Citizens' Health Care Working Group Meeting
United Food and Commercial Workers International Union
1775 K Street, NW, 11th Floor
Washington, DC
Tuesday-Thursday, May 23-25, 2006

Meeting Minutes

Working Group Members Present:
Dotty Bazos
Frank Baumeister
Montye Conlan
Richard Frank
Joseph Hansen
Therese Hughes
Brent James (Wednesday only)
Randy Johnson
Catherine McLaughlin
Pat Maryland
Rosie Perez
Aaron Shirley
Deborah Stehr
Chris Wright
Don Young (Representing the Secretary, HHS, Michael Leavitt)

Working Group Staff Present:
George Grob
Andy Rock
Caroline Taplin
Craig Caplan
Jill Bernstein
Margretta Kennedy
Jessica Federer
Connie Smith (Thursday only)
Lisa Goodnight (Thursday only)

Other Participants and Attendees:
Susanna Knouse, PFI
Jonathan Ortmans, PFI
Elizabeth Magruder, PFI
Mark Marich, PFI
Mary Ella Payne, Ascension Health
Mary Giffin, GAO
Carol Reagan, UFCW
Hala Hayes, America*Speaks*

Randy Johnson began the meeting at 8:40 a.m., Tuesday, May 23, 2006. All members but Brent James were present. Jonathan Ortmans, PFI, facilitated the meeting. PFI also provided wireless keypads to enable the Working Group to conduct anonymous ballots on key decisions, in order to move the proceedings along expeditiously.

All documents that are part of the Interim Recommendations can be found posted at the Working Group's web site, www.CitizensHealthCare.gov.

Dotty Bazos asked what would constitute a majority for purposes of deciding actions that were to be considered approved by the Working Group and also asked what would happen if all members don't agree.

The meeting facilitator suggested the following parameters to allow the Working Group to reach closure on recommendations:

- All Working Group Members should feel comfortable with stated values and principles;
- The Working Group could rely on a supermajority where it failed to achieve unanimous agreement on recommendations; and
- Member-drafted statements could be included, as needed, along with Final Recommendations in order to voice any minority opinions.

Meeting participants observed that, while not always possible, recommendations that reflect a consensus of the views of most commissions are better received than those that do not. Members discussed how to accommodate any minority opinions that might emerge and how these could be reflected in the Interim Recommendations. An alternative to including separate dissenting opinions suggested would be to note concerns or issues in the context of the relevant recommendations.

The Working Group engaged in discussions on the separate sections intended to be part of the Interim Recommendations. They approved the following wording of the Preamble:

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 Working Group discussed several topics for possible inclusion in or exclusion from the draft Values and Principles:

- Indicating, in an introductory paragraph, that the values and principles are intended to provide parameters around which health care policy and legislation can be established and do not imply a specific delivery system (not adopted);
- Clarifying the concept of shared social responsibility as including both public responsibility for health security and individual responsibility to contribute (adopted);
- Replacing the word "practitioner" in one instance with "provider" (adopted)
- Deleting an affirmation that the existence of a set of "core benefits" would not preclude an individuals' ability to obtain additional services or insurance coverage (not adopted);
- Clarifying that private as well as public resources are limited and must be efficiently used (adopted); and
- Deleting the use of a restrictive clause ("to the extent possible") limiting the availability of appropriate health care that is convenient and accessible (adopted).

Reflecting discussion and decisions on these specific items, the Working Group then agreed to the following language for its statement of Values and Principles:

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."

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The Working Group adjourned at 4:00 p.m., Tuesday, May 23, 2006.

The Working Group reconvened at 8:30 a.m., Wednesday, May 24, 2006. All Members were present.

Don Young, Acting Assistant Secretary for Planning and Evaluation, DHHS, indicated that, while not commenting in advance on the recommendations, once the Department of Health and Human Services receives the Final Recommendations, the Secretary will review and comment to the Congress as required by the statute.

A preliminary summary framework for Interim Recommendations, presented by Staff, included:

- Establish a core benefit package for all Americans in a single, simple, seamless system;
- Strengthen community health infrastructure;
- Establish mechanisms for ongoing improvement in quality and access and controlling costs;
- Protect all Americans from financial ruin; and

- Provide core benefits for all Americans.

Members voted 12-2 to support this preliminary framework as a basis for discussion.

A Member suggested that there be an explicit link from the values stated by the Working Group to the recommendations that emerge.

Members agreed, by a vote of 13-1, to support the proposition that the "ultimate goal is universality and core benefits."

The Members took up the issues of quality and efficiency. According to Working Group Members, community meeting participants, hearing presenters, or online respondents:

- Indicated that $1.9 trillion dollars per year should be enough to fund care for all;
- Asked for coordinated, less confusing, transparent care delivery system;
- Identified very high rates of waste within the system although they understood that extracting that waste and recovering those dollars for effective care for all Americans may take time – such effort will require integrated care delivery (a team based approach), evidence-based medicine, electronic medical record systems, and control of fraud.

The Working Group debated and then voted (13-0) to adopt a recommendation regarding the leadership role of the Federal government in developing strategies to improve quality while controlling costs.

The Members then took up the issue of core benefits. Members pointed out that whenever the public was asked to offer trade offs, the most frequent quid pro quo was a willingness to pay more in order that there be universal health care. They pointed out that there were different ways to ration care including: through markets and an individual's ability to pay; establishing some hierarchy of social benefit (the Oregon approach); and offering care but rigorously limiting the technology and practitioners available to provide the care (the Canadian approach). Members pointed in the United States, we need to decide whether to ration care explicitly or allow de facto rationing as at present, to continue. The Working Group then took a series of votes on this subject:

- It voted 10-2 in favor of defining a benefits package;
- It voted 12-0 to continue discussing the creation of an entity that would have responsibility for developing a core set of benefits; and
- It voted 10-3 to set forth some guidelines or principles that would be used to develop the package.

Members then took up the issue of integrated community health networks. They agreed that the following elements be reflected in a recommendation on this topic:

- Coordinated, seamless care
- Public-private partnerships

- Integrated (body for streamlining)
- Start with indigent care and move toward bigger picture
- Tackle chronic care/lack of specialty providers
- Include mental and dental care
- Emphasize primary care with hospital back up
- Fund only services with scientifically demonstrated success

The Working Group voted, 12 in favor and one abstaining, for language promoting integrated public/private networks of health care providers providing low-income vulnerable populations with high quality care.

Members took up the question of financing. They discussed possible funding mechanisms and whether to consider recommending using taxes to fund expanded health care. Members reflected on the clear willingness of participants at community meetings and respondents to the online web Health Care Poll to create a national health plan financed by taxpayers. It was observed that the amount of additional funding participants at the community meetings indicated they were willing to pay would not fully fund the additional costs that are anticipated in the health care system.

The Working Group adjourned at 5:00 p.m., Wednesday, May 24, 2006.

The Working Group reconvened at 8:30 a.m., Thursday, May 25, 2006. All Members except Brent James were present.

Members continued their discussions of financing options. The Working Group decided how much detail to include in the Interim Recommendations:

The facilitator indicated that financing options that they had been mentioned at the community meetings included:

- Use savings from greater efficiency,
- Achieve efficiencies from greater consumer cost-consciousness and more cost-sharing,
- Use savings from increases in information technology,
- Reduce tax exclusions from employer-sponsored benefits,
- Tax income on a sliding scale,
- Provide for income-related premiums,
- Use payroll taxes,
- Establish sales or value added taxes, and
- Initiate ‘sin’ taxes (e.g., alcohol, cigarettes, unhealthy lifestyles)

After discussing a specific proposal to cap tax deductions for employees, the Working Group narrowly decided (9-5) to include a single broad general statement regarding financing of the recommendations (rather than specific financing recommendation(s).

The Chair, with concurrence of the Working Group, established a committee under the chairmanship of Joe Hansen and including Randy Johnson, Richard Frank, and Catherine McLaughlin to prepare a draft statement and submit it to all Members for comment.

Members then discussed some pending administrative matters regarding the 90-day comment period, including: whether to hold a stakeholder meeting (action postponed until after June); whether to proceed with a Working Group meeting on June 21-22 (affirmative).

The Members then discussed and voted on the sections that would comprise the Interim Recommendations:

Interim Recommendations

1. 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. For those unable to afford it, financial assistance will be available.

Approved, 13 to 0

2. Guarantee financial protection against very high health care costs

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

Approved, 12 to 1

3. Define a "core" benefit package for all Americans

Establish an independent non-partisan private-public entity to identify and update coverage for both high-cost protection and core benefits.

- **Members are appointed through a process defined in law that includes citizens representing a broad spectrum of the populations including, but not limited to, patients, providers, and payers staffed by experts.**
- **Identification of 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, patient education and treatment and management of health problems.**
    - **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 effectiveness of treatments.**

Approved, 12 to 1

4. Promote efforts to improve quality of care and efficiency

Federal government will take a stronger leadership role in development and implementation of strategies to improve quality while controlling costs.

- **Using federally funded health programs such as Medicare, Community Health Centers, TRICARE, and the Veterans' Health Administration, the federal government will promote:**
    - **Integrated health care systems built around evidence-based best practices;**
    - **Health information technologies and electronic medical record systems;**
    - **Wellness and preventive care;**
    - **Reduction of fraud and of both clinical and administrative waste;**
    - **Transparency about insurance and health care delivery;**
    - **Health education, patient-provider communication, and patient-centered care, disease prevention, and health promotion; and**
    - **Disease management strategies.**

Approved, 12 to 1

5. Integrated Community Health Networks

The federal government will take a leadership role to aid localities in developing integrated public/private networks of health care providers aimed at providing low-income vulnerable populations with a source of high quality integrated health care by:

- **Identifying within the federal government a central entity responsible for federal efforts that support the health care safety net.**
- **Establishing a public-private entity at the national level responsible for advising that federal organization by monitoring the nation's health care safety net's performance and funding streams, conducting research, and identifying and disseminating best practices on an ongoing basis.**
- **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.**
- **Making additional community-based organizations eligible for cost-based reimbursement for Medicare and Medicaid.** *(Staff were instructed to expand FQHC concept to accommodate other organizations.)*

Approved, 13 to 0

6. End-of-Life Care

Members agreed to include a separate recommendation to improve end-of-life care and asked staff to develop language for their consideration.

Approved, 12 to 1

The Working Group Members then agreed by a vote of 12 to 1 to approve the package of recommendations as a whole with the understanding that a section on financing would be developed by the committee and shared with the Working Group for inclusion.

Members asked staff to prepare a revised set of recommendations for publication for publication by June 2. The final version was to include the language discussed above plus background information on how the Working Group's work in analyzing citizen input was carried out and what the Group heard from those participating in community meetings, web polls, web casts, and other sources. They decided by votes of 12-1 and 13-0 that brief contextual material be omitted but that it be refined for consideration at the

June 21, 22 Working Group meeting. The staff was asked to circulate this material for one final review by Members before publication.

The Chair adjourned the meeting at 12:15 p.m., Thursday, May 25, 2006.