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A New National Health System Is Upon Us. It Is our Responsibility To Understand It—To Recommend Changes To It—and To Implement the Results. Let Us Begin...

by **Bob McEvoy, Managing Editor**

We began, in our prior issue, with Dr. Erika Martin and Commissioner Courtney Burke's excellent initiation to the ACA, "Implementing the Patient Protection and Affordable Care Act: Implications for State and Local Governments," written for the *Journal of County Administration*, March/April Issue.

In this issue, we are again honored to feature the very distinguished health systems researcher and author, Albany Medical College's Professor of Internal Medicine and Pediatrics,

Dr. Paul Clay Sorum. He received his MD at the University of North Carolina-Chapel Hill and also holds a PhD in history from Harvard University. He teaches evidence-based medicine to medical students and has published extensively on health related judgment and decision making in collaboration with psychologists here and in France. We asked Dr. Sorum to spearhead the Journal's next charge: "Recommend changes to it" (ACA). Dr. Sorum's wisdom is presented for you below: ■

The Flaws in the "Affordable" Care Act and How to Remedy Them

by **Dr. Paul Clay Sorum**



The Accountable Care Act (ACA) has many good features (described by Erika Martin and Courtney Burke in the previous issue of the *Journal*

of *County Administration*) (see also, the Kaiser Family Foundation's summary).^[1] It asserts the principle that everyone should have health insurance and—by expanding access to Medicaid and requiring most people who don't have public insurance to purchase it (if, as expected, the

Supreme Court upholds this provision)—expands access to some sort of health insurance. It tries to prevent the most predatory practices of at least some private insurers. It offers a few, if temporary, plums to primary care providers. It pays for a variety of worthwhile, if limited, experiments in changing how care is paid for and delivered.

But the ACA is hardly revolutionary. The lawmakers chose to fiddle with, prop up, and make additions to an already complicated and tottering structure rather than to tear it down and put its pieces back in a more rational and solid man-

ner. Accordingly, the ACA does not change—indeed it tries to reinforce—the basic structure of US health insurance, with its primary reliance for the non-elderly population on employer-provided private health insurance.

The US Census Bureau's determination of the health insurance coverage of Americans during the year 2009 (i.e., prior to the passage of the ACA) is shown in Table 1.^[2] The classification of "no insurance" meant being without insurance all year; those who were uninsured only part of the year were counted in the insured categories. Note that, since many people's

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by Peter Crichton, County Administrator, Cumberland County, Maine



This is my first letter as president of the National Association of County Administrators. I am honored and pleased to have this opportunity to serve NACA and to work with all of you to achieve our goals of encouraging our profession and advancing the value of county governments throughout the nation.

I first began attending NACA meetings ten years ago. What immediately struck me was the high caliber of people who were at these meetings. I knew that I could learn something that would be of benefit to me and the work I am doing as a county manager. In those days I was not thinking about becoming president of the association. Over time I became increasingly involved and began developing my own ideas and vision on what, how and why NACA is important.

Your NACA leadership team is unified in our belief and desire to have more people participating in our association and to build on the good things that have been done in the past through the very popular Idea Exchanges, the sharing of information and valuable insights that we all benefit from, and our other activities like this publication that encourage thinking and promote our profession as public administrators.

I sincerely appreciate the willingness of a number of people—all with very busy schedules—to devote their considerable time and talent towards the association. I am hopeful and optimistic. And for the first time, a strategic plan inspired by immediate past president Gene Smith is beginning to take shape for NACA with the assistance of Patrick Welzel—whom some of you may be hearing from as he surveys members. If you do receive a survey or phone call from Patrick, please take a moment to respond and let us know your thoughts.

As I write this, the Sonoma County Administrator Veronica Ferguson (vaferguson@sonoma-county.org), our NACA West Vice-President, has already organized a successful conference call to get the strategic plan moving forward. Assisting with the strategic plan project is: Bernice Duletski, Mountain Plains Region Vice-President, as well as Peter Austin, Midwest Region Director, and Dave Smith, County Administrator for Maricopa County, Arizona.

In addition, two standing committees are being created for the first time with a Program Committee and a Sponsorship Committee. Both are good steps for NACA and will strengthen our association. With a plan in place and active sponsors under our “Friends of NACA” program we will ensure that our conferences and meetings are supported financially by companies and consultants who are interested in public service and want to promote the work that we are doing as an association.

I am very pleased to report that Veronica Ferguson has agreed to chair our new Sponsorship Committee and that NACA President-Elect Robert Reece reece@pottcounty.org of Pottawatomie County, Kansas is chairing our Program Committee with the assistance of Southeast Vice-President Lee Worsley lworsley@catawbacountync.gov of Catawba County, North Carolina. The three of them will be playing key leadership roles over the next two years on these very important committees. I would encourage you

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

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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](http://icma.org) can be accessed at <http://icma.org/nacamembers>.

Gene Denton Remembered

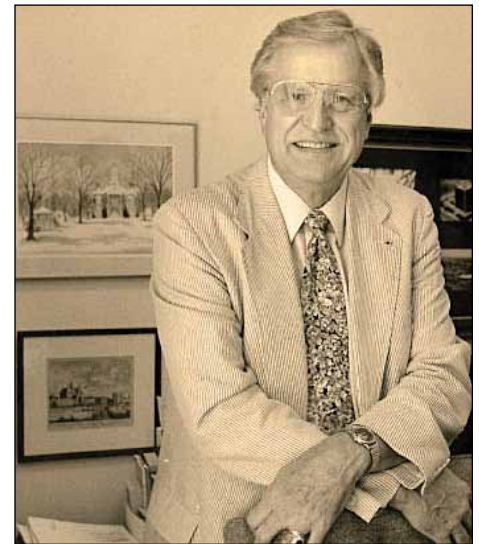
by David Krings, past President of NACA and ICMA

The local government management profession lost a friend to all and a mentor to many with the passing of former Johnson County Kansas Administrator Gene Denton on May 14, 2011. Gene's passing is especially felt by his County Administrator peers. He was an early beacon of professionalism and ethical conduct in county government in the days when those qualities were not widely associated with county government by the profession. ICMA Executive Director Bob O'Neill saw Gene as "a great manager and ... a better person. He always reminded us that we worked for local government not because it was a job but that it was a calling. We were there to make communities better and to help individuals and families have a better life." Johnson County Chief Counsel, Don Jarrett, added that Gene "genuinely liked people, and his friendliness was contagious. Gene was also a true believer in public service and making a better community for the people he served."

Gene is primarily remembered by NACA as the Administrator of Johnson County from 1985-1998. He previously served for nine years as the City Manager of Wichita, Kansas, and as

Assistant City Manager in both Fort Worth and Dallas, Texas. He graduated with a BA degree from the University of Missouri and a MPA from the University of Kansas. He was a Fulbright Scholar at the University of Cologne in Germany and a member of Phi Beta Kappa. He proudly served in the United States Army as an Artillery Officer in Korea.

Gene's early association with the National Association of County Administrators offered his peers the quiet leadership that contributed to the full integration of county administration with the profession. Bob McEvoy, Managing Editor of the Journal of County Administration, explained that "As a young county manager, I knew of Gene as the city manager of Wichita and then County Administrator of Johnson County. Gene was an ICMA icon to me, a role model for all. When he came into the room, he kind of floated like Gandhi and I was glad I was there. Gene shared his wisdom like the Father and Grandfather he was and we were inspired and encouraged to work even harder, to be like Gene." Gene also inspired those fortunate to work directly with him. Former Assistant county Administrator Lenore



Gene Denton

Toser-Aldaz added that "Gene was extremely intelligent, an excellent boss and mentor, and a true gentleman."

Gene is survived by his wife of 48 years, Eskridge "Gigi" Denton; their children Regena and Jon McFarland, Walter and Kathy Denton; and their grandchildren: Anna McFarland, Craig McFarland, Ally Denton, and Jenna Denton.

Memorial contributions may be made to the KU Endowment for Master's in Public Administration student scholarships. ■

("President's Corner" from page 2)
to get in touch with them if you are interested in helping to do some of the heavy lifting!

As time goes by, there may be other standing committees formed if there is a clear need in order to achieve our goals as an association. I look forward to the opportunities and challenges that lay ahead of us as we explore new ways to strengthen NACA and build on our relationship with both ICMA and NACo to better serve you and respond to the needs of county administrators nationwide.

Finally, I would like to thank former county manager and Rockefeller College Public Service Professor Bob McEvoy for producing yet again another outstanding issue of the Journal. Within this issue, among other articles I believe you will find the article on the shortage of prescription drugs very enlightening, as you will Dr. Sorum's amazing article "The Flaws in the "Affordable Care Act and How to Remedy Them" written specifically for the Journal and the second in a series on the ACA. There is also a well deserved tribute

to former Johnson County Kansas County Administrator and Wichita City Manager Gene Denton (above).

Take care and feel free to contact me with your thoughts and ideas on public management and how NACA can be of more value to you. I can be reached by calling 207-871-8380 or writing to crichton@cumberlandcounty.org. ■

Best regards,
Peter Crichton
President, National Association of County Administrators

Unions, Public Pensions, and Fiscal Challenges

A Guest Editorial by Elizabeth Kellar



Where's the easy button to address state and local fiscal problems?

In fact, some 580,000 state and local employees have been laid off since the

recession began and workload pressures have grown on those who remain. Some employees have gone without a pay raise for as many as three years.

Wait—there's more! State and local revenues still have not returned to 2008 levels, while governments watch their health care costs continue to rise faster than inflation. Likewise, the demand for social services remains high due to high levels of unemployment. Are public employees making appropriate sacrifices?

Here are a few facts:

In a May 2011 survey of state and local government human resource managers, the Center for State and Local Excellence found that

- 69% of governments had made changes to their retirement benefits

- 23% raised employee contributions to pension plans
- 10% increased the years to vest in a plan
- 53% of governments made changes to their health benefits and 70% shifted more costs to employees

One narrative suggests that state and local finances are stressed because unions demanded unaffordable benefit enhancements. While many pension plans enhanced their benefit levels between 1999 and 2007, was it because of unions?

The answer is more complex than you might imagine. According to the latest Center for State and Local Government Excellence study, "Unions and Public Pension Benefits," legislators approved increases in benefits just about everywhere, whether in a union or non-union environment. Competitive pressures drive compensation levels and times were good a decade ago. Governments did not want to lose their employees to a neighboring city or state because they were offering less generous benefits.

But is there a statistical correlation between pension generosity and

union membership? Alicia Munnell's team of researchers at Boston College found that union membership has a significant impact on wages, but no measureable impact on the pension benefit formula.

Legislators have been busy rolling back pension benefits for the past two years. According to the National Conference of State Legislators, 42 states have made changes to their pension plans since 2009, including increases in employee contributions and the retirement age, lower benefit level for new hires, and reductions in the cost of living adjustment.

What kind of compensation package will we need in the future to attract and retain the people we need to provide critically important services? If we make changes in retirement plans, will we do so in a way that allows career public servants to retire with a middle class lifestyle?

My bottom line: It will take as long to get out of this economic hole as it took to dig it. Patience is not an American virtue, but we can get focused on a goal when we understand its importance. ■

Hillsborough County, FL Bully Busters Program Wins Prestigious Award

24 August 2011

Bully Busters is a comprehensive public awareness campaign developed by the County's Criminal Justice Office to bring attention to the problem of bullying; educate the public; encourage reporting bullying behavior; and promote a zero-tolerance attitude toward bullying in Hillsborough County.

Hillsborough County's Bully Busters Program received the 2011 Crystal Award from the Florida Government Communicator Association (FGCA). The Bully Busters Program was selected out of more

than 40 entries, and was recognized at the group's annual ceremony.

Bully Busters is a comprehensive public awareness campaign developed by the County's Criminal Justice Office to bring attention to the problem of bullying; educate the public; encourage reporting bullying behavior; and promote a zero-tolerance attitude toward bullying in Hillsborough County.

Bully Busters, the Bully Busters Youth Council, and the Anti-Bullying Advisory Committee are all part of Hillsborough County's anti-bullying

efforts initiated by former Hillsborough County Commissioner Rose Ferlita in August 2009. Commissioner Sandra Murman is now a driving force behind the County's bullying prevention initiatives.

Last year, Bully Busters was featured in the NACo County News newsletter as a national leader in the effort to stem youth bullying.

Bully Busters has won multiple awards including the 2011 Achievement Award from the National

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Protecting our Planet through Data Collaboration



Many counties have become increasingly active in the development and deployment of GIS (Geographic Information Systems).

Representing very useful ways to describe the streets, houses and natural boundaries of a jurisdiction in a way that computers can assimilate and empower scads of applications, GIS has become a familiar and desirable management tool. Occasional small “turf wars” erupt when one department or agency does not want to provide geographic or land use information in a way that can be integrated with everyone else’s, but this has gradually become the exception rather than the rule- the benefits of collaboration are just too evident.

Sometimes county administrators ask that their own GIS system “interface” or be capable of exchanging information with neighboring counties, so that regional planning can move forward on better information. Fire Station planning and mutual aid boundaries can be improved using such coordinated or interoperable GIS systems. If the computer systems or software platforms are interoperable, this can be easily done, but sometimes technical teams are set up across counties to ensure that the data can in fact be useful to all (and accessible to the general public—a growing concern!).

But following the same logic, let’s take it up another notch- what happens if the county GIS can actually work well not only with neighboring counties, but with the state GIS systems? Well, then transportation planning strategies can be accelerated, air

quality studies for entire basins done with stronger data (and cheaper!) and election boundaries drawn in ways that provide better and more equitable presentations. Of course in order to match these systems at state level, our technical folks may have to agree to use standards that are slightly different than the county’s existing ones, or change equipment or software platforms—many times a small price to pay for achieving the benefits of coordinated, statewide action.

Can the same logic be applied to national level GIS systems? Naturally! If we all use the same data frameworks and our systems tie together with those of counties in other states creating a national quilt of information, our national leaders can make decisions on environmental matters of job creation or health policies that are far more accurate than when systems do not mesh together. Again we might have to give up some additional freedom, and perhaps negotiate with other counties and states at a national level to organize our existing systems in a different manner. Yet many times we do that (in initiatives like NSDI, or National Spatial Data Infrastructure) because we can clearly see the benefits.

You can see where this series of arguments is leading- to the ultimate, the global level! Where is the incentive for a county to organize its GIS systems with a global perspective? There is an initiative I am involved with today called Eye on Earth that is making exactly this argument- that if geographic and environmental data systems are coordinated and become more interoperable at global level, our ability to assess environmental damage and develop practical solutions for our natural resources such as water and air might significantly improve at

the local level as well. Listen to how the Eye on Earth strategy introduces this idea:

In order to contribute to the task of keeping the world environmental situation under continuous review, there is a need to foster collaboration among environmental information providers at the relevant level; guarantee information access to a wide array of users; utilize modern information and communications technologies; enhance networking across thematic and geographic domains; and, where appropriate, build capacities to provide and utilize the information to enhance decision-making at the relevant level.

Of course, this vision of interoperable GIS systems at global level may take some time to achieve. And yet there are organizations that are active in this arena at international, governmental, non-governmental and scientific level that are coming together to discuss just how such a dream can be accomplished. There are two different drivers in this process: the desire of individuals to have access to information sometimes held close to the vest by governments and industry that might give stronger signs of the condition of our environment, and the need to improve the understanding of key decision makers (including county administrators!) regarding data-based strategies that can help improve environmental conditions and lead us to a more sustainable future. Both those drivers are sure to create a rich and fertile conversation in Abu Dhabi in mid- December where the Eye on Earth Summit will be held.

And what should you, oh my reader, consider doing at the county level? My advice is to encourage your staff (both technical and functional) to collaborate with surrounding

(continued on page 15)

House Subcommittee Holds Hearing on State and Local Government Defined Benefit Plans; Savings Enhancement by Alleviating Leakage Act Introduced in Senate

by Joan McCallen, President and CEO, ICMA-RC
and John Saeli, Vice President, Marketing Services & Industry Analytics, ICMA-RC



The House Ways & Means Committee Oversight Subcommittee conducted a hearing on the transparency and funding of state and local government defined benefit plans in May 2011. This was an initial hearing following reintroduction earlier this year of the Public Employee Pension Transparency Act in the House (H.R. 567) by Representatives Devin Nunes (R-CA), Paul Ryan (R-WI), and Darrell Issa (R-CA) and introduction of a companion bill (S. 347) in the Senate by seven republican senators.

The bills, unchanged from the version introduced late last year in the House, would require state and local governments to report pension funding levels to the Department of the Treasury annually using a conservative methodology in order to preserve the tax exclusion for interest on state and local government bonds. Plan sponsors would be further required to disclose how they planned to eliminate unfunded liabilities and their success in meeting those objectives.

The hearing focused on whether enhanced disclosures about these plans' financial health and changes in the plans' actuarial assumptions are war-

ranted. Witnesses concentrated their remarks on the bill reintroduced in the House. Most strongly supported the bill, recommending several changes, including requiring plans to use a standardized smoothing period and mandating the discount rate be determined using Treasury spot rates at one point in time (instead of averaging the Treasury yield curve over a 24-month period as called for in the bill).

A speaker who did not take a position on the bill noted that government pension assets and liabilities are factors used by Moody's in its credit analyses of government-issued bonds, and said that the bill will increase both access to plan data and the complexity of the information disclosed. One witness called the bill a "solution in search of a problem," adding that it would lead to public confusion, concern the bond markets, and create a new federal bureaucracy.

In May, Senators Herb Kohl (D-WI) and Mike Enzi (R-WY) introduced the Savings Enhancement by Alleviating Leakage in 401(k) Savings Act (SEAL Act, S. 1121) to reduce pre-retirement leakage from retirement plans.

The bill extends the time for participants to make a contribution to offset outstanding loans at separation from service from 60 days to the tax filing deadline (including any extensions) of the year in which the participant separated service. Such contributions would

not count against IRA or plan contribution limits. The bill would also change hardship distribution rules to eliminate the prohibition on making contributions for six months after taking the disbursement and would prohibit plans from making loans through the use of credit cards.

While this bill targets ERISA plans, both the extended contribution opportunity for plan loan offset amounts and the credit card prohibition would apply to 457 plan loans.

In the regulatory arena, the Department of Labor conducted a Request for Information last spring regarding electronic disclosure by employee benefit plans.

Existing regulations take a restrictive approach to the use of electronic means of communication, providing "safe harbor" for recipients of such communications who either affirmatively consented to electronic delivery or have the ability to access electronic documents at work through their employer's system as an integral part of their duties.

In recent years the DOL has crafted a number of rule-specific exceptions that allow for paperless plan administration outside of the safe harbor. The RFI signals that the DOL will review and possibly modify its existing regulations regarding the use of electronic media to furnish required notices, statements and other information under ERISA. ■

("Bully Busters" from page 4)
Association of Counties (NACo), Superior Award from the National Association of County Information Officers; the Silver Circle Award from

the City-County Communications and Marketing Association (3CMA); and an Award of Merit from the Tampa Bay chapter of the International Association of Business

Communicators (IABC) for its comprehensive public awareness campaign.

For more information on the Bully Busters Program contact the Criminal Justice Office at 813-276-2126. ■

ICMA Credentialing Program: Connection to County Administration

by Amanda Relyea, ICMA



Lifelong Learning with Intent

Learning with Intent

In the last issue of this publication, I introduced the idea of “learning with intent,” a term coined by former ICMA credentialing advisory board member Mark Achen. Learning with intent is the main focus of the Credentialing Program. The idea is to try to find at least one small lesson in each training session or management book—even if you are already familiar with the concepts presented.

Like Credentialed Managers do in their annual reports, you can capitalize and reflect on small lessons by recording brief, yet specific, notes after your training session. For example, instead of recording that you learned a new strategy for budget review, go ahead and write a sentence summarizing what that new strategy is.

In addition to reinforcing what you learned and taking your professional development to a higher level, this type of reflection helps you retain what you learned and reminds you

that there is always something new to learn, no matter how experienced you are. Even the smallest of lessons is important.

Such reflection helps you stay current and remain curious so that your professional development does not stagnate. Dee Tatum, retired chief executive officer of Merced County, California, says, “I wish more of my former colleagues would try this; it really opens your eyes to new ideas and concepts.”

Lifelong Learning

In 2007, in response to member suggestion Learning with intent ties in quite well with the idea of lifelong learning. Harry Truman was fond of the quote, “It’s what you learn after you know it all that counts.”

We all know it’s true that learning never ends, but sometimes we don’t act like it. We go into conferences or training sessions assuming that we will not learn anything new or that they will be a huge waste of time. This is unfortunate because it shuts down our ability to receive the small lessons.

It is much easier to receive the small lessons when we make a concerted effort to assume we will learn at least one new concept or idea. And that is never a waste of time. Even

if the presenter does not touch on new material, it is possible to learn something by thinking about how you can use old ideas in a new way, for a particular problem or situation at work. You can also take responsibility for your learning by asking a question during or after the presentation or by talking to other attendees after the session about how they plan to apply what they have learned.

Talking to other attendees about the ideas and concepts presented will also allow you to contribute to their learning and to become a better mentor, which is a kind of learning in and of itself. This can help hone your mentoring skills for use in your own organization.

Regardless of where you are in your career, remember to learn with intent and never stop learning. It will keep you current, and may even keep you young!

Stay tuned for an in-depth article by Dr. Frank Benest on these topics in a future issue of PM Magazine. Dr. Benest is an ICMA Senior Advisor and former city manager of Palo Alto, California. He will also lead a session on “Learning as a Strategy for Adaptive Change and Self-Renewal” at the 2011 ICMA Annual Conference in Milwaukee. ■

County Officials and Programs Recognized by ICMA

ICMA’s Annual Awards program honors creative contributions to professional local government management and increases public awareness of the value of professional management to the quality of life in our communities. An independent Awards Evaluation Panel of 17 U.S. and international ICMA members selects each year’s award recipients

This year, the following county officials and programs were selected for awards and were honored at the annual conference in Milwaukee:

- **Anthony H. Griffin**, county executive, Fairfax County, VA (Award for Career Excellence in Honor of Mark E. Keane)
- Community Health and Safety Program Excellence Award (popu-

lations 50,000 and greater): Bob Janes Triage Center/Low Demand Shelter—**Lee County, FL**, and county manager **Karen B. Hawes**.

- Strategic Leadership and Governance (populations 50,000 and greater): Local Stimulus Program—**St. Lucie County, FL**, and county administrator **Faye W. Outlaw**. ■

(“Affordable Care Act” from page 1) coverage changed during the year, the percentages of private insurance, government insurance, and no insurance add up to greater than 100%.

The ACA maintains this reliance on employers and on private insurance: it requires employers with more than 50 employees to offer health insurance, either through private companies or through the new state-run insurance exchanges, and the state-run exchanges will also offer to individuals without employer-provided or government insurance the choice among a set of private plans. Table 2 shows the estimates by the Urban Institute and Robert Wood Johnson Fund of the changes for the non-elderly population when the law’s provisions about coverage are fully implemented in 2014.^[3]

Congress’s decision, for political and ideological reasons, to maintain the fundamental structure of the US health care system is the ACA’s major, perhaps fatal, flaw. It contributes to a multitude of more specific flaws.

Flaws in the ACA

First, the system set up by the ACA is much too complex. Patients (or their employers) and providers will still have to deal with, waste time over, and get frustrated by the dozens of private and public insurers, most with multiple different and ever-changing plans and sets of rules. Medicaid will still be means-tested, i.e. potential enrollees will still have to prove they are poor enough. The new law will add to this complexity by creating the health exchanges, also means-tested, which will be allowed to be different in each state (although all will have to fulfill the law’s requirements). It has been calculated that 50% of adults with family incomes below 200% of the federal poverty level will bounce between eligibility for Medicaid or for the exchanges as their incomes fluctuate during the year.^[4] The requirement to purchase insurance requires mechanisms,

Table 1: Health Insurance Coverage of Americans during 2009

Coverage	Percent of population
Private insurance (at least part of year)	63.9%
Employment-based	55.8%
Direct-purchase (individual market)	8.9%
Government insurance (at least part of year)	30.6%
Medicare (the elderly and the disabled)	14.3%
Medicaid (and CHIP)	15.7%
Military (armed forces, dependents, VA)	4.1%
No insurance (for the entire year)	16.7%
Total	111.2%:

Table 2: Health Insurance Coverage Distribution of the Nonelderly in Baseline and Reform (Estimated)

Coverage	Without Reform	With Reform
Insured	81.3%	91.8%
Employer (non-exchange)	56.6%	48.7%
Employer (exchanges)	0.0%	7.7%
Nongroup (non-exchange)	5.5%	1.2%
Nongroup (exchanges)	0.0%	8.7%
Medicaid/CHIP	16.0%	22.3%
Other (including Medicare)	3.2%	3.2%
Uninsured	18.6%	8.3%
Total	100%	100%

mostly through income tax returns, to find, penalize, or give exemptions to people who fail to purchase health insurance. Furthermore, to compensate for some of its deficiencies, the law had to add a variety of fixes, such as a temporary pool for who are uninsurable because of pre-existing conditions, a set of rules to reduce predatory practices by private insurance companies, and a federal watchdog to make sure that states regulate insurance premium increases adequately.^[5] Because of this complexity, the law is hard to understand and hard to defend to the public, and, in spite of provisions to get private insurance companies to agree on common rules, it will increase rather than decrease the administrative costs of health care.

Second, change is coming much too slowly. It will take some eight years for the system to be rolled out completely (although most is to be

done by the end of 2014).^[6] In contrast, Medicare was instituted in less than a year. The reasons for the delay are the complexity of the changes—in particular, the need for each state to set up a health exchange—and the political calculation, I assume, of trying to reduce opposition to change by doing it very slowly (in particular, to spread out the costs of implementation).^[7] This calculation was, however, short-sighted because of largely foreseeable political and economic events. Midterm elections commonly turn against the party in power, especially when the gain of Democratic seats in the House in 2008 came in usually Republican-voting districts. With the loss of the Democratic majority in the House, the Republican opponents of the reform have the opportunity to delay and derail—by withholding funding if not by repealing—as many of the provisions as

(continued on page 9)

(“Affordable Care Act” from page 8) possible. If the Republicans have their way, especially if they win the White House too, we may be left with a partial ACA, which may be worse than outright repeal of the whole act. Moreover, with the financial collapse that President Obama inherited and the resulting economic recession—and the ensuing debt crises on the state and federal levels—the state and federal monies, as well as (to a lesser extent) the business profits, required to expand health care are no longer there. The result is continuing pressure to reduce benefits and increase patient financial responsibilities in both tax-supported and employer-supported plans—we can see that happening already^[8]—and rising opposition to major expansion of health insurance, at least of government-financed insurance.^[9]

Third, the ACA will not reduce costs. On the one hand, most of the excess “administrative” costs of the private insurance company—for insurers and for providers (the most recent estimate was just published online in *Health Affairs*^[10]—such as for marketing, submitting and processing claims, obtaining prior approvals for services, and paying shareholders (for for-profit insurers) will persist, even if the law tries to limit them slightly by promoting common insurance forms and requiring “medical loss ratios” (the percentage of premiums spent on actual health care) to be at least 85% for group plans and 80% for individuals. In addition, as mentioned above, the Medicaid program and the state insurance exchanges will still require costly and burdensome means testing, the insurance exchanges will create an additional administrative layer, and the law requiring people to buy insurance will have to be enforced. The Urban Institute estimates that, if the ACA had been fully implemented in 2010, total spending on acute health care for the non-elderly by the government, employers, and individuals would have increased by 4.5%.^[3]

The Netherlands, which privatized its health care system in 2006 (creating a system similar to that envisioned by the ACA), has found that this “managed competition” is unpopular and has increased costs.^[11] On the other hand, the much-ballyhooed experiments in new ways to deliver and pay for medical care—pay-for-performance, medical homes, accountable care organizations, and the like—are still experiments, promising in small projects but untested as ways to reduce costs on a large scale.^[12]

The Commonwealth Fund had, in its optimistic assessment of a panoply of similar reform proposals, concluded that, together, they could bend the cost curve, but not prevent costs from rising faster than GDP.^[13] Not surprisingly, therefore, the percentage of GDP devoted to health care is expected to rise from 17.6% in 2009 to 18.1% in 2014 (when the state health exchanges are implemented and residents are required to have health insurance) to 19.8% in 2020.^[14] The money to pay for care must come from somewhere. If governments and employers are unwilling to pay more, patients will either have to pay more or do without the medical services they expect. The Affordable Care Act is, therefore, affordable neither for the country nor for the patients.

Fourth, the ACA will not only leave millions still without insurance—the Urban Institute estimates 8.3% of non-elderly adults^[3]—but it is likely to increase the number of “under-insured.” In 2007, the Commonwealth Fund estimated that 14% of nonelderly adults were under-insured—defined as spending 10% or more of income (or 5% if their income was less than 200% of the poverty level) on out-of-pocket medical expenses or having deductibles of 5% or more of income^[15] (although these estimates may be low).^[16] The ACA aims to decrease underinsurance by insisting on a basic set of benefits (yet to be defined) for the state-run

health exchanges (in the footsteps of Massachusetts that lowered its under-insurance from 7.3% of adults to 5.6% a year after the enactment of its health reform).^[17] Yet, even as envisioned now, these health exchanges will impose a financial burden: if people choose the most affordable bronze plan, its “actuarial value” is only 60%, i.e. the individual will have to pay for 40% of his or her expected health costs (up to, as currently defined, \$5,950 for individuals and \$11,900 for families), a large burden for a poor person who gets sick or injured. Moreover, faced with rising costs, increasing enrollments in Medicaid and in state insurance exchanges, and—at least until the economy recovers—stagnating business profits and tax revenues, employers and state and federal governments will have no choice but to offer plans with increased premiums and/or reduced benefits^[8, 18] (as well as, if possible, with reduced payments to providers). In 2010, the average annual premium for employer-sponsored health insurance was up to \$5,049 for single coverage and \$13,770 for family coverage (of which the worker contributed \$899 and \$3997, respectively)^[8] and is surely going higher. Faced with the need to keep premiums as affordable as possible in the exchanges, it seems likely that the state directors and ACA federal administrators will be under great pressure to lessen the benefit package required of all insurers participating in the exchanges.

Fifth, access to care may increase on paper, but it is likely, especially for poor people, to decrease in practice. We need to train more physicians to prevent a growing shortage—the Association of American Medical Colleges projects that by 2020 we will have shortage of 45,000 primary care physicians and 46,000 surgeons and medical specialists^[19]—and we need current physicians, especially primary care physicians, to see the newly insured patients. For this, we need to

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A Public Health Emergency?

An editorial by Bob McEvoy, Managing Editor

Hospital drug shortages are causing harm to patients' health and increased drug costs, as reported by the American Hospital Association several weeks ago.

It sounds like a public health emergency and another manifestation of our out of control drug systems whose confiscatory pricing (compare Canada

pricing with the U.S.) is unjustly driving up health costs for all governments and those who can least afford it, our senior citizens. ■

American Hospital Association Survey on Drug Shortages

12 July 2011

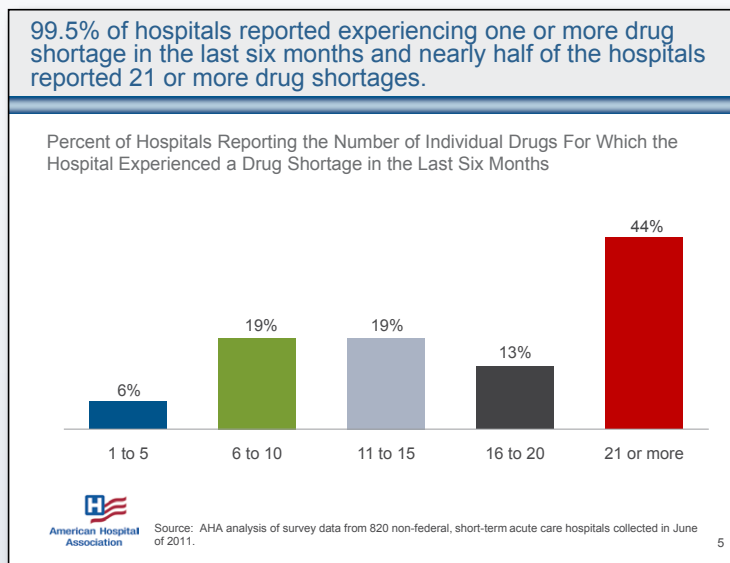
Executive Summary

- 99.5% of hospitals reported experiencing one or more drug shortage in the last six months and nearly half of the hospitals reported 21 or more drug shortages.
 - Hospitals report experiencing drug shortages across all treatment categories.
- 82% of hospitals report they have delayed patient treatment as a result of a drug shortage and more than half were not always able to provide the patient with the recommended treatment.
 - Three out of four hospitals report rationing or implementing restrictions for drugs that are in short supply.

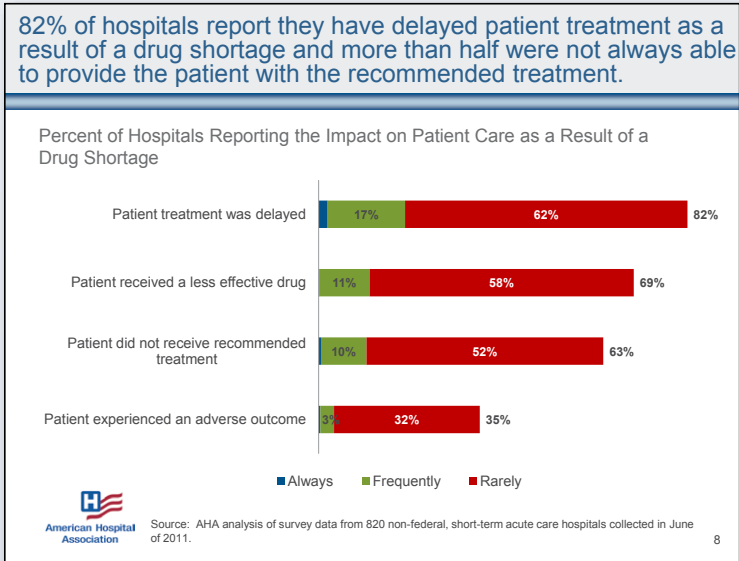
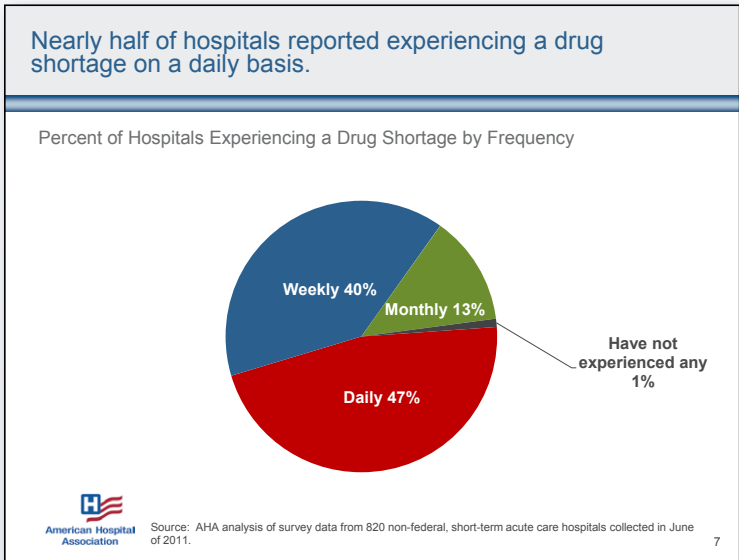
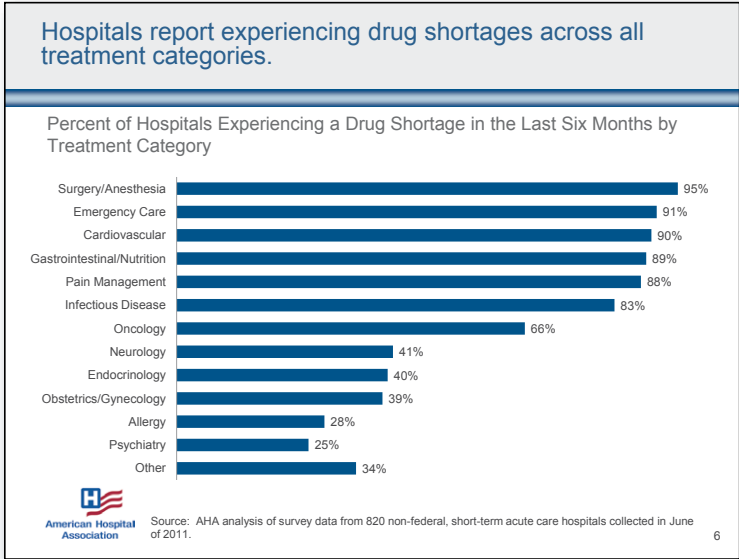
- The vast majority of all types of hospitals reported increased drug costs as a result of drug shortages.
 - Most hospitals are purchasing more expensive alternative drugs from other sources.
- Hospitals report that they rarely or never receive advance notice of drug shortages and are not informed of the cause or the expected duration of the shortage.
- Hospitals are taking many actions to reduce the impact of drug shortages on patients including increasing inventory levels and devoting resources to train clinical staff to address shortages.

Survey Methodology

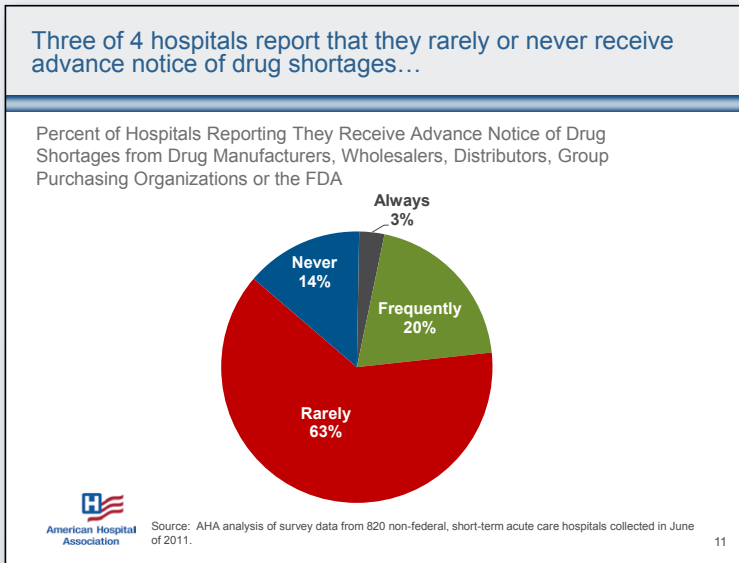
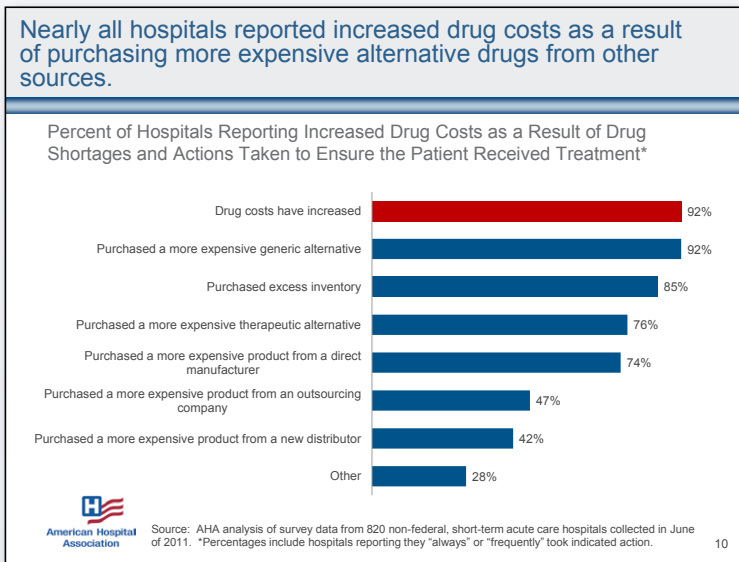
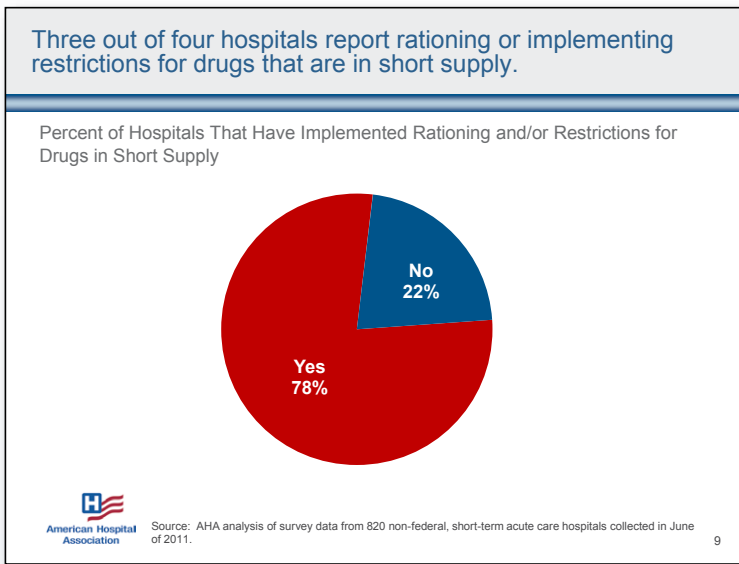
- AHA Survey, *Drug Shortages*
 - Survey was sent to all community hospital CEOs on June 1, 2011 via fax and e-mail.
 - Data were collected through June 22, 2011.
 - Responses from 820 hospitals are included in analysis.
 - Respondents were broadly representative of the universe of community hospitals.
 - Survey questions were designed to assess the impact of drug shortages on patients and hospitals.
 - Nationally, there are about 2,800 urban hospitals, 1,300 critical access hospitals and 1,000 other rural hospitals. ■



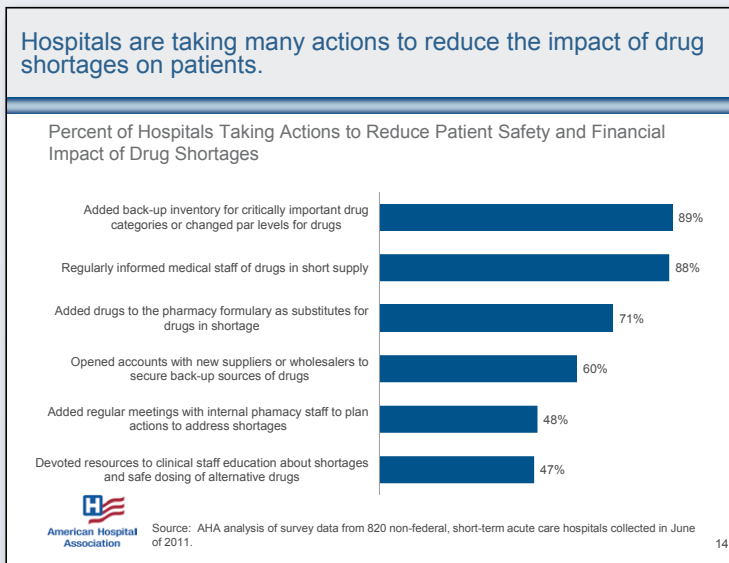
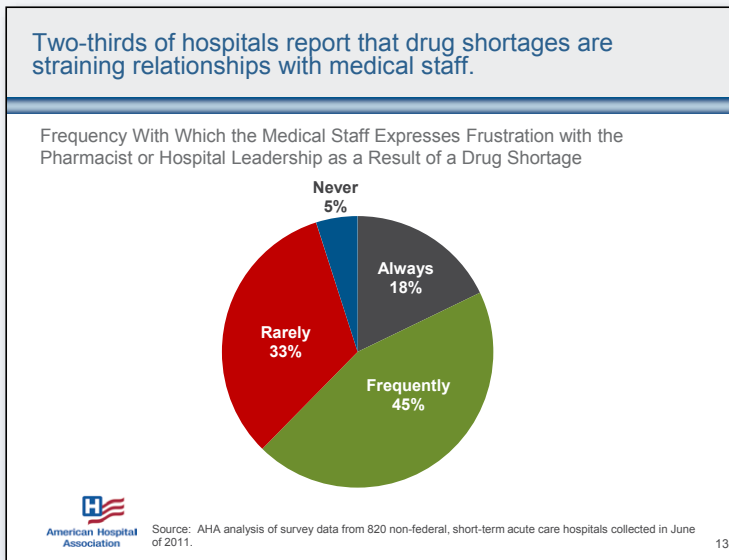
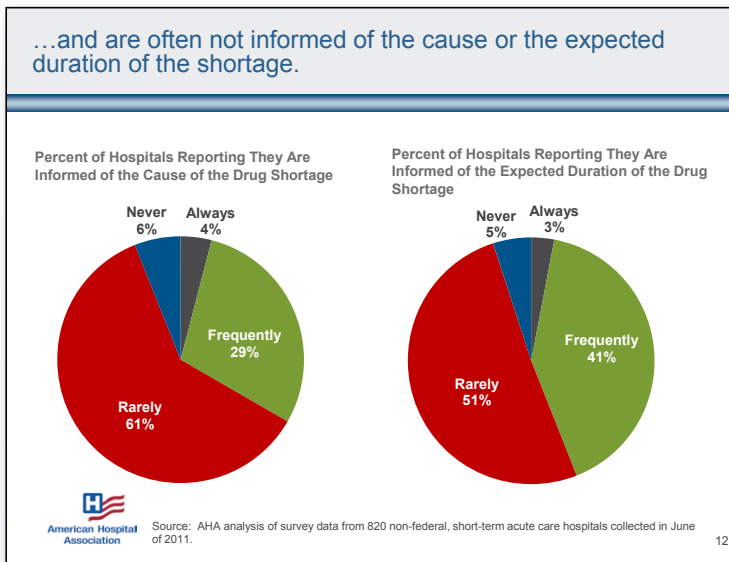
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(“Affordable Care Act” from page 9) offer them sufficient reimbursement. But this is unlikely to occur—indeed, quite the opposite. For Medicaid, payments to physicians are, in states like New York, so low already that private physicians see Medicaid patients largely out of a moral commitment to care for all patients. For Medicare, payments are already less than those from private payers so that some physicians do not accept Medicare and, if Medicare rates drop further (as is threatened yearly by the provisions of the Balanced Budget Act), many more will drop it. Yet state and federal governments are talking about cutting reimbursements to providers—a likely recommendation of the Congressional committee that is to propose further cuts in federal spending to reduce the federal debt—and the ACA sets up a committee that will suggest money-saving cuts if the Medicare budget increases too fast (as it has done repeatedly in recent years).

How to Remedy the ACA

What can we do to remedy the flaws in the ACA? I see three possibilities. First, the Obama administration can try, through administrative acts and legislation, to make small improvements in the new system and, meanwhile, to wait for better economic and political times. This is the most likely course of action, but it does little to fix the ACA’s flaws. (even if the Republicans allow any improvements). Second, the politicians could scrap the new law and institute a better system, which, as I have argued before in these pages, would be a single-payer system, equivalent to an expanded and improved Medicare for All. The radical Republicans also want, of course, to repeal the law and reduce government’s role to providing vouchers for poor people to use to purchase private health insurance (as in Ryan’s ill-received proposal for privatizing Medicare). Neither the single-payer supporters nor the radical Republicans will be able to repeal the

law, both because many of its provisions are already in place and because there is no political majority for either extreme. Third, we can facilitate the changes currently taking place in Vermont and help them spread to other states. This seems currently to be the most promising approach.

Vermont’s recently passed legislation^[20] creates a public plan, Green Mountain Care, “to contain costs and to provide, as a public good, comprehensive, affordable, high-quality, publicly financed health care coverage for all Vermont residents in a seamless manner regardless of income, assets, health status, or availability of other health coverage.” Thus all Vermont residents will be eligible for Green Mountain Care “regardless of whether an employer offers health insurance for which they are eligible.” Green Mountain Care will be managed by an independent board, appointed by the governor and approved by Vermont’s Senate, advised by a committee of stakeholders; the board will contract with private-sector organizations, such as Blue Cross and Blue Shield of Vermont, to administer the system. Green Mountain Care will run the health exchange required by the ACA (which will be set up to be its “foundation”); insure state and municipal employees (including teachers); absorb Medicaid, SCHIP, and Medicare as federal waivers become available; and, it is expected, be more cost-effective for private employers to join than the competing private plans. In order to avoid under-insurance, the legislation stipulates that Green Mountain Care will provide all “medically necessary health services”—including primary care, preventive care, chronic care, acute episodic care, and hospital services—and that it will pay for “at least 87 percent of the full actuarial value of the covered health services.”

The architects of the Vermont plan, led by Harvard economist William C Hsiao, needed to convince Vermont interest groups and legislators that the expansion of coverage

would not result in increased overall costs. They proposed funding through a payroll tax of 14.2% on all wages, capped at the Social Security level, with exemptions for families with incomes below 200% of poverty level. Employers would pay 10.6% (versus an estimated 12% under the ACA) and employees 3.6%. They concluded that the plan would save money each year of its implementation and after 10 years would be reducing overall health care expenses by 25.3% compared to what spending would be without the reform (7.3% from reduced administrative expenses, 5% from reduced fraud and abuse, 10% from payment reform and integration of the delivery system, 2% from malpractice reform, and 1% from changed governance and claims administration). They also argued that at this point the plan would be cutting employer and household health care spending by \$200 million (though employers previously not providing insurance and families earning more than 400% of the poverty level would be paying more than now), would create 3,800 jobs, and would boost the state’s economic output by \$100 million.^[21]

Vermont’s goal in setting up Green Mountain Care was to “provide health benefits through a single payment system.” But the state could not do this immediately, and it is not certain that it will be able to reach its goal. The state must, in accordance with federal statutes, allow individuals or businesses to purchase private health insurance if they want, inside or outside of the exchange (as long as the private plans meet the requirements of the ACA); the assumption is that individuals and businesses will find it in their interests to switch to Green Mountain Care. The state must seek federal waivers to bring Medicare, Medicaid, and SCHIP into Green Mountain Care; these will not be available until 2017 unless Congress passes a law to allow states

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(“Affordable Care Act” from page 14) more flexibility earlier than 2017, and such passage will depend on federal politics and, in particular, on the results of the 2012 and 2014 elections. The Vermont legislature still has to decide on a financing mechanism. But, in spite of these uncertainties, the Vermont law is a momentous first step that shows other states how they too can create the embryo of a single payer system from within the ACA.^[21]

County administrators should be excited by the ability of a Green Mountain Care and, moreover, of a complete single-payer system to reduce county taxes, to take over the health insurance of county employees and retirees, to provide health care to all county residents, and even to increase employment. It is time to take action—to support similar health reforms in your states and to lobby Congress for the waivers needed to make these state reforms successful.

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(“Technology Corner” from page 5) jurisdictions, and to adopt strategies and architectures that encourage sharing and interoperability of geographic and environmental information. If you do, your county will certainly be on a better path to sustainability!

The power of technology and the newly-found wisdom of “crowd sourcing”, where many unconnected people who each feel strongly about helping attain a common end can come together and provide what they know to a communal offering is unmistakable. Perhaps some of you will not be comfortable with the lack of structure, reporting requirements and clear accountability. And yet this is where the future lies- to create affordable solutions to our problems by using technology to tap the wisdom and vision of those we serve! Government “by the people” has truly arrived! ■