

Citizens' Health Care Working Group Meeting
United Food and Commercial Workers International Union
1775 K Street, NW, 11th Floor
Washington, DC
Monday, August 28 and Tuesday, August 29, 2006

Meeting Minutes

Working Group Members Present:

Pat Maryland, Chair (Monday only)
Richard Frank, Vice Chair
Dotty Bazos
Frank Baumeister
Montye Conlan
Joseph Hansen
Therese Hughes
Catherine McLaughlin (Monday only)
Scot Nystrom (Representing the Secretary, HHS, Michael Leavitt)
Rosie Perez (by phone, Monday only)
Aaron Shirley
Deb Stehr

Working Group Staff Present:

George Grob, Executive Director
Jill Bernstein
Carolyn Dell
Margretta Kennedy
Andy Rock
Connie Smith
Caroline Taplin
Lora Wentzel

Other Key Attendees:

Don Cox, ASPE/DHHS
Mary Giffin, GAO
Jeff Jendel, PFI
Susanna Knouse, Public Forum Institute (PFI)
Elizabeth Magruder, PFI
Jonathan Ortmans, PFI
Mary Ella Payne, Ascension Health
Carol Reagan, UFCW

Pat Maryland, the Chair, began the meeting at 8:30 a.m., Monday, August 28, 2006.
Jonathan Ortmans, PFI, facilitated the meeting.

Participants at recent community meetings (in Oklahoma, Wisconsin, Florida, and Mississippi), where the Interim Recommendations were discussed, summarized the results of the meetings.

Most of the Working Group meeting was devoted to working toward a set of Final Recommendations, as called for in the authorizing statute. This was accomplished through discussion, live editing, and assessment of agreements regarding specific changes and change expectations to modify the Interim Recommendations. The Working Group conducted its meeting: making changes on the spot where specific deletions and wording additions could be agreed to and proposing further wording edits to be carried out collaboratively by PFI and Working Group staff for sharing with the Working Group. Broad issues, such as the order of the recommendations, were deferred for discussion at the end of the meeting.

The Members briefly discussed their process for the meeting. It was observed, and agreed, that the purpose of public comment period was to hear the views of the public regarding the Interim Recommendations so that these views could inform the deliberations of the Working Group as it prepared Final Recommendations. Catherine McLaughlin asked whether the Members could consider making major changes to the recommendations to reflect the concern heard from some of the public that the Interim Recommendations “didn’t go far enough.” Since the comments heard, to date, from the public continue to be mixed, there was agreement that changes might be made that reflected what had been heard, consistent with the views of the Members.

Montye Conlan, Therese Hughes, and others indicated that the separate recommendations should be knit together better so that it was clearer that they formed a whole. Dotty Bazos agreed, observing that the recommendations needed to be better packaged to reflect the links between the various recommendations, to clarify what the Working Group was advocating, and to convey more clearly a sense of urgency about the need for action.

Discussion of Interim Recommendations

What follows is a summary of some of the major discussion threads related to each recommendation

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

The Members agreed to delete some redundant language that was part of the interim recommendation. They also agreed to preclude neither a private nor a public system as the mechanism to achieve the goal stated in the recommendation; rather, the Working Group chose to leave action on this to Congress. While many of the individuals who responded to the on-line polls or attended community meetings emphasized the need for a public system, a large number also expressed the desire for a mixed public-private health care system.

The Members agreed that what was clear was that there is a diversity of opinion and the Working Group's job was to summarize this range of views and provide it to Congress for action. As stated by Catherine McLaughlin: "We found that the public is ready for major change now but that there is ambiguity about the direction they want for that change." Richard Frank emphasized that the report is for Congress, that there are lots of approaches that could work and that what is important is not the specific approach, but getting the bottom line right. Joe Hansen observed that the cosponsors of the Working Group legislation were not looking for a "magic bullet" but wanted the Working Group to "find out what the public wants."

The Members discussed clarifying the recommendation to read: "It should be public policy, written in law, that all Americans have affordable health care." However in an 8 to 2 vote, the Members decided omit the phrase "written in law," and agreed, tacitly, to add language of this nature to the text under the recommendation instead.

The Members discussed whether the concept of "core" benefits was sufficiently clear. One of the results of this discussion was to move some of the description of core benefits to the recommendation on defining a core set of benefits and services. During this discussion, several Members stressed that no one should lose benefits during any ensuing transition to a new system. Richard Frank underscored the importance of staying focused on the need for broad system change.

Jonathan Ortman asked the Members whether to retain the 2012 target date for accomplishing full implementation of the recommendations. Joe Hansen clarified that the important question was how to portray the public's sense of urgency that action on health care move rapidly. Dotty Bazos suggested that the order of the recommendations should express the logic of how they would advance. George Grob commented that specific dates and action steps were two available means for the Working Group to signal its priorities and that removing the target year might convey, inaccurately, the impression that the Working Group was backing off its commitment to early action. The Members voted 8 to 2 in favor of retaining the year 2012 as the time frame for full implementation of all the recommendations.

"Define a core benefit package for all Americans."

The Members discussed the portion of the recommendation that defines health as including physical, mental, and dental health and whether the definition was adequate. They considered addressing the topic in the values and principles or, alternatively, expanding the language to include vision and hearing care. They agreed, tacitly, to leave the language as it was but to discuss vision and hearing care in the text of the recommendation. A Member also suggested that staff review definitions from sources such as the IOM.

Richard Frank raised a question about the necessity of considering the design of a core benefit package in the context of a budget. Whoever designs the core benefit package will need to have a spending level in mind. He observed that the innovative aspects of the

Oregon Health Plan were that the benefits paid depended on what was available and low-impact/lower-need services were cut off. Services to be paid for were prioritized based on medical evidence.

Therese Hughes pointed out that purchasing coverage above a core benefit package would remain difficult for poor people and that low income people are unable to “buy up.”. She expressed concern that low income people would not have the services that they needed since, for her, “core” implied the very basics.

Members agreed that the Working Group needed to address the issue of costs further and that while the Working Group was not proposing a universal budget, those who developed a core set of benefits needed to be mindful of cost. Staff and Members commented that, with regard to funds, a national system could be designed so that either a single group dealt with both budget and benefits or that a different group could deal with the budget question, as do the legislators in Oregon. However, it was observed that the recommendations do not explicitly suggest a separate body to deal with budget.

Pat Maryland mentioned that an aspect of cost was enabling clients to accept some personal responsibility by being able to trade off healthy behaviors for financial assistance. Members and staff observed that community meeting participants wanted to ration neither services nor people; basically, they wanted what the Congress had.

The Members discussed what criteria should be used for developing a set of core benefits (e.g., medical effectiveness) and whether to include some language regarding a budget. In response to a question about how an independent analysis would be carried out, a Member observed that CBO provided a budgetary impact estimate for every proposal all the time and that there could be a process such as that. The independent body could consider health impacts as well as cost impacts. The members agreed, tacitly, to adding “economic impact” as a criterion for selecting the core benefits.

Catherine McLaughlin suggested that the recommendation needed some language indicating that the core benefit package that results from this process may look different from both public and private packages and programs that now exist. She also observed that there needed to be discussion about the private sector.

The Members discussed how core benefits should be characterized or the expectations that should exist regarding them. Deb Stehr asked that home and vehicle modifications be included in the core benefit package. Montye Conlan asked whether there was a way to encourage more parity among the states in their Medicaid programs. Other Members expressed concern about continuation of a fragmented system of care. Richard Frank observed that it was likely not feasible to suggest that everyone will be provided the level of care now available in the more generous Medicaid programs.

Members expressed a variety of views regarding how broad the core benefit package should be and whether there needs to be some language in the recommendation regarding a safety net for some populations during any transition to a new system. Members also

expressed varying opinions regarding how specific the recommendation should be. Dotty Bazos commented that there was an inconsistency between providing a long list of services in the recommendation and saying that it depends on the nature of the program. The Members also discussed benefits versus services and agreed not to identify a core set of benefits and services.

“Guarantee Financial Protection Against Very High Health Care Costs.”

Members discussed how to strengthen the proposal and assure that it reflected what citizens had said at the community meetings.

Catherine McLaughlin observed that coverage is decreasing among small employers who account for very few employees; the drop in employer-covered health insurance results from reduced premium support for dependent coverage and for retirees.

Therese Hughes indicated that while community meeting participants had expressed a desire for protection against high medical costs and medical bankruptcy, she disagreed with presenting this as the first recommendation of the Working Group: it addressed the needs of a relatively small percent of the population and, as a stand alone issue, it failed to address the problem of lack of access to primary care. Joe Hansen indicated that the recommendation was one of the main ways to address catastrophic health care costs and that the recommendation represented an interim step on the way to comprehensive coverage. Catherine McLaughlin observed that, if the recommendation were implemented through a market-based approach, people with the lowest income would need to pay the highest deductible and that the policy options provided were for illustrative purposes only. Richard Frank confirmed that there was no way to know how well the proposal would fare in a market-based environment. Joe Hansen observed that there was no “FPL” (federal poverty level) defined for market-based approaches as there was for public systems. The Working Group Members agreed to replace the reference to “200 percent of poverty” with “low income.”

The Members discussed the specifics of how the recommendation would affect individuals and how the recommendation would function. They reviewed how it would make a low-income person who was also a Medicare/Medicaid dual eligible better off. However, Members pointed out that that because the deductible (\$4,000 in the example) applies each year, the proposal does not solve catastrophic cost issues for everyone. Staff pointed out that most Medigap policies would cover the deductible; other individuals might find it possible and advantageous to drop such supplementary policies.

“Bringing the Recommendations to Reality: The Money Question.”

Although the recommendations were not designed to be budget neutral, the Members agreed that this section should address the question of where money would come from, especially considering the way some independent groups might score expenditures versus savings. Richard Frank observed that the section should make the point that there were some reasonable and fair ways to obtain funding. Pat Maryland commented that if all the

recommendations were advanced, the proposals should slow the rate of increase in health care costs.

Joe Hansen recalled that participants in the community meetings emphasized the importance of fair shared responsibility and suggested that this be applied to employers. He expressed concern that employees' tax liability not be increased significantly. Catherine McLaughlin clarified that the examples of how to provide for catastrophic coverage were meant only to be illustrative to facilitate public understanding of the recommendation.

Members discussed the possibility of recommending capping the tax deductibility of employee/employer health care payments. It was observed that experts had recommended capping the deduction of employer-provided health coverage. However, the Members were less clear about the political feasibility of suggesting this be done. Members had heard from some outside experts who indicated that capping the deductibility might result in employees receiving higher wages. Joe Hansen indicated that while employers would agree to a cap, they would need insurance pools to be established that they could buy into.

Members discussed the need for the financing work group to reconvene. Frank Baumeister commented that more input was needed from Brent James regarding the latter's belief that health information technology could provide a significant financial offset. Other members expressed mixed views, including the serious concern that the Working Group's credibility would be undermined by supporting the idea that the bulk of the savings needed to offset the costs of the recommendations could be found in improved health information technology and quality improvements.

Joe Hansen suggested that the Working Group propose sources of revenue that are fair, considering rich and poor, sick and well, and quality and efficiency. He also suggested the possibility of offsetting caps on individual employees with for-profit tax on employers.

Members agreed, tacitly, to make clear that proposals discussed were examples only. They agreed to drop the Medicare example in the current draft and to suggest that increased financing could come from profit taxes, reducing tax deductibility, sin taxes, or value added taxes. Pat Maryland added the desirability, from an employer perspective, of incentivizing healthy behavior.

“Support Integrated Community Health Networks.”

The Members engaged in an extended discussion regarding the portion of the recommendation that called for building on the Federally Qualified Health Center (“FQHC”) concept. Correspondence had been received from both the National Association of Community Health Centers as well as from individual association members and community board leaders opposing the language in the interim recommendation.

The Members agreed that their recommendation did not seek to diminish Federally-funded community health centers but rather to expand its reach to additional types of providers. As such, the Members agreed, tacitly, to retain the recommendation as included in the interim recommendations.

One Member suggested that community health centers should seek hospital partners to help assure an integrated care system across levels of care.

“Promote Efforts to Improve Quality of Care and Efficiency.”

The Members agreed to some streamlining of the recommendation. Members asked that language be added addressing: transparency, sharing information on quality indicators, and the need for consumer friendly information.

Members agreed, to drop language suggesting that eliminating direct-to-consumer advertising could save money. This provision was included in the interim recommendations because there had been a call for it from both the community members and some Working Group members; however, it was observed that while it might not be desirable to some to have such advertising, it was unlikely that banning it would result in savings. Members commented on other similar points made by community meeting participants including: health company profiteering and top CEO salaries. Richard Frank acknowledged that there were a number of questions about whether the health care system serves organizations or people. Likewise, Montye Conlan said that she had heard frequently people saying there is no proper place for profit in the health care system.

The Chair ended the first day of the public meeting at 5:50 p.m.

Richard Frank, Vice Chair, continued the Working Group meeting at 8:45 a.m., Tuesday, August 29, 2006.

“Fundamentally Restructure the Way End-of-Life Services Such as Palliative and Hospice Care are Financed and Provided.”

Members discussed: the need to address language; the fact that hospice care is desirable and the use of the service is steadily increasing; and the inclusion of care in the home as an essential component of hospice care.

Members and staff discussed whether it was relevant to refer to “use of best practices,” or whether knowledge base in this area was yet too thin and whether the phrase was too strongly associated with medical interventions. Members observed that predictions by health care providers concerning how long people will live are unreliable. A Member commented that the recent experience of Art Buchwald (who checked into a hospice, got better, and checked himself out) should be considered cautionary.

Joe Hansen emphasized that the Working Group should avoid broad policy recommendations about, and be sensitive to, the role of religion in end-of-life experiences.

Members generally agreed that raising the issue of palliative and end-of-life care was essential; however the recommendation should not seek simplistic solutions to a complex issue.. Frank Baumeister, drawing from his experience, spoke of the difficulties of “death with dignity” laws that seek to provide greater patient choice. He gave examples of difficulties getting pain medication for dying patients and told of hearing testimony from doctors who had been lost their licenses for prescribing narcotics. He spoke of the many issues that need to be addressed in order to improve end-of-life experiences, including: the availability of narcotics, addressing language issues, and supporting and reconciling family preferences. The solution to the conditions that currently prevail in the health care setting will require, among other things, revising the training provided in medical schools.

Order of the Recommendations

The Members discussed the order in which the recommendations should appear in the final report. It was agreed to begin with the statement about making it public policy that all have access to affordable health care.

The members agreed to the following order: public policy, catastrophic, community networks, quality, end-of-life care, core benefits, and the money issue last.

Montye Conlan indicated that she thought that the relation between the catastrophic and community health networks recommendations needed to be clarified. Members discussed the contention by Brent James that the only place where there were money-saving efficiencies was at the local level so that a new delivery system needed to be based on, or

grow out of, existing organizations. Members commented that the boundaries for the system could be county, city, a special district; the boundaries needed to be based on the way people move; it would be different in different parts of the country. The Members agreed, tacitly, that such boundaries wouldn't be defined in the recommendations. However, they also agreed that a clear, succinct, short description of how the recommendations fit together was needed.

Members discussed how to portray the recommendations conceptually as well as the implementation chronology needed to get to a health care system that works for all. The Working Group also discussed possible revisions to the values and principles statement and asked PFI to provide a redraft for the Working Group's consideration. Frank Baumeister commented that the Final Recommendations offered a rare opportunity to bring the country together around the idea of the importance of health care as a shared social responsibility. Montye Conlan stressed the importance maintaining the spirit of community cohesiveness in the recommendations by not overburdening them with excess focus on reimbursement, payments, and budgets.

Richard Frank suggested that the section of the report discussing the public engagement should point out all the various ways and groups that the Working Group reached out to and emphasize not only that the Working Group engaged the public at meetings but that it did so in a host of other ways as well including personal as well as organizational outreach, formal meetings, one-on-one conversations, and long and intense hours of effort by the Members themselves.

The Transmittal Letter

Members briefly discussed the length, tone, and content of the formal transmittal letter and concluded that it should be brief and close with a request for action.

Preparation for Mid-September Working Group Meeting

Staff reviewed with Members the upcoming meetings for mid-September and the last meeting at the end of September when the Final Recommendations will be issued. Most of the Members expected to be at both meetings.

Jonathan Ortman and Richard Frank proposed that the mid-September meeting would be for members to reach agreement on the final package, not to walk through it line by line and that the group should set a fairly high bar for objections to the draft that they would have for their final action. The draft document would be sent to the Members prior to the next meeting.

Members asked to be able to see, in written form, any dissenting opinions that were to be proposed for inclusion in the Final Recommendations package so that Members could review and be prepared to comment on these, as necessary.

Richard Frank extended his thanks to Jonathan Ortman and his staff, and to the Working Group's staff for having "done more than could be expected of them." Other Members expressed their pleasure with the tone and progress of the Working Group at this meeting just ending.

Richard Frank ended the meeting at 2:00 p.m.