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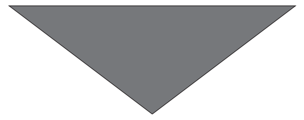

February 2008

The Journal of County Administration

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Medicare for All: Cost Effective Capitalism

Editorial by Bob McEvoy, Managing Editor

A recent *New York Times* editorial, "No Insurance, Poor Health," indicated that two new studies have verified former evidence that the lack of health insurance is very harmful to our residents' health. More specifically, the reports indicate that the uninsured, "suffer significantly worse outcomes from cardiovascular disease, diabetes and cancer than those who have coverage." Our response to the excellent ***New York Times*** editorial is, as promised, Paul Clay Sorum, MD, Part Two.

Why a Single Payer Health Care System Would Be Good for Counties (Part Two)

by Paul Clay Sorum, MD, Professor of Medicine and Pediatrics, Albany Medical College, Albany, New York; Chair, New York Capital District Chapter of Physicians for a National Health Program.

What can counties do to bring about a single payer "Medicare for All" health care system? They can convince Congress and the President to adopt HR 676.

In Part One, in the October issue, I argued that the health reform outcome needed by counties-providing all county residents with access to care without overwhelming county budgets-cannot be accomplished through private insurers. It can be achieved only through a single payer health care system.

The essence of a single payer system is that all members of a specific group of people are covered by one insurance system that is publicly sponsored and financed. The specific group is usually defined as everyone living within a certain geographical area, whether a country (such as England or France) or a state or province (such as a Canadian province). The group must be large enough to spread the risk, so that the modest contributions of everyone will be sufficient to cover the costs of the small number of persons unfortunate enough to have expensive illnesses and injuries. Private insurers have a limited role, usually to provide supplemental insurance (such as in Canada and France), although some countries (such as the United Kingdom) allow people to purchase private insurance to cover the same services provided by the public plan.[1]

National Health Insurance: HR 676

Representative John Conyers of Michigan has repeatedly introduced a single payer bill in the House of Representative: HR 676, the US National Health Insurance (USNHI) Act.[2] It now has 85 co-sponsors. The bill would create "a publicly funded, privately delivered health care system

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President's Corner

by Kathleen Kelley, Douglas County, NE, Chief Administrative Officer

NACA's Idea Exchange is scheduled for Sunday, March 2, 2008 from 1:45 p.m. to 4:45 p.m. at the Washington Hilton (Monroe East Room / Concourse Level). The Idea Exchange offers county administrators a great opportunity to share experiences, initiatives and perspectives from colleagues across the nation who may be addressing challenges today that will be on some of our front doors tomorrow.

It will be particularly interesting this session to hear first hand from colleagues the extent that the housing crisis and a weakened economy are affecting their state and local governments. Over the past couple of weeks I have read news reports on the fiscal crises facing New York, New Jersey, Florida, Arizona, Wisconsin, Michigan and California.

All of this at a time when Nebraska has the largest budget surplus in the State's history. One of the many advantages of living in the center of the United States is that often times it takes a year to 18 months to experience the economic turns that seem so often to occur on the east and west seaboards first.

Several states such as Indiana, Florida and Georgia have given consideration to the elimination of property tax. At the Idea Exchange I am hoping we can get an update on where these discussions have led.

With many state governments facing budget deficits, cost shifting and pushing added responsibilities onto the counties may become more prevalent. It seems that many states are enacting laws whereby counties are responsible for keeping state inmates in county jails who would otherwise be serving sentences in state penal complexes. A discussion of unfunded mandates has been submitted by a NACA member as a topic for discussion.

(Sorum, continued from page 1)

that improves and expands the already existing Medicare program to all U.S. residents, and residents living in U.S. territories." These residents would be issued a USNHI card that would entitle them to all medically necessary services, including primary care, inpatient care, outpatient care, emergency care, prescription drugs, durable medical equipment, hearing services, long term care, mental health services, dentistry, eye care, chiropractic, and substance abuse treatment. They would have their choice of physicians and hospitals, and they would not be subject to any co-payments or deductibles. Private insurers could offer coverage only for services not provided by the USNHI. Physicians would continue to be paid as they are now, largely by fee-for-service. Hospitals and other institutional providers would operate under annual global budgets established through negotiations with the USNHI.

The Secretary of Health and Human Services would appoint a Director who would manage a system of regional and state USNHI offices responsible for the details of reimbursing providers and ensuring quality of care. The Director would be advised by a National Board of Universal Quality and Access, composed of 15 representatives of different stakeholders, appointed by the President for 6 year terms and approved by Congress.

Congress would set annual budgets, and the USNHI would negotiate fee schedules with representatives of physicians and other fee-for-service clinicians, global budgets with institutional providers; and drug, supply, and equipment costs with private companies.

Institutions that deliver health care would participate only if they were public or not-for-profit. Investor-owned

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Published six times a year by the National Association of County Administrators, 777 North Capitol St, NE, Suite 500, Washington, DC 20002-4201

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The NACA Web site can be accessed at http://www.countyadministrators.org.

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providers could, however, participate if, over a period of 15 years, they converted to not-for-profit, with the investors being compensated.

Financing would be done through a Medicare for All Trust Fund that would have a dedicated stream of funding from a combination of payroll deductions, additional income taxes on the top 5% of income earners, and a small tax on stock and bond transfers. Because of savings from reduced administrative costs, bulk purchasing of drugs, and coordination among providers through computerization, Conyers estimates that the average family of four now spending $4,225 yearly under an employee health plan would pay only $2,700 under the USNHI; that for this family of four, businesses that now pay $8,510 per year would pay only $2,700; and that the nation as a whole would save $387 billion annually.

Counties would benefit greatly from HR 676. All county residents, including those presently covered by Medicaid, and all county employees, current and retired, would have comprehensive and affordable health insurance through the USNHI. Counties would be required as employers to make payroll contributions to the USNHI only for their current employees, although they could, if they want, offer additional benefits to their current and past employees. They could also continue to deliver health services through, for example, county clinics, visiting nurses, and nursing homes; for these services, they would be reimbursed by the USNHI. County property owners would get tax relief: they would contribute to the new health insurance system as described above, but no longer through property taxes; and their total taxes would, on average, decrease because the superior efficiency of the single payer system.

Responding to the Nay-Sayers

The scholarly journals and the media are full, however, of critics who argue that, even if HR 676 or another single payer Medicare for All plan is superior in principle, it would be impossible to get it into law. They point out that, even though Americans say they want universal coverage, most of those who vote are satisfied with their insurance, are afraid of losing what they have, like the idea of "choice" in health insurance, do not want to take the risk of paying more taxes, and are distrustful of government and particularly of government control of health care.[3]

They also claim that the dislocations caused by changing to a single payer system would be too painful to undertake. As The Commonwealth Fund's Commission on a High Performance Health System recently put it, "The Commission recognizes the inherent pragmatism of building on our current private-public system of health insurance and the value in minimizing dislocations for the millions of Americans who have excellent coverage."[4] Others cite the loss of insurance employees' jobs and of investors' stock values. Still others suggest that fundamental health reform would be stymied not only by the special interests (in particular, by the insurance and pharmaceutical lobbies) but by the structural impediments in our political system to any fundamental change.[5]

Must we, therefore, give up the goal of a just, transparent, efficient health care system through a single payer? Absolutely not!

First, the impressions and fears of the public about single payer are exaggerated if not simply false.

- In the USNHI, most people would have equal if not better coverage than now, and they could purchase (or their employers could provide) additional benefits if they wanted.
- In the USNHI, patients' choice would increase, not decrease. Currently the choice of insurance companies and plans is largely made for people by their employers. Moreover, when asked, people reveal that choice of physician is more important than choice of insurer.[6] In a single payer system, people go to the providers of their choice because everyone is insured and virtually all physicians and hospitals are participating providers.
- The costs of coverage for all through a single payer system would, as pointed out above for HR 676, be less than our current health costs even though now we do not insure a sixth of our population. The top 5% of income earners will pay more in income taxes, however they would pay less in payroll deductions, other taxes, and out-of-pocket expenses.
- The governing body of Medicare for All would be semi-independent of the government (in the spirit of the Federal Reserve), would be transparent in its decisions and actions (unlike current private insurers), and would be responsible for negotiating with providers their levels of reimbursement and for paying claims and assuring quality of care. The "government" would not be providing care.

The public's misconceptions need, therefore, to be corrected through public education and through political leadership.

Second, the costs and pain of transition are grossly exaggerated.

- The actual delivery of care in offices and hospitals-most of what happens in health care-will be unaffected (except that it will be freed of much of the time-consuming and frustrating dealings with insurers and pharmaceutical benefits managers).
- Who then will experience upheaval? Not the patients, who will merely receive the new USNHI cards as they previously received private or public cards. Not the providers, who will, as before, use the information on patients' cards for billing purposes (except that billing will now be vastly simpler). The only ones to suffer will be the insurance companies. But who and how much?

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The employees, the managers, and even some of the executives will still be needed for administering the new system, will be needed to provide care for the formerly un- and under-insured, and have skills that will be in great demand in other sectors of the economy. They will not have trouble finding jobs! In addition, HR 676 says explicitly that displaced clerical and administrative workers will have first priority in retraining and job placement in the new system. Furthermore, HR 676 indicates that funding will be provided to compensate investors in the current for-profit insurance companies.

Third, the political system is not an insurmountable barrier.

- The government has, in fact, been able to make bold innovations-women's suffrage, Prohibition, the New Deal, civil rights legislation, Medicare and Medicaid. Under pressure from outside groups, the President and Congressional leaders have, through bargaining and strong-arming, been able to create majorities sufficient to pass these major pieces of legislation.
- We-the vast majority of people and groups who would benefit from single payer-must, therefore, take it into our hands to educate and apply pressure on the candidates and on our elected representatives in Washington. Here the counties have considerable power.

Counties Support HR 676

What then can counties do to promote the enactment of HR 676 (or a similar single payer bill)? They can act on the political system on two levels: declaring that counties support HR 676 and directly lobbying Congress to pass it. Both Democrat- and Republican-controlled county legislatures in New York State-currently at 10 and counting-are starting to pass resolutions in favor of HR 676.[7] These resolutions can help change the opinions of the public and of voters and, therefore, can affect who gets elected to Congress and what they stand for.

Furthermore, because of their expertise, the national organizations of local governments have considerable lobbying power in Washington. If they adopted single payer as a primary cause, they could help to convince our Congress to acknowledge that the way to get a just, efficient, and effective health care system is to institute an expanded Medicare for All.

The path to single-payer health care runs through the counties!

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1 I discuss the French system, in comparison with other countries' systems, in: Sorum PC. France tries to save its ailing national health insurance system. J Public Health Policy. 2005:26:231-45. Reprinted in Rodwin VG. Universal Health Insurance in France: How Sustainable? Washington DC: Embassy of France; 2007:15-30. The World Health Organization publishes useful descriptions of individual counties' health systems; these can be accessed at http://www.euro.who.int/countryinformation.

2 Conyer's summary is available at http://www.house.gov/conyers/news_hr676.htm. The full text of the bill is available at http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=109_cong_bills&docid=f:h676ih.txt.pdf.

3 Most recent (at this writing) is the Associated Press-Yahoo poll of December 14-20, 2007, available at http://news.yahoo.com/page/election-2008-political-pulse-voter-worries. When asked to choose between descriptions of the current system and of Medicare for All, 34% chose the former and 65% the latter. See also the Quinnipiac poll of November 2007, available at http://www.quinnipiac.edu/images/polling/us/us11012007.doc. The source of much of the skepticism is a report on focus groups and a national poll conducted by Lake Research Partners and American Environics for the Herndon Alliance, available at http://www.herndonalliance.org/PollingSummary.pdf.

4 Commission on a High Performance Health System. A high performance health system for the United States: an ambitious agenda for the next president. The Commonwealth Fund. November 2007, available at http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=584834.

5 The essay by Aaron on "Why has health care reform failed?" in the Los Angeles Times on November 6, 2007, can be accessed at: http://www.brookings.edu/opinions/2007/1106_healthcare_aaron.aspx.

6 Lambrew JM. "Choice" in health care: what do people really want? Commonwealth Fund pub. #853, September 2005, available at http://www.commonwealthfund.org/usr_doc/lambrew_853_choice_ib.pdf?section=4039.

7 See the newspaper essay by Tim Joseph, the chair of the Tompkins County Legislature, at http://www.timesunion.com/AspStories/story.asp?storyID=635848. Information about the campaign to convince New York county legislatures to pass resolutions in support of HR 676 can be obtained from the leader of the campaign, Rebecca Elgie, at healthylink@earthlink.net.

NACA Events at NACo Legislative Conference

Saturday, March 1, 2008

NACA Executive Board Meeting
3:00 p.m.–5:00 p.m.
Independence Room (Terrace Level)

Sunday, March 2, 2008

NACA Idea Exchange
1:45 p.m.—4:45 p.m.
Monroe East Room (Concourse Level)

ICMA and ICMA-RC Hosted Reception
6:00 p.m.–7:00 p.m.
Caucus Room (Terrace Level)

Monday, March 3, 2008

NACA General Membership Meeting
3:30 p.m.—5:30 pm
Hemisphere Room (Concourse Level)