Citizens' Health Care Working Group
Public Meeting
March 2-3, 2006
Los Angles, CA

Meeting Summary

Attendees

Members
Randy Johnson, Chairperson
Frank Baumeister
Dotty Bazos
Montye Conlan
Richard Frank
Joe Hansen
Therese Hughes
Rosie Perez
Aaron Shirley
Deborah Stehr
Chris Wright

Staff
George Grob, Executive Director
Jill Bernstein
Craig Caplan
Carolyn Dell
Jessica Federer
Margretta Kennedy
Andy Rock
Connie Smith
Caroline Taplin

Other Participants and Key Attendees
Jonathan Ortmans, The Public Forum Institute
Surjeet Ahluwalia, America*Speaks*
Jack Molnar, Molnar Inc. (by phone)
Jon Comola, Wye River
Marcia Comstock, Wye River
Mary Giffin, Government Accountability Office

MEETING SUMMARY

Randy Johnson, the Chairperson, began the meeting at 1:00 p.m., Thursday, March, 2, 2006.

Carolyn Lukensmeyer, America*Speaks*
Los Angeles Community Meeting
(See Power Point Presentation)

Carolyn Lukensmeyer provided an update of planning efforts for the Saturday, March 4 community meeting in Los Angeles. She indicated that there would be fewer participants than sought and that the proportion of Hispanics, in particular, would not reflect the demographics of LA County, where the meeting was to take place.

Discussion

Members expressed concerns regarding lack of clear communications with the contractors involved in the Los Angeles meeting and less than satisfactory outreach to the local communities; both of which may have contributed to the lower-than-anticipated meeting participant turn out. As a result of this discussion, the prime contractor, America*Speaks*, the Executive Director, and the Working Group Member from California, were asked to prepare written comments about what went well, what could be improved, and what suggestions they might have regarding how to best use the further services of the prime contractor.

Jonathan Ortmans
Summary Results from Community Meeting
(See Power Point Presentation)

Jonathan Ortmans provided a summary of the results of the first 8 community meetings. He pointed out that the Public Forum Institute (PFI) had contracted for several meetings that had not yet been scheduled and that this fact offered the opportunity to make sure that a variety of types of communities were included. Some cities that could be considered included Oklahoma City, Salt Lake City, and Boise, Idaho.

Discussion

The Working Group discussed and generally agreed that the meaning of results from the community meetings (such as services that community meeting participants thought could be removed from a basic benefits package) needed to be understood and used, during the development of recommendations, based not only on comments from community meeting participants, but also on a careful review of the specific polling data that resulted from the meetings. Members indicated that, to the maximum extent possible, the remaining unscheduled meeting slots should be used to help assure a diversity of perspectives.

Jill Bernstein and Jack Molnar
Preliminary Summary of Responses to Questions on the Web
(See Power Point Presentation)

Jill Bernstein, Jack Molnar, and Craig Caplan presented preliminary summaries of the individual responses to both the open-ended and the structured questions available on the web.

Member Discussion
Developing Recommendations

Members discussed how the Working Group should weigh the various sources of information in framing recommendations. The Working Group agreed that they should consider the content from all information sources (e.g., hearings, community meetings, web-based polling information, and Member knowledge and experience) in developing recommendations. The Members discussed whether or not public comments at the community meetings represented fully informed opinions. Members observed what was most important was that they hear from the public regarding values and that these required less technical expertise.

George Grob and Members
Practical Means to Develop Recommendations
(See "Developing Recommendations" and "Proposed Schedule" Documents)

The Executive Director described some approaches to developing recommendations, for the Working Group's consideration. Members agreed that the greatest strength of the Working Group, and what made it unique, was its opportunity to listen to and reflect the opinions and recommendations of a large number of Americans. A Member expressed the opinion that the Working Group ought to list out major health care changes needed and then identify what the Working Group hears about how to achieve the objectives that most of the public wants.

With regard to cost estimates, some Members stated that the Working Group should not try to estimate costs of its proposals other than by citing the estimates of others. Another perspective expressed was that, to be credible, the Working Group must deal with cost issues and seek to cost out its recommendations. In this view, the Working Group needs to address the cost and financing, but the cost estimating shouldn't come first. The Members agreed that rising costs are part of the main problem the Working Group was established to address. Even more important than estimating costs for individual proposals is solving the fundamental problem of rapid and continuing increases in overall health care costs. Some Members were concerned that making cost estimates might jeopardize the credibility of the Working Group's proposals; others were concerned that without cost estimates, the proposals would not be taken seriously. It was clarified that the cost estimates could be in broad ranges; basically ball park figures and that this might well be within the competence of the available staff.

Working Group Members
Discussion of Structuring Recommendations

Alternative ways to format and structure recommendations were discussed. The Working Group sought to come to grips with the difficult task of defining a path by which it can arrive at meaningful recommendations. An approach that appealed to several of the Members was they would start with identifying principles they could agree on and then identify practical ways to achieve these principles.

Staff questions for the Working Group included how radical an approach the Working Group wanted to take. Members requested information on the Veterans Administration health care system and regarding Medicare-Medicaid dual-beneficiaries. The Members discussed whether the audiences attending community meetings were adequately informed about health care and representative of the local communities.

There was general agreement that "health care that works for all Americans" should be taken as the primary vision of the Working Group. Members discussed whether the principles, that would be included in the Interim Recommendations, should be based on quality, cost, and access OR whether the principles should be framed around the four questions in the law.

Members & Staff
Community Meetings

Members and staff listed some of the things they had heard from the public:

- People in the United States want security from the consequences of illness and injury.
- People want simple systems; they are tired of the complexity.
- Americans want it to be public policy that all people in the United States have affordable health care.
- The system of health care should be void of artificial barriers. (e.g.: language, location, etc.).
- A safety net is needed.
- Quality care should be readily available to all and especially to those on the lower rungs of the economic scale.
- People want and need access to specialists (including the working poor).
- There was a desire for preventive care.
- People need to take greater personal responsibility.
- People want to be more informed and engaged in their own health care.
- Cost must be controlled more effectively in the future.
- People don't want nipping around the edges of the health care system.
- Every citizen should be required to enroll in basic health care coverage either public or private.
- There should be universal coverage, based on ability to pay.
- Citizens want input into design of benefit coverage.
- There is a great desire to continue to advance medical science and appropriate application of this research (evidence-based practice).
- There is distrust of some of the players in the system: drug companies, excess profits of insurance companies, direct to consumer advertising.
- There was a willingness to accept government controls on advertising or profits of insurance and drug companies.
- Endorsement of a single payer system at some meetings.
- Willingness to pay more (e.g., in taxes or premiums) to expand access to care.
- A strong appreciation of local health clinics.
- Wanting a dramatic change in the way we think about end of life.
- Education as key to improving the health of individuals.

- Most people think that the purpose of insurance is to cover major expenses, yet when identifying a benefit package, they want to expand services that are covered.
- Individuals should not loose their home, or go bankrupt, because of a health care need.
- People don't want important health care decisions driven by money.
- People didn't like the idea of talking about trade-offs.
- Government and the private sector need to operate more efficiently.
- A shared sense of responsibility for the health care system; everyone should contribute.
- People want something at a reasonable cost that works.
- There is some ambivalence about state programs.

Subjects for Principles

Members brain-stormed regarding the types of items that should be considered for inclusion in a basic set of principles upon which to base the development of recommendations at future meetings and in developing Interim Recommendations for the targeted June 1 release to the public. Suggestions included:

A system perspective is needed: transparency.

Cost

- Costs need to be controlled.

Quality

- To the greatest extent possible, care should be evidence-based.
- Implementation of health information technology will result in improved quality of care.
- Steps will be taken to reduce medical errors.
- There will be incentives for evidence-based medicine.
- The system will move toward value-based payment, i.e. pay for performance.

Access

- Everyone shall have access to health care.
- There should be a basic level of health care/coverage below which no one should fall.
- The necessary infrastructure for care needs to be in place.
- Artificial barriers to access such as geography, location, affordability, insensitivity, language, hours of operation need to be addressed.
- No one should be frozen out of insurance through underwriting practices.

Navigation/Simplicity

- The system will be less complex and navigation of it will improve.
- There is a desire for clarity simplicity and consistency in benefits, transparency in prices and consistency in medical records.

Fairness

- Willingness to do one's part—step up to the plate—and be part of the solution, a similar sentiment to post-9/11 public reactions

Public Health/Research and Development

- The health system needs to be able to protect the public in emergencies and epidemics.

Wellness

- Preventive care, case management and disease management should be emphasized.

Delivery System Choices

- People in need of care for chronic conditions, disabilities and end of life should have choices about where and how care should be delivered.

Staff was asked to refine the above list and share with the Working Group for its use in moving toward development of recommendations. Further discussion with the Working Group would take place at future meetings.

George Grob
Administrative Matters

A number of organizational and operational issues were briefly discussed:

- Preparation of reports from the community meetings would be a combined effort including initial drafting by staff, review and formatting by the Public Forum Institute, and final review by staff and Members.
- Articles for the opposite-the-editorial pages of papers would vary from market to market and from Member to Member. Members are encouraged to write draft op ed pieces and the staff and contractors will supplement this effort.
- The staff was asked to further clarify the relative roles and responsibilities of the project officers, contractors, and Members.
- Members advised that after the community meeting in Los Angeles, there needs to be an evaluation that would then be used to advise and guide the next meetings.
- It was reported that the effort to have a meeting with Tribal representatives was unsuccessful; only four individuals from the National Congress of American Indians and the National Indian Health Board came to meeting at which one of the Working Group members was present.

Randy Johnson
Outreach Efforts

- The Chairperson reported briefly on the success of a meeting with two groups, one of employers and the other of nonprofit organizations to seek their involvement in the work of the Citizens' Health Care Working Group.

Members
Community Meetings Planning

Others mentioned that the Working Group should reach out to included the chronically ill, mentally ill and the disabled. There was some discussion regarding the extent to which the statute required that the needs and views of these groups be heard. Members discussed whether to have targeted meetings with particular groups or to seek their participation at the scheduled regular meetings.

The Chairperson asked whether the Working Group should have an individual Member work with the staff regarding each groups designated; Montye Conlan offered to work with the staff to plan a reach out event for the disabled. With the mentally ill, it was suggested contacting the National Association for the Mentally Ill. Other groups of interest included employees and employers. In addition, other topics discussed or mentioned included: locations of meetings, an invitation for a meeting in Utah, the Medicaid population, Hispanics, and involvement in cities that represent conservative populations.

Aaron Shirley mentioned that he could reach out to the Native American population in Mississippi; he though he could obtain their involvement and could seek assistance from the local Extension Service as well. Therese Hughes indicated that for the upcoming meeting in Sacramento, she could also meet with some of the California tribes separately although she thought she would need a facilitator for this purpose. Therese Hughes also mentioned working with employees and employer groups, such as E-Bay and VeriSign, in Menlo, CA.

Members also discussed what "conservative" cities they could go to in order to assure that all political persuasions were represented among the locations where community meetings were held. A preliminary table of alternative locations and groups was discussed:

Group Targeted	**Possible WG Member**	**Possible Mtg Type**
Medicaid	TBD	TBD
Hispanic	TBD	TBD
Mental health	Richard Frank	Member
Disabled	Montye Conlan	Member
Employees	Therese, Randy, Joe	Staff Assisted
Mississippi, Native Americans	Aaron Shirley	Member
Sacramento, Native Americans	Therese Hughes	Member
Chronic illness	(Special outreach but include in regular meetings)	
Provo, Utah	Brent James	Staff Assisted
Mississippi (rural)	Aaron Shirley	Independent w/funds
Iowa (rural)	Deborah Stehr Member	
Montana (rural)	TBD	Staff Assisted
Corvallis, Oregon	Frank Baumeister	Staff Assisted
SBA in DC	Randy Johnson, George Grob	Member (April)

PFI recommended holding back a couple meeting slots for possible employer/employee involvement; also Small Business Administration will be in DC in April for possible meeting and could represent an opportunity for a staff assisted meeting also.

Other possible locations: Boise, Idaho; Dallas, Texas, Oklahoma, OK; Montana; Atlanta, GA.

Another option would be to cancel the NY city meeting and use this slot for another standardized meeting such as in Utah.

Staff was asked to summarize the options and possible direction for the meetings.

Another option proposed was to change the large Cincinnati meeting into a regular meeting and use the excess resources to assist in other meetings.

The Chairperson adjourned the meeting at 4:46 p.m., Friday, March 3, 2006.