

Citizens' Health Care Working Group

HEALTH CARE

THAT WORKS FOR ALL

AMERICANS

Interim Recommendations

of the

Citizens' Health Care Working Group

June 1, 2006

(updated July 18, 2006)

Preamble

The health care system that captures vast amounts of America's resources, employs many of its most talented citizens and promises to relieve the burdens of dread disease badly needs to be fixed. Health care costs strain individual, household, employer and public budgets. Often our citizens forego needed treatment because they are priced out of the market. At the same time, public budgets are buckling under the burden of public health care programs.

We spend nearly \$2 trillion on health care each year, yet geography, race, ethnicity, language and money impede Americans from getting appropriate care when they need it. People in Utah recently spoke for tens of millions of Americans when they noted

“[the] inability to navigate the health care system without luck, a relationship, money and perseverance”.

Far too often sick Americans lack one or more of these factors needed to get health care.

Given the breathtaking advances in medical science—American health care sadly under achieves. The health care system gets Americans the right care, and only the right care, about 50% of the time. As many as 98,000 Americans die because of medical errors each year. Polls of American households reveal that about one third of Americans report that they or a family member have experienced a medical error at some point in their life. While no system can ever eliminate all error, we can do better. While most Americans are generally satisfied with their health care, too many Americans are being let down by their health care institutions. Many people are afraid of the health care system, they are bewildered by its complexity and are suspicious about who it aims to serve.

Addressing the problems of U.S. health care involves considering the perspectives, interests and circumstances of providers, payers, health plans and consumers. We have spent 15 months reading, listening and learning about U.S. health care from a wide range of perspectives. We have held 6 hearings with experts, stakeholders, scholars, public officials and advocates. We have conducted 31 community meetings, as well as special topic meetings and sponsored events, in more than 50 communities across the nation. Members attended meetings in 30 states and the District of Columbia. We have reviewed all the major public opinion polls focused on health care conducted between 2002 and 2006. Citizen responses to the Working Group's internet polls (over 10,000 as of May 15) were studied. Finally, we have read close to 5,000 individuals' commentaries on health care matters submitted by residents of this country.

A picture has been sketched for us of a health care system that is unintelligible to most people. They see a rigid system with a set of ingrained operating procedures that long ago became disconnected from the mission of providing people with humane, respectful and technically excellent health care.

The legislation that created the Citizens Health Care Working Group emphasizes the need to bring the views of everyday Americans to the job of creating a better health care system. In previous health care reform efforts, too little has been heard from the public about several key issues, including:

- The overarching values and aspirations that are at the heart of the mission of health care, and
- How they see the key elements of solutions to health care financing and delivery.

It is in the spirit of giving a greater voice to everyday people that we deliver these recommendations on how to make health care work for all Americans.

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The Charge to the Citizens' Health Care Working Group

The Citizens' Health Care Working Group was created by the Medicare Prescription Drug, Improvement and Modernization Act of 2003, Sec. 1014 to provide for the American public to "engage in an informed national public debate to make choices about the services they want covered, what health care coverage they want, and how they are willing to pay for coverage." Appointed by the Comptroller General of the United States, the Working Group consists of 14 individuals from diverse backgrounds, representing consumers, the uninsured, those with disabilities, individuals with expertise in financing benefits, business and labor perspectives, and health care providers. The Secretary of Health and Human Services also serves as a member of the Working Group. Because the Working Group's final recommendations will be submitted to the Department of Health and Human Services, the Secretary of Health and Human Services has neither participated in the development of these recommendations nor has he endorsed them. He will carefully consider them and take appropriate action.

The legislation charged the working group with holding hearings on various health care issues before issuing *The Health Report to the American People*. This report, completed in October 2005, provides an overview of health care in the United States for the general public, enabling them to be informed participants in the national discussion organized by the Working Group.

The law specifies that this national discussion take place through a series of Community Meetings, which at a minimum, address the following four questions:

- ***What health care benefits and services should be provided?***
- ***How does the American public want health care delivered?***
- ***How should health care coverage be financed?***
- ***What trade-offs are the American public willing to make in either benefits or financing to ensure access to affordable, high quality health care coverage and services?***

As noted in the Preamble of this document, we held 6 hearings with experts, stakeholders, scholars, public officials and advocates. We conducted 31 community meetings, as well as special topic meetings and sponsored events, in more than 50 communities across the nation. Members attended meetings in 30 states and the District of Columbia. We reviewed all the major public opinion polls focused on health care conducted between 2002 and 2006. Citizen responses to the Working Group's internet polls (over 10,000 as of May 15) were studied. Finally, we have read close to 5,000 individuals' commentaries on health care matters submitted by residents of this country.

Following this nationwide citizen engagement, the Working Group is required to prepare and make available to the public this interim set of recommendations on "health care coverage and ways to improve and strengthen the health care system based on the information and preferences expressed at the community meetings." Following a 90-day public comment period on these recommendations, the Working Group will submit to

Congress and the President a final set of recommendations. The law specifies that the President shall submit a report to Congress on the recommendations within 45 days of receiving them, and designates five congressional committees that will hold hearings on that report and the recommendations: the Committee on Finance of the Senate, the Committee on Health, Education, Labor and Pensions of the Senate, the Committee on Ways and Means of the House of Representatives, the Committee on Energy and Commerce of the House of Representatives, and the Committee on Education and the Workforce of the House of Representatives.

Following are the interim recommendations of the Citizens' Health Care Working Group, along with descriptions of how we conducted our work and what we heard from participants in community meetings, respondents to our Web polls, and citizens who wrote in to tell us their views.

These recommendations outline a vision and a plan for achieving broad-based change in health care in America. We recognize that the issues involved are complex and challenging, and that it will take time and a great deal of technical expertise, as well as political will, to make the changes we think are necessary. Over the next three months, we will continue to actively pursue public input as we deliberate and further refine these proposals. During this process, we will provide greater detail and explanation of our recommendations, as well as further analysis of what we are hearing from the American people before issuing the final recommendations to the Congress and the President.

Those wishing to comment on the interim recommendations may do so by August 31, 2006 in any of three ways:

- online at www.CitizensHealthCare.gov;
- by e-mail to citizenshealth@ahrq.gov; or
- by mail to the following address:

Citizens' Health Care Working Group
Attn: Interim Recommendations
7201 Wisconsin Ave, Rm. 575
Bethesda, MD 20814

Values & Principles

The Citizens Health Care Working Group believes that reform of our health care system should be guided by principles that reflect values of the American people:

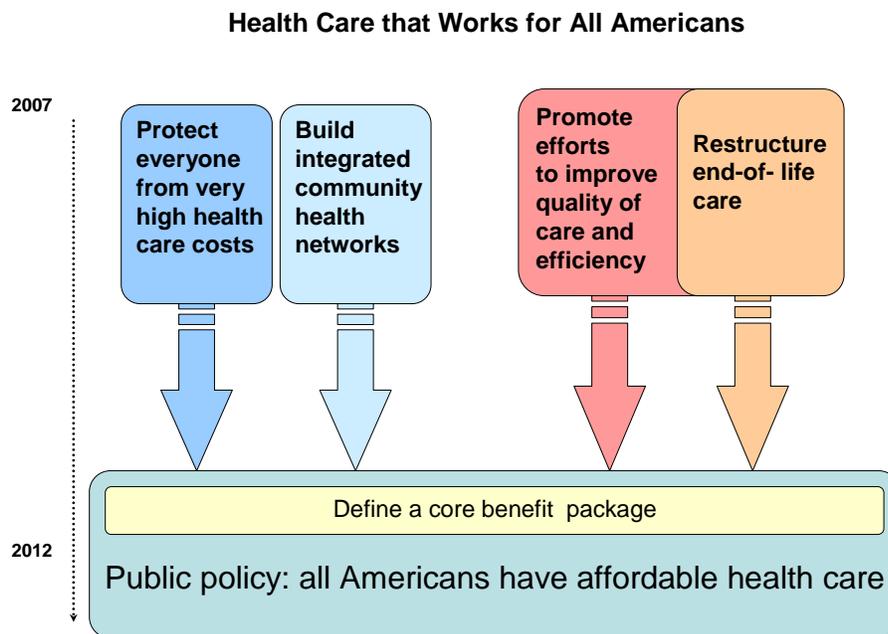
- Health and health care are fundamental to the well-being and security of the American people.
- It should be public policy, established in law, that all Americans have affordable health care coverage.
- Assuring health care is a shared social responsibility. This includes, on the one hand, a public responsibility for the health and security of its people, and on the other hand, the responsibility of everyone to contribute.
 - A defined set of benefits is guaranteed, by law, for all, across their lifespan, in a simple and seamless manner; the benefits are portable and independent of health status, working status, age, income, or other categorical factors that might otherwise affect insurance status.
 - Individuals' security is assured: as defined in law, changes in circumstances cannot be used to limit full access to benefits.
- All Americans will have access to a set of core health care services across the continuum of care throughout the lifespan.
 - Access to care means that everyone should be able to get the right care at the right time and at the right place. Appropriate health care must be available and affordable, as well as convenient and accessible for people in their communities. People's ability to get services and be treated appropriately and in a respectful manner are also essential aspects of access to care.
 - Health care encompasses wellness, preventive services, and treatment and management of health problems.
- Core benefits/services will be selected through an independent, fair, transparent, and scientific process which gives priority to the consumer-health care provider relationship:
 - Identification of core benefits will be made and updated by a public/private entity whose members are appointed through a process defined in law which
 - Includes citizens representing a broad spectrum of the population
 - Will specify core benefits taking into account evidence-based science and expert consensus regarding the effectiveness of treatments.
 - Additional coverage for services beyond the core package can be purchased.

- Shared social responsibility implies consideration of health care costs.
 - Health care spending needs to be considered in the context of other societal needs and responsibilities. Because resources for health care spending are not unlimited, the efficient use of public and private resources is critical.
 - Individuals should be responsible, to the extent possible, to be good stewards of their health and health care resources.

Interim Recommendations

These recommendations, which we believe reflect the principles and values we derived from our dialogue with the American people, call for a fundamental change in health care in this nation. What we heard, loud and clear, is that Americans believe that the health care system is not working for many Americans, they want change, and they want the hard work that will be needed to bring about change to begin now.

Based on what we heard from the public, as well as from a wide range of experts in hearings we held across the United States, we do not believe that the most important barriers to achieving a health care system that works for all are technical. Solutions exist, but to achieve change, we need to find a way to reconcile contrasting views about the role of the marketplace and government, of competition and planning, and of individual and shared responsibility. What we heard helped us to design a framework for moving ahead. Taken together, these recommendations provide a strategy for the United States to achieve the broad goal of health care that works for all.



- We begin with two focused efforts that can be developed in the near term that would protect all Americans from the most serious threats to their health security. One ends the threat of impoverishment that many Americans now face if they experience catastrophic illness or injury. The other improves the capacity of community health programs to provide basic care and health promotion services for people where and when they need it. Both efforts would also help build the

foundation for the broader system of coverage that we are proposing over the longer term.

- Achieving the vision of health care for all Americans will require the development of tools and systems that can be used by individuals and their families as well as others who pay for health care, and also by health care providers, to improve the quality and efficiency of our health care system while enhancing our ability to also control costs. Improving care at the end of life will require a special focus. This means finding ways to help individuals, families, and health care professionals deal with complex medical and supportive care needs more effectively, while reflecting personal values and preferences. Two recommendations address these topics.
- These initial efforts are part of a commitment to a longer-term vision of health care in America. This system would be built on public policy establishing that all Americans have affordable health care. An ongoing private-public mechanism would determine the benefits and services that would be guaranteed to all.

Below, we provide a rationale for our six recommendations, as well as additional description of how these recommendations would work. More detailed information, including background materials on health care in America and the analysis and findings from our community meetings and citizen comments and opinions provided to the Working Group, as well as relevant data from national polls and surveys, is provided in the Working Group's *Health Care Report to the American People (rev. March 31, 2006)*, and *Dialogue with the American People*, that accompanies these *Interim Recommendations*.

Recommendation:

Guarantee financial protection against very high health care costs.

No one in America should be impoverished by health care costs.

Establish a national program (private or public) that ensures

- **Coverage for all Americans,**
- **Protection against very high out-of-pocket medical costs for everyone, and**
- **Financial protection for low income individuals and families.**

Rationale

At community meetings throughout the country, as well as in online submissions, individuals described disastrous financial results of ill health, including the loss of their businesses, homes, and life savings, and disruption of family relationships due to catastrophic medical expenses. National polls [[link to reference](#)] show that notable majorities of Americans are concerned about not being able to pay medical costs for serious illness or an accident. These concerns are understandable given national statistics reflecting the importance of health care expenses as a cause of personal bankruptcy. According to one national poll [[link to reference](#)], almost one in four Americans report being heavily burdened by health care costs. Other polls report [[link to reference](#)] that

people think the most important function of health insurance is to protect against high medical expenses, and approximately 60 percent of the participants in our community meetings and Internet poll said that the most important reason to have health insurance was "to protect against high costs." Taken together, these stories, fears, and facts indicate that providing Americans with protection against high out of pocket health care costs is a priority for Americans.

Discussion

In our society, health care costs, and their effects, depend on circumstances. Devastating injuries and serious illness can result in hundreds of thousands, or even millions of dollars of medical costs. Experiencing an injury or illness that requires considerable health care services may not bankrupt a family, either because they have high income or because they have health insurance coverage that pays for much of the costs. But, even with insurance, some people can face very large out-of-pocket expenses for some types of care. And, for others of us, what on the surface appear to be health care services with relatively low costs may in fact bankrupt a family with low income and little or no health insurance.

Protecting all Americans against impoverishment from high out-of-pocket costs involves balancing the practical considerations of designing a simple health insurance product with the reality that catastrophic costs are experienced relative to income and wealth. There are many ways that universal coverage against high out of pocket medical costs could be designed. A number of states have designed reinsurance programs that cover the highest health care costs in small group or individual insurance pools. These are intended to help open up insurance markets to more people, by limiting the risk that insurers face if people incur very high health care costs. Policy experts have also proposed different types of federal programs to provide reinsurance or to protect individuals from very high out-of-pocket costs.

Although there are important differences in the ways that these approaches would work in a national program that covered everyone, they all have to deal with the basic issues of making sure that everyone is able to get, and keep, coverage, regardless of their health care status, need for health services, or ability to pay for coverage. Building a system that protects all Americans from catastrophic costs will, therefore, not only provide immediate help to people at serious risk, but also provide a means of evaluating whether the policies designed to provide this coverage can also work to provide broader coverage of core benefits.

As an illustration, the following design features provide one possible framework for this coverage:

- A requirement that all Americans have coverage against high out-of-pocket costs; and
- Specifying several standardized high cost insurance products that are easy to understand and to compare to each other, offered in the market that would provide protection at different levels of out-of-pocket costs to individuals with varying

income levels. For illustrative purposes only, consider Policy A with a deductible of \$4,000 of out of pocket expenses prior to full coverage of covered services, Policy B with a deductible of \$12,000, and Policy C with a deductible of \$30,000. These deductible levels are similar to policies currently offered in the individual market. Based strictly on coverage offered, Policy A would have the highest premium, Policy C the lowest premium.

- Individuals would be free to purchase the policy that suits their needs best. We understand that individuals with low incomes, by definition, face impoverishment with even relatively low out of pocket costs. At the same time, they will face the highest premium. Therefore we recommend premium subsidies for low income individuals (e.g. people with incomes below 200 percent of the poverty level) for, in our example, Policy A. These subsidies would diminish with increasing income levels.
- In order to help to build an insurance market that can provide high cost coverage to everyone, regardless of their health status or use of services, there would need to be several accompanying regulations, including the organization of risk pools; benefit standardization; and guaranteed reissue provisions.
- Because it is not clear how the market will respond to this new type of coverage, it would be important to consider ways to ensure that coverage is available to everyone, and that there is real competition on price and quality.

This proposal to provide catastrophic coverage to all is offered at a time when many employers, facing high and rising premiums, are withdrawing from offering health insurance to their employees, exposing more Americans to the potentially devastating financial impact of getting sick or injured. It is our intent and expectation that a policy requiring all Americans to be covered for high out-of-pocket costs would both help stabilize existing employer based health insurance and expand the private individual and small group health insurance market offering protection to Americans who are currently uninsured or underinsured against high health care costs.

We recognize that when new requirements for insurance coverage are put into place, incentives to employers and individuals are affected. In the current environment, some employers may reduce the coverage they offer because their employees would be able to obtain this new high cost coverage on their own. However, we also expect that many employers who were intending to drop health insurance coverage as a fringe benefit would now participate in the purchase of high cost coverage for their employees, resulting in an expansion in coverage over what would occur under current market conditions. We also believe that this policy would result in lower premiums for "first dollar coverage" for individual, small group, and large group health insurance products.

Recommendation:

Support integrated community health networks.

The federal government will lead a national initiative to develop and expand integrated public/private community networks of health care providers aimed at providing vulnerable

populations, including low income and uninsured people, and people living in rural and underserved areas, with a source of high quality coordinated health care by:

- **Identifying within the federal government the unit with specific responsibility for coordinating all federal efforts that support the health care safety net;**
- **Establishing a public-private group at the national level that is responsible for advising the federal government on the nation's health care safety net's performance and funding streams, conducting research on safety net issues, and identifying and disseminating best practices on an ongoing basis;**
- **Expanding and modifying the Federally Qualified Health Center concept to accommodate other community-based health centers and practices serving vulnerable populations; and**
- **Providing federal support for the development of integrated community health networks to strengthen the health care infrastructure at the local level, with a focus on populations and localities where improved access to quality care is most needed.**

Rationale

At the community meetings and on-line we heard stories about the difficulties many people, especially those who are low-income and/or uninsured, have in what our meetings called “getting health care.” A lack of primary care providers; inability to access specialty care; and difficulties in navigating a complicated system, especially for those with chronic conditions, were among the problems cited. “Fix the delivery system first,” was the closing comment at one community meeting. Participants emphasized the importance of having access to care in their local communities and the need to keep it simple and easy to navigate. We also heard strong support for neighborhood health clinics. When we asked about expanding these clinics as a way to help assure access to affordable health care services, this consistently ranked as the second or third choice among participants at community meetings. On-line, 74 percent of respondents either agreed or strongly agreed with this approach. We also heard support for strengthening the health care safety net for those in need both through the on-line poll and at community meetings.

Discussion

We have been impressed by the creativity and energy some communities have brought to improving their health care delivery systems. Some notable examples are described in the *Health Report to the American People*. However, more needs to be done to fill in gaps in both financial support and services provided by different kinds of health care providers and organizations. At present, local providers seek funding for a host of special programs targeted to subpopulations from a variety of state and local government agencies as well as national, regional, and local foundations and private organizations, as well as receiving reimbursement for services from public and private insurers and direct payments from patients. The result is a mixture of revenue streams, starting and ending at different times, and a stitched together a set of short term programs providing services some of the time to some of the people. Inconsistency in who is provided what services, from which provider, contributes to confusion, frustration, and missed opportunities.

We want to encourage innovation at the community level through new public-private partnerships, and are recommending public support, both structural and financial, to build more coordinated and seamless revenue streams and services. Better communication, both within the community and among communities is essential. The use of tools such as electronic health records is critical as well. Implementing these new technologies at the community level has the potential to benefit community providers and their patients by improving the continuity of care. We heard about several programs already being implemented. We want to encourage innovation within communities, but reforms also need to hold new programs and participants in the local health delivery system accountable to their communities and funders.

The goal is to support a basic reworking of the organization and delivery of community health services. We also want to see community networks that take a broad and inclusive view of their mission, providing not only primary care to those in the community with acute and chronic health conditions, but also providing health promotion and prevention, health education, nutrition counseling, and wellness checks to the healthy members of their communities, in essence, providing the tools needed to help everyone in the community be good stewards of their health and their health care.

To encourage the development of these integrated networks, we are proposing an expanded and broader approach to federal support for community-based providers. Currently, federal benefits such as grant funding, cost-based reimbursement under federal programs, access to reduced priced prescription drugs, and malpractice liability coverage under the Federal Tort Claims Act are limited to organizations that are federally-funded Community Health Centers or, in some cases, other qualified organizations. As an incentive for participation in an integrated network, we are proposing that some of the requirements for eligibility for benefits such as these be relaxed for certain community-based organizations, if they serve the same populations and provide comparable services.

Recommendation:

Promote efforts to improve quality of care and efficiency.

The federal government will expand and accelerate its use of the resources of its public programs for advancing the development and implementation of strategies to improve quality and efficiency while controlling costs across the entire health care system.

- **Using federally-funded health programs such as Medicare, Medicaid, Community Health Centers, TRICARE, and the Veterans' Health Administration (VA), the federal government will promote:**
 - **Integrated health care systems built around evidence-based best practices;**
 - **Health information technologies and electronic medical record systems with special emphasis on their implementation in teaching hospitals and clinics where medical residents are trained and who work with underserved and uninsured populations;**
 - **Reduction of fraud and waste in administration and clinical practice;**

- **Consumer-usable information about health care services that includes information on prices, cost-sharing, quality and efficiency, and benefits; and**
- **Health education, patient-provider communication, and patient-centered care, disease prevention, and health promotion.**

Rationale

The Working Group heard considerable support for improving the effectiveness and quality of health care services. Participants expressed preferences for using medical evidence to decide which services are covered and provided. Many participants discussed the importance of focusing on evidence-based medicine. Many participants also agreed that greater investment in health information technology and moving to an integrated system of electronic health records could improve administration and treatment and reduce medical errors. If implemented in conjunction with the previous recommendation, these initiatives could become an engine for advancing quality improvement and evaluating health care outcomes across multiple payers. More than two-thirds of respondents to the Internet poll supported more investment by doctors, hospitals, and other providers in health information technologies as a means to improve quality and increase administrative efficiency; similar results have been found in national polls [*link to citation*] conducted by other organizations. In the Internet poll, participants overwhelmingly supported the view that the private sector and government programs should improve the efficiency of health care. Participants also expressed general support for individuals having the ability to be informed health care consumers and to be involved in treatment decisions. They expressed a desire to have information about how to use health care better and more effectively. National polls [*link to citation*] have also shown that many Americans believe they do not have enough information about hospitals and other health care facilities to make educated choices for health care services.

Discussion

Important, innovative work is underway in the Medicare program, the VA, and a number of local and regional private systems around the country. New initiatives are being tested often with the private sector and federal government working together on projects to allow doctors, clinics, and hospitals across the country to share medical information safely.

Private groups of health care providers and employers who purchase health care, as well as public programs, such as the VA and Medicare, are also working together to reduce preventable medical mistakes. These groups are also developing programs aimed at providing information about the performance of providers to consumers to help them make better health care choices. Public and private organizations are also testing ways to measure performance of physicians, hospitals, and other health care providers using data available to the public, and to use information on provider performance to reward high-quality providers, or to reward consumers for using more efficient, higher quality providers. This recommendation would use the purchasing power of the federal government to accelerate the implementation of these critically important efforts. In addition to using its leverage to spur innovation, the federal government could also

partner with the private sector to ensure that these programs are evaluated fully and fairly.

Recommendation:

Fundamentally restructure the way that palliative care, hospice care and other end-of-life services are financed and provided, so that people living with advanced incurable conditions have increased access to these services in the environment they choose.

Individuals nearing the end of life and their families need support from the health care system to understand their health care options, make their choices about care delivery known, and have those choices honored.

- **Public and private payers should integrate evidence based science, expert consensus, and culturally sensitive end of life care models so that health services and community-based care can better deal with the clinical realities and actual needs of chronically and seriously ill patients of any age and their families.**
- **Public and private programs should support training for health professionals to emphasize proactive, individualized care planning and clear communication between providers, patients and their families.**
- **At the community level, funding should be made available for support services to assist individuals and families in accessing the kind of care they want for last days.**

Rationale

We heard a clear endorsement at the community meetings of limiting end-of-life interventions of questionable value in favor of providing more at-home and comfort care for the dying. This care can take place in hospitals, but need not involve “extraordinary measures.” Care at the end of life has surfaced at virtually every community meeting. It is part and parcel of the frustrations many experience with health care in America. We heard that such care is expensive, does not improve the patient’s quality of life, is too often based in hospitals and nursing homes, and may not comport with the wishes of the ill person or his family. This idea also received strong support in both the Working Group Internet poll and the University town hall meeting, where 61 percent and 63 percent respectively either agreed or strongly agreed with the proposal. This dissatisfaction with the care people receive at the end of life that we heard at community meetings echoes the sentiments of a 2002 national poll [[link to reference](#)] that found that nearly six in ten respondents gave the current system a rating of fair or lower. Three quarters of those surveyed believed that the current system is just fair, or worse, with respect to assuring that families’ savings are “not wiped out by end-of-life care.” At some community meetings, we also heard concerns about the very difficult issues surrounding the care of very low birthweight infants.

Discussions at the community meetings, and, in particular, the one meeting devoted to end-of-life issues held in New Hampshire, underscored the need for rethinking how care at the end of life is delivered and financed so that this care incorporates the values Americans say are important to them, including honoring personal choices, pain relief, and being treated with dignity and respect by health professionals. Payment incentives

now are misaligned: they encourage heroic interventions and care in hospitals and nursing homes. They also do not encourage physicians to spend time talking to patients. In New Hampshire, we also heard about the important role non-medical services play at the end of life and the need for new models of care delivery that better take into account the dignity of patients in their last days.

Discussion

Aspects of the three preceding recommendations are especially salient in considering care of the dying. It has been estimated that last-year-of-life expenses constitute 22 percent of all medical expenditures. A major fear for many people as they approach death is the financial burden their care may place on their families. There is a critical need for new models of care delivery that do a better job of piecing together the support and community-based services which often are non-medical that the dying and their families need. A stronger focus on knowing both “what works” and when medical intervention serves no good purpose, coupled with more consumer-friendly information and better provider-patient communication, will help the seriously ill make more-informed choices about their care.

Helping Americans have the “good death” they desire will require change. At the policy level, care models have to address the longer lives people are leading and the often extended periods of fragility they experience. Payment policies and professional medical training programs must be adjusted accordingly. For example, payment for hospice services needs to better account for the most common patterns of death and dying; payment for providers needs to be less procedure-driven and take into account time spent talking to patients; and care for the dying needs to be a central component of training for all health professionals who have direct contact with patients. A starting point for the fundamental restructuring we envision is for individuals and families to think about their wishes for their own end-of-life and make their views known.

Serious illness and death can occur at any point during life. We hope that as new models for care delivery and patient and family support mechanisms develop, attention is paid to the special problems faced by terminally ill newborns or children and their families.

Recommendation:

It should be public policy that all Americans have affordable health care.

All Americans will have access to a set of core health care services. Financial assistance will be available to those who need it.

Across every venue we explored, we heard a common message: Americans should have a health care system where everyone participates, regardless of their financial resources or health status, with benefits that are sufficiently comprehensive to provide access to appropriate, high-quality care without endangering individual or family financial security.

Rationale

In community meetings throughout the nation, an overwhelming majority of participants told the Working Group that “it should be public policy that all Americans have affordable health care.” In the discussions underlying values and perceptions that began each community meeting, 94 percent of all participants agreed with this sentiment. Similarly, 92 percent of respondents to the Working Group’s Internet poll strongly agreed (80 percent) or agreed (12 percent) with this statement. People at many of the community meetings expressed the desire for “cradle to grave” access to health care.

A clear majority of participants at every community meeting preferred that *all* Americans receive health care coverage for a defined level of services. Between 68 percent and 98 percent at all community meetings said that we should provide a defined level of services for everyone. In the Working Group’s Internet poll, 85 percent of participants also opted for a defined level of services for everyone. These findings are also consistent with the results of other national polls asking similar questions. In surveys conducted by other organizations, a clear majority have expressed the opinion that all Americans should have health insurance. For example, a national poll conducted in September 2005 [[link to reference](#)] found that 75 percent of U.S. adults somewhat favored (23 percent) or strongly favored (52 percent) universal health insurance.

Discussion

What kind of health care system do Americans want? People told us they want a system that guarantees *health care for everyone*, but not, at least not with as much consensus, a program providing everyone with *health insurance*. This distinction between health care and health insurance is critically important. The notion of health care we heard about focused on access and security. People are seeking a system in which everyone is “enrolled” in a plan that covers most health care costs and, unlike the current system, cannot be cancelled, lost due to change of employment, priced at levels that are unaffordable, or not cover some people because of previous or ongoing health problems. The health care system envisioned by the people we heard from would provide comprehensive coverage for preventive care, treatment of illness and injury, and palliative care, with a level of cost-sharing that does not keep people from getting that care. It would be a system that respects the value that Americans place on choice of providers, and one that enables consumers to make good decisions about their health care.

We heard a wide variety of views about how we as a nation could accomplish the goal of health care for all. Some of the systems people advocated are administered by or through private sector health plans; some are organized through employer-sponsored coverage in the group market; others are run directly by government. Many of the people we heard from believe that either Medicare or the Federal Employees Health Benefits Program could serve as a basic model for a national system for everyone; some also singled out the Veterans Health Administration (VA) system as a possible model. Others suggested that some of the large integrated health care systems that now provide care to large numbers of people in some parts of the United States could provide good models. People pointed to these programs not only as examples of how to provide

coverage, but also as systems that can better control costs and provide the infrastructure and resources needed to improve the quality and efficiency of health care delivery.

People attending the community meetings often asked why other nations could provide universal coverage and still spend less per capita on health care, with good health outcomes, than we do in America. Some pointed to problems with rationing or lack of choice in other countries, but there were many others who talked about their own positive experiences with foreign health care systems. For many of the people we heard from, the problems with cost and access to health care in America reflect a failure to apply the principles of fairness and shared responsibility that are embodied other nations' programs.

A clear majority of people we heard from, like the majorities responding to a variety of national polls conducted over the past few years, are in favor of a national system that guarantees health care for all Americans. Others expressed doubts, or strongly opposed, any increased involvement of government in health care markets. There was, however, across the board agreement that overall the current health care system has major problems, or is in a state of crisis.

How will we pay for health care for all Americans? Establishing public policy that all American have affordable care and other recommendations contained here call for actions that will require new revenues to provide some health care security for Americans who are now at great risk. The opinion polls we examined, the community meetings we held, and the web-based surveys and comments we received, all showed large majorities of people willing to make additional financial investments in the service of expanding the protection against the high costs of illness and the expansion of access to quality care.

We recommend adopting financing strategies for these recommendations that are based on principles of fairness, efficiency, and shared responsibility. These strategies should draw on dedicated revenue streams such as enrollee contributions, income taxes or surcharges, "sin taxes", business or payroll taxes, or value-added taxes that are targeted at supporting these new health care initiatives. Another funding option would be to change the rules that now give both employers and employees a federal tax subsidy for employer-sponsored health care, and use the additional tax revenue to help pay for broader coverage. For example, Congress could cap payroll tax exclusions at the average cost of group coverage for full time employees. This additional tax revenue would then be specifically earmarked to help pay for expanding coverage.

We note that improvements in efficiency through a variety of mechanisms such as investments in health information technology, public reporting, and quality improvement may be realized over time. Improved efficiency could in turn affect the rate of growth in health care costs. To the extent that such efficiency gains are obtained, they could be used to assist in paying for new protections recommended here such as those against catastrophic health care expenditures and the impoverishment of individuals as a result of getting the health care they need. These "savings", however, may be difficult to capture as a major source of financing for expanded coverage. We also recognize that, in addition to new revenues and the savings noted above, there are ways that current funds

could be reallocated within the system to pay for health care that works for all Americans.

There are many analyses and estimates of what various approaches to expanding health care coverage might cost. All involve making assumptions about how benefits would be structured, how access to, and use of, health care would be affected, and how the responsibility for paying for health care would shift around among families, insurers, employers, and public programs. Experts can't develop credible estimates of potential costs, or savings, without some fairly specific details. What we can say, however, based on our conversations over the past year, is that many Americans believe that a simpler, more seamless system could provide coverage to everyone more efficiently than the current system. The implications of this view are very important: many Americans believe that the primary focus of public policy needs to be controlling national health care costs *and* guaranteeing that all Americans have the health care they need.

We understand that the transition from the current system to a system that includes all Americans will take time and that multiple financing sources will need to coexist and may continue to exist during a transition to a health care system that assures Americans access to core coverage.

During the transition to a system that guarantees core benefits to all Americans, there needs to be special attention to people who are now being helped by private and public programs. For many Americans, the services and benefits being provided represent specific forms of commitment that our society has made to tens of millions of us, including women and children living in poverty, people with disabilities, the elderly, people living in isolated or to hard-to-serve areas, veterans and military families and retirees, and Native Americans.

People throughout the United States attending our community meetings expressed serious concerns about the continued availability of vital services and benefits for those unable to afford adequate health coverage. If major reforms to the current health care system are enacted, it will be critically important to make sure that any changes made to coverage or benefits make it easier, not harder, for people to get the care they need.

Recommendation:

Define a 'core' benefit package for all Americans.

Establish an independent non-partisan private-public group to identify and update recommendations for what would be covered under high-cost protection and core benefits.

- **Members will be appointed through a process defined in law that includes citizens representing a broad spectrum of the population including, but not limited to, patients, providers, and payers, and staffed by experts.**
- **Identification of high cost and core benefits will be made through an independent, fair, transparent, and scientific process.**

The set of core health services will go across the continuum of care throughout the lifespan.

- **Health care encompasses wellness, preventive services, primary care, acute care, prescription drugs, patient education, treatment and management of health problems provided across a full range of inpatient and outpatient settings.**
 - **Health is defined to include physical, mental, and dental health.**
 - **Core benefits will be specified by taking into account evidence-based science and expert consensus regarding the medical effectiveness of treatments.**

Rationale

Participants at the Working Group’s community meetings nationwide recognized that the process of sorting through what should be included in a basic health package, and what might be optional, or left to individuals to pay for entirely out of pocket, would be very difficult. Discussion groups at the community meetings strained to come to any consensus about what types of services would be “optional” in part because different people value services or types of care differently. Discussants pointed out that some services may be more important for some segments of the population than others, such as children or the elderly, or those with particular types of health problems. What might seem optional for some may be viewed as essential for others. This often led participants to conclude that a broad set of services should be covered. There was a general recognition, however, that there needs to be a structured process for determining what benefits should be included in the core benefit package. In meetings throughout the country, the majority of participants told us that consumers should play a major role in this process, along with medical professionals, federal government, state and local government. A smaller number of participants indicated that employers and insurance companies should also play a role in determining the content of the core benefit package.

Discussion

Identifying the benefits to be included in the core package for all Americans is key, not only to ensuring access to necessary and appropriate care, but also for helping to make all health care more effective, and, as a result, controlling health care costs. This recommendation is therefore closely related to Interim Recommendations on efficiency, effectiveness, and quality of care, because up-to-date evidence on what works best in health care should be the basis for decisions about the benefits and services that are included in the core package.

There are well-established models for assessing the effectiveness of medical therapies, procedures, and devices, including programs organized by professional organizations and providers, state-led efforts to inform coverage policy for Medicaid and SCHIP programs, and federal activities such as the U.S. Preventive Services Task Force and the Evidence-Based Practice Centers supported by the Agency for Healthcare Research & Quality, as well as international collaborations focused on assessing the effectiveness of clinical care. The group created by this recommendation would draw upon the expertise that has been developed by these other organizations in order to establish a clear set of rules for assessing the evidence that will be used to decide on the benefits and services in the core package, and to update the core package when it is appropriate to do so, based on new evidence. The legislation establishing this group could, for example, specify that benefits

and services to be included in the package should meet established standards based on specific levels of evidence, such as clinical trials, effectiveness studies, comprehensive reviews of published analyses, or expert consensus.

The goal of this recommendation is to ensure that the best methods are applied in an open and transparent way. Consumer participation is critical to ensuring public trust in the process. Consumer input is also essential for ensuring that issues related to personal values and preferences are taken into consideration in coverage decisions. The private-public structure of the group is intended to insulate the group from both political and financial influence. Establishing the group as an ongoing entity with stable funding will help guarantee its independence and will also help assure that the benefit package continues to be responsive to evolving medical knowledge and practice.

Members of the Citizens' Health Care Working Group

Patricia A. Maryland, **Chair**

Frank J. Baumeister, Jr.

Dorothy A. Bazos

Montye S. Conlan

Richard G. Frank

Joseph T. Hansen

Therese A. Hughes

Brent C. James

Randall L. Johnson

Catherine G. McLaughlin

Rosario Perez

Aaron Shirley

Deborah R. Stehr

Christine L. Wright

Michael O. Leavitt, **Secretary of Health and Human Services**

Because the Working Group's final recommendations will be submitted to the Department of Health and Human Services, the Secretary of Health and Human Services has neither participated in the development of these recommendations nor has he endorsed them. He will carefully consider them and take appropriate action.