



Newsletter of the Capital District Alliance for Universal Healthcare

Volume 3

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Calendar of Events

- May 5:** Wednesday, May 5, 7:30 pm. **CDAUH Monthly Meeting, B'nai Sholom Reform Congregation**, 420 Whitehall Road, Albany. All are welcome. 482-0420 for information.
- May 15:** **Single Payer New York Regional Conference "Expanded and Improved Medicare for All – Round 2!"** Speakers include Dr. Steffie Woolhandler, MD, MHP, co-founder of PNHP, Terry O'Neill, President of NOW, and Rose Roach, Field Director, California School Employees Association. Saturday, May 15, 9:30 am to 3:30 pm, First Unitarian Universalist Society, 405 Washington Ave, Albany. Pre-registration: euthemia@nycap.rr.com; Questions: singlepayerny77@gmail.com or 518-729-3068. **See attached flyer for more details.**
- June 2:** Wednesday, June 2, 7:30 pm. **CDAUH Monthly Meeting, B'nai Sholom Reform Congregation**, 420 Whitehall Road, Albany. All are welcome. 482-0420 for information.

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Comments from the Chair

At least someone is reading our Newsletter! My Comments in last month's edition elicited a strong reaction from a fellow member of the medical community who thought I was much too negative about the recently enacted federal healthcare legislation, and that the commentary in the Newsletter was too one sided. Be sure and read the "letter to the editor" which appears below. Do you agree? Let us know your reactions. This is one way we can get a better sense of what the less vocal community is thinking – and it will help us better address your most pressing concerns about the current and future state of healthcare in this country.

At our last CDAUH meeting, we had a roundtable discussion on our reactions to the "reform" legislation. A number of participants had positive reactions. Some thought that this legislation established an important benchmark by acknowledging that everyone is entitled to healthcare and that it was a good starting point. Many remarked on the positive elements of the legislation: eliminating insurance company bans on insuring those with pre-existing conditions; closing the "doughnut hole" in prescription coverage for seniors; and extending the period for keeping young people on their parents' insurance policies. Others were more negative, noting that this legislation was not really reform but rather a continuation of the status quo. It keeps private insurance companies in control of healthcare while enhancing their profitability by providing them with more customers for their overpriced and undervalued product.

Everyone seemed to agree that the future cost of healthcare is a big unknown and a huge concern which this legislation really did not address. Insurance companies are not known to provide additional benefits without passing the cost on to policy holders. One of the fears articulated was that insurance policies will be priced out of reach of even more consumers, even before folks are required to be covered. The press is reporting that insurance companies are already taking defensive steps to protect their bottom line by increasing premiums and limiting coverage.

Everyone also seemed to agree that the political process which culminated in the healthcare legislation was disappointing at best, or as some termed it just "ugly". Where will this lead? Will it affect the mid term elections coming up in November, and how? Is the debate over healthcare over for good or is there still a possibility that we could achieve real healthcare "reform"? These issues and others will be on the table at the upcoming Single Payer New York regional conference to be held at the First Unitarian Universalist Society in Albany on Saturday, May 15 from 9:30 am to 3:30 pm. Steffie Woolhandler, MD, MHP, a co-founder of Physicians for a National Health Program, will be joined on the speakers' podium by Terry O'Neill, the national president of NOW, and Rose Roach, an articulate teacher union organizer from California who is helping to lead the movement for single payer in her state. There will also be a number of workshops. A flyer with full details is attached to this Newsletter. Please try and attend – this is an impressive group of speakers and we are very excited to have them here in Albany. In addition, please pre-register for the conference. It will be worthwhile and we value your input as we try and chart a course for the future and the achievement of real healthcare reform.

Richard Propp, MD, Chair

Letters to the Editor

Please feel free to email your letters to the editors at crangy@aol.com or euthemia@nycap.rr.com.

This letter was received by the Chair and is printed with permission. We invite comments and discussion.

Dear Dr. Propp,

I am sending you this letter in response to your "Comments from the Chair" which I received last week together with notes from many others. They all were critical of the health care reforms enacted by Congress and signed by President Obama. While I agree with you that these accomplished less than we had hoped for, the changes enacted are important first steps on a long road. The planning of the (British National Health Service) was initiated by Winston Churchill in 1944 during World War II with the appointment of Mr. Beveridge, who was later rewarded with a peerage for his accomplishments.* His committee worked for 4 years to develop a universal medical coverage program in the midst of war and major financial issues. I was a medical student in England at the time and remember how tough it was to overcome the opposition. But it did come to pass and it is still evolving.

It seems to me that we should celebrate our hard won first steps and continue to plan and advocate for future evolutionary steps such as :

- Increase coverage of the uninsured from 32 million to all the estimated 45 million.
- Make primary care and geriatric care viable options for future physicians by providing scholarship support and better reimbursement.
- Advocate for cost control measures such as a single billing system at federal or state levels and meaningful tort reform

John Balint, MD, FRCP
Professor of Medicine and Medical Ethics
Albany Medical College

**Chair's note: The history of the NHS with the upper class social reformer William Beveridge as architect and lower class union politician Aneurin Bevan as builder is well described in T.R. Reid's new book, THE HEALING OF AMERICA.*

Reprints of Interest

Each month we will try to reproduce articles or columns we have read that we think are of interest to everyone. If you see something on the web or are sent an article that you think we should include, please feel free to forward it to either crangy@aol.com or euthemia@nycap.rr.com.

The following article is a reprint from Don McCanne's April 5, 2010 *Quote-of-the-Day*, "Gaming the individual mandate". Don McCanne's *Quote-of-the-Day* is available free from Physicians for a National Health Program. To subscribe to McCanne's excellent daily health policy comment, log onto <http://two.pairlist.net/mailman/listinfo/quote-of-the-day>.

The Boston Globe

April 4, 2010

Short-term customers boosting health costs

By Kay Lazar

Thousands of consumers are gaming Massachusetts' 2006 health insurance law by buying insurance when they need to cover pricey medical care, such as fertility treatments and knee surgery, and then swiftly dropping coverage, a practice that insurance executives say is driving up costs for other people and small businesses.

In 2009 alone, 936 people signed up for coverage with Blue Cross and Blue Shield of Massachusetts for three months or less and ran up claims of more than \$1,000 per month while in the plan. Their medical spending while insured was more than four times the average for consumers who buy coverage on their own and retain it in a normal fashion, according to data the state's largest private insurer provided the Globe.

The typical monthly premium for these short-term members was \$400, but their average claims exceeded \$2,200 per month.

The problem is, it is less expensive for consumers — especially young and healthy people — to pay the monthly penalty of as much as \$93 imposed under the state law for not having insurance, than to buy the coverage year-round. This is also the case under the federal health care overhaul legislation signed by the president, insurers say.

http://www.boston.com/news/health/articles/2010/04/04/short_term_customers_boosting_health_costs/?page=full

Comment: Health policy science told us ahead of time that a mandate for individuals to buy private health insurance would not work if the penalties for not doing so were quite modest. Yet Massachusetts enacted such a plan, and now very similar policies have been enacted into federal law.

The Massachusetts experience has demonstrated that health care consumers will act in their own financial interest. Individuals who perceive themselves to be in good health will elect to pay the much lower penalty for being uninsured. If they then develop expensive medical problems, they will sign up for a health plan, but then will drop their coverage after their medical needs are met. It means little to them that this drives up premiums for those who remain in the insurance pools.

There are legitimate reasons that state and federal legislators have been reluctant to assign greater penalties for not being insured. The most important is that insurance premiums are simply not affordable for moderate income individuals who do not receive adequate public or employer assistance. Even the modest penalties create a financial hardship for some. Pushing the penalties higher would compound the financial stresses that too many middle income families are already experiencing.

There are policy interventions available, but those under consideration are based on leaving the private insurance industry in charge. One suggestion is to close enrollment except for a short period of open enrollment once or twice a year. This would leave already financially strapped individuals without a safety valve should problems arise during closed enrollment periods. Another suggestion would be to reinstitute (Massachusetts) or expand (federal) the waiting period before preexisting disorders are covered, even if of very recent onset, again preventing coverage for more urgent, serious problems.

Though some might suggest that these individuals would be getting what they deserve for not being insured, the real fault is with policies inherent in the design of a financing system based on private insurance plans. Individuals are forced to choose between private insurance coverage that they may not be able to afford, or exposing themselves to the potential of greater financial insecurity by remaining

uninsured. If solving problems in a system creates new problems, then we should question the system itself.

We can do this far better. We can separate the financing from the delivery of health care. With a single payer, improved Medicare for all, everyone would be automatically covered, for life. The financing of the system would not be through premiums tagged to private plans, but rather would be through progressive tax policies in which each person would pay an equitable share, and no one would face a financial hardship.

Gaming the individual mandate is not a very fun game. Let's shut it down, and change to a system that works for everyone.

The following article is a reprint from Don McCanne's April 7, 2010 *Quote-of-the-Day*, "Why are insurers buying back their shares?"

American Medical News
April 5, 2010

Health plan profits: Relying on the market

By Emily Berry

Boosting earnings per share keeps Wall Street (and shareholders) happy. And in for-profit health insurance, shareholders come first.

When companies have extra cash, they think of the best way to benefit shareholders. "It is a fairly straightforward decision: they have dollars. They could potentially use those to buy new computers, hire new staff, open new markets, increase reimbursement or deliver more services, but in the for-profit world, their first obligation is returns to their owners," said Joe Paduda, principal for the consulting firm Health Strategy Associates in Madison, Conn.

So how are they making money?

Administrative cost controls play some part. But there are other factors: First, insurers also make money from investing premium dollars, and the returns they make on those investments have stabilized since the market crash of 2008.

The other factor is plans' billions of dollars worth of share buybacks, which affect the figure Wall Street watches most -- earnings per share. Even if cash profits don't change, per-share earnings will go up, because a company has fewer shares in the market.

Insurers' investments and share buybacks matter, because they can indirectly affect doctors' pay. If the market isn't doing well and investment income drops, insurers feel even more shareholder pressure to raise premiums or cut costs, rather than risk an operating loss. That means less flexibility for doctors in negotiating reimbursements.

"They have less margin for error, because investment returns are so low," Paduda said. If health plans see higher-than-expected spending, "or they sell a policy to folks who, God forbid, actually get sick, then they've got a problem."

(Dave Shove, a New York-based senior research analyst specializing in managed care for BMO Capital Markets Equity Research Group) said share repurchases are simply a way to reward shareholders. Other options are paying dividends or buying other firms.

But health insurers historically have made very few dividend payments, he said, and "the health insurance business is pretty consolidated now. That just leaves one thing to do, and that is buy back stock, so they're doing it."

(Scott Harrington, PhD, professor of health care management at the Wharton School of the University of Pennsylvania) said health insurers, like other companies, have favored share repurchases over paying bigger dividends, in part because the tax code favors repurchases, but also because if shareholder dividends are increased one year then cut the next, the market interprets that as very bad news.

WellPoint Chief Financial Officer Wayne DeVeydt told investors at a March conference that the company plans to spend nearly \$4 billion on share repurchases in 2010, following \$2.6 billion in 2009.

Not everyone likes the way investments and stock prices drive the U.S. health care system. But short of a single-payer, government-controlled system, health system reform proposals are not aimed at changing this part of the way health insurance companies work.

"This is the world we live in," Shove said. "These guys are for-profit, and as long as we have insurance companies, we have to live with the consequences of that."

<http://www.ama-assn.org/amednews/2010/04/05/bisa0405.htm>

Comment: When some of the non-profit Blues insurers converted to for-profit status, the primary reason given for that conversion was to open access to capital markets. What does that mean?

When a shareholder-owned corporation issues new stock, it is allegedly for the purpose of raising capital to expand operations, growing the industry and increasing profits. That is what capitalism is all about.

But when a corporation buys back stock, it is not for the purpose of contracting operations, but rather it is to pump up the per share value. It is not merely a coincidence that this increases the value of the large blocks of shares held by top management and the board of directors, by increasing the percentage of ownership in the company. New stock issues dilute ownership, whereas stock repurchases concentrate ownership.

The funds used to buy back the shares could have been used instead to slow the growth in premiums or to reduce the excessive cost sharing burden created by the shift towards underinsurance products, benefiting their customers - the patients. But no. As this article states, "shareholders come first."

As Dave Shove states, ""This is the world we live in. These guys are for-profit, and as long as we have insurance companies, we have to live with the consequences of that."

Perhaps the most important statement in this article: "... short of a single-payer, government-controlled system, health system reform proposals are not aimed at changing this part of the way health insurance companies work."

The obvious conclusion is that reform should not stop short of a single payer system. We have more work to do.

The following article is a reprint from Don McCanne's April 12, 2010 *Quote-of-the-Day*, "Mutual fund managers are relieved".

The New York Times
April 9, 2010

Health Care Overhaul May Help a Fund Sector

By Geraldine Fabrikant

Now that President Obama has finally gotten his sweeping health overhaul passed, mutual fund managers can breathe a sign of relief. Finally, there is some certainty about the changes, and most of them appear to be beneficial for health care stocks.

"There does not seem to be any onerous cost control," said Les Funtleyder, a health care analyst at Miller Tabak, an insitutional brokerage firm and asset manager.

In the wake of the new bill, the only negative he sees is a potential problem for insurance companies, like WellPoint, the UnitedHealthGroup and Aetna, because at some point they will have to cover all potential clients. "Then the question is, will they price these things so that they can avoid losing money?" he asked.

<http://www.nytimes.com/2010/04/11/business/mutfund/11health.html?hpw>

Comment: For those of us who continue to express concerns about the failure of the reform legislation to adequately control the excess growth in health care spending, this news is no surprise. Mutual fund managers are relieved that there are no onerous cost controls, allowing them to continue to include health care stocks as an important part of their portfolios. The only concern they've expressed is that health insurers now are going to have pay for health care for high-cost patients that they've been successful in excluding from their plans.

Expanding our expensive dysfunctional health care financing system works well for Wall Street, but it doesn't work for the rest of us. It is absolutely inevitable that we will have to adopt a program of social insurance, preferably an improved Medicare for all. The sooner, the better.

The following article is a reprint from Don McCanne's April 13, 2010 *Quote-of-the-Day*, "Healthcare overhaul won't stop premium increases".

Los Angeles Times
April 13, 2010

Healthcare overhaul won't stop premium increases

By Noam N. Levey

Public outrage over double-digit rate hikes for health insurance may have helped push President Obama's healthcare overhaul across the finish line, but the new law does not give regulators the power to block similar increases in the future.

And now, with some major companies already moving to boost premiums and others poised to follow suit, millions of Americans may feel an unexpected jolt in the pocketbook.

At least in the short term, regulators will be able to do little more than require insurers to publicly explain why they want to raise rates. Consumer advocates think that will not be an effective deterrent against premium increases such as the 39% hike that Anthem Blue Cross sent some California customers last year.

"It is a very big loophole in health reform," Sen. Dianne Feinstein (D-Calif.) said. Feinstein and Rep. Jan Schakowsky (D-Ill.) are pushing legislation to expand federal and state authority to prevent insurance companies from boosting rates excessively.

But more intensive oversight would not begin until 2014, when states set up new regulated insurance markets, or exchanges, where consumers who do not get insurance at work would shop for coverage.

The healthcare bill allows regulators to ban insurers from the exchanges if their rates are deemed unjustified.

<http://www.latimes.com/news/la-na-health-premiums13-2010apr13,0,3121779,full.story>

Comment: The health insurance overhaul that is now law does not include significant regulatory control of private insurance premiums. At most, plans can be excluded from the state insurance exchanges if their premiums are considered to be excessive. Thus the call for more legislation to increase oversight of premium increases. But would this really address the problem?

Actually the bill does require that 75 to 85 percent of premium dollars must be spent on health care. As long as the insurers demonstrate that they are complying with that requirement, the premium increases are not deemed to be excessive as far as excluding them from the exchanges. Of course they will be excessive, but that is because health care costs will continue to rise at excessive rates.

There are two questions we should be asking. One is why we should consider 15 to 25 percent of the premium to be a reasonable share for the private insurers to consume for their own intrinsic purposes, especially when they place an administrative burden of another 12 percent or so on the providers of health care, amounting to an administrative cost of 27 to 37 percent of the insurance premiums. You would think that this would be a prime target in our efforts to improve health care spending.

The other question we should be asking is why we should finance health care using using a market model that has a half century track record proving that it is ineffective in controlling costs, when we could be using a public insurance model that would use proven economic tools that can actually slow health care increases to sustainable rates.

Regardless of the hoopla, we didn't reform health care financing, we only expanded our existing dysfunctional system. We don't have to accept this. We can still do it right.

The following article is a reprint from Don McCanne's April 15, 2010 *Quote-of-the-Day*, "Ohio's lesson for Medicare Part D".

The Columbus Dispatch

April 14, 2009

State, patients, doctors like new Medicaid drug plan

By Catherine Candisky

When the state took back control of Medicaid's prescription-drug program last year, there was a lot of talk about how the move would save millions.

It has.

But it's also making it easier for patients to get the medications they need.

An analysis by the Ohio Coalition for Patient Rights found that Medicaid patients have improved access to "quality and appropriate" treatments and medications.

On Feb. 1, the state created a single, statewide drug formulary for all Medicaid programs, replacing eight different managed-care pharmacy plans.

At the time, state officials said the so-called carve-out would save money because the state is eligible for savings programs such as drug-company rebates.

The Coalition for Patient Rights' analysis compared access to 122 drugs for health conditions including asthma, heart disease, diabetes and mental illness. It found that the state formulary, in many instances, placed fewer restrictions on patients' ability to obtain medications prescribed by their doctor.

Such restrictions include the need for prior authorization from the insurer before a drug can be obtained and requiring patients to try different drugs before medications prescribed by their doctors can be made available.

Physicians also are applauding the change.

"We supported the idea of the carve-out because each managed-care company had its own formulary, and from an administrative perspective, it was a nightmare," said Ann Spicer of the Ohio Academy of Family Physicians.

"It's much simpler dealing with a single formulary, and the number of prior authorizations have been drastically reduced."

http://www.dispatch.com/live/content/local_news/stories/2010/04/14/state-patients-doctors-like-new-medicaid-drug-plan.html?sid=101

Comment: Enactment of Medicare Part D - the Medicare drug program - was a gift to the pharmaceutical industry and the private intermediaries managing the drug benefits. The government was even explicitly prohibited from negotiating drug prices in a competing plan. Many of us at the time objected to the rejection of the broader concept of having the government as the exclusive administrator of the Part D pharmaceutical benefit. We could have had greater savings and less third party intrusion if we had adopted a public program instead.

The story from Ohio is a vindication for those of us who still insist that the Medicare Part D program should be revamped into a public program that would better serve patients, without wasting funds on the excesses of the pharmaceutical firms and the pharmacy benefit managers.

Think of how this compares with the recent health care financing reform process. The debate ended up being over a competing public insurance option, after totally rejecting any consideration of a single publicly administered insurance program for everyone. Eventually even the public option was rejected, just as a competing public Part D option had been rejected. The Republicans established the flawed policy principles with Part D, and the Democrats have now followed the same path.

The Ohio experience demonstrates not only that Medicare drug benefits should be administered by the government, but also, by extrapolation, that our entire health care financing infrastructure should be converted into an improved Medicare for everyone. We can still do that.

The following article is a reprint from Don McCanne's April 19, 2010 *Quote-of-the-Day*, "Restrictive provider networks".

The Boston Globe
April 17, 2010

Some health networks drop elite hospitals

By Liz Kowalczyk

Health insurers are starting to sell policies that largely bar consumers from receiving medical care at popular but expensive hospitals such as Massachusetts General and Brigham and Women's — a once radical idea that is gaining traction as a way to control soaring health care costs.

Amid intense scrutiny into why health care costs in Massachusetts are climbing 7.5 percent a year, limited networks have emerged as the most immediate way to control costs.

The Group Insurance Commission (the agency that oversees health insurance for state employees) required its two largest providers — Harvard Pilgrim and Tufts Health Plan — to develop restrictive networks this spring.

(Dolores Mitchell, executive director of Group Insurance Commission) acknowledged that restricted plans could lead to problems in the market, if healthy employees migrate to cheaper plans and those with serious illness remain in more expensive open networks because they need broad access to the advanced care provided at teaching hospitals. That outcome could raise costs for individuals in the open plans, since costs would be spread among fewer employees.

http://www.boston.com/news/health/articles/2010/04/17/some_health_networks_drop_elite_hospitals/?rss_id=Boston.com+--+Health+news

Comment: Massachusetts intends to expand the use of limited provider networks in order to slow the rise in costs. The Patient Protection and Affordable Care Act also specifically allows the use of limited provider networks for the private plans that are to be established within the state insurance exchanges. The campaign rhetoric was that patients should have choice, yet the legislation limits patient choice of hospitals and health care professionals.

Losing choice is a big price to pay for allowing each private insurer to assemble provider lists based on lowest prices, especially when that doesn't control total costs but only shifts costs. Contrast that with a single payer that negotiates appropriate prices with every provider on behalf of all patients. Appropriate prices would be based on legitimate costs plus fair profits throughout the health care delivery system. An expanded and improved primary care system would provide a portal for access to appropriate specialized services in any appropriate institution.

How would that work for expensive academic medical centers? Institutions would negotiate global budgets with consideration of patient care, teaching, and research services, and separate budgeting for capital improvements. The patient care component should not be any more expensive than similar care provided at the community level, except for high-tech services provided exclusively by the academic center. Even those services should be priced appropriately and accessed only when clinical screening indicates that they are warranted. Patients need guidance in order to prevent inappropriate choices of non-beneficial, high-tech services.

Restrictive provider networks are simply one more perversity that we don't need in our health care financing system.

The following article is a reprint from Don McCanne's April 21, 2010 *Quote-of-the-Day*, "Will regulatory oversight of premium increases slow spending?"

Los Angeles Times
April 21, 2010

Democrats seek greater control over health insurance rates

By Noam Levey

Congressional Democrats have begun pushing legislation giving government regulators greater authority to block big increases in health insurance premiums.

The move, which comes less than a month after President Obama signed the healthcare legislation, is aimed at giving all states the power to stop premium hikes deemed excessive and allowing the federal government to step in if the states don't act.

"There is no need for federal involvement in states with insurance commissioners who are protecting consumers," (Sen. Dianne) Feinstein said Tuesday.

"Health plan premiums are a symptom, not a cause of the problem," said Karen Ignagni, who heads America's Health Insurance Plans, the industry's Washington-based lobbying arm.

<http://www.latimes.com/business/la-fi-health-premiums-20100421.0,2986100.full.story>

Comment: The cause of high health insurance premiums is high health care costs. State insurance regulators have no control over that, nor over the administrative costs of the insurers. If insurance company profits are abusive, then regulators can pare back profits to a reasonable level.

The problem is that insurance company profits are an almost undetectable portion of our \$2.5 trillion national health expenditures (NHE). Dramatically reducing insurer profits will not even appear as a footnote in the report of our NHE. The terrible waste is not in insurer profits but in the profound administrative inefficiencies of a fragmented system based on a multitude of private and public plans.

Karen Ignagni of America's Health Insurance Plans is correct when she says that insurance premiums are a symptom and not a cause of the problem. High health care costs are. Unfortunately, her industry has been and will continue to be ineffective in controlling rising costs. Throughout the reform process she had stated repeatedly, in effect, that the government must provide the solutions to rising costs.

Under the reform model approved by Congress and the President, there are no effective solutions. Merely experimenting with meager health policy proposals holds little promise for effective cost containment at the level that we need. (Those who contend that the independent Medicare advisory board would be effective should keep in mind that it would ratchet down Medicare while allowing the private insurers free run. That could be a disaster for Medicare.)

Of course, the government solution that Karen Ignagni doesn't want, but one that would be truly effective, would be an improved Medicare that covers everyone. (Is there an echo in here?)

SINGLE PAYER NEW YORK & PHYSICIANS FOR A NATIONAL HEALTH PROGRAM - CAPITAL DISTRICT

Capital Region/Hudson Valley Regional Conference

Expanded and Improved Medicare for All - Round 2!



Saturday, May 15, 2010

9:30 am - 3:30 pm

registration/coffee: 9:00 -9:30 am

First Unitarian Universalist Society of Albany

405 Washington Ave. Albany, NY

WHERE DO WE GO FROM HERE?

Join with activists and supporters from across New York's Capital Region and the Hudson Valley to learn more about the state of health care reform and develop strategies to strengthen the grassroots movement for Expanded and Improved Medicare for All.



www.singlepayernewyork.org

SPEAKERS

Steffie Woolhandler, MD, MPH. Professor of Medicine, Harvard Medical School, Co-founder, PNHP

Terry O'Neill. President, National Organization for Women

Rose Roach, Field Director, California School Employees Association (CSEA), AFL-CIO

PANELISTS

Hon. Wanda Willingham, Albany County Legislature

Shaun Flynn, Director, Government Affairs, NYS Nurses Association.

Wayne Bayer, EnCon, Public Employees Federation, AFL-CIO

Pricilla Bassett, Vice President, StateWide Senior Action Council

WORKSHOPS

STRATEGY SESSIONS

Pre-registration: Euthemia@nycap.rr.com

Questions: singlepayernow77@gmail.com or 518-729-3068

\$10 - 20 contribution requested to cover lunch and costs.

Endorsed by: National Organization for Women - New York State; NYS Nurses Association; Capital District Alliance for Universal Healthcare; SPNY - Saratoga; SPNY - New Paltz; Troy Area Labor Council; The Solidarity Committee; Hunger Action Network-NYS; Social Responsibilities Council, FUUSA.