Healthcare-NOW's HR 676 WIN-WIN CAMPAIGN

Guaranteed, quality health care for all

Big savings for state and local government

Healthcare-NOW!

info@healthcare-now.org

1-800-453-1305

Contents

Win-Win Campaign Guide…….Pages 1-7

Resource Materials

1. Win-Win/Healthy Cities Campaign Brochure

2. Paul Sorum, MD published in *NACA: The Journal of County Administration* (October 2007 and February 2008). Louis Uchitelle, "Think the Economy is Bad? Wait Till the States Cut Back," *New York Times*, 6/1/08.

3. Navarro, Vincent. Unch Special Report. *Yes We Can! Can We? The Next Failure of Health Care Reform.*

4. Healthcare-NOW. *Financing Expanded and Improved Medicare for All (HR 676), A Briefing Paper*, May 2008.

5. Testimony before the NY State Partnership for Coverage by Tim Joseph, Chair, Tompkins County Legislature, Syracuse, NY, 11/13/07

6. Local benefit calculations worksheet

7. Kingston City School District data and trend analysis sample

8. Sample fact sheet

9. Sample Letter to the Editor

10. Sample resolution and guide for getting local resolutions passed. Mayor Lois Frankel, West Palm Beach, FL cover letter w/ Resolution submitted to U.S. Conference of Mayors

11. Sample media advisory

Healthcare-NOW's HR 676 WIN-WIN CAMPAIGN

- **Guaranteed, quality health care for all**
- **Big savings for state and local government**

CAMPAIGN OVERVIEW AND ORGANIZING GUIDE

This Healthcare-NOW organizing guide outlines the steps to win local government endorsements for HR 676. Use this guide in conjunction with various training materials that are listed at the end of this guide, and are highlighted in the text.

This is a self-pacing, hands on campaign. Take the tools we provide and run with them as fast as you want or can. You will learn and implement this campaign at the same time. If you have questions or run into a snag, get in touch (see last page for contact information). We'll either help you or find help for you. We'll update and improve this guide and the resource materials as you/we learn more.

Once you are successful, you can help get others involved in winning more endorsements. There are over 87,000 local and state government entities in the U.S., so we won't run out of targets! We'll need lots of endorsements to form a formidable delegation that will meet with the new administration early in 2009. **The time is NOW to build a new network of supporters so that we will be ready for that opportunity when it comes.**

This campaign uses a financial "hook" to interest local government officials. But remember to talk about other reasons HR 676 is so important: comprehensive and quality care for everyone; treating people with dignity; eliminating waste; controlling costs; and restoring treatment decisions to patients and their chosen medical professionals.

1. **Get some background** so you have a clear picture of what this campaign is about and where it's headed.
   - **Resource #1.** Basic brochure that explains it simply for others you involve in the campaign. We will have hard copies available NLT 6/16. We'll send you as many as you think you will need, subject to supply and cost limitations.
   - **Resource #2**. Two part series by Paul Sorum, MD published in *NACA: The Journal of County Administration* (October 2007 and February 2008). Also, a very recent *New York Times* piece 6/1/08 showing how state and local government savings will be vital for our struggling economy.
   - **Resource #3**. Vincent Navarro's recent piece (*Yes We Can! Can We? The Next Failure of Health Care Reform*) is very good at explaining why national health insurance is the best solution, with non single-payer reform measures falling short.

2. **Recruit your local team.** As with all organizing campaigns, more heads are better than one, and many hands ease the workload. Pull together a good group of 3-5 people (if you can). Talk things through, divide up the work, and pool skills and resources. Your team might want to take on a couple of local government bodies at the same time, for example a county, and a town or city within the county.

3. **Understand how HR 676 will be financed.** Read the briefing paper that Mark

Dudzic prepared for Healthcare-NOW (**Resource #4)**. Get back to us with questions.

NOTE: You may notice two things that are different from what you may have already learned about HR 676.

First, the paper doesn't mention savings. There will be savings from a single-payer system that result because private insurance companies will no longer be involved. They will not be paying profits to investors, marketing and advertising costs, and big salaries to managers and CEOs. A single-payer system also controls costs because the national health insurance program will negotiate fees with providers, monitor budgets and capital plans for medical facilities, and purchase drugs and medical supplies in bulk.

Much of those savings will be needed to cover the 48 million Americans who have no health insurance. However, to be conservative and to allow for problems that we can't anticipate in the huge endeavor of converting to national health insurance, we do not deduct any remaining savings from the total funding required. The $2.7 trillion needed to fund our health care system in 2010 is a projection based on actual current spending of approximately $7,500 per capita. We expect that a few years into the implementation of HR 676, we will know a lot more, and the finances can be reviewed and changed if necessary. Until then, the expected savings are our safety margin.

Second, you will notice that the employer side of the payroll tax that will help fund HR 676 is no longer 3.3% of payroll, but 4.5%. Healthcare-NOW believes this change is prudent because it reduces the amount of any new revenue that may be needed to make HR 676 work. Page 5 of Mark's report identifies a gap amount of $121.7 billion, and lists a number of plausible sources for it. We wanted that gap to be less than 5% of the total.

4. Understand your local situation and choose a local government entity to target. The most likely candidates are: town, township or city, county, school district, or local quasi-public authority. Quasi-public authorities usually have their own revenue, and are run by Commissioners who are appointed by local elected officials. Examples are:

a. Municipal utility authorities – run sewage treatment or water systems and collect fees for their services;

b. Transit authorities – run public transit systems and collect revenue from riders;

c. Bridge authorities – operate and maintain major bridges and collect tolls to cover costs;

d. Parking authorities – operate public parking facilities and get revenue from meters and parking facility fees.

Some things you might consider in choosing a local government target include:

- How big is its budget? Bigger often means more employees and more clout.
- Does the entity have a good web site where you can find employment, budget and other financial information?
- Do you have contacts there – people you know? They might help get you get information you need, or get in the door to make your pitch.
- Has local press reported financial problems? Have rising health care costs been cited as a particular problem?
- How progressive is the Mayor, Town Manager (more important than Mayor in many southern towns), County Executive, Commissioner (often key person in County government or quasi-public authority), or Director (quasi-public authority)?

Pick a local government entity that makes sense to you. You might also choose a large private institution (college, hospital) or business. The savings on employee health benefits and worker compensation insurance will be comparable for them.

5. Understand how HR 676 saves government entities money.

There are two major sources of savings, and some smaller, less obvious ones. The major ones include:

a. Reduced employer share of health benefits for government employees.

b. No obligation to cover health benefits for retired government employees, also known as "legacy" benefits or "post-retirement" benefits.

c. Other savings can result from the following:

- No need for workers compensation insurance premiums to cover medical treatment for injuries on the job.
- No need for vehicle insurance covering police, public works, and other public vehicles to cover medical costs from accidents.
- No need for special programs to cover the uninsured – often more an issue for states than local governments.
- Reduced labor negotiations costs because health care will no longer be a major collective bargaining issue.
- Other reductions as described in testimony that Tim Joseph from Tompkins County, NY presented to the NY State Partnership for Coverage on 11/13/07 (**Resource #5**).

6. **Gather information.** You will need data about the chosen government entity's current financial situation, and its budget so that you can determine and quantify the savings under HR 676.

a. Local press will be the best source about local government fiscal crises in your area. Many cities have a non-profit(s) that gathers data and functions as kind of a watchdog over government. These entities often report on fiscal problems. Be a creative and determined user of your favorite on-line search engine …

b. Get a copy of the most recent budgets for your targeted government body. Five years worth is a good goal – then you can see trends. The most recent budget may be on line, but back ones usually are not. You will have to visit the Clerk (City Clerk, County Treasurer, County Clerk, etc.) to request this information. You won't need the whole budget (some are hundreds of pages, and you may have to pay for copies) – just the pages from the expense side that include line items for wages and salaries and health benefits. Also record the total expenditures from every budget you examine; you may want to compare the growth in total spending with the growth in health benefits spending to show how the latter has been growing faster than the former (see **Resource #7**).

NOTE: There are some tricky aspects to this data that you need to keep in mind.

1. *First, all employers must take 1.45% out of payroll for Medicare. That amount*

may be included in the health benefits line item, but it may be grouped with other payroll deductions. Try to determine where it is shown as an expense (what expense line item); this will help you later.

2. Second, the health benefits line item may include the cost of benefits for both current employees and retired employees. If it includes both, try to get the amounts of each that make up the total. If legacy benefits are shown elsewhere, find out where.

To get these answers, you may need to talk with some one in the Finance Department. This may be easier than you think; lower level government employees usually respond favorably to the public. In the process, you might meet someone who has a good grasp of local information and who will be a very helpful resource during this campaign.

c. From the current budget, look for information that will help you identify other sources of savings, e.g. line items for workers compensation insurance, health services (the local government may run a free clinic, provide immunizations, etc.), labor negotiations (could be included in a line item for legal fees), Office for the Aging, etc.

d. Budgets usually don't include information about the number of employees, and you will need this number. Again the Clerk may be helpful, or make a call to the Human Resources Office or Department of Finance.

e. Get some information about the health plan(s) that cover local government workers. Most public employees are unionized. Find out what union represents them; it will know what co-pays, deductibles, and co-premiums employees have to pay.

7. Calculate benefits and prepare a concise and accurate summary fact sheet. Show how your local government can save money with HR 676. We have provided a worksheet (**Resource #6**), and a sample fact sheet (**Resource #8**) to help you complete this step.

a. Put together a few key statistics and a short summary from press reports to document the local entity's current fiscal problems. Show the trend in health care benefits cost increases. (We have a summary sheet of trend data for the Kingston City School District, featured in the brochure, which may help. See **Resource #7**)

b. Determine health benefits for current government employees. The key here is to make sure you are comparing apples with apples. The health benefits costs under HR 676 are the easiest to determine. Simply multiply the total payroll by 5.95% (0.0595) to get a total figure that includes both the current obligation for Medicare (1.45%) and the obligation for all the rest of health care under HR 676 (4.5%). Compare this to the total health benefits spending you determined from the most recent budget. To be comparable, this figure should include current and retired employee health benefits costs and include the 1.45% payroll tax for Medicare. The difference between these two figures will be the largest source of savings.

c. Name other expenses in the current budget that would be saved under HR 676.

- Worker compensation – According to the National Academy of Social Insurance, 47% of worker compensation benefits in 2004 covered medical expenses, a number that has steadily increased from 36% in 1987.
- All local costs that provide direct health services to residents that are low income or uninsured will be savings under HR 676. Everyone will have health coverage as soon as HR 676 takes effect, and all providers will be entitled to reimbursement from the National Health Insurance Program.

d. List other areas where savings will occur, but for which you do not have sufficient data to estimate the amount of savings. **Resource #6** provides specific examples of other savings you might find.

NOTE: Based on recent research, The Institute of Medicine estimated the annual discounted present value of lost health up to age 65 resulting from lack of insurance to range from $1,645 to $3,280 per uninsured person. This is an example of a hidden cost that most people don't consider. (Institute of Medicine. Hidden Costs, Value Lost – Uninsurance in America. National Academy Press, 2003.) Every local employer with uninsured workers incurs these losses.

e. Calculate the effect HR 676 will have on what government employees pay out of pocket. Under HR 676, employees will pay 3.3% of their gross pay, but will no longer have any co-pays or deductibles. Many services that their current benefits do not cover will be covered under HR 676 (e.g. mental health, drug rehabilitation, chiropractic care, long term care, etc.).

A good way to make your case here is **to divide the total local government payroll by the number of employees to get an average employee salary. Take 3.3% of that, divide it by 12 to get a monthly figure, and compare that amount to the value of monthly co-pays and deductibles that most employees currently face.** The employees' union should be able to help with this.

Many public employees have the best health insurance coverage of any workers. Some local governments pay 100% of the health insurance premiums for their workers. Showing that HR 676 will not be an added burden for each individual employee may be a challenge, but is necessary.

NOTE: HR 676 provides a very significant, but hard to quantify benefit to all workers – health insurance security. Under HR 676, no one risks losing health insurance when they change jobs or experience unemployment. No one will have to stay in a dead end or abusive work situation for fear of losing health insurance. This is huge!

f. Finally, put the highlights from your work in (a)-(e) above together in a one-two page fact sheet that you can take with you when you meet with local government officials. **Resource # 8** provides a sample. Send us a copy as an example for others!

g. Use some of the information you have gathered to write a short Letter to the Editor asking that your local government entity endorse HR 676 because it can help

remedy two major problems – lack of access to quality health care, and local fiscal strain. Hence the WIN-WIN slogan. For a sample letter, see **Resource #9**.

8. Win the victory. You're ready to start meeting with local officials and win the endorsement for HR 676. You may want to start by meeting with the Business Administrator, Finance Director or Comptroller. If you win them over, then ask them to join you to meet with the Mayor, Town Manager, City Council member, Commissioner or other high-level official you have targeted. The end result that you want includes the following.

a. A local government endorsement for HR 676. The preferred format is a resolution; we have a generic form you can modify for the local situation, and a guide for getting local resolutions passed (**Resource #10**). Get a commitment to introduce the resolution before the local government body, and to ask for its passage. Issue a press release and turn out local residents when the resolution comes up for a vote.

b. A public announcement/press event. Ask local officials to stand with members of your local coalition to announce the endorsement and/or passage of the resolution to the press, and explain how crucial HR 676 is to the health of state and local government. Offer to work with the local government's press or public relations staff to organize a press event. Be creative. **Resource #11** provides a sample media advisory from Healthcare-NOW's multi-state road show last fall.

c. Send copies of the resolution and press coverage to local Congressional offices, and to appropriate national organizations (see **Resource #1**). Many of these national organizations have state chapters; they should get copies, too.

d. Finally, ask representatives from your local government to join you when local leaders meet with state officials to ask for a state endorsement for HR 676. If all goes well, state delegations should be forming in the fall of 2008.

RESOURCE MATERIALS

1. Win-Win/Healthy Cities Campaign Brochure
2. Paul Sorum, MD published in *NACA: The Journal of County Administration* (October 2007 and February 2008). Louis Uchitelle, "Think the Economy is Bad? Wait Till the States Cut Back," *New York Times*, 6/1/08.
3. Navarro, Vincent. Unch Special Report. *Yes We Can! Can We? The Next Failure of Health Care Reform.*
4. Healthcare-NOW. *Financing Expanded and Improved Medicare for All (HR 676), A Briefing Paper*, May 2008.
5. Testimony before the NY State Partnership for Coverage by Tim Joseph, Chair, Tompkins County Legislature, Syracuse, NY, 11/13/07
6. Local benefit calculations worksheet
7. Kingston City School District data and trend analysis sample
8. Sample fact sheet
9. Sample Letter to the Editor
10. Sample resolution and guide for getting local resolutions passed.
    Mayor Lois Frankel, West Palm Beach, FL cover letter w/ Resolution submitted to U.S. Conference of Mayors
11. Sample media advisory

For assistance, questions, encouragement and support

Tom Knoche	knocheberg@aol.com	856-966-3241 (cell)
Katie Robbins	info@healthcare-now.org	800-453-1305
Rebecca Elgie	erelgie@eartthlink.net	607-272-0621
Art Richter	arichter@hvc.rr.com	845-338-9009
Jeff Muckensturm	cityinvincible@gmail.com	267-515-2400 (cell)
Janet Hand	jlynnxo@aol.com	617-817-5701

Resource Materials

Resource #1
Win-Win Campaign Brochure

What could you do with

$70 billion dollars?





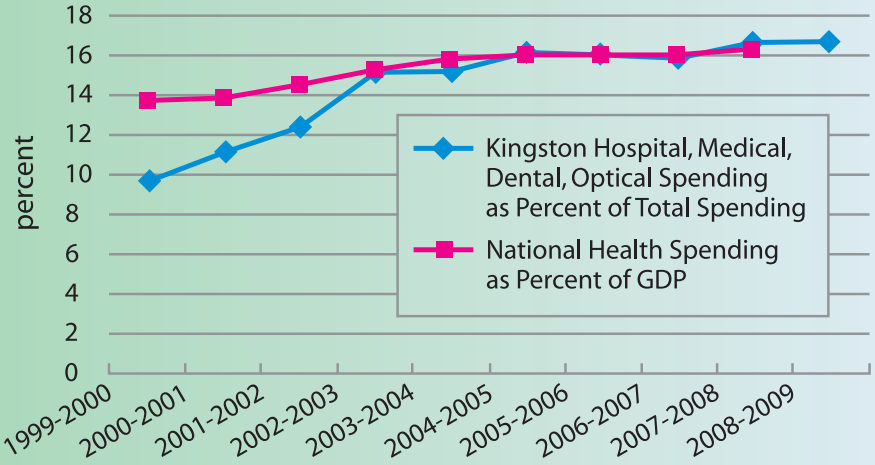





HR 676: Healthcare Savings for Healthier Cities

The ABCs of Improved Medicare-for-All
A Primer for the Kingston City School District

Here's an example of how HR 676 could benefit just one school district.



Following national trends, each year a larger share of the budget of the Kingston City School District (Ulster County, NY) is needed to meet health benefit costs, which have nearly tripled over the last ten years.

In 2007-2008 the Kingston City School District paid out $65.6 million in wages and $22.6 million for health benefits, including basic hospital, medical, dental and vision care and a 1.45% payroll tax for Medicare.

Under HR 676, the school district would have paid only $3.9 million for health benefits, resulting in a savings of $18.7 million for the 2007-2008 school year.

Under HR 676, the average school district employee with an annual wage of $44,700 would pay only $123/month in a new 3.3% payroll tax—eliminating co-pays and deductibles.

The savings could:

- support 200 new teachers
- fund major capital improvements to every school
- reduce class size and provide a teaching assistant for every class

The Kingston City School District is just one of 87,850 state and local government jurisdictions in the U.S. Imagine the impact of replicating these savings over the entire country!

HR 676

Win-Win Campaign

Rebuild 30,000 lane miles of road?

Build 560,000 units of affordable housing?

Hire 1 million teachers, firefighters, police and other critical employees?

Renovate 7,000 schools?

Healthcare Savings for Healthier Cities

For far too long, rising healthcare costs have drained local and state budgets of the resources they need to rebuild, renovate and restore the vitality of their communities.

- Our employees are paying more in premiums, co-pays and deductibles, yet too many are denied needed care.
- Increasing health benefits costs—averaging 11% a year since 1999—consume city and county budgets, leaving more and more of our residents uninsured. (Currently, 48 million Americans lack health insurance.)
- Tax revenues cannot fill the gap, especially during an economic downturn.
- As state and local government debt increases, bond ratings go down.
- With state and local coffers bleeding, residents face cuts in needed services such as police and fire protection, medical services for the uninsured, parks and recreation.

The passage of HR 676—Improved Medicare-for-All—is a win-win situation. It could transform this bleak picture, providing guaranteed health care for all while helping financially-strapped state and local governments find new monies to underwrite growing challenges. ***Indeed, estimates show that they could realize at least $70 billion in annual health care savings.***

Healthy Cure for Ailing Cities

State legislatures and the US Congress have proposed reform measures to address the health insurance crisis. Because most do not change the way we finance health care, they fall woefully short.

BENEFIT	STATE REFORM BILLS	HR 676
Guarantee, comprehensive coverage for everyone from the "womb to the tomb"	NO	✓
Reduce state and local government health benefits costs for employees	NO	✓
Reduce government employee share of health benefits costs	NO	✓
Remove state and local responsibility for retired employee health benefits	NO	✓
Reduce charity care	Some reductions	✓
Reduce administrative and labor negotiation costs	NO	✓
Limit treatment decisions to patient and doctor only	NO	✓

HR 676—Improved Medicare-for-All—is the best cure for the American health care crisis because:

- It **saves money and controls costs** by replacing multiple public and private payers with a single national health insurance program. The national program will negotiate fees with providers, purchase drugs and medical supplies in bulk, and monitor budgets and capital plans for hospitals and other medical facilities.
- It **minimizes risk**, combining the whole US population into one large pool of over 300 million people.
- It **eliminates private insurance**. Private insurance eats up 30% of every dollar in profits, marketing and administration. Medicare operates on less than 5% overhead.
- It **simplifies health care**. One program will cover all health issues for everyone.
- It guarantees quality **care for all**. No one can be denied care or forced to use an emergency room because s/he has no doctor or coverage.

Winning HR 676 is Up to You

- Have your city, town or state pass a resolution supporting HR 676 and send it to your Congressional representatives and state legislators. Go to **www.healthcare-now.org** to download a sample municipal resolution.
- If you are a Mayor, Governor, Commissioner or other local elected official, call a press conference and declare your support for HR 676, Improved Medicare for All. Explain that it is the only health insurance solution that will save your local jurisdiction money, eliminate bureaucracy and guarantee quality health care for everyone. Healthcare-NOW will help you identify other leaders and organizations in your area who support HR 676 and who will stand with you before the press.
- Form a delegation of local elected officials in your Congressional District. Meet with your Congressperson and ask that s/he endorse HR 676. Explain that it is critical to restore fiscal health to local government.
- Win endorsements from national bodies that represent you, such as:
  The National League of Cities
  The Council of State Governments
  The United States Conference of Mayors
  The National Governors Association
  National Conference of State Legislatures
  The National Urban League
  The National Association of County Administrators
  The International City/County Management Association
- Be an effective advocate about HR 676. Learn more at:
  www.healthcare-now.org
  www.house.gov/conyers
  www.pnhp.org
  www.calnurses.org

Sources

Centers for Medicare and Medicaid Services (CMS), National Health Expenditures data, 1987-2006 and 2002-2017.
The US Census. State and Local Government Finances, 2004-2005; State and Local Government Employment and Payroll data, 2006.
Bureau of Labor Statistics, Quarterly Census of Employment and Wages, 2001-2007.
Woolhandler, Campbell and Himmelstein, "Costs of Health Care Administration in the United States and Canada," N Eng J Med 2003; 349:768-75.
Woolhandler, et al. "Paying for National Health Insurance—And Not Getting It," Health Affairs 21(4); July / Aug. 2002.
Kingston City School District budgets provided by Art Richter, Healthcare-NOW!, Business Coalition for Single Payer.

For more information on the Win-Win Campaign, contact:

Healthcare - NOW!

Health is on the way!

info@healthcare-now.org
(800) 453-1305

CALIFORNIA NURSES ASSOCIATION

NATIONAL NURSES ORGANIZING COMMITTEE

PNHP PHYSICIANS FOR A NATIONAL HEALTH PROGRAM

Resource #2

Paul Sorum, MD published in *NACA: The Journal of County Administration* (October 2007 and February 2008).

Louis Uchitelle, “Think the Economy is Bad? Wait Till the States Cut Back,” *New York Times*, 6/1/08

Why a Single-payer Health Care System Would Be Good for Counties

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

The Journal of County Administration

October 2007

What can save counties from impending heath insurance driven financial disaster? A single-payer health care system!

"The problem for counties is the soaring health care responsibilities and costs that already consume much of their budgets. County governments have a responsibility for the health of all their residents, especially for those at the margins. Many expend substantial taxpayer dollars on Medicaid, county hospitals, nursing homes, health departments, and other health costs. They provide health insurance for their current employees and retirees. All these costs are rising faster than people's incomes and property values. County governments desperately need, therefore, a means of fulfilling their responsibilities without causing serious financial problems for county taxpayers.

The first step of a solution is to recognize the need to provide adequate health coverage to all residents of all counties. Almost all health reformers, interest groups, and politicians agree that everyone should have health insurance. If people do not have health insurance, they do not get preventive care, they delay seeking treatment for illnesses, they use the emergency rooms more frequently than those with insurance,and counties end up paying in different ways for the unpaid and higher bills.1 The cost of the health forgone because of uninsurance has been estimated at $65 to $130 billion.2

Not everyone is willing, however, to provide coverage sufficient for people's health needs. The number of "underinsured" is rising as employers offer reduced coverage. The barebones basic packages envisioned by the Massachusetts reforms, the donut hole in Medicare part D, the high deductible policies increasingly offered to employees—all these leave millions of people underinsured, unable to pay all the co-payments on their medications, at risk of allowing their illnesses get worse, and of going bankrupt if they get seriously injured or sick. Consumer Reports reported that in May 2007 that "29 percent of people who had health insurance were 'underinsured,' with coverage so meager they often postponed medical care because of costs."3 Even the Reader's

Digest is alarmed: in its recent poll, “two-thirds of adults 21 and older said they feel they ‘can’t afford to be sick.’”4

The second step of a solution is to decide how to go about providing this adequate coverage. Reform plans fall into two categories, proposing either to utilize the private insurance companies—through tax credits or vouchers, individual mandates, employer mandates, and/or expansions of public programs for the poor—or to set up a “single-payer” system. In this issue, I will explain why private insurance companies cannot provide the solution and a single-payer system can. In the next issue, I will explain how a single payer system would work and how it can be instituted.

Private insurers add enormous costs to our already skyrocketing medical expenditures. These include both insurers’ administrative costs—the salaries of their highly-paid executives and armies of employees, their marketing expenses, and (in the case of for-profit insurers) their profits—and the billing related costs imposed on providers. In California, billing and insurance-related functions for insurers and providers represent 20-22 percent of privately insured spending in California acute care settings.5 In the US, we spent in 2001 $351 per capita on administrative costs, while the Canadians spent only $54 and the French only $48.6.

The health premiums charged by private insurers are soaring, owing in part to their administrative waste and profits. Premiums have increased 78 percent since 2001, while wages increased 19 percent and inflation was 17 percent. For employment-based insurance, they averaged $12,106 for a family of four in 2007 and $4,479 for a single person.7 As a consequence, employers, especially small employers, are dropping health insurance benefits—60 percent of companies offered them in 2007 versus 69 percent in 2000, and only 45 percent of companies with 3-9 employees in 2007 versus 57 percent in 2000—and individuals have difficulty in paying on the open market for adequate insurance (especially since premiums are higher for non-employment-based insurance). Thus, in spite of the widespread conviction that people need health insurance, not only has the number of uninsured risen to nearly 47 million (15.8 percent of the population) 8, but the number who are inadequately insured is rising even faster.9 So the counties’ health burdens are increasing. Even if counties self-insure for their own employees, they may buy health administrative services and pay for health care in markets inflated by the unneeded expenses of the private insurance companies that dominate these markets.

Private health insurers must, according to the logic of the free market,contribute to uninsurance and underinsurance. As long as health insurance is a market commodity, private insurers must promise

prospective enrollees as much as possible, but also reduce costs as much as possible, i.e., must spend as little as possible of their premiums on actual health care. Even if individual medical directors and other employees are virtuous and well meaning, they must avoid sick patients and deny care if their companies are to survive in the market.

Furthermore, private insurers cannot, unlike county governments, make the health of the population a top priority. They must, like other businesses, focus on short-term results, not on the long-term health of their enrollees (especially since these people are likely to change insurers and eventually switch to Medicare). In addition, in marketing their products to select groups, they fragment the population and undermine our already-fragile sense of social solidarity: they reinforce people's short-sighted inclination to refuse to pay for those with more health needs, and fewer means, than themselves. They encourage healthy people to forget that they might one day suffer major illness and injury and that they, and the county as a whole, benefit if all county residents are as healthy as possible.

Private health insurers do not, therefore, provide the solution to the crisis in health expenses faced by county governments. But a public single-payer system, similar to but more inclusive than Medicare, is the solution with public financing but largely private delivery of health care.10 All legal residents would have an insurance card entitling them to basic but comprehensive care, i.e., access to the health services that would provide significant benefit to them. The structure of the single-payer system will be discussed in the next issue. The counties would continue to play a role in delivering health care, through their clinics and hospitals, but would no longer be burdened with paying for this care.

Critics will argue, however, that a single-payer system, an expanded Medicare for All, would not be desirable. These criticisms are found not only in the distorted charges of political candidates, but also in the serious and reasoned arguments of single-payer opponents in scholarly articles and in public forums, such as in Albany, NY, the series of four forums on "The Pros and Cons of Medicare for All" sponsored by public radio WAMC in spring 200611. It is necessary to address the three major criticisms.

First, opponents of a single-payer system assert that it would amount to "socialized medicine," to "government run medicine," with health care decisions made by government bureaucrats rather than by physicians. This set of charges distorts the reality of what is proposed.

* Medicare for All is not socialized medicine. In socialized systems, the physicians and other providers are government employees; in Medicare

for All, they would remain as they are now, mostly private practitioners, paid not by salary but by fee for service.

* Physicians and patients in countries with national health insurance have greater freedom of decision making than do physicians in the U.S.; in Medicare for All, medicine would be macro-managed; in current managed care, medicine is increasingly micro-managed, as insurance companies strive to reduce their own costs (and thereby increase the psychological as well as financial costs to patients and providers). Second, opponents of a singlepayer system point to Canada and the United Kingdom and charge that it will result in underfunding and waiting lists.

* In fact, single-payer systems do not necessarily result in waiting lists; they are not a problem in, for example, France and Japan.

* Even if they are a problem in Canada and the United Kingdom, the extreme cases are not typical (just as the cases in the U.S. documented in, for example, Michael Moore's movie, SiCKO, are atypical); the waiting lists involve noncritical care; and lists are being reduced through government efforts to increase capacity, even as the number of Americans without health insurance increases.12

* Not only do those of us with health insurance often face delays to getting certain services, but those without insurance or money face uncalculated waiting times.

* Even if our own capacity is strained as health coverage becomes universal, the American public, the American voters (most of whom currently have insurance) will not put up with longer waiting lists and will insist on increasing our capacity. Third, opponents charge that national health insurance will causes taxes to rise and will bankrupt the country by increasing health care expenses.

* What should interest individuals is not how much they pay for health care in income taxes, but how much they pay in all taxes—sales, property, payroll, and income—plus over-the-counter health expenses. The question is, therefore, what happens to overall costs.

* The only way to achieve universal access to comprehensive health care without increasing costs is to adopt a single-payer system. The reduction in administrative costs of insurers and providers and the elimination of marketing costs and insurance company profits would save far more money than would be spent on providing health coverage for the currently uninsured. On the national level, Hadley and Holahan estimated in 2001 that the cost of the additional health services that would be used if the uninsured were provided insurance would be $33.9

to $68.7 billion.13 Woolhandler, Campbell, and Himmelstein calculated in 1999 that reducing our administrative costs to those of Canada would have saved $209 billion14. In his critique, Henry Aaron argued for a lower figure, $159 billion, but still far more than the estimated additional costs.15 On a state level, the Lewin Group has made estimates of the cost of various plans for universal coverage in numerous states from California to Mississippi; consistently, the single-payer plans save money, the others cost money.16

We must, however, be realistic. Even if having a single-payer health care system would seem beneficial to county governments and residents across America, what would it actually look like, and would it truly be possible to institute such a system? These are the questions to be addressed in the next issue.

Endnotes

1. Ayanian JZ et al. Unmet health needs of uninsured adults in the United States. JAMA. 2000;284:2061-9. Institute of Medicine. A Shared Destiny: Community Effects of Uninsurance. Washington: National Academies Press, 2003. Ross JS, Bradley EH, Busch SH. Use of health care services by lowerincome and higher-income uninsured adults. JAMA. 2006;295:2027-36. County-level estimates of uninsured in 2000 by the US Census Bureau are available at http://www.census.gov/ hhes/www/sahie/statecntyest2000.html, accessed September 24, 2007.

2. Miller W, Vigdor ER, Manning WG. Covering the uninsured: what is it worth? Health Aff. 2004.

3. Are you really covered? Why 4 in 10 Americans can't depend on their health insurance. Consumer Reports. August 2007. Available at http://www.consumerreports.org/cro/health-fitness/health-care/health-insurance-9-07/ overview/0709_health_ov.htm, accessed September 24, 2007.

4. Howley K. I can't afford to get sick Think your insurance has you covered? Just wait till you need it most. Reader's Digest. April 2006: 57-70. Article and poll available at www.rd.com/healthcare, accessed September 24, 2007. A lower estimate of nearly 16 million people ages 19-64 underinsured in 2003 is given by the Commonwealth Fund: Schoen C, Doty MM, Collins SR, Holmgren Al. Insured but not protected: how many adults are underinsured? Health Aff. 2005;w5-289-302.

5. Kahn JG, Kronick R, Kreger M, Gans DN. The cost of health insurance administration in California: estimates for insurers, physicians, and hospitals. Health Aff. 2005;24:1629-39.

6. OECD Health Data. Accessed by David Himmelstein.

7. Kaiser Family Foundation. Employer Health Benefits 2007 Survey. Available at http://www.kff.org/ insurance/7672/index.cfm, accessed September 24, 2007.

8. US Census Bureau: http://www.census .gov/hhes/www/hlthins/hlthin06.html, accessed September 24, 2007.

9. See the references in notes 3 and 4 above.

10. The single-payer system most commonly proposed is described, with multiple links, on the website of the Physicians for a National Health Program: www.pnhp.org.

11. Sorum PC. The pros and cons of Medicare for All a series of public forums on health reform. Health Law Journal 2007;12: 24-37. Audio available at www.wamcarts.org (click on “Archives”).

12. Canadian Institute on Health Affairs. Waiting for health care in Canada: What we know and what we do not know. 2006. Available at http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=AR_1385_E&cw_topic=1385, accessed September 25, 2006. Statistics Canada. Access to health care services in Canada,January to December 2005. Ottawa: Minister of Industry, 2006. Available at http://cansim2.statcan.ca/cgi-Hadleywin/cnsmcgi.pgm?Lang=E&SP_Action=Result&SP_ID=2967&SP_TYP=2&SP_Sort=-0, accessed September 24, 2007.

13. Hadley J, Holahan J. Covering the uninsured: how much would it cost? Health Aff. 2003;W3:250-65.

14. Woolhandler S, Campbell T, Himmelstein DU. Costs of health care administration in the United States and Canada. N Engl J Med. 2003;349:768-75.

15. Aaron HJ. The costs of health care administration in the United States and Canada—questionable answers to a questionable question. N Engl J Med. 2003;349:801-3.

16. Available at http://www.lewin.com/ NewsEvents/Publications/. Look in the category “uninsured & safety net.” Accessed September 16, 2007.

NACA

February 2008

The Journal of County Administration

Inside

President's Corner
page 2

NACA Events at NACo Legislative Conference
page 4

Technology Corner
page 5

Editorial: Medicare for All—Now is the Time to Act
page 6

ICMA-RC's Capitol Review
Congress Spotlights PPA, Roth 457 Accounts, Housing Crisis, and Fee Disclosure
page 7

From Your NACo Board Representative
page 8

The National Emergency Management Network (NEMN)
page 9

Affordable Housing Strategies Require Creative Approaches
page 9

The Doctor Will See You for Exactly Seven Minutes
page 10

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 excel lent ***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

(continued on page 2)

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

(continued on page 3)

NACA

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

Does NACA Have Your E-mail Address?

Members are encouraged to alert NACA staff of changes to their e-mail addresses. New addresses or corrections to addresses can be e-mailed to naca@icma.org.

Visit the NACA Web Site

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

The NACA members-only area of ICMA.org can be accessed at http://icma.org/nacamembers.

(Sorum, continued from page 2)
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?

(continued on page 4)

(Sorum, continued from page 3)

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!

---

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)

Think the Economy Is Bad? Wait Till the States Cut Back

By LOUIS UCHITELLE

Published: New York Times, June 1, 2008

Struggling as we are with the housing bust, the credit crunch, shrinking consumption, rising unemployment and faltering business investment, we can be forgiven for thinking that all the big shoes have dropped. There is another one up there, however, and it is about to come down.

State and city governments have yet to shrink the economy; indeed, they have even managed to prop it up. They have quietly maintained their spending at pre-crisis levels even as they warn of numerous cutbacks forced on them by declining tax revenues. The cutbacks, however, are written into budgets for a fiscal year that begins on July 1, a month away. In the meantime the states and cities, often drawing on rainy-day savings, have carried their share of the load for the national economy.

That share is gigantic. At $1.8 trillion annually in a $14 trillion economy, the states and municipalities spend almost twice as much as the federal government, including the cost of the Iraq war. When librarians, lifeguards, teachers, transit workers, road repair crews and health care workers disappear, or airport and school construction is halted, the economy trembles. None of that, or very little, has happened so far, not even in California, despite a significant decline in tax revenue.

“We are looking at a $4 billion cut to public schools and deep cuts that will result in thousands of Californians losing their health care,” said Jean Ross, executive director of the California Budget Project, offering a preview of coming hardships. “But the reality is we have not pulled money off the streets yet.”

Quite the opposite, the states and municipalities have increased their spending in recent quarters, bolstering the nation’s meager economic growth. Over the past year, they have added $40 billion to their outlays, even allowing for scattered spending freezes and a few cutbacks in advance of July 1. Total employment has also risen. But when the current fiscal year ends in 30 days (or in the fall for many municipalities), state and city spending will fall, along with employment — slowly at first and then quite noticeably after the next president takes office.

Sometime next year, the decline will reach an annual rate of $50 billion, Goldman Sachs estimates. “It is a big reason to expect a weak economy in 2009,” said Jan Hatzius, chief domestic economist at the firm.

The $90 billion swing — from more spending to less — could be enough to push down a weak economy to zero growth or less, because state and

city spending has accounted for as much as half of total economic growth since last fall. (A robust economy has a growth rate of 3 percent to 4 percent, compared with the 0.9 percent or less of the last two quarters.) The $90 billion would certainly offset most of the $107 billion stimulus package now going out from the federal government to millions of Americans in the form of tax rebate checks. The hope is they will spend this windfall on consumption and in doing so sustain the economy. That might happen — for a while. But with the cutbacks in state and city outlays canceling out the consumption, the next president, struggling to revive a weak economy, will almost certainly have to consider a second stimulus package.

But what should it be? Should it be a reprise of the checks, relying again on private-sector spending for rejuvenation? Or should Washington channel extra federal money to city and state governments so they can sustain their outlays for the numerous programs that otherwise would be shrunk? The answer, even on Wall Street, is often: subsidize the states and cities.

“If you want to make sure that federal money gets spent, and jobs are created, you give it to them,” said Nigel Gault, chief domestic economist at Global Insight, a forecasting firm.

Like many others, Mr. Gault contends that more than 50 percent of the $107 billion in stimulus checks now going to households is likely to produce no stimulus at all. Instead, it will be used to pay down debt or buy imported goods and services. Imports bolster production in other countries; not in the United States.

Still, rebate checks have been a standard tool for years in efforts to revive the American economy. So have tax cuts and — the most popular tool of all — the Federal Reserve’s lowering of interest rates. Each tool assumes that people will respond to the incentive with more spending and investment, and markets will then work their magic. Not since the 1970s, when politicians still paid attention to the teachings of John Maynard Keynes, has public spending — government spending — surfaced in mainstream political debate as a potentially effective means of counteracting a downturn.

Government has to step in, Keynesians argue, when private spending is not enough to lift the economy, despite the nudge from tax cuts or lower interest rates or rebate checks. This downturn might be one of those moments, involving as it does the bursting of a huge housing bubble. That has precipitated sharp declines in various tax revenues on which the states and cities depend, forcing them into extraordinary spending cuts — not yet, of course, but after July 1.

The issue barely dents the presidential election campaign. The Republicans in particular are less than enthusiastic about Keynesian economics, with its use of government to rescue markets. They, and many mainstream economists, for that matter, argue that government is inefficient, bureaucratic, wasteful and unable to spend fast enough to counteract a downturn. The two Democratic candidates, in contrast, argue that a second stimulus package, if one is needed, should include federal subsidies to the states and municipalities, not to start new projects but to prevent cutbacks in existing ones.

No state seems more vulnerable than Florida, with its plunging home prices and slashed property-tax assessments, not yet on the books but soon to be. In anticipation, the legislature in May approved a $66.5 billion budget for the coming fiscal year, down from $72 billion in the current one.

Schools are a target, said Michael Sittig, executive director of the Florida League of Cities, “but none has been hurt yet. Nevertheless, everyone is scared. Everyone is in the mode of trying to figure out how to get through next year” — starting 30 days from now.

Resource #3

Navarro, Vincent. Unch Special Report. *Yes We Can! Can We? The Next Failure of Health Care Reform*.

Yes, We Can! Can We?

The Next Failure of Health Care Reform

By VINCENT NAVARRO

Taken from: http://www.counterpunch.org/navarro03062008.html

A major problem--if not the major problem--for many people living in the U.S. is the difficulty of accessing and paying for medical care when they are sick. For this reason, candidates in the presidential primaries of 2008--the Democrats more often than the Republicans--have been recounting stories about the health-related tragedies they have encountered in meetings with ordinary people around the country (an exercise conducted in the U.S. every four years, at presidential election time). These stories tell of the enormous difficulties and suffering faced by many people in their attempts to get the medical care they need. I have been around long enough--I was senior health advisor to Jesse Jackson in the Democratic primaries of 1984 and 1988--to know how frequently Democratic candidates, over the years, have referred to such cases. The only things that change are the names and faces in these human tragedies. Otherwise, the stories, year after year, are almost the same.

In the Democratic Party primaries of 1988, for example, candidate Michael Dukakis talked about a young single mother who had two jobs and still could not afford medical insurance for herself and her children. In 1992, Bill Clinton did the same, changing the story only slightly. This time it was the case of a woman with diabetes who could not get health insurance because of her chronic condition. And now, in the 2008 primaries, Hillary Rodham Clinton (whom I worked with on the White House Health Care Reform Task Force in 1993) describes a similar case. This time it is a single woman, with two daughters, who cannot pay her medical bills because her congenital heart defect makes it impossible for her to get medical insurance coverage. And Barack Obama describes similar cases, with the eloquence that characterizes all of his speeches. He frequently refers to his own mother, who had cancer and had to worry not only about her illness but about paying her medical bills.

All these cases are tragic and are representative of a situation faced by millions of people in the U.S. every year. But, I am afraid that unless the winning Democratic candidate, once elected president (and I hope he or she will be), develops a more comprehensive health care proposal than any of those put forward in the primaries so far, we will see the same situation continue. Democratic candidates in the 2012 primaries, and in the 2016 primaries, will still be referring to single mothers with chronic

health conditions who cannot pay their medical bills. The proposals put forward by Obama and Clinton underestimate the gravity of the problem in the U.S. medical care sector. The situation is bad and is getting worse: the number of people who are uninsured and underinsured has been growing since 1978.

Let's start with the uninsured, those people who do not have any form of health benefits coverage. There were 21 million uninsured people in the U.S. in 1972. By 2006, that number had more than doubled to 47 million. And this increase has been independent of economic cycles. The number of uninsured grew by 3.4 million from 2004 to 2006, even as a resurgent economy raised incomes and lowered poverty rates. Meanwhile, during those years, the Democratic Party establishment distanced itself from any commitment to resolving these problems. Even though the 1976, 1980, 1984, 1988, and 1992 Democratic Party platforms included calls for health care benefits coverage for everyone (what is usually referred to as "universal health care"), that call was usually made without much conviction. In the primaries of 1988, when I was involved in preparing the Democratic platform, Dukakis (the winner of the primaries) resisted including universal health care in the party platform. He was afraid of being perceived as "too radical." He had to accept it, however, because Jesse Jackson agreed to support Dukakis (Jackson had 40% of the Democratic delegates at the Atlanta convention) only if the platform included this call for universal care.

Then, in 1992, Bill Clinton (who borrowed extensively from Jackson's 1988 proposals) put the call for universal health care at the center of his program. But, once president, his closeness to Wall Street and his intellectual dependence on Robert Rubin of Wall Street (who became his Secretary of the Treasury) made him leery of antagonizing the insurance industry. It was President Clinton's unwillingness to confront the insurance companies that led to his failure to honor his commitment to work toward a universal health care program (see my article "Why HillaryCare Failed" unch, November 12, 2007). The type of reform President Clinton called for was a health insurance–based model called "managed care," in which insurance companies remain at the center of health care. An alternative approach could have been to establish a publicly funded health care program (which was favored by the majority of the population) that would cover everyone, providing medical care as an entitlement for all citizens and residents. This could have been achieved, such as by expanding the federal Medicare program to cover everyone. To do so, however, would have required neutralizing the enormous power of the insurance companies with a massive mobilization of the population against them and in favor of a comprehensive and universal health care program.

But President Clinton's loyalty to Wall Street prevailed. His administration's top priorities were reduction of the federal deficit (at the cost of reduced public social expenditures) and approval of NAFTA (without amending President George H. W. Bush's proposal, which Clinton had inherited, and refusing to address the concerns of the labor and environmental movements). These actions antagonized and demoralized the grassroots of the Democratic Party. Clinton lost any power to mobilize people for the establishment of a universal health care program. This frustration of the grassroots, and especially the working class, also led to the huge abstention by the Democratic Party base in the 1994 congressional elections and the consequent loss of the Democratic majority in the House, the Senate, and many state legislatures. At the root of this disenchantment with the Clinton administration was its unwillingness to confront the insurance companies and Wall Street. Could that happen again?

The health care mess (Nixon dixit)

Before addressing this question, let's look at the problems people face in the U.S. But first, I should stress that the country has sufficient resources to provide comprehensive, high-quality medical care to everyone who needs it. The U.S. spends 16% of its GNP on medical care, almost double the percentage spent by Canada and most countries of the European Union (E.U.) on providing universal, comprehensive health care coverage to their populations. We in the U.S. spend $2.1 trillion on medical care, making the medical care sector one of the largest economies in the world (if the medical care sector were a country, rather than a massive sector within a country). And it has been estimated that this spending will reach 20% of GNP in a few years (7 years according to some, 12 years according to others). Lack of money is not the root of the medical care problem in the U.S. We spend far, far more than any other developed country, and far more than what we would need to provide comprehensive health care coverage for everyone. The frequently heard argument that the U.S. cannot afford universal, comprehensive care has no credibility. It is a poor rationale for keeping the situation as it is.

Despite the huge amount of money spent on medical care, the situation of the U.S. medical care sector is a disgrace. Even Richard Nixon, in an unguarded moment, defined it as a mess. And as noted above, it has gotten much worse since Nixon was president: in 2006, 47 million Americans did not have any form of health benefits coverage, and 108 million had insufficient coverage. And people die because of this. Estimates of the number of preventable deaths vary, from 18,000 per year (estimated by the conservative Institute of Medicine) to a more realistic level of more than 100,000 (calculated by Professor David Himmelstein of Harvard University). The number depends on how one

defines "preventable deaths." But even the conservative figure of 18,000 deaths per year is six times the number of people killed in the World Trade Center on 9/11. That event outraged people (as it should), but the deaths resulting from lack of health care seem to go unnoticed; these deaths are not reported on the front pages, or even on the back pages, of the New York Times, Washington Post, Los Angeles Times, or any other U.S. newspaper. These deaths are so much a part of our reality that they are not news. How can this be tolerated in a country that claims to be a civilized nation?

The Democratic candidates' proposals

The proposals put forward by the current Democratic candidates for president, Barack Obama and Hillary Clinton, will improve the situation. They will diminish somewhat the number of those not covered by health insurance and will reduce the level of undercoverage. But the major problems will remain unresolved, including the problems the candidates have referred to during their campaigns. People will still experience incomplete coverage, and many millions will continue to be uninsured and underinsured. Not even the mandatory health insurance called for by Hillary Clinton will resolve these problems. Her plan proposes that, just as a car driver in the U.S. must have car insurance, so a citizen or resident will have to have health insurance. The problem with this mandate is not only--as Obama has pointed out--the matter of enforcement (note that according to some estimates, up to 20% of car owners drive without car insurance), but the assumption behind the policy. The assumption is that most people who are not insured are "free-riders," people who could afford to buy insurance but choose not to, and choose to let someone else pay for their care when they get sick. But the vast majority of people who are uninsured are people who cannot afford to pay for it. It's as simple as that. Massachusetts passed a mandate of this sort (under Governor Mitt Romney), but 198,000 people still remain uninsured. The subsidies and tax incentives proposed to help the uninsured pay for health insurance premiums under plans of this type are insufficient.

Another proposed mandate (put forward by Clinton more strongly than by Obama) is that all employers must provide insurance coverage to their employees--a policy proposed by President Nixon back in the 1970s. But with this proposal, unless you force employers to provide comprehensive coverage at an affordable cost to everyone, the problem will still not be resolved. An even greater problem with the employer mandate, however, is that it continues to tie health benefits to employment, which is a perverse system and a nasty one. The reason employers, in 1948, pushed to make health care benefits dependent on employment (in the nefarious Taft-Hartley Act) was that this was a way of controlling workers. The Taft-Hartley Act forced the labor force to get health care benefits through

collective bargaining agreements that are highly decentralized and are negotiated at the place of employment. In the U.S., workers who lose their jobs lose not only wages, but also health benefits coverage for themselves and their family. And if these workers want to keep their insurance, they have to pay prohibitive premiums. So, a worker will think twice before striking. This is one reason why the U.S. has fewer working days lost to strikes than other developed countries. Until recently, employers have been the major force--besides the insurance companies--for keeping the current system of funding and managing health care. This system, then, is based on an alliance between employers and the insurance industry.

It is this alliance that is responsible for the biggest problem of health care benefits: undercoverage. Most people believe that because they have health insurance, they will never face the problem of being unable to pay their medical bills. They eventually find out the truth--that their insurance is dramatically insufficient. Even for families with the best health benefits coverage available, the benefits are much less comprehensive than those provided as entitlements in Canada and in most E.U. countries. And paying medical bills in the U.S. is a serious difficulty for many people. In fact, inability to pay medical bills is the primary cause of family bankruptcy, and most of these families have insurance. Furthermore, 20% of families spend more than 10% of their disposable income on insurance and medical bills (the percentage is even higher for those with individual insurance: 53%). In 2006, one of every four Americans lived in families that had problems in paying medical bills. And most of them had health insurance.

The inhumanity of this situation is made evident by the fact that nearly 40% of people in the U.S. who are dying because of terminal illness are worrying about paying for care--how their families are going to pay the medical bills, now and after they die. No other developed country comes close to these levels of insensitivity and inhumanity. Meanwhile, the federal government parades around the world as the great defender of human rights, ignoring the fact that among the developed democratic nations, the U.S. is the most deficient in human rights. The basic right of access to health care in time of need does not exist in the U.S. The United Nations Human Rights Declaration includes this right in a prominent position, but this is a declaration that the U.S. Congress has never signed. It should come as no surprise that the world's people do not believe the U.S. government is a great defender of human rights abroad, since it does not guarantee even basic rights at home.

And here again, things are getting worse. The percentage of uninsured and underinsured has been increasing. The proportion of people with employer-based health benefits coverage declined from 67.8% among the

non-elderly in 2000 to 63% in 2006--even though the economy was booming during those years. In the same period, the number of adults without coverage increased by 8.7 million, and from 2004 to 2006 the number of children without coverage increased by 1 million.

Why does this situation persist in the U.S.?

For any society, medicine is a mirror of the power relations in that society. And nowhere is the lack of human rights more evident than in the house of medicine. In the U.S., insensitivity toward human needs goes hand-in-hand with enormous profits made from that suffering. The root of the problem, as noted earlier, is not lack of money but the channels through which that money is managed and spent. The problem is the privatization of the funding of medicine that allows profits to boom. The insurance and pharmaceutical industries enjoy the highest rates of profit in the U.S. Just last year, insurance industry profits reached $12 billion, and pharmaceutical industry profits $49 billion, the highest in the U.S. and in the world. According to Fortune Magazine, health-related industries are among the most profitable industries in the country. A lot of money is being made from people's suffering. This scandalous situation is easy to document. For example, lanzoprasol, a gastric secretion-reducing medicine widely used in the U.S., costs $329 in Baltimore, U.S.A.; the same medicine (same number of doses) costs $9 in Barcelona, Spain! And the current Bush administration signed legislation for a program that, in theory, covers drug costs for elderly people, but in practice this is an enormous rip-off. It forbids the government to negotiate with the drug industry on the cost of drugs--that is, the price of their products. What this means is that the federal government pays the prices dictated by pharmaceutical companies.

Now, one might well ask, Why does this continue? Why hasn't our government done something about it? Is it that the government could not provide comprehensive health benefits coverage? It certainly could. All E.U. governments do so. All provide publicly funded, comprehensive health care coverage to their entire population. And on this side of the Atlantic, Canada (which once had a system identical to ours, health insurers included) also provides this entitlement to all its citizens. In Canada in the 1960s, a social democratic government in Saskatchewan did a very logical thing. My good friend, Dr. Samuel Wolfe, who was then Chief Health Officer of Saskatchewan, proposed to the province's social democratic government that rather than paying premiums to insurance companies, people would pay earmarked taxes to a public trust fund, controlled by their representatives. This trust fund would negotiate with doctors and hospitals for the payments they would receive for the care they provided. This saved a lot of money by bypassing the insurance companies. The Saskatchewan Health Plan provided comprehensive care

to everyone in the province at a much lower cost than before. Soon, the other provinces adopted similar plans, establishing Canada's nationwide health plan that now covers everyone. The overhead for the public system in Canada is only 4%, compared with 30% in the U.S. insurance industry--30% that goes to marketing, administration (a lot of paper shuffling goes on in U.S. health care), and the salaries of extremely well-paid executives and insurance lobbyists. One of the best-paid individuals in this country is William McGuire, CEO of an insurance company--United. He makes $37 million a year, plus $1.7 billion in stock options. And all of this money comes from premiums paid by people, many of whom have insufficient coverage.

The insurance companies have enormous power, both in Washington and in most state legislatures. In Maryland, for example, a former governor arranged for candidates for Insurance Commissioner to be interviewed by the insurance associations before he made his final selection. But, insurance industry influence is strongest in Washington. In the U.S., money is the milk of politics. The electoral process is also privatized. And the insurance companies pay a lot of money to candidates. According to the Center for Responsive Politics, the insurance industry has contributed $525,188 to Hillary Clinton, $414,863 to Barack Obama, and $274,724 to John McCain. As a consequence, not one of the candidates is asking for a publicly funded system. The major players in medical care in the U.S.--insurance companies, drug companies, professional associations, etc. (the list is long)--have given a lot of money to the candidates. The splendid document called the U.S. Constitution, which begins "We the people " should have a footnote "and the insurance companies, the drug companies, " The U.S. Congress is indeed the best Congress money can buy (for a further discussion of how money corrupts the electoral system, see my article "How to Read the U.S. Primaries: Guide for Europeans," unch, February 13, 2008). The privatization of the electoral process (with most of the money that pays for campaigns coming from economic, financial, and professional interests, and from 30% of the nation's highest-income earners) corrupts the democratic process. I am not implying that politicians are corrupt (although some are). I am willing to admit that most are honorable persons. But the need to constantly raise funds for their campaigns (election and re-election) corrupts the democratic system. And the unwillingness of most members of Congress to change this situation makes them accomplices in that corruption. Such practices are illegal in most democratic countries.

And people know all about this. In surveys, 68% of people believe the U.S. Congress does not represent their interests, but the interests of the financial and economic groups that fund political campaigns. But the establishments, including the political, media, and academic establishments, want everyone to believe that the reason we don't have a

universal health program is that people don't want it. They would like people to believe that Congress legislates what people actually want. Meanwhile, the long list of public policies that people want but do not get from their government is growing: 65% of people want a publicly funded health care system similar to that in Canada, a system that in academic language is called single-payer. In a single-payer system, the government, rather than the insurance companies, negotiates with providers--doctors, hospitals, nurses, etc.--for the provision of medical care. We already have a system of this type in Medicare (with an administrative overhead of only 4%, compared with the 30% in the insurance system). By eliminating the huge administrative expenses, we could provide comprehensive health care coverage for everyone without spending an extra penny.

The possibilities for major change

Obama and Clinton are ready to admit that single-payer may be better than any other alternatives. Obama spoke out in favor of it at one time:

> "So the challenge is, how do we get federal government to take care of this business? I happen to be a proponent of a single payer health care program. I see no reason why the United States of America, the wealthiest country in the history of the world, spending 14% of its Gross National Product on health care cannot provide basic health insurance to everybody. And that's what Jim is talking about when he says everybody in, nobody out."
>
> "A single payer health care plan, a universal health care plan. And that's what I'd like to see. And as all of you know, we may not get there immediately. Because first we have to take back the White House, we have to take back the Senate, we have to take back the House." (Barack Obama in 2003 before the Illinois AFL-CIO)."

But, something happened on the way to Washington. The train derailed. Now Obama claims that his declaration was taken out of context. And Hillary Clinton, in 1993, told me that while single-payer might be the most logical model, it was politically infeasible.

I hope both candidates will reconsider. At this time, neither candidate's proposal will resolve the health care crisis we are facing. And in 2012, candidates will still be talking about single mothers who cannot pay for medical care for themselves or their children. The candidates of 2008 should be asking for government mandates rather than individual mandates. It is not people who should be mandated to get insurance. It is the government that should be mandated to provide insurance for everyone as an entitlement.

The need to mobilize

Obama has been able to capitalize on the anti-establishment mood in the country. And he has inspired many. While I believe that large numbers of people--the grassroots of the Democratic Party who support him--do want change and are firmly anti-establishment, I am concerned that they are putting too much faith in one individual. Without diminishing what candidate Obama has achieved, the fact is that he has already shown himself to be adaptable to the political context. He was once against the war in Iraq. But, in Congress, his votes on Iraq have been indistinguishable from those of Hillary Clinton. And in health care, his rather disappointing proposal will not resolve the problems. I am very worried that once in power, he will not have the courage to confront the extremely powerful lobbies primarily responsible for the lack of health care coverage and the undercoverage of the American people. It happened with Bill Clinton's administration and it may happen again. Contrary to what Obama and others have said, the main problem with Hillary Clinton's Task Force in 1993 was not its secrecy (although secrecy was indeed a problem) but a conceptual framework based on an insurance model--managed care--that was pushed on the political, media, and academic establishments by the insurance companies. The ideologues of managed care were clearly in charge of the Task Force. It could happen again.

To prevent this, there is a need to mobilize. History is not made by extraordinary figures but by ordinary people who can move mountains when they believe in a cause and get organized. It has happened all over the world, and it has happened in the U.S. We saw it in the establishment of the New Deal, Social Security, unemployment insurance, job creation, minimum wage, and subsidized housing, among other programs. These were not just the outcome of President Roosevelt's position, but the result of huge social agitation and mobilization. As usually happens in historical moments of societal change, government leaders were not so much leading as trying to catch up with what millions of people were demanding. Similarly, the Great Society Programs--Medicare, Medicaid, Environmental Protection Agency, NIOSH, OSHA, and many other examples of progressive legislation--were the outcome of massive mobilizations. Candidate John Kennedy's proposals for change were rather moderate, and his domestic policies, once he was elected, were also disappointing. But the mobilization triggered by his election was followed by many more, such as Appalachian coal miners' strikes against their working conditions, the splendid civil rights movement led by Martin Luther King, and the ant-Vietnam War movement led by student groups. They all established a political climate in which progressive legislation could occur. History, indeed, does not repeat itself. But it offers us pointers on where to go. And it should be obvious that change will not

occur unless there is a huge mobilization to complete the unfinished agenda of civil rights: a full development of social rights, with the human right to access to health care at the center.

To achieve that right, we need reforms more substantial than those put forth by either Democratic candidate. The splendid slogan first used by the great trade union leader Cesar Chavez, founder of the United Farm Workers of America, was Yes, We Can! This should guide the call for establishing the right to health care. But, for that to happen, the current holders of the slogan must heighten their expectations and become more ambitious in their proposals. This is what the electorate expects from them in their promises of change

Dr. Vicente Navarro is Professor of Health Policy, Public Policy, and Policy Studies at the Johns Hopkins University. He has written extensively on economics, health, and social policy, and has been advisor to many governments and international agencies. His books have been translated into many languages. He was the founder and president of the International Association of Health Policy, and for almost forty years has been Editor-in-Chief of the International Journal of Health Services. He is also a founding member of Physicians for a National Health Program. The views expressed in this article are his own, but are shared by millions across the United States.

Resource #4 Healthcare-NOW HR 676 WIN-WIN Campaign

Financing Expanded and Improved Medicare for All (HR 676)
A Briefing Paper
May, 2008

HR 676 would establish a national health insurance program for the United States that would provide universal and comprehensive health coverage for every United States resident. By establishing a publicly financed, privately delivered health care system, HR 676 would eliminate the massive administrative waste and profit of the private insurance industry and rein in other for-profit entities such as the pharmaceutical industry which currently consume a disproportionate share of the health care dollar. These savings will more than pay for uninterrupted coverage for all Americans. Coverage would include all medically necessary services including prescription drugs, nursing home and long term care, dentistry and the full range of mental health services. There would be no co-pays or deductibles. Out-of-pocket expenses would be reduced to over-the-counter medications and supplies and medically unnecessary treatments such as cosmetic surgery.

We propose an equitable financing program in which everyone pays their fair share. Under this program, all employers and employees will pay a modest payroll tax. This will produce a dramatic savings for those responsible private employers and state and local governments which currently purchase health insurance for their employees. By drawing on the immense wealth that has accrued to the richest Americans and large corporations over the past 25 years, 95% of all Americans will pay less for their health care than they are currently paying.

Key Components of HR 676 Financing

- Keeps most public financing in place—the government already accounts for nearly one-half of all health care spending.

- Eliminates all employer contributions to private insurance premiums—replacing them with a modest payroll tax of 4.5% (in addition to the 1.45% currently paid towards Medicare).

- Eliminates all individual premiums, co-pays, deductibles and nearly all other out-of-pocket costs—replacing them with a modest payroll tax of 3.3% (in addition to the 1.45% currently paid towards Medicare).

- Relieves state and local governments of the immense burden of paying insurance premiums for medical coverage for their current and retired employees—replacing them with a modest payroll tax of 4.5% (in addition to the 1.45% currently paid towards Medicare).

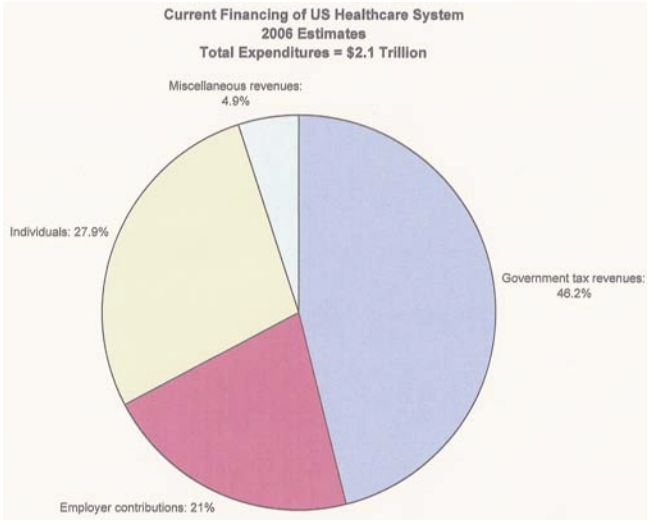
- Establishes a modest income tax increase for the wealthiest 5% of Americans.

- Reverses the 2001—03 "Bush Tax Cuts" for the rich and applies those monies to health care for all Americans.

- Creates new funding sources that ensure that corporations and the wealthy pay their fair share.

How Much Does The United States Spend on Health Care?

In 2006, total U. S. health care expenditures reached $2.1 trillion ($7026 per person)[1].



The total health care budget is currently funded by:

Government Tax Revenues: $970.3 billion[2]
Federal expenditures ($704.9 billion) include Medicare and Medicaid, public health programs, medical and pharmaceutical research, military and veterans' health care and private health insurance for federal employees. State and local expenditures include the state share of Medicaid and SCHIP programs, public health services, charity care subsidies, employer Medicare contributions (1.45% of payroll) and private health insurance for state and local employees. In 2006, state and local governments paid approximately $104.6 billion in health insurance premiums.[3]

Employer Contributions: $441 billion[4]
60% of American workers are still fully or partially covered by employer-provided health insurance. Those employers contributed an average of 11% of payroll towards health insurance premiums in 2005[5]. In addition, all employers must purchase workers compensation insurance for workers injured on the job. These insurance plans paid out an additional $26 billion toward health care expenses in 2004[6]. Some employers also spend a small amount on in-house clinics and other health care services (approximately $8 billion in 2004[7]).

Individuals/Households: $585.4 billion
Some individuals and households pay all or part of their health insurance premiums ($282 billion[8]). They also pay considerable out-of-pocket amounts to cover co-pays, deductibles, non-covered expenses, over-the-counter drugs, etc. ($256.6 billion[9]). Individuals over the age of 65 pay Medicare Part B premiums ($46.8 billion[10]).

Miscellaneous Revenues: $102.9 billion
Funds raised from foundations and individual charitable donations constitute a small part of the overall healthcare budget ($52.5 billion[11]). Other funds flow into the system from auto insurance policies, court settlements, medical and pharmaceutical research, etc..

How Much Will It Cost to Cover All Americans Under HR 676?

A number of studies conducted by the Congressional Budget Office have concluded that a single payer system similar to that proposed by HR 676 could provide expanded coverage to all Americans without any increase in overall health care spending. More recent state-level studies conducted by the Lewin Group and other economic consulting firms predict immediate cost savings after implementation of single payer financing[12].

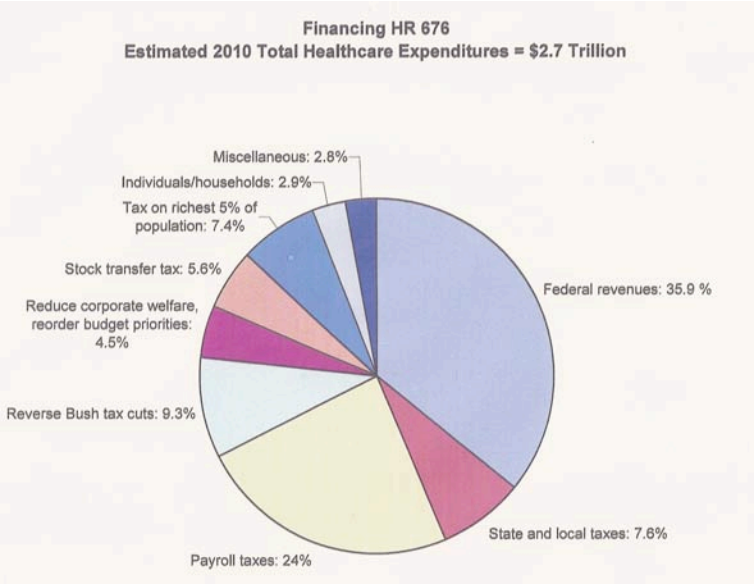
For purposes of this proposal, we assume that aggregate health care expenses in the first year after implementation of HR 676 will be equal to the total health care expenses under the current financing system and that these expenses will increase at approximately the same rate as general incomes increase during the initial implementation period. This assumption will allow for the payment of significant transition expenses including the recruitment and training of additional health care professionals as well as income security, educational and transitional benefits for displaced insurance company and health care administrative workers.

The Centers for Medicare and Medicaid Services estimates that, in 2010, total national health care expenditures will be $2.7 trillion[13]. We take this as our base number for our financing proposal.

Sources of Revenue

Reallocate/Recapture Federal Tax Revenues: $969.3 billion
All existing federal health care expenditures (including amounts currently paid for private health insurance premiums for federal workers) will be paid into a single health care financing system[14] ($926.5 billion[15]). In addition, $42.8 billion in new tax revenues will be raised through the transfer of the tax-deductible costs of employer paid private health insurance and individual/household out-of-pocket medical expenses into taxable wages, profits and income.[16]

Reallocate State and Local Tax Revenues: $206 billion[17]
All existing state and local expenditures for Medicaid, SCHIP and other public health services will be paid into a single health care financing system.[18] State and local employers will be relieved of the expense of private health insurance for their employees as well as their substantial obligations for retiree medical benefits. Instead, they will pay a payroll tax of 4.5% (in addition to the 1.45% they currently pay for Medicare).



Payroll Taxes: $648 billion[19]
All employers will pay a payroll tax of 4.5% in addition to the 1.45% they currently pay for Medicare. This is a substantial savings for the 60% of employers who currently pay for private health insurance for their employees and an equitable requirement for the 40% who do not.[20] All employees will pay a payroll tax of 3.3% in addition to the 1.45% they currently pay for Medicare. This new tax will be more than offset by the elimination of all premiums, co-pays, insurance companies' denial of care, deductibles and most other out of pocket expenses.

Reverse the 2001 through 2003 Tax Cuts: $251 billion[21]
The "Bush Tax Cuts" provided an unwarranted windfall to large corporations and the richest 1% of Americans. A return to the tax rates of the 1990's will not jeopardize the economy and will allow for the allocation of these revenues to pay for the health care of all Americans.

Income Tax Surcharge for the Wealthy: $200 billion[22]
The richest 5% of all households would pay a 5% income tax surcharge. The richest 1% would pay a 10% surcharge. Only households with incomes over $184,000 will be charged this additional tax. It would take income in excess of $280,000 to qualify for the 10% surcharge.

Stock Transfer Tax: $150 billion[23]
Both the seller and buyer of stocks would pay a tax of one quarter of one percent each time the stock changes hands. There would be a one tenth of one percent rate for transfers of government and corporate bonds and currency trades. This tax will be minimal for long-term investors. Speculators who buy and sell rapidly will pay more.

Individuals/Households: $78.5 billion
Individuals and households will continue to pay a small amount of out-of-pocket expenses for over-the-counter medications and supplies and elective medical procedures such as cosmetic surgery.[24]

Existing Miscellaneous Revenues: $75.5 billion
Funds from foundations and individual charitable contributions, the cost of in-house medical clinics and services, etc. will continue to contribute a small percentage of the total health care budget.

Reduce Corporate Welfare/Reorder Budget Priorities: $121.7 billion
A fair and equitable health care financing system will require some additional funds that can come from some modest reallocations within the federal budget. There are many targets to choose from:

- **$170 billion.** The amount that Citizens for Tax Justice reports as the annual value of corporate tax loopholes and shelters.[25]
- **$2.3 billion.** The annual cost of special tax breaks given to big oil (a windfall profits tax could generate billions more).[26]
- **$6 billion.** The amount of additional tax revenues each year if hedge fund managers paid taxes at the same rates as all other Americans.[27]
- **$7 billion.** The annual amount of taxes dodged each year by offshore corporations.[28]
- **$195.5 billion.** The amount requested by the Bush Administration for "war related activities" in fiscal year 2008.[29]

This financing proposal will provide guaranteed healthcare to all Americans. Income taxes will only increase for those households with incomes in excess of $184,000. Corporations and employers will pay their fair share. And, by eliminating premiums, co-payments, deductibles and most out-of-pocket costs, **95% of all Americans will pay less than what they are currently paying for their health care.**

Footnotes

1. Centers for Medicare and Medicaid Services (CMS). "National Health Expenditure Accounts. 2006 Highlights."
2. CMS. "National Health Expenditures; Aggregate and Per Capita Amounts, Percent Distribution and Annual Percent Change by Source of Funds: Calendar Years 2002-2017" (Table 3).
3. CMS. "Sponsors of Health Care Costs: Businesses, Households and Governments 1987-2006" (Table 1).
4. Kaiser Family Foundation. "Employer Health Benefits. 2007 Summary of Findings".
5. Ibid.
6. U.S. Census Bureau. "Workers' Compensation Payments: 1990 to 2004" (Table 542).
7. Ibid.
8. CMS. "National Health Expenditures" op. cit.
9. Ibid.
10. CMS. "Projected Medicare Part B Expenditures under Two Illustrative Scenarios". March 25, 2008
11. Debs-Jones-Douglass Institute. "Financing Just Health Care." 2002
12. Physicians for a National Health Plan. "How Much Would a Single Payer System Cost?" January, 2008.
13. CMS "National Health Expenditures" op. cit.
14. Under HR 676, the Veterans Administration and Indian Health Services would continue as intact and separate. Since this has a revenue neutral effect on overall financing, we do not break it out as a separate budget item.
15. Ibid.
16. Following Woolhandler and Himmelstein ("Paying for National Health Insurance and Not Getting It", Health Affairs. July/August 2002) we calculated a tax subsidy of 14.46% of the projected 2010 cost of employer-paid private health insurance less the cost of new employer-paid payroll taxes and a tax subsidy of 6.23% on 75% of the projected 2010 cost of individual/household out-of-pocket expenses. We chose not to add in the additional tax subsidies accruing to social security payroll tax as we assumed that those amounts would be used to offset the growing social security deficit. For simplicity's sake, we chose not to include an estimate of additional state and local tax subsidies as those amounts vary greatly by state and local jurisdiction.
17. Using CMS figures for 2010 minus cost of health insurance.
18. We intentionally left charity care out of the list of available funds. The American Hospital Association ("Uncompensated Hospital Care Cost Fact Sheet" October, 2006.) estimates that uncompensated costs were $28.8 billion in 2005 but this includes both charity care and bad debts. Only a few states have dedicated funding to reimburse some or all of these uncompensated costs. Others support public hospitals and clinics and attempt to direct uninsured patients to those facilities. Given the lack of uniform policy for handling charity care, we believe

state funds used for that purpose cannot reasonably be included as payments into the national health insurance system.

19. Projections from, "The 2007 Annual Report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Funds" (Table VI.F9).
20. As of the date of writing this paper (May 6, 2008), Congressman Conyers, and many other HR 676 advocates, still propose an employer payroll tax of 3.3% (in addition to the 1.45% that they currently pay for Medicare). However, in light of the rapid escalation of health care costs since the introduction of HR 676 and in further consideration of the rapidly increasing federal budget deficit from other sources, we propose that the employer payroll tax portion of health care financing be increased to 4.5% of gross payroll and we recommend that all HR 676 advocates adopt this formula.
21. Derived from Congressional Budget Office estimates of the cost of the 2001 through 2003 tax cuts in 2010.
22. Mishel, Bernstein & Allegretto. The State of Working America. Cornell University Press, 2007. Table 1.1
23. Dean Baker. "Taxing Financial Speculation", CEPR, February 2000.
24. Estimated at 25% of CMS out-of-pocket expenditures in 2010.
25. Citizens for Tax Justice (CTJ). "Surge in Corporate Tax Welfare Drives Corporate Tax Payments Down to New Record Low", April, 2002.
26. CTJ. "The 110th Congress Should End Tax Subsidies for Big Oil", December, 2006.
27. Dean Baker. "Welfare As We Know It Now", CEPR.
28. CTJ. "Senate Should Enact the Doggett Proposal to Close Loophole That Allows Foreign Corporations to Dodge Taxes on U.S. Profits", August, 2007.
29. Congressional Research Service. "The Cost of Iraq, Afghanistan and Other Global War on Terror Operations since 9/11" February, 2008.

Resource #5 Healthcare-NOW HR 676 WIN-WIN Campaign

Testimony Before the NY State Partnership for Coverage By Tim Joseph, Chair, Tompkins County Legislature Syracuse, NY 11/13/07

My name is Tim Joseph, and I am the Chair of the Tompkins County Legislature. I want to tell you how pleased I am that this taskforce exists and is exploring the options for universal health care. I also want to thank you for holding public hearings and for the opportunity to speak to you today.

There are two fundamentally different approaches that can be taken to solve the problem of health care access. One is to build on the current patchwork of, employer provided insurance, Medicare, Medicaid, Child Health Plus, Family Health Plus, individual pay as you go, indigent care provided by emergency rooms, etc. This approach involves making the health care system more complicated by adding additional patches to cover people who are currently left out. The other approach is to replace the current system with a single government managed health insurance system, sometimes called "single payer" or "Medicare for all."

As an elected county leader, I find that a tremendous amount of my time, and my budget, is devoted to one or another aspect of health care for some segment of our citizens. Nearly all of that time is devoted, not to the actual delivery of health care, but to sorting out who will pay for it. One of the big advantages of a single payer system, when compared to our current patchwork, is that it resolves this issue once and for all, and thus offers substantial savings in administrative costs. I have seen estimates of those savings that range from 10% up to 25%, but every estimate I've seen overlooks a myriad of hidden costs associated with our current system. I'd like to point out just a few of those costs that I encounter every day in county government.

1) My county, like every county, has an Office for the Aging. We have a 10 person staff and the largest part of their work consists of helping seniors to navigate the health care system, find the programs that are available to help them, and plan how they will manage health care costs now and in the future.
2) In our Personnel department we have a full time benefits manager who is mostly occupied with assisting employees in dealing with the health insurance program. Those employees also lose productive work time consulting with the benefits manager and fighting insurance company denials, which can take hours from the workday.
3) When we negotiate with our employee unions, health care is always the biggest topic. We have a health care consultant on retainer to help us examine and cost out plan changes that we present to our unions in an attempt to control costs. At least two thirds of the staff time devoted to collective bargaining is spent on health care issues.

4) We devoted hundreds of hours of staff time to developing and publicizing a discount prescription drug card available to all county residents to reduce drug costs for those without insurance.
5) We have a $400,000 grant from NY State to form a health insurance consortium among local governments so that we can purchase employee health care as a larger group.
6) We will be hiring a consultant to help us through the process of forming that consortium and then finding a suitable plan. Various county staff are devoting substantial time to moving this project forward.
7) We have staff in our Mental Health Department, Public Health Department, and Department of Social Services, devoted to collecting fees from private insurers to reduce the public cost of programs that deliver various health services.
8) We have people waiting in jail that judges are prepared to release to drug or alcohol treatment programs as soon as we can assure payment to the treatment center. We have staff in local agencies and our Department of Social Services who work on getting these inmates into health care programs, mainly Medicaid, that will cover treatment. Meantime, we pay the cost of incarceration.
9) Our economic development staff encounters aspiring entrepreneurs who would like to start their own business, but are tied to a job by the health insurance benefits. Young businesses that do get started often have trouble attracting the employees they need, because they cannot yet offer a health plan.
10) We have staff who don't like their jobs, and perform at less than the desired level, but who remain because they need the health insurance.
11) Nurses and other health care professionals routinely leave direct service to take jobs in insurance companies processing claims, thus contributing to our severe shortage of nurses and physicians.

This is just a partial list of the many ways that county government and local economies spend both time and money dealing with the question of who will pay for health care. None of these costs are ever included in cost comparisons between single payer and other health care systems, but every one of them would go away if there was a single, simple and consistent answer to the question, "who will pay." Only a single payer system will accomplish that.

Resource #6 Healthcare-NOW HR 676 WIN-WIN Campaign

LOCAL BENEFIT CALCULATION WORKSHEET

A. Local government benefits

1. Health benefits savings for employees

   (a) Total 2007-2008 payroll (all salaries and wages) 1(a) _____

   (b) Total amount spent on health benefits 2007-2008 (from budget) 1(b) _____

   Does this amount include 1.45% for Medicare?
   If yes or you aren't sure, continue to (c) below.

   If no, take 1(a) above X 0.0145 and add it to 1(b) above.
   Put the new total here. 1(b) _____

   (c) Total cost of health benefits under HR 676
   Take 1(a) X 0.0595 1(c) _____

   (d) Calculate annual savings on employee health benefits
   Deduct 1(c) above from the applicable total in 1(b). 1(d) _____
   SAVINGS

2. Health benefits for retirees

   (a) If you can, find the total amount of unfunded health benefits for employees who are already retired. 2(a) _____
   SAVINGS

   (b) 1(b) above may include a payment toward those unfunded benefits. Record it if you know it. You have accounted for it as an annual savings under 1(d) above. 2(b) _____

3. Worker compensation insurance
   Take total amount from budget X 0.47 3 _____
   SAVINGS

4. Health services provided by government entity
   Take amounts right off the budget wherever you can find them.
   You may find them lumped together.

   (a) Local immunization or testing program 4(a) _____
   SAVINGS

(b) Medical vouchers for general assistance recipients 4(b) _____
SAVINGS

(c) Prescription drug subsidy programs 4(c) _____
SAVINGS

(d) Free clinic or primary care facility 4(d) _____
SAVINGS

(e) Other 4(e) _____
SAVINGS

5. Other savings worth mentioning that may be difficult to quantify.
   Possibilities include (see Resource # 5):
   - Labor negotiations costs (health insurance consultants, lawyers)
   - Human resources staff who advise about health coverage
   - Reduced vehicle insurance coverage
   - Office of Aging staff who advise about health insurance

B. Local government employee benefits

1. Calculate the average employee income

   (a) Total payroll from Part A, 1(a) above 1(a) _____

   (b) Total number of employees 1(b) _____

   (c) Divide 1(a) by 1(b) to get average income for employees 1(c) _____

2. Current employee out-of-pocket costs for average income employee

   (a) Insurance premium co-pay _____
   (b) Medicare (1.45% of pay that is already deducted)
   1(c) X 0.0145 _____
   (c) Deductible _____
   (d Hospital or doctor co-pay _____
   U.S. average is 4 doctor visits/capita/year
   (e) Prescription co-pay _____
   U.S. average is almost 12 prescriptions/capita/year
   (f) Health care not covered by insurance _____
   (most common not covered include the following)
   Vision care
   Hearing services and hearing aids
   Dental services, except cosmetic dentistry

Mental health and substance abuse rehab/treatment
Chiropractic services
Long term care

(g) ANNUAL TOTAL OF OUT OF POCKET COSTS
Add (a) – (f) above. This will be a "best-guess" estimate. 2(g) _____

3. Calculate current average employee savings under HR 676

(a) Find annual cost under HR 676 for average employee
Take 1(c) X 0.0475 3(a) _____
(4.75% = 1.45% for Medicare that is already deducted, plus
3.3% employee share under HR 676)

(b) Deduct 3(a) from 2(g) 3(b) _____
SAVINGS

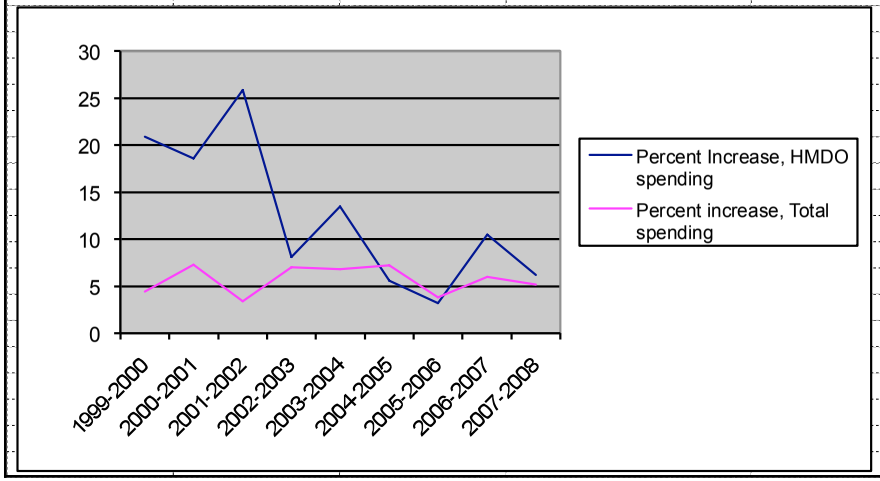
Resource #7 **Healthcare-NOW's HR 676 WIN-WIN Campaign**

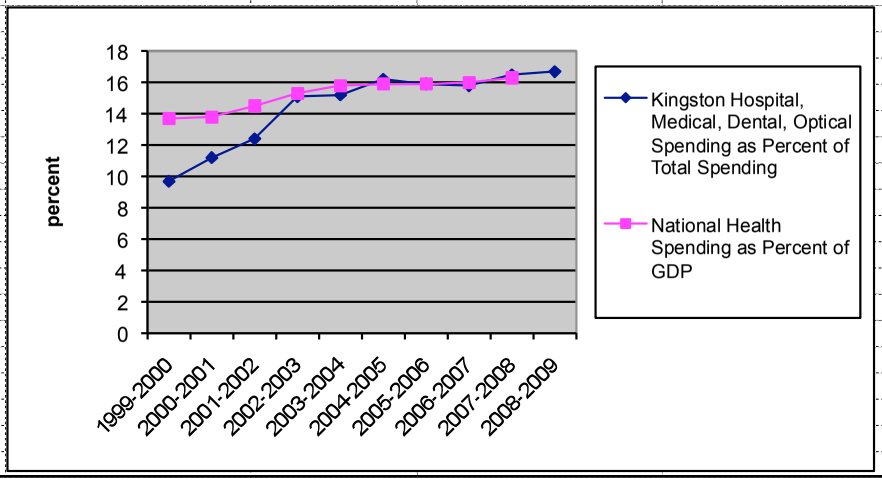
KINGSTON CITY SCHOOL DISTRICT

Financial analysis for savings under HR 676

In 2007-2008, the Kingston City School District had a total payroll of $65.6 million.
Since the HMDO expenses listed below do not include the current 1.45% payroll tax for Medicare, the total health benefits expense for 2007-2008 was $21.6 million plus $0.95 million (65.6 X 0.0145) for a rounded total of $22.6 million.
Under HR 676, the health benefits cost in 2007-2008 would have been only $3.9 million ($65.6 X (0.045 + 0.0145)). This results in a savings of $18.7 million from employee health benefits alone.

YEAR	TOTAL SPENDING (millions)	% INCREASE	HEALTH, MEDICAL, DENTAL, OPTICAL (millions budgeted)	% INCREASE	HEALTH, MEDICAL, DENTAL, OPTICAL (millions spent)	% INCREASE	HMDO SPENDING AS PERCENT OF TOTAL SPENDING	NATIONAL HEALTH SPENDING AS PERCENT OF GDP
1999-2000	83.87		8.37		8.1		9.7	13.7
2000-2001	87.56	4.4	9.21	10	9.79	20.9	11.2	13.8
2001-2002	93.94	7.3	11.61	26.1	11.61	18.6	12.4	14.5
2002-2003	97.09	3.4	15.15	30.5	14.62	25.9	15.1	15.3
2003-2004	103.84	7	15.8	4.3	15.8	8.1	15.2	15.8
2004-2005	110.85	6.8	19.31	22.2	17.93	13.5	16.2	15.9
2005-2006	118.83	7.2	18.94	-1.9	18.94	5.6	15.9	15.9
2006-2007	123.37	3.8	19.88	5	19.55	3.2	15.8	16
2007-2008	130.83	6	21.81	9.7	21.6	10.5	16.5	16.3
2008-2009 (proposed)	137.62	5.2	23.13	6.1	22.94	6.2	16.7	





Resource #8 Sample Fact Sheets (Camden and Philadelphia)

CAMDEN, NJ - WIN-WIN CAMPAIGN FACT SHEET

Camden is one of our nation's poorest cities. Its 2008 budget of $153 million barely covers the cost of police and fire protection, and trash collection. Over 75% of its budget comes from the State of NJ. ***National single-payer health insurance as proposed under HR 676 could save Camden over $17 million based on 2008 figures.***

CAMDEN, NJ IS IN FISCAL CRISIS

Camden is a troubled city with a huge structural deficit that is growing every year.

- Camden requires Special State Aid to close its budget gap. The amount of aid increased from $11 million in 2001 to $61 million in 2008.
- During this same time period, the City's other revenue sources remained relatively constant at about $92 million/year.
- Health insurance benefits for employees have been a major contributor to this rapidly growing deficit. Health benefits expenses increases from $12.9 million in 2001 to $20.8 million in 2008.

CAMDEN, NJ ALSO HAS A HEALTH CARE CRISIS

- The infant mortality rate in Camden (2003) was 16.4/1000, vs. 5.7/1000 for all of NJ.
- 21% of Camden's residents (16,800) are uninsured, vs. 16% nationwide (2006). Uninsured people accounted for one-fourth of the hospital visits in Camden (2003).
- 30% of Camden's residents reported that they have failed to fill prescriptions because of cost (2006). The comparable figure in Camden County was 18%.
- Many uninsured Camden residents have no choice but to use hospital emergency rooms for medical care. Because of the State's fiscal crisis, hospitals only receive partial "charity care" reimbursements. Cooper Hospital gets close to full reimbursement, but Lourdes Hospital only got 61% last year, and is projected to get only 31% in 2009.

HR 676 – A WIN-WIN -- ADDRESSES BOTH OF THESE CRISES

- Quality Health Care For Every Resident
- Huge Savings For Camden

National single-payer health insurance as proposed under HR 676 could save Camden over $17 million based on 2008 figures. It could save $15.9 million in health benefits for employees, and $1.2 million on worker compensation insurance.

Employees' out of pocket costs will be reduced, too. Current coverage offers limited mental health benefits, no long-term and no chiropractic services. Current co-pays ($ amt.) and deductibles ($ amt.) will be eliminated.

By guaranteeing health insurance to every resident, Camden residents would get much better care. Lourdes and Cooper Hospital would not face losses of $4 million and $2.6 million, respectively, because of partial charity care reimbursement.

Sources:

CamConnect. *Camden Facts 2008*; *Budget and Taxes, 2005*; *Camden's Fiscal Outlook: A review of the Revenue and Expenses in the Municipal Budget*, Sept. 2007.

SFY 2008 Municipal Budget, City of Camden, NJ accessed at http://www.camconnect.org/resources/documents/SFY2008forintro662008.pdf

Jeanne Ridgway, "Charity Care Funding Comes Up Short," *Courier-Post*, July 6, 2007.
Joseph Gidjunis, "Charity Care Squeezes Hospitals," *Courier-Post*, May 12, 2008.

Employment data from the City of Camden Business Administrator's Office

PHILADELPHIA'S WIN-WIN CAMPAIGN FACT SHEET

Philadelphia is facing a $34 million budget shortfall this year—which could grow to $450 million deficit over the next five years—despite having the second highest tax burden in the nation.

The shortfall is partially to blame on rapidly increasing healthcare costs for City employees. Healthcare benefits made up 6.5 percent of the total budget in 2001 and will grow to an estimated 11.5 percent by 2011.

A budget deficit, and increasing healthcare costs, means that City services and employment numbers will decline. With a poverty rate around 25 percent, only 20 percent of residents with college degrees, and a 40 percent drop out rate in our public schools, we simply cannot accept cuts to social services.

There is a solution, however, that could dramatically reduce the City's healthcare costs, and free up funds for much-needed services. **HR 676, the National Single-Payer Health Insurance Act, could save Philadelphia $539 million a year.**

HEALTHCARE COSTS ARE OUT OF CONTROL

Philadelphia spends considerably more on healthcare per employee than other municipalities. The City will spend $374 million for City employee healthcare costs in 2008. That's **$13,030 per City employee this year**.

The state/local average is $9,082 per employee. The private sector average is $4,292 per employee, since many employers refuse, or can't afford to provide full coverage.

We can expect healthcare costs to increase every year. In 2007, employer health insurance premiums increased by 6.1 percent—two times the rate of inflation. The annual premium for an employer health plan covering a family of four averaged nearly $12,100.

PHILADELPHIANS NEED QUALITY, AFFORDABLE HEALTH COVERAGE

Our dedicated City workers deserve quality healthcare, as do we all! However, Philadelphia Health Management Corporation estimates that there are **137,000 adults in Philadelphia without health insurance**.

Many uninsured residents have no choice but to use hospital emergency rooms for medical care. Each visit, on average, costs $1,049 and most hospitals bill patients regardless of their ability to pay.

Infant mortality in Philadelphia is nearly twice the national average. According to the *Philadelphia Inquirer*, "Philadelphia's African American infant mortality rate was 15 per 1,000 live births between 2003 and 2005. That's more than 50 percent higher than the white infant mortality rate of 9.9 per 1,000 live births. But there's more: Philadelphia's white infant mortality rate is almost 46 percent higher than the national average of 6.8."

HR 676 CAN SOLVE PHILADELPHIA'S HEALTHCARE CRISIS

HR 676, the National Single-Payer Health Insurance Act, would provide quality healthcare for every Philadelphia resident—taking the burden off the City to provide healthcare for its residents and employees.

HR 676 would effectively level the healthcare playing field regardless of race or employment status.

Philadelphia could save $539 million a year --the cost of healthcare for city workers and emergency care for Philadelphians without health insurance. This money could be used to improve our schools, create jobs, and reduce the poverty rate.

Philadelphia's Savings from HR 676 (FY 2006)	
Employee Wages	$1.25 Billion
Total HR 676 Cost to City	**$74.4 Million**
City Staff HC Cost (2008)	$374 Million
City Retiree HC Cost	$43.5 Million
Services for Uninsured Residents	$171 Million
Workers' Comp. (Medical Portion)	$25 Million
Total City Healthcare Cost	**$613.5 Million**
Savings	**$539.1 Million**

The US Conference of Mayors, with Mayor Nutter in attendance, **endorsed HR 676** at its annual meeting last June.

According to a report by the Philadelphia Department of Public Health: **"Philadelphia should be advocating for national insurance coverage and reform."**

Chicago, Detroit, San Francisco, Boston, and over **45 other municipalities have endorsed HR 676**.

59 percent of American doctors support single-payer and **65 percent of Americans support a universal health insurance program** like Medicare.

It's time the City of Philadelphia does too.

For more information about HR 676 and Healthcare-NOW!'s Win-Win Campaign, visit **www.Healthcare-Now.org** or email Jeff@Healthcare-Now.org.

Sources:
1. Katherine Barrett and Richard Greene, "Philadelphia's Quiet Crisis: The Rising Cost of Employee Benefits." The Economy League of Greater Philadelphia, 2008.
2. Walter Tsou, "How to ensure Phila. babies live past their first birthdays?" *Philadelphia Inquirer*, March 24, 2008.
3. City of Philadelphia, "The Mayor's Operating Budget Summary FY 2009." May 22, 2008.
4. City of Philadelphia, "Comprehensive Annual Financial Report FY 2006." June 30, 2006.
5. Philadelphia Department of Public Health, "Decent Health Care for All: Local Leadership Action." May 2005.
6. Editorial, "Feeling City's Budget Pain." *Philadelphia Inquirer*, September 17, 2008.

Resource #9 Healthcare-NOW HR 676 Win-Win Campaign

Sample Letter to the Editor

Most newspapers ask that Letters to the Editor be kept to 250 words or less. Most ask that they be mailed or emailed.

National single-payer health insurance is a Win-Win for (town or county) and the people who live in it. If HR 676, the United States National Health Insurance Act is passed in the next administration, it would save (town or county) $ _____, and would provide guaranteed, comprehensive and high quality health care for all of its residents.

Financial problems stare us in the face. Rising health insurance and pension costs for (town or county) employees take a larger share of the local budget. Residents are asked to pay more co-pays and deductibles at the same time we face rising food and gasoline prices. *(Rework this paragraph to highlight your local research.)*

Critics say that national health insurance isn't feasible. Pharmaceutical and insurance companies won't let it happen. But it is a Win-Win bringing huge savings to state and local governments, and removing every resident's worry about health care. Don't we have enough financial worries already? Aren't our needs more pressing than those of high profit insurance and drug companies that take over 30% of every health care dollar for profits, advertising, fat management salaries and administration? Can we afford not to consider national health insurance?

The (name of your group of coalition working on this issue) urges the (town or county) Mayor and Council to endorse HR 676. We have met with local officials and shown them the savings and benefits. The time to act is now.

Resource #10 (part 1). Healthcare-NOW HR 676 WIN-WIN Campaign

How to Pass a Local Resolution in Support of HR 676

1. This resolution will help to build a national movement in support of national health insurance as proposed in HR 676. It is an expanded and improved Medicare for All health plan which covers all necessary care, and is publicly funded and privately delivered. It ensures that all U.S. residents will have access to the highest quality and cost-effective health care services regardless of employment, income, or health care status. By passing resolutions, local governments build political will in support of HR 676.

2. After preparing your summary fact sheet (steps 1-7 in the organizing guide), prepare a draft resolution for the local jurisdiction that you have targeted. We have provided a couple of samples to help you. Check with a City Council aide, the City Clerk, or the Town Manager's office to learn the correct procedure for introducing a resolution before City Council, County Commission, etc. It may have to go before a committee before consideration by the local legislative body.

3. Begin approaching local public officials to present your case. Your main back-up information will be your fact sheet, the WIN-WIN campaign brochure (**Resource #1**), the draft summary resolution, and perhaps an HR 676 summary (John Conyers, Jr. web site) or the basic orange book we use. *(Note that the current printings of the orange book still show a 3.3% employer payroll tax.)* Choose an initial contact that you think will be supportive.

4. When you meet with key public officials and/or legislators, take a strong delegation of 5-6 residents with you. Try to make it gender, race, and interest-group (labor, community, business, faith, health care professional, etc.) diverse. Do your best to win their commitment to get the resolution introduced, and tell you when it will be considered. Reach out to the decision-makers (phone, email or in person) between the time it is introduced and the time it will be considered (voted on). Make sure all questions get answered.

5. As mentioned in the guide, we must work to get the press interested. Send out a media advisory before the meeting when the resolution will be considered (see **Resource #11**). Send out a Letter to the Editor asking Council to support the resolution. Have a rally or press conference before the meeting. Get one of your group on a radio show, etc. Do what you can; be creative.

6. At the meeting where the resolution will be considered, have people prepared to speak from various points of view and interest groups. Often local governments vote on resolutions in bunches at a time, accepting public comment prior to the vote. Some require that those wishing to speak sign in. Pay attention to these procedures so you don't miss your chance. If possible, take some one with you who is an experienced activist who knows the ropes.

7. If the resolution passes, send a thank you to your contacts and to the legislative body. Tell them you'll ask for their help later as part of a delegation to meet with State officials. Get an official copy of the resolution from the City or County Clerk (usually available in a week or so) and send copies to the local Congressman, state legislators, local unions, Healthcare-NOW, etc.

Resource #10 Healthcare-NOW HR 676 WIN-WIN Campaign

This is a sample based on one that Albany County, NY passed. Modify and add to it as necessary to reflect the local situation. This can be a learning tool for elected officials who consider it. Make sure it mentions the local savings that will result from national health insurance.

(Name of local jurisdiction)

Resolution to endorse Congressional H. R. 676 US National Health Insurance Act

WHEREAS, every person in (name of jurisdiction) and in the United States deserves access to affordable, quality health care, AND

WHEREAS, the existence of thousands of public and private insurance providers and regulators has resulted in extraordinarily complex health care business procedures that consume almost one third of our nation's expenditures for health care, AND

WHEREAS, (jurisdiction) annual cost for health benefits in (year) reached ___ million, ___% of our tax levy, and ___% of our annual budget, (substitute appropriate local statistics and savings here; add additional WHEREAS clauses as necessary), AND

WHEREAS, rationing health care according to ability to pay has diminished the overall health of our citizens to the point that the United States ranks thirty-sixth in quality by the World Health Organization and as many as 100 million citizens are denied appropriate health care in any year, AND

WHEREAS, statistics show that inequalities in healthcare diminish not only our well-being but also everyone's ability to work and prosper,

WHEREAS, the failure to provide affordable and appropriate preventative health care services places unnecessary and more costly demands upon (local jurisdiction; eliminate if yours does not provide direct health care services) emergency health care services, AND

WHEREAS, HR 676, a bill introduced in the U.S. House of Representatives, also known as the US National Health Insurance Act and Medicare for All, would cover every person in the United States for all necessary medical care including prescription drugs, hospital, surgical, outpatient services primary and preventive care, emergency services, dental and vision care, long-term care, AND

WHEREAS, ninety members of Congress including # from (state) and Congressman (local Congressperson, if appropriate) have already signed on in support of HR 676,

NOW, THEREFORE BE IT RESOLVED, that the (jurisdiction) Legislature endorse HR 676 and call on the Congress of the United States to pass this bill assuring appropriate and efficient health care for all residents of the United States.

The City of West Palm Beach
"The Capital City of the Palm Beaches"

Lois J. Frankel
Mayor
P.O. Box 3366
West Palm Beach, Florida 33402
Telephone: 561/822-1400
Fax: 561/822-1424
e-mail: lfrankel@wpb.org

May 8, 2008

Mr. Eugene Lowe
Assistant Executive Director
The United States Conference of Mayors
1620 I Street, N.W., Suite 400
Washington, D.C. 20006

Dear Mr. Lowe:

On behalf of the City of West Palm Beach, Florida, thank you for processing the attached resolution in support of the United States National Health Insurance Act (H.R. 676). As so many other cities nationwide, our budget is stretched thin and the deficits are impacting our citizens well being. Millions of people are suffering due to lack of access to care and too many are losing their homes to bankruptcy due to skyrocketing medical costs.

In Florida we have 3.8 million uninsured and a $4 billion projected budget gap for the 2009 fiscal year. Quality, affordable health care for our city employees and our citizens is at a critical crossroads. It is a service to our nation for the United States Conference of Mayors to encourage our federal legislators to work towards the immediate enactment of The United States National Health Insurance Act (H.R. 676).

We are pleased to be working with a local organization, Floridians for Health Care (FFHC) whose contact person is Alison Landes. FFHC is a member of The Conference of Mayors Allied Council. On our behalf they are assisting us in reaching out to other mayors who will join us in bringing this resolution to Children, Health and Human Services Standing Committee and ultimately to the attention of the body of mayors as a whole at the upcoming Annual Conference June 20-24, 2008.

We will forward the names and required information of other mayors who agree to co-sponsor this resolution prior to May 21, 2008. Thank you for your assistance in processing this resolution.

Sincerely,

Lois J. Frankel
Mayor

cc: Crystal Swann
Alison Landes

RESOLUTION IN SUPPORT OF THE UNITED STATES NATIONAL HEALTH INSURANCE ACT (H.R. 676)

WHEREAS every person deserves access to affordable quality health care; and

WHEREAS the number of Americans without health insurance now exceeds 47 million; and

WHEREAS millions with insurance have coverage so inadequate that a major illness would lead to financial ruin, and medical illness and bills contribute to one-half of all bankruptcies; and

WHEREAS proposals for "consumer directed health care," such as Health Savings Accounts (HSAs) or Health Reimbursement Accounts (HRAs), would only worsen this situation by penalizing the sick, discouraging prevention and saddling many working families with huge medical bills; and

WHEREAS managed care and other market-based reforms have failed to contain health care costs, which now threaten the international competitiveness of U.S. manufacturers; and

WHEREAS administrative waste stemming from our reliance on private insurers consumes one-third of private health spending while the single payer Medicare system has administrative costs of less than 5%; and

WHEREAS U.S. hospitals spend 24.3% of their budgets on billing and administration while hospitals under Canada's single payer system spend only 12.9%; and

WHEREAS Harvard researchers estimate that more than $300 billion could be recovered by replacing private insurance companies with a single public payer, enough to cover the uninsured and to improve coverage for all those who now have only partial coverage; and

WHEREAS entrusting care to profit-oriented firms diverts billions of dollars to outrageous incomes for CEOs and threatens the quality of care; and

WHEREAS The United States National Health Insurance Act (H.R. 676) would assure universal coverage of all medically necessary services, contain costs by slashing bureaucracy, protect the doctor patient relationship, assure patients a completely free choice of doctors, and allow physicians a free choice of practice settings; and

WHEREAS most polls show that the majority of Americans support universal healthcare; and

WHEREAS, as of the date of this resolution, the majority of American physicians (59%) believe that Single Payer is the best method of securing universal healthcare; and

WHEREAS The United States National Health Insurance Act (H.R. 676) will guarantee every mayor that all residents and employees of his/her city will be fully covered for healthcare and save millions of taxpayer dollars now spent on premiums to provide less than full health insurance coverage for government employees,

NOW THEREFORE

BE IT RESOLVED that the United States Conference of Mayors expresses its support for The United States National Health Insurance Act (H.R. 676), and calls upon federal legislators to work towards its immediate enactment.

RESOLUTION BY THE ALBANY COMMON COUNCIL, OCTOBER 20,2008

Council Member Conti offers the following Resolution:

Resolution Number 77.102.08R

RESOLUTION OF THE COMMON COUNCIL IN SUPPORT OF THE NATIONAL HEALTH INSURANCE ACT AS PROPOSED BY H.R. 676

WHEREAS, every person in the City of Albany and the United States deserves access to affordable, quality healthcare; and

WHEREAS, over 45 million Americans and over 15,000 residents in the City of Albany live daily without healthcare coverage; and

WHEREAS, even those now insured often experience burdensome medical debt and sometimes life-threatening delays in obtaining healthcare; and

WHEREAS, illnesses and medical debt annually cause five hundred thousand bankruptcies in the United States affecting two million people and an increasing number of home foreclosures are also associated with medical debt; and

WHEREAS, administrative costs and profits amount to 30 percent of healthcare spending in the United States, with rising costs contributing to decreased international competitiveness and massive layoffs; and

WHEREAS, Americans spend double what other industrialized countries spend per person while they are covering all their citizens; and

WHEREAS, the City of Albany's 2008 salary expenditures are approximately $71.5 million for 1420 employees, F.I.C.A. is $5.4 million, and health insurance is $24.4 million, including $10 million for retirees, and

* WHEREAS,* under the National Health Insurance Act, there would be a F.I.C.A. increase of 4.5% or $3.2 million, resulting in a new F.I.C.A. expense of $8.6 million and elimination of the $24.4 million expense for health insurance for a net savings of $21.2 million to the City of Albany; and

* WHEREAS,* these savings could be applied to reducing the current heavy property tax burden which is forcing seniors and others with limited means out of their homes and undermining the Albany's financial viability; and

WHEREAS, U.S. Representative John Conyers has introduced the HR 676, the National Health Insurance Act; and

WHEREAS, the goal of HR 676 is to guarantee that all Americans have access to the

highest quality and most cost-effective healthcare services, regardless of employment, income, or healthcare status; and

WHEREAS, HR 676 will cover all medically necessary services, including primary care, inpatient care, outpatient care, emergency care, prescription drugs, durable medical equipment, long term care, mental health services, dentistry, eye care, podiatry, chiropractic, and substance abuse treatment, and

WHEREAS, HR 676 will give patients their choice of physicians, hospitals, providers, and clinics with no co-pays or deductibles in a publicly financed, privately delivered system, and

WHEREAS, HR 676 has 92 co-sponsors in the House of Representatives as of October 2008, including Representative Michael McNulty of the 21st congressional district of New York State; and

* WHEREAS,* the United States Conference of Mayors at their 76th Annual Meeting in June 2008 adopted a resolution in support of HR 676.

* NOW, THEREFORE, BE IT RESOLVED,* that the Albany Common Council expresses its support for the National Health Insurance Act (HR 676) and joins with the US Conference of Mayors in calling upon federal legislators to work toward its immediate enactment; and

* BE IT FURTHER RESOLVED,* that a certified copy of this resolution be transmitted to United States Senators Hillary Clinton and Charles Schumer, United States Representative Michael McNulty, and James Buhrmaster and Paul Tonko candidates for the House of Representatives from the 21^st Congressional District of New York.

Resource #11 Healthcare-NOW HR 676 WIN-WIN Campaign

This is a simple media advisory. Make sure you provide contact information and the highlighted WHO, WHAT, WHERE and WHEN segments. Any commentary must be very brief and concise.

MEDIA ADVISORY
HEALTH-CARE NOW!

FOR: Monday, November 12, 2007

Contact: Mike Mitchell 219-781-6568 mmitchell@usw.org
Bill Gibbons 708-280-9956 wgibbons@usw.org

****** GREAT VISUALS – Including the Road Show bus and rally for HR676******

Healthcare-NOW! SICKO-Cure Road Show Makes First Stop in Merrillville; Steel Workers Host Free Screening of Michael Moore Documentary

(Merrillville, IN)- Healthcare-NOW will kick off its first Sicko-Cure Road Show campaign for a national program that provides guaranteed health care on Sunday night, Nov. 11 from in front of the Chicago Midway Marriott.

The SICKO-Cure Road Show's first stop is Merrillville, IN and is hosted by local members of the United Steelworkers Union. Local leaders will meet with members of Congressman Peter Visclosky's staff at the Congressman's Merrillville office. Congressman Visclosky has been a past co-sponsor of the National Health Insurance Act.

Later in the evening, the Steelworkers will host a free showing of Michael Moore's award-winning film SICKO, just released in DVD format. Members of the Road Show Team will facilitate a discussion after the movie.

WHO: **Health-Care NOW!** Indiana members
Steel Workers Union, Indiana
Marilyn Clement, Healthcare-NOW's National Coordinator; and members of the Road Show team including **Donna Smith,** whose health insurance abuse story was documented in SiCKO; **Julia Atkins** of Tampa, FL; **Gloria Maloney** of Roscoe, IL; and Joe Friendly, a videographer from New York, NY.

WHAT: **SICKO screening, discussion**
WHERE: USW Union Hall at 1301 Texas St.
Gary, IN, 46402

WHEN: **Monday, November 12, 2007, 6:30 PM**

Healthcare-NOW! is a national organization that advocates guaranteed, single-payer insurance coverage for every U.S. resident. With over 50,000 members and coalitions in 41 states, Healthcare-NOW! is a critical part of the growing movement for guaranteed health care. The Healthcare-NOW! SiCKO Cure road show will reach thousands more Americans who embrace the call for a sane health insurance system. For more information about the Road Show and other upcoming events please visit www.healthcare-now.org or contact Tom Knoche at knocheberg@aol.com or at 856-966-3241.