# Citizens Health Care Working Group

## Hattiesburg, Mississippi Listening Session

## March 30, 2006

## Final Report

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## Introduction

Two listening sessions were held in Hattiesburg, MS, on March 30, 2006. The groups were very similar to each other in terms of gender, age, race, and education. For the twenty-six participants that attended the sessions, 27 percent were male and 73 percent were female. Four percent were under 25 years of age, 12 percent were between 25 and 44, 77 percent were between 45 and 64, and 8 percent were over 65. The group was predominantly white (76 percent) with the remaining 24 percent being African American. No participant indicated a Hispanic ethnicity.

A larger percentage of the participants held a bachelor's degree or higher (81%) than reflected in the county's demographics (22.8%). Four percent of the participants had some high school experience, 4% had completed a high school degree or GED program, 4% had some college experience, 8% held an Associate's Degree. Of those with a Bachelor's degree or higher, 46% held graduate or professional degrees. The majority of the participants had employer-based insurance as their primary source of health care coverage (65 percent) while 27 percent relied on self-purchased insurance and 4 percent relied on Medicare as their primary insurance source. Four percent of the participants indicated that they had no health care coverage.

Hattiesburg, located just 60 miles from the Gulf Coast, was one of the heavily damaged regions from Hurricane Katrina, and still serves as a "home base" for many recovery efforts continuing to the community's south. Hotels stay booked with both displaced families and those involved in relief efforts. Hattiesburg is the county seat of Forrest County. Data from the U.S. Census Bureau indicates that the population of the county is evenly divided between males and females, but that white persons comprise 64.3 percent of the population. Black or African American persons comprise 33.6 percent of the population, with the remainder being made up of other ethnic groups. Seventy-nine percent of the population age 25 years and over are high school graduates while 23 percent has a Bachelor's degree or higher. As home to one of the state's largest universities, The University of Southern Mississippi, it is not surprising that these county education levels exceed those for the state. In spite of higher education levels, the percentage of people living below the poverty line in the county (22.5%) exceeds that for the state (19.9%).

## State of the U.S. Health Care System

In a discussion centering on the state of the U.S. health care system, 35% of the participants believed the health care system to be in a state of crisis while the remainder (65%) believed the system had major problems. The group was fairly evenly divided as to whether they believed the most important reason to have health insurance was to pay for everyday medical expenses (46%) or to guard against high medical costs (54%).

## Summary of Key Points Raised by Discussion Groups and Related Polling Data

### Values:

The afternoon and evening groups identified the same top three values. First was affordability, followed by quality of care and accessibility and availability of local doctors and providers willing to treat all patients, all the time. The relationship between accessibility and availability

can be seen in such statements as, "It (health care) may be accessible but not available if it is 150 miles away." Another person commented, "In Jackson, you may have major facilities, but not one family doctor in a rural area." Other common values held by both groups was a need to emphasize prevention as a part of the whole health care system and to have true equality in who gets health care (regardless of citizenship status, health insurance, or medical home). The recent hurricane tragedy brought concerns for equality to light further as participants reported that some doctors were reluctant to treat dialysis patients that came to the region from New Orleans. Choice was a major theme in both groups. Choice of physician, facility, health care plan, treatment plans (understanding available options), and the right to die were all expressed concerns.

Approximately two-thirds of the participants (69%) agreed that it should be public policy that all Americans have affordable health care coverage. One person commented that it was "scary the number of people out there with nothing." The evening group expressed particular concern for the "large group in thee middle who work, but don't have access to health insurance benefits. They are at the world's mercy and should have something." Again, on the question of whether the current model of coverage based on who you are was preferred or defining a level of services for everyone was preferred, 65% of the participants favored a defined level of services for all. One person commented that neither option was good. The group did, however, favor the concept of accessible and affordable health care for all. Some discomfort with having the government "dictate" services to be covered was expressed.

**Benefits:**

Between the two groups, a fairly long list of potential additions to the Working Group's hypothetical basic benefits package was suggested. The two common elements suggested by both groups and receiving a high level of support were hospice services and home health care. The afternoon session's top ranking suggestions were chronic illness care (9.37 on a 10-point scale), durable medical equipment (8.67), and hospice care (8.52). The evening's top selections were home health care (8.6), long-term care and rehabilitation (7.8), and transportation including ambulance and non-emergency (7.6). Other suggestions were vision, full dental coverage, organ transplantation, experimental treatments, allergy treatment, sleep disorders, corrective developmental surgery, family nurse practitioner/physician assistants, pathology, radiology, and hearing. Both groups listed chiropractic care as a potentially removable benefit. However, neither group's ratings of that care indicated support for the removal. The first group favored removing home visits from the package, but the latter group did not even consider that an option.

When asked who should decide what is in a basic package, the participants indicated that they thought consumers should have the strongest voice (average rating 8.6 on a 10 point scale), closely followed by medical professionals (7.5). The remaining three potential stakeholders were rated much lowerindicating the group thought a much lower level of input was appropriate: employers (6.7), insurance companies (5.5), and government (5.2).

**Getting Health Care**

In the wake of one of our nation's worst natural disasters, it is not surprising that these participants from the state's southern region, had a vast number of Hurricane Katrina-related stories in discussing difficulties related to getting health care. For the state's lower six counties,

hardest hit by the storm, doctors left and patient records were destroyed or disappeared. Even as some doctors attempt to return, their patient base is scattered and possibly gone for good, jeopardizing the stability of the doctor's practice. Other storm concerns involved the lack of generators for respirators and difficulty accessing medication. One person related a personal story of inheriting a 3-year old child after the storm who is covered by Medicaid. "I don't know what to do or how to access the system." One participant left the afternoon session highly distressed contending that, in light of our inability to quickly respond to Katrina, we had no business focusing on health care issues that would take 5-10 years to resolve (in the person's estimation). This individual felt we needed to focus our attention on the possibility of other natural disasters, a potential pandemic, or a bio-terrorist event; essentially we needed to be able to insure rapid response to potential health disasters.

Not all difficulties began with the storm. Many already existed and continue to be of concern. Delays in the ability to schedule an appointment combined with physicians unwilling to accept Medicaid and/or Medicare patients were cited frustrations. Problems related to communicating with the system led one participant to advocate the establishment of patient navigators. An example offered was fluctuating prescription costs and the perception that Medicare Part D was not a stable playing field. Disallowed claims for pre-existing conditions and out-of-network providers, as well as limited mental health coverage were additional stated concerns. A concern that as you get older it can be more difficult to get coverage was expressed. The afternoon group focused on the plight of small businesses and independent contractors in their inability to secure reasonable group rates; it was mentioned that 28% of the members of the National Realtors Association have no health care coverage.

**Financing:**
Two thirds of the participants (67%) felt that everyone who can afford to do so should be required to enroll in basic health care coverage. "If we are going to provide affordable, accessible, quality care, then people should be required to enroll," stated one participant. Some compared it to "requiring" car insurance and social security and Medicare buy-in. Still, some felt that determining who can "afford" and using the word "require" sparked concern. Most (63%) thought that should such a system be developed to require all to participate, that some people should be responsible for paying more than others. The greatest support came for using family size as a criterion (63%). The concept of using health behaviors as a criterion also received support (58%). The least support came for using income as a criterion. However, one suggestion was to allow those with higher incomes to be able to choose higher deductibles.

A majority (83%) felt that tax rules should continue to favor employers who offer employees health insurance. There was an expressed opinion that self-employed individuals should, likewise, receive tax incentives for paying for their personal health care coverage. The group also strongly favored continuation of government support for current programs that cover some people who can't afford it (92%). When asked how much more each would be willing to pay in a year to support efforts to provide access to coverage for all Americans, the group was almost exactly evenly divided among the options: $0, $1-$100, $100 – 299, $300-$999, $1,000 or more, or "don't know." Thus, no clear preference was established.

**Trade-Off Priorities & Options**
While all of the presented spending priorities received support, "investing in public health programs to prevent disease, promote healthy lifestyles, and protect the public in the event of epidemics and disasters" was the highest rated option (8.7 on a 10-point scale), followed closely by "guaranteeing that all Americans get health care when they need it, through public "safety net" programs (if they cannot afford it) (Rating: 8.4.) The third rated option was "Funding biomedical and technological researchthat can lead to advancements in treatment and prevention of disease (8.0).

The top three rated proposals were to (a) offer uninsured Americans income tax deductions, credits, or other financial assistance to help them purchase private health insurance on their own (9.1), (b) expand current tax incentives available to employers and their employees to encourage employers to offer insurance to more workers and families (8.1), and (c) expand neighborhood health clinics (7.5). While much was said earlier in the sessions about the lack of health care providers and the importance of providing insurance to all Americans, participants expressed skepticism as these options were presented. Regarding getting an adequate supply of physicians into rural areas, one participant commented, "How many doctors can you get here? How can you defray costs for getting them here?"

**Closing Comments and Other Ideas:**
A number of other thoughts were shared throughout the sessions that are worth noting:

- System should incorporate incentives for proper use of health care coverage – use it prudently, when needed, "not when you get a stubbed toe."
- Everyone needs to participate at some level; render service if you cannot provide a monetary payment. "If you invest in what you do you use it more judiciously." People "have to get past the attitude of someone owes me something."
- Cafeteria plans are good ways to monitor how much health care you access – gets you to make better use of the system. Health care spending accounts should also be considered.
- Physical education needs to be put back in the schools and the nutritional environment in schools and the workplace needs to be healthier.
- Prevention/wellness/health education should be emphasized in the workplace
- More programs are needed to get qualified students into Medical School.
- Caps on hospital medical equipment purchases are needed.
- Providers' fees should be more equitable.
- Tort reform is needed.
- Governmental agencies should streamline services. Example - Six agencies put out nutritional education information.
- Consumers need to demonstrate personal accountability, particularly in taking preventive care steps.
- Abuse within the system needs to be prevented
- Small business associations should be allowed to offer group health insurance
- Limits should be placed on pharmaceutical marketing
- "If you want the very best, you should be able to get it. If you want plain vanilla – simple- that's your choice." Individuals should be able to establish their own priorities and pay for what they want.