would say that our entire addition is 500 words, so it fits on one page, and you can look and find it on our website. Some positions run three sentences, and some positions run three pages. It depends on how much you split up the issue into sections, and how much you treat healthcare like one thing.

Linda Mahan: Barbara Pearson, would you like to add your comments now?

Barbara Pearson: I would except I am writing somebody else's chat. I think the biggest thing that people don't talk about, and it was so clear in the slides that Judy and barb showed us, that we don't have services where we need services. One of the fall-outs of having a profit-based system is there are no services where you cannot make a profit.

So if we had democratic governance on our healthcare, they would be able to make system wide decisions and not ones that require them to give more resources where there are already resources. That is a huge piece of what could happen. The fact of having democratic governance of our healthcare instead of arbitrary decisions made by corporate executives whose job is to make as much money as they can. And they are making it

where the money is. But look at those maps; look at all of the places where you don't have maternity.

Judy Esterquest: One of the really dense places for doctors and hospitals is New York's Upper East Side. I don't know if the rest of you know what the Upper East Side is like, but it has a life expectancy that is higher than Japan's and a wealth per block that would scandalize anybody. And ten blocks north, life expectancy drops ten years because it was redlined – it is part of Harlem. The per capita income is probably, what, 5%?

Yes, Barbara, thank you. Healthcare follows money.

Barbara Pearson: And then the other point is that somebody said about not having to do a study. The study has been done. This is just leveraging the study that they already did. It is going to make it a more useful position so that it is longer.

Linda Mahan: Carol Mattoon

Carol Mattoon: On the top of the survey, it says only complete surveys will be used to summarize the program planning surveys results. Does that mean that if you leave one of the questions empty, that they won't use your survey?

Judy Esterquest: I notice that Betsy Lawson has joined us. Can we ask her?

Linda Mahan: Betsy was a long time League staff person, now consulting with the national League. Betsy, would you like to answer that?

Betsy Lawson: The answer is no. We prefer that you answer all questions, but no. Everything that is submitted is counted.

Carol Mattoon: What does it mean to have a completed survey then?

Betsy Lawson: It means that if you don't hit "submit" which is a problem we have had in the past.

Carol Mattoon: Thank you.

Linda Mahan: We are at an hour now since we began. If there are people who would like to leave, we appreciate your coming today. We do plan to send a follow-up email. It will include the link to this recording on the YouTube channel. We will also include the slide deck with the little bit of the script that we have. It will include the link to the page where all of the concurrence materials are available on the New York State site. And it will include an invitation if you would like to join the national google group, and conference calls, we will give you some information about that – that connects you between now and the convention about what is going on.

And then, I will just say, all of us in Colorado are looking forward to seeing you in Denver in June. Hopefully things will come together that we all can meet. Meanwhile, I hope there will be a lot of virtual opportunities for caucuses and other conversations around the convention, so stay tuned for that. There is a link for a convention concurrence discussion group that I would like to include that link too, so that if you have not seen it yet with the different concurrences that are being proposed from around the country, that will help prepare you and your League to be informed ahead of time. Also, you can include them in your program response.

Judy and Barb have agreed to stay on for another 20 minutes.

Judy Esterquest: I received a question: how different is this from the US position? It is additive. It is built on the US position, which in principle is really good, but it is 30 years later, so we are adding things that no one would have expected in 1990 when they started their study.

Mary Schreiber: Would the Leagues support expanding access to healthcare in other ways before we can politically get to single payer. For instance, (I'm a retired nurse, by the way) it seems to me that expanding Medicaid, we call it MediCal here in California, and lowering the age for Medicare would be a faster way to get more people covered.

Judy Esterquest: Which level League are you talking about?

Mary Schreiber: Any League.

Judy Esterquest: What I would say is that, Barb is probably going to correct me because what I know about the League is because of the last three years of her mentoring, but my first reaction is: Medicare is controlled by the federal government; if we want that to be extended, it is something the Congress has to do. Medicaid expansion to a large extent is in the states – that is where you advocate for it, is at the states. And then there are local things that you can advocate for, so yes of course we want to expand healthcare geographically, by income, by marginalized status, by ZIP code. Part of what this concurrence does is give more ways to try to expand it. Step back from the legislature…

Positions allow you to have principles that allow you to score legislation. Write positions so that you could advocate for things. You write positions because they make sense, and then you look at this legislation and see if this legislation makes sense.

What you want is as robust a position as possible for the kind of issues that Leagues and legislatures will be wrestling with. One of the things that this does is gives you more ways to expand healthcare, including telemedicine, clinics in schools and home care.

Linda Mahan: Jan, do you have a question?

Jan Phillips: I was just wondering if we are able to use any of the graphs you had in your presentation for letters to the editor or a brochure? Anything we want to come up with for our League?

Judy Esterquest: Some of those graphs are ours; some of the graphs known as PNHP, Physicians for a National Health Program. It is my understanding that if one League does it, other Leagues can use it. And I know that from PNHP, if you are using it for good, have at it. So Yes, the answer to your question is "use away."

Linda Mahan: Carol Mattoon

Carol Mattoon: Back to the question that was asked before that. As far as doing more piecemeal and not trying to get everything at once? When Medicare was passed originally under Johnson, at that point it was supposed to be everyone would be covered. Because they were having trouble getting it through Congress, they did it for people 65 and older. After that, piecemeal parts of that to make it better. They didn't think it would take over fifty years to actually get everybody covered, which we still have not achieved the goal yet.

So the League has piecemealed pieces in, the government has piecemealed parts in. Isn't it time for us to go for the goal. Olympians don't try to get the Bronze medal, we try to get the Gold medal. So as much as we can get in, and having New York State do this two year study is a super big deal. To have another League do this, or the national, is another ten years or so. I really admire what New York State has done, and I think we should try to go for the Gold. I would like to have even more than you did, and I think this is really an excellent addition. Someone had mentioned, well is 500 words too much? There is no limit in how many words has to be in there. That is the position that we can have so that all of the Leagues can use it, I think is really advantageous.

Linda Mahan: Thank you Carol.

Barb Thomas: I want to say something about that. Obviously, I think it would be fantastic to actually have a "good" single payer system. I think that some of the other parts that we are adding through this like the telemedicine, like paying attention to disadvantaged populations, are things that we can use in terms of specific legislation at the state and the national levels. Maybe I am just thinking from the New York point of view, but at the local level, we don't have any control over, you know, the rules for healthcare providers.

Judy Esterquest: However, local control does have influence over public health. Some of our issues around dispirit incomes, dispirit treatment, dispirit access, dispirit quality. Those can allow a bolstering of local public health. What I would say to people is, "The U.S. League has its hands full right now. It has in fact advocated for single payer. It has supported some of the bills in the past. But right now, voting rights is a dumpster fire, and it is ALL HANDS ON DECK. But at the state and local levels, we have a lot more room. I agree. I think, New York has expanded Medicaid more than any other state. It

is very expensive, but it means that the delta between New York going for single payer, which is what the New York Health Act does without all of those taxes, it is a smaller delta to get there. It means that our healthcare costs are high enough that when you look at it, you can see a real difference.

Whether your state has expanded or not expanded healthcare, and is closer or father away from universal, think about what you can achieve. Look for legislators who will propose bills and get their bills up.

Linda Mahan: I also was corresponding with Linda Hawkins in Louisiana this week. They had expanded Medicaid in that state. She is concerned now with their election of a new governor coming up in the fall, that may go by the boards. Those of us who are in states where we are changing elected officials also can keep this in mind going forward.

And use our position to continue to strengthen if it is Medicaid where you are.

Judy Esterquest: Yes, Medicaid is a good program. Karen has her hand up.

Karen Sheek: I think one of the things that we can do at the local state level is begin a massive campaign to educate our legislators. They bought bought the Kool-Aid too, that Medicare for all is socialized medicine and nothing good can come from that. Adequate resources that can be shared. Colorado and Linda Mahan, you have much more information on this, but a document has been developed in Colorado refutes a lot of that. If we could just get that information to our legislators, and figure out some way that they could actually read it, and then have a conversation, the more people you have that really understand what is happening now and switching can change. The costs and the benefits to everybody. That might be another way of approaching this.

Barb Thomas: I'd like to add that speaking with your own local legislators and letting them know what you think, and letting them know what is important to you is a really important thing. Even if you suspect that the legislator agrees with you, they like to know, that you think the same way, or that you support something. So I would encourage you, and if we have this position let them know. There are parts that you probably can use at a fairly local level. Letters to the Editor.

Judy Esterquest: What our legislators hear, they hear from a couple of very large supposedly non-profit hospital corporations, which my daughter says she is never going to use again because she went in for a test of her throat, not Covid, and it cost her $180 a week ago. She said, "how can a strep culture cost $180?" Then she saw some reviews that said that this particular non-profit hospital which owns many of the hospitals and many of the urgent care clinics, and many of the on the street doctor clinics, has enormous revenues, which they use for things other than shareholder value. They don't use them as a non-profit would.

I agree with Barb. Those are the ones who are talking to our legislators. They need to hear from voters and the League about what we care about, why they are buying myths, and drinking Kool-Aid that do not have a basis in reality or fact.

There are groups in new York that will happily tell you that all the Canadians are coming to the US for healthcare, and Canadian doctors are coming to the US, when in fact the exodus of doctors from the US to Canada is far, far higher.

Linda Mahan: You have a question, Betsy?

Betsy Lawson: The number of organizations that lobby on healthcare is phenomenal. There are so many vested interests, whether you are talking about the hospital or the doctors, or the subsets of all of the doctors groups. I remember attending a meeting on Capitol Hill, back in the days of the Clinton healthcare plan, and there were 300 people in the room. You cannot underestimate that.

Sandy Schuster: Don't forget the insurance companies.

Barb Thomas: Don't forget the pharmaceuticals.

Judy Esterquest: The pharmaceuticals have hired five lobbyists for every member of Congress every year. With health insurers it is two or three lobbyists for every member of Congress. Think how big the League's lobbying force would have to be just for healthcare to counter that.

Karen Sheek: Maybe this is something we need to do a better job of getting out to the American public: how much money is being spent to maintain a system that is broken, and is costing us way more than we are getting in return for our investment that has nothing to do with healthcare. Television advertising for pharmaceuticals, massive marketing, large dividends for people who invest in healthcare; none of that money goes into actual healthcare provisions, making the American people healthier. I don't think most Americans realize how much money is spent on those things in order to maintain the status quo so that those who are making excessively large amounts of money, including CEOs of insurance companies and pharmaceutical companies and others, you know. It is a heavy burden to take on, but you know I think that is part of it too: education.

Judy Esterquest: I want to thank Betsy for all her work when she is surrounded by hordes.

Linda Mahan: Fighting off those hundreds of lobbyists for healthcare. I hope that you did see in the chat that she put up earlier that the League has in the past lobbied for some healthcare for all legislation.

Barb Thomas: And the national League has been very strong on supporting the Affordable Care Act and expansion.

Linda Mahan: And defending it.

Barb Thomas: It is not the whole ball of wax, but it is very important for everybody, really, because it improves our health.

Linda Mahan: Carol Mattoon?

Carol Mattoon: When we talk about education, it is really hard to get our message out there when you are fighting all the big money that is out there. The real answer here is campaign finance reform. That is the underlying problems there. Kyrsten Sinema has received $750,000 from healthcare. That is influencing her decision right now on the whole filibuster and Build Back Better and all of that. Both Democrats and Republicans including Nancy Pelosi, all of them are receiving huge amounts of money from the pharmaceutical medical supply whatever you want to call it healthcare that it it very difficult for us to get our message out.

Linda Mahan: Carol, to applaud you is also important, because you and some of your colleagues in Arizona have been doing a good job of opinion pieces, in the papers. Just letting the public know, what kind of funding is going to their elected officials.

I am going to close this off for today, and hope that in the next week we can get to you this powerful follow-up email with all kinds of links and ways that you can keep working on this.

Please do come to Denver in June, join the convention, and meet us all in person. I think Barb and Judy have pretty much prepared their caucus material right here that we will see in June. Maybe it will be virtual. As well as in person.

Thanks to all of you for joining us today, and have a good weekend.

Judy Esterquest: Thanks to Colorado.

Barb Thomas: Thanks to everybody who was here.

Beth Hendrix, CO
Judy Esterquest, NY Port Washington Manhasset
Karen Sheek,
Linda Mahan, CO Larimer
Barb Thomas, NY Saratoga
Anna Makovec-Fuller, CO Larimer
Anne Mueller
Annette DeMartine, CO Larimer
Barbara Dungey, CO Arapahoe Douglas
Barbara Pearson, MA Amherst
Beth DeHaven, CO Larimer
Beth Kinney, San Luis Valley

Bette Seeland, CO Jefferson
Brenda Garrison, CO Jefferson
Carol Mattoon, AZ, NW Maricopa
Carolyn V Brown, AL Juneau
Celeste Landry CO Boulder
Christina Manthey CO Jefferson
Cindy Lau CO Pueblo
Fred Levine
Gale Henson, KY Louisville
Harriette Seiler KY
Jan Phillips, La Plata
Jean Hopkins VT Champlain Valley
Joyce Devaney
Judith Jones
June Hyman-Cismoski, CO Larimer
Karenlee Robinson CA San Diego
Kathleen Conroy La Plata
Kathy Wilson
Madeline Zevon
Marilyn Brown, CO Jefferson
Mary Schreiber CA Diablo Valley
Maud Naroll CO Arapahoe Douglas
Phyllis Graham
Ruth Nerenberg, CO Pueblo
Sally Grubb, Tompkins
Sandra Vandehey CO Jefferson
Sandy Schuster CO Jefferson
Sue Taigman, CO Jefferson
Suzanne DeVore, CO San Luis Valley
Toni Larsen
Viola Gonzales