Question	We all have different experiences getting health insurance or in seeking health care. Sometimes these are good experiences, while other times they are not. We may meet very special providers or encounter new and innovative practices. Other times the American health care system disappoints us. Please tell us what has worked well or hasn't worked well for you or your family.		
	Response	**State**	**Date/time received**
	With the vast number of health care dollars going towards chronic health conditions, I think it is of the utmost importance to continue to shift our healthcare paradigm to more of a preventative model. So many of the chronic diseases in our country such as heart disease, diabetes, and possibly cancer can be traced to lifestyle and environmental factors which we can modify. By investing more federal dollars in and improving access to alternative medicine such as nutritional couseling and naturopathic medical services, I believe we can lower the rates of chronic disease and therefore lower the insurance costs for the population at large. One other area I think we need to reduce spending is in the heroic medical options given to people in their final days of life which are so costly and do little to prolong life or increase the quality of life. I realize that this would also require a paradigm shift in our culture to becoming more comfortable with death, but I feel that this could potentially open up health care dollars for those earlier in life where it would increase overall survival. Thanks for listening	WA	2/16/2006 7:37:58 PM
	I am uninsurable. I'm a trim, fit woman in her early thirties who eats well, doesn't smoke, takes no medicine beyond vitamins, and has no illnesses whatsoever. However, late last year, I had a miscarriage at approximately 8 weeks. Although miscarriage is very common, occurring in about 20% of all pregnancies, two insurance companies have declined me for coverage on this basis alone. In disbelief, I called the underwriting departments to check, and sadly, they both confirmed that a miscarriage without a subsequent full-term pregnancy makes me uninsurable. I am self-employed, so no group coverage is available for me. It appears that I must have a baby without the benefit of medical assistance, wait a year, and then reapply with my fingers crossed. How can this system be so broken? Who *is* insurable?	UT	8/2/2006 11:21:42 AM
	My man concern with me and my family's healthcare is that I believe we are underinsured. My husband and I both are self-employed. He works more than full-time. I work part-time and also take care of my 3 year old daughter. We have a PPO private insurance. The premium is manageable but our deductable is very high and copayment is very steep. When I had my daughter it cost us well over $6,000. I am very concerned that if one of us experienced a serious medical condition we would lose our modest savings. Another experience which frightened and disappointed me is when i was preparing to become pregnant with my daughter I attempted to get better coverage. I was hoping I would have good luck with Kaiser but because I am on Lexapro for a very manageable anxiety disorder they told me my premium would be $700 per month. This made me feel as if I was being punished for taking care of myself. For actively and effectively treated myself for generalized anxiety I can not qualify, at an affordable cost, for better coverage. I was also surprised at this because I am extremely healthy otherwise. It made me wonder how others who are worse off them me fare in getting coverage. I am perfectly willing to pay a significant amount more in taxes for universal health care. I do not believe in getting something for nothing. I also believe, very strongly that is absolutely immoral that healthcare is largely a for profit business. This nations priorities need to put in order and healthcare needs to be at the top of the list. Working people like me and my husband are left to cross their fingers that we don't have a medical crisis. I would also like to add that i worked for many years in a hospital emergency room and saw, firsthand, how the ER is a place where the poor come for basic healthcare because they have no place else to go. i also saw that many people let there medical problems go until they are so serious they end up in the emergency room. It is a sad state of affairs. Thank you,	CA	5/11/2006 12:08:50 AM

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	I am concerned about our lack of emphasis on preventative care. I can't believe the amount of money we spend on drugs for chronic conditions such as diabetes and atherosclerosis as compared to the paltry sums we spend on awareness and prevention.	MS	8/30/2006 4:52:17 PM
	I am a chiropractic physician. I am hopeful that a comprehensive health care plan can become a reality. I hope that preventative measures such as chiropractic care, exercise therapy, and nutrition will play a role in this plan. These preventative measures need to be present in community health centers and in all basic coverage. MDs should not be allowed to be the gatekeepers for these services, as they do not fully understand them. Chiropractic care needs to be a core member of any wellness package.	MS	8/30/2006 5:16:12 PM
	In my first career in education, I had tradional insurance with no coverage for office visits or preventive care. At the time, when costs for routine care were reasonable, it was fine. In my second career in high tech I had employer-paid coverage for all care and prescriptions. This was terrific but unnecessary. Then I had cancer at 56. Now I can't get any coverage at any cost, and am holding my breath until Medicare. At the age of 62 I feel completely left out of all medical systems, because I'm not eligible for Medicaid.	NM	3/10/2006 9:21:48 PM
	My husband and I are both self-employed. My husband is covered by the VA system, but I have no coverage. What I need is a plan that will allow for office visits and routine care. These kinds of plans are unbelievably expensive, and it is cheaper at this point for me to go without insurance, and pay the fees when I get sick and need to see a doctor. (The other day I paid $160 for a few antibiotic pills for a throat infection! Why in the world has medicine become so expensive?) However, I do worry about the catastrophic event that would land me in the hospital, or worse. I think health insurance is way too expensive for the average worker to afford, and we know many peple who stay at dead-end jobs just for the health insurance ---this is a sad situation. We are the richest nation in the world and yet we cannot insure health care for all people.	IN	3/20/2006 3:23:36 PM
	When my husband left the corporate world a couple of years ago we needed to get private health insurance for the two of us and our four children. Not only is it exceedingly expensive, our then 13 yr. old daughter was not allowed on our plan because she broke her finger playing soccer a few months earlier. Just to clarify, it's not that they wouldn't cover the cost associated with the injured finger (which I would have understood), they wouldn't include her in our plan at all. We are a VERY healthy family; no smoking, no chronic illnesses of any kind, not even allergies. Yet, the insurance company that denied my daughter coverage (it was Blue Cross/Blue Shield by the way) employs, and offers health insurance coverage to it's dozens of overweight, smoking employees. Figure that one out!	IL	3/21/2006 2:42:55 PM
	Having read many horrendous accounts of Americans who are suffering because of a lack of affordable universal health care I feel lucky to live in Canada where I don't need to worry that my insurance will be discontinued or become unaffordable because of some mishap! This said, I hope to retire to my home land sometime in the future but this may not be possible because of a lack of a health care safety net like there is in Canada.	na	6/8/2006 1:18:36 PM

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Response	State	Date/time received
I've noticed that most of all the insurance plans offered to me have been pretty good plans. Across the board I've noticed that when it comes to anything that helps to relieve a problem or that is preventative based, it is not covered under insurance. Whether it is massage, acupuncture, herbal remedies, or colonics to clean out digestive track and cleanse the body...nothing is covered. Not even subsidized gym memberships. If we are ever going to be free of illnesses insurance companies need to start paying for preventative procedures to stop the problems before we die.	NY	5/25/2006 11:44:46 PM
I was young, naive and living hand to mouth raising 3 small boys alone when I accepted a "better" position in San Diego, having no clue about the cost of living in California. I could barely afford to pay my rent and put food on the table. Before I was able to enroll in company health benefits, I became ill with a kidney infection. I went to county clinic for a nominal fee. The clinic was bustling with unregistered immigrants whose sick little ones ran amok spreading flu germs. I remembered thinking I was going to get sicker sitting in that clinic than I was before I went. These young moms couldn't afford health care because they either weren't working or worked for less than minimum wage for employers who were cheating "the system." It's a no-win situation that adds to and perpetuates poverty in this country. Even the registered immigrants are poorly paid and, like me, either didn't have health care available or couldn't afford it. Why not use these resources to help defray the expense of services - doing childcare, filing or janitorial work? At least then they would have a vested interest in the programs they utilize. For me it was a one time visit under extraordinary circumstances. For many others in that clinic it's the only healthcare they'll ever have. I think it's the same in all the states, not just California.	CO	2/16/2006 12:21:16 PM
I've had three major back surgeries and have sustained permanent nerve damage. As a result, I've spent a lot of time in doctor's offices, hospitals and physical therapy. Unable to do anything for a sustained period of more than an hour without a lengthy rest, I will never be able to hold a full-time regular job again. For years I was on pain medications and anti depressants due to the physical damage and emotional ravages. Being able to do one's part in society affects one's self esteem greatly. I'm fortunate that I have an able bodied working husband who supports me and has good insurance. Without it, I'm not sure I'd have survived. When we had an opportunity to move to Colorado after my mother passed away, it was a blessing because the cost of living is significantly less than where we'd lived before. Unfortunately, when he changed jobs, we were without regular coverage for a few months and were forced to use a Cobra extension. The premiums were outrageous and all my medications cost us more than $800 a month. Living on Social Security Disablilty would barely provide for me if anything happened to my husband, and I wouldn't have private health insurance. Fortunately, through prayer and gritting my teeth, I've been able to get off all medications and be content with my circumstances. Not everyone is so fortunate. If I had a heart condition, or went on the medication I need for my hepatitis condition, I wouldn't be able to afford life sustaining medications. Needless to say, I'm an advocate of healthcare for everyone. I also believe that people need to contribute to their own care as much as possible. Americans shouldn't be saddled with higher taxes and higher premiums or co-pays for private insurance premiums because we're supporting healthcare for illegal immigrants in this country. Most Americans who are forced, by circumstances beyond their control, to accept government assistance for health care, have already paid into that system for many years either through social security or income taxes. While I'm a charitable person by nature, I think it's wrong to give hand-outs to anyone. Our forefathers (and mothers) worked their way into this country and proudly earned their citizenship. That's not too much to ask of those who want to share in the bounty of the United States. I pray that however our government reforms healthcare, it does something positive toward eliminating illegal immigration and stops giving free healthcare to unregistered aliens who come just to take advantage and not contribute. That costs all of us.	CO	2/16/2006 12:54:15 PM

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Response	State	Date/time received
Our biggest asset as a family is the fact that I am a nurse. Today it seems that knowledge is invaluable. Our healthcare professionals need to be held to the highest standards. I think that there are many places that high standards of education and practice are not practiced. All doctors, nurses, and the others in the field are not the same. As all illnesses are not the same from one individual to another. We must speak up when things are not right and we must cooperate with the health professionals when they are doing things right. Trust in your doctors is of utmost importantance. Knowledge is power.	CO	2/16/2006 1:37:02 PM
As a provider of midwifery services for women wanting home births I did prenatal care out of an office in mine and my midwifery partner's home. I saw first hand and heard from the women I cared for how very important it is that practitioners have the time to get to know the people they serve. There is no substitute for a caring professional who really knows you and can therefore best help you figure out your health care needs. To offer this kind of high quality, continuous care we will need to shift our perspective from cranking out as many appointments as possible and thus stretching providers to the limit to have many more PRIMARY care providers such as midwifes for maternity and well-woman care, family practice doctors for general primary care and naturopaths, homeopaths Chinese medical care providers for those that want a complementary primary provider. We need many more such providers who have smaller case loads so that continuity of care is really put to the fore of what is offered. This would allow time for good care, be more rewarding for the providers and not burn them out. with a single payer system, paperwork would be much reduced, some of the billing code stuff could be reduced or eliminated. This would allow the practitioner to trouble shoot such common problems as the tendency to pile on drug Rx just because that is easy and fast, something that particularly happens with seniors a lot. Were there more time it would be easier for doctors and patients to work out what was helping and what wasn't. While more time for visits may seem to some people as frivilous, a return to the family doctor mentality where practitioners knew their communities of patients and followed them for a life time would help move us out of the current tendency to order more tests and take more drugs to a more holistic approach which is only possible when patients and practitioners know and trust each other. Incorporating and mainstreaming alternative providers will further this because it will help people be aware of what options they have and keep people off expensive drugs and get them into therapies that can really build or restore their health in many cases. This will ultimately save us all lots of money in dollars, productivity and general national well-being. In attending the meeting in Seattle it was so obvious that people have a vision of fully comprehensive coverage, the list of things to be covered was long and growing, only limited by what people could remember should be on there. It seems that congress has a very miserly view of what a national plan would have to look like but the people in Seattle did not. If we are the richest country there is no excuse for not having an excellent health care system that does not see good care as fluff but as a basic right. I was in the drug store not long ago when I went to the back of the store to find a young woman sitting in the Rx area, with a pool of vomit at her feet. She said, I have thrown up, could someone help me? A pharmacist went to the front of the store, I went to check to see what was being done for her. Basically nothing other than getting staff to clean up the floor. I went back to her and asked if she wanted me to call someone, which I did for her. Then I asked her if she needed anything. It came out that she was there to pick up a Rx but did not have the money to pay for it, she had had be call her mom to bring the money. Obviously she felt terrible, she was shaking and not doing well, she did not have the wherewithall to call herself. I asked if she got the drug now would it work quickly to help her feel better. She said yes so I bought her meds for her and she took it right away. By the time her mom got there, she was feeling better. This is what is a big part of what is wrong with the system, that money should EVER stand in the way of a person getting the help they need is absolutely unacceptable in this country or	OR	3/3/2006 1:37:43 AM

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	Response	**State**	**Date/time received**
	anywhere for that matter.		
	My experience is not in actual access to care, but healthcare delivery. I am a registered nurse who has worked in the intensive care unit in an acute care hospital in ***, NV for the last 15 years. The health care delivery system is *** is dominated by for profit hospital chains, HCA and UHS. This has lead to a decline in the quality of care delivered in Hospitals. The Hospital I work at is chronically short staffed, not leaving enough nurses to care for patients. This leads to "nursing by crisis", nurses are running from one crisis to the next and do not have time to deliver basic nursing care. This leads to bad outcomes for patients like increased mortality rates, pneumonia, blood clots, bedsores, urinary tract infections, etc. Patients and nurses are suffering due to the working conditions in Hospitals in ***, Nevada, and across the Country.	NV	3/22/2006 6:21:02 PM
	I am a physician assistant and have taken care of other people for 20 years. I have to work at a part-time job as an independent contractor because of an undiagnosable condition the past 8 years (I couldn't work full time). I have finally discovered that my "undiagnosable" condition is Lyme Disease, CDC positive by Western Blot. I have been getting better the past 5 months with regimens of heavy duty antibiotics. I have paid a BCBS health insurance premium since 1993. Now, BCBS doesn't want to pay for my antibiotics. They are conveniently siding with a group of physicians who don't believe in such a thing as "chronic lyme", despite many lyme patients improving with months of antibiotic therapy. So our idiotic health care system wants me to go without antibiotics, get sicker, get disabled, stop paying taxes, and then maybe I can get BCBS to pay for treatment for some horrible neurolgical disease that mimics Lyme like MS, or ALS. The US health care "system" is a national SHAME. It is simply propaganda that we have the best health care in the world. What a joke. Perhaps we have the best health care in the world for millionaires and government workers, but NOT for everyday Americans. (How about no more tax-payer subsidized health care for our congresspeople until We The People get the same level of healthcare??! That would fix the system real fast). It is sixty years past due for universal health care converage for EVERY American, based on preventive care. Medicare for every American. Get the profit-mongers like BCBS and the pharmaceuticals out of the policiy-making picture. The money to pay for a civilized health care system can come from the Dept of Defense if they were ever made accountable for the trillion dollars of tax payer monies that they can't seem to find.	NC	7/4/2006 9:22:40 AM

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I'm pregnant with our fifth -- it's very frustrating to be subjected to expensive, needless tests, and forced to use an obstetrician because homebirth and non-nurse midwives (the most appropriate form of care per the WHO) are not permitted in our state nor do physicians sponsor them. Non-nurse midwives and homebirth are statistically associated with excellent outcomes. I'd like to see consumers given more latitude, our judgment trusted if we want to use non-MD-directed health care (midwifery, chiropractic, alternative cancer treatment etc). The way things are now, I doubt that will happen. Cost-efficient, alternative health care is antithetical to physicians' lobbies and the power weilded by the pharmaceutical and hospital industries.	AL	7/24/2006 6:03:52 PM
I am a physician. One of my patients was a bed-bound woman whose son cared for her full-time for the last few years of her life. He had no income and no health insurance; they lived off her social security, food from a pantry, and household items that they managed to sell. The man was sued for $18,000 by a hospital to which he was admitted for a kidney stone. The hospital got no money, the man got no more medical care. After his mother's death he disappeared; I think he went to live on the streets.	IL	3/25/2006 12:14:47 AM
as a hospitalist physician on the hospital frontlines i see marked abuse of the healthcare dollars repeatedly by patients who have no financial accountability, have little understanding of their medical diagnoses, have very little input if any by their primary care physicain - if they have one, regarding a specific problem for which they present to the emergencey room; and horrendous expenditures on multiple procedures of rapidly vanishing returns on obviously nonsalvageable patients.	TX	2/27/2006 8:55:06 PM
I am self-employed. My health insurance costs are $800 month for me and my spouse and our son. The costs will only go up from here. What happened to the American dream? When the cost of insurance premiums exceeds the cost of a mortgage then something is wrong. Do Americans really have to make a choice between a house and health care?	CO	3/19/2006 12:29:17 PM
I am a 57 year old woman recently divorced. I have no health insurance. I am unemployed because of a work injury. Therefore, I cannot get health insurance through an employer. I think it is horrible that women in my predicament cannot get affordable health insurance. I am afraid to get ill. I pray every day that I stay healthy. I am on a limited income and have taken over the home. It's ashame that we have to choose between having a place to live or having health insurance. Is this really America? I don't feel like I am living the American Dream.	PA	7/25/2006 1:14:44 PM
I am 57 years old and divorced. I have no health insurance. I think it is horrible that women in my situation cannot get affordable health insurance. I am afraid to get ill. I pray everyday to stay healthy. I am presently unemployed because of a work injury. I am on a limited income. It is unacceptable that we have to choose between having a home or health insurance. Is this America? I am not living the American dream.	PA	7/25/2006 1:39:47 PM

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	I am a consumer, provider, and have been a health care insurance salesperson. There is vast waste in our current system because of the cost of having so many money hungry executives and expensive VPs in the system all of whom what salaries in the 1 million plus range. The profit motive does not work in healthcare because the object is to provide the best possible service not the cheapest. The presence of multiple companies in the marketplace makes for vast overhead expenses and the use of market dynamics causes a focus on cheapness above all. we need a single payer system based on the models provided by Canada, Australia and other countries. Our Medicaid system is actually much cheaper to run and provides as good financial services as do the expensive private systems currently in use. the employment based system currently used here is the product of a World War II need and is badly antiquated. We need a universal coverage model with a single payer for everyone. the cost savings of this system would pay for all of the currently un-insured people in the country.	CO	2/17/2006 6:05:02 PM
	In 1989 I was diagnosed with an autoimmune condition destroying my liver. I had full health insurance coverage. By 1999 the condition had worsen and was liver transplanted at our local hospital. I was required to pay a $5,000 co-payment and some other costs. Soon after that the hospital discontinue liver transplantation due to cost effectiveness. Now individuals have to compete at a regional level for organs and many are not surviving. At this time my employer was paying 60% of the health insurance premium and presently paying 80%. Even with our employer increasing its share in paying the health insurance, in the last 10 years our salary raises are pretty much absorbed by our increasing cost of our share. Through my health insurance cost has tripled (300%) in the last 15 years, I have not noticed any substantial improvement in healthcare. Maybe Walmart needs to run our healthcare system. You may be getting closer to getting what you pay for. Currently, after 32 years of working I am not able to retire because my health insurance cost will go up by about 500% about 25% of my retirement income. I am looking for other options, but have been unsuccessful. I may have to just settle on working the rest of my life to have the health coverage I need. When you look at health care coverage in our state of NM, I am one of the fortunate ones who at least has health care coverage. As a hard working independent individual who really wants to assume responsibility for me and my family the time has come when I will need to rely on governmental or societal assistance for survival. I have come to the realization that our country needs national healthcare like our public education system and give it the same importance and entitlement. You need health before education. Our country can make it work.	NM	6/2/2006 9:04:34 PM
	I am a Family Physician who has been working in a Community Health Center for the past six years in the southwestern part of Virginia. *** and *** Virginia, the towns we serve, have some of the highest rates of unemployment in the country due to laid off textile and furniture workers. Currently 58% of my patients are uninsured. We provide primary care, basic labs and medication assistance on a sliding scale but face daily challenges with regards to specialty care, diagnostic tests(MRI, CT scan, etc.), and medication affordability. Some of my patients are disabled but their disability check puts them over the limit for medicaid. Does the government really expect someone to live off of their disability and purchase health insurance? Numerous patients have told me they were turned down for Medicaid because they weren't blind, disabled or pregnant. These are the criteria used in Virginia to determine eligibility for adults. Many of my patients have expressed sadness that they worked hard all of their lives and payed taxes into a system that cannot help them in their time of need. This saddens me as well since America should be able to do better by its people. I worry seriously about the health care system as more jobs are exported overseas and incresing numbers of people find themselves uninsured and out of luck. The government cannot continue to ignore this problem.	VA	8/3/2006 10:41:08 AM

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My Father-in-law and Mother-in-Law moved to USA in 2000 and were granted Permenant Residencey Status in September of 2001. When they moved they were 75 and 70 years old respectivly and now they are 80 and 75 year old. Since, they have not worked here and they have their own asset and income they did not qualify for Medicaid nor did we wanted to enroll them in Mediciad. With great difficulty they could enroll in an HMO by paying premimum of $600. The HMO after couple of years started demanding that we enroll them in Medicare as they are of the age where they should qualify for either free Medicare Part A or enroll by paying the prmimum and if they do not qualify then provide the proof. We went to Social Security Administration and applied for Medicare Part A and B with the request that we are ready to pay the premiumum for both A & B. The application was denied on the ground that they need to complete 5 years of continuous stay as permenant resident and than only they can apply. We were told that we can apply three moths prior to completion of 5 years. We went to SSA office this July and submitted our application. We received a letter after a month from SSA office that you are not eligeble to receice Medicare as you should have applied when you were 65. Ofcourse there was some mistake, they were not even residing in USA at the time when they turned 65 and hence how could they have applied. We went to SSA office and now we were told that we cannot apply until we have completed 5 years which will be on 27 Septembe. We were treated very badly, different people provided differnet rules, some said you can apply three months prior to completiono of 5 years and some said you cannot apply until the general enrollment period which starts in Jan-March of every year. This is so frustuating, first of all if some one is ready to pay the premimum for Both Part A & B why should they be denied Health Insurance if they are alredy in this country legally. On one hand we have millions who do not have health insurance and are somehow receving the healthcare through tax payers money and here are two legal immigrant who are trying to purchase Government sponsored health insurance becasue no private company want to provide them health insurance, but the system is so screwed up that no one knows what is right and they are denying to provide health insurance.	MI	8/15/2006 9:13:50 PM
My mother in law was recently diagnosed with Chronic Reneal Disease. Her BP has been high for the past several years. She has been visiting her Primary Care physician regularly for the past 5 years ever since she moved to US. One day when I was examining her past 4 years blood report i saw that her Creatinine level were higher than the normal value. We called her Primary care physician and pointed out to him the high value. He just simply said that it appears she has kidney failure and she should see a nephrologist. I could not believe that for the past 5 years he has been doing physical exam every year collecting the Blood report but never even once said that she has kidnely problem. Her BP has been hight and he never mentioned that we should do something to control her BP. One reason is that physician do not use electronic system to monitor their patients. They still use the antiquated paper system, whenever we go to see the Doctor he is shuffeling through a bunch of papers and half the time the reports are missing. How can we expect our healthcare system to deliver proper care when one provider cannot talk to the other and determine what is the best treatment.	MI	3/19/2006 10:15:27 PM
I have not had health care for 3 years since I am the caregiver of my parents and cannot afford it. I would like to be covered for major medical since I do not go to doctors unless absolutely necessary. My daughter is a skydiver and has been turned down by three insurance companies, who probably still cover smokers and obese meat eaters and others who do not take care of themselves. It's just not right. Universal health care is the answer for all.	WI	8/29/2006 11:11:30 PM

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Insurance companies in some states pay for people to have a naturopath for a doctor, but Pennsylvania is not one of them. Also, natural medicines are not covered. I go to a regular MD so I can get tests and checkups covered by Keystone 65, but have to pay for my own naturopath visits and my own natural medicine. People would be much healthier and insurance companies would save a lot of money if they encouraged people to rely on healthful food and natural medicine instead of all the prescription medicines with side effects. Insurance companies do a great job of encouraging exercise by refunding some of the money spent on gyms, Y's, health clubs, etc. They should do a similar job of keeping people healthy by encouraging them to use natural medicine. I never took prescription medicine in my life until I got osteoporosis and the doctor told me I had to take something or I would be bent over and probably break bones. I took Fosamax for 2 and a half years and woke up in the middle of the night with what everyone thought was a heart attack. However, the dreadful pain was caused by the lining of the esophagus being eaten away by Fosamax. After that the doctor put me on Evista, which made me wake up several times a night with leg cramps so severe that I had to get out of bed and walk around to make them go away. After 3 and a half months of this, I woke up with a leg cramp so bad that walking around didn't help it. The pain was so severe that I fainted from it. Now I am taking Ethical Nutrients Ultimate Bone Builder with Glucosamine Sulfate and Ipriflavone. My bone density is improving just as much as it did with the prescription medicines, and there are no side effects. Please include natural medicine in your health care plan for the benefit of our nation's health. It's a wonderful way to stay healthy, and too few people know about it because of the ubiquitous, expensive advertising constantly put out by prescription drug companies, and the lack of support by doctors, the FDA (who refuse to test natural medicines for some unknown reason), and the insurance companies. Our nation is behind most of the other nations of the world in using the effective, time-tested remedies given to us by mother nature.	PA	2/18/2006 10:04:52 PM
I recently helped care for my mother during her final illness. Her Medicare plan was the easiest aspect of her final days. In some ways it's a blessing that she didn't live long enough to have to suffer through enrollment in the Republican's failed Medicare Drug plan disaster. This to me shows that people-centered policy developed by Democrats is superior to the typical Republican type corrupt pseudo-market based pay off to political contributors. I'm sorry that I have to put it this way, but we must make sure that lobbists and corrupt politicians are kept out of the process.	MI	3/22/2006 8:14:02 PM
My husband and I are in our second year on a Consumer Directed Health Plan with Health Savings Account. Our experiences have led us to the decision to switch back to a PPO plan next year. See attached file for more detail.	CO	4/7/2006 5:05:19 PM
Until recently, the Blue Cross/Personal Choice/PPO plan most of my colleagues and I have through our Union's Health and Welfare Fund was splendid. I have a number of medical problems that demand ongoing treatment; with this care, I can continue to live independently, work full-time, enjoy activities outside work, and contribute to society and to the tax rolls. All of a sudden IBX has begun denying medically prescribed and necessary treatment for (the most egregious and most recent example, in my case) lymphedema. I have Health Advocate and we are fighting Blue Cross...but this fight could become a regular thing...and suppose we lose? Without my compression garments, devices and other items, my goose is cooked, and a disease I can live with will progress to one I can't. Other people I know have similar complaints. We need health care that covers us for chronic conditions that are manageable, not just for incredibly costly hospitalizations necessitated by our insurance company's decision to refuse to cover us so that these hospitalizations can be prevented!	PA	4/12/2006 8:35:00 PM

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Response	State	Date/time received
I retired from US West (now Qwest) in 2000 at age 57. My husband and I have health insurance that Qwest provides to its retirees. Our out-of-pocket health care costs have risen from less than $1000 in 2000 to over $7000 in 2005. This is largely due to Qwestâ€™s policy of passing on increasing amounts of healthcare costs to its employees and retirees, as well as the fact that we are getting older and seem to have greater health care needs. This situation has certainly made me more aware of health care costs. The Qwest Benefits open enrollment package for 2005 included an option for the new Consumer Direct Health Plan (CDHP), authorized by the Medicare Act of 2003. I explored its potential to save us money as compared with the more familiar Preferred Provider Option (PPO). The premium savings for the CDHP as compared with the PPO were essentially offset by the higher deductible. My calculations, based on our use of health care services over the previous 12 months and a lot of estimating, made me believe the CDHP might save us some money, and I signed us up for it. After doing this, I learned that this also made us eligible to establish a Health Savings Account (HSA), since neither my husband nor I had reached age 65. Here is a summary of our experiences, as well as my conclusions about these additions to our countryâ€™s health options. CDHP The goals of this insurance plan, as I understand them, are (1) to make consumers (patients) more aware of the costs of the health care services they purchase, (2) to encourage them to shop for those services as they would for toothpaste, by making price comparisons, (3) to encourage them to take better care of their health. The first goal was certainly achieved for us, but only after the fact of actually receiving the services. Under the plan we had previously, we rarely saw all of the billing for a given service, because all we were responsible for was a fixed co-payment. Under the CDHP, we see all of the billing in all of its complexity, which is to say the least overwhelming. But, the second goal has not been achieved for us. We have not become shoppers for the least cost option, mainly because that is not a priority for us. Instead our priorities have been, (1) to continue seeing the doctors with whom we already had relationships as patients, and (2) to choose doctors and hospitals based on recommendations of those familiar doctors, whom we trust. I canâ€™t see that I ever would shop for the lowest cost surgery, for example. Instead, I â€œshopâ€ for the best treatment for my given condition and the best doctor to provide that treatment. The third goal was appealing to us, because a feature of the CDHP is that preventive care is covered 100%, before the deductible. As it turned out, United Healthcare had no clear policy on what would be considered to be preventive care, and I had to fight hard to get them to pay for my annual physical exam as preventive care. I finally had to go to our Retiree Advocate, who contacted a Qwest Benefits manager, who got United Healthcare to pay. I shudder to think of the wasted time, effort and expense involved in getting this resolved. Maybe, as these plans are in effect longer the policies will become clearer. At least I hope so. As it turns out, the CDHP has not saved us money in comparison with the PPO. My calculations were based on our previous 12-monthsâ€™ experience, which turned out not to be predictive of our greater needs in the following 12 months. However, these greater needs did not become apparent until after the open enrollment period for 2006 had closed, so we are still on the CDHP this year. This points up the fallacy of asking people to choose an insurance plan based on their individual needs. You donâ€™t know what you need until you need it. My husband and I exercise regularly, eat right, and generally do all of the recommended preventive care, but we are getting older, and some things just happen in spite of our individual efforts.	CO	5/13/2006 12:24:44 AM

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An unfortunate side effect of the CDHP is that it is a more complex form of insurance to deal with than is the PPO. I spend hours going over the Explanations of Benefits (EOBs), comparing them with the bills we receive from providers, making phone calls when there are discrepancies, etc. I feel this is necessary, because we pay 100% of the approved charges until we satisfy the deductible, after which we pay 20% of the approved charges. Of course, we rarely know how much the approved charges are going to be until after we have received the service and the provider has submitted the claim. Also, confusion has happened each year over whether we had fulfilled the deductible yet or not, and United Healthcare goes back and forth between saying we owe 100% and saying we owe 20%. Another source of confusion is when a provider submits a second claim for additional charges later for the same date of service, and we get hit with yet another bill for something we thought we had already paid for. This has happened to us twice so far. My husband and I are not really sick, have all of our faculties, are educated and are reasonably intelligent, and we find it to be a real chore and frustration to deal with. I donâ€™t know how a really sick person copes.

My conclusions: It has been an interesting and eye-opening experience to be on the CDHP. I certainly know more about health care costs now than I did before. But, it has gained us nothing in terms of our personal health care or finances and has been a major hassle. Rather than spending time shopping for the lowest price in health care, we have had to spend a lot of time trying to keep track of bills and EOBs. We will switch to the PPO plan for 2007, assuming Qwest still offers it to retirees.

HSA

When I learned that being on the CDHP qualified us to open a Health Savings Account, I thought, â€œWhy not?â€ A little tax savings is always welcome. As I understand the goal of the HSAs, it is to encourage people to save for their future health care needs. As my husband and I were already retired, the future is now for us. So, our reasons for opening an HSA were not to save for the future, but to get a tax deduction on money that we would use to pay our current health care expenses.

In January of 2005, when our new CDHP became effective, I went in search of an HSA. The local financial institution with which we do most of our business, Bellco Credit Union, does not offer this new type of account. The only banks I could find who offered them were Internet banks, most of which seemed to be set up specifically for the purpose of offering HSAs. I decided to open the account with Exante Bank, which is a wholly owned subsidiary of United Healthcare. I thought that Exante Bankâ€™s relationship with our health insurance company would expedite matters. I was wrong.

Our whole experience with Exante Bank was a disaster from start to finish. They consistently and regularly gave me incorrect information, including giving me a fee schedule that they later said was the wrong one. I couldnâ€™t rely on what Exante Bank told me, and I had to keep reading the IRS rules about HSAs. Exante Bank made it very difficult to set up the account. I never received the promised debit cards. I thought Iâ€™d pay the bills with checks, until I learned that Exante Bank charged 25-cents per check for check printing. Their online bill-paying service was slow and inefficient. They stopped payment on a check without my asking or authorizing them to do so. I finally quit trying to pay bills from the account and just paid the bills from our regular funds. Finally, we had paid health care bills amounting to more than the balance in the HSA, at which point I withdrew all of the funds to reimburse myself. I still donâ€™t know if the account is officially closed or not. It is clear that the people running Exante Bank have little or no experience in operating a bank.

In the meantime, I learned that our neighborhood bank, Mountain States Bank, had started offering HSAs. Mountain Statesâ€™ HSA is structured the same as a

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Response	State	Date/time received

regular savings account, which is not convenient for paying bills as you go. But, I hadnâ€™t succeeded in paying bills as I went from the Exante Bank account either, so I decided to set up my 2006 HSA with Mountain States Bank. I am using it the same way I ended up using the Exante Bank HSA. Iâ€™m just leaving the money there until we have paid health care bills from our regular funds amounting to the balance in the HSA. Then, I will close the account, withdraw all the funds and reimburse myself.

My conclusions:

This was too much hassle and work to go through for a $2500-2800 tax deduction. Since my husband and I will be reaching our 65th birthdays this year and next, we will soon cease being eligible for an HSA. But, even if we were eligible, I wouldnâ€™t do it again.

Â· If Congressâ€™ intent was to give people a tax deduction on their high deductible health insurance, then there are more direct and less confusing and less expensive ways to do it, like modifying the rules on deductions for health expenses. I would suggest making all health care expenses tax deductible, rather than the present system of making you spend more than 7.5% of your income before you can start deducting. And, I would de-link this tax savings from the CDHP insurance.

Â· If the purpose was to get people to save more money, then Congress should loosen the rules on the existing IRAs rather than creating still another kind of tax-free account.

Â· The only reason my husband and I were able to benefit from the HSA at all, was that we had enough available cash that we could fund the account up front plus pay our deductible on our insurance and other health care bills while we wrestled with all of the problems the account presented to us. A lot of people wouldnâ€™t be able to do that.

Â· I fear that the main result of Congressâ€™ authorizing HSAs is that it has spawned a new industry of HSA banks. I think it is telling that mainstream financial institutions have been very slow to jump on the HSA bandwagon. I donâ€™t think there is much money to be made by offering these accounts. I predict a bunch of failures of Internet HSA banks.

Finally â€“ I think that some of Congressâ€™ reasons for legislating CDHPs and HSAs are laudable. I think we all should be encouraged to take more responsibility for our own health care, and I think we all need to save more money for our future needs, including health care needs. But, this seems like a counterproductive way of trying to achieve these goals. All it does is add more layers of complexity to a health care system that is already too complex. I hope that some of the lessons learned from this experience can be applied to designing a comprehensive health care system for our country that simplifies the system for us all.

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Response	State	Date/time received
Employer-based health insurance is a faulty system, because employers lay off employees so frequently. I've been laid off twice over a two year period--once because of a merger and the second time because my new boss wanted me out so she could give my job to her friend. I'm single and find that COBRA premiums are way too expensive, and, COBRA benefits don't even cover the entire job hunting cycle. It can take 2 years or more to find a job in my field. I applied for individual, "catastrophic" insurance, but was refused for a pre-existing condition that most women in their middle years also have. My friends who are wheat intolerant tell me they can't even get individual health insurance. I am working now, but my employer is a small non-profit and doesn't yet offer health insurance. I own a home and know that if I become ill and have to be hospitalized, my savings will soon run out, leaving my home vulnerable. I'm a hard worker. I don't want a handout. I just want a fair system that treats all Americans the same. Let's fix this broken U.S. health care system.	UT	7/4/2006 8:34:47 PM
COBRA doesn't work, it's way to expensive.	FL	2/1/2006 11:12:49 AM
A couple of years ago, fully insured, I survived a life threatening infection. My infectious disease doctor told me I was one of those "miracle" patients. I was in the hospital for 5 weeks, at a cost of about 1/4 million dollars. Of this, we only had to pay $1,000 out of pocket. I currently like to hike and play tennis, have a job, and am the mother of 2 very bright teenage kids. My husband and I make $100,000 per year. Now my husband and I have both suddenly been diagnosed with diabetes, and find we are not insurable at any price if he somehow loses his current job. Recently, I googled "health care for diabetics", and, under a diabetic advocacy site, one of the suggestions was "Consider moving to another country." I am now researching such a move.	CA	3/10/2006 2:45:10 PM
My family has been fortunate to have very good medical coverage through my employer; especially helpful is the prescription drug coverage, and we use a mail-order pharmacy for routine meds. I am appalled at the difference in costs of the same brand name (not generic)meds for people--how inexpensive through the VA, for example, vs the full cost for someone without drug coverage. Why is this allowed to happen? Our most recent experience was with my quite elderly mother in the ER, and getting her seen--I finally had to get very assertive as her condition was deteriorating while she was waiting in the waiting room--she had E.Coli sepsis, pneumonia, CHF, UTI, and later DIC. We were fortunate to be at a hospital that could care for her; in our city, the medical services are so stretched due to the aftermath of Katrina that had she been in New Orleans (where they had lived previously), she would probably have died. The major hospital ER's were also on Divert that evening, so EMS could not transport her to any of the hospitals of choice, but helped us get her into the car so that we could transport her, as the ER could not turn us away if we came by private vehicle. It made me even more cognizant of the problems for those who aren't savvy about the system, and how to get the care that is needed. I am an RN, and grateful to know how to pull the strings to get the care my family needs.	LA	4/5/2006 5:44:18 PM

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	Response	**State**	**Date/time received**
	My sister has been diagnosed with inflammatory breast cancer. She has no insurance; therefore, no one will even see her. She is a recent widow with 2 small children, who has worked her entire life, until last year. Her husband passed away in 2005 and the company she worked at for 9 years went out of business, so she does not qualify for COBRA benefits. Her children receive social security benefits from her decease husband so she does not qualify for Medicaid. She has applied for Individual Medical insurance, but is considered uninsurable. She has applied for the state risk pool, but there is a waiting period of 12 months. NO ONE will see her. I think the Health care system has miserably failed her.	TX	8/22/2006 11:52:53 AM
	My husband was in the Army for 21years. The military system of health care is a great model. If you are in the military, you receive health care. If people are willing to work, they should receive health care from their employers. For those who work in military institutions, there is standardized forms/procedures to be used no matter what State or hospital you choose. Just think of all the energy, time, and resources used to create standards, policies, and documents for the same procedures throughout America. Why should there be different standards to take care of patients who have Acute Myocardial Infarctions? Why not standardized that care throughout America...use the same policies and documents? This could decrease the amount of law suits because there would be a national standard. Also, hospitals and physicians that participated in this standardized system could receive rewards for their performance in the standards. In other words, if hospitals had a very low infection rate while participating in the standard, they would receive a financial reward.	MS	2/21/2006 10:06:26 AM
	I lost my husband to a motor accident about 1 1/2 years ago. (At the age of 50) He was the carrier for our insurance. So that meant that I had to go look for my own insurance after being with a good insurance company all my life. He was an Iowa State Employee. Before my husbands death I was experiencing chest pains. (I had lost several family and friends to death in the short span and I contributed to stress related.) But the doctor ran all types of test to rule out the heart. Which he did because all tests came back normal. After my husbandâ€™s death, I had gone back to the doctor for depression and I also had slightly elevated blood pressure and nothing that call for medication. But, because of these visits and I had to find my own insurance. I was considered "pre-existing" and was refused insurance. I was able to find an insurance company that would cover me but I pay almost $500 a month for insurance and on my salary I'm running out of money. My husband and I have always taken care of ourselves and never asked for handouts. Matter of fact I'm a Donor volunteer, Red Cross volunteer and other volunteer organizations. I would rather give then take! I do have a good job but they donâ€™t pay for insurance benefits. A large plant is closing and jobs arenâ€™t out there right now. So, because of the expense of insurance, I'm finding myself having to now ask for help! I don't understand why the government wants people like me to use up all their money, then to have to go on welfare. (Iâ€™ve even had to stop my 401 K plan so I can use it for insurance money. It doesn't make since. I want to help myself and pay for myself through out my life. But without affordable insurance I'm afraid this isn't going to happy much longer. Thank you for listening.	IA	6/14/2006 7:03:19 AM

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	Response	**State**	**Date/time received**
	I took my disability retirement from the school district in my town because I have post-polio syndrome. I have filed through the railroad retirement for my disability too but they are just dragging their feet. I only have till April 28th to pick up my cobra insurance through the school district but I only get $953.00 a month from the school. I can't afford to pay the $500.00 a month for the insurance. If I was getting my railroad disability then I could pay for it. I have checked with other insurance companies. I would not be covered for my pre-existing condition for the post-polio syndrome. So what good would the insurance be? I need the insurance because I have a lot of problems because of the polio which I got when I was a year old. I have to wear a brace on my left leg and walk with a cain but I also have other problems because of the polio. What erks me the most is, I have worked hard all my life even on days when I was so tired and in so pain that I could hardly walk, but I went to work anyway. Now I just pray that nothing happens that I need to go to the hospital for some reason because I can't afford to go without the insurance. I just would like to know where the help is when you need it. I worked all my life and wasn't a deadbeat and this is what I get for it. Only in America. Thank you.	PA	4/22/2006 12:40:48 PM
	When my husband retired we had health care insurance through his company.The company he left went bankrupted and we were left on our own. Thankfully my husband had the VA to fall back on. We tried every insuance company out there to cover me, but because of my age they would not. I was very healthy at the time. I was forced to either go without heath care or take out HIP of Utah, which I did. It started out at 423.00 a month for me alone and sinse IHC took it over I am paying 723.00 a month. I do not qualify for medicare or medicade and will not for 4 more years. It is getting to the point now that either we pay the insurance or eat. We are in a position now that we have no other options, as a matter of fact we just took out a second morgage on our house just to get dental care. I am amazed that in this country with so many resores that we are in this mess. We don't know where to turn now.	UT	5/9/2006 10:49:04 AM
	At 40 I gave birth to my first child at home, in Florida. I was attended by the midwife who had worked with me througout the pregnancy and an assistant. Calmly, quietly. Chloe came into the world, weighing 9lbs, a happy healthy baby. I didn't need drugs, back up was available in case of complications. That day would not have been as special if I had had to go to hospital, nor would the day of my son's birth 2 years later. Midwife attended home birth is an option that has proved itself safe & appropriate for many, please make it available nation wide.	RI	3/15/2006 8:51:40 PM
	I lost my job after 27 years due to the company going bankrupt. My COBRA coverage ran out, and I have been unable to obtain insurance coverage due to a blood clot that I had 11 years ago. The doctors were never able to determine a cause for the clot, therefore I continue to be on Coumadin (a blood thinner). Numerous insurance companies have denied me coverage because of this. I have not been able to find work with an employer who has group medical coverage because I am now the full-time caregiver for my 91-year-old mother. I am caught between the proverbial rock and a hard place.	IL	5/27/2006 7:48:46 AM

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Response	State	Date/time received
Several years ago, I was diagnoised with bi-polor disorder with post tramatic symptons. At this point in my life, it was impossible for me to hold down a job of any kind. Thanks to indigent health care programs and new medications, I was able to work and function very close to a normal person. During the past 12 years, I have worked very hard to financially secure my future. I bought a house on a modest income which I have had trouble making payments owing to the high cost of my medications even with co-pay, my doctor bills, and my insurance payments which only cover health insurance without dental or vision insurance. My eyesight is getting worse and I cannot afford to get my teeth fixed which I need in order to maintain a healthy diet. The insurance premiums more than abosorbed the cost of any token raise I have received. Throughout the years, the stress of this particular job took its toll on both my mental and physical health after a series of nervous breakdowns tyring to keep my job, and I had to quit my job in search for a job I might be able to manage. I have friends who have offered to help me with a small business that I could manage with less stress, but access to aforable insurance is a problem. Since I own some real estate which I have made some very hard sacrafices to gain over the years I was able to work, I am afraid something could happen to me and I would loose everything I struggled hard for to have for my security. It seems that indigent people do not have the same problems. They can run up all the medical bills they want and have nothing to loose although they do not have access to good quality health care and many of them have teeth and gum problems like myself which in turn it can lead to poor health. I feel I represent the struggle of the middle class and with the high cost of medicine and health insurance, the middle class who have the ambition to pursue the American Dream does not have the same inalieable rights to freedom and pursuit of happiness no matter how modest their needs are when they cannot cover the most fundamental and necessary needs which are the same access to good quality health care as those who have money or those who are fortunate enough to work in good companies who cover most of the cost of insurance. As you probably know, the companies that do offer affordable insurance plans will eventually have to absorb the cost of all those on indigent plans which are eventually going to cause companies to have little to offer their employees. This problem is going to create a very weak structure in our economic system as well when small companies cannot like the company I worked in could not afford to give their employees affordable health care benefits. I have never really thought through a solution to this growing problem other than pushing our representative to run a more accountable, effective and efficient system in several areas where we are waisting our taxes, and use these taxes and possible raise some taxes to give our nation affordable health care. I know we are using some of our money to help the world wide communities and in these days and time, I do not think we can afford not to do so. But, how can we afford to help our neighbor when we are neglecting ourselves?	SC	6/8/2006 10:29:10 AM
There are many Americans that do not have Social Security as teacher groups, postal workers, etc. What happens to these people that pay for their own health care programs through their state groups. We have to ask the Legislators in State Congress each two years to give our retired teachers their health care package that they still pay the premiums. Texas Retired Teachers	TX	7/25/2006 2:45:06 PM

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	Response	**State**	**Date/time received**
	I am a certified nurse midwife and about 20% of my practice is for medicaid recipients. Midwives get only 65% of the reimbursement and MD would get for the same vaginal delivery. Nurse practitioners get 95% of MD reimbursement. Midwives should get the same as nurse practitioners so that they may continue to serve the many women who benefit from culturally sensitive care. Many women prefer a female provider because of past abuse issues with males and midwives provide the gentle and thorough care they need. They should get properly reimbursed for their services.	UT	3/4/2006 5:35:36 PM
	My son's health care premiums have risen 300 percent in the past year alone from approx $150.00 per month to almost $600 per month just for himself, same insurance company, same coverage, not as was stated in the email, "50 percent since 2000." This is absolutely ludicrous. The health care industry is crying poverty all the while building larger and more fabulous hospitals and office buildings. Something has got to change!	CO	2/16/2006 2:25:13 PM
	I recently had surgery on a rotator cuff tear. The provider was excellent but the 90 minute experience cost approximately $30,000. Of this amount I paid out of pocket about $5,000. I appreciate the training, experience and the support that this operation took, but I feel the cost was way out of line. If I haden't had good health insurance coverage I would be paying this bill for a long time.	CO	2/16/2006 5:40:29 PM
	I'm 77 years old. When I was 65 I discovered that I had only completed 39 quarters of employment which was covered by Social Security, leaving me 3 quarters short for eligibility. I joined Medicare anyway, paying a significant portion of my income in premiums. After a while I realized that Medicare covered only a tiny fraction of my health care expenses, most of which were for care of my teeth, eyes and mental/psychological health. So I cancelled my Medicare coverage. Shortly thereafter I was hit by appendicitis, and bills in the neighborhood of $17,000. After I dug myself out from that, I re-upped for Medicare, which went on as before, costing a lot for premiums and paying out little or nothing for my health care. By this time I had discovered alternative medicine, and my health had significantly improved, however Medicare paid for none of my expenses now. But never mind - I moved a couple of times, missed a couple of payments, and Medicare cut me off. For now, at least, absent any medical insurance, my health care costs are much smaller than with.	NM	8/31/2006 7:28:23 AM
	ssdi and ssi is disappointing to me and to the people that have to work in the ssdi or ssi limits we meed HALP WE CAN NOT GET PAST MA AND SOME PEOPLE WOULD LIKE TOO WORK AND NOT LOSE MA NO Limits	ND	4/28/2006 10:19:22 PM

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Eight years ago I had breast cancer. I was covered by an insurance company and had been for about three months prior to my diagnosis. The insurance company tried to get out of paying for the surgeries by saying I had a pre-existing condition when I signed up. When the fight over that was over, they lost my records three times, I went to the Colorado State Insurance Commissioner and got satisfaction. Since then I have switched insurance companies due to working conditions and illness other than the breast cancer. I have been diagnosed with Bi-Polar II and am on medications I will have to take for life. My new insurance came on board in January as my insurance and medicare part D provider. Now I must pay Fifty dollars a month for a med I was getting for free from the manufacturer due to Medicare part D. It is my mood stabilizer so I will have to pay the money to get it so I stay level and don't go manic or deep depression. You may use my story, or call me to get further information on either the breast cancer or Bi-polar experiences. Thanks for the chance to speak out.	CO	2/15/2006 10:06:35 PM
My healthcare experience in America is at the moment, terrible.My health insurance is has hit an all time high, and the government seems to be just well ignoring this issue. I am a hard working citizen who does'nt mind paying a fair share for insurance, but this has gotten way out of hand.The talk is about the poor people who dont have coverage, but what about the people like me who have to spend their life savings just to see a doctor for a cold. This has got to stop.	MS	6/11/2006 1:14:25 PM
I am a nurse practitioner with over 25 years experience. I have had many experiences over the years. First most health care providers are very caring indivduals who want to help others and don't want or need to be in the position of denying service to other people. The current system makes providers deny or limit care due to insurance companies whose bottom line is to make money not care for people. The second part of my experience is personal in nature. I thought I was covered by a good insurance policy only to find out that it was very inadequate and caused more problems. Nine months ago while painting at home I fell and broke my leg. It happened to be a very bad break and I had to have an ambulance take me to the hospital. I had to have a 3 1/2 hours of surgery to repair the break (more on that later) After a week in the hospital, I was released to find out the "insurance" did not cover physical therapy. The hospital bill came to $52,000. The insurance did not cover the ambulance,emergency room, anesthesia for surgery, any of the medications, hardware inserted into my leg,x-rays and nursing care. The "insurance" paid only $6000. of the $52,000. They only paid the $433. to the Orthopedic surgeon for 3 1/2 hours of work. My husband and I were left with all bills from the hospital bills, doctors, physical therapy treatment,which was an additional $3000. We don't qualify for any assistance programs because we are middle income people with a home. How are we going to pay for this huge expense? I am unable to work because I can't stand for very long. I was told in March after months of recovering that I will need more surgery, a total knee replacement. The job that I had at the time of the accident ended. The insurance was so poor that I didn't want to continue with it. I have been denied any insurance because of need for further treatment. A "catch 22" situation, we can't pay for a total knee replacement on top of the bills already incurred. After months of trying to get insurance I found that our state has a very high deductable insurance for citizens unable to get insurance. The preminum are	CO	8/7/2006 1:33:21 PM

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	Response	**State**	**Date/time received**
	double that of my husband's insurance but they are suppose to cover my knee and leg surgery. We are waiting to hear from them. In the mean time, I am unable to work. I have applied for many different jobs that I could possibly do but have been rejected. If they provide insurance they don't want to add a person who may increase their preminum. The health care system is broke and we need more than a bandaid.		
	I have worked in the health care industry for several years. My mother was a RN in the Intensive Care Unit (ICU) at a local major hospital and then later she became one of the medical ethics advisors to the company running the hospital. I have worked with Ophthalmologists and Optometrists over the last 15yrs. The combination of personal work experience and conversations with my mother has given me an invaluable insight into the physician/health insurance company/patient relationship. If anyone today has been led into thinking that health care companies have our best interests and health at heart, well, it just goes to show how good or not so good the insurance companies marketing department and lobbyist have been doing. Money, money and money are what medical diagnosis and treatment decisions are based on...even when it comes to possible treatments for those that only have a minor chance of success, instead of making the investment in hope and a small chance of success, health care operators and insurers will cut their losses and have a physician and/or hospital make the suggestion that the ill individual go home and get hospice care until they pass away. I know that this is an extreme example, but still it exists and gets to the heart of the problem..the problem of, good health care for only those that can pay for it and insurance companies only wanting to insure those that are at extremely low risk of becoming ill. Hospitals now are building expensive extentions of huge master suite rooms for the wealthy to recover in...hoping to make even more money from those that have disposable income. I have no problem with a business making money, or making profits, but when it comes to health care, something I feel is a basic need in an advanced, caring and nuturing society, having any semblence of have's and have nots I feel is not only innappropriate, but disgusting and unethical. Cosmetic surgery or elective medical services that are not medically needed are not included in my argument and as far as I am concerned, can charge their patients out the wazoo for services rendered....because the patient has chosen to engage their services...not out of need, but out of choice. Health Insurance Companies approach physicians with the idea of bringing a select group of patients to the physician, only to charge the physician a cost up front, then a percentage of income the physician makes from seeing patients, then also charges the patient and/or the patients employer a fee to insure the patient, meanwhile discounting the rates in which physicians are paid for services rendered	CO	2/16/2006 11:35:09 PM

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	Response	**State**	**Date/time received**
	and then turning around and charging patients, based on their coverage, either a high co-pay, deductible or out of pocket expense for the service rendered by the physician....Insurance companies are the biggest pyrriah in the doctor/patient relationship and have created a wedge that has split that relationhip into a very unhealthy condition. I use to work in an office in which it cost us $95 to see a patient (based on wages, rent, equipment costs, ect..) and the insurance company was paying us between $65 and $110 based on the patients insurance. Try running a business within those confinements...no wonder every time you go to see a physician people are racked and stacked and lined up like an assembly line production. Government in this particular case needs to step in and bring some sense and structure to a industry that is out of control. My experience has been more on the business side of health care and I have seen and born witness to how the Health Care Insurance Industry has taken the decision making process out of a physicians hands, whom is intimately familiar with a patients condition, usurped his or her wisdom and compassion and inserted a recommendation based on cost effectiveness and risk. This situation has continued for so long which has ultimately created an environment of mistrust between patient and physician, leaving the decision making process up to those motivated by profit/cost and not health and quality of life.		
	My concerns lie within the research, and funding or there lack of. My family has been hit hard with a rare blood disorder, Hereditary Hemorrhagic Telangiectasia. (HHT) I have lost my mother, and two brother's from this disorder. (ages 68,58,&43) I am also battling HHT. HHT is a long neglected national health problem that affects approximately 50,000-70,000 Americans. 50% of the children of a parent with HHT will inherit the gene. (my son is a carrier) The HHT Foundation is a voluntary agency representing HHT families, has invested heavily in raising private funding for maintaining 8 National HHT Treatment Centers in the US., research, education, and outreach WITHOUT EVER RECEIVING ANY FEDERAL FUNDING. NEW FUNDS FROM THE FEDERAL GOV. ARE NEEDED FOR THIS LONG NEGLECTED NATIONAL HEALTH PROBLEM. Possibly with help from the Federal Gov. my grandchildren's children will not have to experience what my family has. We need support.	WA	5/7/2006 1:42:06 PM

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Response	State	Date/time received
I would love to have an HSA (Health Savings Account) but the government restrictions have made this impossible. I am a self-employed person who pays for my own high deductible health insurance policy (Blue Cross Blue Shield of Texas with a $5,000 deductible). I carry this policy only for major medical emergencies. I pay for everything else out of pocket. Unfortunately, even though my insurance plan is an HDHP (high deductible health plan), I do not qualify for an HSA because my out of pocket espenses are up to $8000. The HSA requires that the out of pocket expenses be no higher than $5000. I have shopped around for an HDHP that would qualify for an HSA but these policies have premiums that are at least TWICE what I am paying now and the coverage is not as good. So I have to choose between having an HSA with an inferior more expensive insurance policy or not having an HSA but having a better less expensive health plan. This is not right! Someone needs to change the government restrictions so that my current health plan qualifies!!	TX	4/22/2006 9:46:41 AM
When I was unemployed in The Netherlands, we never worried about the healthcare of our family. Quality health care, with the same providers and services, was always provided. When I was unemployed in America, we could not afford any healthcare. We lived in fear of having a significant healthcare requirement with no organization willing to assist us. The private cost would have been prohibitive. It is not clear why our great nation, in the most prosperous times ever in human history, can not figure out how to care for our citizens.	CA	2/15/2006 10:17:44 PM

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	Response	**State**	**Date/time received**
	I run a small one man shop. I have tried to buy health insurance, but it is just too costly. Last year I spent a three days in the hospital and the bill was over $20,000. I don't have the money to pay for insurance or the bill. What I want in an insurance plan is not available to my knowledge anywhere. I don't want a health maintenence program. I don't want a program that pays a little bit of each visit. I don't want a program where I have to go to one certain place or see one certain doctor and I sure don't want a program where I have to go to my primary care guy, and pay him, to see anybody else. What I want is the old fashoined major medical program. A program where I pay everything up to a selected dollar figure and the insurance company pays after that. I don't want restrictions on what they pay after that and I sure don't want to have to get some idiot manager of the insurance company to approve a treatment the a real doctor feels will help me. I believe that you could include medication in this kind of plan as well. To make a claim, the doctor should have to fill out a simple form that is common to all companies and the insurance company should be required to respond imediatly with a check or request for more information. An insurance policy like this should be able to be written on a single sheet paper and be as binding as all of those thousand pages of leagal ease contracts. I beleive that all contracts, wheather for medical insurance or anything wlse should be written in language that any eigth grader could understand. If it were done this way, there would be far less leagal proceedings based on the small print in a policy.	WA	2/21/2006 7:41:44 PM
	My wife and I had to get a divorce so she could get needed health care. We had two insurance policies but neither of them provided extended nursing care in our home or a nursing home when she was put on a breathing machine. Only Medicaid provided this coverage and now this service is being abolished in Missouri.	MO	5/12/2006 4:26:05 PM
	To steal a good title: A Tale of Two Health Care Systems: Canadian and US. Our daughter attends college in Vancouver and so has access (for $50. per month) to medical services. She was found to have a VENOUS MALFORMATION that required interventional radiology treatment. Within two months of the initial diagnosis, she was treated and a second follow-up procedure scheduled. I pay $9,000 per year for self-employed health insurance in New Mexico. NO health issues, no 'pre-existing conditions they are not willing to cover. The deductability is $5,000. and the co-pay at the end of that 'trip wire' is 80/20. NO one at our 'provider' would commit to covering our daughter's condition without an expensive series of exams and referrals. Even with those steps, we may not have been covered. And, to go through all those hoops would have taken at least 6 months. At the end of that time, she would have had to be treated in either Denver or D.C. -- IF the 'provider' deigned to cover her at all. Her coverage is 'portable', our US coverage is not. Guess which system works best for the end user? Quite frankly, all the talk about health care misses the fundamental point. Economy of scale (the mantra of all companies seeking to buy another company) works just	NM	6/15/2006 6:42:25 PM

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as well in health care as anywhere else. The current system is defended and perpetuated because -- despite protestations to the contrary -- it is a vast profit center for those who defend it. Unless your recommendations/actions attack this central reality you will get nowhere. And, no one will have the health system they are entitled to and deserve.		
I became disabled from the fire dept. in 1983 and my wife had to go back to work for us to have health insurance. 7 years later we divorced. I was lucky that she was a federal employee and that due to the length of our marriage that I had survivor rights in her pension. That allowed me to buy at 102% the federal employee group health insurance rate. I've done this for 16 years. BUT I couldn't remarry before 55 or I would lose the insurance. I am diabetic, with a number of other conditions- Degenative disk disease, diabetic neuropathy in all limbs, Raynaud's disease, hypothyroidism, High blood pressure and cholesterol, GERD, etc. etc. I have lost a chance to remarry twice because I wouldn't have access to insurance except under the federal ex spouse program. I wish all Americans had an affordable group rate or access to the federal employees health insurance plan . I pay 400.00 a month but where else could someone with my conditions get insurance at a group rate(employer + employee cost + 2 % admin. fee)	MO	3/8/2006 10:12:03 PM
I am a 53-year old divoriced woman and an 8-year Breast Cancer Survivor! I think it is UNFORGIVEABLE that I have tried to obtain Individual Health Insurance and have been turned down from various companies over the years due to my previous "Cancer" History! Now, I have been told that WE (former Breast Cancer or Cancer Patients) have to wait 10-YEARS in order to be eligible to "switch" to another insurance company (Pre-Existing Clause!). Not to mention, the numerous jobs I have been "let go" from once I hit my 3-month "Probation Period" to become a Permanent Employee, and they find out once I fill out the "Proper Paperwork" that I have had Cancer! I had one of the largest car companies in Michigan tell me they would hire me as a Direct Employee (I worked as a Contract Employee at the time) and then let me go due to "lack of work" a few days after I had a Breast Biopsy! My Contract House actually told me they new of my Cancer! Cancer can strike ANYONE at anytime and is not something that we choose to get! So, why are we being punished? GOD PLEASE HELP US ALL!	MI	8/24/2006 8:52:36 PM

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Response	State	Date/time received
The most efficient health care service I received was in London. Studying abroad one summer I found my annual respiratory problem getting worse. My US doctor had already prescribed two antibiotics and administered an immunosuppressant shot as usual. The London clinic doctor questioned me thoroughly and sent me immediately for a lung tidal volume test thus discovering I was asthmatic. I haven't had bronchitis since! In the first year I moved to NYC from the midwest I was informed by two dentists, medical office manager and one internist that it wasn't in their best financial interests to have me as a patient. One dentist called the old fillings in my mouth "time bombs" before he dismissed me. The internist (who I signed onto sight unseen as my primary care physian) complained about my phone messages over the weekend where I requested a referral to a hospital for my Achilles tendon injury. Not returning my calls I reached his office manager two days later. She "fit me in" the next day.The internist misdiagnosed the 85% Achilles tendon tear as a mild sprain. He and the two dentists spent more time explaining my health insurances didn't pay them enough for their time. One explained the need to turn over patients like a waitress needing to turn over tables to earn more tips.I found myself telling the internist that I couldn't help him as he signed up to be in network. Though in great pain my health insurer mandated I wait one month before approving a second opinion. Second opinion verifed what seemed obvious so I went into surgery the next day for Achilles tendon repair. Also, we need to eliminate employer based health insurance. As a middle manager I have been directed to encourage one employee to quit due to their family's usage of the company's health insurance. Since I balked I found myself laid off. Recently my physical therapy for a shoulder injury was challenged as possibly not my health insurer's responsibility. As reported to my doctor carrying too heavy of a shoulder bag was the cause. I was interrogated over the phone by a nice but hard to understand gentleman based in India. He did not know what a pocketbook could be. My doctor told me my injury didn't warrant this confusion but this was computer generated. Not too long ago the Wall Street Journal reported on the millions dollars pay package the head of this national health insurance company reaps.	NY	8/31/2006 9:31:32 PM
In the late 70's and early 80's I was the directory of two successful HMO development projects. I taught health administration at the graduate level for 6 years. I worked for one of the orginal HMO's in the early 70. I have spent the last few years of my professional life developing residential services for the mentally ill. I am now retired with a managed plan through AARP involving the U of WA med center. I have been extreemly pleased with the care I have been provided (routine care and radical prostatectomy). I believe that eliminating administrative waste through the elimination of employer and insurance company involvement will go a long was to paying for the cost of a single payor health care system. I believe it is unrealistic to think that any system will not provide some kind of rationing and that the wealthy will still be able to purchase services and products that the population at large will not have financial access to. That should not deter us. Getting employers and insurance companies out of the business should be a priority, however unrealistic some may find this notion. It makes no sense accept owing to their historical involvement which has not served our country well. Why should employers be in the health care business. That does not mean they should not contribute significantly to the cost of a new system, particularly during the transition, but this would be, I believe be less costly than major companies are currently paying. The focus of the plan should be on delivering the largest amount of quality care to the largest number of people, not profits. I also believe that the wealthy should pay proportunatley higher taxes to finance the plan.	WA	3/25/2006 8:15:23 PM

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	Response	**State**	**Date/time received**
	Having the priviledge of working as a hospice social worker, I would have to say that the MOST beneficial thing I have seen is the availability and coverage for hospice and end-of-life services. Medicare and Medicaid currently cover this benefit 100%!!! Private insurances haven't quite caught on to that yet, and I hope that Medicare and Medicaid will continue their provisions for this service. I have seen many people die with dignity and in complete comfort due to the efforts of hospice care. This is the one thing we have gotten right. I think that's because death is the one thing certain for all of us (besides taxes, right?). I wish more people could have the opportunity to receive hospice care during their final moments of life. There are still a lot of people who have situations where they aren't able to utilize hospice care. I have seen hospice workers work miracles for their patients, bring families back together, provide unwaivering support and assistance, and relieve pain and discomfort. It is truly amazing. The other thing I have had personal experience with is cancer research. I would hope that if we adopt a new plan for a socialized health plan (which I think is a good idea to some extent), we would not lose the financial backing for researchers. We need people searching for cures, and I know that part of the money we spend on health care now goes to help pay for some of that research. I believe there are good things about our health coverage as well as bad. The bad is that health coverage is not available to everyone. I have seen the suffering and lack of health care first hand. Something needs to change.	UT	5/3/2006 2:40:45 PM
	I have had to have a knowledgable doctor since I was young. Most of the doctors I have found for myself have been exactly what I was looking for: knowledgable, kind, compassionate, friendly, easy to talk with. I have, on the whole, been satisfied with the choice of doctors I have had.	PA	2/15/2006 8:29:07 PM
	For myself only - My husband retired 13 years ago and I lost my health insurance coverage as a result. So, I looked for private individual health insurance. The first company I used went out of the health insurance business and passed me along to someone else. That one then went out of the health care business and I got passed along again. This final company also went out of the health insurance business, tried to pass me along, but failed. I was unable to obtain any private health insurance because of several pre-existing conditions. THANK YOU ILLINOIS FOR HAVING AN "ICHIPS" PROGRAM AND THANK YOU THAT I ACTUALLY WAS ACCEPTED. Fortunely my family can afford high premiums but $8,000 a year is one big bill for those less fortunate than ourselves. There needs to be a better way!!	IL	7/11/2006 6:07:20 PM
	We have belong to an employeer paid HMO since we were married. Both our children were born and raised within this HMO. Aside from a few experiences this HMO has provided excellent care and I think managed care such as an HMO is the way to go. In general I believe the publice is not well informed about HMO service. There is alost of public misinformation about HMO's. And it probably is a benefit to private health care providers both medical and insurance companies that there is such misinformation. They financially benefit from the fear factor of HMOs. Likewise there is much misinformation about national health care programs in other countries. The British and Canadians I know are quite satisfied with their system. I have also had experience with private health care and Tricare when assisting relatives. In general I found that private care is a waste of time. I spent more time waiting for three private appointments than totaled in the HMO over a number of years. Tricare is fantastic. The military hospitals are state of the art and I was able to advocate for my Father, no questions asked. I am a cancer surviver and have looked into a private policy if I could not get insurance through my employeer. Even though the scientific basis for a remission at this point is as if I never had cancer, the only cverages I could find were extremely expensive over $600 to $1000 per month. This is outrageous. This is not	WA	8/30/2006 4:33:33 PM

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	Response	**State**	**Date/time received**
	health care this is care for insurance companies. Since insurance companies are risk adverse and shove all risk onto clients, pulbic financing is the only alternative.		
	Thank you for the opportunity to comment on your health care recommendations. I am 68 years of age and suffer from Kidney failure. I have had fairly good company sponsored health care over the years including care for my diabetes and cardiac problems. My Kidney failure is under control through Peritoneal Dialysis, financed by Medicare and a small supplemental policy provided by my employer to which I also contribute. Because of the high prices for drugs and high co pays associated with my present health status, my wife and I are close to bankruptcy and are using the equity on our home to stay afloat. We have no other revenue stream other than Social Security, so I have no idea how long we will be able to keep going. We used to have very good credit, so being a responsible American has not helped. Your objective to use Medicare and the VA system to develop a national health system is commendable, but please pay special attention to controlling the waste and high profits from "add-on" providers. Health care should not be a high profit item. By its very nature, reasonable profits times high volumes should yield acceptable private industry participation in delivery of services mandated and controlled by a government agency, such as Medicare and the VA do today. In order to develop a successful system, you will have to provide for oversight to control waste and fraud. Your recommendations seem to allude to all I have said above, but they are too robust and difficult to read. I hope your final submission is concise and to the point.	NY	7/30/2006 5:30:30 PM
	Health Centers they never have the BP meds she has to take everyday. They donâ€™t make it easy to get free health care. They send you to the county assistant or a benefits specialist to see how much you would have to pay. -Are there places to get free dental besides the health centers? Her father has veterans insurance that does not cover dental, but he does not make enough money to pay for dental out of pocket. He went to a teaching hospital for emergency work (Temple) and they charged ($25 /tooth extraction). If you are not in the military during a certain period, you do not get dental coverage through the VA. Everything else it paid for, they even send his meds in the mail. A lot of doctors donâ€™t take Health Partners.	PA	5/25/2006 12:00:29 PM

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I used to be self-employed and carried an independent insurance plan for my family. Over the years out premiums continued to increase dramatically even though we weren't using services. When we called to inquire why that was, we were told that our "pool" had gotten more expensive and, if we wanted to, we could try to get into a new "pool" but we would have to have a physical exam and reapply. After some health issues, none of which turned out to be serious, the insurance company decided they no longer wanted to cover my "female organs". Well, her I had always thought that my entire body was a female organ, not a male with ovaries and breasts. The above comment is sassy but represents my level of frustration. I had paid premiums for many years and the moment I utilized some services I was pushed out. I eventually changed jobs and began working at one third the income so I could be insured through a major organization. I had to get rid of my business and let employees go. This whole scenario was a negative for the economy. I could have been making, and spending, more money all this time if I hadn't had to sell myself short for the insurance coverage.	UT	5/1/2006 4:21:12 PM
In my youth I worked for the Federal Govt and McDonnell Douglas Aircraft in California. Now, I'm in my 50's and no longer have the insurance plans that went with these jobs. McDonnell Douglas no longer exists - I was laid off and the Long Beach Naval Shipyard has been closed down, as well. I started my own small business in Arizona and recently, having moved to Utah, have had to reenter the workforce - I'm in my 50's and this is no easy feat. My husband works (age 70) for Home Depot. He wants to quit the rat race but the only thing keeping him from doing that is insurance . . . or the lack of it, if he quits. I'm disgusted with our representatives in Washington DC since they enjoy (at the taxpayers expense) the very best insurance coverage in this country and they also voted themselves a pay increase recently, although they just couldn't see fit to raise the minimum wage. That's what I will be earning for quite some time trying to obtain a job with insurance. It's no wonder people are having to work longer, for less . . . at two and three jobs, just to make ends meet - let alone to have insurance coverage. It is a crime what this Republican Administration has visited on our citizens. They should all be fired and replaced with representatives who actually give a rat's butt what the real world is like.	UT	7/3/2006 8:47:13 AM
i am a registered nurse with over 35 years of experience in the health care field. fear of litigation has turned end of life experiences for elders into an abyss of uncomfortable and even painful procedures in isolation from all that is dear to them... our nursing homes are dismal warehouses with state inspections a ludicrous sham..as hospitals have competed to hang the best 'mission statement' and to have the largest sign out front ...they have always stiven to cut staffing. nurses frequently have to struggle with inadequate basic equipment while hospitals spend huge amounts on advertising to attract business. i have watched fortunes spent on patient surveys, employee classes on attitude, and meetings to come up with hospital slogans.... all the while remaining in direct contact with patients and their families... all i have ever asked for as a nurse is adequate equipment to do my job and adequate staffing to provide safe and compassionate care... it has always seemed self-evident to me that good patient care speaks for itself. i am gratreful to be near the end of my career. i am truly tired of so much nonsense in the midst of so much need.	WA	4/5/2006 10:51:05 PM

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I am an RN working in the ICU at the University of Medical Center in ***. At the same time the Congress cut millions of dollars from Medicare, we had a patient who was a longtime quadraplegic in our unit. He had come into the hospital for a simple procedure, but would require 24 hour care when he went home. Medicare would only cover 16 hours per day. So, rather than pay for 24/7 care for him at home (not RN care), the taxpayers payed for 4 months of ICU care (he is ventilator dependent and couldn't be cared for in a non-ICU setting). It is shortsightedness like this that is so frustrating.	WA	3/17/2006 4:27:01 PM
Our son who is 46 years old with Tourette Syndrome,highblood pressure and gout . He has no insurance because he lost his job that was outsourced. He can not pass a physical to get a truck driving job. His medicine is $200.00 a month. When we say we are a caring compassionate country I do not believe it. The doctor claims that he will get a stroke if he doesn't get his blood preasurre under control. If he shows up in a hospital with a stroke it will cost the tax payer 10 times as much as if there would be preventative health care available. By the way he is not overweight. Frankly our whole family is very disappointed in our country for showing so little concern for those who can't afford insurance.	MI	8/27/2006 5:52:58 PM
The inconsistency of coverage is, I believe, the most pressing problem for many Americans. When employers,insurance companies,or even union trust funds, change or eliminate coverage or providers without warning, folks often lose continuity of care. If you are a chronically or seriously ill patient, and you lose the relationship your treating physician, there isn't always a seamless transition to the new provider.Medications, procedures, testing, and other care related issues may be disrupted and result in poor health or the exacerbation of the condition. The new provider may not agree with your previous doctor's course of treatment---or may not be adequately aware of pre-existing conditions or problems, resulting in less than optimal care for the displaced patient. My own father was laid off and lost his medical insurance as a result. (He was a heart patient, who had previously undergone successful open heart surgery to repair a valve damaged by a chilhood illness.)He had to be seen at a county facility when his health declined; they did help, but it was too little, too late. By the time we contacted his long-term cardioligist for help,my father had become seriously ill---due to misdiagnosis. Months of waiting for critical appointments, long waits for the approval of tests, and an assumptive, incorrect diagnosis by a doctor unfamiliar with his medical history shortened my father's life. By the time he was admitted to a facility where he could get the help he needed, a specialist found advanced lung cancer. They tried surgery to repair his heart and remove the cancer, but it was only paritally successful. He died, after spending nearly three months in a post-op coma on a ventilator. The only reason I can even tell you this, is that my good health care coverage allowed me to survive breast cancer---that required agressive advanced treatment!I have a hard time understanding the denial of care to anyone; it is immoral in this day and age to allow a citizen to suffer and die simply because of bad luck. My father's story is only one of many, but there are so many people who work hard all their lives, and then fall into a coverage gap---too young for Medicare, too rich for Medicaid---unable to get gainful employment, and struggling to afford simple daily living costs along with medicines they cannot live without.	CA	7/27/2006 10:12:57 PM

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	Response	**State**	**Date/time received**
	I worked for 37 years for the same company and had health care insurance. When I retired my wife was forced onto the high risk pool because of previous cancer that now costs 7000 per year and I was charged a premium because I was on Lipitor. That doesn't sound like a workable insurance plan to me. Our medical bills including this insurance cost was $22,000 last year. We can afford it but I submit that 90% of the Population can't. People bemoan the system in England but their citizens are healthier than we are at less cost per citizen. That's the ultimate measure of effectiveness. Look at many other developed countries and the story is the same. Fix the system. Universal insurance is the answer.	TX	6/8/2006 9:56:30 AM
	My husband and me have a health insurance provided by my husbands employer. Our big problem are the copayments. While I am very healthy and pay only once or twice a year a copayment between 25 - 40$, which is absolutly ok, my husbands copayments are the problem. He had a kidney transplant, has Diabetes and recently had a minor stroke. His copayments for doctors and for his medication are very high. He takes over 13 different medication a day. In other countries (like the one I am from) people who are chronical ill and relay on medication on a daily basis have reduced copayments. Since I was laid off a month ago from my job we really have a hard time to pay all those copayments. I think it is not fair that people who need very expensive medication on a daily basis and have to go more than other people to the doctor have to pay the same copayments than healthy people like me. I don't know what exactly can be done about it, but I know that there are possibilties, because in a lot of countries those problems don't excist. We both still young (29 years old) and pay monthly hundrets of dollars copayments. I would like to go to a dentist or gynecologist for a regular check up, but currently I am not, because I don't want to spend more money than necessary on copayments. That is not a good basis for a healthy life.	NY	7/20/2006 3:44:56 PM
	My 10 year old has diabetes. She was recently taken to the emergency room because she had trouble seeing and was speaking giberish (words you and i could not understand). She had a build up of ketones in her system that caused this reaction (despite normal blood sugar readings). I asked my father in law (former chief of staff of a major Denver area hospital) to meet me at the ER. While *** was being rehydrated, poked with needles to get blood and arterial gases, I made a comment to my father in law that the US is moving towards a national health care system given the expense of health care insurance (I am a widow - my husband having died from melanoma...COBRA is a joke...we could not afford 1300 per month for coverage - I was in a bind. I am an attorney but no one wanted to hire me as I had "too much on my plate" an actual comment from the head of a City Attorney's Office who is now a judge). I did not have much of a choice. I needed health insurance and took a part time call center job with a local airline to get health insurance at $400 per month. Anyway, my fatehr in law commented (having been a doctor for about 45 years) that we are running towards a national health care program and that the private industry has ruined affordable health care. My concern at this time is whether my 10 year old will have affordable medical insurance since she has a preexisting diabetic condition.	CO	2/16/2006 2:13:26 PM

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Response	State	Date/time received
My 22 year old son works two part-time jobs and has no health insurance. He was injured in a car accident 5 years ago and received a severe knee injury and dislocated job. He now has severe headaches and has difficulty sleeping. After months of experiencing severe stomach pain, I paid $1000 for him to go in for a scope of his stomach and he was found to have pre-cancerous cells in the stomach lining. The medication he is required to take costs more than $400 each month. I have pancreas insufficiency due to Celiac Disease and my medication costs me $1300 for 90 days and that is AFTER the insurance pays their part. I have to work two jobs. The income from my second job is used to cover my medication and to help my son pay for his. If you have Celiac Disease in the Netherlands, the country pays for any related medications AND the COST OF THE FOOD!! We are the richest country in the world and we have people going without medical care and medication. What is wrong with this picture??	UT	7/5/2006 7:46:26 AM
I sent this letter to all Louisiana state congress and the President, Vice President, and the First Lady on 4/17/06. I have not heard from any recipients....and don't expect to. I hope that, as I stated in my attached letter to officals, Americans can stand up and reclaim this "free" country. Our fore-fathers did it more than 200 years ago and now its time for the American people to stop watching their lives go down the tubes, and find the strength to fight for what they know is right. I know what is right....the continued prosperity of my family....my husband and I work very hard every day to provide the best that we can for our boys. If all the American people really have all the same opportunities, this country could get back to believing that America is the place to be. As far as healthcare....what an atrocious institution! We are seriously considering immigrating to Canada just to be able to have healthcare. It would be nice to live in a country that has a government that really provides what people need....good health....and a less violent way of life.(check out Canada's crime stats)	LA	6/8/2006 2:56:01 PM
I love the United States....we need to save it and its people. God bless! I have Hepatitis C. It is surpassing AIDS in the number of people affected. 200 million globally. Because the current 'treatment' leaves people blind, psychotic, incapacitated, with tinninitus and can die, and is only 25% effective regardless of what they say about interferon, I chose herbs and ozone. (Schering Plough, makers of interferon, do not iniclude in their 50% success rate the people who relapse after 2 years) 'Alternative' methods can cost up to $17,000 a year. Because I choose to not take pharma drugs, I am being 'penalized' for all the years I paid into health care and not being able to utilize any benefit. Something must be done to allevieate the burden of healthcare costs.	CT	2/16/2006 9:50:51 AM

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My wife recently experienced tightness in her throat, and thought that it might be constricted, and she was very worried about choking. I took her to the emergency room of the local hospital, Boulder Community Hospital. After a long wait (45 minutes) she had her temperature taken and her blood pressure. After explaining the the cost of care would exceed several thousand dollars, she declined treatment. We received a bill from the hospital for $200, even though she was not treated and never saw a nurse or a physician.	CO	2/16/2006 1:41:15 AM
I had an emergency appendectomy in 1996. My family doctor made arrangements for a surgeon to do the appendectomy. However, the surgeon was not a "preferred provider" on my insurance. This meant that he could charge me whatever he wanted to but my insurance only had to pay what is "usual, customary, and reasonable" charges. I was responsible for everything else.	CO	2/15/2006 6:39:32 PM
While I was employed, I was able to have BS/BS coverage for myself and husband. When my position terminated, I could only afford to cover myself with the COBRA insurance (about $240/month). Cost for the two of us would have been about $800/month. We have moderate savings which disqualify my husband for the local health care plan and thus are self-pay for all his care. I understand that the prices of service to us are much higher than what a corporation pays through insurance. It is also nearly impossible to find out what these costs and related outcomes are are in advance, to make informed decisions. The bills just show up and are what they are. The hospital arranged a monthly payment plan that will work for us. When I asked whether there was a plan for reduced service prices based on low income, I was told no. A community agency, however, says that we can make a case for an appeal that would allow for reduced charges. That is in process. We are willing to pay for our care, but if the cost is high, believe that there should be some way to be on a "sliding scale" based on income and/or savings. We are in that middle ground of having moderate assets that disqualify us for assistance (more than $4000 in savings), but not so large that they couldn't be quickly used up by large medical expenses. If we were so aflicted that our only real living expenses were health care, we could see the point of "spending down" to meet aid limits. However, we are an average middle-aged, active homeowning couple. I believe people will agree to pay for manageable medical/health expenses, if they can be guaranteed that major or chronic/ongoing expenses would be taken care of if needed. I also believe our tax money should be shifted from benefiting corporations/investors looking for monetary profit to benefiting the taxpayers themselves directly. Universal health care coverage would do this.	NM	4/2/2006 2:49:50 PM

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	My husband and I both developed major health problems right after we got married in 1994. He had several heart attacks and bypass surgery, while I developed Type II diabetes. As a result of his health problems, he had to go on disability. We ended up having to go bankrupt. We had tried to pay up all our health care bills and mortgaged our home. We lost our home and had to start over. Now I work at an Urban Indian healthcare clinic and Mr. Bush has proposed closing these. I cannot believe that the leaders of our country do not see how much damage our lack of quality healthcare does in our society. Working with the poorest minority population and having gone through my own healthcare nightmare, I struggle to understand how anyone can permit the continued cuts to our healthcare system.	WA	2/16/2006 11:45:12 PM
	Honestly, I feel pretty fortunate to have had health insurance. My best experience was with United Healtcare & I had a PPO. I just never had a problem. When I was unemployed I had to pay a ridiculous amount of money & ended up dropping my coverage, because I couldn't afford it. My mother is currently having difficulty getting insurance. She had it, but was dropped b/c her payment was late. Now she can't get it.	PA	4/11/2006 9:00:36 AM
	I am a chronically ill person who is considered self-employed. I am a medical transcriptionist working from my home. Because of constant pain, I am limited in the number of hours I can work in a day, which means less money coming in. I cannot afford to see a specialist (in my case, an orthopedist) to get my pain under control, so I can work more. It's a nice little catch-22. If I could work more, I might be able to afford health insurance, but I need medical care so I can work more.	GA	6/17/2006 1:13:17 PM
	My husband and I, both small business owners, pay $600 a month for health insurance. You'd think that would be enough money to cover well checks for our children and annual examinations for ourselves. You would think that paying $600 a month might cover immunizations for our two children. You will have to think again, because it doesn't. For the past two years we have paid over $12,000 to the insurance company and they have not paid for any annual visits, emergency room visits or any other necessary procedures. In fact, in addition to the $12,000 we have paid our insurance company, we also owe various doctors and hospitals about $3000. Why even be insured? We could have saved $9000 over those 2 years!	WI	7/23/2006 3:43:45 PM
	I am a COTA. I am the sole provider for my home which includes another family member. When PPS came along(during Bill Clinton's administration) I could not get work and we were homeless. I finally got work @ a hamburger place. No one would hire an assistant because we don't do evals. It was a terribly frightening time so when I hear of health care changes it really scares me. I do believe I should be able to put my taxable dependent on my work healthcare insurance. I don't understand why I can't do that when I work with people who put their step children on their's. But PLEASE don't do anything that will make me unemployable again. I am a voting citizen who does not want to utilize the government to pay for my living expenses.	TX	4/27/2006 8:43:28 AM

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Response	State	Date/time received
Dear Senator..good for you getting involved in a issue of grave concern to the american people....i just recently found myself at the workplace being cut from fulltime/benefits to partime with none which means i now must go back to paying out of pocket for health insurance which is very costly because i'm at the upcoming age of 60 (***) this is certainly an issue that needs to addressed by the entire country. please be assured i will be following this issue with great interest. thank you for you efforts and time sincerely yours *** p.s. also have been a widow for 4 yrs and have had the experience of COBRA wich i personally feel is way to costly AARP is alot better coverage with UNITED HEALTH being the carrier	CO	2/16/2006 10:58:21 AM
I would comment that the 2012 date is too far off, people need help with insurance now, and six years is a long time to wait. My comment concerns college students, covered under their parents' insurance upon graduating are able to purchase insurance at an extremely high rate (unaffordable to a new grad) to continue that insurance and most employee insurance does not take effect right away which may ok for a healthy person, but I have a diabetic son, and have read in Diabetes Forcast magazine how many young diabetics are not able to afford to purchase their supplies during this time frame-recent graduate, and taking time to find a job resulting in not taking care of themselves to the level they need. Also purchasing their own private policy would not cover their preexisting problem, or cost is prohibitve. I would not want limits placed on supplies needed to carefully care for someone such as a diabetic, such as how many times per day they can test their blood glucose, based on the number of testing strips covered by insurance. And I would expect they should be able to choose their own MD, or change MD's if desired, as often as needed if they are not satisfied- I have heard of some plans that do not allow for changing your MD more than once per year. I am also aware of many employers offering only part time postions to avoid needing to pay benefits.	MN	6/12/2006 11:43:40 AM
My name is ***, and I am a retina specialist in ***. I believe the private insurance companies need to take some responsibility in the health care crisis. While physicians continue to make less and less money each year and hospitals are acquiring huge debt, insurances companies continue to show a substantial profit (25% increase in annual profit per year). I have personally experienced extensive insurance tactics such as: 1. Insurance companies trying to force patients to only see "cheap" doctors without any attention to quality of care. 2. Simply denial of payment---this requires manpower and additional paperwork to resubmit claims to receive deserved monies...insurance companies are hoping doctors will just "forget about it". 3. Pressure on doctors not to bill for all services---doctors then "eat" these costs...insurance companies will drop doctors if they feel the charges are too high...irrespective of medical need. Because of these negligent financial tactics by insurance companies, Many good doctors are leaving medicine by choice, and others are being forced out by bankruptcy!!! The Denver Medical Society newsletter actually has a section specifically for "indigent physicians"! Ultimately, the greedy insurance companies are hurting patients. In my opinion, the only way things will change, is if PATIENTS refuse to stand for this...my practice was recently dropped by an insurance company for "high charges", and patients were told they would have to change physicians...our patients were outraged....they barraged the insurance company with phone calls and letters, and	CO	2/16/2006 4:28:30 PM

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finally the insurance company put us back on their panel. There is currently a class action lawsuit in progress, Shane vs Humana et al, in which physicians have finally banded together and are pressing charges against many large insurance companies for doing these egregious things. There certainly is a financial healthcare crisis in this country, in large part because money which could be used to provide care for needy patients is being wasted and extracted by insurance companies.		
I have Anthem Blue Cross/ Blue Shield and have seen a rise in our copays and deductibles within the last year due to my husbands employer but the insurance still doesn't cover medically necessary procedures like invetro fertalization because the employer doesn't want to pay for it and some of the employees at his work need this procedure. Also Medicaid has cut us back to Healthy Start for my boys because my husband was making more money due to overtime but our insurance plan through his employer has changed and is more costly.	OH	2/16/2006 7:44:31 AM
My husband & I are semi-retired. Our insurance coverage was under his employer. I have major medical problems, so I am "Uninsurable". We are currently under Cobra but that will end in November. We have been told that HIPPA laws will protect us by being able to get insurance to cover pre-existing conditions. However, the cost could be astronomical + it will probably not cover as much as our current insurance does. If it turns out to be more than we can afford then we will have to go back to work to get insurance.	AZ	8/29/2006 10:57:05 AM
This is not a bad experience with the health care system, but a major disturbance about your reporting. Today, I attended the meeting at the Cinergy Center in Cincinnati, and when leaving I--and others--was given a "summary" of how the votes went. I was shocked when I saw that the sheet summarizing the voting, reversed the actual voting. It lists all the voting in the reverse order of what the people voted for. This can be verified by looking at No. 5, "To get universal health care etc." the summary states that 62% agree or strongly agree, that they are willing to pay higher taxes to assre that everyone is covered with it. That is not what the summation table shows. If someone's intention is to mislead the people who will review the opinons--the voting--they will be successful unless the errors are corrected. ***	OH	4/29/2006 9:12:28 PM
My mother who is in her 60's now has had several health problems that have brought on medical bills that she is afraid to not pay otherwise she believes she will be denied treatment. She can't really afford these costs and is unable to work.	TX	2/16/2006 3:12:07 PM

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	Response	**State**	**Date/time received**
	I would like this message to go along with my responses to the poll. I feel that many of the questions asked, or the responses listed lack some element of what I consider an ideal health care system. I understand that this is not the proper forum for these comments, but I wanted you to have them on record, and could not, after gently browsing if this site fite the right place for these comments.	CA	2/17/2006 1:58:12 AM
	I am a single mother, an RN. My ex husband was physically disabled after a motorcycle accident and is on disability insurance and medicare. My son, who was 16 years old at the time, got very ill with a respiratory infection and required hospitalization. At that time I had just started a new job and was not due for my health insurance coverage to begin until the middle of April, my son got sick at the end of March. He spent 4 days in ICU because his throat was so swollen they weren't sure if they might need to trach him at anytime. I contacted the hospital social services as soon as he was admitted to the hospital and told them about my lack of health insurance and requested help with programs available to pay the bill or help with the bill. I was told there are none and that since my income was 40,000 per year I did not qualify for any programs. My sons's hospital bill was 14,000 dollars, the hospital would not discuss payment if I didn't have at least one thousand dollars to put down on it, which I didn't. I was raising 3 kids alone and even though 40,000 a year is well above poverty level, it is not easy to raise 3 kids on. I ended up with a judgement against me for 17,000 dollars, my wages were garnished and I finally had to settle it from the proceeds of the sale of my house. My credit was ruined. I would not wish this kind of situation on anybody. I was lucky enough to have some resources to lean on, but many others are not. We are all really one medical catastrophe away from financial ruin in the current health care system	NY	2/13/2006 2:57:48 PM
	What is not working for my family is the cost of perscriptions. We have a son with cystic fibrosis and his medications run over $1,000 a month for copayments. The cost rises every year. I believe the drug companies are getting rich on the backs of the poor, elderly, chronically and critically ill in this country. Prior to my husband finding a job with health coverage at the age of 58, we paid over $20K annually for coverage. That's ridiculous and there aren't many people who could afford to do that.	CA	3/20/2006 4:52:38 PM
	I have malignant melanoma and have been disappointed in the medical system. When things need to happen in a rapid manner the calls to insurance and approval process is cumbersome and can cause problems that will jeopardize a life. The HIPPA regulations are still not understood and delays access to records and accessibility to the client of their own records.The Public Health system is now bogged down in giving and getting records with unnecessary paperwork and it has also created probems in the MD and clinic offices and reluctance to share information including the VA system. The system has complicated the sharing of important medical treatment that may be necessary and life saving.I have fortunately been able to advocate for myself despite the identification of a brain tumor. The system is complex for people with disability and also demanding especially the social security system. I have had problems with the pharmacy and medication distribution. The pharmacy was not willing to provide me with antiseizure medicine when I knew I would run out of my medication at a time when I could not access it as I was to be out of town. The insurance company was a block to access my medication at insurance rate and required self pay at exorbitant prices. This is unacceptable as for people who do not have the funds would chose to go without and the result could be a seizure or car accident while without seizure medicine or something that could have caused additional expense to our medical system. Why abuse the emergency room when something can be easily fixed. Provide a refill. Or work on a system that will allow cross county access from another pharmacy with adequate documentation or a phone call ppharmacy to	NV	3/28/2006 11:45:19 AM

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	pharmacy rather than trying to contact a MD office out of state or visit and Emergency room to get a medication refill.In order to obtain the medication I had to pay out of pocket for something that should be obtainable but blocked by insurance. For the 12 pills I paid three times the amount. As an RN retired and APN-C and over 30 plus years of medical experience I have been Blessed with knowledge and personally received support from the MDs that I knew and also knowledge to be assertive to obtain rapid and necessary care otherwise I would be dead now. From a professional standpoint I have observed abuse of the system and the government needs to make changes related to people who are not American citizens and getting all the resources. Women(children and teenagers)illegally come into the US for childbirth and then get care for their child and immediately American citizenship and welfare and Medicare. This is tapping the resources that our Seniors could be receiving in another form or fashion. There needs to be a change and not allowing automatic citizenship for that child that will save the government money and help to reduce the illegal movement into the United States. I am not opposed to supporting life and know some people need assistance but there also is a range of abusive use of our system. I have seen this often while working in Public Health how people outside of the US take advantage of the system and know how to work it and spread the word for further abuse. They get people advocating and supporting them and our own American citizens are left high and dry. There should be required social security numbers from the parents, and documented living in the US for a period of time not just automatic free care and Medicare for birthing a child in the US. This occurs primarily from Mexico and when you ask where is the father he is "in Mexico". We need to support our seniors better. I have an 87-year-old mother who lives with me and the new paperwork for insurance was not user friendly and understandable for individuals of that age. My mother was unable to do that form without assistance (her part was to sign, no independent decision making as she was clueless) and did not understand. There are a lot of seniors in housing that have no one to assist them and had I not intervened in her be half she would have lost her choice in presciption insurance or a delay in the system which happened when she was on her own. There is no way without my support my mother could have gotten her insurances changes. Most seniors can't read and understand the complicated paperwork and it needs simplification and to be user friendly. At her age it was impossible. She needs hearing aids and dental care and her social security check is not enough to support her needs. This should be mandated support for the elderly. If they can chew and eat properly what is the alternative? We need a universal health/dental and prescription care plan that people can buy (minimal fee) or is free for American citizens. It needs to be affordable and available . Naturopathic medicine has a place in health care and not recognized by Western Medicine and insurance and can often cure things like cancer but not recognized. I have had a personal experience with natural product for cancer cure and the American citizens should have the ability and finances to obtain what they need. I have had the experience of working in London and the UK citizens do not have to worry about their care and the US needs a system such as that especially if not for the whole population, which would be ideal. Consider exploring other countries and the system they have. The seniors and vets need advocates and special attention to aid them in their present and graceful years. As a registered nurse I have seen the homeless who have no resources for care and they are another neglected population. Provide benefits to agencies that are working to recuperate those people such as the Missions. There will soon be increased tuberculosis in the US as the money has been cut for sources of TB, STDs, immunizations at least in our area or they have been rerouted and a person who has gonorrhea will not go to seek help when the Health department wants $45 for them to be seen in clinic. It is no longer public health it is pay for your service and discourages people who need the care and treatment. The powers to be are too removed from the homeless and helpless and need to look at correcting the system or there will be a far worse problem with greater expense to the government overall. Prevention should be a focus and if initiated a benefit. Provide funding to seniors to encourage use of such a program to maintain health or weight loss. Give motivational/exercise programs. Social security needs to be preserved. If the government officials had to survive in the aging years on $1200 a month they would soon work to see changes made. I		

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	would like to see an experiment with them now having that challenge! The medical professional also needs to be relieved of law suit as they order unneccesary lab work and testing to avoid law suit and financial benefit for the system could happen if they didn't think they needed to cover themselves. Create an opportunity for no malpractice and protection for professionals to allow freedom and that too will lower expenses. Another disapointment had to do with the insurance billing and not wanting to pay for a service that was not on my insurance plan. I was told it was prior approved as my tumor had doubled in size in four days and the procedure was urgent. Later the insurance denied payment.I had a radiation procedure to "kill " my cancer and the only machine available in the state was in Nevada at a hospital that was not on my insurance plan. I later found out that I would have to go to Los Angeles CA for the prodedure if it was covered by my insurance. The insurance company did not even know at the time I spoke with them if LA had the machine and which hospital had it. After working with the neurosurgeon and radiation oncologist in my town is it reasonable to fly to LA get hotel,flight and medical expenses and go to a complete stranger who I have not been in their care? The insurance company and I had to have many paperwork trail and argument to get payment for the expensive procedure that was not available in my hsopital. When I spoke to the insurance person they recommended that I could go to a radiology department thinking it was a simple x-ray and not offered at that facility. When you are feeling sick and near death do you really need to deal with that? My husband would not have insurance also when he retires as it is not offered in his retirement package. That too is not acceptable. Every American citizen should have coverage especially after working your entire life and contributing to social security since high school and not at the age of 65.There age gaps for people who must retire early and need medical care. A solution needs to be there for those individuals. I pray to God that the system can be improved, innovative and simplified practices for our communities benefit.		
	I just completed your Health Care Poll, but felt I needed to clarify some of my responses to the questions in that poll. In question #2, rather than responding "no opinion" I would prefer to say that both reasons are so important I cannot choose between them. Regarding question #5, the services included in "basic health care" should be defined by two groups - first those whose quality of life are most affected by basic health care, i.e. "consumers," and secondly those who are best able to determine the importance of various health care services based on their impact on the consumers' overall health and quality of life, i.e. "medical providers." I am also concerned about the use of the word "efficiency" in the context of medical care without a clear definition of what type of efficiency is referred to. Although efficient and expert use of medical technology by health care providers can have some impact on the efficiency of the health care system, I believe it is more common for access to the most MEDICALLY efficient services to be restricted when profit-driven health care corporations prioritize FISCAL efficiency over MEDICAL efficiency at the expense of the wellbeing and quality of life of patients. Lastly I cannot help but notice your having left out of this discussion the biggest elephant in the health care living room, the cost of pharmaceuticals! I believe this is the single most significant factor in the cost of health care, caused by our total dependence on a profit-driven pharmaceutical industry for the development, production, distribution and sale of medications. Any discussion of health care funding has to include the consideration of a significant level of government participation in, and perhaps even primary ressponsibility for this aspect of health care. Otherwise the cost of health care will continue to be inflated by the multimillion dollar get-rich schemes of entrepreneurs!	CA	2/16/2006 10:08:09 AM

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Response	State	Date/time received
Over the years Iâ€™ve seen many people that werenâ€™t eligible to get Health Insurance, because they had a chronic disease, Diabetes. Most people realize that diabetics, with kidney failure, must go on dialysis, in order to keep on living. People donâ€™t realize that when an American has kidney failure, they are eligible to receive Medicare, if they have enough work credits. And if this person is fortunate enough to get a kidney transplant. Which is one of the greatest gifts that a person can receive. The real shocker is. . After 3 years of a successful transplant. The person has their Medicare Health Insurance Terminated What this means is that transplant patients are, on their own, to get Health Insurance. In Ohio Iâ€™ve seen quotes of a premium of $7000 a year for Health Insurance, at open enrollment. The policy had no drug coverage, covered 40% of hospital expenses and had a $5000 deductible. The only chance, that people with high-risk health issues have to get Health Insurance. Is if their state offers a High- Risk Health Insurance Pool. Like 32 states now have. I canâ€™t understand how a country that has all the wealth and good medicine. That the United States has. Can have a Health Insurance Industry that discriminates against people, that need it the most, and is so patient unfriendly. Like it has been said many times. Too many people are making a lot of money the way it is. In order to have it changed.	OH	5/4/2006 8:01:12 PM
My wife and I are still relatively young (although we have grown kids who have left the nest), have been free of any serious medical illnesses, and have never been inclined to over-utilize medical services under any previous medical plan. Nearly three years ago, I partnered with a colleague and we went into business for ourselves after many years each in typical corporate environments. Because of the choices we made in starting our business, I needed to enter the individual private market for health insurance. I consider myself pretty fortunate, in that we make a good enough living from our business that what I'm about to share with you has not resulted in the kinds of crippling financial choices other people face in dealing with health care decisions. Well, thus far, at least. Seeking individual coverage in the open markets turned out to be a nightmarish process for us. I have a known liver enzyme syndrome (known as Gilbert's) that is believed to affect 3-8% of the population, but which has never impaired my health to any known degree (and a specialist at the Cleveland Clinic years ago indicated that it likely never would). Yet, Gilbert's has the effect of tripping up any health insurance exam that I've taken due to unexpected liver enzyme levels that may/may not point to liver disease later in life. My wife has had normal female issues that have never arisen to the level of requiring an active response, but annual monitoring for her always goes beyond the nominal minimums. Excessive defensive medicine? Who am I to make this kind of judgment? I'm not a trained medical professional with years of insight and experience to draw upon. After several attempts to get joint coverage for us from private insurers doing business in Florida, it became apparent that no company would take both of us -	FL	6/8/2006 9:35:46 AM

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given the widely varying degrees of acceptance criteria in each company's underwriting guidelines. So, as if we were merely roommates instead of longtime husband and wife, we have each purchased health insurance policies from separate companies.

Our deductibles on each policy are fairly high - $1,000/year. Neither one of us has ever met the deductible for our respective policies during the past three years. Nope, not even come close, frankly. Perhaps we have gotten $500 worth of expenses paid each year through co-pays for basic annual exams. Our pharmaceutical coverage - such that it is - has never qualified us for a discount at Walgreens. Always full price out of pocket.

In three years, our collective premiums have increased at levels far outstripping normal inflation (nearly 40% during this 3-year period). Our regular premiums are now approaching $1,100 per month to cover both of us.

So, this represents for us a $500 annual return on an investment of roughly $13,000/year. I work in the insurance industry, so I'm no stranger to the concept of using premiums to fund risk pool requirments.

I am, in most cases, a general proponent of free market solutions to most economic issues. I co-own a business, so my livelihood depends upon the effective functioning of free market forces. I also have no problem accepting the general concept that personal lifestyle choices represent something that should be bourne in cost by the folks making the bad choices in life.

But my experiences in helping two healthy people (my wife and myself) with generally acceptable lifestyle choices (OK, I like to eat and am probably 15 pounds overweight) obtain reasonably priced health coverage have taught me an important lesson in the unanticipated effects of philosophical policy choices. Our respective DNA profiles have essentially turned us into marginal prospects for health insurance policy coverage - think auto insurance for 19-year olds with two accidents and a few speeding tickets.

We are already highly efficient users of health care services. We already provide a significant subsidy to the two carriers who grace us with their generous decisions to grant us individual coverage. HSAs are not going to make a material difference in our financial position - nor are they likely to help us "become better consumers of health care."

The unequal bargaining position of the individual health care consumer relative to the statistical precision employed by major health insurers clearly represents to me an example of where pure market forces will likely work to the general detriment of society rather than in its favor.

I can only hope that folks who make a typical $40-70K/year in total household income are able to find a more creative way to financially navigate the health care system without significantly decreasing their overall standard of living. My own efforts to achieve a reasonable return on our health care investments - and that's what they are, investments - have been a dismal failure.

I sincerely hope your efforts can lead to a positive impact going forward. It is sorely needed.

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Response	State	Date/time received
The health care system needs to open its eyes up and learn that the reason it is here is to take care of PEOPLE, we are individuals not numbers. I have been kicked out of a doctor I have seen for 10 yrs because medicaid has decided to bill something some months and not other months and back charged 9 yrs and told by the dr pay up or do not come back. Medicaid trying to get through to someone other than a recording or someone who cares or someone who knows something is unbelievable slight. This I have found with Medicare as well. When does the system become a PEOPLE SYSTEM. Where the person means something not the high and mighty dollar because if the person is not treated right the first time it will cost more the second and third time in the hospital or doctor for the same problem.	FL	7/30/2006 3:13:30 PM
I am a 38 year old practicing internist in Delaware. I was surprised upon starting practice to learn the realities about out health care system. I was astonished to learn that we are the only industrialized country that tolerates having 15% of its population excluded from its health care system. What's more, since we alone have a healthcare system whose goal is to make profits for shareholders of large companies (HMOs, who control the flow of most of the money) the system ACTIVELY EXCLUDES sick people from the system, since they are costly. You would think we would save money by not insuring the sickest of our 0-64 year olds. Yet our health care system costs roughly DOUBLE what other industrialized countries, like Japan or Germany, spend. Where does the money go? Here's 2 hints: there is no such thing as a "HMO Industry" in most other countries, and they spend much much less on pharmaceuticals. Stated more simply, our health care system is designed to keep sick patients away from the doctor, while enriching an enourmous middleman industry. How many times have we all heard "we have the best healthcare system in the world"? Countless. Unfortunately this glib statement is untrue. In 2000, the World Health Organization ranked the world's health care systems, and the US ranked #37. 37 is not equal to 1. What's the real consequence of our health care system that permits 15% of its population to be uninsured? Real Americans are getting sick or injured, losing their health care, going into bankruptcy, and even dying. Every day. What about the argument "these litigous Americans just want a free ride". First of all, how can people budget for tens of thousands of dollars in costs associated with uncovered hospitalizations, prescription drugs, and other. And guess what - when you are injured or wronged a health care system like ours, you are a fool if you do not try to sue. Unlike in Canada, the UK, France, or elsewhere, if you are disabled by illness or injury in the US, you are out on your own. Studies show that most dollars awarded in malpractice suits in the US go to paying for future health care costs. For over a century we have heard the excuses, seen the shrugged shoulders and rolled eyes. What we need is a solution tot he problems. Given that every other industrialized country has somehow managed what the US perpetually fails to deliver (universal healthcare at a much lower cost) I have to conclude the only avenue to success is what they have all done: institute some form of national HEALTH INSURANCE. Like medicare expanded to all Americans.	DE	8/27/2006 7:55:13 AM

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Response	State	Date/time received
My husband and I have only recently joined the ranks of the "senior community," which amuses us, since we're more active and healthier than most of the younger people we know. We have had (and are still experiencing) a nightmare of experiences seeking independent health insurance. We find the insurance industry entirely mercenary and self-serving. Their profit margins are obscene. In fact, they are doing more than their share to eliminate the middle class and to punish people who are or have been productive, hard-working, and honest about their conditions. They follow strict but secret underwriting guidelines that somehow permit the companies to keep deposit money (and collect interest?) for at least a month before they deny applicants and return the deposit--minus processing fees, of course. What follows is our particular story: My husband worked for twenty-seven years with a City/County police department, secure in the knowledge that when he retired he would have retirement funds proportionately tied to the payscale of the active officers as well as access to affordable group insurance until age 65. After he retired to a rural community, our health insurance premiums shot up from $350 to $1100 in the space of four years as our original employer-based provider went bankrupt and we were shuffled along to a new provider. The City and County that had employed him found a loophole that allowed them to disregard the rank at which he had retired, so that his retirement funds decreased. We both used our extensive educational backgrounds to find part-time jobs to make up the difference, although jobs are scarce and unstable in our area. Last year, the City and County decided that a good way to save money was to remove the retired officers from the active pool and set them into their own group. Those who still lived in the city could suffer less as they were covered by Kaiser Health Care. Those who hadn't stayed in the city were given only one option for group coverage. Thus, our health insurance premiums reached $1600 per month--without vision or dental and with only 80/20 coverage. A man who had spent his life serving the public at the risk of his own life, who had protected several presidents of these United States, the heads of state of eight nations, and the Pope was excess baggage. We began looking for independent insurance with AARP. Of course, a huge organization of aging Americans would offer insurance that would suit us. Wrong. We were denied coverage by United Health Care, because of a history that included an hiatal hernia that was causing no trouble at all and a crooked nose that was also merely a quirk of construction. So, we tried an indemnity insurance company. It sounded too good to be true. It was. When we researched the company more closely, we discovered that they were infamous for misleading their customers--often abandoning clients (who believed they were covered) to catastrophic health costs that devastated those clients. We backed out of that commitment and moved on to be denied by two more companies. We discovered that underwriters look for key words in health histories. After holding our hefty deposit for fifty-three days and losing a set of applications, one company denied my husband (in part) for a basal cell carcinoma when the record clearly noted that the spot that was removed and sent to a lab turned out to be a simple, normal cyst. It seems that underwriters not only read poorly, they are also directed to take each small problem a person has and add it to any other minor aberation that might exist. Thus, an elevated cholesterol number PLUS blood pressure that is elevated (not counting the medication that maintains safe levels)PLUS excess weight (even five pounds over the secret limit)add up to a flat denial--although the patient is active, healthy, and has a family history of unusual good health and longevity. They made a big fuss over a routine colonoscopy that removed a pre-cancerous polyp and identified a mild tendency toward diverticulitis, even though a colonoscopy is preventative and won't be repeated until after the patient is under Medicare, and no treatment or interim examination was recommended for either the polyp or the diverticulitis.	CO	2/16/2006 1:56:37 PM

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	Yet a third company wants MORE copies of my husband's diverticulitis records before they can tell us anything about our eligibility, while they won't cover any prescriptions for me, because I buy allergy medicine plus an annual tube of estrogen cream to alleviate vaginal dryness. Needless to say, we suspect that if we jumped through this company's hoops, we would probably still be denied according to their secret formulas--and we would spend a month living without the deposit money. As I write, we are "hoping" to be accepted by a plan that will require us to pay a monthly premium of well over $700 while we pay ALL of our health costs up to $5400 per year(we have never paid that much for our 20% of our health care expenses to date, including our vision and dental that will be excluded from this deductible). We're assured that we'll be able to take SOME of our health payments out of an HSA that we are supposed to feed out-of-pocket monthly. (Amusingly, we're repeatedly instructed that we won't be allowed to put MORE than $5400 per year in our account, as if that were feasible.) If we turned to the insurance coverage guaranteed to be available by our state, we would have to pay $993 per month, according to our income. (Naturally, that $993 would not cover 100% of our costs, and we don't know yet what "riders" would be added.) We plan to research this option more, but we aren't optimistic about the reliabilitiy of a program run by our state. In the meantime, as we wait for these various companies to cogitate over our eligibility, we are still paying $1600 per month to maintain our present 80/20 coverage, an expenditure which requires that we dip further and further into our meager savings. The health insurance lobbyists should feel proud. They must be superb salespeople to be able to convince our representatives to betray their constituents and the middle class strength of our country.		
	Job makes everyone use Principle Health Insurance at $180/per pay. That is too expensive. Itâ€™s not commonly known and itâ€™s hard to find docs and dentist that take it. I told them that the website is not user friendly. The information they give out does not have a list of providers that take Principle Health Insurance. They tell you to expect you to call around or search the web yourselft. Not helpful at all. I hate it. The Co-pays 10, Spec 15, Rx 10-25 (way to high for meds and the co-pays add up). My sister went to the ER and was asked for a $50 co-pay while she was still being seen. She didnâ€™t have the money so they gave her a pre-addressed envelope. Tacky.	PA	5/25/2006 11:57:15 AM

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Response	State	Date/time received
I grew up with no healthcare. Consequently, I never went to the doctor/dentist as a child. As a young adult, I had few choices. Infrequently, I paid cash for an extremely expensive 15 minutes with a doctor, and another large sum for any prescription. Other times, I used emergency room services where I qualified for Charity Care. I would wait extremely long periods of time and receive less quality care, I assume because ER doctors have a different specialty than family doctors, and are not accustomed to seeing things that patients don't normally bring into an ER. Most of the time, I used free clinics/dentists. Particularly with dentistry, the preferred manner in the free clinics is tooth-pulling. The fastest, cheapest way to deal with cavities and other problems. Mental health programs were largely unavailable to me as well. I would only be eligible for services related to mental health through disability, which took years on a waiting list consisting of regular assessments at different offices that were often unaccessible, as I did not have my own transportation. In New Jersey, I had to be a welfare recipient in order to receive healthcare. I went to college as an adult, this was the first time I had something close to health insurance. I could see the doctors for free at the school only, and I still paid for prescriptions. I did see a psychologist once a week, free of charge. Even though I worked full time all through college, I was still ineligible for health care. The Hair Cuttery has cut its benefits as a result of the rising costs of health care, which they explained in a letter when I was hired. It is only now, when I am nearly 30 years old that I finally have healthcare. My fiance works for an institution that offers healthcare to domestic partners, which I am. I do not have healthcare because I work, I do not have healthcare because I am a student, I do not have healthcare because it is my right as a human being, I have healthcare today because my boyfriend's job has a voluntary policy that extends its services to domestic partners. While I am grateful for this "privilege", I will only maintain as long as I am a partner with this man. Because of that, I do have some reluctance to use the insurance, and I also have some shame around it, because I have not "earned" it. I also have been accustomed to distrusting doctors and dentists because of my inability to see them, and because of the poor services I have received.	NJ	3/20/2006 2:46:46 PM
This is the impact of our nation's lack of affordable healthcare. My employer provides healthcare for "signifigant others", even if you're not married. This is a great perk at my job, that my boyfriend is able to get afforable health care without us being married. I have not had any problems with the health care system personally; however, I feel that all people have the right to have healthcare since we are all humans, especially children. My younger sister does not have healthcare since she is too old to be on her mother's plan and isn't working full-time at one job, nor is she a full-time student. But she does work 40 hours/week and does go to school on Saturday's. Being a productive person who is contributing to the economy and future of this country should get her basic healthcare, but that's just not the case sadly.	PA	3/20/2006 3:24:41 PM

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Response	State	Date/time received
As a researcher and administrator working to provide health care services to 30,000 patients and over 100,000 patient visits per year, I find it hard not to feel a little angry that this is the first time that I have heard of this site. As a rapidly growing federally qualified network system in the Midlands of South Carolina, providing care to low-income, underserved and underinsured patients our current system is overwhelmed by the cost of providing care. Our ability to provide quality care is hindered by having to utilize price as a deterrant to patient's seeking all the care they need. I believe that the key to our current health care crisis can be traced to a series of decisions made in the 1990's called Disproportionate Share; the introduction of computers into hospitals, meaning that everything and anything could be charged and the cost of hospital services has escalated ever since. As Dan Rather recently reported, I believe that the Master List costs of hospitals are being adjusted to allow hospitals to maximize their DISH money. The third issue is the advertising of controlled substances by pharmaceutical companies. I have no problem drug comapnies advertising OTC drugs, but the advertising of pharmaceuticals that can only be obtained by prescription, make the drug comapny pay for a thity minute education program to teach about the disease and have the pharmacist and the physician advise the patient on the best treatment. Chronic disease management needs to focus on CARE not COST. Focus on care and you achieve the best most effective treatment with early intervention and reduce the risk of disability. Health Insurance and Health Care are really antethetical, because the two principles of health insurance are avoid adverse selection and moral hazard, health care seeks to identify and intervene to lessen the impact of disease or illness. For federally qualified health canters to be able to actually be a safety net, they would need to be three time their current size to meet the needs of the uninsured. Our center serves approximately eight percent of the uninsured population and receives only 9% of its revenue in federal grants. Without vertical integration with secondary and tertiary care, we are facing a hopeless situation with the poor and minorities experiencing a health care gap that is only widening. We have to take a step back, look at the dignity we owe to each other regardless of our economic status. In the Book of Haggai the prophet warns against neglecting the right for personal gain and warns against putting your money in pockets riddled with holes, which is rapidly becoming a description of our health care programs.	SC	3/8/2006 11:18:08 PM

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They haven't killed me yet, but not for lack of trying. I got impetigo in the hospital when I was born. When I got whooping cough, they mis-diagnosed it as allergy to mother's milk. I got chronic fatigue syndrone before it had a name. They said it was all in my head. Turned out I had dysbiosis, heavy metal toxicity, malabsorption, food allergies, stress, unhealthy diet, inadequate exercise, and dental work that was electro-plating. It took me years of study (and ill health) to learn what the pig-headed doctors could not tell me. I found a holictic doctor (a fellow of ACAM), a holistic dentist, and a BGI chiropractor and changed my lifestyle to restore my health. I do not trust mainstream doctors. Their whole paradigm is a failure. I trust drug companies even less.	NJ	2/17/2006 3:59:17 AM
Our son has Tourette Syndrome, Obsessive Compulsive Disorder, Asperger Syndrome and Attention Deficit, Hyperactivety Disorder. We have had to fight long and hard to get medical coverage for him. In 1997 our health insurance was rated up to $1200 per month and this only covered 50% of his medical needs because the insurance company called his disorders "mental disorders" rather than physical. One year 30% of our income was paid for medical coverage and medical needs. People need medical coverage. Our system is a national disgrace.	OH	4/27/2006 3:05:13 PM
Dear Editor, Two and a half months ago I felt like one of the happiest and luckiest people alive. My new job as a high school science teacher was rewarding and challenging at the same time. My daughter was doing great in school and was growing more beautiful everyday. My parents were living with me wile my dad was building up a new business after huge financial losses. His counseling endeavor was gaining steam and making good money - finally. My daughter and I loved having "Mom-mom" and "Pop-pop" so close. My younger sister and brother also live in North Tampa and visited us a couple times a week. Yes, I was one of the privileged few who had everything always work out great. But my luck changed one morning during Spring break. I was taking a mid-morning nap and enjoying my vacation when my mom woke me up. "Debbie, its your Dad. Something's wrong!" The look on her face made my heart sink to my stomach. I don't remember how I got there, but I will never forget what I saw in the living room. Dad was sitting on the sofa, has pallor put my mother's to shame. Dad's mouth was slightly open and his hands. . . In my memory, burned there for all time down at is sides, palms up and his fingers curled in. After running to him I felt his cold pale unshaven skin. The 911 operator walked me through CPR but he was gone. I said it over and over again to the operator while doing the chest compressions, "Dad!. . He's gone. He's gone." Through my tears I could see my mom crying, "Oh, Kevin," while looking at her daughter desperately trying to save her husband of 34 years. Though I am shaking and crying as I write my story, I know I have to do it. I have to because I know mine is not the only family who has had to endure a loss like this. Thousands of Americans die who never had a fighting chance because they didn't have healthcare. Since his first business failed, my dad lived without health	FL	6/27/2006 11:41:13 PM

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	insurance and hadn't been to a doctor in two years. For a few days before he died he was feeling nauseous and had a sore shoulder but attributed it to a cold or flu. We will never know if the result would have been different, but with preventive medical care without the threat of huge debt, my dad would have had a fighting chance. A chance to see his granddaughter graduate kindergarten. A chance to make his counseling business succeed - he worked so hard for it. This is a plea. I am calling out to everyone who reads this to let their representatives know that no one should die because they couldn't afford a doctor in the country with the best healthcare. This is an epidemic with little press coverage and no one is counting the bodies. In a country where anyone can feel like the luckiest person in the world, our congressmen and women and our senators should not give themselves another raise until they make sure everyone can see a doctor and get medicine when they should, not just in emergencies.		
	I am a 47 year old female. My husband was born with C M T muscular dystrophy and was fully diag. with it in 2002. He worked 17 years at the plant and had insurance. He broke his foot by just walking on flat land and was out of work for it. The dr he seen knew nothing about cmt and kept him coming knowing his foot was not healing, and even told him it wouldn't heal that he would have to see a surgon who knew about the m.d. well we wouldnt scheduale him an appt. he kept him coming for the 12 weeks till his insurance ran out and it took 14 months my husband went with a broken foot till we finally found a dr in roanoke who would do the surgerys he needed to fix his foot he knew we had no insurance but still accepted him. we lost our home everything because it took 2 years to get his disability started and his medicare i have no insurance at all. I have had a knot under my left are and bad back problems and stomach problems but everyone i try to get insurance with it will cost me around 350 to 400 a month to get it so i do without. we to fall between the cracks im the only one working and it is like if you arent rich you dont matter. it is hard to try to stay well when your not and work everyday sick. i have a bad absessed tooth now and cant go to the dentist cause i have no insurance. and i cant afford to quit work and stay home to get help or we will loose everything again. people need medical and dental ins. but when you are in the crack no one sees you or cares. the billions of dollars going into space could really help to give us all health care we will never live on the moon.	VA	7/4/2006 12:43:56 PM
	I have been a RN for 21 years and have obviously seen countless different outcomes regarding the uninsured or underinsured. A recent situation comes to mind. A 28y/o female was seen in the neurosurgical clinic where I work with a brain lesion. The physician's differential diagnosis included brain tumor, cystic lesion vs. brain abcess. To make a long story short, she was a Missouri Medicaid recipient and we could not find a dentist to take her. The physician could not operate until the badly infected tooth was removed and treated. She was given an appointment prior to leaving our office with the last dentist we contacted, he finally agreed to see her. The dentists' office staff contacted her later and cancelled the appointment. She tried on her own to get another appointment and it was not for a month. She was temporarily lost to follow up since she did not have a phone and had moved in with her mother and we could not reach her by mail. While waiting to see the dentist, she her brain partially herniated due to the pus that collected from what ended up to be a brain abcess-very treatable initially. A lengthy hospitalization, rehabilitative phase, etc. followed. She was working prior to the illness but probably won't again or not for a long time now. Medicaid ended up paying much more when everything was done than if the treatment was initiated sooner. But of course the physician and hospital were not reimbursed at a rate comparable to private health insurance patients despite the patient/condition that required intensive observation, treatment, and follow-up. The same level of	MO	8/23/2006 1:31:07 PM

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	Response	**State**	**Date/time received**
	intensive and compassionate care was delivered. What the public doesn't realize is that many times people from the local community; privately insured patients too, are referred to other facilities when the neurosurgeon on-call is tied up with critically ill patients requiring their full attention at the time. When people think they are not affected by this problem because they are "responsible for their healthcare and pay for pirvate insurance" they are very wrong. It is all of society's problem and we should collectively help solve it. This is obviously a huge topic not even uncovered at the tip with these comments but I'll stay active on the site and learn more and contribute where I can. Thank you for this educational and interactive opportunity to be a part of the solution and not just complain about the problem.		
	I've spent a lot of my adult live uninsured - when I did manage to work I kept finding the employers that'd find ways to classify me in ways that'd disqualify me from benefits like insurance. But when they they say that if you have money you can get care they're telling you a half truth - many places won't give you the time of day if you don't have insurance even if you show up with a large wad of cash and just needing minor, one time care. Navigating the system without insurance is very tricky at best - though if you can find a doctor, it's pretty easy to get meds (whoopie). Unfortunately, the time I got REALLY sick was one of those times I was uninsured. And when I managed to get really sick, it wasn't my physical illnesses that flared up - it was my bipolar. Did you know that access even to public mental health is often very limited if you don't have insurance of some sort? I didn't. I'm now on SSDI because the only way to get the care I needed was to get Medi-Cal, and the only way to get Medi-Cal without a child was to have the SSA declare me disabled. But something had to happen. With a mental illness I'm uninsurable as far as private insurance goes and with my skills my work is mostly contract work so no benefits... So now I subsist on SSDI and what's become Medicare instead of Medi-Cal instead of working (when able) in IT contracting. Somebody besides me has to be missing that income and those taxes.	WA	6/9/2006 3:55:54 PM
	I AM A SELF-EMPLOYED, SINGLE WOMAN (AGE 58) AND CAN'T AFFORD HEALTH INSURANCE. I HAVE BEEN FORCED TO LET MY HEALTH INSURANCE LAPSE THREE SEPARATE TIMES IN 15 YEARS DUE TO THE HIGH COST OF PREMIUMS. IN 2003, WHILE UNINSURED, I HAD TO GO TO THE EMERGENCY ROOM FOR FOOD POISIONING FROM A COMMERCIAL FOOD PRODUCT. THE "NON PROFIT" HOSPITAL CHARGED ME THREE TO FOUR TIMES MORE THAN WHAT THEY WOULD HAVE CHARGED AN INSURANCE COMPANY. I COULDN'T PAY THE BILL. THEy TURNED IT OVER TO AN AGGRESSIVE COLLECTION AGENCY WHO SUED ME (AND I LOST). IT IS A NATIONAL DISGRACE THAT AMERICAN CITIZENS ARE PRICED OUT OF THE MARKET FOR HEALTH CARE. IT IS A NATIONAL DISGRACE WE HAVE OVER 46 MILLION UNINSURED PEOPLE, MANY OF WHOM WORK FULL TIME AND ARE MIDDLE CLASS. IT IS A NATIONAL DISGRACE THAT AMERICANS MUST CHOOSE BETWEEN HEALTH INSURANCE OR A ROOF OVER THEIR HEADS. C'MON, CONGRESS, DO YOUR JOB AND GIVE US "NATIONAL HEALTH INSURANCE: MEDICARE FOR ALL". AMERICA CAN'T AFFORD TO DO ANYTHING LESS!!!	CA	5/15/2006 1:00:00 PM

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Response	State	Date/time received
I am a Certified Nurse Midwife. I am employed by a FQHC. Our group of 6 (soon to be 7) nurse midwives and 3 OB/GYNs delivered approximately 1550 babies last year. We also employ 2 OB/GYN nurse practitioners. Our FQHC provides Women's Health, Pediatric, Family Practice, and Dental Health Services in one building. We also have Lab, Pharmacy, and will soon have an Ultrasound department. We have social workers, and a Medicaid specialist on site. We use computerized medical records & Rx writing. We are truly a "one stop shop". I am the Clinical Operations Manager for Women's Health. We are working to improve the efficiency of our practice as well as to improve our patient's satisfaction with their health care experience. One national trend that I find disturbing is the increase in ceserean section rates. This is being fueled by ill advised hype in the media that does not explore the down side... more risks in this and future pregnancies, painful adhesions, increased risks of stillbirth, placenta previa, etc. It is also much more expensive for the health care system! Ceserean sections can be a life saving procedure, but they should be reserved for when they are truly necessary. Certified Nurse Midwives have been shown by research studies to provide safe, effective care with equivalent or better outcomes to that provided by OB/GYNs. Other Advanced Practice Registered Nurses (ARNPs) can provide safe, cost effective care also. Nurse Anestitists could easily provide epidural services in a much more cost effective manner to laboring women than Anesthesiologists. Our OB/GYN ARNPs provide routine gynecological and family planning care to our patients, referring those with complicated conditions or in need of surgery to our OB/GYNs. Litigation is an issue that must be addressed in this debate; fear of lawsuits is driving up the cost of providing adequate health care. Sometimes we need to "think outside the box" to come up with ways to provide care in a cost effective, safe manner.	FL	3/13/2006 12:47:49 PM
The health care that I have received here in ***, Nevada has been good. The 2 doctors that I am able to afford to see currently, one is the most kind and caring and tries to reduce the cost of my visits with her. The other only cares for the money he receives and doesn't take more than 10 minutes with me, just long enough to fill my prescriptions and that's it. I have filed for Social Security Disability 2 years ago and am now waiting to see a judge to determine my fate and they say that will take another 9-18 months more!!!! In the meantime I have no insurance and the welfare here will not cover me until I am accepted by Social Security. This is a detriment to my health, as I should be seeing 5 doctors and have to decide which of my 12 medications I will have to skip this month so that I might eat. I have surgeries that I need done, but can't afford them. I know that I have probably blown my shot with Social Security, because I have filed a tax return for the last two years. I put on there that I am watching my grandson and that I am paid $12,000 every year for babysitting, but what really happens is that I am not the one that watches him, I am on too many drugs to keep me from as much pain as possible. But, at the end of the year, I need that Earned Income Credit to be able to afford to pay for my medication and to see my doctors. Social Security would deny me if I wasn't seeing my doctors, yet there is no help here to be able to pay for those doctors. There is no insurance that will take me, because of my pre-existing conditions and I can't afford to pay for one full year to see if they would after that. The system does not help people like me and you wouldn't believe how many of us there are. What am I supposed to do. Everytime I tried to go back to work, I would end up in the hospital. I sometimes think it would be better if I just died. Thank you for your time,	NV	5/12/2006 7:22:54 PM

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Response	State	Date/time received
It took me over 7 years to convince my doctor WHAT pain medication would work best for me, partly because it is highly addictive. He is NOW surprised that I have NOT refilled the prescription frequently, unlike most of his patients who use it. (I only use it when needed!) My "other half" recently got a prescription for pain medication that, because of how written, required "prior authorization" that the doctor was unaware of. After more than 1 week with NO medication due to NO authorization, my other half obtained a "personal loan" to buy medication. (10 days worth cost him $80 due to having NO "prior authorization"! His income is $628 month) The doctor then re-wrote the prescription in a manner that gives him the SAME medication WITHOUT a prior authorization, by splitting it into 2 separate prescriptions for different dosages. (30 days worth then cost my other half a $2 co-pay) As yet, 3 weeks+, NO authorization has been received so that he can get a "refund" of the difference from the pharmacy for the ORIGINAL 10 days worth which was all he could afford, even WITH a loan!! THIS IS RIDICULOUS!	CO	2/17/2006 1:06:06 PM
My son age 32 has Glioblastoma grade IV (Brain tumor),with the out come of 18-24 months to live. He had surgery 1/2/06 to remove the tumor and has been on chemo (Temodar) and radiation for 6 weeks. He will now start another round of chemo (temodar) for 5 days a month and off chemo 23 days a month for about a year. He has insurance through his work that is helping, his chemo alone in over $9,000 a month. Because of this high medical costs, he is fighting to try to work. As sick as he is he continues to work. Without his job he has no insurance and this is not right, When someone has a terminal or catastrophic illness where is the government to help. For medicare/medicade I have been told that you have to lose everything to qualify for this, and it takes longer to qualify then my son has to live. It amazes me that in this rich and properous country we live in, that people who are suffering suffer more. If this was your son what would you be doing? When a doctor looks you right in the eye and says your son has 18-24 months to live your life changes for ever. Selling the farm to help him is what we are doing, is this the AMERICAN WAY?? I guess so. We should be ashamed on how we treat the young,old and helpless who need us the most. When the government treats their citizens without respect what hope do we have for a cure?? The money spent on reasearch is very important, but I also believe that the money we spend on helping our young, elderly and sick must also be what our country and nation is about.	TX	3/28/2006 10:20:56 AM
I am a psychotherapist and I deal with families every day with severe mental health issues who cannot get care due to the interference of so called "managed care" arms length companies who limit care, drain off funds from providers and leave care incomplete. People have no recourse to this. I also have disabled spouse who under ERISA is dropped from his health care every few years and has to go to federal court to get reinstated (something many disabled folks cannot do -- the reason he is dropped? A form is not returned by a medical provdier. Health care is disgraceful as is the limits on access to care and interference with medical providers --- we should begin again by starting with expanding Medicare to all US citizens. Insurance companies have made a mess of our health care system in the last ten years as have medical malpractice cases. lets do an overhaul in my lifetime!	NC	4/22/2006 8:38:32 AM

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	Response	**State**	**Date/time received**
	I am presently on medicare. My concern centers on what physicians charge for services. No wonder the system is going broke. Example: 3 recent injections of a drug in my knee. Cost $707. An ear infection called for inserting a wad of cotton laced with a chemical to cure this. Time spent doing this about10 minutes or so. $270 bucks. I currently need a stress test done for $900. This is nuts.	MI	3/13/2006 1:06:34 PM
	I believe that health care is a right, and not a privilege. In other words, you should not have to be employed for example to be qualified for health care benefits. About 17 years ago, I was unemployed, and my husband was working but without benefits. I got pregnant, and had a miscarriage after 3 months of pregnancy (which by the way was probably brought on by the fact that I did not know how I was going to manage having a baby without health benefits). My husband took me to the hospital, where I miscarried, and the next morning, a hospital representative called me at home and asked me how was I going to pay for being treated for a miscarriage when I had no health insurance. To make a long story short, we had to file for bankrupcy, because the hospital bill was over $10,000 and we could not afford to pay for it.	MD	2/16/2006 8:34:20 AM
	My health care was free from IBM. Then in the 1990s IBM began charging me a monthly fee. On the same day the Chairman of the Board of IBM got a $10,000,000 bonus for saving the company money, my monthly cost went up $40 per month. Now my monthly cost are $440 per month. It seems obvious to the casual observer that Executive greed has entered into the health care cost equation. Now we see that an Exxon executive received about $500,000,000,000 in one year. In 1980, the typical executive pay was about 35 times the national average income. Now the typical executive pay is over 400 times the national average income. In 1980 the typical worker in a large company did not pay a monthly fee for their health care. Now the typical worker pays a few thousand dollars a year for their health care. When Ronald Regan got the top tax brackets removed, he release the unintended consequences of executive greed. It really is terrible to consider that anyone might be forced to pay 91 percent of their pay in taxes. However; it is more terrible to consider that executive greed would cause executives to stop giving raises to workers then raise workers health care cost while keep all the company profit for themselves. That is what we have seen happen for the past 20 years. The tax brackets we had in 1980 were too low because of bracket creep. We should not have removed the top brackets and unleashed executive greed. We should have instituted bracket indexes based on the national average income. Executive pay of 35 times the national average income might be fairly taxed at no more than 30%. However executive pay at 400 times the national average income should be taxed at over 91%. Stopping executive greed could help in many areas in addition to health care. We might see the cost of gasoline come down if the oil company executives could not keep all the profit. We might see fewer jobs leave the country if the executives could not keep all the profit.	TN	4/22/2006 10:27:01 AM
	I use mail order prescriptions for reduce cost of the 13 meds I take for HIV and depression. The mail order company only cares about one thing, getting paid. They hold up meds shipment when flex spending account auto pay did not work causing me to run out of meds. They have told me to buy them locally because they could not send them fast enough due to high demand, and I could not afford to buy they locally.	TX	6/4/2006 10:25:31 AM

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Response	State	Date/time received
Hello, I am a Daimler-Chrysler retiree. I am 75 years old and have been retired since Oct. 31, 1987. They offered me a choice to take early retirment in 1987 or wait until Feb. of 1988. I was a management employee and I did not have to retire, in fact I was offered a promotion prior to my retiring. I had only 21 years of service but I elected to retire in 1987 because I read in the newspaper that the U.S. congress had passed a bill that required corporations to set aside sufficient funds to cover the prevailing medical benefits for employees that retired prior to 1988. I recently received a letter from Daimler-Chrysler informing me that as of Jan. 1,2007 they will no longer provide any medical benefits to their retirees. They will put SOME amount, up to $1750 a year, for me and a similiar amount for my wife, in an account for us to use to pay for Medicare or whatever medical insurance we wish to purchase. The amount is based on your years of service, etc. I have not yet been told how much to expect but I expect it to be less than half of the $1750 for each of us. Do you know about this bill that was passed in 1987,or can you tell me where or how to find it? If I can get the bill number and verify its existence we may not lose our medical benefits at this late stage of our lives. Please reply if you can or cannot help us. In the event that you cannot, maybe you can suggest avenues or approachs to pursue. Thank you for any help you can provide.	FL	6/12/2006 1:38:58 PM
As a former farm family we have endured a great deal of financial hardships due to health insurance. When our daughter was born disabled in 1979 our insurance at that time froze our benefits. By the time she was 16 we were paying up to $1500.00 a month in premiums, at times our milk check for two weeks did not cover this expense and we had to pay some from the the next two weeks. We were a family farm, and had three other children,insurance companies are in it for the profit. I now work and pay $85.00 a week for a premium and have been told this is going to increase, I make $8.50 an hour, very soon I will be working just to pay insurance. This insurance is for only myself as my husband is on Medicare and my daughter is MA and Medicare. We know of farm families who are paying $2500.00 a month because one or the other of them have developed cancer. What a wonderful thing our government is maybe we should all have their insurance. ***	WI	2/10/2006 6:06:34 PM

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Response	State	Date/time received
I just retired as a Nurse Practitioner after 25 years in the medical field plus an additional 7 years prior to that as an RN. I have seen such a huge waste of money . For example: entitlement programs that are 'limited to those with low income' BUT the administration of the clinics 'look' the other way and even insist that the staff accept patients when these people are enrolled because of pressures to keep the number of enrollees up in order to have future funding for the clinic. In other words, the incentive is NOT to serve the poor...the incentive is to keep the jobs of the director and staff of the entitlement program by ever increasing enrollment of the clinic, whether or not the enrollee qualifies. 2nd example: the number of illegal immigrants enrolled in these entitlement programs is staggering. Which of course causes a tremendous burden on the taxpayers. I could give you examples all day long...and all of them are discouraging.	IA	2/20/2006 1:20:33 PM
I do not have health insurance.The lowest health insurance I have found, since I am unemployed, is $350 a month premium with a very high co-pay. My husband is disabled and we live on a small disability income. Thank God that my Doctor let me enroll in a low income program that his office offers, and I can get my medication half price. I still cannot afford my medication some months.	NC	4/10/2006 1:45:11 PM
I have been unable to work since my knee surgery which was on Oct.18, 2006. I was injured on the job at Starbucks on April 14, 2005. I know that my injuries would have been totally healed within 6 months but Workmansâ€™ Compensation Insurance hired by Starbucks kept delaying my healing process by denying treatments. I had never been on workmansâ€™ compensation before and needed guidance. The laws have changed in the past ten years so the employer is totally protected and the employee has to do their best to figure out every little detail of what to do in what order and when. The insurance has the job to make sure the injured does not spend to much money, they donâ€™t care whether the injured person suffers for a day or forever. My knee has either healed wrong somehow or is as healed as it will ever get. My doctor did his part very well but he told me before the surgery that he would not guarantee it would ever be at 100% since I had been denied treatment by the adjuster from Starbuckâ€™s hired Insurance company for several months after the injury occurred for petty reasons. The injured has to do the job of the adjuster now as far as paper work or anything time consuming. I cannot climb stairs, squat, walk, run, crawl, twist, or some therapy moves without some degree of pain. Each of these movements causes different degrees of pain. Physical therapy has helped. I cannot climb stairs like a normal person. Going up I put my left foot on the stair and then my right foot on the same stair. Going down I put my right foot down on the stair and then my left foot on the same stair. I repeat this for each stair. I cannot lift little children or play with them in the floor. I cannot do a lot of things I could do before I was injured at work. I want my back and right knee back the way they were before the work injury. I want to work again and be able to give 100% like I always have when I worked for any company. But I cannot do that because the laws do not protect me, or anyone who is seriously hurt at work I have never been on Workers Compensation in my life and never thought I would be. I think many people who go through the same experience would like to know why they are treated so badly for something that was the fault of someone else. People just want to get back to the way they were if possible and get on with their lives and go back to work. My back was injured at the same time my right knee was injured. I cannot do any	TX	6/3/2006 5:50:02 PM

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	Response	**State**	**Date/time received**
	type of activity for very long, not even sitting down. After about 45 minutes of sitting which would include driving time there is severe pain. There is pain in the lower back all the time unless I am lying down. There is pain in the mid-back area after standing, walking, sitting, bending, or reaching as mopping, putting dishes up, vacuuming, grocery shopping, any shopping, carrying anything heavy such as a gallon of milk, and in fact, I have had to take breaks while typing this information. Everything I do has to be done in segments of time. I have to stop when pain gets so severe that I can barely walk and then lay down awhile and when it is not to painful to get back up, I go back to what I was doing. I worked at Starbucks and did all duties without pain and even helped my partners who could not do some tasks such as crawling in the walk in refrigerator and scrubbing the floor, reaching under the shelves as well as every inch of the walls and shelves in the walk in refrigerator. I love to deep clean and for awhile I was almost the only one who scrubbed the floor drains. I climbed their ladder (that is taller than I am) to change light bulbs. I helped stock the New Starbucks when it first opened in 2001. I did a lot of heavy lifting. For example the gallons of milk and the coffee urns as well as putting heavy 45 gallon bags of trash into the dumpster. I swept and then mopped with a large commercial mop from the front of the store to the back of the store. My back did not keep me from doing any tasks whether at work, at home or anywhere. Neither of my knees ever kept me from doing anything until April 14, 2005, when I was injured at work.		
	When I was told I had liver cancer I was self-employed, no insurance. I applied for early social security. I then applied for medicaid, which I got. I was told that I also had to apply for ocia security disability. I didn't think I'd get it because of the horror stories I've heard abut how long it takes. Imagine my surprise when it came through in just a few weeks. Imagine my surprise when I lost medicare because the additional $120 a month I now received made me ineligible. If it had not been for CICP from the state of Colorado I'd have died. I'm not willing to reveal my identity, but the stories real!	CO	8/30/2006 12:34:40 AM
	we are in our late 50's and self employed. We have 3 children in college and we could not afford health insurance for many years, We recently got a very high deductable which means no more vacations or resturant meals or retail shopping (thank goodness for Goodwill)We do not go to the doctor, I have learned to stitch my husband up when he cuts himself and I resurch medical advise at the library or on the internet. This great nation is in disgrace for letting the rich prey on the poor.	WA	8/31/2006 2:10:56 PM

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I am a Board-certified Pediatrician and former NHSC "provider" who was fired (from my hometown hospital) for saving a newborn baby's life. I sued the practice. I was unsuccessfully counter-sued for "libel" because I reported what happened to USDHHS. I got no protection as a "whistleblower". After three hellish years, all litigation was eventually settled in my favor, yet I still "lost", because I later found out that hospital administrators lied under Oath about the confidentiality of their "non-profit" books and salaries in order to avoid scrutiny and defraud me at settlement. My life and reputation was destroyed. I have not been able to return home to practice. In eight years, I have been unable to get any substantive help from the state & federal regulatory agencies that are supposed to offer "oversight". JCAHO is useless. Local and state law enforcement have refused to investigate or prosecute my case against hospital administrators for perjury. As an aside, I've had two ENT procedures botched at that hospital (one as a child, one as an adult) - the first required palatal reconstruction. The second will require revision - as there is a hole in my skull in the wrong place. I was unable to have this surgery last year as my insurance company (BCBSNC) was "at war" with the center where I was planning to have the procedure done. So I've had to wait. I did not sue in either instance.	NC	2/17/2006 9:29:23 PM
We moved from Oregon (where we were satisfied with our insurance coverage but ached at paying high premiums)to California where we were almost not able to get coverage at all. My 5 yr. old son struggles with seasonal allergies which can cause very mild asthma (incredibly common for *** where we live) and so does my husband. I have a history of migraine headaches which I experience maybe a few times/year, which respond to OTC meds. Because of these "pre-existing" conditions, one or all of us was either denied coverage or offered coverage at a 25-50% rate increase. By law, the insurance co. has to offer coverage but there's no law to protect the consumer from premiums, deductibles and copays that are sky high. Last year we paid $10,000.00 out of our own pocket for our premiums, doctor visits and meds only to look forward to increased costs this year.	CA	4/23/2006 11:49:57 PM
I am a social worker in ***, Indiana, and have been very discouraged about health insirance for my adult childre, one with a chronic illness, the other an entrepreneur. With the best and most affordable health insurance available only through large employers, many cannot afford health insurance. It surprises me that either political party can speak of growth when the middle class is at risk, and may not be able to afford healthcare for themselves and family. Anyone with a pre-existing condition, that is often quite treatable when healthcare is accessible, cannot get coverage outside of a large network. Though Medicare D has been badly handled, I am still in favor of single payor, and watch with great interest as states consider mandatory coverag. This muct be followed by mandating that companies have policies that are affordable, and cover pre-existing conditions.	IN	6/16/2006 3:34:31 PM
I signed up for medicare D for prescription drugs. Now my prescription costs 4 times as much as it did before!! I had "Together Rx" before and it cost me $12.00 a month. Now I must pay $26.65 a month insursnce premium plus $20.00 copay for the same prescription.	PA	4/8/2006 3:23:26 PM

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Response	State	Date/time received
I started receiving social security disability payments in August of 2002, but did not start receiving Medicare until August of 2004. For those two years I was not able to go to the hospital on three separate occasions, was unable to buy badly needed prescriptions and was unable to have badly needed tests done. I shall be forever grateful to have found an internist willing to treat me who accepted $10 a epayments, gave me as many free samples as he had available, hooked me up with drug companies offering patient assistant programs, etc. Eventhough the Medicare Part D prpgram was a NIGHTMARE for three months, I am extremely thankful to CMS,region 9 for their fanstatic help in finally getten my policy straightened out with Blue Cross for me...it was the most stressful period I've EVER encountered with American medicine. Medicarae Part D has been a literal life saver for me. I am VERY concerned for everyone who ise 100% disabled, but are not able to receive Medicare benefits until after two years on social security disabiity. I have no idea WHY it is necessary for us to wait two years in order to get Medicare coverage since it is impossible, once one is disabld, to be able to afford private health insurance if one can even find a company willing to insure us.	CA	3/23/2006 7:22:52 PM
As a citizen, what works best for me is to obtain an appointment with my provider in a reasonable time frame with a low cost deductible and copay. As a provider, what works for the community of adolescents that I see is to have access to services such as school-based health care, to provide a safety net of services for children, where they can be reached. This takes the load off of the emergency room and there is a significant lower number of providers for this population. School-based health makes sense for education and health, and keeps kids healthier to achieve more and make future healthier adults.	FL	8/14/2006 4:40:03 PM
I would like to share my experiences as a health care professional and patient anonymously, so give no details here, inasmuch as my name, zip code and e-mail address are required below. Please make it possible to submit recommendations and ideas anonymously.	IN	2/27/2006 7:52:25 PM
Fix your damn survey! None of my answers would checkoff! We need a singlepayer healthcare system in the U.S.! We should have had it 60 years ago when Europe & Japan got theirs or 40 years ago when Canada got theirs. Consequently we pay twice as much per capita as Europe & half again as much as Canada & have over 40 million uninsured! We're the most expensive & least effective! People in Europe & Japan live longer than in the U.S.!	WA	2/20/2006 11:54:33 PM

Question	We all have different experiences getting health insurance or in seeking health care. Sometimes these are good experiences, while other times they are not. We may meet very special providers or encounter new and innovative practices. Other times the American health care system disappoints us. Please tell us what has worked well or hasn't worked well for you or your family.

Response	State	Date/time received
August 31, 2006	NY	8/31/2006 1:46:10 PM

Randall L. Johnson, ChairCitizensâ€™ Health Care Working Group701 Wisconsin Avenue Suite 575Bethesda, MD 20814

Dear Mr. Johnson:

Bronx Community Health Network, Inc (BCHN) commends the Citizensâ€™ Health Care Working Group (CHCWG) on its efforts to include citizen input on improving access to quality health care for all Americans. BCHN is a federally qualified heath center that provides for comprehensive, quality health services for 57,000 Bronx residents in five community health centers and two school health centers. Its 16-member Board of Directors, 53 percent of whom are patients of the health centers, provide a voice for health center patients, advocating for services that meet the needs of health center clients and their communities. Over 80% of BCHNâ€™s patients are Hispanic/Latino and Black/African American and a similar percentage have incomes below 200% of the Federal Poverty Level. Fifteen percent of our patients have no health insurance. The Working Groupâ€™s Interim Recommendations are generally on target and we support the CHCWGâ€™s efforts to ensure that these messages are heard by Congress. We strongly support the recommendation that coverage must be ensured for all. However, I am writing you today to express our deep concern regarding one aspect of the second proposal in the Interim Recommendations. Specifically, the recommendation to â€œexpand and modify the FQHC concept to accommodateâ€ other providers could remove or reduce the federally qualified health center community board requirement. This recommendation departs significantly from the goal of health centers of ensuring a community voice in the provision of services, and undermines existing patient democracies.Our State Primary Care Association and New York health center providers, participated in the Working Group meeting held in New York City on April 22nd and BCHN offered testimony in the Bronx on March 26th. From what I understand, modification of FQHC statutes was not a part of the discussion or recommendations made at either meeting. I am concerned about their inclusion when they were not addressed in the community meetings.The Citizenâ€™s Working Group is an important avenue for American voices. As an advocate for community-based, high quality and affordable health care, I ask you to remove this recommendation and shift your support to build upon the successes of community-governed health centers by protecting their community boards.

Sincerely,
Eleanor Larrier
Executive Director
c: Board of Directors

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Response	State	Date/time received
When I resigned from my job as a family physician in 2000 I sought out private health insurance. I thought I was pretty healthy. I excercised nearly daily, had a total cholesterol of 164, and had no chronic health problems. As a physician, I also knew how to care of myself and did a pretty good job. When I applied for insurance, I was astonished. The insurance company wanted all my medical records for several years. In them, it discovered that three or four years prior to my application, I had developed a small esophageal erosion which was diagnosed by endoscopy. I had been treated for it and had recovered fully. I believe it had been caused by work-related stress. Not only was I no longer symptomatic, I had also dealt constructively with the problem by resigning and finding a different work environment. Well the insurance company felt differently. As a result of that incident, it offered me insurnce that excluded any coverage of almost any upper gastrointestinal problem. On top of that, the premium I had been offered doubled!! I don't understand why the premium doubled when they were already excluding coverage of the one lone problem I had had. Several months later, I received through the mail an application to buy insurance offered by the state of Colorado to patients who were high risk and could not buy insurance! So, there I was at 48 years old, with excellent physical health and good health habits such a excercise and diet, with good cholesterol and no chronic medical conditions, and also a physician myself, being considered "high risk!" What do people do who really do have health problems? As a physician, I have been blamed by patients for diagnosing a chronic condition like hypertension or hypercholesterolemia that then prevents the patient from buying insurance--as if their illness is my fault! Obviously it is not my fault, and often not the patient's fault either. Insurance should be just that--insurnce where the risk pool is spread out, thus decreasing the cost/risk for each individual. The way insurance works now, the risk pools are divided and then divided again. The "high risk" patients are excluded so that the government has to pick them up because no private insurer will take them. This is NOT how insurance is supposed to work! Since the governemt has the pick up the more expensive patients anyway, let it pick up everyone and get rid of the profit mongers in the insurance industry. Ultimately, that would be far cheaper for everyone while giving everyone the medical security each of us deserves.	CO	8/1/2006 5:53:54 PM
Managing my aged mother's health care, most recently dis-enrolling in Part D since she has Tri-Care Rx coverage, has been a complex nightmare. My own Blues supplement to Medicare continues to go up, nearly $600/month at this point, for no change in coverage. Without question the complexity and administrative snarl of the current system contributes to short tempers and higher costs...something most of us worry about in a government-based new system. Getting true experts with field experience to design a totally new system would be an encouraging start!	MI	6/8/2006 8:08:23 AM

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When my father had a stroke he was denied health coverage because his insurance company wanted him out of the hospital as soon as possible. The had meetings about how to get him out as quickly as possible after only a few days. I was absolutely disgusted by how they so obviously only care about their bottom line. All insurance companies have someone who's job it is to limit the ammount of coverage someone get to limit the cost to make sure their share holders don't pick up the tab; they are thinking of their share holders and not the patient who the proport to work for. We begged them to keep him in the hospital longer and the doctors were on our side and even privately said they would "pull for us" but that ultimately the insurance company was in charge, people with MBAs and not MDs. In the end, my father suffered a fatal stroke that would have been preventable if he had been allowed to stay in the hospital. It is my belief that their refusal to keep him in the hospital to lessen their costs is the largest factor why he is not here today. I loath these people and any system that supports them. While he had to leave the hospital, I noticed his roomate (a homeless person with no means) was able to stay for 5 months because the government paid. I actually feel unsafe in this country because I know that I am not safe being that I am only middle class...here one needs to be either extremely wealthy or poor to get good coverage in the United States. I feel that of all the numerous taxes we have to pay, universal health care coverage is the only thing I really want. I look at my pay check and it kills me to see how much the government takes but it wouldn't bother me if I knew that at least they were truly taking care of normal people. Forget terrorism, I'm afraid of having a health problem, its much more likely and much more likely to ruin me (either physically or financially). Although I love this country dearly, I hate our health care system. Mamsi was the company in question. I hope someone takes the time to read this...	MD	6/7/2006 9:51:59 PM
I recently became a father of a daughter who was born with Vacterl Sysndrome. My daughter was treated at Miami Childrens Hospital under my PPO insurance. She recd the best medical care one can receive and thankfully she is doing well. It would appear once again that our entitlement society wants the minority to pay for the majority. This would certainly in the long term promote seperation of classes and create more problems. I am very familiar with Universal health care Canada, Germany, both of which the goverment deceides what is considered a medical emergency and many people die in these countries waiting for surgeries which are deemed by the process to be non life threatening. I did not read in your article about free health care that all taxpayers already pay for called the General hospitals in all metro cities. What is scary is who is going to determine what basic needs are? Who is going to determine who pays more or less? I do not agree with the Universal Health care system premise of 100% participation. No one has the right to tell me how and when my daughter receives her tx, especially a goverment program. If it were not for my current medical insurance and the choices I am allowed to make my daughter may not be with us today. I do agree we have serious health insurance issues, ie fraud which is not addressed in your article. HMO's have been proven to be abused by their members causing them to go bankrupt and raise their costs. One should first address the medicaid fraud, medicare fraud as well as fraudulent billing by doctors. This is just one more goverment sponsored headache that apparently the people who earn a certain amount of money will have to pay for those who do not. I am not referring to people who have legitamate disabilities who are limited in their earning capacities or who have suffered a catastrophic event. Your idea will only promote more fraud, and freeloaders who will take advantage of a flawed system and take away benfits for those you really need a universal health care service, all the while driving up cost for the rest of us to pay.	FL	6/13/2006 12:13:30 PM

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We have been members of a particular HMO for 38 years. Due to a job change, this provider was no longer available to us. I applied to continue coverage as individuals since my family is comfortable with the provider. They denied one of my children: a healthy, athletic, active kid, who only sees a doctor for sports physicals, because five years ago her pediatrician found border-line levels of calcium in her urine. To add insult to injury, the provider assumed I would want to pay the exorbitant fees for the rest of us, and simply not insure one of my kids. My family is athletic and very healthy, just the kind of people I would think the insurers would want. We pay our monthly fees, yet we hardly use the system, and then it is for well-care check ups. If they won't enroll a four-sport student athlete who eats right and exercises daily, who will they insure?	CA	6/8/2006 10:35:55 AM
Since I had polio when I was 13 I have a severe disability so I was unable to work. We paid a high amount for private insurance. And had high medical bills besides. So there was no money left for a penison plan. My husband worked two jobs until he was 45. We had insurance through his work starting in 1983. Last year we paid over $7,000 in premiums and had a co-pay for medications of $60.00. The company he works for has dropped all insurance coverage on all their workers as of 2006 because they can not pay the high premiums. My husband is still working at age 72 because the high cost of my medications. Even though we have Medicare and a med-a-gap the Medicare Part-D is costing us almost more then it is worth. I run a support gr. and hear terrible stories about people going without health care and suffering because of not being able to get treatment.	MI	4/19/2006 8:44:07 PM
We are 60 and both lost our employment after 20 plus years. We were on COBRA. When that ran out we applied to Blue Cross Blue Shield but were refused coverage because we were both being treated for high blood pressure. We now have a policy for the only thing we can afford, from Golden Rule. It consists of a $5000 deductible (per person) and covers virtually NOTHING until the deductible is met. We pray we have no medical problems that will wipe out the little savings we have left.	WI	2/11/2006 7:54:05 AM
On February 14, 1960, while in the U.S.Air Force stationed in Great Britian during peace time, I sustained a bad motorcycle accident. The diagnosis was a dislocated Rt.Hip and compound fractures of the Rt.leg nothing really serious. The medical facility on base never relocated the hip or set the fractures. Instead they sent me to the A.F. General Hospital, R.A.F. Burderop Park by ampulance (no medical personnel involved) after laying on a stretcher in the medical facility for a long while. At Burderop Park they relocated the hip back into the joint and set the fractures then put me into a body cast. The trouble was when they relocated the hip, they put the leg on backward. Once the body cast came off, my Lft. foot faced forward normally and my Rt foot faced backward. (These were three high ranking Orthopedic Surgeons with many years of practice). Then they sent me to a Naval Hospital stateside for further treatment where they found the head of my Rt. leg had died while originally waiting for medical help (remember this was peace time, nothing going on). Without many choices facing me, (I volunteered as a military member) to undergo an artificial hip implant that had never been done before except on baboons. The hip never really worked giving me hellish pain for the past forty six years. But everyday I have the	SC	2/16/2006 10:55:04 PM

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	Response	**State**	**Date/time received**
	satisfaction of knowing it paved the way for future patients to walk again pain free, my mother for one. They learned most of the mistakes made, from studying me.		
	In general, I have had good experiences in getting health insurance (Medicare + supplement) and in care. I had prostate cancer, had a radical prostatectomy, and resulting loss of erectile function. None of the low cost treatments worked. I was offered a prosthetic device which struck me as unreasonably expensive. I would not feel right about asking the gov't to pay for what is a desirable but not essential treatment.	WA	4/8/2006 9:39:21 PM
	Having worked for 30+ years,paying into the health system that whole time, I was permanently disabled 10 years ago. The medicare system was fair to me until more medication became necessary. Because of the lack of prescription coverage,and the increasing costs of that medication,I am 20,000 dollars in debt.I thought that the new medicare D program would help me. Because of the complexity and irrationational exclusions,this program for me is virtually worthless. I am holding on by a very thin line right now, but being trapped in the thin line between between medicaid benefits which I cannot receive because of a few dollars on the income chart, I am being unfairly punushed, and on the road to bankruptcy. The current system is simply unfair to those people who have worked hard and tried to do the right things.	MI	4/12/2006 11:20:58 AM
	Private health care was good to us until the costs became prohibitive. Worrying about having Health care as everyone knows, keeps our citizens in a constate of worry. We are the ONLY westernized and techological society that DOES NOT take care of our peoples health care. This is immoral and show we do not value human life. Frivolous lawsuits have been rewarded to the point medical care givers walk around in paranoia and cannot treat alot of clients, as malpractice insurance is out of control. Greedy lawyers, CEOs and polticians are another major cause of this horrendous and shameful problem. AMERCIA.. you need to look at yourselves in the mirror. MANAY of you have CAUSED a national health care crises, due to your own greed and selfishness. You have taken life from countless folks who are left with nothing. What a sad commentary on our nation!	IA	5/12/2006 8:49:45 PM

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Response	State	Date/time received
I am lucky.I have Medicare and good supplemental policy and few drug needs. REecently I was in a car accident. At ths hospital a walking boot was put on my leg. No weight bearing but it was well wrapped and snug.After surgery I got a cast.I asked what woud happen to the boot."Throw away or I could take it". It cost 331.00 paid for by public dollars and my monthly fee of course. I took it. Now the cast is off and the boot I brought with me is on. Had I thrown it away another would have had to be bought. Why is this allowed to happen.I know..It is full of dead skin cells so there is a cleanliness problem. But why aren't people told to keep these things especially if they have more work to be done;they may need it again soon. I happen to have had experience with another boot that I took to the Goodwill for them to clean and reuse.Our health system is full of waste like this. Why doesn't someone come to the hospital and pick up all the used appliances,clean them up and make them available to those in need. Take them to clinics for the poor,sanitized and ready for reuse. This is huge.	MN	8/24/2006 10:18:03 AM
I have over 30 years experience in the medical billing industry. The system has grown to the point where what was once done by one employee in a medical practice now takes three. Where one employee would send one claim to the insurance company to get paid, now there is another to verify, pre-certify/authorize the service and a third to resubmit for reimbursement. Even with the best systems the insurance companies reject claims repeatedly. The only exception has been Medicare.Now my story...I always had health insurance through my employers. Thankfully, I have worked for large practices and had my choice of PPO over HMO, also I was always able to keep my coverage between jobs thru COBRA. I am now taking care of my 85 year old mother in my home and, therefore, unable to work full-time. I hold 2 part-time jobs that allow me the flexibility I need to look after her, but no insurance coverage. I am on COBRA, but know that I will have a huge problem when the COBRA ends. There is some money to pay for my insurance if it were affordable. But my research is that no insurance company will write me an individual policy, because I have been diagnosed with Rheumatoid Arthritis. It is a mild form and in remission for now. But that doesn't seem to matter. What about all the years of premiums paid to the insurance companies on my behalf with no claims? Where is the insurance now that I need it? I am 56 and have a lot of years before Medicare coverage. My mother's physical health is excellent for her age and she most likely will live for many years to come, but mentally she is unable to care for her self. If I let my insurance lapse, I will get hit with a pre-existing condition on the RA when I get coverage again. So my only choice is to find a full time job for the insurance benefits only! I will have to also hire a stranger to look after my Mom while I'm at work. It will be very difficult for her. It just doesn't make sense. I can afford insurance, but can't get it. I will not put my Mom in a home. She was in one and stayed in bed all day for lack of attention. So, in our case, even when we can afford something for insurance the "system" won't work for us. Also, as a side note...because her supplemental insurance premiums became so high (AARP) due to her age, we switched her to Humana Gold, a Medicare HMO. Excellent coverage, but sub-standard quality of care. It has taken us over a year to find a good physician (#3) under that plan. The first two shouldn't even be in business, in my opinion (please remeber, I have 30 years experience working for physican's). I pity the elderly that do not have a knowledgable person to look out for them.	FL	6/21/2006 9:19:05 PM

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	My wife and I live in *** NH. My wife has a rare long term illness called Moya-Moya. As a result she has had several strokes and othe vascular problems over the last 30 years. Last year she had a stent in one of her cardiac arteries fail. I got her to the local hospital (which is very small, 40 beds) and her local doctor decided that she needed to be transported to another hospital in Maine. I requested that she be sent to a hospital in Boston that has been treating her for the Moya-Moya for over 20 years. The doctor told me he couldn't do it because Medicare would not pay for it. I know the Medicar rule pretty well and continued to insist that she be sent to Boston. Finally the doctor agreed. However, the helicopter service would only transport to Maine and not to Boston so she ahd to go by ambulance (It's a 2 1/2 hour drive). When the ambulance showed up at the hospital they required a guarantee of $3,000.00 with a credit card (Just in case the Medicare wouldn't pay). If I had been unable to do that I would have had to request an ambulance from Boston. She was finally transported to the Boston hospital and arrived @ 2:30PM (Thursday). By 4:30PM the Boston doctors had removed the old stent, installed a new one , and cleared another artery. She was discharged by noon the following day and was back home by 4:30 that afternoon. I believe that the Boston hospital was very efficient and effective in providing appropriate care. The bill for the Boston Hospital was $25,000.00 Of which I had to pay 20%. If the illness doesn't kill you the bill will...	NH	3/24/2006 7:27:40 AM
	Elder Care: Only certain Skilled Care facilities; i.e., those that meet a certain set of criteria; e.g., medical professional staffing, etc., qualify as Medicaid approved facilities. Cheaper Elder Care facilities are available in many communities, some of which offered better quality care than the Medicaid approved facilities; however, in our case Medicaid drives us to the community's highest cost provider. The Medicaid program could learn something from providers of Long-Term Care Insurance contracts/policies, with most of these being fairly similar in design; however, I am most familiar with the Genworth Financial product. These programs use Benefits Coordinators in communities where people live to work with medical professionals and care providers to determine need for assistance with ADLs, and how those needs can be met. These contracts permit use of qualified care givers to make home visits necessary to meet ADL requirements and, if trained and qualified, family members can provide the care and receive payment from the insurer. In most instances, family members/children of the elderly are near or approaching retirement age themselves. However, many will be working (two income families), and if loss of second income is a price associated with caring for elderly parents, families will most often opt for Medicaid care (for Medicaid qualified patients)at a skilled nursing facility. If Medicaid were to use Benefits Coordinators, similar to insurance companies, and permit provision of care at home, by family members, etc., I wonder how this would impact Medicaid program expenditures, especially in view of escaluating cost of care at Skilled Nursing Facilities. Respectfully yours,	FL	2/2/2006 10:51:53 PM

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Based upon experience with the Executive and Legislative Branches of government, an expectation that a path for Health Care legislation will go directly from a citizenâ€™s working group to â€œcongressional actionâ€ is probably unrealistic. The CWG has gathered voluminous amounts of data on health care issues, using both qualitative and quantitative measures of success/failure of the current system plus projected future scenarios; however, this research effort will probably not serve as a platform for enactment of problem solving legislation. I believe that the second half of the GAO CWG charter should involve bringing in representatives of those elements of the total â€œhealth care systemâ€ that will have to be part of the solution(s) process, including WG subcommittees that represent portions of the â€œsystemâ€ that, inherently, will have play a role in finding solutions/answers, if in fact this is possible, for the glaring problems already manifest, with exacerbation under future demographic, health care cost, etc., scenarios. The subcommittees may come from communities such as: (1) Medical professionals [doctors and nursing professions]; e.g., AMA; (2) Medical facilities, both for profit and non-profit/publicly owned; (3) Health insurance companies; (4) Independent/assisted living and skilled care facilities; (5) Architects of models that demonstrate a degree of success, such as the current VHA system; (6) Medicare and Medicaid system administrators; (7) The pharmaceutical and biotechnology industry; (8) The medical technology community, including companies such as GE, JNJ, BSE, etc., with advanced testing machines, joint replacement therapy, coronary stent technology, etc.; (9) The CBO, to provide future discretionary/non-discretionary budget projections; and, (10) The Department of Health & Human Services. The CWG can facilitate this process by providing a venue or forum that is not partisan, and that has a common goal of resolving problems or finding solutions or answers that are realistic and objective (at least from a partisanship perspective â€“ as profit/earnings motives will drive input from a number of these subcommittees). Also, if the CWG is judged to be â€œpartisanâ€ or reflects preconceived personal or working group bias(es) by some of these communities and subcommittee representatives, they will resist the process. So, the CWG absolutely must be a non-partisan forum if there will be any hope for facilitation of a free exchange of information and an honest attempt to address possible solutions or answers to problem issues. If the CWG can serve as â€œhonest brokers,â€ much more progress will be realized/achieved than having issues/answers being first addressed in bipartisan congressional forums/committees. Question: does the CWG want to be recognized as a group that actually produces actionable solutions, alternatives or options that are likely to receive bipartisan support, or a venue for championing personal agendas, which will be non-starters in a legislative forum? Also, as possible courses of action are mapped out, principal pros and cons of each ought to be listed. A broader spectrum of options, with incorporation of up/downside of each, will result in Legislative and Executive Branches of	FL	2/3/2006 2:39:37 PM

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government being more likely to implement recommendations, with distinct possible that the entire package could include elements from a number of options, while also eliminating actions that would have been in any single approach to the problem.		
Pseudo Cost(s) of Health Care Services in America: We currently have a pseudo system of charges and compensation for health care services in the United States. Health care facilities (hospitals, ORs, anesthesiology, etc) pretend to charge a realistic fee for services, and health insurance companies pretend to pay realistic compensation for services rendered. Disconnects from what ever "reality" might be are becoming progressively broader and broader. It appears that health care professionals/hospitals, etc., are submitting fees that are purely artificial based upon knowledge that health insurance companies will only pay a fraction of the amount they are charging. This pseudo system will make it progessively more difficult to for efforts, like yours, to actually know what realistic health care expenses should be. The experience that we had in conjunction with prostate surgery for a standard BPH condition is provided as an illustration of this scenario. The total bills submitted to our health insurance plan for pretests, one hour of surgery and one night in the hospital was $23,057.54 and the allowed charges by the insurance plan was $4,288.91, or 18.6% of the amount billed. Even more extreme, the prep for surgery, one hour in the OR, one night and portion of a day in the hospital (a public/non-profit hospital) resulted in a bill for $19,322.20 and allowable charges by the insurance plan was $2,670.00, or 13.8%. Question: what number would have reflected a "realistic" charge for this service? Would a non-insured individual receive a bill for $19,233.20? Or, are these pseudo charges part of the current compensation game being played between providers and insurers? How can "honest brokers" or designers of health care legislation and programs get a handle on "realistic" charges when such games are being played?	FL	2/6/2006 11:16:21 AM

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	Response	**State**	**Date/time received**
	I had great health care coverage attached to my great paying former job until two years ago. Then I fell, was badly injured, was temporarily disabled and could no longer work my great paying job with great health care coverage. I lost my health insurance. I got a much lower paying job as I could no longer work the previous job because of the physical demands which my body was no longer able to keep up with. I paid COBRA until it ran out, then could no longer to pay for individual insurance and lost my health insurance. I no longer have any health insurance and have a low income, but just high enough to not qualify for any aid with health care. I support universal health care (not health insurance) but health care through our state and federal government with a single payer format, such as Canada. Folks say that, "Oh, in Canada, coverage isn't perfect, etc. Well, at least there is coverage in Canada, even if you wait 12 weeks, you eventually receive medical care, if you're not dead. In the United states, 12 weeks from now, I still cannot receive health care whether I am dead or alive because of my financial restrictions, which are not uncommon to millions of other Americans. We need to heal our health care format in this country and boot big business out of the provider picture. I believe it is a human right to receive great health care and great preventative health care. We do not need insurance companies profiting from human frailty. In Ohio I support SPAN (Single Payer Action Network) since I have gone from complacency (when I had health insurance) to a lot of knowledge of how big business profits from human illness and prevents Americans from receiving the medical care they are absolutely entitled to receive as a human right. We also need to look at the financial picture nationally. If we have a sick work force that cannot receive health care, where is the incentive to set a business up in the United States. What happens if as a business you have a valuable worker that cannot get well because they have no access to health care. Guess who loses then, the business. We need to really think about what we are doing in this country. We are the ONLY developed nation in the entire world to not have Universal Health Care for our citizens. And we like to say we are the greatest nation in the world . . . . hmmm . . . . Thank you!	OH	2/16/2006 11:56:45 AM
	I'd like to relate a true story concerning my difficulty in getting insured. The company I worked for here in Ohio went out of business a few years ago, suddenly leaving 65 employees without work. When 'COBRA' insurance ran out several months later, I had to find health insurance on the private market. Most companies I applied to did not want to insure me at all, or wanted to charge me THOUSANDS per month, just because I had common hypertension, and was on a few meds!!! Now mind you, I was (at the time) otherwise a healthy 40 year old, whose ONLY health issue was I had high blood pressure. MILLIONS of Americans HAVE high blood pressure (hypertension), and they have health insurance, I thought. Why can't I? Finally, feeling dejected and dissapointed, I had to use the services of a 3rd party rep, and he finally found me health insurance approximately ONE YEAR LATER!!! I was uninsured for a year, despite my trying to desperately procure health insurance. Thankfully, I did not get sick during that year. I can't begin to think what a financial catastrophe it would have been for me and my family if I had an illness or condition that would have cost tens or hundreds of thousands during that time I was uninsured and looking! Something is seriously wrong when we can call ourselves the most advanced nation in the world, yet so many of our citizens can't afford, or can't find health insurance! This is utterly disgraceful and unacceptable.	OH	6/7/2006 10:28:59 PM

Question	We all have different experiences getting health insurance or in seeking health care. Sometimes these are good experiences, while other times they are not. We may meet very special providers or encounter new and innovative practices. Other times the American health care system disappoints us. Please tell us what has worked well or hasn't worked well for you or your family.

Response	State	Date/time received
As a child my father had good medical coverage. Went into Air Force had good medical care. Then worked steel mill good medical coverage. Now retired on medicare good coverage. I'm sure glad i'm not one of the poorest 45 million americans with no medical coverage.	OH	3/19/2006 3:27:33 PM
My daughter was on our helthcare plan (military tri-care) and going to college which made her eligible. Due to mental illness (bi-polar)she tried to kill herself and ended up in an institution. Not being able to go to school anymore, she was taken off of our healthcare plan and no longer receives treatment. I worry everyday whether she will have another breakdown and not live to see tomorrow.	CA	2/15/2006 7:32:37 PM
My health care coverage thru my employer is soon to be changed effective April 1, 2006. At that time, it will no longer be reasonable for me to d rive 50 miles to work in a full time job. My employer will not transfer me as a full time employee, and if I go as a part time employee, I lost MY health care coverage as well as my husband's coverage. I will be 62 this December and my husband is already drawing his Social Security. If I quit my job, we will both be without health care coverage, but I cannot afford to continue driving 50 miles each way to work and back again. And, I cannot afford to go part time either.	OH	2/10/2006 6:50:40 PM
The american health system is an good one just not effective. TO many uninsured. It must be mandatory all are covered. If they choose no coverage there will be an increased tax or late penality to get in. The plans need to stay private. Federal goverment is not efficent. They can set the boundaries but let the private companies compete for the business. Plus there needs to be streamlining of the health care services such as monitoring and paperwork.	ID	6/13/2006 3:02:27 PM
I am a 44 year old mother of 4, grandmother to 3 who has been married for 23 years. My husband is 48 years old. He has been injured on the job more than once â€“ he is supposed to have lifetime medical, but has yet to receive it, even when we both had excellent health insurance coverage through my employer, I was told it was against the law to use our private insurance and the doctor would not even book him an appointment to see him. Anyway, treatment for my husband is something we have learned to live without because we have never had the money for an attorney. My husband has lost a lot of weight â€“ mostly muscle â€“ from his injuries, and suffers constant pain. My whole life changed about 5 years ago, when I began menopause. My father passed away, my marriage was suffering, and I lost my job. I have not been able to find another decent job since then. I have had odd jobs, but nothing like I used to. We even lost our home. We were paying for a double wide and were purchasing the property, but could not afford it anymore when my husbandâ€™s boss retired and he was without a job. I used to be the primary bread winner and brought in 70% of our household income for 15 years of marriage. We have not had insurance since 2001. We are basically a healthy family with the exception of I am hypothyroid, and my husband has compression fractures in his back and dental problems. Anyway, what it boils down to is this, of the 40+ million uninsured people in the world, we are two of them. I am unemployed, while my husband is employed. As we get older, I worry how I am going to raise my children all by myself if something were to happen to him. And what really blows my mind is after looking at the 2000 Census figures and seeing that just hospitals alone (not the entire health care industry) brings in a whopping 500 trillion dollars, nothing is going to be done about the rising costs of health care. Instead, everyone wants to make it a law that you have to have insurance or go to jail. Everyone, wants this because they believe it will bring down the high costs of health care. What if they are wrong?	FL	7/26/2006 1:28:12 PM

Question	We all have different experiences getting health insurance or in seeking health care. Sometimes these are good experiences, while other times they are not. We may meet very special providers or encounter new and innovative practices. Other times the American health care system disappoints us. Please tell us what has worked well or hasn't worked well for you or your family.		
	Response	**State**	**Date/time received**
	What I would propose, I know they created this committee and this site and have asked American people what they think, but I think what needs to be done is a survey like the Census. With it, you find out income levels, health problems, uninsured problems, etc. for everyone in the U.S. You could even find out about sole proprietors and small business as well with such a survey. Because these health care problems are so diverse and equally important for everyone, I feel that is the only way we can even begin to look at the problems and fix them. Each survey card that goes out to each household can be numbered and the number and address it is sent to would be entered into a database and for each one that does not come back, there would be a number associated with it to see which ones were not completed and the location. An individual could go to that location if necessary to do any leg work. My husband, on the other hand, thinks we should let the IRS do the investigation into health care issues, because they have all of that information anyway. I donâ€™t think this siteâ€™s investigation is enough. I think the government needs to do more. I donâ€™t think we have hit the tip of the iceberg on what needs to be done. As far as what my family is doing about our health care today - we are self pay. We pay cash at the doctors or we do without. My husband recently suffered from a bad case of pneumonia, and I worried that he would not recover because it was so bad. I know I have probably given too much information, but I can't help it. This has been a problem for us for over 5 years now. I hope something is done soon. I am one of those people who has fallen through the cracks of the system, though I have generally been able to hang on for a while. I had good health care coverage for years, when for the most part I didn't need it. Some would say I had a gold plated medical insurance plan, basically full coverage with very small co-pays. That all ended when after 17 years with the State of Michigan, I was right sized out of a job. Fortunately at the time, my then wife had coverage. But there still was a problem. I lost my coverage effective 02/1993, and even though I lost my job "through no fault of my own," her insurance carrier kept putting up roadblocks to adding me to the policy, though the policy said spouses who lost their coverage because of a job loss that was "through no fault of my own," they kept asking questions, asked for medical records, though there was nothing about prior conditions in the policy. I had been in a near fatal car accident the year before, and though I was "fully" recovered, they kept asking for records from the accident. Finally, after six months, they added me to the policy. Fortunately I was able to keep my coverage through my HMO until my then wife's policy finally kicked in. And then two years ago, my then wife announced she wanted a divorce. I was just recovering from a long term bout of pneumonia, and had gone to the doctor the day before the announcement and my internist and I had agreed that I should have a stress test. So with a space of two weeks, I found out that I was losing my health insurance due to the impending divorce, and that I had two silent heart attacks, and would require two stints or maybe by-pass surgery. Fortunately, I was allowed to stay on my estranged wife's plan, only through my and my attorney's insistence. But then this past October, the divorce was final, and she would have not part of me staying on her plan under a separate maintenance agreement. So off into the medical insurance wilderness I went, and only because I am a self employed real estate appraiser, I was able to qualify for a small group plan though the Small Business Association of Michigan and Blue Cross Blue Shield to the tune of nearly $500 a month. And they don't cover all of my nearly $1,000 a month in prescriptions due to my cardiac condition. Again, I was fortunate, my cardiologist is providing me with samples for two of my heart medications, and three of them are now in generic form, but I still spend over $200 a month in prescriptions and co-pays. How is anyone able to afford that? I am barely able to, and I make decent money in my business. But with the mortgage payment, car payment, insurance, license fees, other fees necessary for my business, I scrape it out from week to week. It is utterly amazing to me that the rest of the world recognizes health care as a	MI	2/10/2006 2:38:40 PM

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	Response	**State**	**Date/time received**
	right, and in the greatest county on the planet in economic and demographic terms, we see it as a privilege. My ex-wife tells me that I was "privileged" be covered by her. "Privileged?"		
	As an EMT AND a Midwife, I see health care from a couple of different aspects. As an EMT, it is often difficult to deal with being called to houses for "emergencies" that actually make you more of a taxi service. Often-times there is a whole house full of people there that could drive the person to a doctor for the emergency "cold", but because you cannot legally refuse care, you take the person to the emergency room. As a midwife, watching as the infant mortality statistics keep us at barely above those of third world nations despite using more technology, drugs, etc., I often want to scream and pull my hair out. I think the problems in our health care system go even deeper than everyone having access to good health care. I see people as having no faith in themselves to care for their most basic health care needs for themselves. Educating people to help them regain some of their self confidence would help tremendously. Realizing that every time you sneeze you don't need to run to a doctor (by ambulance) would be a great help. Health care..... doctors, nurse practitioners, midwives should all be at a local/community level. There are so many different varieties of health care, and each of us should have access to that type which fits our family.	AL	5/1/2006 12:53:56 PM
	My experience is actually from England. My family and I were there on vacation. I managed to cut the back of my head open on a radiator. We went to the local hospital. When we walked in we were not sure that we were in the correct place as there were no people in the waiting area. My mother went to the reception counter and let the woman know what had happened. The woman asked her to complete a one page piece of paper with infokmation such as vital statistics, any allergys, etc. My Mom said "Oh, but we are from America." The womna told her that didn't matter, to please have a seat and someone would be with us shortly. In approximately a total of forty-five minutes, I was ushered back, given a shot, had stitches sewn in and was ushered back out to the waiting area. The entire process took probably no longer than 1 hour. I have also been to our emergency rooms here a few times and haven't been able to speak to someone with any medical knowledge sooner than 1 hour.	CO	2/16/2006 5:19:11 PM
	My husband is covered by my health insurance and Medicare because of his disability. He was automatically enrolled in the new prescription plan under Medicare instead of staying 100% under my coverage (Kaiser). I'm not sure of the advantages or disadvantages of this new coverage, but we were satisfied with services prior to the new plan.	WA	6/21/2006 11:38:34 AM

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Response	State	Date/time received
I am looking for practitioners who are sensitive to patients and know how to handle them as human beings. I've been in situations where the practitioners were rather rude and treated me without the respect a person in need of medical help should receive. Needless to say I didn't return to that physician. I strongly believe that our system is corrupted by the insurance companies. Without them we would take more than 13% off the top of medical costs with one fell swoop. Plus all the aggravation that the insurance industry causes consumers and medical practitioners would be erased. Only the political establishment keeps this system alive (no pun intended). Politicians seem to be afraid to vote against the insurance "industry" knowing that vote would endanger the monies they get for their election campaigns. An ugly situation to say the least. A system of national health care is the way to go. Single payer seems best. The US is the only country without some kind of a govt. controlled system of health care. Let's get off our rear ends. Businesses are dying due to health coverage they can no longer extend -- and watching their employees walk away taking other jobs where they can still offer those benefits...those ESSENTIAL benefits!	NY	7/24/2006 6:11:38 PM
My family has been without medical or dental insurance for about half a year now. My husband lost his job (which paid well and included full benefits) early last year. While he was unemployed and looking for a new job, we were able to continue his insurance via COBRA, but that cost almost as much as our mortgage--unemployment benefits were far from enough. When he found a new job, he could get insurance--which would have cost him about 1/4 of his annual take-home (which was already close to 1/2 of his previous salary as it was). There was no way we could afford that with our dwindling savings, so we have had to do without. It is very scary to be a parent of a young child and to have no insurance. My husband makes too much to qualify as low income and get some assistance, but he doesn't make enough to cover our monthly expenses as it is, without insurance and not even counting the cost of my college tuition and books (which again, we don't qualify for assistance with). We are part of the lower middle class that always seems to fall between the cracks. Without some change sometime soon, we may even have to give up our home just to survive.	WA	6/8/2006 12:16:27 PM
Well, now I'm a casualty too. Unable to find employment that provides insurance in recent years, I was at least radiantly healthy for a middle-aged American man, sticking to my lifestyle doing all the right things, such as working out religiously. Unfortunately that may have also backfired, as it seems the cartilage in my joints, particularly knees, has been wearing out--it's possible my bicycling motion has been out of whack. Anyway, recently I took on temporary work delivering telephone directories, a hard job especially when you find yourself climbing a lot of stairs. Somehow I tore something loose in my left knee, surprisingly unceremoniously as I'm not even sure exactly when it happened. I'm studying the problem myself and it's likely the medial meniscus. I can't run on it. An operation will run somewhere between 10 and 20 thousand bucks. I don't know what I'm going to do besides pray I can get a job with medical coverage; meanwhile let's all find out what life is like walking and cycling around with a torn knee meniscus, won't this be interesting research! My contribution to our wonderful health care system! Stay tuned, folks.	CA	7/21/2006 10:04:51 PM

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Response	State	Date/time received
Ultimately I see no reason at all for any American citizen's health care to be tied to employment rather than citizenship. I mean, I could understand supplemental insurance being offered optionally by employers as an actual competitve benefit- come work here, we offer- AFLAC, or whatever. But overall, our current system has never made one iota of sense to me. And even as a small business owner who chooses to skip what feels like paying for simple graft & corruption each & every month to an insurance company- I just don't get it. When I worked for other people my healthcare benefits would typically change every few months. I know I have to sit down & make those phone calls & bite my tongue & open my pocketbook & force myself to spend this money every month & honestly- I might as well open my front door & throw money out into the street. I paid for benefits for seven years- every month- I used them for two appointments- one for strep throat- not something I needed a doctor to tell me I had. How many thousands and thousands of dollars did that cost? I honestly feel like I am being blackmailed. All Americans should have unfettered access to health care based on citizenship, period. Old, young, in between. Employment changes. Citizenship doesn't. Why can't this country reinvent itself around taking care of our own people, pursuing alternative energy & making America a fair & just place to live in peace & prosperity?	PA	2/16/2006 11:52:20 AM
As a Physical Therapist in rural Utah, I have found that nearly 30% of my clinic costs go towards billing insurance companies. It is time consuming, complicated and tedious. If we are to control healthcare costs, we need to remove the third party payer system. A true free market approach would eliminate the need for extra employees for insurance billing. I recently had a patient that I was to see on home health. As we were filling out the paperwork, she stated that if she had to pay anything she would not need home health but if her insurance (in this case Worker's Comp) was paying, she wanted all of the services. Health care is consumer driven. American's have an entitlement attitude. Most feel they deserve all of the best care...especially if someone else is paying. To change the quality and control cost, we need to remove the clinician from between the patient and their insurance provider. Patient's need to choose which care provider they want and be responsible for the payment. Consumers will then choose the best care they can afford and clinicians will be driven to provide the best care at competitive prices. Government regulations also increase costs. HIPPA implementation has cost my office nearly $45,000 over the past 3 years. HIPPA was a reaction to drug companies contracting with large HMO's and Hospitals to release patient diagnosis' for direct marketing advertising. Rather than sanctioning the drug companies, congress passed sweeping legislation that has imposed huge demands on offices large and small. Who will absord the costs? The office will and the patients might. Threats of litigation are common in health care. A current ad on TV in Utah encourages people to call this attorney because he can get them 20X what a settlement might be. Healthcare providers must carry malpractice insurance not only for errors in practice but to defend frivilous law suits. My insurance continues to skyrocket and I have never had a claim made. OB-GYN's can not afford to deliver babies due to the cost of insurance to defend lawsuits. If we want to control health care costs, we must address the third party payer system, government over regulation and limit liability. A more free market system will force patients to choose their healthcare more carefully and providers to be	UT	5/8/2006 12:58:48 PM

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	Response	**State**	**Date/time received**
	more competitive.		
	I like the Medem Network and iHealth Services where one can communicate with a physician and enter one's medications, allergies, and other history so they are accessible from anywhere. ===== I know someone who finished graduate school and moved to another state to settle and work in 1998. She was a member of Blue Cross in the first state. When she moved, due to pre-existing conditions, the Blue Cross in the new state wanted to charge her $1500 a MONTH or $18,000 a year!!! Fortunately she qualified for minimal insurance through the state for people who couldn't get private insurance.	MA	2/15/2006 8:51:27 PM
	I hate being seen for 5 or 10 minutes by someone who is in a hurry to see the next person (and is in fact rated by how many people they can see in a given amount of time.) Want to see the same person consistently and be referred to specialist if needed.	CA	2/4/2006 6:32:12 PM
	I have just completed a an unhappy year in an HMO. Before this I've always had good coverage through my employer in a PPO. The care I received in the HMO seemed competent but was so "bare bones" that I was uncomfortable with it. I hope this is not the future of health care! I have a medical condition that requires monitoring and I am much more comfortable back with my chosen medical providers. At the same time, I truly feel for those who have no health coverage. We have a disabled daughter who works only part time & has no health coverage. She is unable to qualify for any government programs because (1)she has always tried to work and (2) she has no history of health care! She refuses to obtain health care because she cannot afford it! Go figure.	WA	2/12/2006 12:00:59 AM

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Response	State	Date/time received
My husband was involved in a Catastrofic Accident in 1998. He was at that time the sole provider in our household. Everything after that changed our lives forever. Trying to pay peter to pay paul I had to get a Full Time Job fast to help pay for Health Insurance for my Family. I longed for to be home with him takeing care of him, and my son to make everything all ok. I left four years working to take care of them at home. I felt miserable and empty until I could put my home back in perspective again. Now I had to find Insurance for my son most inportant. My husband had Social Security Disability Thank God. But of coarse through all this I am the only one not Insured for at least eight years now. I am so worried about makeing things right for everyone else. I dont care about myself anymore. Takeing a chance because Insurance is so expensive paying Independent. I cannot seem to allow myself to do it. I have done my research, and because of the constant increase's the VARIABLE yearly increases are like a credit card!! The deductables are rediculous $500 minimum for female who will have to pay $500.00 a month premiums. For a smaller monthly premium a $2,000 or more deductable!!I have a mild case of MVP so the premium would be higher. I would be considered a risk. I might as well throw in the towel with the ever increaseing premiums every year. You get to the point that you dont care anymore about yourself and your health at all. I am ashamed knowing if anything would ever happen to me that Im willing to not go to Hospital even if I really need to because of the expense even if it is my life we are talking about. I never thought I would have felt this way fifteen years ago??? It surprises me the gamble I take for extra income in our household rather then giveing it to the Dr's. and Hospitals, and Insurance Companies.	IN	2/16/2006 12:18:10 PM
First of all webtv cannot access PDF files and so I was not able to fill out the survey; a single payer system is the only answer; we spend huge amounts of money on healthcare and still are 77th in goodhealhcare. We in addition to S. Africa are the only 2 industrialized coutries which do not have universal healthcare. In my lifetime I have spent a fortune on premiums and was always frugal with the way I managed my money. I know lots of people who made more money but wasted it all and now get all the perks. I found that even with paying high insurance both Medicare and a supplement in addition to my own prescriptions in large facilities I wasn't even getting basic care. Because I have multiple disabilities most doctors simply ignored my symptoms and said they were overwhelmed. I finally got sick of it and reported some to the clinic managers. I decided to change to a doctor who work with low income people and use my insurance. They are getting this great care free and my insurance is getting billed a huge amount but I am getting some testing done which was ignored for years even though I had breast cancer and treatment. Chiropractors on the whole have much more training in the total system and know what vitamins and minerals a person is missing; yet they get allowed only a tiny amount by Medicare or any insurance. Dental insurance is practically non-existant except for people who are in unionized jobs as I was when I could work, but even then there were low ceilings on the amount that was allowed. Individual dental insurance is practically impossible to get. Maybe one dentist in a city of hundreds of them participates. Dentists overcharge! and most are not in favor of universal healthcare. If we had single payer, all would be covered and people who were poor; some through their own fault would get the same treatment as the rest of us. As it is they get all kinds of perks; I worked for social services with thousands of cases and I know what I am talking about. The working poor often have NO healthcare and work several jobs as my son who is the director of a vocal ensemble which is non-profit; he has had no health insurance most of his adult life and works 7 days a week with very long hours. We cannot afford bandaid solutions anymore. I have worked on trying to get universal care inacted for 20+ years and we still are without it and worse off than before. Medicare could have been extended to all since the overhead is low; instead it is a big mess and Congress has got to stand up and speak out. I get incensed with some that don't care because they have supreme coverage and we are paying blood. I hate to think what I have spent for the lousy care I have gotten on the whole since about the late 70's. As soon as Reagan got in office went lost big time and now are in the worst situation in generations. Corporations don't want to pay benefits and we shouldn't be paying for these people who have to go on welfare. We pay taxes too. It is all a BAD SYSTEM!	MN	2/16/2006 1:01:42 AM

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Response	State	Date/time received
Have everyone to tell their Congressman to support H.R. 676 http://www.healthcare-now.org/	IN	2/15/2006 7:05:30 PM
Many years ago aI was on the board of a community health center in *** Pa. It was publicy funded and accepted everyone. It was a great idea and provided good services ti the community. What I learned is that se can't have resonabel helath care if everyone is not covered. We desperately need universal health care. And we need it now. I will support any program or person who leads us in this direction. Bush's HSA only really benefit the rich. HSAs cannot solve the problem. Why can't we look at Canada; France; Mexico, etc.. See what has worked. Take the best of all and put a plan into place. If the insurance companies have to take a hit, so be it. A society which allows so many to go without care cannot long afford it. I wish you luck. ***	CO	2/17/2006 1:28:53 PM
As is the case with many younger Americans, my wife and I did not think much about health care issues- until it affected us personally. We thought we had a good private plan through our employer, with a low monthly cost, but with a high deductible and coverage of only 80 percent once the deductible was met. After 2 hospital stays it became apparent that a higher quality plan is well worth it, despite a higher initial cost. It is after all insurance, meaning protection against unexpected or catastrophic costs. The key is keeping -those- costs down. We then had a son born with autism, and were immediately overwhelmed with the complexity and costs of the system. We now strongly favor universal, single-payer care such as exists in Canada or Europe; basic human decency demands it. We realize this means higher taxation, but we are already paying high costs anyway through payroll deduction (which would go away, offsetting taxes)and one provider or processor would result in great efficiency. American business would also be relieved of direct health care premium costs. We have a relative who is using the new HSA (Health Savings Account)and is not pleased with it. It appears most market-driven reforms fail, because there is an automatic conflict of interest between a company/shareholder and the patient. The market is great for selling goods and some services but sure is a lousy way to deliver basic health care. Thank you.	MN	2/16/2006 2:46:58 PM

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Response	State	Date/time received
Experience #1 I mashed my big toe at work on a Sunday night. I was advised by my manager that the hospital probably wouldn't do anything and refer me to their clinic on the next day, Monday. But he was careful to advise me that they weren't denying me medical care. Well, I went home that night and my toe was throbbing so badly I couldn't stand it any longer. I took a small hand drill (like an egg beater) and took the smallest bit I had 1/16" and poured alcohol over my toenail and slowly drilled through the nail myself to relieve the pain and pressure. Monday I went to the clinic for a tetnus shot. Experience #2 I went to the skin doctor to have a skin cancer removed, after removing the cancer and five moles the doctor advised me that was all he could do for the day because that's all the insurance company would allow for one visit. We finished up the following week. The cost of removal in the doctor's office was TWO THOUSAND FIVE HUNDRED DOLLARS. I went to a United health care doctor off of a United health care list of doctors. With a $30 office copay, somehow I ended up with a bill of $500 I had to pay out of my pocket.	MO	3/22/2006 2:37:37 PM
We know that we have a huge problem with our health care system and all we do is talk about the problems. I think we have enough horror stories. It is time to act now - build the solutions and get the dam resolution enacted - NOW. How long did it take to go to war in IRAQ? We seem to know how to do that pretty dam fast. Wake up America.	DE	3/22/2006 8:50:00 PM
Resolution to the Health care crisis. Our great citizens should see to it that a new law is passed removing all forms of Health care coverage for our state, federal legislators and government officials. No legislator/official would be permitted any form of health care coverage until every man, woman and child was provided with affordable health care. The health care crisis at hand would quickly become the #1 priority in our great nation.	DE	3/22/2006 9:06:45 PM
Because we can afford a large deductible, private health insurance has worked for us. The concept of "in-network" and "out-of-network" providers, however, has cost us DOUBLE the usual deductible when care was required out of state in an emergency. This is unacceptable and would be absolutely unaffordable for most Americans.	TN	3/26/2006 9:17:20 AM

Question	We all have different experiences getting health insurance or in seeking health care. Sometimes these are good experiences, while other times they are not. We may meet very special providers or encounter new and innovative practices. Other times the American health care system disappoints us. Please tell us what has worked well or hasn't worked well for you or your family.

Response	State	Date/time received
This is some thing that I shared with the ABC news and this is still going on at the Uiversity of Michigan Medical center. it is sad that the patient care is not a concern for the Unviersity of Michgian and the M-care insurance. The hospital operators are the answering service for the m-Care insurance company after 5 every day and they have no medical knowledge and experience. If you are interested, I have alot more to share. ABC News Home Good Morning America World News Tonight 20/20 Primetime Nightline World News Now This Week Home U.S. International Business Technology & Science Health Entertainment Politics ESPN Sports Travel Local News & Weather Video & Audio Planning for Life Events Cosmetic & Elective Health Center Shopping Center Legal Center Career Center Wireless E-mails & News Alerts Message Boards RSS Headlines Podcasts Send Photos, Video NEW: Blogs Subscribe to alerts Subscribe ---------- Log in Forum Home *** Re:Re: Fired over workplace conflict?reply Posted: Jan 08, 2006 05:32 AM 4 Posts Registered:Oct 07, 2005 11:01 PM This is the america and you can be fired for any thing and no one cares. This past year, I was fired soon after I TOLD that co-workers were sleeping and were not doing there job, during the midnight shift at the University of Michigan medical Center in Ann Arbor, Michigan. I gave names and dates of Medical Staff that had the workers snoring in their ears and then I was told I had no proof and was fired over the phone, the supervisor that was friends of the co-workers said I spoke to loud and that was the only reason given after working for the University of Michigan for 17 years. I am 49 years old and do not	MI	5/10/2006 8:58:02 PM

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	Response	**State**	**Date/time received**
	talk to loud. I was concern for the patient care. I wrote to the u of m administrators, president of u of m, the money donors, the state of michigan employment dept, civial rights and no one cares. oh, and a few months later the two sleeping workers were fired and I am still fired and no one contacted me and said oh, I was right or sorry or any thing, the supervisor was promoted and the director just lied about me and the u of m went along with the two young females that enjoy a little power. The University of Michigan Medical Center is only out to make money. when I wrote to the Medical Affairs about the patient care all they did was work at having me fired, they contacted the director and she worked with the supervisor to make up some thing to have me fired. So, yes you could be fired, I was and I did not deserve it. *** Contact ABC News . ABC.com . Help & Info . Advertising Info . Terms of Use . Privacy Policy/Your California Privacy Rights Copyright Â© 2005 ABC News Internet Ventures		
	I am entitled to medicaid. I have tried for 4 years to getit. I am 73 years old disabled since 1992. I have diabetes,heart problems, and anxiety disorder.I cant afford to see a doctor because they charge $91.00 a visit. Cant afford any medicines. I receive $10.00 a month food assistance,can you live on that per month.After I pay rent and utilities and only needy essintiels I have nothing left. I have $33.00 left at this time.Life is not worth living.Had auto dealer steal about $25,000 from me on lease. I was having a blood sugar at the time.I do not have food most of time. It is time the USA helped americans instead of all other countrys and and immigrants.	IN	6/8/2006 2:47:41 AM

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Response	State	Date/time received
Read with the kind of open mind that conquers the unknown. "SUICIDE VACCINE": .....You don't have to believe in God to sense that there are unseen, negative forces at work against the human race; vast, heartless, loveless and unsympathetic. (If you don't believe in anything you can't see, touch or feel, you're vulnerable! Expand your horizon to understand that ALL of life is connected and has a great impact on us, whether we can see it or not!....like a virus,with the naked eye, for instance.) Fallen angels (who are JUST as real as YOU are, who hide behind our deceived ignorance of their REAL methods, who lost their "day jobs" and have nothing better to do than prey on us, and who are called "demons") get sheer delight in tricking humans into self-murder and slaughter us like slave/cattle daily (as well as other deadly deceptions such as incited, outward violence)! One such deception we call "suicide". The word "angel" means "messenger". The 'Maker of All Things' had designed angels to carry His thoughts and put them into the mind of man. The fallen angels can still place their thoughts directly into any human's mind, in that human's very own thought voice....YOUR thought voice! (Ever had an angry or impulsive thought, word or action that you knew wasn't you? We all have!!) "Suicide risk" people (and others) that don't know or ACCEPT that this tampering can be done to them are stuck thinking that was what they really wanted to do. In play also is the demon's ability to incite, to manipulate our feelings and emotions, dragging us along the bottom of our lives (depression or pain of any sort, whether physical or emotional) and setting us up for a deadly trick, often through isolation, arrogance, never-ending boredom or impulsive behavior (we are most vulnerable here!). Also, the more self-absorbed or self-centered the individual is, the more susceptible they are (involve yourself with other's needs as a defense....others-centered rather than self-centered LOVE is what you do for ALL others that is in their highest or best interest, anytime, anywhere, selflessly! 24/7). People with good fortune shining on them would hardly listen to a suicide thought, as out of place as it would be there and a noticeable implant into their thought process. The bad guys have thousands of lures that get most of us (like $$money$$...which took the place of Love in the USA....entertainment, sports & business....which took the place of Family, "soaps" etc., but we can be inoculated against the fooling trick of suicide and eradicate it now that the REAL source has finally been revealed! HELP to spread this objective truth around freely to PREVENT more needless deaths and tragedies, to PROTECT the human race, including those you love! "People who don't believe that the devil walks this earth have not seen the things I've seen (terrible human slaughter). I believe that there is such a thing as true evil, and that there is true goodness." [Broward County Medical Examiner, Florida] Mick's response: "I realised recently that if I ever caused an upset with someone - knowingly or unknowingly - that I would try to handle this upset by harming myself in an effort to placate the other person. This included serious physical damage to myself and attempted suicide. Having spotted this info (Suicide Vaccine), I am now no longer going to do it and wished to let you know this. It would be better for me to confront the things I have caused and handle them. Love Mick." "The greatest trick the devil has ever pulled is convincing the human race that he doesn't exist." The Usual Suspects	NM	6/8/2006 9:56:07 AM

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Response	State	Date/time received
"Reality is something that when you stop believing in it, it doesn't go away".		
I am the father of a child whom consumed $4,500,000 of life sustaining health care as a result of her near drowning on July 1, 1984. Christen was severely brain damaged much like the now famous Terry Schaivo who was used for political purposes. Christen Michaela Shannon died March 10, 1997. At the time of her near drowning, we lived on a lake 11 miles from the nearest hospital and she was revived at the neighbors pier by her, American Heart Association CPR Certified Instructor CRNA, mother in the greatest act of personal heroism I will ever witness. She was taken to Lakeland Hospital flown, Flight for Life, to Milwaukee Childrenâ€™s Hospital. Her ordeal and that of my family was long and extremely expensive and painful. Cost shifting best describes the reality of my experience with Health Care. Not one single insurer willingly paid the bill, including Medicaid. Nothing but broken promises and lies. I can state without hesitation that I am a unique National expert on the reality of our health care system from a consumerâ€™s perspective. I was also considered by U.S. Senator Russ Feingold to be a consumer expert and was appointed by him to be a member of his Health Care Advisory Committee back in the early 90â€™s when the Clinton Administration attempted to address the very difficult issue of National Health Care and was stopped by the Republicans. I believe I may have been the only person on that committee, not representing some hospital, insurance company, the state, or some law firm or group of doctors. Over the last two decades, health spending has grown 2.2 percentage points faster than GDP, and total US health spending has now grown from about five percent of GDP in 1960 to about 16 percent of 2004's $11.7Trillion GDP or $1.9Trillion or $6280 for every single citizen. At the same time that national health care spending has risen dramatically, the federal share of that health care spending has risen even more dramatically. It grew over that same period from 10 percent of total spending to 32 percent of total health care spending. When you put those two factors together, rising health care spending and the rising federal role in that health care spending, it becomes painfully obvious that we are going to have an enormous strain on the federal budget through the unfunded liability (projected by various economists at $50 to $65Trillion)of Medicare and Medicaid, and everywhere where health care spending rears its ugly head. Your not gonna want to hear this but your survey totally fails to educate the public	IL	6/8/2006 12:37:05 PM

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	Response	**State**	**Date/time received**
	on what we are already spending on health as a nation, and is almost useless. GIGO The Corrupting influences of power and greed in the Health Care Industry has already Bankrupted the future of our society. Our Government is controlled by that force and is incapable of change or ethical behavior. The system is broke and cannot be fixed. The sky is truly falling.		
	I am currently unemployed, and on COBRA. The monthly premium for my health insurance is now $397.00. At the very time that it is the most difficult to pay, I have to pay the most. Thankfully I have the resources to do it. I tried to apply for individual insurance, but was told that since I take 4 medications on a regular basis, no insurance company would be willing to provide individual insurance. I am not in ill health, but the insurance companies only want to insure those in perfect health. It is very likely that I will find work on a contract basis, which does not provide benefits. COBRA is available for only 18 months. What will I do after 18 months? Our health care "system" is not a system. It is a cobbled together set of programs that has huge holes in it. We deserve a system that insures everyone, regardless of their employment status or age.	CA	4/27/2006 5:57:15 PM
	I am unemployed my hsuband started a new job, as he finished his previous job, I made sure all our doctor's appointments and prescriptions were taken care of, so that we would not have to pay full price for anything. So far it is ok, with summer here and 2 very active children, my thyroid medicine, and bad back all have me worried that I may end up with medical bills soon. Our new coverage will start in 90 days, the customary time for employee benefits to start.	PA	6/8/2006 1:30:18 AM

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Response	State	Date/time received
I am a retired PERA employee. When I retired in 1999, my insurance premium was less than $100 per month. It gradually increased until now I pay $79 but for a $5000 deductable plan. Previously I had only a small deductable. On my retirement I can barely afford to pay for basic medical tests for prevention. I find myself ignoring signs of medical problems because I cannot afford to pay for the medical costs incurred with an illness. When I have my prescriptions filled the pharmacy staff tell me that people are only taking their medications every other day to that they will last longer. This is deplorable in a Country as rich as ours. I am a retired Safety Engineer and Loss Control Specialist from a large insurance carrier. I know that there is no reason that middle America should be going without medical care. My husband died in 1999 and was on an HMO. I was surprised how they covered all of his extensive medical care. I don't think that would be the case today. I recently needed some medical tests. I was required to pay in advance for these tests because the physician's office called my insurance company and they informed them that I had a $5000 deductable. Had I not taken the money in, I would not have gotten this test which proved to be positive. I had another friend who needed a baseline Colonoscopy. She was denied the test by her insurance company because she was not having symtoms. I guess she must have colon cancer first?? She is a retired school teacher, again middle America. The wealthy can pay for their own medical care, the government pays for the poor and indigent but what about the bulk of Americans who are supporting this Country. Soon we will be using all our resources for medical care and high insurance premiums and there will be no middle class. We will become like our South American neighbors where there are only the very rich and very poor.	CO	2/15/2006 11:29:00 PM
The frustrating aspect of HMOs/PPOs is that no matter how healthy and well your family is, and the infrequency of doctor/hospital visits, a catastrophic event can totally wipe a family's finances out. Last year I gave birth to our son, Sean, during my pregancy I found out that I had a DVT, I was hospitalized for a week, and then again after I delivered. The cost for those visits ranged in the 20-30000 dollar range, and even though our coverage was 90% in our PPO, the extra out-of-pocket and other expenses, labs, doctor visits, really added up. It really broke us last year.	NV	3/28/2006 11:00:40 PM
Healthcare for my family has been varied, depending on how long they lived. I have almost always had healthcare insurance myself. My father would have benefited from today's healthcare had he lived to the present day. Probably both parents who lived in a rural community might have had somewhat better healthcare, I don't really know. I chose to be a nurse during WW II under the Cadet Nurse Program. I believe it is important for families to have information available to them, and that abuse and neglect of children needs to be prevented more than it is today. I don't think citizens should be deprived of family planning if they choose.	IN	4/9/2006 1:45:46 PM

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	Response	**State**	**Date/time received**
	I am a 47 year old single parent that has been fortunate enough to have been provided health insurance through my employers all throughout my working career. I do pay a hefty premium, however it's worth it to know that whenever my family or I need quality health care, it is obtainable and readily available. The issue for affordable healthcare and coverage is not the insurance company's responsibility - it is the responsibility of the individual consumer as well as the provider of care - it pays to shop around and compare prices and quality just as you would when purchasing a new home or car. As a consumer, it pays to take charge of my health and that of my children so that preventable diseases and injuries are avoided. Our current system is not perfect and obviously doesn't work for everyone. The only bad experience with health insurance was 20 years ago when I chose to go with an inexpensive HMO in order to save money. My daughter required surgery at the time but the physician (due to financial incentives from the HMO) would not refer us to the specialist she so desperately needed. Needless to say, I dropped the HMO and elected a traditional Major Medical Plan and she received her much needed surgery. It was more expensive, but worth it.	FL	4/27/2006 12:22:48 PM
	My complaint is that I think state employees should NOT have to pay a percentage of their health insurance. Our union is supposed to be working for us, not against us. Our Governor forced our union to back down & accept a percentage to be paid by all state employees, UNLESS we get in a wellness program. The problem with the wellness program is that we are forced to converse with health coaches over the phone, which I obviously don't feel comfortable with. I am borderline type 2 diabetes, I used to have a nurse educator, which I lost when this wellness program started..so now I have no one to help me...PLUS, I have to pay a 1/2% of my pay toward health insurance...what a bunch of crap!!!	PA	6/13/2006 3:46:19 PM
	Just three months after graduating college, after falling off of the required school insurance, but before finding full time work, my appendix gave out. I took myself to the hospital, fearing the bills. I was far more terrified of the cost than of the surgery I was about to undergo. I begged the hospital to let me out as soon as possible, given the stress of staying, knowing every hour was costing me. In the end, I was there less than 24 hours, yet had a hospital bill of over $11,000 (not including the surgeon's bill, the anesthesiologist, etc.). This was of course far more than my annual income, and was laughable in the insanity of the billing. I had to put this on my credit card, which I had carefully kept paid off during my school years, thus blowing all the good work I had done financially while studying. There is no reason for the costs I endured, nor my fear of this uncontrollable illness. National Health Care is the only answer, as every other civilized country in the world has already found.	PA	2/15/2006 8:54:00 PM
	As a family caregiver I've had to change jobs to be with my family so I haven't always had insurance. I'm now worried about my 20something year old daughter and her friends who don't always have jobs that pay for health insurance. We cannot depend on employment anymore for health insurance. A universal health care system would help to create a more equitable and secure democracy.	VT	3/22/2006 8:23:10 PM

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Response	State	Date/time received
My experience has been price gouging, or stealing by the Pharmacies and Pharmaceuticals . Our dear government helping it along the way. I have never been more out of tune with our leaders than today and I say, Shame on the lot of them. Our Michigan Senator, Stabenow has suggested is program like the Veterans have. Is it all too simple. And just think. No Lobbyists. Also I have subscribed to no plan, as yet.	MI	4/10/2006 4:23:11 PM
My husband and I are both paying for Medicare as well as for expensive private insurance while he is working. I can no longer work because of disability and health problems. We are paying so much and will not be able to afford this kind of insurance when he retires in less than a year. I have a number of doctors I have to see, some more often than others. When my health insurance changes, I have to change doctors and that is not good. Every doctor I go to is worried about their reimbursement. Some change insurance options while I am seeing them. I also need equipment and use a wheelchair and crutches as well as a spinal cord stimulator. Why won't Medicare pay for a wheelchair if I can walk a little bit, when I cannot walk anywhere out of the house? There are so many Americans stuck inside their houses because they do not have the equipment they need. Wheelchairs are expensive to repair, but insurance won't pay. Why not? The government pays lip service to get people with disabilities into the workforce but how are we going to ambulate? I have had a few helpful doctors, a few rotten ones, and many indifferent ones who seem overworked and who do not keep up with their fields. I worry about us getting older and getting the proper care we need. I also cannot figure out why we have to wait so long to see the doctor once we have an appointment and why the appointment times are inconvenient. I thought there was supposed to be a revolution in medicine with doctors seeing people in the evenings and on weekends. Over all, when we get sick, it is a crapshoot whether or not we will see a doctor who knows what he or she is doing and can help us. And heaven help us if we have to be hospitalized. Why are hospitals so short of nurses? To get better, we have to have family with us night and day. Not every family can provide that.	NY	4/23/2006 4:01:13 PM
We are self-employed and buy our own insurance. When our first insurance company doubled rates in one year, we decided to shop around. We ended up finding a good plan by becoming a member of the Tennessee Farm Bureau (we're not farmers, but they allowed us to join). However, in order to get the coverage at their group rate, I had to agree to exclude coverage for my asthma. We decided to take the chance as my asthma is well-managed. It's a scary thing though as now I live in fear that I would be reluctant to go to the hospital if necessary and possibly die as a result. I know two people who have died for that very reason. I would like to consider getting an HSA but the option is not available to us for a few reasons: 1) our premium would be higher than most because of my asthma and a couple of other things in my health history as well as my husband's age and his health history; 2) I now have the "black mark" on my record that the exclusion brings which would further increase my premium or cause me to be denied; 3) any time you change insurance, you have to agree to a 12-month pre-existing condition clause. This is an out for the insurance company that would allow them to deny paying for anything that we were previously treated for. Since my daughter and I have both had emergency room visits in the past two years, I would be worried that they could deny payment for just about anything. It's not worth the risk. A consumer-driven system does not make sense when the rates charged by insurance companies are a mystery and are determined based on individual	TN	4/5/2006 9:52:03 AM

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	Response	**State**	**Date/time received**
	circumstances. Imagine shopping for a car and being told that the cost of the car would be higher for you because of your age and previous accidents. Oh, and you can't have air conditioning because you blew out the air conditioning in your last car. There is just no way for the general public to influence rates and health care costs in the way the President would like us to. The same health care plan should be available to all for the same price (with some kind of sliding scale for the poor only) with no exclusions or preexisting condition clauses.		
	I have been self-employed and self-insured for the past 14 years. Every year my insurance premium has increased. So have my out of pocket expenses. This year I went from a $2000 deductible policy to $3000 deductive and opened a health savings account with Wells Fargo. I found that the only available fund that didn't charge a "front-end load" of 5.25% on my $2,700, which I would be drawing down for medical expenses, was a money market fund paying a total yield of 1.1%. That's about what the administrative expenses cost. Okay, so I get to draw that money tax-free. That should save some money. Except that with my higher deductible, my prescription drugs for asthma are about twice as expensive. Not only that neither the insurance company nor pharmacies will reveal what their contracted discount is so there is no way to comparison shop for the best price. My insurer, Anthem, told me that that information was confidential. All the pharmacies, who have contracts with Anthem, told me they can't tell me what the discounted price will be until the prescription is filled. I've decided to forgo one of my asthma medications because it's just too expensive - even from Canada. The cost of prescription drugs is beyond outrageous. As far as I'm concerned the HSA concept is a total bust. I would have been no worse off in terms of my total yearly medical expenses to have stayed with the lower deductible and higher premium. In addition, if I want to return to my previous, lower deductible plan, I have to reapply to Anthem. It really is a broken system. Hopefully we'll find a way to fix it before there are 100 million unisured people and the yearly cost of health care for those of us who do have insurance will supercede the yearly mortgage payments.	CO	2/28/2006 7:36:32 PM

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	Response	**State**	**Date/time received**
	â€œOver 30 years ago I was asked by a publisher to write a treatise on acute abdominal pain, but after serious consideration declined because it seemed impossible to improve on what Cope had already accomplished. â€¦ â€œRecent years have brought a proliferation of both invasive and noninvasive laboratory and radiological tests, the likes of which undoubtedly would have been a great surprise to Sir Zachary Cope. With these tests has come the unfounded belief that a number or a laboratory report is somehow more reliable than the clinical history of physical findings. The consequence has been an ever-increasing reliance on expensive and sometimes dangerous laboratory examinations. This trend is partly responsible for increasing the cost of medical care, and perhaps for some morbidity and even mortality. The more pernicious outcome however, is the continuing atrophy of the clinical skills of history taking and physical examination. The vicious cycle of more test and ex-rays, together with less history and physical examination, had been accentuated even more in the last few years by managed care, whose administrators insist on our seeing more patients in less and less time.â€ page v-vi, from Preface by William Silen, Copeâ€™s Early Diagnosis of the Acute Abdomen (originally published in 1921), 12th Ed., Revised by William Silen (Oxford U. Press, 2000.)	OR	2/18/2006 11:23:57 PM
	As a cytotechnologist, I saw the high-tech thin-prep technology replace the low-tech conventional Pap smear, giving a very small bang for the bucks. Technology is not always the best answer. I am a middle aged paraplegic. I am enrolled in medicare. Medicare will not pay for relatively inexpensive cushions and supplies that will prevent serious problems like decubitis when I need them. Yet , they will pay hundreds of thousands of dollars when the small problems become an emergency and put me in hospitals and nursing homes for months. They do not have a system that can allow me to pay for drugs because an old life-insurance policy prevents enrollment in medicare. They don't have a clue about preventive care and general health maintainence. If they paid for preventive services like dental checkups, cleanings, and more preventive medicines and devices they would save money. To be able to get a new anti-decubitis cushion (cost around 600 dollars) I must order an entire new wheelchair. It is the only way they will pay for one. Better food exercise ect. would , as community programs. solve medical problems that effect many people , such as obesity, diabetes, and heart problems. Even routine healthcare for people who aren't middle-class or above have become too expensive.	NY	2/28/2006 8:38:54 AM
	Doctor refuses to take a 'phone call. As a result, when the TV ad says "ask your Doctor", it would cost over $50.00, for an office visit.	TX	4/13/2006 9:30:14 PM
	A major problem with our health care 'system' is the hefty discounts that providers accept from patients who are employed by large employers while the same providers bill individuals who are not part of an employer plan 100% of their fee. This is upside down. People who can better afford to pay get large discounts while those who are less able to pay are expect to pay full freight. I'll gladly expand on this if contacted.	DC	5/15/2006 5:20:48 PM

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Response	State	Date/time received
Iâ€™m a 49 year old woman with two children. Because of divorce my children and I lost healthcare insurance. Their father insures himself and neither of his children. One child required surgery so I applied to CHIPS. The children were covered until my present husband was awarded disability benefits for being a war veteran. This put our income too high to qualify for CHIPS anymore. My present husband has no legal responsibility for my children yet they are denied insurance coverage because of his benefits. I am self-employed and have been for 13 years. My income is meager though it covers most non-insured costs. Recently I wove through the insurance maze applying for coverage. In this state the insurance companies cannot ask health history further than 2 years. I applied to four companies, two of them asked for health history beyond 2 years. One of them requested medical records from my family doctor and declined my application for conditions over 10 years old which were non-medicated and minor. I consider these practices unethical and bordering on illegal. Applicants to health insurance donâ€™t usually know the legal limits and their legal rights while undergoing this process. It forces people to out and out lie about whatever condition they might have, or be denied. I did acquire health coverage. The premiums are around 370.00 per month with 500 deductible and 1500 out of pocket max per year. The policy can be cancelled in the next two years. I wonâ€™t be agreeing to prescription medications until this 2 year period is over unless its life threatening. The family doctor made diagnosis for the previous insurance 10 years ago so he would receive payment. Those same notes he wrote caused a denial of coverage. Itâ€™s a catch-22. The patents on medicines are driving the costs and policies. If medicines are advertised they are entering a free market system, yet for the consumer of healthcare, it is not a free market.	UT	7/5/2006 1:04:26 PM
Currently we are fortunate to have insurance through my husband's employer-sponsored plan. I know all too well how lucky we are to have this plan, but I know that we are also just a job-loss away from losing this vital coverage. We feel especially vulnerable because both my young son and husband have pre-existing conditions. My son has Down syndrome and needs to have access to MANY different types of medical services and my husband has had Type 1 Diabetes since the age of 14. Both would be denied private coverage if my husband lost his job. This is a very scary prospect that I know is a reality for many people. Even with our current private insurance, we have been denied vital therapies for my son, including Occupational, Physical, Speech, and Vision therpaies. All were determined Not Medically Necessary under the plan. It is infuriating to me that when a person mosts needs services that are necessary to assist in their daily living that the insurance companies are allowed to deny services because the condition wasn't caused by an "illness or injury." Helping him now and preventing further complications will cost less than allowing his problems to worsen. Because my of my son's disability and his level of functioning, we applied and were accepted into one of Colorado's Medicaid Waiver programs (a program that waives parental income). We feel lucky - a strange thing to feel lucky about -that we qualified because our experience with this Waiver has been very positive. The state actually seems to care about my son getting the vital services he needs to help him function. Because this Waiver is re-evaluated annually, when and if he needs it again next year, we will have to requalify. The thought of losing this waiver is scary but I think the yearly assessment and evaluation ensures that the right children are getting services. It is an important checks and balances component of the waiver that I think is necessary to its continued existence.	CO	5/9/2006 3:08:40 PM

Question	We all have different experiences getting health insurance or in seeking health care. Sometimes these are good experiences, while other times they are not. We may meet very special providers or encounter new and innovative practices. Other times the American health care system disappoints us. Please tell us what has worked well or hasn't worked well for you or your family.

Response	State	Date/time received
I am a licensed nursing assistant. Out of about 4 million direct care workers,42% do not have health insurance, either because it is not offered or they can not afford it. Why is it ok for us to provide care and assistance, but it is not ok for us to have access to it. There is one worker in Oregon who has cancer. Because she does not have health insurance, her cancer was detected too late. I have clients who have to choose between there medicine and food or oil. Everyone should have health insurance. It is not fair for people to be sick and dying form things that can be prevented or fixed. Sincerely,	NH	6/5/2006 5:57:18 PM
I am 35 and in 2001 I had Chiari Decompression surgery(brain). I have since had a clean bill of health but can't get health insurance. Because it has the word "brain" in it, they wouldn't cover me. I have been told by another company that they have written policies for people with cancer. But they denied me due to this surgery that was done 5 years ago. I was told to get a job that offers group ins. that is the only way to possibly get coverage. I am a stay at home mom with a 2 year old and 9 month old, now I am forced to go to work and put my kids in day care for someone else to raise them. Now, I could take that money for daycare and put it towards an insurance premium that I am willing to pay for. Why can't I choose how I want to pay for my ins.?	FL	6/8/2006 6:04:39 PM
I had Chiari Decompression (brain surgery) in 2001. At the time I had group ins. and now am a stay at home mom with two kids under the age of two. I am not able to get insurance due to the surgery. All of the companies I've talked to say that I will never be able to get coverage. I have been told that some of these companies have written policies for people with cancer and diabetes, yet I can't get one even though I have a clean bill of health. What does a person do? I can't go through my life uninsured at 36...	FL	6/14/2006 7:56:42 AM
I am the Director of the Southwest Iowa Latino Resource Center in Red Oak, Iowa. I work primarily with first-generation Mexican immigrants with very limited English ability. I have been an interpreter in a wide variety of medical settings for the past seven years. I'm also somewhat of a health care manager, assisting people with insurance, billing, appointments, referrals, prescriptions, etc. Over the course of the past years, engaged as I have been with the health care system--with immigrants who seldom if ever qualify for health care benefits and personally, as a health care consumer and mother of a seven-year old, I've become very opinionated about what's going on. I don't think I could express all my feelings here about the current state of the health-care system(I think I would get an error message, "COMMENT TOO LONG") I think "something's gotta give!" We need some form of universal health care that is NOT dependent on employers--I believe an expansion of our current Medicaid/State Children's Health Programs is the answer. I know that most low-income working people would be willing to pay a MODERATE price for health care--dependent on income, or just a flat rate based on family size(way less administrative cost?!) that is subsidised by the government--by our taxes. Private insurance could still exist for those willing to pay for it(getting those costs to go down is a whole other story!) but for the low to moderate income folks(the majority) there would be a way for them to receive medical care that would not require even the thought of bankruptcy. It's one thing to require everyone to have health insurance, but it's another to make it affordable and accessible to ALL--including immigrants--including UNDOCUMENTED IMMIGRANTS--and not just their citizen children! Peace,	IA	5/13/2006 11:18:59 PM

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	Response	**State**	**Date/time received**
	I'm retired on Medicare and have been covered by a good employer health plan when working so I've seen the U.S. health coverage in action. My son lives in Australia which has a much much better system: public health care for all, no big private insurance bureaucracy, no profits for shareholders. In addition reasonably priced private health care for those who have higher income or can pay to jump ahead of the line. No big health expense overhead for employers.	NH	3/24/2006 11:19:54 AM
	I earn over $70,000 a year at my job with a small business, but because of the small size of our business I can't get health insurance. I manage the businesses and also am at an extreme disadvantage in attracting employees who need health insurance. I would like to stress that health concerns are not just (though they certainly include) poverty related. They also have some very real business implications. I have ended up on our State's HIP or "uninsurable pool", but our family pays over $1300 a month with deductables for my wife and I that are around $800 in practicle terms. This means that I spend more on my health insurance than I do on my mortgage. I basically work a second job to pay for our health insurance.	UT	5/8/2006 6:57:42 PM
	I just wanted to share an observation about how our publicly funded health care system can save money and be more responsive to the needs of our citizens. Many people who need assistance for their activities of daily living can receive this assistance as an entitlement in a nursing homeâ€"they can immediately move into any nursing home that has an opening. However, if they want to remain in their own homes, surrounded by friends, family and neighbors, where they have greater freedom, protection from abuse and dignity they often have to wait years for home and community based services. In other words, often all they need is a little attendant care, but because this is a state option and not an entitlement, they are forced to wait years for these services which have been proven time and again in many varying states to be less expensive than nursing home care. Frequently, they are forced into nursing homes. We need to pass MiCASSA, which is a bill that has been introduced into the House and Senate that, if passed, would require the state and federal government to make up to equivalent amounts of money available for the purchase of attendant care and adaptive equipment for persons who quality for federally funded nursing home care. MiCASSA would preserve the freedom and dignity of persons who need assistance, while providing a cost-effective alternative for the stateâ€"a rare â€œwin-winâ€ for everyone.	UT	5/8/2006 7:13:50 PM
	I think one needs to read about the Swiss Health Care System, the facts of which may be found by googling "Swiss Health Care System". Theirs is probably the most cost effective as well as the most efficient system yet devised. It limits what the central gov't can do while giving states, or cantons in this case,more ability in tayloring the needs of the people. I believe that the less the central gov't is involved, the more efficient the system.	TN	3/6/2006 2:35:46 PM
	Well I first should say that I am an ER nurse. My lifes work has given me an insight to our health care system in America. The good the bad and the ugly, if you need a cliche. Four years of my career were spent as a travel nurse. I was given the oportunity to work in many different communities. Rich and poor, everyone needs a little help sometime. I do belive that society, as a whole, does have a resposibility to care for the less fortunate. However I feel that a lack of personal responsiblilty plays a major roll in the inadequacy of todays health care system. I see people every day not wanting to take responsibilty for there own healt care. At times I don't know, if some people know, what that even means. Many times people wait too long to realy look a problem in the face and work it out. Wheather or not that problem is health care or anyone of the myriad of problem we deal with in day-to-day life. In doing this you miss the root of the problem. I feel a national healt care system is just throwing money atthe wrong end of the problem. Every body talks about making the system more efficient. There are many ways to do that and some ways are better than others. However,in America this will be driven by the all mighty dollar. I can't tell you how to fix the system, nor can the man next to me.	CO	2/15/2006 7:20:09 PM

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	Response	**State**	**Date/time received**
	This problem is bigger than the individual, yet in our socity it is about the individual. We need to come to-gether as a nation and fix this for the nation.		
	My son 4 yrs old has an individual PPO plan from BlueCross as to save money from the high cost of insurance that my company offered for HMO and POS plans. In to order to get PPO I had no choice but to get an individual plan for me, my wife and my son. Recently my son had a left forearm fracture and the doctor said that we have two choices to set the bone and we can do it either in his office or at the hospital. I was told that if itâ€™s done in the office then the child might have to go thru bone setting procedure more then once while he is conscious. Having heard we preferred to get it done in hospital which they called a minor surgery with general anesthesia. The so called procedure was done in about 45minutes and myson was discharged back on the same night with a total stay of about 4 hours in hospital. After insurance having paid their share of 60%, my co-insurance is about 3500 dollars which includes the hospital bill, emergency treatment bill, anesthesia bill and doctors charges for the procedure. I believe the total bill would be more than 10,000 dollars including the insurance payments, insurance write-offs or adjustments and my co-insurance. The question here is that are these charges legitimate for a simple procedure like this. Who governs the charges for the services provided by these health care facilities? Can we question them? I tried my best talking to hospital to get the charges subsidized but ended up with payment over monthâ€™s option. I am seeking for a help to fight this out but not sure how to go about it.	CA	7/13/2006 2:45:06 PM
	My adult daughter was injured in an accident a few years ago and she had to have a rod and pins put in her lower leg and ankle. They were supposed to be removed when her leg healed. She was working at a low wage job and couldn't afford health insurance. She was single and had no children, so didn't qualify for any government programs and couldn't afford the cost of having rod and pins removed. Last month she took her own life because she could no longer bare the pain. I think our government should be ashamed that things like this happen in this country. Why are we the only country in the industrilized world that doesn't have universal healthcare? My wife has dental insurance through the State of Ga. employees healthcare system, she recently had gum surgery. After the surgery was completed her insurance plan informed her they would only cover the surgery on 2 teeth instead of the 4 oral surgeon recommended and operated on. This cost her over $600 out-of-pocket expense. I recently had a rotater cuff injury. The office call and a shot of Cortizone was over $800 through my PPO. If I didn't have insurance it would have been over a $1000 and I wouldn't have been able to afford to go. The shoulder pain kept me from sleeping at night and if I had been poor like my daughter I might have made the same decision she did. These are things that have happened to my family just in the last 60 days and I am sure we are not alone in this nightmare we call a healthcare system. I think it is the time we take control instead of the insurance companies. If a small country like Costa Rica can afford universal healthcare, why can't we?	GA	3/18/2006 4:44:11 PM

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Response	State	Date/time received
Considering the high risk of medical error and the fact I suffer from several chronic health conditions,I do my best to be an informed patient about those conditions, my medical history, and my current medications. Given that my worst fear is being taken unconscious into an emergency room where I am crippled or killed by an unexpected drug interaction, whenever I venture outside in my wallet are my appointment cards with my current physcians' names, addresses, phone numbers, and a listing of medications. Given that health care professionals are human and capable of error, I submit that this habit is a prudent precaution that serves my own best interests. I have been forced to resort to hospital emergency rooms twice recently for bone fractures. After providing the usual information, which includes a medical history, list of medications and attending physicans, I attempt to provide a concise history of the injury and explain that I have either observed an obvious deformity or that I am unable to manage the pain and swelling. When the Doctor eventually shows up, I explain among other things that I am not happy to be there, that I do not want to be admitted, that I have a lot of other things to do, and that if he would just patch me up, I will be on my way, thank you very much. I may also explain that the history of my family is such that when we go into hospitals,we die and that my most recent admissions have been accompanied by medically interesting complications. Typically, this results in a reasonable if temporary relationship with the ER Doctor, a sound outcome and even a smile or two. To Date, however, I have not figured out how to get the initial interviewer in the ER on my side, but I am working on it. As for negatives, certain for profit hospitals will no longer treat individuals with state Medical Assistance or Medicaid as insurance coverage. In other for profit hospitals, Medicaid patients are treated as second or third rate patients and are more or less discouraged and passed over; although you are never expressly told to go elsewhere, the staff does a good job of giving you the non-verbal message. Since I have found a quality hospital where I am treated with respect, I go there and avoid the greedy for-profit hospitals. When my health collapsed and my finances followed, I wound up in a shelter for homeless men maintained by the City. If a homeless shelter resident became ill enough to be hospitalized, the policy of the City's emergency services was to transport the sick individual to the nearest hospital. This sounds reasonable until one realizes that the nearest hospital had one of the worst reputations in the entire city. In the nine months I spent in that homeless shelter, several homeless men went to that hospital, but to the best of my knowledge, only one man ever returned and he died the following year. To be sure, I have no evidence whatsoever that this was calculated, deliberate, or intentional; however, the outcomes exceed happenstance or coincidence. My suggestion that the hospital in question should be renamed a hospice has not been favorably received by the powers that be. My other negative health care experiences revolve around HMOs. My HMO seems dedicated to the principle that preventing physicans from caring for their patients constitutes preventive medicine. These circus ringmasters seem to take positive delight in their ability to make patients and doctors jump through hoops that reflect the mind of Rube Goldberg. Other HMO personnel excell in playing games, such as demanding letters from Doctors who are too busy to play such letter writing games who understand that the game is rigged in favor of the HMO, so much so that you have a better chance at a casino. The outcome in my case is clear: most of my medications for chronic medical conditions are not paid for by my HMO, but provided by my primary care physican from drug company samples. I did file a grievance once with my HMO, but it is not an experience that I have any intention of ever doing again. Before becoming disabled, I had practiced law in the city for twenty-five years and had a developed idea of what constituted such niceties as due process of law, an opportunity to be heard, impartiality, rules of evidence, making a record, extenuating circumstances, and so forth. If I had practiced law the way that HMOs manipulate their own grievance procedure, I would expect to be thrown out of court by the Judge and lose my license to	PA	4/11/2006 4:35:14 PM

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	Response	**State**	**Date/time received**
	opposing counsel's complaint to the Disciplinary Board. I did discuss this with the responsible state officals who felt they could do nothing but recommended that, in the future, pursue a fair hearing rather than the HMO controlled grievance procedure. In the event that the federal bureaucracy arbitrarily or capriciously abuses its discretion in reaching a decision or in overriding my rights, I can bring suit against the offending agency and responsible bureaucrat and, if there is some merit in my complaint , have the matter decided by an impartial federal judge. Yet HMOs are immune from such legal action, and so we have a private local bureaucracy empowered to behave as it sees fit since it is neither supervised nor accountable. And now, a question for you. Based on a survey about five years old , I understand that about 18,000 Americans die annually because they did not seek medical care in a timely manner, i.e., these individuals delayed their own medical care. How many of these deceased individuals were HMO members? Thank you.		
	I am a quadriplegic & I work full time. The biggest issues for me are the lack of well trained community based services in our area. The pay scale for taking care of people with disabilities is at about the same level as a fast food worker or a janitor. Refering to Home Health Aides(HHA's), Personal Care Aides(PCA's), and the like. With out a pay scale that is an insentive to work and stricter guide lines on injury specific training, along with equipment use trainings. I don't ever see the quality or quantity of community based services improving. It is very hard to find people to work weekends and evening with proper training at such a low pay rate. I wish that I could give up my disability on weekends and evenings. That would solve all of our problems. But I can't. Please look hard at improving the community based services.	NY	4/26/2006 11:50:35 AM
	After spending 27 years on soil and water conservation issues, I was recently assigned a project to look at the cost competitiveness of health care. I was surprised to find out that we could easily cut health care costs by 20 to 50 percent if we would just apply the innovative programs that have already been tried and proven to cut costs and improve quality of health care. For instance, there are more than 20 elective surgeries that could be performed in other countries that would cost 75 percent less (including air fare) than they would cost in the U.S. Imagine going on a hip replacement tour and recuperating in the warmth of tropical ocean breezes in India rather than recuperating in the ice and snow and cold of Minnesota. What is needed is some kind of international accreditation so that insurance companies could pay for those services (of course, accreditation would raise the overseas treatment cost, but hopefully not to Americaâ€™s level of cost.) Have a hernia problemâ€" go to Shouldice Hospital in Canada. All they do is repair hernias. It costs $997 compared to an average in Michigan of $4,000. Shouldice is so efficient that only $24.50 (Canadian) of surgical materials goes into the trash. Each operation in the U.S. produces up to $600 of disposables. Quality, you bet, their recurrence rate is only one percent compared to 10 percent in the U.S. (Specialty hospitals are also a lot safer than mega-do-it-all hospitals that harbor germs from every type of sickness they treat.) Doctors do what they get paid for and get trained to do that which they get paid for. They get paid for cutting you up, stitching you up and stuffing you with drugs after you are sick or hurt. They donâ€™t get paid for offering alternative advice or prescribing preventative medicine and Medicare doesnâ€™t pay for it either. Insurance companies generally follow Medicareâ€™s lead. Congress should mandate that Medicare should pay for proven lifestyle and preventative care	DC	5/15/2006 2:45:28 PM

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	Response	**State**	**Date/time received**
	advice and treatments. Lifestyle changes alone could save $50 billion per year in heart surgeries and reverse coronary artery disease. (check out the Preventitive Medicine Institute, Dr. Dean Ornish) Insurance companies should offer catastrophic insurance that incentivizes us to improve our health. Contracts could be for 3 to 5 years, instead of the one year renewables that most of us now have. Customers would take a health exam at the start of the contract. If their health numbers improved by the end of the contract, they could get a rebate of up to half their premiums. Participating in healthy practices could also bring discounts on fancy hotel stays, airline miles or other incentives. (the Swiss have these) Combine high deductible insurance with a Health Savings Account. The several hundred dollars of saving per month for the high deductible can go into the HSA. Then make people aware of insurance-free mail order pharmacies that can provide generic prescription drugs at average savings of 45 to 80 percent compared to even the big chain discount pharmacies. I am aware of one smart consumer who, with his doctorâ€™s blessing, buys a 90-day supply of pills that contain four times more medicine than the prescribed dosage and splits them into fourths, thus extending his supply for a full year. The cost is about the same as for the low dosage pills. Letâ€™s say the normal prescription costs $1.00 per pill. Buying from the insurance-free pharmacy brings the cost down to maybe $0.24 per pill. Splitting the pill in fourths would make it $0.06 per pill. In other words, by paying cash up front he is paying less than most people would pay for their copay for the same yearâ€™s supply. And heâ€™s building up his savings account. Medicaid participants ought to be able to choose the person who best provides them care and comfort and not be locked into caregivers designated by the government. Itâ€™s saving Colorado 21 percent on their Medicaid program and the disability patients are much happier. A big chunk of the 46 million uninsured are temporarily uninsured. Golden Rule Insurance Company now offers a new Short Term Medical plan that can fill those gaps for individuals and families in transitionâ€"people between jobs, students not covered by parentsâ€™ plans, recent graduates, and early retirees. Consumers can opt for one to six months coverage and drop without penalty. They can renew for an additional one to six months. The answers to higher quality, less expensive health care are all around us (there are hundreds of them), if we look for them. In fact, the book Consumer-Driven Health Care by Regina Herzlinger contains 40 or 50 such examples. Sixteen of those examples are summarized in the attached table. For too many years weâ€™ve been handed the answers on a costly silver platter, served up by a third-party. Itâ€™s time for consumers to get in the game, find out what treatments truly costs, pay cash and negotiate prices where we can, and push our system to provide better quality care at reasonable prices.		
	I attended my first health care conference on 5/05/05 which is a once in a hundred years event in itself. But it certainly opened my eyes to the health care savings opportunities that exist all around us, but are known to so few of us. So we wring our hands and cry for government solutions that the Canadians have already proved they dislike. Attached is an article that sums up many of the ideas that were new to me, but in a way were like going back to future of how things were when I was growing up in the 1950's when you paid cash and the doctors really cared and took some time with you. (Today it is you pretend to pay and they pretend to care.)	DC	5/15/2006 2:57:52 PM

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	First, I don't like survey's that I can't read. Downloaded, and can't find it. Second, would appreciate our government leaders to NOT be doing business with less then reputable people. Like where did you get my E-mail address?? these people broke through a ligitimate site and lied to me about being a winner, and then, gave me a run around to answer this survey or that one, and would never leave me off there web site. I KNOW that is where you got my name, because I don't use Jimmy anywhere else, used it to track these dispicable theives. Has taken me over a month to get ride of all the unwanted JUNK spam from them, and YOU are one of them. YOU as a leader CANNOT be doing business with these type people, and expect your constituents to have faith in your and what you are doing. When you respond to me about your doing business, I'll be glad to reply to your needs. I do have a lot to say on the subject of health care, but will only share my many opinions once I know you care about your voter's feelings. Yours TRUTHFULLY ***	CO	2/19/2006 9:41:26 AM
	1. My daughter was making Cobra payments for $900 plus a month for her family while her husband was out of work. I actually was sending her money out of my retirement funds while I am out of work myself to be sure that they have coverage. The insurance company misfiled her payment and then told her she was no longer covered because they weren't payed on time! In the interim, all of the EOB's that were sent to her all summer from this insurance company have come to my bome in a different state. They have the whole thing, the insurance company being they, botched up. The cost to her is exhorbitant! None of the doctor visits all summer long have been covered even though she sent her payment to the insurance company on time because they misfiled the money! Go prove it. No one can fight the insurance companies. THey always win! 2. I am paying 415 a month in cobra payments and have been told the payments will probably go up in May. I am out of work. The cost of the cobra payments is so high I will end up taking a position that is beneath my qualifications just to stop the flow of money going out. If we all had health insurance, I would be able to search longer for the right position, earn more money, and would be glad to have more of my money go to taxes paying for health insurance.	KY	3/23/2006 3:10:44 PM
	Medicare works very well. My private insurers, whose premiums are mostly paid for by the companies my husband and I retired from pick up most of what Medicare does not pay. However, it has become my full time job to track what they do and convince them to do it correctly. Their error rate is about 50%. It is generally in their favor but has also been in my favor. I am convinced that they hire low paid incompetent help and insist on them doing a certain number of claims per hour. As I insist on them getting it right, their overhead on my claims has to come to more than the amount I am asking for. If your asking about special providers, we are of an age where we have had to use lots of care. My husband was admitted to Dartmouth Hitchcock Hospital in Lebanon NH because he passed out with Ventricular Fibulation on the way to a campground. I cannot say enough good things about them or the Doctorassgned to my husband. We've been in lots of hospitals and none come even close to the level of care they provided us. If you want details, I will be glad to provide them.	WA	2/13/2006 8:17:09 PM

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Response	State	Date/time received
I had a stroke several years ago, and was unable to cover the costs of hospitalization because I was not covered by insurance at the time. Fortunately the State of Arizona's AHCCCS program covered all my medical bills. I was lucky to be living in a state that made sure there was a system in place that would cover my treatment & recovery, including therapy. I had better health coverage then under state funded AHCCCS than I do now under Federally funded Medicare. I have not signed on to part D of Medicare (the drug coverage) because it is for all intents and purposes a boondoggle for pharmaceutical companies, NOT a boon for seniors. That is why I'm a strong advocate of a UNIVERSAL HEALTH CARE SYSTEM for everyone in the US. Health care shouldn't be made a question of how lucky one is, but rather should be a human right and accessible to everyone. I believe the UN Charter guarantees it, along with Social Security. It is about time we had it here.	AZ	2/15/2006 10:05:02 PM
I have a child with Down Syndrome who has had 8 surgeries 2 being open hearts. She is insured through her dad in WI. It is a HMO. I have applied for medical assistance for almost 5 yrs. off and on. My income excedes the whopping $1400.00 per month for a family of 3. I have called every health care provider/Insurance Co. and of course I can NOT buy her insurance due to her past health concerns. What is the disability Act? Who does that protect? Surely not my daughter who's family has paid taxes and not one of her family members EVER recieved public assistance. I have called Governers,Senators and every agency here in Cabarrus Cty. When I spoke to a representative in Raleigh NC. I was told point blank (NO KIDDING) to work less and make under the income requirements!!!!!! Do they not realize something so basic as to if I work.....I pay taxes!!! When I was in DSS last week, appling yet for another denial... the room was filled with foriegners walking out of the office with medical ast., food stamps,heating/oil ast. You name it. Come to America for a FREE ride while we deny our own, forget that the disablied Americans whose families are paying the price..for Non-American citizens. We need to reform every aspect of the American health care system. Starting NOW, TODAY!	NC	2/9/2006 12:24:22 PM
I work at a school-based health center. Every day children are treated by a nurse or a doctor, which helps to keep kids at school and parents at work. I am a social worker that provides mental health treatment. If I were not here, the majority of my clients would not recieve the intervention they need to be successful, nor would they be referred to appropriate providers. The mental health field is so overtaxed and stretched, I can't imagine the neglect and dire situation our communities would be in without school-based health centers.	LA	3/22/2006 11:05:57 AM

Question	We all have different experiences getting health insurance or in seeking health care. Sometimes these are good experiences, while other times they are not. We may meet very special providers or encounter new and innovative practices. Other times the American health care system disappoints us. Please tell us what has worked well or hasn't worked well for you or your family.

Response	State	Date/time received
I have been turned down in the past for health insurance (American Family) because I had a little grief counseling, which I paid for myself. I have relatives who can't afford health insurance because they had cancer or had a pre-existing condition. One fried who had no health insurance, was in a terrible auto accident and was in intensive care for 6 months. Her hospital bill was 2.25 million. Her mother had to sell off property, my friend's house was put up for auction. A nurse almost caused her death by trying to feed her even though she had a trach. The hospital dropped the last million dollars of the bill if she would not sue. She is now disabled and the only health insurance she can get has a $50,000. deductible. This country does not care for it's people like other countries who have national health insurance for their citizens.....much to our shame.	MO	2/15/2006 8:17:13 PM
I have been an emergency physician for 25 years. I have seen a hospital (Humana) try to refuse to let an orthopedic surgeon operate on a patient who was bleeding to death because he had no insurance. The national average collection rate for emergency physicians is 30%. That means that 70% of our work in uncompensated. That works out to 17 years of charity work for me. I think that is enough. My own family's health insurance is about to become unaffordable. When my 9 year old daughter was born (I delivered her!) we had a PPO and our hospital co-payment was $250. My wife and I are both doctors and now we can only afford catastrophic coverage with a $20,000 deductible. If I was made health care Czar of the U.S.A. I could cut costs in half and provide needed coverage to all Americans by a few simple steps 1. Accept the fact that people die. Every day I work I see very elderly patients from nursing homes in a persistent vegetative state admitted to the ICU for problems such as pneumonia. They should be allowed to die in peace. 2. Get all the goldbricks off disability and Workman's Comp. 3. Make alcohol and tobacco illegal. 4. National Health Care with co-payment dependent on patient's financial status and medical necessity. In my state (Florida) we get what we call "family plans" - whole families on Medicaid with the COMMON COLD coming to the emergency department and using it basically as a walk-in clinic. The emergency department is one of the most expensive places anywhere to provide care. They have no co-pay and Medicaid pays for all their prescriptions. This should be outlawed.	FL	2/15/2006 6:08:23 PM
My experience was with socialized medicine in England. I saw a man with an aortic aneurism have his surgery cancelled seven times in as many months--because there were no beds. His family could not even buy him a place. He could have died at any minute. He got his Minister of Parliament to pull strings and get him a bed, hours away from his home. This is the meaning of government medicine: an aristocracy of pull. This is what people want in America? This is what is coming.	OH	2/20/2006 11:38:12 AM

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Response	State	Date/time received
A few years back I was diagnosed as having a rare blood cancer. My physician put me in the hospital for the first round of medication incase there were any side effects. The therapy reguired the nurse to make regular checks on me as they gradually increased the rate of the intravenous medication. What should have taken about 4 hours but because of the typical short staffing that goes on in our area it took over 10 hours and would have taken longer had I not gotten involved. You see, I am a nurse. What eneded up happening was the nurse left her recording sheet & blood pressure machine in my room. I began to take and record my vital signs and then increase the rate of the drug. The nurse would pop in every few hours to see how I was doing. As bizarre as this may sound it is not unusual for patients therapies to delayed or dragged out due to the lack of staff. In many cases this effects the efficacy of the therapy. As a nursing instructor today I wish I could tell you it is getting better. Unfortunately it is not. As a nursing instructor in the hospital setting I see it all the time.	FL	5/3/2006 9:35:24 AM
I go to whoever treats my condition or problem - ask questions and figure out what to do - pay the bill or maybe get some of it covered by insurance and get on with it. If it doesn't work I try another avenue. Medicine is not an exact science and those who think we can treat everyone the same and get the same results are in for a big surprise. I have had good care or treatment wherever I have been. I will go wherever I want for health care whenever I want - get it?	CO	6/6/2006 10:33:52 PM
I was not concerned with illness before I came here from Europe in 1954. During my hospitalization in Bremen, Germany, my expense amounted to nothing. Even when I switched jobs or became temporarily unemployed, my health care continued uninterrupted. I joined the USAF just 4 months after my immigration. A short time later I fell sick and went to a hospital with a temp of 104, not exactly an enviable state for an adult. The hospital denied me treatment or some recommendation, because no "financial responsibility" was established. This brings the VP of a large Chicago-based company to my mind. While travelling in Europe, as he usually did, he required emergency surgery for an appendix. The Dutch hospital handled it without charge to him. Why can smaller, poorer western countries do what our rich capitalist system refuses to do?	OR	6/13/2006 3:28:00 PM
I have an older brother who currently does not have health care and is unable to afford the Cobra benefit. He has not been able to get steady employment for sometime and, along with that, he has not subsequently been able to get consistent medical care. A few years back, he was unable to afford medications and, due to existing health problems, he lost the entire vision in one of his eyes. If he had been able to see a physician, secure ongoing treatment for his diabetes, and get his medications, he may not have ended up blind in one eye. Now, to this date, he still does not have consistent health care or prescription access. He has not yet reached the age of 50 so what will happen down the road? We need to ensure that everyone has access to consistent and decent medical care. It is a human 'right' to have health care access and not a privilege for the few.	MA	7/4/2006 1:14:28 PM

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	Response	**State**	**Date/time received**
	My thoughts are simple and succinct. Preventive care is too often not covered. Instead, the plan is to wait for something major to happen, and that is covered. For example, accupuncture helps my wrists. My plan does not cover it. Their solution? Carpal tunnel surgery. No thanks.	CA	8/23/2006 10:40:26 AM
	After 13 years, I was laid off from my job due to company cutbacks. I was forced to go on assistance which was barely enough to cover living expenses. I could not afford COBRA so my health insurance expired. Sure enough, I got appendicitis at that time, requiring surgery. After the surgery and a ONE day stay at the hospital, I had amassed a $12,000 bill. If it hadn't been for family help, I would have had to declare bankruptcy. I now have a job I hate but need to stay at because of great health benefits. What happened to our system and country? Something has to change!	WA	6/9/2006 12:31:52 AM
	Thank God we are insured now; but this didn't come easy by any long shot. I use to be employed by somebody, tried to get me on, had problems. First, I had, wife didn't due to pre-existing conditons. I quit job, later came back, company that previously insured me refused me too, due to pre-existing conditions, and I did no doctoring while I was gone. p. My wife became insured by medicaid, but I had to watch what I earned, less than $100/month from maximum. Occured I had to get onto large employers that had large group insurance. In June 1996 went to work for an employer that had such insurance packages as fringe benefits. But I have failed to make their initial probation. So I lost old job and new job. p. Finally, took job, where I am now working October 1997. But place downsized several times, so far, survived it. But could be next downsize from losing insurance. p. Since 1991 wrote to US senators and Congress Men about need for healthcare reforms. In last 2.5 years I have been writing songs in concern for healthcare crisis, 2 of them about people who died because lacking insurance failed to obtain proper medical attention. p. Through my years at my present employer the value of my insurance package has decreased, I have to pay higher part of the premium, meet higher deductables, and copays. Medication was $10/filling unless the medication costed less than $10. Now, we have to pay 40% of the cost of the medications. I have even put off buying medications because of it. p. The answer is clearly, The Single-Payer. My old friend Martin said, "Of all the forms of inequality injustice in healthcare is the most shocking and inhumane."	NE	3/18/2006 2:22:14 PM
	I have a hidden disability. It requires the services of a Helper Dog. My husband (has diabetes & asthma) and I both live on my SS check and $86.00 of Food Support. There is no other reliable income. By the time we pay the rent, phone & electric there is not enough to supplement our food budget and feed and care for my dog. I believe that if a Service Animal is needed, as a medical necessity, at least the regular vet costs should be included as part of health care costs. I would also like to propose that we go back to the concept of letting the actual doctors suggest treatment and have the insurance companies pay for the appropriate treatments/medications a person needs. The doctors are the ones that go to school and have the training required to diagnose and perscribe treatments. What medical shcool did the insurance agents/processors go to? I also am a Massage Therapist (starting a new practice on my own), and would very much like to recommend that alternative, preventive/supportive care be included in any national health care program. From aromatherapy to massage, chiropractic, to Essenital Oil treatments byond aromatherapy, accupuncture and reflexology, and any others I left out, these all support wellness. There has been significant research conducted that tells us the value and benefits of massage. The therapeutic effects of massage are recognized by personal and clinical experience, and supported by scientific research. They include: general relaxation; improved circulation; muscle relaxation; alleviation of certain kinds of muscular pain; improvement of cellular nutrition; relief fromt he negative effects of stress; and reduction of anxiety. Therapeutic massage recieved regularly helps work out chronic muscular tension. Massage melts away a certain amount of tension in	MN	7/19/2006 5:34:49 PM

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	Response	**State**	**Date/time received**
	each session, and if recieved regularly, keeps tension from building back up again. It helps you identify and correct patterns of holding tension. You can learn to relax and let go of tension you may not have been aware of. Many of today's major health problems are caused by chronic stress and conditions of modern living and working. Prolonged mental and emotional stress may lead to tension headache, backache, ulcers, colitis, blood sugar irregularities, high blood pressure, and heart disease. Too much stress has also been proven to impair the immune system leaving us vulnerable to many diseases, and inhibiting recovery as well. Driving or riding in daily commutes, and sitting for long periods of time at workstations tax the body. The repetitive movements required in certain occupations, for example, with some office work (e.g., computer data input, filing and sorting), physical labor (e.g., carpentry, gardening), playing musical instruments (e.g., violin, guitar) and sports (e.g., tennis, golf) can lead to chronic muscle tension, dysfunction and pain. Muscles shorten with chronic tension. This may lead to loss of flexibility in joints, misalignment and poor posture. Circulation in tense muscles is decreased causing ischemia and pain. Trigger points are commong with chronic tension and the pain-spasm-pain cycle may set in. Lets call it the National Wellness Program. Also, if we are going to a national system, I would like to suggest that only U.S. citizens and legal aliens be able to avail themselves of the services. I don't want to be denied care because my tax dollars pay for health care for people that are breaking the law. Another question comes to mind, as a sole proprietor business owner, I am unable to afford health insurance other than my medicare. I think insurance premiums need to come back down to earth so individuals that need it, are able to get in without losing their food/housing. Would this proposed system address this issue, and if not, why not.		
	I have been a union worker for 23 years and have been very fourtunate for the most part, but in the last 3 years or so the rise in health care costs have taken its toll on our members and there families. Since that time we have paid close attention to what has been affecting our health care coverage in this country. It seems to me that the more these big time corporations go on not giving health care coverage to there workers the more of a burden it is on the middle class working families. When is everyone in this country going to realize, that the reason they pay so much to keep there families covered is because they are also paying for the workers who are not covered by companies like Wal-Mart. I do not shop in Wal-Mart and niether does any family members, because we know that companies like Wal-Mart is the reason why american families cant get affodable health care coverage, and that is unexcetable in the richest country in the world. Shame on Wal-Mart and shame on our goverment for allowing the likes of Wal-Mart for dictating the rise in health care costs. Working people in this country need to understand that for every Wal-Mart worker that is not covered it just another worker that needs help from its goverment. When they need help from there goverment, who pays the bills? The working people in this country pay that bills and thats why we have such high health care costs in this country.	NY	2/16/2006 4:46:16 PM

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Response	State	Date/time received
1) Paying $650 a month to cover my family (3) with large deductible to allow me to see the Dr. or specialist I choose is obscene. My alternative is an HMO for profit substandard health care. 3) I broke my leg several years ago. I chose the surgeon that I knew was my best bet for recovery. The hospital charged over $40,000 for my surgery and two days in the hospital. The costs of this one event was absolutely obscene at over $40,000. The insurance company was able to reduce the costs over 50%. This means the hospital was charging 100% over "resonable" costs. I however had to pay full price for my 15% deductible. How can americans with and without insurance negotiate with hospitals to also reduce their costs 50% to reasonable prices? This is a root problem that requires government regulation open hospital books and yearly audits of both hospitals and insurance companies to fix.	CO	2/18/2006 11:47:44 AM
I am disappointed that those with diabetes have a very difficult time finding adequate, affordable, and available health insurance coverage. Insurance companies as well as state governments as well as the Federal government should be working on ways to make assistance available to those with diabetes who are uninsured or underinsured.	OH	4/26/2006 9:39:34 PM
I am blessed with health care insurance that pays most of what Medicare doesn't cover. I receive this as part of the pension benefits of my deceased husband. Most employers no longer offer pensions or health care to retirees. This is a big problem for my aging friends. I also have many friends who have very low paying jobs at which they work long hours in poor conditions which increases their need for health care but they do not receive health care benefits and while there is CHIP coverage for their children there is no coverage for themselves so they go without and get less and less able to do the work. I also experience wasteful "behavior" on the part of my health insurer. Instead of combining reports, I will get six or seven reports in the same day, each in a separate envelope with a separate first class stamp. They also require me to get a letter from a state Medicare processer that says that Medicare does not cover a certain treatment, even though that is clearly stated in the Medicare handbook. This wastes my time and the time of Medicare staff. Health insurance agencies are wasteful and inefficient. Because of this, I think insurance providers should be eliminated, and payment for health care should be provided directly to the doctors or hospitals by a newly created government funded medical agency. We need health care, not insurance. Delete insurance from any new plan. Give us access to treatment by all the doctors and hospitals who are providing service now. Where service is not available, e.g. inner cities and rural areas, make sure service is available there. Subsidize medical education so doctors don't have to charge such high prices to make their education loan payments and liability insurance payments. The money for all this will be there if we quit involvement in wars in Iraq and military aid elsewhere, discontinue the nuclear weapons program totally since any use of nuclear weapons will eventually cause fall out here in the US -- the wind carries it and we cannot control the wind, and quit tax cuts for the rich who enjoy many more benefits living in this country than the poor and can afford to pay for them. I am affluent, but I am not greedy. I do not want to get richer at the expense of	OH	4/23/2006 6:07:46 PM

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	Response	**State**	**Date/time received**
	those who can barely make ends meet. These young mothers have to move into subsidized housing (where crime and drugs are rampant) paid for by taxpayers because their employers do not pay them a living wage. This subsidizes the employers but of course in the political climate of these times that is considered just fine, but benefits for these hardworking low-paid employees are considered wasteful and are cut by Congress.		
	When I read the present statistics on the uninsured, I realize that I am a verteran of the non-insured status. Although well educated with an MSW degree in Social Work, I have always tended to work in positions where there was no health insurance due to my part-time status (even 36 hrs. per week) or where health insurance was too high for me to afford and still pay for necessities for myself and four children. Thank heaven that things have changed since I brought my uninsured kids up during the 1970' and early 1980's. Now Wisocnsin where I live, has Badger Care for children of lower income wage earners which definitely would have been me at the time. Now, however, after going on to school and doing many training events, I have a small private practice that could support me well, except i cannot at age 63 afford health insurance on my own. And so I work endless hours at two jobs, one is my heart job, my own practice and the other is at a hospital which is fast paced and demanding, but which I must keep, although I have no free time to speak of, simply to have insurance coverage. Why is insurance coverage tied in with employment?????? This occurred in the fifties and sixties and is really a bad idea. Why as a private small business owner couldn't I just buy into affordable health insurance?????? Because i live in a state which has extended health insurance to most children who would not otherwise be covered, I have hopes that this state health insurance for families with children will soon extend to others, small business folk, entrepreneurs, farmers, the hard working self-employed who don't earn a whole lot of money. Let's free up this woe-begone economy by offering creative persons who are out on their own, a chance to get good and affordable health insurance. Let's make this happen today! Not ten years from now. Having persons from more moderate incomes, say $25,000 to $50,000 who are in their own businesses buy into something like Badger Care here in Wisconsin and pay some kind of income based premiums or co-pays would build up the state health insurance system which is now only for the poor with children. Let's bolster the State insurance system and get more money into the system while helping small business owners, the self-employed and entrepreneurs> This would allow people to leave jobs they are keeping mainly to have insurance. This would end having many persons who are older but not of "medicare age" from falling through the juge cracks.	WI	6/9/2006 8:26:33 PM

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I work in a nursing home and have 2 young children, thus I have experience in the HC system on these extremem ends as well as for myself. I feel I am a good consumer and a bit better informed because I am a nurse, however I feel a lot more can and should be done to make the system more user-friendly. Firstly, I am pro-nationalized HC. If there was one designated provider who would insure all citizens regardless of pre-exsisting conditions or income, then there would be no one w/o insurance. Such a system would also cut down on a lot of waste as well as overhead cost in that with a single provider there would only need to be one set of paperwork for everyone to use (insurance claims forms) and one set of rules to follow. Right now, there are some many companies that even the providers have to use palm pilots with access to the insurance companies to know what is covered to what extent and if pre-authorization is needed, etc. This delays neccessary treatments at times and is ineffective in general. A final consideration on this point is that any provider could also take fee for service...i.e. work outside the national insurance plan and receive private payment. I know in England and Canada people worry about disincentive for expensive, elective, high technology, or otherwise non-covered services, but this can be avoided with either a 20 / 80% out of pocket coverage system or a patient pays all. A second thought I have is a better focus on prevention, especially in terms of education, diet, and exercise. Citizens need easy, quick, and understandable information about their health. I personally hate all the drug adds on TV's and billboards...I hate the "pop a pill" mentality. I wish we could take a more "back to the basics" approach and teach people how to incorparate little changes in their life to make big difference. Start young! We have to use the schools to teach kids to be better consummers in all areas including healthcare (nutrition, exercise, and the rest too). But we have to do it the way they learn best which is by leadership and example... we have to take soda and fast food out of schools and replace these with healthier alternatives. We have to make gym class manadatory through all grade levels including college. Parents have to be encouraged to serve as role models and should be offered exercise options through their employer or through the national HC plan. Organic farmers should be supplemented so the costs of their products goes down. These are what I can think of of the top of my head, but it is enough to convey my thoughts. Perhaps also making it clear what HC costs would make a difference. I believe I read that we are the #1 spender on HC in the world but that of the developed countries (25 listed) our citizens ranked satisfation outside the top 10. This mismatch says a lot.	OH	6/26/2006 8:25:54 AM
I went without insurance for several years as a young adult. I waited tables and attended college. Then as a young mother, I paid outrageous sums to obtain private "catastrophic" insurance for my son and me. The situation has to change in America. My belief is that we can siphon off just a tiny portion of the UNBELIEVABLY, IRRESPONSIBLY HUGE allocation for the Department of "Defense" and thereby pay for every single American's basic health insurance. It's NOT BRAIN SURGERY to figure this out.	SC	5/21/2006 10:35:15 PM
â€œWhy I need to pay a co-pay? On SSI why the pharmaceutical companies charge up and raise rates for you. Why can I be refused if I donâ€™t have money for meds? I go hungry because I pay co-pays on SSI that are $30.00, that is my food money.â€	PA	5/25/2006 11:58:57 AM

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Response	State	Date/time received
I've tried for many years to find out my specific "problem." Dr's have told me they can't find anything, don't want to listen. It's only by attending workshops on ADD, doing a lot of research on ADD/ADHD, snoring/sleep apnea, weight gain, extreme sensitivities, tinnitus, menopause, depression, & many other things that most of these actually STEM from snoring & sleep apnea, & that there are things I can do, such as tongue exercises, & restricting caffiene, wheat & highly processed foods, & eating fresh orgai=nic things that I can make a difference in my own life.... Doctors care, but are EXTREMELY ill equipped to handle complexities of reallife. They think " Patient - pill, patient - pill, patient, surgery & pill." Wholistic approach is THE way, help us pay for it instead of creating laws that allow only "acceptable" pills (drugs)	CA	2/15/2006 8:40:36 PM
PHENOMINAL prices are charged for surgery & hospital stays. $35,00 for pneumonia, more for a new hip.	CA	8/28/2006 4:47:03 PM
We don't need government run health care!!!! We do need government regulated health care insurance. For example. When insurance companies issue policies, government should regulate the language and the explanations given. Insurance companies should not be able to have endless exclusions, ifs, ands, and buts in the polciies which virtually grant them authority to exempt whatever they please by the complexity of the policy language. The push to have universal health insurance is a failed socialist idea and countries that have universal coverage dod not have gross national products that are vibrant. The cost of government run health care become a burden. What we do need is standard policy language that is regulated so that the consumer will know what he or she is buying. For example, The government should force an insurance company to disclose the following: 1) whether the person has bought a policy that allows them to see any kind of doctor, a select group, or an ultra select group. The government should force an insurance company to disclose how the select doctors are paid whether by capitation, fee for service or discounted fee for service, global, or other fee arrangement and how this may affect the doctor's decision. The government should force an insurance company to not interfere with the doctor-patient relationship through its phony or unacceptable reimbursement policies. The government should not obligate people to buy health insurance. Some people are simply healthy enough that they lead their whole lives without needing doctors or the cost of the insurance. The government should foster a group rate for everybody so that insurances cannot cancel for frivolous reasons and cannot deny people coverage. Any Plan that has more than a thousand subscribers cannot deny a person a policy. The government should set ground rules for the sale of health insurance but it should not run health care or health care coverage. We all know that we have doctors refusing to cover people on Medicare, Medicaid and other government programs because they are sick and tired of their ivory tower evaluation of reimbursement and dollar amounts to be paid. It's as communistic as anything I've seen. The government should be a facilitator or equal access to health care, but should not pay for it, tax for it or run it. Thanks	UT	8/18/2006 2:50:37 PM

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Response	State	Date/time received
***, UT		
I became an insulin-dependent diabetic when I was 21. A few years later, while I was working part-time for the state government, going to school and didn't qualify for group insurance, it became necessary for me to get private insurance coverage. Sure, there was a law in place that no insurance company could turn me down on the account of my being diabetic. But there was no law saying how much they could charge me for it. I was paying over $800 a month for insurance - more than I made working. That's insane. The reality is that there are millions of Americans out there who simply cannot afford health insurance. As the cost of health care continues to rise, employees working for my state government are being asked to cover more and more of it themselves through higher co-pays and premiums. But at least we have an option for coverage. So many people have no such option. A few years ago, I was in a very bad car accident. Afterwards, I was in a lot of pain that made it very difficult for me to do my job. I was seeing a lot of doctors for treatment at the same time, on my insurance plan. My boss suggested I go on long-term disability, which was really the right thing for me to do at that point in order to heal. The problem was, if I did that, my salary would have gone down to 60% of what I was used to, and as I was only a part-time employee, basically my whole salary would have gone to paying for my insurance and medical bills. I wouldn't be able to live with that wage cut and so I was forced to continue working. It's now been 2.5 years since the accident and the pain that the doctors said would heal never has - it's a chronic situation that requires constant attention, office visits, and prescription meds. I still feel if I had had the ability to take off work and heal instead of continuing to work and exacerbate the problem, I wouldn't be in this predicament now. And that says nothing about the quality of life aspect of the past few years or how many thousands of dollars of healthcare I've needed that I might not have had I been able to afford my insurance while on long-term disability. The United States needs universal health care coverage for all its citizens. Please do something about this for the good of all our citizens.	AZ	8/25/2006 7:19:39 PM

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	"If only" are frequently the "regrets-words" of a whiner: I'm not whining--I'm worried! I own my home, have no credit card burden, have a "healthy" IRA and have saved for retirement--"too much" to have current eligibility for medicaid, and I am "too young" for Medicare. To sleep a bit better, even if I think of using all of my savings as a health savings account in lieu of medical coverage, I can't begin to pay for a heart attack or surgery! Yikes--"If only" I believe I did "the right thing at the right time," paid my bills, stayed blessedly healthy, and yet now I'm at the highest risk--with no rewards for good behavior. "If only" a court of "financial justice" to equal Wall Street incentives would motivate Wall Street and our collective healthcare, energy exectuives,church hierarchies and corporate and legislative leadership to do the "right thing at the right time"--as often as we know they whatever is in "the party's" or "the company's" best interests. No "party" around my house when medical trauma happens and the "company" is EMT's earning so much less than the healthcare systems executives who employ. There are cost/benefit ratios for all of us--it's the economics of a reponsibile culture. I would "barter" time and talents to a hospital or clinic in order to be "paid" for coverage; I would pay a membership fee to a health consortium--however I join millions of others who cannot balance my budget to accomodate $650 a month for coverage. I'm not extravagent, I work Part Time tutoring, I don't even compare myself to 40 year old healthcare workers' needs for themselves and their children. It doesn't have to be all or nothing but I do believe we could do SOMETHING Maybe we who are educated, responsible citizens should start a healthcare revolution by dumping band-aids into the Potomic or Viagra into the Monument's reflecting pool--Hooray for MA initiatives. Thanks for doing SOMETHING!!!	NC	5/15/2006 2:02:28 PM
	I am a transgendered woman, and as you are probably aware of, the 'gender reassignment surgery' is available only to those who can pay out-of-pocket. In my state (New York), Medicaid regulations specifically exclude any care related to gender identity disphoria. As transgendered people face overwhelming, legally sanctioned discrimination, this lack of health care pushes us to the margins of society, where our murder rate is 16 times the national average, and four times that of African-Americal males of the ages 16-30. It is well known that a Washington DC EMT team laughed as a transgendered person bled to death. My own safety is constantly threated by the risk of someonefinding out about my 'genital status' and reacting violently. I have been sexually assualted by police due to my transgendered condition, denied housing, and a host of other indignities, all due to the 'status' of my gentitals.' As it stands now, I will probably die without ever having my medical conditio rectified, and I will likely die much sooner than the average American. All because, among other sources of discrimination, the medical establishment maintains serious barriers to my accessing what amounts to a life-saving surgey.	NY	5/15/2006 12:46:46 AM
	My father was in the hospital recently. The most frustrating thing to me, was-besides the poor and unsafe staffing conditions in the hospital-was that the hospital owned his doctors practice, so he would only refer within that group of physicians that are also owned by the hospital. Whether they were the best in their field at that hospital or not.	KS	2/22/2006 12:03:34 AM

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	When I retired in May 2001 at the age of 42, I left behind a wonderful benefits package that included health insurance that worked. My children and I were added to my husbands plan which provided adequate coverage. Our problems began immediately. Every time I showed up for a medical appointment,I was told I did not have insurance. My husbands benefits department showed that we did and continued to deduct his premiums. Due to administrative problems between the insurance company and my husbands employer, this continued the entire time he worked there. When my husband changed jobs in November 2002, we were to be covered in 90 days. Just 7 days before that, I had to have emergency gall bladder surgery. I HAD NO INSURANCE. With this new employer, our premiums started out at $350 a month in March of 2002. They increased every 3 to 6 months until the total for my husand, myself and 1 child was $1,250.00 a month in June 2005. At that time, we had to cancel the coverage for me and my son. The clinic we used while covered does offer a small cash discount to patients without coverage. But it is impossible to find out how much it will cost until after the appointment. I have been going only when forced to get my blood pressure medication prescription refilled (prescriptions are another horror story). My husband works hard and makes what we thought was a decent income. But there is not enough to cover the insurance premiums; or the medical expenses since we do not have health insurance. I think all employers and individuals should be able to purchase health insurance at the same price. Our current situation is primarily due to the fact that my husband works for a very small company. Since I worked for a major organization, we have experience on both sides. It doesn't make sense that one company can provide great coverage at one price, while another can barely get coverage for their employees and when they do - the price is so high no one can afford to buy it. When is this going to stop?	TX	5/2/2006 10:39:23 AM
	I have had mostly decent doctors and mostly quality care, but have seen costs going up every year by an alarming rate, and a reduction in my benefits, leading to less preventative care. Bental health benefits have also been more difficult to come by, despite them being as necessary as other medical care. Something must be done to fix our broken system; insurance costs too much and provides too little to too few people. This is a disaster waiting to happen and the lack of preventative care leads to a need for more expensive emergency care. The U.S. is one of the few modern nations not to provide its citizens with national health care.	CA	6/19/2006 5:52:45 PM
	Employer funded health care benefits 85/15 co-shared with the employee. I don`t support socialized medicine.  I don`t suport all doctors being entitled to be millionairs!	MD	2/16/2006 1:03:06 PM

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	Response	**State**	**Date/time received**
	I am a self employed small business owner with no health coverage. I go to a local community clinic for my preventative care but have no coverage for emergencies. Currently my husband needs follow up work for an abnormal blood test but we cannot afford it. He doesn't even want the follow up work done since if anything is wrong we cannot afford the care he would need. A couple of years ago we did have health coverage because my husband had taken a night job to supplement our income. During that time we each had an emergency room visit. We had to take out a loan to pay the out of pocket expenses. We each had about a $500 balance that our insurance didn't cover.	WA	7/31/2006 12:44:09 PM
	I am disabled with Chronic Fatigue and Multiple Chemical Sensitivity. I have severe sometimes life-threatening reactions to the chemicals in many personal care products, laundry products and their residue on people's clothing, cleaning products, and pesticide , herbicide, fungicide residues. I have not been able to find any health care facility covered by my health insurance through the AHCCCS program in Arizona I can tolerate. I know in an emergency if I go to a hospital I could die because of what I am exposed to there.	AZ	2/19/2006 5:59:39 PM
	I recently became employed at a charter school as the school nurse. This enabled me to have full coverage for myself,my husband and my youngest son,a ful time college student. My coverage is comprehensive,there are no deductibles and my co-pays are only $0,415 for a specialist. This is wonderful and results in a considerable savings but itdisturbs me that I have access to this care simply bt virtue of the fact that the teacher's union was able to negotiate for these benefits for public school employees,while other,extremely hard-working and productive people are unable to be offered even basic care that is affordable. This includes my two older children,who were cut off from my husband's health insurance while they were still full time college students. They each attended college full time and also each worked close to 40 hours a week but did not have access to basic services,such as physicals and pap tests for my daughter.These preventative services often prevent future serious illnesses. Most young people I know between the ages of 18 and 25 don't have health insurance,althought the majority of them that I know have a strong work ethic and are paying taxes to support older citizens on Medicare and the poor and uninsured. I do not resent that I or my children pay taxes to support these populations. I simply believe that they should have access to the same services at an affordable price. I am a registered nurse who works in the inner city and I also believe it's unconsionable that many poor people are working two and three jobs and still cannot afford health insurance yet are considered to make to much to qualify for publicly funded health insurance. I believe the insurance industry and the pharmaceutical industry in the United States exploits all of us in order to make what I consider to be obscene profits.	NJ	4/7/2006 3:38:26 PM
	I worked for a fortune 500 company as a full time employee until I had a baby. I didn't fully realize how lucky I was. I manueverd myself into a part-time position after my childs birth and I was job eliminated within a year. I believe that I was specifically targeted for the elimination because I'd had to use short-term disability more than once because of medical issues and because of my expendable part-time status. That was when the nightmare started. No one offered benefits to part-time employees I realized as I began looking for a new job. I'm married but my husband works in the auto industry in a locally based shop and the healthcare benefits the provide for a family are at astrononmically high monthly rates, around $600.00 or more a month. We could not afford those costs and still allow me to work part time to avoid putting my daughter into daycare. Finally I found a part time job with no benefits and had to settle on buying an individual health care plan. It was far cheaper than the insurance offered by my husbads job but still the expense of which is the primary reason that I have to work outside the home at all. Every year the premuims go higher and higher and I'm still making the same amount of money. Each year I have to drop our coverage level down to keep it within our price range. The means all the co-pays and deductables go up as well. So far we have been very lucky to not have any major health problems arrive but it	IN	6/22/2006 2:37:56 AM

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	is like living in a house of cards. One serious illness would paralyze us and that is with both parents working and having insurance. If I were to become ill and be unable to work than I would have to drop my insurance. I have no disability benefits or sick time at work since I am part time employee. I have not had a second child because that would mean yet another monthly premium. I have watched health care problems paralyze so many people that I know. My dad is diabetic and while insured the frequent hospitalizations and deductables for these stays are being put on credit cards until they are maxed out and at some point the next illness will send them into bankruptcy. My sister is a single mother who works as a bartender to support her daughter and has no health insurance. She has been forced many times over to wait until her illnesses are so severe that she ends up at the emergency room. She can't pay the bills when they come and she too will probably be facing bankruptcy. When she does go to a doctor, she often can't afford to fill the prescriptions that she is given, unless the doctor has a sample of a product that he can give to her. This can not go on any longer. All people in this country should have access to healthcare. People shouldn't wait for treatment until they are deathly ill to seek medical attention because they are afraid of the costs. Nearly everyday I sit and try to figure out a way to make healcare coverage work for my family. Coverage that I can afford and that will always be there, coverage that doesn't sky rocket in cost every single year while my income stays the same. There are an awful lot of days anymore that I genuinely wish that I'd been born a Canadian instead of an American and that's sad.		
	I worked in a county public health system for 14 years and now work in a private Medicare Advantage Plan. It appears to me that those individual in the middle class-from lower middle to upper middle are finding themselves in a rather lareg crunch with the cost of all aspects of health from co-pays for doctors to prescriptions. One of the largest issues has to do with Medicare Part D. Anyone who is is Medicare and takes approx. 5 to 6 brand name medications will be in the coverage gap sometime in May, June, July, and most commonly prescribed medications are not costly enough to push most people into the catastrophic category so that they will be paying $500 to %600 pr. month for approximately 4,5,6 months per year for medications. In 2007, the cost will even be higher and on fixed incomes this is pretty outrageous.	AZ	8/13/2006 2:17:05 PM
	My 79 year old father-in-law spent the last 10 months in several hospitals in Pennsylvania. He was a diabetic on pills and insulin and had had eye complications fomr diabetes. His doctors in Florida did not want to operate on his knee as they said his heart was not good enough. He and his wife moved to Pa and a doctor there Oked the surgery. That's when he had the first of 3-4 heart attacks, a quadruple by pass in between them , renal failure on dialysis and the amputation of both feet shortly after each other. Then he was intubated and they put mittens on his hands so that he couldn't pull the tube out. He finally died on the way to his 3rd or so hospital !	FL	3/22/2006 1:39:36 PM

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Response	State	Date/time received
I have young onset Parkinson's Disease. It was correctly diagnosed when I was 39. Prior to the diagnosis I attempted to get longterm disability insurance. All my medical records were requested by the potential insurers, a Physician had written in pencil Parkinson's ? on one record - boom, my application for LDI was thrown out. For two months last year I did not have health insurance.....a pill (Requip 3 mg) that my insurance company was charged $1.38 for - suddenly because $4.50 for me to pay for. Given that I take 6- 7 of these pills a day it was a frightening wake-up call. Late stage of Parkinson's Disease "Care" frightens the hell out of me.	MI	3/26/2006 5:45:43 PM
I have had chronic pain for 12 years, and know a lot of people in the same boat. It is very difficult to get adequate treatment due in large part to ignorance and fear of addiction on the part of the public AND health care professionals. My pain management specialists has me on so tight a leash that I am forced to miss some work every month to come to his office because he thinks (or says he thinks) that he needs to do this to protect his license, since he is prescribing narcotics. This monthly visit is an unnecessary expense and time from work, as it is just a nothing in terms of actual treatment. The state of pain treatment in this country is deplorable. I have many years of experience working with people with all types of chronic pain, and I know whereof I speak.	OH	5/10/2006 10:54:07 AM
I have been buying medical drugs from Canada for 8 years at tremendous savings to myself(for example, celebrex costs $132.00 for 90 in Canada, $290.00 in US from cheapest source). My drugs were seized at SeaTac Airport and confiscated. My name and address have been "flagged" by US customs. If I don't change my address, I can expect confiscation again. RX North in Canada sent me a free supply when I reported this to them. I have a Medicare RX plan that does nothing for me. It would be more expensive and have more hassles than Canada! Could you possibly tell me the names of committee members in the House who are taking up the issue of buying drugs from Canada before it goes to a vote?	WA	8/30/2006 1:55:34 PM
On December 24, 2005, my husband and I found out that our son, who was inutero, did not have any kidneys nor a bladder. Because I was six months pregnant and was advised that this condition had a 100% mortality rate as there was no blood flow to the lower half of his body, it was recommended by doctors that I was to be induced in order to avoid going septic when the baby passed inside of me. I informed my insurance company (which was TRICARE because my husband has been in the Airforce for 10 years) about the tragedy and the fact that I was going to be induced as soon as my doctor was ready. I was told it was not a problem and to call when I was on my way to the hospital. Ten days later, after sobbing through Christmas Eve, Christmas and New Year's, we were informed that we would be induced that day (January 3rd). We contacted Tricare on the way to the hospital and were told that everything would be taken care of and the representative wished me luck. After 22 hours of labor, by son, Stefan William Kokotajlo was stillborn. After the unbearable pain of losing my son, in the weeks that followed the induction, we started receiving medical bills for all services rendered to me during the hospital stay and the days surrounding the induction. When we contacted Tricare to advise them that they had made a mistake, they informed us that none of the services would be covered because they considered the induction to be an ABORTION! We were going through enough grief and were (and still are) expected to fight an insurance claim when we wanted nothing but a	NY	8/28/2006 5:17:35 PM

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	healthy baby!! Then we found out through Tricare's bylaws that even if a baby has no brain or the mother attempts to commit suicide, if the baby's life is terminated, it's still considered an abortion and therefore not covered! Tricare expected us to wait until my son was confirmed dead inside my womb (and risk me going septic), and THEN be induced. The question of fact seemed to be whether my son died BEFORE the induction or BECAUSE of the induction, which is impossible to gauge considering I did not feel any movement for over a day before we were induced and there were no life monitors on him our of respect for our emotional pain. My husband has served this country for ten years, and we have been told that we will not receive any help from (supposedly)the "Best" insurance company for America's soldiers. So before you decide to use Tricare's model or Tricare's input as a deciding factor in how to run the nation's healthcare, PLEASE remember my story and think of how you would feel in our situation, losing our first child and then being expected to pay for it all when we thought we did everything right. Please feel free to contact me at if you should need any further information. Thank you for your time. ~***		
	Recently my husband stepped away from his company to start his own practice. We knew that part of this process would be to apply privately for health insurance, which we did right away. Unfortunately we found out all too late that I am uninsurable since I have had skin cancer. I am only 31 years old and am in perfect health otherwise. We are now having to pay huge costs to Cobra his old policy for me, while also paying a large amount for health insurance for the kids and my husband. The high cost of this situation is putting financial strain on our family. I think it is ridiculous that so many people are uninsured in this country!!! It is ridiculous that such high costs and discrimination are taking place!!! I am in complete support of national healthcare to fix this situation.	AZ	8/11/2006 6:40:19 PM
	I have worked in the Health Care Industry since 1959, first as an RN and now as a PA.(Yes, I've been around awhile). I've seen the cost of a 30 day supply of oral contraceptives soar from $5.00 to $30.00 or more, while the need, especially among low income people remains acute. I have worked in public and private settings. To me the closed Panel HMO, with physicians, PAs, and NPs on salary is the best private system I have worked with. This similar system is seen in that operated by the USPHS for their Indian Health Service, by the VA, and by the military which cares for service members and their dependents. Sure there is some "rationing" based on level of need and budgetary considerations, but these systems seem to me to provide the highest quality of care to the greatest number of people at the lowest cost, even providing needed pharmaceuticals at reasonable rates. Some people, of course will never be satisfied with such a system. These, however, should be required to contribute to Universal Health Care and allowed to buy additional insurance for the Cadillac quality care they want (which would include transplants----I consider these heroic measures.) Essentially, this would be a 2 tier system. I think the nation would benefit by developing a healthier, more productive population, wherein people would be less likely to become disabled early. We could, then, remove the incentives to consider themselves "disabled", too,increasing productivity and reducing disability payments. After retiring from Government Service, I have worked intermittently in the private sector where I have been appalled at the number of people with serious, even life threatening conditions who had no health insurance, and thus no access to regular, preventive care or treatment. Many of these had insurance plans available, but had chosen not to enroll due to costliness (over $100/month per person) which would make it difficult to provide for their own and family members other needs. These are working people earning $20,000 to $40,000 per year,	TX	8/2/2006 9:43:53 AM

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Response	State	Date/time received
which sounds like a lot, but does not go far in today's world. If I can help with this project, please advise. I am limited in the expenses I can cover, though.		
CORPORATIONS ENGAGED IN OFF SHORE BUSINESS WITH REVENUES HIGHER THAN 25% OF THE COMPANY'S BOTTOM LINE SHOULD BE CHARGED A 'WIND FALL PROFIT' TAX INTO A NATION WIDE 'COMMON HEALTH' INSURANCE POOL.	AR	2/16/2006 9:24:20 PM
TO: Citizens Health Care Working Group www.citizenshealthcare.gov I have read your site and am giving you my comments as requested. I will very soon be age 54, and have always been and am still pretty healthy for my age, yet I will soon be totally priced out of health insurance. The industry has made a decent amount of money from me to date and yet when I need the insurance the most, I will have lost it, and that really pisses me off. My friends and I talk often now about our lifelong experiences with health care. We worry a lot about whatâ€™s coming because we see things constantly getting worse instead of better, and from our prospective, we do not see anyone addressing the REAL problem with the industry. The problems as we see it are mostly not with the system itself. The problem is with the PEOPLE working in the system. The vast majority of them are greedy, apathetic, mostly incompetent because of their automaton nature, or just downright stupid, and have no business in the business of taking care of anyone. It would seem that those in charge of trying to fix things are not much better, as they seem so concerned about being liked by everyone or just keeping their jobs, they donâ€™t get anything done. Now, if something serious or unpredictable happens to you, such as a car accident, heart attack, stroke, etc., you might fair OK, if you consider that at least they are good enough that you may not die from it. However, finding competent, reasonable care for most everything else is just a crap shoot. More specifically, I have found that the diagnostic part of health care from doctors now-a-days is so pathetic, that you are much better off studying the subject yourself, knowing your own body as best you can, and then just try to find a doctor that will order what you want done. Leaving it up to the doctor to decide on your condition and your care is a joke, and not very effective. An example is, many times I have seen a doctor for a follow up visit on an ongoing issue, only to have the doctor ask me some stupid question that he should have known better, because of inaccurate or incomplete notes he made from the previous visit. That is not surprising since most doctors have poor communication skills. Seldom do they even listen to or understand what YOU have told them, and even when they do, they are likely to not record it properly, and/or they may consider the patient too stupid to get it right or to understand whatâ€¯s happening to them, and so instead	CO	3/18/2006 6:32:37 PM

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they simply plug you into part of some average group, so as to make their job of treatment easier. In addition, they normally donâ€™t have enough common sense or guts to do anything other than remember some perhaps outdated notion or procedure they learned in medical school, prescribe what some biased drug company has recommended, or just do something the insurance company requires so they can get paid. For this they think they deserve to earn some ridicules amount of money? I donâ€™t think so!

People want to be healthy and of course donâ€˜t want to die, and they may not have the time or ability to research things themselves, so they trust the doctors instead, who take advantage. We are all paying for that, because now the doctors really donâ€˜t have to be good in order to make money. Of course the doctors wish to think they are just getting paid for their expertise,â€¦â€¦. yeah right! I just described their true level of expertise. The reality is, patients are getting ripped off, because they are paying thru the ass, getting mediocre or downright poor care, and the cost and so-called care continues because the doctor so seldom diagnoses and fixes it. I have also learned that if you try to be proactive and wise about your own care, you are simply labeled as difficult and/or uncooperative and may even be dropped by your doctor. It is obvious that doctors feel there are too many easy patients around to have to put up with that.

Something which I know less about, but also suspect as being wrought with extreme greed, are the medical equipment manufacturers. Having heard from time to time what is paid for certain equipment, I do not believe for a moment that it cost that kind of money to develop and make it. It would seem that doctors and hospitals are just being talked into ridiculous prices by good salespeople who are convincing them that it can all be passed along to the patients and insurance companies anyway, and so it is. I believe they are gouging everyone.

The fact that there is a big problem with medical errors does not surprise me one bit, because of the possibility of inaccurate records. I have a personal experience where I discovered that accuracy in your medical records is a joke also, and there is such a myriad of strict and sometimes ridicules laws about privacy, that you pay hell just to get copies of your own damn records. This idea that your medical records are the property of the providers rather than you is bullshit. Who the hell decided that was reasonable? In addition, I discovered that if you do find out that someone made an error, there is hardly a damn thing you can do to force them to correct it. What is up with that?

There is way too much greed and not enough truly dedicated people in the healthcare industry, and if it is not stopped somehow, anyone who has even just a few health care issues as they age, which will be almost everyone, will simply be sucked dry of anything and everything they have worked for and built up through their entire working life just to line the pockets of an industry which takes advantage of you any way they can, and considers they are just doing you a favor by keeping you alive.

In the past, whenever I heard or read about people in charge or people supposedly in-the-know talking about health care problems, it was nothing more than broad generalizations and buzz words that sound good but are useless in fixing anything. It seems they didnâ€™t want to hear about specific instances and individual problems, because looking at all of them is such a massive task. Thatâ€™s where you defeat the purpose, because thatâ€™s where you really see whatâ€™s happening. I sincerely hope that this is not just another one of those, and you can really make a difference.

Sincerely ***

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WHY NOT TAKE A HARD LOOK AT THE CANADIAN HEALTH INSURANCE AND CARE SYSTEM? SEE THE ARTICLE IN THE CURRENT ISSUE OF "HEALTH aFFAIRS" - "COMPARING HEALTH AND HEALTH CARE USE IN CANADA AND THE UNITED STATES". VOLUME 25, PP33-1142. MY LATE BROTHER-IN-LAW (PRESIDENT OF A CANADIAN BANK AND CERTAINLY NO "SOCIALIST") HIS WIFE AND MY SISTER ALL USED AND STILL USE AND SPEAK HIGHLY OF THE CANADIAN SYSTEM. WHT, ON EARTH, CAN THE UNITED STATES NOT USE THAT AS THE CANADIAN SYSTEM AS A MODEL? EVERYONE IS COVERED, DOCTORS PRACTICE INDEPENDENTLY AND HOSPITALS ARE COMMUNITY-BASED AND OPERATED. M.D. RETIRED ROCKEFELLER FOUNDATION AND DEPARTMENT OF HEALTH ORGANTIZATION, JOHNS HOPKINS UNIVERSITY.	VA	7/14/2006 8:36:25 AM
I am the international product manager for a mainline machinery company. I bring salesmen from all over the world to the US for training programs on our equipment. It has always been my fear that we might some day have some one get accidentally hurt and then what would we do? I had one of the owners of one of our dealers in Brazil attend one of our programs and he slipped and hit his elbow on one of the attachments to the machine. It was quite obvious that there was something wrong so I took him to the closest hospital (our proving grounds are in Arizona) to get this fixed. We waited 3 hours to get him admitted, after a good deal of wrangling about insurance etc because he did have a travelling insurance policy. We ended up calling Brazil twice and finally, we got him in the hospital. They took the X rays etc and it turned out that he had dislocated his elbow and that they were going to have to do some surgery to ensure that the elbow fit back together and the felt that there might be some bone chips that needed to be removed, but it was not major , major surgery. The next day, the surgery was done and he finally got on his way home after a couple more days. Then, the bills started to come....not that I didn't think there would be some charges, but the final total was in excess of $39,000...to cover 2 nites and 3 days in the hospital and the surgery. Frankly, I have never been so embarrassed in my life to think that someone would come to our country, visit the hospital and end up with a bill equivalent to more than median yearly salary of an American, for something that was far less than life threatening. My wife passed away in Japan and the total bill for all the care, hospital room etc for more than 3 weeks in the hospital was not even $30,000. I don't believe it is really worth it to bring people here any longer for there is always a chance that someone might get injured and it is impossible to get group insurance to cover a group like ours and to think that for relatively minor care would cost so much is just frightening, not only to me but to the people that come. This person told me that in Brazil, the same procedure would have cost $5,000 or so and please don't tell me that our health care is so much better...it is not. Our people have heard of this incident in this region and frankly, people are almost afraid to come. I have lived almost all my life living in different parts of the world. At the time of the Clinton proposal, I was living in Belgium and I was living under the Belgium health care system. At that time, I didn't think much of the system for it seemed expensive etc, but you ever worried about get care. The argument that letting the market determine the price of health care would keep the price down has proven to be untrue because health care now focuses on providing the most sophisticate health care possible while forgetting that most people want to be able receive care for the things that happen to them in the course of day or month or year, without	ND	6/8/2006 1:25:29 AM

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	Response	**State**	**Date/time received**
	having to take out a second morgage on their home to pay for it. The consumer in in healthcare has no power; you cannot vote with your checkbook for there is no competition. You cannot vote by walking out because, where would you go? My solution is that we cancel all insurance for 2 years....you better be sure that the cost of going to the doctor would drop dramatically, the care would improve, and the focus of health care would move from making sure that we can do the most intricate brain surgery to making sure that a baby born in our hospitals, goes home with his/her parents, which, if the statistic are right now, we don't do so good that those most basic needs of healthcare. If universal healthcare can provide a high level of day to day care without breaking the bank, let insurance handle catostrophic conditions like cancer etc, and provide quality health care that we as individuals can afford and the government won't go broke providing the mechanism to provide the same		
	My cousin's little boy (who just turned three years old) has been battling leukemia for over a year. My cousin has a very low income, and so they had to resort to Medicaid for his little boy's hospital care. It turns out that the hospital doesn't treat Medicaid patients well at all. They have discharged him from care despite high fevers, refused diagnostic testing (such as chest x-rays when he was in fact developing congestive heart failure), and kept him out of the ICU despite available beds. He actually arrested minutes after they finally conceded that he should be in ICU, and they nearly lost him. We need a system of universal care so that this sort of preferential treatment never takes place again. A three-year-old boy should never, ever have to suffer an appalling level of healthcare because of his parents' financial status. -- As a separate issue, my husband and I are self-employed. The most affordable individual health insurance plan that we could afford takes up almost 20% of our income, yet it has an incredibly high deductible, and covers virtually nothing until we've met the deductible. So we are essentially paying almost 20% of our fairly meager income for "disaster insurance" healthcare coverage - something to take care of a major, life-changing health event such as cancer or being run over by a bus. We're trying to live the "American Dream" of running our own business, and we're struggling to keep our heads above water. It would be nice for healthcare to be a standardized, universally available right, instead of a privilege for which one pays dearly. Again, I'm not wishing for a free handout - just for things to be a little bit easier. -- Thanks for letting me share these experiences. And thank you for working to make things better for all of us.	MN	6/8/2006 12:51:47 AM
	For the past year I have gone without health insurance because my company stopped offering it. I can not afford private insurance because I have been treated for asthma my whole life and the insurance companies hike up the rates for me. Thank god my family doctor understands this and tries to always give me samples of medication when I get sick plus a lower rate of his fee. It upsets me that I run a risk of getting really sick and not being able to afford to get better.	IN	6/12/2006 1:25:52 PM

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Alternative healthcare has worked well for our family. (acupuncture, herbs, homeopathy, naturopathy, chiropractic, engergy healing, etc.) We would not even consider seeking the vast majority of traditional allpathic treatments with their outrageously high costs. Nor are we interested in synthetic drugs with lists of side-effects long enough to choke a cow or in surgical treatments that line the pockets of docs and hospitals. BTW, my husband is an anesthesiologist. We have lived well off the poor choices people have made concerning their healthcare. He has tried to educate patients who have come in for repeated surgical procedures, but he has found that the great majority of people are not interested in taking responsibility for their health. What they want is to get healthcare as easily (and as cheaply) as one gets a burger at McDonald's drive-thru window. We believe the solution to the healthcare problem is individual responsibility. People need to live healthy lives and pay their own way if they choose not to do so. Also, heroics should be abandoned by the docs and hospitals.	CO	2/15/2006 7:48:02 PM
Person's with disabilities are often denied adequate health care due to no accessible features in a doctor's office or in the lab. The PWD is often blamed for the problem IE "if you don't cooperate and get on the xray table, we can't help you" to a person in a W/C and no ability to transfer independently. OR not being weighed when they can't stand on scales; OR a wound not being fully inspected when the patient can't move to position. These are all real stories.....	CA	2/28/2006 11:27:02 PM
This experience happened a number of years ago, but is a glaring example of the 'unfairness' of our medical practices on both the state and national level. It also is a glaring example of how people can come into this country illegally and literally be given everything on the proverbial 'silver platter' while American citizens can't get any help through the system. At the time our daughter was 19 years old. She was going to college part time and working part time. Therefore she wasn't eligible to be on our health ins plan nor did her employer offer any health ins. She was diagnosed with having a large cyst on one of her breast and surgery was highly recommended. When she told the doctor she didn't have any health ins he recommended she go apply for Medicaid. On the day of her appt with Medicaid she asked me to go with her for moral support. When we arrived at the Medicaid office the waiting room was FILLED with Hatian families, Hispanic families and various other families from Carribean Islands. All of the people had to have interpreters with them because they couldn't speak, read nor write a word of English. When it was finally my daughter's 'turn' she asked me to go back with her...the first question out of the 'conselor's' mouth was; 'Are you married?' Our daughter replied 'No'. The second question asked by the 'counselor' was "Are you pregnant?' Our daughter replied 'No'.And the third and last question asked by the 'counselor' was "Are you an American citizen?' Our daughter replied 'Yes'...Our daughter was then informed by the 'counselor' that she wasn't eligible for any kind of help!!!!!!!!!! Our daughter was willing to accept the rejection without anything being said. However, ole Mom here freaked out...I went off on the 'counselor' and told her that was rediculous! Our daughter was ineligible because whe wasn't pregnant or an illegal alien????? What kind of rediculous criteria was our government using???? She not only was a native Floridian but a direct descendant of a person born on the Mayflower!!!! Needless to say my ranting didn't get us anywhere! Something has to be done to protect the United States Citizens in this country!!!	FL	3/24/2006 8:40:30 AM

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	Response	**State**	**Date/time received**
	Thank goodness for Catholic Social Services. They are the people who paid for the entire procedure.		
	I am 60 years old. After a 30 year marriage and also working for 30 years of my life...I found myself divorced and then layed-off. I paid into COBRA ($500/mo) for a few months, then looked for other ins. I was denied by every insurance company for previous illnesses. In 2006, I experienced blood clots and a pulmonary embolism. I was rushed to emergency and had no insurance. I applied for disability because it is impossible for me to stand or sit for long periods of time, due to Edema and pain in my legs. I have been denied twice. I pray every day that I will die in my sleep because I cannot go to the Dr. or hospital if I need to.	UT	5/18/2006 10:47:43 AM
	I am a christian scientist we dont go to doctors or take meds, and my health is just fine. This is the answer to lower health care costs. Christian Scientists dont worry about health care costs. OUr religion works well for us. Just attend a christian science church any wednesday night and hear for your self/	CO	2/15/2006 5:57:25 PM

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	Response	**State**	**Date/time received**
	When I planned to retire from full time work, I found that I could not get individual insurance anywhere because I had a "pre-existing condition". I had a heart attack at age 53 with bypass surgery, and minimal medical expenses for 10 years since. My cardiologist sympathized. He told me he could not get insurance either since he had a small skin cancer spot that had been cured many years ago. Why don't the anti-discrimination laws apply to "pre-existing conditions"? Why do the health insurance companies insure only healthy people? They may be following the law, but is the law in the public interest, or theirs? A disqualifying medical event can happen to anyone. HIPAA is such a costly effort to keep medical information private, but it doesn't seem to count when it matters.	OH	4/29/2006 11:06:16 PM
	I am 58 years old with no medical insurance. While working on my home I fell off a step ladder injurying my elbow. After soaking my arm for a week with no improvement, I went to the hospital emergency room. Turns out the end of my arm that connects to the elbow was broken off. I required an artifical implant which was costly. The surgeon was companionate, he cut his bill to $1,500. The hospital was ruthless, their bill was over $20,000. Because I was uninsured they withheld the 50% discount normally given to the insurance companies. The administrator of the hospital threatend to sue me, what a crook. After months of attempting to negoiate I got extreamly irrated and told the administrator I'd pay $10,00 or he could go ahead and sue. He didn't even hesitate, took my offer without batting an eye. I put the bill on my credit card and am still paying and paying and paying. If you're uninsured consider the hospital will bill you list price, but there is a discount to be had, 50% is a nice even number. To be treated fairly you must go after hospital and get the discount you're entitled too. AND DON'T TAKE NO FOR AN ANSWER!!!!!	IN	6/12/2006 1:53:42 PM
	I have had a diffult time getting my insurance to pay for covered services. It seems like everytime I make a claim, regardless of how basic, they always deny it at least once. No seems to be their default position. And they refuse to pay for things like chiropractic or physical therapy, that could alleviate more costly care later. My doctor is so busy, I can barely get 5 minutes of her time when I schedule an office visit. I feel like I am making health care decisions without any real information or guidance.	KS	6/6/2006 6:09:53 AM
	I work in a nursing home with dual eligible residents. It is very difficult getting all of their medications approved. Why do they need prior approval for Namenda and Aricept when these drugs are to be used for dementia/alzheimers. We already have pharmacy consultants and federal survey guidelines to go by, why do we need another agency (insurance formulary) telling us what is right or wrong for our patients. It seems like we get it all set up, then we get a whole new batch of prior approvals that need to be done. By the time we get the information that it's only a short term supply or an appeal is needed, the deadline is usually passed. We have to deal with approximately 10 different insurance companies. When we had to just deal with Medicaid it was bad enough.	TX	6/13/2006 9:15:52 PM

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Response	State	Date/time received
I have been a RN (with a BSN) for 25 years and will have put in 40 years full time in the health care business, working in an ICU area in a hospital, by the time I reture. At that point, I will have NO health care benefits from my job. None. No prescription coverage, nothing other than Medicare. After serving the public in health care all this time, I will recieve no health care benefits. My siter, who is mentally disabled and on SSI, will have better benefits than myself. It is the working class who needs help in this matter: the very rich and the extremely poor will eventually be the only people who will be able to obtain or afford health care in this country.	MI	8/30/2006 10:58:53 AM
As a self-employed woman living with multiple sclerosis, affordable health coverage was impossible for me to obtain, much less afford. I had health coverage only because of my husband's job-related health benefits. When he was laid off in 1992, we had to pay high premiums to keep our coverage through COBRA. After COBRA ran out, we were able to convert to individual policies with Kaiser. However, at the time, individual Kaiser plans didn't include prescription drugs. Kaiser later added a prescription drug benefit for individuals, but because of my MS, I didn't qualify. Our out-of-pocket health-care expenses typically accounted for a very large portion of our income. I eventually went on Social Security Disability Income (SSDI). Getting SSDI was a very difficult and emotionally wrenching process. I had spent years trying to emphasize what I *could* do as a woman with MS, but in order to get the health care I needed, I had to emphasize instead what I *couldn't* do. (Most people are rejected at least once before qualifying for this program.) After starting to receive SSDI benefits, I had to wait two years to qualify for Medicare Part B coverage--which, once again, did *not* cover prescription drugs. And because I have MS, Medigap coverage wasn't an option for me. Since I take Avonex, a very expensive drug for MS, prescription drug coverage was a big issue. Fortunately, we were able to get some help from the Patient Assistance Program at Biogen, the company that makes Avonex, for the first year I was on the drug. Medicare later approved Part B coverage of Avonex (with coinsurance that some people wouldn't be able to afford). Meanwhile, my 17-year-old mobility scooter needed repair. Medicare refused to cover the repair on the grounds that I didn't need to use the scooter in my house. This ridiculous Medicare coverage rule is notorious among people with disabilities. It ignores the fact that without mobility aids like scooters and wheelchairs, many of us would be imprisoned in our homes. I fought the decision through the appeals process for a full year but was never even given the opportunity to challenge the rule. The only thing that was considered was whether Kaiser's/Medicare's denial of my claim had violated any contractual agreement between Kaiser and me or between Kaiser and Medicare. By that time, I learned that the parts needed to fix my scooter were no longer available, because the manufacturer had gone out of business. So I asked my neurologist to prescribe a new scooter. I expected to be turned down again, but apparently, my MS had progressed by then, and I was approved for a power wheelchair. This experience has reinforced my strong belief that the Medicare rule on coverage of power wheelchairs and scooters is wrong. For people with disabilities, the health-care system is about more than medical care. In many ways, it is a critically important bridge to our freedom and our civil rights. I was able to work for many years in large part because of the assistive technology and health-care services I received. Now that I am on disability, I continue to be involved with my family and my community thanks in large measure	CA	2/28/2006 9:21:45 PM

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	Response	**State**	**Date/time received**
	to the health care services available to me. I believe such health services should be available to all Americans who need them.		
	I would like to have access to nurse-practitioner care as a first-line contact with the healthcare system. My family has had wonderful experiences receiving safe, satisfying, cost-effective care from nurse-midwives and nurse-practitioners, and I cannot understand why some health plans do not cover these providers at all when the evidence is so strongly in favor of their use.	KY	3/9/2006 1:33:21 PM
	Iam a 43 year old woman married to a self employed businessman for 21 years. We had managed to purchase health insurance for a number of years. However, due to the economic situation in Michigan the past few years, the self employed have been hit very hard. We no longer are able to pay the monthly premium for health care. I am w/o insurance now and have high blood pressure. I can afford the monthly prescriptions necessary but that is all. If I needed to be seen by a specialist, I could not afford it. A hospital visit? Not even possible. Please work hard for those of us falling between. We work hard; help us find a solution for this health care crisis so many are facing today. Thank you.....	MI	8/27/2006 2:36:26 PM
	I was exposed to mold, mildew, pesticides, cleaning fluids for a 3 year period of time at the school where I taught. I developed fibromyalgia, multiple chemical sensitivities, chronic and sometimes acute hives, severe allergies(dust, pollen, mammals, medications, etc....). Indeed, I am allergic to my own blood serum. I am one big auto-immune mess. When submitted my 30 day notice and asked for a transfer to another school site, I received notification that the school district had accepted my "resignation". I had COBRA for a little more than a year while unemployed. I then got a job at a Charter school, that provided medical benefits. I have 2 Administrative Level Instructional Leader licenses(K-6 General Ed.and K-12 Special Ed.) a Master degree, etc...In spite of chronic illness, I did my job in an exemplary fashion(got excellent annual assessments). Our governor, in an effort to attract more new teachers in the field mandated teacher salaries raises for all 3 levels of licenses. However no mandate was made that the schools make any effort to attract or keep experienced, highly educated teachers. After 2 years at the Charter school, I got an an exemplary assessment, and was not re-hired for "no particular reason". This is an "at will" state, and this was legal. You see, with the signing of a contract for a 3rd year, I would have had tenure. They had to get rid of me because I would have cost the school over $50,000 a year when the new academic year began. It took me close to 20 years to make what a newbie fresh out of school makes now. So with my career gone, chronically ill, unemployed...Cobra coverage again. As of this writing, my coverage ends in less than 13 days. My attempts to find medical insurance have been terrifying. I get automatically turned down because I have fibromyalgia. My only option is the State Insurance pool. About $460 a month premium, and	NM	2/16/2006 12:03:08 AM

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	fairly high co-pays for doctor visits and Rx will cost me a fortune; I use 11 medications to manage my health. Most services under this plan do not count toward my deductible. I have exhausted my educational retirement money, and am now dealing with great anxiety, depression, and the possibility of selling my home. My mortgage is less than $500 a month. Can't even rent a one room studio for that amount. So, at what point do I sell my home and car so I can buy a van to live in? I can never teach again, anywhere. My references have said, and will continue to say that they would never rehire me. They do not have to say "Because she would cost too much". Such is my life. The reality of public schools, medical insurance, etc...it all bolls down to class war. Be a cheap worker bee, and maybe you can have a job, but health coverage.....God Bless America!		
	I am extremely fortunate. I have a good union job and my employer pays for all of my health care. However, just because I have generous health benefits doesn't mean the quality of healthcare is that great in the U.S. About 4 weeks ago, I got a terrible ear infection. I went to the urgent care as my doctor was not available. I was met by a somewhat disinterested doctor who told me that I had swimmer's ear. She placed an earwick in my left ear, drenched it with anti-biotics, gave me oral antibiotics and codeine and told me to keep the wick in for 48 hours. (I later found out that I was supposed to keep it in until it fell out.) The next night I removed it and the next day was in more pain than ever. I went to my own doctor who told me that because the ear canal was still open I didn't need another wick, just keep taking the antibiotics and using the drops. I kept taking the antibiotics and nothing helped. The next day, in tears, I went to a very competent and empathetic ENT. He put a wick back in my ear, again drenched it with antibiotics, ordered me to keep it in until it fell out, made sure I had enough pain killers and oral antibiotics and told me to go home and rest. In 2 days I was better. The point of this story is: it cost my insurance company 1 urgent care visit ($85.00), 1 doctor visit ($75.00) and 1 specialist visit plus follow-up ($285). The last two could have been avoided if the urgent care doc knew what she was doing. In addition to health care for all, we need to insure that all Americans receive QUALITY health care. It saves money and gets the patient back to their life as quickly as possible.	CA	7/27/2006 11:47:10 PM
	Unfortunately I have spent the greatest part of my adult life (15 years) without health insurance, so this issue is near and dear to my heart. I even was forced to file bankruptcy in 1997 due to some $25,000 in medical bills I had accumulated without health insurance because I could not pay them. These bills were from one hospitalization alone. I can assure you that most of the folks working jobs at McDonalds, gas stations and the like have no health insurance through their employer. It is not affordable or even a good program most often. In lieu of health insurance we (my husband and I) have done things like "borrow" other family members prescriptions (antibiotics and such) and self medicating on old prescriptions to avoid outrageous health care costs. Not a good idea you would say? What choice is there? We have a family of 6 and cannot lay around sick. The worst experience was probably when my husband was laid off and we could not even afford the COBRA policy at some $600 a month- I mean that is what laid off means, being without money. My children were subsequently covered by state funds, but my husband and I did not qualify even though we were unable to pay our bills on his income at his new job. It was so unfair to me and our health suffered. What good are 2 sick parents to 4 healthy children? Do they not need us? In relation to medical errors and quality of healthcare, my Mother was killed due to medical error only 18 short months ago. She went in at age 54 (otherwise healthy) to have her gall bladder removed. The surgeon nicked an artery while placing one of the ports and it was not discovered until a sudden drop in blood pressure. It took the surgeon 1 hour and 15 minutes to discover the cause of the BP drop. My Mom	VA	6/7/2006 11:06:21 PM

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	subsequently went into shock and died. This man still practices medicine and we have since learned that he has made other medical errors on the serious side, including the EXACT same mistake on a former high school classmate. Fortunately, they found his problem sooner and he did not die. Why is he still practicing medicine? Aren't their peer reviews? Aren't doctors held accountable for these things? I realize no one is perfect, but this man is leaving a trail of destruction.		
	My wife takes oxycontin, a federally regulated narcotic, for severe back pain due to degenerative disk disease, two crushed vertebrae, scoliosis, and spinal stenosis. She must see the doctor every month just to get the prescription. She used to be able to get 3 pre-dated prescriptions for 3 months at a time. Since then the government has established regulations prohibiting this, requiring monthly visits to pain management just to get the prescription. This means increased co-payments, $35.00/month, instead $35.00 every 3 months. Also it has seriously curtained our travels since we have to be home to pick up the Rx. We are very upset at the government clamp down on pain killing Rx, which penalizes innocent patients who need this badly.	PA	3/28/2006 11:18:18 PM
	My wife takes oxycontin, a federally regulated narcotic, for severe back pain due to degenerative disk disease, two crushed vertebrae, scoliosis, and spinal stenosis. She must see the doctor every month just to get the prescription. She used to be able to get 3 pre-dated prescriptions for 3 months at a time. Since then the government has established regulations prohibiting this, requiring monthly visits to pain management just to get the prescription. This means increased co-payments, $35.00/month, instead $35.00 every 3 months. Also it has seriously curtained our travels since we have to be home to pick up the Rx. We are very upset at the government clamp down on pain killing Rx, which penalizes innocent patients who need this badly.	PA	3/28/2006 11:18:58 PM
	All I want is to be able to have a child of my own. I've paid health insurance my entire working life that has helped pay for others to have their children. Assited reproductive technologies and medicines have been around for over 30 years and still cost outrageous amounts, purposely taking advantage of women in a horrible situation who will do anything possible to have their children. Health insurance costs more to cover infertility yet claims that it's up to employers to decide if they want pay more in order to cover it or not. In trying to find a job with insurance that does cover, that coverage information in nearly never available upfront, yet tons of information about pregnancy coverage is. Some states intervene to make sure that basic "preventative" options are covered. That didn't help me at all when I was three years old and the doctor did not use scar prevention techniques during an abdombnal surgery which is known to lead to scar tissue that killed my chances at ever being a mother. West Virginia has only two reproductive endocrinologist facilities, one in the Northern part of the state and one in the southern. The first doctor I saw at the site closest to me wouldn't even complete any diagnostic tests, but said I would need	WV	8/14/2006 11:07:01 AM

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$18,000 up front and to see his financial counselor. This situation is not right. It's cruel, discriminatory, and repulsive. Great Britain provides at least one attempt. Canada provides three if both tubes are blocked. Even Australia helps. People tell me to adopt, but I all I want is a chance to have my own child and adoption only costs a little less. The government sugar-coats the option of foster parenting by adding in payment and assistance. What gives them that right, to stear me into something that is NOT what my body, health, and mind screams for 24 hours a day, sixty seconds of every single minute of the rest of my life? Please include this in your report. Trust me, there's a ton more... Feel free to contact me.		
I worked most of my life for one company and didn't think much about health care since I had insurance that seemed to do the job. In 1993 my company decided to cut costs and started laying off the senior workers (I was 53 years old) with the higher salaries and the most benifits. Typically, I found myself without a job and without health insurance. That was a minor problem for someone in good shape and still young enough to get another job or so I thought. I took a job as a consultant and made good money but had to travel. Within two years I was diagnosed with cancer and had to leave work to get treatment. I found out at that time that I could only get insurace through a high risk pool and premiums were close to $30,000 / year just for my policy. That Premium also excluded certain treatments. Now I'm old enough to get Medicare and but having gone through this I suggest that we remove the for-profit insurance companies from the equation, regulate an out of control health care system (one fee for a specific procedure (insurance or no insurance) and make health care available to the masses. If one is rich and willing to pay for extra's let them. Lets also start looking into alternative medicine as a option evern though it won't make the big Pharma's happy. Thanks	MI	3/23/2006 12:23:07 PM
To whom it may concern, For our family health insurance coverage is a patchwork puzzle. You see we had private health insurance until my daughter max out two private health insurance plan's. My daughter was born missing organ's and has required over 50 surgeries and has spent 1.5 year's total in the hospital. When my daugther's father's company renew there health insurance plan our coverage when so far down and our share of cost for health insurance tripled and we had to choose between our mortgage payment or private health insurance. Well we chose our home so that our daughter had a home. The patchwork looks like this. My daughter because of her disabilities has Medicaid via SSI. Her father has VA benefit because he was in the service for 18 year's of his life. I have not had any health insurance since 2001. This is not fair or the American way. Why are we sending our money oversea's when we are not even taken care of our citizen's.	FL	4/25/2006 11:50:07 PM

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Response	State	Date/time received
As a civilian nurse in a military hospital in the 70's, not having to charge the patient for every item used was wonderful and left much more time for real nursing....as a nurse for the German Red Cross in the 70's, having access to their national health care plan was outstanding and MUCH simpler (at least for the patient) than our system. On disability now and under Medicare, my age prevents me from obtaining a medicare supplement in this state. My prescriptions alone are over $2400/year and I haven't tallied my dental expenses or "my part" of the medical bills which I suspect will easily be a couple of thousand dollars.	FL	2/20/2006 9:56:43 PM
My family was finally in a position to apply for medical insurance. We are in an income bracket that excludes us from Healthy Families but doesn't leave a lot of extra money at the end of the month. I initially applied with an independent insurance agent and applied to HealthNet, the application was taking weeks to process and finally my husband and children were approved. I was sent a letter telling me that I needed to contact my physician for the reason of my denial. My doctor was very supportive and attempted to determine the reason for the denial. Based on my medical file he did not understand why I had been denied. Please note that I have only been in the hospital for childbirth. My only other visits were annual checkups which were always normal. It took several weeks of correspondence with the insurance company which claimed that they had never received my records, medical records claiming they had sent them twice and the doctor saying the file was sealed. It became a run around that felt like a stall tactic. I had personally sought counseling for depression and after six months of my therapist recommending anti-depressants I hit a low and gave it a try with the plan to get off the meds in six months. In the interim our family moved to another state and I sought help at the local community center to get off the medication. This ultimately would be the reason for the denial and an additional waiting period of six months before reapplication. What became glaringly obvious to me was the double standard that an uninsured person seeking preventative care could then establish a medical record that would bar them from coverage in the future. I reapplied with Blue Cross and we were approved at $255/mo premium with $5000 deductible for first two family members. I consider myself a fairly intelligent person, someone who reads the fine print, asks questions and understands a good deal of the information and choosing a program requires an advocate that can explain the coverages, deductibles and limitations. We were able to maintain coverage for about five months and then my husband who is in the loan business hit the slow winter months at first we fell behind, then a cancellation was issued with a grace period in which the past due premiums could be paid, the total was $765 to reinstate benefits. When income is limited and you are stretching every dollar to buy a meal for dinner, a few gallons of gas(which at this time is also climbing)to continue to get to work, falling behind on utilities there is no lump sum available to pay up premiums. We are uninsured again and I hesitate seeking any medical help for the reason stated previously; will I be denied in the future? This country can do better. There are working models in Canada and Europe.	CA	7/10/2006 1:31:16 PM

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Response	State	Date/time received
I currently work for Walmart at $8.00 an hour.I'm an attractive, 45 yr.young, Mom of two teenage daughters. For two 1/2 years I have had to use my credit cards to "bridge the gap", to make up for what my salary doesn't cover each month, for just the absolutely necessities of life. Now, I am 15,000. in debt, and these min. balances cost me close to 400. per mo.(soon it will be $350.) I did not see how I could even pay my bills, and afford to spend 60 to $80- paying for insurance offered thru Walmart- when I would still have to pay for my Rx's (For 2-$160.00 per mo.) and fulfill a deductable. I just applied for the County Indidgent HealthCare Program in my Co. and I was rejected.At $8- an hr, I make too much. I am an intelligent, once, middle class income person,responsible, a great worker, a great employee, and I cannot afford the insurance, much less the doctor visits @ $50. I have also applied for a zillion jobs and have had no success getting through. I have experience but not high computer skills (programs like excel, and access) That's my story.Hope it helps.	TX	2/16/2006 6:32:59 PM
My first wife and I were forced to divorce so she could qualify for Medicaid. Neither Medicare or Blue Cross/Blue Shield provided long term care in home or nursing facilities.	MO	3/19/2006 4:20:46 PM
After 3 appeals, I was finally granted Social Security Disabilty last year (2005). I had Health Insurance through my same-sex partner until her employer eliminated it at the end of 2005. (Massachusetts' same-sex marriage act has caused a widespread elimination of this important benefit in many sectors.) There is a 2 year window from the SSD determination til I am eligible for Medicaree. I cannot currently afford any private Health Insurance and am over-income for any other assistance. I consider this a very serious and frightening personal situation, feel let-down by my own government and think this will be more costly to us taxpayers in the long-run.	MA	2/21/2006 10:33:12 AM
My husband and I were able to retire early -- he at 50 and me at 49. He worked his entire life for the same company. When he retired, our health care was free; now only 6 years later we pay about $350 per month. His former company has informed us that our premiums will continue to rise until we are paying 30% of the premium. Not only are we paying high premium costs, but our coverage gets worse each year. He may have been fortunate enough to retire at 50, but we are still living on a fixed pension. That $350 hurts and he has had to go back to work in order to pay it. This is certainly not our idea of the American dream! One of my daughters has a high deductible of $500 through her work insurance. Since she only makes $10 per hour, this $500 is very difficult for her so she avoids going to a doctor when she should and only goes when she is really desperate. This is not how health insurance should work for any one. Health insurance was my major issue during the last presidential election and will be the same for the next election. So far, Mr. Bush has done nothing to help anyone. I think his medicare program is a joke and he has done nothing for the rest of America either.	PA	4/16/2006 11:28:36 AM

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Response	State	Date/time received
Recently my son broke his toe and needed care. He went to outpatient and was told it would cost $800.00 for an xray. Since he has a large deductible of $5000, he decided to check 2 or 3 other facilities with xray capabilities. He found one that would accept $200. for the xray alone with additional costs for the physician. He paid the $200. and waited several hours. They then told him it would not be ready until tomorrow, when he came back the next day they had sent it to a radiologist, without his permission. He asked for the xray, which he paid for, and they couldn't or wouldn't come up with it. This has been several days, he paid for an xray, has not yet seen the xray to give to his doctor, and has not had treatment. This facility is obviously upset at having to keep their price low and my son not using their high priced radiologist.	CA	6/8/2006 4:37:30 PM
I found out in May that I had breast cancer. I had the cluster removed, and have almost finished my 7 weeks of radiation treatment. I have medical insurance, but have had to dip into our retirement account to pay my share of the bill. I have heard numerous elderly patients in the treatment waiting room talk about how overwhelmed they are by the bills. I find it extremely upsetting that this is the USA and we can't take better care of our elderly who have worked hard all their lives. I do not think our lawmakers understand the common persons problems, because WE pay the lawmakers bennifits.	MI	7/7/2006 9:42:12 AM
In 2003, I was misdiagnosed in an ER and sent home with a grossly dislocated knee that was diagnosed as a "sprain." Despite the fact that I am a doctorally prepared NP with a history of a dislocated knee, told the Dr. I had a dislocated knee, and had all the symptoms of a dislocated knee, I was treated like a hypochondriac and told that "you just need a few weeks of rest." Due to an almost unbelieveable series of errors (x-rays were misread, I was never called back for a suggested MRI on the 2nd x-ray reading, to name only a few) my condition was not addressed until 33 days after I fell - the standard of care for repair of a dislocated knee is 48 hours. I was not able to bend my knee after the surgery and eventually had to have one of the finest surgeons in the world at the MAYO Clinic operate on me in December 2004 - he basically had to saw apart my patella and femur from all the inflammation that developed after the original surgery. I still have residual disabilities from this incident. Despite all this incompetence, an "expert witness" told my attorney that I needed a knee replacement "anyway" (even though that was totally untrue) and my complications could have occurred "anyway." Therefore, my attorney dropped my malpractice suit (after I had invested much time and resources into it), and I am left with physical therapy bills, costs to put lifts on all my shoes, and the continuing prospect of future surgery, pain and frustration. I feel that this level of carelessness is totally unacceptable, and that the very Drs who defend their conduct would never have accepted that level of care for themselves and their families. I have recently joined the American Nurses Association and hope to work with other nurses on patient safety issues and ways to change the malpractice system to more fairly serve patients injured by negligence and malpractice. As it is now, many people cannot even afford to enter the system. Speaking also as a nursing provider, I believe the current malpractice system does not serve either providers or patients well.	NY	4/7/2006 5:40:09 PM

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Response	State	Date/time received
Having an aging mother has really opened my eyes as to the differnet needs an aging parent goes through. My mother, and not only her, lives in one of the poorest towns in California, 93640, and it has been my experience to see a lot of misdiagnosis done on this population. Doctors just keeping prescribing medication after medication and nothing really works, I am aware of the misuse of Medicare by some of these physicians and that is why it really irritates me that they are still practicing! I know that because our aging parents can no longer get their appointments in the larger cities they have no other otion that to go to to these doctors near them. This brings another point up, transportation, some rural care centers have transportation and some do. Why can't monies be allocated to this health centers so that they may all provide transportation for the elderly? I can go on and on about the probelms they(senior citiizens)face but what can I do other than provide for my own parent.	CA	6/20/2006 1:58:43 PM
There was a time when I worked a well paying job. And then I had children with several different disabilities which forced me to make a choice to stay home and care for them. My insurance at work was not enough to pay for in home health care. And to maitain medicaid to be able to keep my girls in good health, I could no long work. Something is wrong here. Why should I remain poor to recieve health care? And why did I have to go so long waiting for a waiver program. My girls are over 18 now. But caring for them with very little help has put me in a wheelchair also. I am now trapped in a web of poverty and living in a neighborhood that I never dreamed I would have to be in to maintain it. And yet many people think that this is where I should be, because my family is such a burden to society. If there was health care from the begining, I believe that things would be much different. Maybe I would still be in the suburbs? Maybe I could have maintained a job to keep me from ending up in poverty for life? I don't know. People who judge my situation could be in my situation in a matter of minutes. A major accident could spiral a family down faster than anyone could imagine. Without good health care nationally there will be more families in my boat. Making choices that really are no choice at all. And as I continue to survive, the government in its wisdom continues to cut benifits across the board. Which forces me into more cuts in my already stretched to the limit poverty. We need a one payer health car program for everyone. People are dropping their disabled off at hospitals and nusing homes all over the country. This costs the government so much more, and the person who is disabled gets the bare minimum of care in these places. People say it can't happen to them. But it can.	OH	7/9/2006 11:49:39 AM

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Response	State	Date/time received
First of all, I think the idea of a federally-funded universal health care system is so long overdue. Not just from a social service perspective but also from an economic perspective. Lack of health insurance is a widely cited reason why people do not start small businesses. To mitigate this deficit should launch a swell of growth and innovation!! Secondly, my strongest health care opinion centers around the maternity health care model. My hope for a federal system would be a focus on "normalcy" for a pregnant woman and her birth. As a nation we have one of the highest rates of mortality and morbidity for almost any industrialized nations. Our model of care is obstetrician-centered. 90% of pregnant women see obstetricians for their care (as opposed to midwives). Obstetricians, well meaning as they are, are simply focused on "treating" a pregnant woman; there is a large focus to look for anything going wrong, and to offer interventions... induction, pain management, cesarean section. All of these interventions, while essential in case in the right circumstances, are simply used much too frequently now and to the detriment of the well-being of mothers and babies in our country. The midwife model, where midwives are the professional of choice for most normal pregnancies and births, looks at birth as a normal process. If a mother and her baby are both healthy, midwives are content to offer support and help the mother give birth the way her body was naturally designed to do. Midwives bring to the table experience, coping techniques, and enough medical knowledge to help the vast majority of knowledge through birth. In this model, if a woman or her baby is deemed high risk due to complications like pregnancy-induced hypertension, gestational diabetes, etc, the mother is referred to an obstetrician for care. Most industrialized nations more closely follow the midwife model of care and their rates of mortality and morbidity for babies and mothers sincerely put ours to shame. My hope is that in a nationalized health care system, we can work with more success to move our country to a more midwife-based philosophy; where it is easier for women to utilize midwives for care, where more midwives are entering the career, and where non-hospital births (birthing centers and even home births for low-risk moms) are covered. The costs associated with this model of care are reduced substantially from the obstetrician model which involves more medical people, more interventions, and the costs associated with a hospital and an M.D. present. Thank you for taking this issue on and I truly hope that it will succeed -- and succeed without the red tape and limits that the influence of lobby groups could present, much to the detriment of the program and the American people. Remember, this should be an effort with the PEOPLE'S best interest at heart. Short-term it might be a hard pill to swallow for many groups who will lobby very hard against it, but in the long-term, those groups will adapt, change their business to fit into the new model, and the American people will be better off (and healthier) for it. Good luck and you have my full support!!!	NJ	6/8/2006 9:58:08 AM

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Response	State	Date/time received
Our local Mental Health Clinic is part of the system run by the State of Georgia.The National Allience for the Mentally Ill (NAMI) recently graded all of the states, and Georgia was one of the many awarded a D (as in Dopey). I guess they are bucking for an F next time, because they have just had the state Medicaid system taken over by some Managed Care company, and as of July 1 some changes have gone into effect. I was told today that they are eliminating Individual Councelling, and making everyone go into various Group Therapies. I feel this is a penny-wise and pound-foolish move, that will result in more people getting less professional oversight & attention,leading to less medication adherance & more dr0op-outs from the clinic, and more people in trouble with the police, in domestic disputes, street-drug use, and costly hospitalizations which can be avoided with good individual councelling. From having been in many groups before, I can tell you that many who do attend do not say anything out of shyness or depression, attendance is very spotty, and the meeting times are much less flexible than individual appointments. Transportation is often a big problem for poor people, and if a group only meets at one hour on one day a week, a ride may not be available. Keeping long-term, seriously mentally-ill people stable in the community and out of the hospital is supposed to be the goal of community mental health centers, and elimination a proven asset like individual councelling is a stupid move.	GA	7/8/2006 4:30:14 AM
Midwifery care has been a beacon of hope in the medical system. Out-of-hospital based midwives provide low risk pregnant women with high-quality, patient-centered care, with minimal interventions, while producing outcomes as safe as OBs and hospitals without all their inherent expense. The only downside of this kind of care is that it's only available during the childbearing year, and it is tough to find equivalent quality and compassion in other branches of medicine. I believe if medical schools would train their students with a midwifery-model-of-care, we'd have more compassionate caregivers who use fewer unnecessary procedures and expensive medications.	WA	4/15/2006 4:53:54 PM
If Universal Health Care will provide better experiences than the current system, yeah I am all for it. However, people in general have gotten the problems in medicine all wrong. Yes human beings want health care. We want it dibbied out equally too. That not only means appointments and medicines but also recognizing diseases immediately and treating them appropriately. I am a Registered Nurse with over 20 years of experience. I've been ill off and on most of my life. Personally I can vouch for telling the truth about disease the first time. I was misdiagnosed for over 30 years. This costs the system enormously. The entire health care system fails to recognize my infection. The system fails to recognize my germ's DNA PCR test based on a Conference of greedy people a long time ago in Dearborn Michigan. When the system is ALLOWED to discriminatorily treat people, Universal Health Care won't work. It is not the answer. The answer is to stop GREED and price treatments within the consumer market. Doctors don't really have to make a million a month. So my experiences in America's health care system equal that of a third world country already. As a nurse I have been asked to wash and repack surgical equipment for resterilization that is plainly marked " single use only". Universal coverage will increase all of these problems so I am really curious who ya'll asked	SC	6/9/2006 6:44:40 AM

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	Response	**State**	**Date/time received**
	about Universal coverage... and when. No one I know even knew about your group representing America. Did you ask Senator Clinton? She will always say yes since this is Her favorite project! *** SC		
	My friend is aged 55 and on disability. She has Limb Girdle Muscular Distrophy. She is barely able to walk with the help of a cane. Her doctor was amazed that she can even stand because of her condition and extreme weakness. She has a standard wheelchair (not motorized) and is finding it more and more difficult to get out of the chair. She needs a motorized wheelchair with a seat/standing system. Medicare needs to change their rules regarding what equipment they will cover. They only cover power wheelchairs if you cannot walk around your home, but will only cover seat/standing system if you can walk once standing. This sound like a major contradiction. My friend has fallen many times and needs to be able to navigate throughout her home without having to worry about falling and injuring herself futher.	WA	7/3/2006 7:51:18 PM
	Why we should have universal health care in the United States of America: I am a medicaare patient with good health insurance, who has very few ailments. I would be willing to pay more if a medicare form of insurance covered every citizen in the US. This should be financed through, as you describe, a one-payer insurance. Way back in the 1960's there was just one health insurance available, Blue Cross. Doctors had only one set of rules to go by, and they knew their payments would be coming on a regular basis. Maybe this might keep doctors in their practice. Since 2002 I have had three different internists in the same office. I had been a patient of Dr.A since the early 1970'sw, who left to work for the Veterans Administration. He was fed up with the insurance companies. Doctor B left within the first year to waork in a hospital full time. Doctor C, who is leaving August 31, 2006, was here two years and is leaving to work in a hospital full time. I hate seeing the dissolutionment each are feeling. Now, I have just learned that privately owned phaarmacies are closing their doors in northwest Connecticut, because of Medicaare Part D, again due to the insurance companies. I don't know if it was the Republican administration or the Republican Congress' intent to have just large corporation handling the prescription drugs or not, but that is what is happening. Something has to be done now! I don't know if we have any person in Congress "brave" enought to confront the Republican push for privitization. Privitization doesn't work in medicine. There are too many greedy corporations out there.	CT	8/29/2006 3:05:27 PM

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	Response	**State**	**Date/time received**
	Please push, push for universal health care!		
	What is wrong with this picture? In September 2006, my 26 year old daughter was back packing through Central America. In Nicaragua she tripped and hurt her foot, which after two weeks it was still very painful. She went to a clinic, where they x-rayed her foot, and after determining that it was not broken, they provided her with pain medication. Her bill was approximately $7.00 USD. She explained to them that she was an American (which they probably assumed â€¦ she is 5â€™10 and blond) and wanted to pay for her services. They explained again, the bill is $7.00. In November 2006, my 22 year son was in an accident and went to the emergency room of a hospital in Rochester, Michigan at 4 AM. The ER proceeded to give him 13 stitches and one tenuous shot. His bill was almost $1,200. He was unemployed and had no health insurance. Third world countries have universal health care, but not the richest country in the world.	MI	5/8/2006 11:15:40 AM
	I was taken off work by my physician 2 yrs ago due to a variety of health issues. I realized that I was not improving, and filed for social security disability. Upon being denied, i obtained legal counsel. In looking for health insurance to cover me in the interim, i was denied because of I had a renal angioplasty in 2000. Additional reasons for the denial included the medications i was on and the frequency of hospitalizations. When my cobra ran out in Feb, I first attempted to utilize the supposed discount savings plans. I immediately realized I would be unable to afford my medications. I turned to the state for assistance, and now have been informed that it will be 6 - 12 months before i hear of a determination. In the meantime, my physician has possibly found a new condition that needs treatment, and i am currently without several of my medications and praying that i am able to stay out of the hospital	OH	6/2/2006 11:19:33 PM

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Response	State	Date/time received
I have run into a couple of doctors that have been generous with me, by allowing me to pay for my emergency care with what I produce or my services rather than money. Otherwise I don't know HOW I would have paid for their services. I often forego care because of lack of money. Because of passing on care, I worry about whether I am letting something go that I shouldn't. For instance, I went two weeks before going to the doctor with a broken thumb, because I didn't have the money to get it taken care of and hoped it would get better on it's own. I did not know it was broken, I just knew it hurt a lot. If I had health insurance or at something similar, I would have gone in immediately. As it stood, the doctor had to rebreak it to set it properly. I would like to get all those tests we are told to do, like a colonoscopy, mamogram, blood tests for glucose, chloresterol and all the rest, but just don't have the money.	AR	3/29/2006 4:40:18 AM
Iâ€™m writing to whom ever will listen, I am at the point where I donâ€™t know where to turn to. I am a morbidly obese mother with a BMI of 40.7, Poly Cystic Ovarian disease, Diabetes II , high blood pressure, back and joint problems. I struggle every day with pain in my back, controlling my diabetes thru insulin injections.My primary doctor says that most of my medical issues could clear up if I lost this weight. I have tried and tried and have not lost the weight. My doctor says I can loose the weight if I have bariatric surgery. My insurance is controlled by my union and this surgery although medically necessary is an exclusion. I do not qualify for loans to pay for the surgery. I do have a job I can make payments but no doctors will accept them. If you can help in anyway, convince a doctor to take payments, a clinical trial that will include the surgery, a hospital program that will allow payments or take charity cases or charge based on income. Please let me know. I will barter web designing services, graphic design services. I will do just about anything to get this surgery that will help me be healthy again. Thank you for taking the time to read this. ***	NJ	7/22/2006 10:47:46 PM
I have been without health insurance for several years. I have paid out of pocket for any health care I have received, and I've been lucky; I haven't had any catastrophic illnesses. However, I did injure my knee a couple of years ago. I was unable to pay the $1000 plus that an MRI costs, so I've been living with the pain and hoping that I'm not increasing the damage to the knee. I wonder how long my luck will hold out and what will happen to me when it turns (I'm in my late forties). This is no way to live.	NY	2/19/2006 6:08:21 PM
I am a California insurance agent. High-deductible health plans are clearly more cost effective. Example a 45 year-old with a PPO $20 copay plan would pay $362/month. This same person would pay $175/month for a $2400 deductible PPO plan. That is a $187 monthly savings or a $2,244 annual savings. In other words the savings basically covers the deductible. Not to mention that the annual out-of-pocket limit is $1000 less for the high-deductible plan saving the person even more dollars. Traditional plans are no longer financially viable.	CA	3/2/2006 12:51:46 PM

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	Response	**State**	**Date/time received**
	I am 31, I have never had any signifigant form of health insurance in my life. I am in constant fear of getting hurt or sick and then if I have to go to the hospital I would loose every asset I have to pay the bill. When I lived in the UK, my fear of doctors/hospitals/etc. almost prevented me from going to the emergency room, but in the end I went, and what a relief to know a doctor saw me and I was able to get medication for about 12.00 USD. That was it, I paid for the medication, that was my only expense.	NY	2/16/2006 1:42:20 PM
	Dear Ladies and Gentlemen, I beg of you, please think carefully and speak to those with experience before recommending national healthcare for all. One size does not fit all! What we need is simply health care that is prescribed per each individual and each situation; just as it was when healthcare began. I did a little experiment a few years ago on the advice of my wise Father, a Minnesota dairy farmer. I went into emergency for a visit and told them I had no insurance/HMO plan. The care I received was gentle, accurate and most cost effect since as far as they knew, I had to pay for the treatment out of my own pocket. I had even heard several times, if you had insurance we would do this or that but because you don't we are not going to in your case and honestly, it is not necessary anyhow. It is just that the health insurance companies will reimburse us for the treatment. I paid the small bill which was actually smaller than what my copayment would have been had I opted to inform them of my coverage and the ancillary treatments completed. This is only one example of why I say NO! to universal coverage. Thank you for considering my view and have a terrific day!!	MN	8/31/2006 10:41:33 AM
	Medicare, my only insurance, has worked fairly well for me, with these exceptions: 1) It covers very little dental and vision care, which are major concerns of people as they get older. Aren't teeth and eyes considered part of our bodies? 2) It does not cover alternative remedies and therapies such as vitamin/mineral supplements, herbal, homeopathic and Chinese medicine, acupuncture, and other hands-on massage and treatments to relieve pain and chronic symptoms, and to support body systems and prevent illness. Together with dental and vision costs, the majority of my health care costs are out-of-pocket, consuming a huge portion of my very low income at age 77 and keeping me in debt to take care of myself.	CA	2/15/2006 6:25:28 PM

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Response	State	Date/time received
I would like to know why insurance rates for Pueblo and the Arkansas Valley are so much higher than the rest of Colorado and why the same area is limited for insurance coverage, including Federal Medicare Plus,to all the areas north of us. I am paying $436.00, which includes a "2%surcharge" for Federal Medicare Supplemental!I have been unable to find out why I am paying this "surcharge". The plan itself is full of things that could be changed and save everybody money. We need to have hearing, dental and eye care paid for. It would save money in the long run because this would be preventive medicine.Anybody ever check the cost in these areas? Trying to get some of the insurance companies to pay for care and procedures is nothing but a fight and should not be. Many just pay it themselves, if they are able, rather than have to fight the big boys. The Medicare D is a joke and should be junked! Nobody understands it and, as usual, the drug companies are the ones making the money at the cost of the taxpayers.	CO	2/16/2006 12:11:09 AM
This is a letter I have been sending out to as many legislator's and advocacy groups that I can find. I would like to meet other people with similar circumstances....please e-mail me. There is power in numbers. March 20, 2006 My name is ***. I am 53 years old and live on Social Security Disability of $636 per month. Prior to Jan. 1, 2006, I had been receiving Medicare and Medicaid, with Medicaid paying for my prescriptions, the 20% of other medical costs that Medicare does not cover as well as transportation to required appointments with medical specialists outside of Monroe County, an important service for me. After Jan. 1, I, along with all clients enrolled in Medicare and Medicaid, was put on Medicare D, which now requires co-pay. The transition went smoothly thanks to the hard work and compassion of David and the staff at Dennis Pharmacy. My plight, and something that is now affecting untold numbers of disabled and elderly, especially in the geographically cut-off Florida Keys, is that most of us receiving both Medicare and Medicaid were switched to â€œMedicaid Share-of-Cost.â€™ The letter informing me of that switch stated I make $456.00 too much (doesnâ€™t say if that is per year or per month) to be eligible for straight Medicaid now. That is confusing since my SSDI yearly cost of living raise has only increased my income by $250 per year! In the last ten years I have had numerous surgeries and have been diagnosed with more than my share of illness. I have Multiple Sclerosis (the closest MS Specialist is in Miami); a major defect in my cervical spine and a benign brain tumor (both requiring neurosurgeons, also out of County), and Peripheral Arterial Disease (no vascular surgeons are based in Monroe County) and Optical Hypertension in which last eye exam showed change in the optical nerve of my left eye, in all probability the beginning of Glaucoma. The problem is that with the loss of my straight Medicaid, I lost transportation to see necessary medical specialists outside of Monroe County. Iâ€™m sure there are many, many more people who suffer from complex medical problems that cannot be adequately treated by primary care physicians and that require the services of specialists. So, in essence, the change in my Medicaid status has cut	FL	4/4/2006 9:41:05 PM

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	Response	**State**	**Date/time received**
	me, and many others, off from any specialized medical care because the necessary specialists do not practice in Monroe County. My situation is most likely the same for many people here in the Keys and all over Florida and the US. I have lived here 25 years and worked, paying taxes, until becoming disabled. C&FS is telling me is I am eligible for Medicaid services after I pay $436 in medical bills, each month, out of my pocket. When I asked if this could be a mistake, one lady asked me how much my check is each month. I answered, â€œI receive $636 per monthâ€ and she said, $636 minus $200 is $436, so that is what you are responsible for each month.â€ So, they deduct $200 per month to cover a personâ€™s living expenses (rent, utilities, food, prescription co-pays, etc.) â€“ an impossible idea â€“ and then expect the recipient to pay the rest of their income in medical bills. In my case, since I live in the Keys, this would include not only doctorsâ€™ fees but roundtrip transportation to Miami more than once a month as well. I am caught between a rock and hard place: Not enough money to pay for living expenses once the medical funds are put aside, not enough to pay for medical expenses now that Medicaid doesnâ€™t cover transportation to my much-needed specialists and the 20% that Medicaid was paying for medical care. Iâ€™ve made numerous phone calls, from Tallahassee to Key West, and never got a friendly or informative answer. Most answers were standard, â€œpatâ€ answers, not pertaining to my specific questions or showing any interest in finding answers, let alone solutions. Maybe you can. It would be a Godsend if you could step up and look at my case, analyzing whether any errors have been made in the way my income has been analyzed in the Share of Cost program. If no errors have been made, I would like to know whether, under dire circumstances of severe disability â€“ and my medical records can substantiate this â€“ the formula can be reconfigured for an individual so that more funds are available for living expenses and less goes toward medical. If not, I would have to spend much more than $200 in order to survive, and the remainder left for medical could not possibly reach the required $436 level. This would mean that I could not get to my doctors, my health would further deteriorate, and possibly thanks to the â€œMedicaid Share-of-Costâ€ program, I could end up unable to care for myself and require a government-funded assisted living facility. Right now I am proud to live as independently as I possibly can. However, without some intervention from an empowered champion who sees the folly in this process, I donâ€™t know how long Iâ€™ll be able to remain independent. Should I end up in a government-funded assisted-living or nursing facility, the costs the government would bear will be significantly more than $436.00 per month. Thus, instead of saving the State of Florida money, the effect of the current policy would cost the state thousands of dollars more. Sincerely, ***		

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Response	State	Date/time received
I have a chronic disease, and I am disabled from it. I'm trying to get back to work by learning new skills. BUT.... Our society frowns on people like me, because I am living "off the system." Yet, I had to wait five years to have a joint replacement, because I couldn't afford the medical costs. I also am unable to afford the medication to help me keep from having further joint damage. Oh, you say, have you tried the new Medicare Part D program? This program, which was designed to make HMO's and Pharmaceutical companies richer, is not affordible for most people. If you are very poor or have extremely high prescription drug costs (like about $10,000-$15,000/year) then it will help you. It would only cost me a lot more. WE NEED A ONE PAYER HEALTH CARE SYSTEM, NOW! Everywhere I go I hear this, and very few people speak against it. SO WHY DON'T WE HAVE IT? Well, I will tell you. Our elected officials get big bucks from the pharmaceutical companies and the HMO's. The best congress big money can buy. Remember this when you vote this November!	MN	7/21/2006 9:53:27 AM
I would like to share a statement with you regarding my personal experiences with bipolar disorder. Please see the attached file. Thank you.	MN	3/21/2006 2:01:54 PM
I have been a health care provider as an ICU nurse for 20 years and a Nurse Practitioner for the past 3 years. I am actively involved in the care of patients with chronic disease in a heart failure clinic. I also work part time in a free clinic here in Charlotte for uninsured adults. I am aware of the health care crisis from several perspectives. I suffer from a chronic condition that requires expensive medication and medical follow up. I am acutely aware of the cost of care from a provider and patient point of view. In reading through the information provided on your site - I think you have done a good job of assessing some of the present health care system problems. There is one blatant omission however - the outrageous cost of medications in this country. No other country in the world allows pharmaceutical manufacturers to hold it's citizens hostage to overinflated prices. If the govenment wants to make a true impact on the cost of health care - medication prices MUST be addressed.	NC	2/13/2006 9:29:59 AM
I am self employed and so do not have a group insurance. It seems no one invites us to the table when there's talk about healthcare. We carry our own which is very expensive. When I got cancer, Blue Cross came through for me. Afterwards, however, they raised my premiums so that I could no longer afford them. I dropped my insurance only to find that if you have the misfortune of getting sick in the US, you become an untouchable in the world of insurance. No one would talk with me. Today, 15 years later, it is the same. Insurance companies even hang up on me.	CA	3/24/2006 4:16:25 PM

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My husband and myself currently have insurance because he happens to work for a company that supplies a policy to its employees. We currently are separated and if we were divorced, I would have no way to obtain health insurance. The coverage we currently have is very mediocre. We happen to have the means currently to pay for the care that we need because we are healthy, but even so the out-of-pocket expenses are steep for us. My husband has a neck injury currently, and we are spending about $700 a month out-of-pocket for his treatment even though we have insurance and we are health people generally. For at least half of the past 15 years, we have had no insurance. I am self-employed and my husband was self-employed or worked for companies that didn't offer insurance. This was frightening, and we were lucky that we were healthy during that time. Private health policies were out of our reach financially. Currently, we have three children in their twenties, one of whom is married to a man who is self-employed and has a one-year-old baby, and none of our three children has health insurance. My family uses what are currently considered alternative health care practitioners such as chiropractors, accupunturists, and homebirth midwifery care because we have seen that these practitioners support us to stay healthy. We also rely on good nutrition and excercise to stay healthy, and we have been lucky so far. I want any health care reform system to cover all licensed health care practitioners who the provide covered services in a basic health care plan. I believe a health care system that paid for such services would encourage greater health in the population and save enormous amounts of health care dollars.	VT	3/18/2006 10:11:43 PM
I am a nurse and have had many experiences with clients that are mostly negative in trying to obtain and or use health insurance. It is too confusing and complex,discriminatory and unpredictable. You have to spend part of your life applying, reapplying, updating, and then advocating vigorously for care. Recently I have been without insurance and it is very scarey. I just was aboe ti get on Mass Health, but the minute I go over a certain income I am bumped off. the only solution that will equitable and secure is universal health care. I compoleted your health care poll and felt you were not open to universal health care. It was worded only around health insurance for all but at a price!!! The current system isn't working and really never has. We need UNiversal Health Now!!!	MA	3/29/2006 11:03:55 AM
Here's a positive example: My nurse practitioner of fifteen years noticed some odd looking surface tissue on my breast during my annual exam. She referred me to an Ob/Gyn who checked this skin, asked her nurse to get ready with a mini-surgical kit and make her time available, and right then and there, without expensive hospital care, she numbed and cut out this patch of skin and sent it for analysis. It turns out to be an infrequent condition which can be a marker for breast cancer, though it is not breast cancer itself. Both these providers were medically knowledgable, compassionate, clear in their explanations, and acted quickly to make sure my health was not threatened. My insurance company did not have to pay a lot for this diagnosis, and now I get checked twice a year in addition to annual mammograms; one of these checkups is by a breast cancer specialist, one by my nurse-practitioner. So I have a confident feeling about the care I'm receiving and anything else that would be recommended. Here's a bad example: A young mother brought her three-and-a-half year old in to the dentist at our health center; she wants to be a good mother and start her daughter on preventive care. I believe the WIC program urged her to see to this. Most all the mother's teeth are gone. She has had them pulled, but has no way to pay for bridges, and is afraid to go job-hunting, which she is supposed to do under welfare reform. She will not be able to get a job supporting her daughter with	MA	6/5/2006 2:14:21 PM

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	Response	**State**	**Date/time received**
	many of her front teeth missing! A father of two lost his job when he came down with several chronic conditions at once; diabetes, arthritis, and depression. His wife has a decent job and has health insurance. He cannot get Medicaid because her income of high thirties is supposedly enough for all four of them. However, the copays for his medicines, under her HMO, come to $400 a month, and he feels useless and more and more depressed! And a third: A man had surgery and developed an infected wound. He is not old enough for Medicare and VNA care. So he lost his job after not returning to work in three weeks. Therefore he lost his health insurance, and now they have bills of thirty thousand dollars, because he had to go back into the hospital twice again. We were called because we have a public health nurse who could go see him and we have staff who help people apply for Medicaid. They are not poor enough for Medicaid, but now they are about to lose their house due to the bills. It is not clear how to cure his stubborn infection, or when he will be able to return to work. Thanks for listening!		
	Last year, our union negotiated a new contract with different health care. I used to have a 20 dollar office copay, now I have to pay the first 600 dollars myself. I am married with no children, but have to pay the same minimum as someone with 5 kids. I'm not anti-child, but my husband and I don't use medical care unless necessary. We are both in our mid 40's and this year we had to forgo our annual checkups, my mammogram and pap smear and other testing because we can't afford it. I work full time, but what peeves me is that people who are on welfare and not paying taxes get access to not only free healthcare, but free dental as well. Both my husband and I have tooth loss because we cannot afford dental care, but make too much to qualify for assistance. The system needs to be fair for all.	OH	6/13/2006 5:08:23 PM
	I have been fired from the job I had held for over 24 years. I have a brain injury and cannot get affordable health insurance. The Cobra plan was available to me after my employment but now I cannot afford Cobra, nor my rent that is due.	KS	7/5/2006 12:38:43 PM
	Becauae my son Joseph did not work at a job that provided health care nor could he afford the premiums that are so high he was denied health care and now rests with the Lord, unfortuanately his lif ended to short he was only 32. He left his family on 5/03/05, leaving me his mother with a heart that will never heal all because he has a blood clot travel to his heart and ended his life, had he had insursance he would have had the proper testing and still be with us today, someone needs to change these laws, heath care is for all not just for the rich!!! joey's mom	PA	4/6/2006 9:34:58 PM
	Health care for young people age 30 to 40 years old that require many medications to stay healthy cannot afford the cost of health care. Even with a minimum wage job or under $24,000 they cannot afford health care and copays for their meds and health. Canada and England have some issues with health care but they provide health care for those in need.	MI	8/31/2006 2:53:54 PM

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Response	State	Date/time received
The following scenario has actually occurred in my family. Jim ran his own small business (tile and flooring) until he had back problems too severe to continue working. He was over 60 and decided to retire. Kay also retired from her work as a hospital technician. At age 61, Kay was diagnosed with colon cancer. The required surgery wiped out the health insurance coverage Jim and Kay had thought was adequate. They had to use personal savings to pay for her chemo-therapy. It wiped out their savings. They had to sell their home and move into a mobile home on their daughter's property. This situation highlights a terrifying gap in our health system - persons who are not old enough for Medicare, who have worked hard, paid their taxes, saved and made fully reasonable preparation for their older years, can be financially devastated in a matter of months when catastrophic illness strikes. We need to provide a cushion for catastrophic illness in our health system.	CO	3/3/2006 5:57:47 PM
Presently,I don't have any health insurance.I know I should but can't afford it.The pre-payment that most insurance companies ask for is just too alarming.Insurance companies should be eliminated as far as I'm concerned.Besides medical doctors, more allied health professionals should get involved with patients' health if the patients do not mind.Public health practitioners,Physician Associates,Nurse practitioners,Social Workers,Registered Dieticians and other important and valuable health professionals should be allowed to be involved in the health care system.It's a big shame that about 47 million Americans do not have basic health care.And I'm one of them. I really want to make a difference.My goal is to earn dual degrees in Public health and Physician Assistant and be part of those that would improve the health policy and management in America.We need health volunteers for rural communities, Indian reservations,nursing homes,and community clinics to make health, just basic, simple health,affordable for every American,every human being in America.	KS	3/22/2006 8:35:05 PM
In the last week out of the blue, I was diagnosed with stage 3 multiple myeloma/plasma cell leukemia. It has been a staggering blow and any money cut from the budget will have a devastating effect on people like myself, who through nno fault of our own end up with what could be a death sentence. The cost of thalidomide treatment for 28 days is $4,300 - a staggering sum which may not be covered. And it is difficult to get a pharmacy to stock it because of the cost. I offer my comments as practical experience not as theory. Our Delaware state retirees prescription coverage will change in July to Medco. Who knows what the future will bring? Do I die because I'm not wealthy. Will Medco cover the cost? It's a frightening prospect and one that lawmakers and especially President Bush should think about. The average person suffering and trying to make his/her way through the health care mess is this country. ***	DE	6/15/2006 2:49:18 PM

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Response	State	Date/time received
As a physician I am confronted daily with the realities of our failed health care system. The truth is that the current situation is the most devastating to the middle class and people who work. I have seen countless people who develop cancers or other serious illnesses through no fault of their own, and either have no insurance or realize too late that it is inadequate. They are left choosing between ignorning their conditions or going deep into debt, losing their house, and eventually declaring bankruptcy. No one in the richest country in the world should be forced to make that kind of decision. In my opinion, there were never be an adequate solution to this problem unless we implement a single payer universal health insurance program.	WA	2/1/2006 12:53:17 AM
I am a legal assistant at a large firm that does a very lucrative business on Wall Street. I was hired as a part time worker and have no health insurance unless I pay for it. As a reward for my hard work, I once asked my employer at his cost to let me into the full-time worker dental program. I was turned down. Recently, I had to have extractions (of wisdom teeth) and periodontal surgery, both of which are very costly for the high standard of care which I received. I paid out of pocket but feel that the government should foot the bill for all workers, including workers like me, since private industry refuses to accept its responsibility.	NY	3/22/2006 11:17:41 PM
In our senior years my wife and I, both on Medicare PPO using mostly UCLA Medical Facilities have had major fiscal problems with UCLA who we believe inflates medical charges and has multiple doctors visit when in hospital who we do not know, and then bill us for a visit. The entire medical billing process should be investigated.We had three medical insurance policies, including Medicare and still got supplemental bills. Blue Cross is the worst.	CA	2/2/2006 7:34:41 PM
My nephew was born with a cleft palate, but because the HMO doctor was too rushed between patients, it wasn't discovered until he was over a year old. In the meanwhile, my sister couldn't understand why her son wouldn't breastfeed, could barely eat, and was always crying. Treating medical care as a for-profit venture is immoral. The human right to good health should NEVER be suborned in favor of wealth and greed, yet this happens every day. Low-income children die of malnutrition, young mothers suffer needless complications, and seniors can't afford their prescriptions - but CEOs and Executive Board members are draining company profits dry for their salaries, or shunting earnings into stock market ventures. Medicare operates with miniscule overhead and incorporates plenty of oversight; patients don't have to buy their own health or that of their children and parents.	WA	8/31/2006 7:59:22 PM

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Response	State	Date/time received
My name is *** . I'm a registered nurse residing in ***, Florida.	FL	2/16/2006 2:11:12 PM

In late 1998 I became ill with a serious neuromuscular disease. Although I had always had private insurance through my employers prior to this, I found myself unemployed, unable to afford COBRA coverage, and without access to health care. Furthermore, since I was a breast cancer survivor, I was unable to obtain any private insurance of any type, although my family was (then) willing to assist me in paying premiums.

Because I was unable to obtain even basic health care, my physical condition deteriorated even further. My only option was to file for social security disability, even though I knew I would not be eligible for Medicare until two years after acceptance. I received SSDI on my first application, due to the seriousness of my condition.

From 1999 through 2001, my hospital bills mounted. Since I was unable to pay for private health care, my only option for care as my condition worsened became hospital emergency departments. I was hospitalized mutliple times, including twice for severe depression secondary to my then-circumstances (prior to this, I had always been an independent, working woman, with excellent credit).

Over the course of two years, my medical bills skyrocketed. I was unable to pay these bills, so, in 2002, I filed personal bankruptcy. My credit was ruined, of course. Fortunately, I was able to keep my house, although I went through foreclosure on my mortgage during 2002, during the 14th year of a 15-year mortgage.

In late 2002, I was able to return to work on an extremely limited basis. My goal was to get off SSDI as soon as possible as well as obtain health care coverage from my employer. I accepted a fulltime position in September, 2003. In the late fall of 2003, I had a recurrence of my breast cancer that necessitated surgery, chemotherapy and radiation. Since I had insurance through my employer, I received treatment. In May of 2004, when I attempted to go part-time with my employer in order to rest for a few months, I was fired. Once again, I was unable to financially sustain COBRA coverage, although I tried desperately to do so. The premiums were just too high.

Now, a year and a half later, I am once again unable to work at all. Thankfully, I now have Medicare, though paying even my hospital portion on a limited income has proven quite difficult. I nearly lost my personal physician last month due to this, though I was able to borrow the money to pay her, at least. I don't know if my hospital will continue to treat me at this point - time will tell. Also, since there are few local physicians who now accept Medicare (thanks be to the Bush administration's lack of foresight), I once again faced trying to survive without the services of a personal MD. I knew it would be the "go to the emergency room when the symptoms become uncontrollable" routine all over again. Thankfully, this hasn't happened - yet.

That is my story. I must add that I have been a health care activist for over ten years. As a nurse, I became involved in the movement for healthcare access for all before I myself experienced that lack of access to healthcare. Prior to my own experience, I started an online "project" for nurses that resulted in demonstrations and rallies in nine states back in May of 1998. Due to my work, I was one of the guest speakers at the convention of the Physicians for a National Health Plan in Boston in May of 1998.

It is my faith that our healthcare system will change, indeed MUST change, as well as the knowledge that I can be a part of that change, that brought me through my own time of turmoil, although at times I wll admit that my faith wavered. I view the Citzens' Health Care Working Group as both a harbinger and instrument of that change, and would very much like to be a part of this effort.

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	Response	**State**	**Date/time received**
	Sincerely,***		
	The health care system is broken and needs immediate help in serving all americans. Costs are out of control and this is due in part to the diversion of control to the insurance companies who have become irresponsible gate keepers. They have no idea what patients need and don't need and they have failed to keep their promise. The poor and the old have been abandoned and the middle class has been sold out by the politicians and the insurance COMPANIES (hmo'S). wE NEED TO PUT THE SYSTEM BACK IN THE HANDS OF THE PROVIDERS AND PATIENTS. Place some proper monitoring in the system and allow it to work correctly. Stop gutting the Medicare system and restrict its use to need not want!	FL	8/13/2006 1:19:54 PM
	I worked for a small company (7-10 total employee's/employers) who offered no health insurance. I have since been diagonosed and had surgery to partialy resect a rare tumor on my spinal nerves. In four years or less I won't be able to walk any more. I am now over $100k in debt and am planning on bankruptcy if my medical expenses aren't going to be partially or fully covered by various social agencies. One problem that you didn't address in your poll as well as why I wasn't able to get insurance or why my company didn't offer insurance is because of the overwhelming drain on the system from ILLEGAL IMMIGRANTS!!! If anything meaningfull will be done with today's problematic health care issues it's to DENY COMPLETELY ANY HEALTH CARE TO ILLEGAL IMMIGRANTS FREE OF CHARGE. THEY HAVE TO PAY CASH MONEY!!! I'M TIRED OF BEING A TAX PAYING, LEGAL, LIFE-LONG CITIZEN OF THIS COUNTRY AND I'M IN THE SITUATION I'M FACING WHEN HUNDREDS OF THOUSANDS OF ILLEGALS ARE GETTING A FREE RIDE AND THEY CAN'T EVEN SPEAK THE LANGUAGE. It's a shame and an embarassment that it's come to this in our society. I can no longer legitimatly work and I'm fighting the federal government to get SSI Disability while Paco Sanchez down the street is getting every freebe known to mankind and he's only been in this country less then two years and is doing so ILLEGALY.	WA	4/29/2006 5:29:46 PM

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Response	State	Date/time received
That, in my opinion, is what needs to be done first and formost in our country. LEGAL, TAX PAYING CITIZENS need to be the first in line for ALL services medical and otherwise and if anything is left over, then the ILLEGALS get it and THEY STILL MUST PAY CASH MONEY FOR IT, NOT THE OTHER WAY AROUND. Regards,		
What works is Health Savings Accounts. Patients need to be responsibly for paying for health care costs. If an HMO pays the bill, then they get to decide what they want to cover. If the government pays the bill, then a government bureaucrat decides what they cover. If the patient pays, then they decide whether the service is worth it or not. Only the patient can decide whether something has value for them. Government run health care is a disaster in every country it is tried. There isnâ€™t a single country that has socialized medicine that isnâ€™t having s crisis of their own definition. Everyone know socialism doesn't work, and never will. Why would socialized medicine work? Appealing to peoples desire to have someone else pay for their healthcare is a poor way to convince people that government-run healthcare is the best solution. People will pay for it no matter what. There is no free lunch.	CA	6/8/2006 10:45:39 PM
As a substitute teacher in Denver in 2004, our pay was cut one-third, in part to pay for higher health care costs of teachers. Under our current system, we are constantly cost-shifting, moving more people into the uninsured category, and putting greater burdens on Emergency Rooms, which in turn are closing because they are regarded as cost losers. Taxpayers are paying more for goods and services (e.g., $1600 extra for each U.S.-made car) due to our inflationary health care costs. Business, in turn, is less competitive in the world. After 24 years on Kaiser insurance, I was forced to revert to catastrophic health care coverage last year.	CO	2/28/2006 1:21:06 AM

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	Response	**State**	**Date/time received**
	I am a 60 year old disabled Registered Nurse; I worked all my life in health care. Because of my disability, insurance premiums are completely unaffordable for me. Having some assets prevents me from qualifying for any existing public programs. Single Payor is my only solution. It is fair, accessable, transparent and desparately needed.	CA	5/4/2006 7:03:40 PM
	When I moved to Colorado 8 years ago there were 16 major health insurance companies for me to choose from. Now, as a result of several health care laws, there are only 3. These laws required minimum coverages, mental health care, maternal care (for me a 45 year old male!) and other items. They also required more and more paperwork. By interferring with the free market the state government has reduced the quality of health care for everyone. Government must be removed from the health care system. The more we emulate the failed Soviet system the more we reap the disasterous results.	CO	2/15/2006 9:23:51 PM
	I had a skin condition yet I couldn't afford medical insurance covering anything more than emergency care. I applied for Ability To Pay medical insurance but was denied because they said I "made too much money". I was so frustrated that I ultimately lied to them so that I could get medical attention. I hadn't seen a doctor in four years and my condition was quite painful. It's sad that I had to lie, reporting a lower income, just to get medical coverage. Nobody likes to lie but I had no choice. We need a change in America and we all need medical coverage. Dozens of countries has socialized medicine and it works. Critics scoff at this yet they never ask themselves this question: Isn't it better than the arbitrary and inefficent medical system we have now? The answer is Yes, almost anything is better than what we have now in America. Please, let work together to change all this for the better.	CA	2/16/2006 1:21:57 AM
	I have been self employed for over 30 years. I have paid for health ins. during these years.my wife and I are now having health problems, and our premiums keep going up. Our monthly premium is now $1600 per month. If it continues to increase as it has the past 3 years my Insurance will cost $4000.00 or more per month by the time we retire, we are 60 years old.	KY	4/22/2006 9:44:19 AM
	Not having a national health care system has prevented my wife and I from starting our business and from taking the kind of entrepreneuial risks that make this country stronger. We have found that the stress of living without health care is easily the greatest threat to our health and well-being. Like many other Americans we desparately want to see a national health care system for ALL Americans. We will support any efforts in this direction and we will always vote against anyone or any party who opposes such an effort.	NC	6/8/2006 7:48:12 AM

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	Response	**State**	**Date/time received**
	I am really disapointed that Judges in America deny working familes a chance of basic human rights healthcare- for arguments sake we supply that Judge with the best of healthcare and recently in Maryland he fundamentally said large corporations our excempt from fairness. This Fair Share act should be past all through the country or a similar act to aid the 50 million or more from healthcare that the Government has been debating for twenty years or more. While their our many laws to protect discrimination from healthcare and abuses by providers they our rarely enforced, kind of moronic that suffering and healthcare is sanctioned by the wealthiest country in the world- In areas of science such as brain injuries America is 100 years behind some European countries and suffering can be very painful- Wal Mart and all companies have to stop exploiting labor- American Executives our paid the highest compensation in the world and our giving bonuse for cutting or eliminating healthcare and this has been going on for twenty years or so- The Government has to start representing the people and not profits and we need to enforce laes on the books for equity sake	RI	7/22/2006 10:50:12 AM
	my daughter spent two days in the hospital due to heat exhaustion at a cost of $6,000. i couldn't believe it when i saw the bill. we are lucky. we have insurance. still we will have to pay a hefty amount of that. we will have to make payments. how someone without insurance could handle medical costs that high for something so relatively minor is beyond me. it's going to be hard for me and my wife. we are putting two kids through college and a two day encounter with our current health care system costs as much as a semester of college!	KY	8/15/2006 10:40:50 PM
	As a RN I am witness daily to the waste, fraud and abuse of out medical resources by patients and physicians. Too many physicians are ordering unnecessary inpatient tests that could be done much cheaper on an outpatient basis. Many doctors place young adults on medicare and medicaid just so they can get paid. And then there are the addicts who use the hospital for a bed and breakfast when they've spent their medicaid and medicare checks on drugs and alcohol. We need to start here with medical reform.	IL	3/26/2006 8:45:43 PM
	Every citizen of the United States should have health care. Those of us who have Ins. get it socked to us. I have heard from reliable sources, the person who this happened to. If you don't have Ins. you can get your bill cut in half. That means that we pay higher Ins.premiums and not only that. they want more than what our deductable is and the Ins. pays. Dental and optical should also be covered. Oral health is inportant to all over health. Give us a nationwide Health coverate for everyone.	NY	6/15/2006 5:32:24 PM
	AS A DIABETIC, I CANNOT APPLY FORHEALTH INSURANCE IN THE TRADITIONAL FORM. MY INSURANCE COMPANY LEFT GEORGIA IN 2001. NO ONE ELSE WOULD CONSIDER ME. I HAVE A CONTRACTED PRICE POLICY WHICH COVERS ME TOTALLY ONLY IF I AM IN A WRECK OR OTHER ACCIDENT. DOCTOR VISITS,PROCEDURES ARE COVERED OR ARE LOOSELY COVERED. I AM WILLING TO PAY, JUST NO ONE WANTS TO TAKE ON DIABETES. I GUESS I COULD MARRY SOMEONE AND BE COVERED. MEDICARE IS 10 YEARS AWAY.	GA	6/8/2006 10:44:30 AM

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Response	State	Date/time received
I am a 26 year old divorced mother of two young children with an income too high to qualify for medicaid/community health programs for my children, but also too low to afford quality healthcare or health insurance for them. The court in my Indiana county has ruled that a noncustodial parent has no responsiblity to provide health insurance, which leaves all health insurance premiums and the first $900 in health care expenses to me. I am a local government employee working a 39 hour work week, but still considered a part time employee, therefore no benefits. When I requested full time employment status through a fully funded grant to the county, I was threatened with a cut in hours. I have become very frustrated, and when I was diagnosed with mild depression as a result of my divorce and the full financial responsbility of raising two kids, insurance premiums for myself skyrocketed. Now, I feel that I should discontinue treatment for my depression so that I can enjoy lower health insurance premiums and better afford health insurance for myself and my kids. Currently, the kids still have no health insurance, do not qualify for CHIPS or any health program and I cannot afford to be the sole payor of health insurance premiums for them and still pay for their upbringing. I receive no child support or government assistance of any kind. I feel like I am being punished for trying to work and do the right thing. Something has gotta change.	IN	5/31/2006 11:08:54 AM
the system is wrong....healthcare should not be a business...the business of hospitals, insurance and profit...profit from ones health?? That is the problem? There are zillions of ways to bleed the system dry and it is done everyday...everyone wants a piece of the "body" that is of no benefit to the patient. so Let's simplify the system...SIMPLIFY yes...PREVENTION....THERE ARE NO CURES OUT THERE WHILE THE SYSTEM IS PROFITABLE FOR THE PHARMACEUTICAL COMPANIES AT THE EXPENSE OF THE "body". Put a cap on all the abuses and defensive medicine practices and yes "simplify" the layers of beaucracy in the system...Let every family be in control of their "expense" account the same price for all. I lived and worked and trained as a nurse in England back then it was and is a good system but was also abused. I have ways and vision how to change and simplify the system and make it affordable and available to everyone in the USA. I have seen the abuse and corruption and bleeding of the body for over 30 years...not to benefit of the "body" but to the drug companies who now run the system and the country.... I have vision for Positive change in the system. Please contact me: ***	AZ	4/11/2006 11:38:31 PM
I found a lump in my breast while I was uninsured and didn't go to the doctor because I was concerned that I would be diagnosed and would then not be eligible for insurance due to having a pre-existing condition. It was several years later when I was finally in a position with health coverage at which point the lump had disappeared. However, the years prior to having insurance were difficult. My productivity suffered, I was depressed, I felt like a walking corpse, I had basically resigned myself to an early painful death. Not having health insurance is more than not having access to preventative care, it also has an emotional cost. My sister is currently uninsured, she has a blood clot in her arm and the hospitals won't schedule an appointment with a specialist because she is uninsured, the local clinics have her on blood thinners but she's exhausted all the time and it is affecting her work. DSHS covers single mothers before people without children so she's not likely to be covered by public programs so she's just living with this chronic condition that could kill her at any point. Now our whole family is pooling our resources to cover the $10,000 treatment because without paying up front, the hospitals won't even give her an appointment with a specialist. All our savings are going to fund her treatment.	WA	8/30/2006 3:27:14 PM
Briefly, I have type 1 diabetes and cannot obtain health insurance. Therefore, I cannot afford to pay rent, afford essential prescriptions on my own or count on being able to obtain health care when I need it. This has been a disaster and I doubt I will ever recover financially, or any other way. My life has been destroyed.	OH	2/15/2006 9:14:23 PM

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	Response	**State**	**Date/time received**
	I am a senior citizen and have been with Florida Health Care for many years. I can't praise it enough. I had bupass surgery in 1999 and had excellent care and have no idea how much it cost. I had no waiting around. I don't understand why so many have a bad impression of HMO's. My husband and I have excellent care for a very small fee, and our drug benefit with the new program is excellent. Thanks for letting me sound off. Sincerely,	FL	3/27/2006 8:24:09 AM
	After an injury I lost my job (for being injured) and my health insurance. Without insurance I was not able to get the care I needed to be able to return to work. Without the ability to work I was unable to pay for care or obtain insurance. I went for four years unable to get the care I needed and even now with insurance, pre-existing clauses prevent me from getting all the care I need. Lack of insurance left me unable to work for over four years. If national healthcare would have been available I could have been back to work in six months. This financially ruined our family and we would have ended up homeless if not for our extended family.	SD	6/21/2006 8:54:16 PM
	My husband has had two heart attacks. He works 60 hrs a week and we cannot afford COBRA coverage. If he loses his job, no one will sell us affordable coverage. He would like to retire for health reasons, but can't until he is eligible for medicare. His employer cannot afford to offer more than a $4000 deductible policy, but would like to offer more. Jobs in this area are moving overseas at an alarming rate because employers can't compete with manufactures that don't provide health care to their employees.	MI	3/14/2006 6:17:31 AM
	Every one refers to the insured and the uninsured. I fall into the category of the underinsured, I guess. I have an individual insurance policy (which covers only me). For that I pay $354.50 a mo in premiums, and the policy has a $2,000 annual deductible. So I pay almost $7,000 a year before my insurer will then pay 80% of costs. In the last 5 years my premium has increased almost 45% each and every year over the prior year. There is no protection for anyone who has an individual policy, they have no bargaining position, they have to pay whatever the insurance company wants them to pay. In my state of Minnesota there are 218,000 people with individual policies with my insurer alone, but there is no way to let them group together to get group rates, everyone fends for themselves. Also, please note, the last few years I have not gone in for my "annual" exams (ie mammogram or pap). They have become every other year simply because I cannot afford them with having to pay for my premiums and deductible. So for me, the affordability issue has now influenced my preventative care and I'm bypassing it. Having a colonscopy is not even in the picture. I used to be a small business owner, therefore I have had an individual policy for the last 20 years. I currently do not work and I am not able to collect medicare for a few more years. So I am spending my retirement funds on health care. My retirement funds are not that great, and I own my own home,and that keeps me from being eligible for low income subsidies. However, it is leaving me in a position that I will not have retirement funds to help support social security payments. I need to decide which is more important to me, retirement or health. All I know is, I can't have both.	MN	4/10/2006 11:03:11 AM
	I have been turned down by my local MA office and minnesota care because I do fall a little bit above their guidelines and I am not understanding thatwhen my husband is on social security and I work as a casual worker in a nursing home. What are people suppose to do just end up running huge medical bills if they get sick or hurt that they can't pay and when a person does go in the doctors office and they are asked about their outstanding bill at the desk is very embarrasing and should not be done.What is wrong with this country that they can let people go without medical insurance until it is to late for them.	MN	5/24/2006 6:32:54 PM

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Response	State	Date/time received
My husband lost his job. He carries the family benefits. Fortunately he found a new job with benefits in 2 months, but our COBRA payments for those two months were $1224 a month! COBRA? At those prices, they ought to call it boa constrictor! This is how strongly I feel. If I lost health insurance, I just would not go to the doctor. You can't be wiped-out financially if you don't go in!!! Develop a suspicious growth? I'd put a scarf over it. Bad cough? Turn up the IPOD. If I had a car accident and were bleeding at the side of the road, I would not let the EMTs take me to the hospital. I would have a few requests. That they keep the morphine drip flowing (morphine, cause it's out of patent (!) is cheap. My family could afford this out of pocket.) Then I would ask the EMTs to take out a sharpie and write "No Health Insurance" on my forehead and then call the press. I would demand that they leave me on the side of the road. With any luck, the local CNN affiliate would patch the story straight to Wolf Blitzer's Situation Room. Hopefully, I would live through Paula Zahn, manage to mumble a few words to Anderson Cooper, and then sign off with Larry King. I would not impoverish my family. If this is what it's going to take to wake Congress up, I would literally give my life to be the alarm clock. I am fed up!!! Keep posting your comments, Americans. There will be a tipping point here PDQ. Congress will figure out that we're all furious. Then just you watch. Both parties will propose a universal health care plan! Denny Hastert and Nancy Pelosi will trip over each other racing to the podium to declare it was their idea first. Memo to Congress: we don't care who proposes it. Follow the recommendations of your own Working Group! WE WANT ACTION!	MN	6/9/2006 2:19:05 PM
I am on a fixed income. I have had the same insurance for about 14 years. I got the insurance shortly after having back surgery. The insurer not only considered anything to do with my back as a pre-existing condition they insisted on putting in a ryder that states that nothing related to my back will be covered. Because it is an individual policy the new laws concerning pre-existing conditions don't apply. I can't understand why. If anyone needs that help to eliminate pre-existing conditions it is those of us who cannot get into a group policy and have to resort to an individual policy. Recently I had my third back surgery. WHat good is insurance if it will not help you with the health cares you have. Other than my back I am fairly healthy and have not required much from my insurance.	OH	6/28/2006 5:12:07 PM
I am 75 years old. When I was in high school many many years ago, Congress was talking about universal health coverage but in all these years, nothing was definitely accomplished to help the average American get basic health care. Why are we still struggling with this issue when all other developed nations have found ways to cover their citizens health needs? I think we have to look to the lobbying of those with financial interests such as insurance companies. It is long overdue that Congress serve the interests of the public, not the lobbys. It is a shame to have sold out the American public's medical needs. I favor a single payor Federal government system in which all citizens would form a major financial pool. The process by which this would be accomplished should be left to the financial experts in this field. We need basic health coverage now, not 50 years from now. I commend you on your extremely worthy program and hope that this dream finally comes true.	UT	7/6/2006 11:19:33 AM

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Response	State	Date/time received
As a retired Senior Citizen, I cannot have my eyes or ears tested unless I pay for it separately, nor will Medicare cover the extremely expensive cost (especiallt for those on limited incomes) of glasses or hearing aids. I guess our government likes Seniors to be blind and deaf.	CT	8/24/2006 6:14:21 AM
I am a school nurse in Philadelphia and my opinion is that in order to qualify for health insurance you have to be very very poor. The qualification guidelines that have been established leave many working parents that are not recieving health insurance through their employers with the dilemma of having to choose in between paying for food and utilities or paying for health care. Health is more im portant than any other issue that society faces. Without health children cannot perform in school and adults cannot be productive in society. If this city, country, doesn't do something about affordable health insurance for all its citizens, tax payers will have the burden of having to pay for dissability income for many american citizens.	PA	3/22/2006 11:10:29 AM
I am disaled and live on Social Security Disaility checks of $660 per month, which is my only source of income for rent, food & all other necessities. I have no other support. Few people realize that there is virtually no dental care eing provided for low income people on Medicare & Medicaid any longer, & there hasn't been for many years. Dental care is expensive & just as necessary to good health as any other kind of health care! Provisions should e made so that all Americans can get the dental care they need. A growing number of people, myself icluded, are becoming increasingly disenchanted with the Allopathic method of health care, & would much prefer to see an acupucturist, a herbalist, naturopath or masseuse for preventative health care & have help with purchasing supplements, herbs, etc. instead of pharmacuticals. Medicare & Medicaid do not provide for this. This is discrimiatory & should be changed!	MO	3/20/2006 6:01:34 PM
I have been laid off for 10 months and it is just as hard to find a job let alone try to get insurance for me. My 2 children are covered, one under her father and one thru Husky, but I make too much money on unemployment for me to get insurance thru the state (about $150 over the monthly limit). I cannot make ends meet now and the deductible and downpayment on insurance quotes would put me in more debt. There has to be some form of Fund that can help single parents get basic insurance, (preventive care, Dr visits, perscriptions coverage) until they get on their feet. There is help for people w/ AIDS, for elderly, and disabilities, but what about us!! I am willing to pay a reasonable amount, and I dont expect anything for free but there are times I (we) need help to and there is nobody out there to help.	CT	5/8/2006 10:17:37 AM

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Response	State	Date/time received
My family is quite healthy. We make special effort to take care of ourselves and lead a balanced lifestyle. However, on occasion we do require a visit to the doctor. About two years ago, I needed to have my annual check up and had been experiencing a few problems. After the check up, labs, etc. It was determined that I had developed mild depression due to multiple stress factors. After paying $6,000 in premiums in the past year, as well as an additional deductible of about $1000 I was denied coverage through my insurance company. As well, my son had been diagnosed with Attention Deficit Disorder (without hyperactivity)and was also denied coverage under the plan. Since we rarely go to the doctor for anything other than routine checkups, we could not justify paying the $500 + monthly premiums, plus prescription costs and deductibles (that rarely get met)...so we had to drop our coverage. Now, if something "bad" should happen, we are at risk of losing everything we've worked for our entire lives because we cannot justify paying $6000 premiums each year for NO COVERAGE!!! The "healthcare" system in this country is NON EXISTANT!!	WA	2/18/2006 1:03:29 AM
My husbamd had head and neck cancer surgury five years ago. I can say the experience we had with the doctor that did the surgery was less than desiable. He got paid a lot of money through our insurance company. He was rude and indifferent to our situation. Since it would have been and 80 mile one way for radiation we chose to go stay with our son and have radiation there with only six miles each way for the seven weeks of treatment. Then we were told to return to the surgern for the follow-up visit. Every time we ask a question he would say go back to radiation. I know he certainly didn't make a hard experience very easy. I did write the hosiptal administration about how he treated us hoping he would be removed from their staff but of course that was never done. I feel he got paid a lot of money and we didn't get the service and that cost us all. I will say the doctors and staff were we had the radiation were great and when I called them and told them the situation they were very unhappy since they said a positive treatment helps heal and my husband didn't get that from his doctor. We need better ways to revoke doctors licences and fine hosiptals that don't give good care.	MI	3/17/2006 8:25:28 PM
Our family pays out of pocket about $1300 per month for insurance! We are pleased with the coverage. You buy what you can afford and you get what you pay for.	CO	2/16/2006 12:37:11 PM
My mother-in-law, at 84 was in Sarasota Memorial Hospital. She was diabetic, had kidney failure, and had suffered numerous heart attacks. She had stopped eating. She was recussitated after hospital had no-recussitate orders. They called family every time to get orders to keep her alive even though they had orders not to do so. My brother in law always told them to go ahead to try to revive her. She stopped eating. She had numerous brain wave tests and numerous dialysis treatments. She was in hospital 3-4 weeks. She was losing an ability to breathe when the assigned doctor wanted to place a feeding tube. I told him I disagreed and the doctor had paperwork in place so he should not do this. Fortunately, the poor lady died. This entire situation could have been avoided. Hundreds of thousands of dollars would have been spared the Medicare system had that doctor not called the sons of the dying woman, asking if they just wanted to try one more thing to help save her. Both sons were out of town and feeling guilty they couldn't be there. The doctor played on that to build a larger bill. I was angry. It was deplorable.	FL	2/15/2006 10:26:05 PM

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Response	State	Date/time received
Updated: July 24, 2006	CA	7/24/2006 8:31:01 PM

Or how I ended up having my monthly less-than-sustenance income cut almost in half.

I am receiving Social Security Disability Insurance benefits for systemic lupus and some other just-no-fun health conditions. This insurance program is abbreviated as SSDI. Contrary to popular myth, it is often NOT very easy even for people who are quite sick to get awarded SSDI, so kids, don't try this at home.

SSDI comes automatically with Medicare coverage, after a 2-year waiting period. I was told once by a government official that a lot of money is saved due to people dying in these 2 years. Don't have to pay benefits to dead people. However, I am long past my two years.

Until this year, when Medicare Part D was established, Medicare did not provide any prescription drug coverage. I was therefore very dependent on being accepted to my state's Medicaid Medically Needy program (known as Medically Needy Medi-Cal here in California) to pay for my long list of expensive monthly prescriptions. I am part of a local managed care program for this Medi-Cal coverage, which has to be re-applied for annually.

Since I now have the Medicare Part D, at least for this year (so far no one has been able to tell me what happens to me after December 2006), I am able to get my prescriptions through this program and Medi-Cal has stopped paying for my prescriptions. However, I am still dependent on Medi-Cal to pay for my Medicare-allowed copays for medical procedures. Since many medical procedures are expensive, this can add up to a not-inconsiderable amount of money.

This year, through no fault of my own, I lost "free" Medi-Cal. If this had happened last year, before Medicare Part D prescription coverage, I would be dead now, and as things are it is still going to be a hardship.

I lost the no-share-of-cost Medi-Cal coverage due to the annual cost-of-living increase in my federal SSDI benefits. This put my income very slightly above the limit for a program called the Aged, Blind, and Disabled Program which was allowing me to get Medi-Cal with no share of cost.

Unfortunately, the deductible I now have to pay is not something reasonable like, for instance, the difference between the amount of benefit I was getting last year and what I am getting this year. Instead, Medi-Cal gives me a monthly allowance of only $600 per month -- less than people receive on the "welfare" program of SSI here in CA, which comes with no-share-of-cost Medi-Cal--and I have to pay for any medical expenses up to what would leave me with that $600 "maintenance" level of income before Medi-Cal will kick in and help me.

In California, I cannot live on $600 per month. Since it took me years to build a personal support system and to find good doctors who accept the coverage I have, moving is probably not an option. And, of course, there are many states where Medicaid is not even as generous as California's.

I think I am still eligible for the special lower copays for my medications that I really need to have under Medicare Part D, as well as for the payment of my Medicare premiums, under a program called Qualifying Individuals (QI-1). But I confess to being concerned about eventually ending up being kicked out of that program as well. I have no control over the annual Social Security cost of living increases.

There IS recognition that people should not be put in positions like mine due to the Social Security cost-of-living increases. If I were receiving SSI, the disability benefits program for people who have not paid at all or as much into the Social Security system, and I lost Medi-Cal due to a cost-of-living increase, I would be protected from losing my no-share-of-cost Medi-Cal by the Pickle Amendment.

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Also, if Social Security had not decided a few years ago to switch my benefits from being partially funded by my deceased father's income (Adult Disabled Child benefits) to being fully funded by what is based on my own earnings, I would still be eligible for no-share-of-cost Medi-Cal. That these protections exist for some indicates to me that those of us on straight SSDI should have what is now quite a punishment under the law be changed to protect us as well from losing Medicaid due to cost-of-living increases. While I am on the subject of SSDI, I want to mention that I personally find it deplorable that the rules for work attempts are so much more favorable under SSI than SSDI. I have heard many people on SSDI say that they are afraid of attempting to work as they know they would eventually lose their medical benefits, and with the U.S.'s present health care system, this can be fatal to a person with a severe illness. On SSI, you can work a certain amount in perpetuity and still keep your health benefits. For many SSDI recipients, this is not true. Although some have been able to earn up to a "substantial gainful activity" amount of $860 per month (for 2006, before-tax income) and not lose their benefits, others, like myself, have been told that any work activity could trigger a re-evaluation and a decision that they are not disabled at all. In any case, SSI recipients can earn more than that $860 before losing their health benefits. Since SSDI is the program for people who have actually paid into the Social Security system, it makes no sense to me that it has punitive elements other programs do not have. I face another work disincentive due to the provisions of Medicare Part D. Medi-Cal has recently been changed to allow beneficiaries to keep some of their earnings before those earnings are added to the monthly share of cost that must be paid before Medi-Cal kicks in (the formula, as I understand it, is that you keep the first $65 and then 1/2 of the rest of your monthly income, with the balance being added to your share of cost, which allows at least some people a work incentive). But if I earn money and go over the income limit for the federal program QI-1, I will have to pay for my Medicare premiums and also, it looks like, some very hefty copays for my medications. I would have to have enough income after taxes to pay for all these before working even broke even for me. And I don't know if I will have to deal with the nasty "doughnut hole" of no medication coverage for quite some time per year on Medicare Part D if I am not on QI-1 any more. This is all pretty complicated, and I don't know how sick people are supposed to be able to easily find all of this information and understand it, let alone fight it when something happens to hurt them. The penalty for getting it wrong, if your illness is severe, is death. I hope caring people feel free to share their feelings on the above problems with SSDI with their elected representatives. This is just one person's example of a health care access morass. Surely the US can think of a fairer, not to mention less administrative-cost-heavy, way to ensure health care for all citizens.		

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In 1998 I was stopped in traffic on the hwy when a semi hit me from behind going full speed. Since then I have undergone several surgeries including a spinal fusion, which was done in 2000. Thank God I am not permanently disabled, but I do have to live with pain and medication is necessary for me to function on a daily basis. I am having a hard time being able to afford the medications required to live with chronic pain. My doctor cancelled Regence Blue shield so he doesn't accept them any more and I have to pay cash for every visit. Currently, Regence does not want to cover the prescribed medications. Our monthly family medical premiums are over $1000/mth. I am on Cobra and when it expires I have to worry about whatever new insurance company I end up with will not cover me due to preexisting conditions. I was told this is illegal, but the insurance companies get away with it anyway. My neurosurgeon left the state in 2001 because the insurance premiums were too high and they were not paying him properly for his services. For an example, I had a 6 1/2 hr fusion surgery and he was paid a total of $1300. This is outrageous; it was just after that when that doctor left the state permanently. He simply wasnâ€™t making enough to make ends meet. I support a wife and 2 kids, ages 2 and 5. It is vital for me to manage my pain level to get through the day. We pay over $12k/year in medical premiums and we are not seeing any benefit to our family. I can easily be accepted into permanent disability status based on my condition. I work very hard to overcome my condition and the insurance industry seems to only be concerned about making profit. They have way too much control. I have made several calls to pharmacies that agree. Every doctor I have talked to regarding this issue over the years also agrees. The patients and the people paying the high premiums suffer the most. There must be tighter controls on the insurance industry.Please help us stop the insanity and greed. There are so many people I have worked with who feel the same way, but there doesn't seem to be many avenues of approach. Many are busy making a living and have to work extra hours just to keep up. There literally is no time during the day to make calls to legislators, ect. Please, help.	WA	2/17/2006 3:36:45 PM
I am a health care professional. I take care of patients after they have been released from the doctor after a heart attack and or bypass surgery, which both Medicare and Medicaid cover in a program known as Cardiac Rehab. I knew that Wal-Mart had a reputation for poor care to employees, but I had no idea until I was referred a Wal-Mart employee to help recuperate from a heart attack. She was working at the time the symptoms began, including the strange chest pressure,shortness of breath, nausea, and co-workers telling her how badly she was looking at the time. Her employer did not call 911, or rush her to the emergency room. No, they insisted that she get coverage for her shift, before she sought medical help. She also told me about similiar cases in which employees ill with chemotherapy were encouraged to be greeters, rather than utilize the FMLA, which protects their jobs. These emplyers use fear and intimidation and guilt to make desperate, uniformed people to do things some of us would consider cruesl and appalling in this day and age.	WA	2/21/2006 6:55:45 PM

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	Response	**State**	**Date/time received**
	When I retired I lost access to a very good health care benefit that was self-funded by the organization I worked for. The big problem in terms of health care was a constant struggle between peoplewho chose not to participate because of high costs and then wanted in when they began to face high costs. We need everyone in the same program paid for by a progresive tax. Thankfully, I do have access to health care through my wife's employment. It is Anthem, Blue Cross, Blue Shield. Fortunately I was able to keep my same physician. This is extremely important to me since I am a transgender person and have specific and often unrecoginized health care needs. It would be a disaster for me to give up my physician after working with her for years. As it has turned out, taking a low dose of Premarin (estrogen) as a male has been extremely beneficial. Think of it as a desperately needed vitamin I didn't know I needed so badly. My general physical health showed an immediate and significant positive turn around. I got a powerful sense of generally improved body health and it soon showed up in better functioning of my digestive system, terrific improvement in general skin quality, muscle quality, etc. (Estrogen though thought of as a sex hormone functions as a growth hormone.) Anthem immediately denied coverage for me for Premarin because I am a male legally and genetically. They rejected an appeal from my physician. So I have to pay about $500 a year for my Premarin out-of-pocket. I had coverage for Premarin under my previous health care plan. So, we need a better appeal process with real patient rights and the recognition that not everyone has standard issue bodies. When there is disagreement, the judgement of physicians should be trusted. I am so glad I do not have to rely on Medicare Part D, at least not yet. Part D gives all the power to the private provider and there are no real appeal rights. I also had another major prescriptions problem. I am seriously allergic to statins, the drugs of choice for treating high cholesterol. I have a history of moderately high blood pressure and had a procedure to put two stents in my coronary arteries. It took about 6 months to get Anthem to approve and deliver the drug Zetia to deal with my high level of triglycerides, though with my primary care physician we finally won on that one. My learning is that private pharmacy benefit managers are incomepent and profit driven and that my needs were of little concern to them. All the sweet talking that seems to be standard patient relations policy is no compensation for such mistreatment. Specific drugs that treat for life threatening diseases are not appropriately managed through patents and profit driven production and then manipulation of the management and delivery system. It is insulting when politicians suggst I am taking drugs I don't need and assume that denial of coverage is the right policy, even including the rejection of prescriptions by physicians.	MD	3/23/2006 5:29:29 PM
	As a registered nurse, I worked in not-for-profit hospitals for 22 yr. I watched as these hospital systems began to duplicate services, build luxuious facilities, have far too many chiefs and not enough Indians, and cut back on programs like Diabetes Management, that would benefit public health. It became all about competition and rivalries, instead of efficient,competent and compassionate health care. Millions are spent on advertising. CEOs are offered outrageous salaries. Offices are remodeled and redecorated even if this has been done the year before. Waste is everywhere in trying to keep up with the Joneses. The hospitals dont pay taxes. Yet, they behave like for-profit corporations. They are supposed to meet the needs of the community, but either duplicate services offered or skimp on those that could be helpful. If it looks like a duck, walks like a duck and sounds like a duck, it is a duck. These hospitals should be paying taxes to offset the cost of assisting the uninsured. Instead, they are wasting money in competitive ventures. If you are meeting a necessity, you dont need to compete. Much of the reason there is a nursing shortage is that nurses burn out quickly. Long hours, critically ill patients, and staff shortages will do that. Instead of putting a nurse behind a desk,	IN	2/16/2006 1:57:56 AM

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	Response	**State**	**Date/time received**
	she/he needs to be part of the patient care staff. The emphasis needs to be on quality patient care, not hotel-like facilities and top heavy management structures. As a patient, I have waited hours for pain medication because of short-staffing. I have suffered nosocomial infections. I have had poor care and even insulting care. I was denied life-saving surgery, at one point, when the doctor accused me, a Roman Catholic, of wanting an abortion. I had to threaten legal action. When I finally had a laparotomy, it was discovered I had a tubal pregnancy, which ruptured in the surgeons hand. Had it ruptured in the peritoneum, I would have suffered sepsis, with a high mortality rate. My coverage was an HMO. As far as HMOs are concerned, they should not be allowed to deny visits to specialists, deny medications,necessary tests or approved treatments. They keep raising the co-pays and deductibles, while their CEOs feed at the trough. My husband and I pay over 600 dollars a month for medication. The pharmaceutical companies and insurance companies are rolling in dough. All of this needs to stop. The system should not be based on making the rich that much richer, like Larry Glasscock and Sidney Taurel. It needs to be patient care and compassionate care centered. What we have now is anincredibly unfair system focused on creating wealth not health.		
	In 1999, I got a staph infection in my artificial hip. Evenutally, it had to be removed for the infection to be treated fully. During the past few years as I've dealt with that situation, I have had many, many complications with my healthcare insurance, which has made my medical problems so much more stressful. Even though my doctors wrote to justify my treatment in NY (out of network), I had many complications with the insurance companies. My problems with the current system were that the insurance companies made so many mistakes in their payments that I had to call on every single bill numerous times. When all was said and done, I had very high medical bills, even though I was covered by insurance. Another big problem was that my employer switched insurance companies in between the last two required surgeries to rebuild my hip. (I had no say about this, as the company made the choice to save money.) The new insurance company would not cover the surgeries in NY, so I had to rush the last surgery and risk getting the infection back in order to complete the series of surgeries at the Hospital for Special Surgery where there was a doctor who specialized in rebuilding infected hips. Also, the expense of the insurance coverage was over $300 a month while I was eligible for Cobra. The Cobra coverage ended in 18 months, when the Medicare coverage wasn't available for another 6 months. In that time, I had to buy indivdual coverage, which was so expensive I couldn't afford to use it, because there was also a large deductible and plenty of co-pays. Now I have Medicare, which is so poor in terms of coverage, leaving lots of costs, that I self-treat more often than not and hope for the best. One of my biggest complaints about Medicare is that it doesn't cover vision or dental. (This is what we offer our seniors???) This month, I will pay $2,000 to get one tooth fixed. Since I've run into health problems resulting from infection I got in a hospital, I have gone so far into debt that I don't know if I'll ever dig myself out. And much of this debt is on credit cards, which I understand is exempt from bankruptsy risk. Where do you think people put medical costs when so many dentists and doctors require payment in advance? or who don't agree to insurance company rates? It goes on our credit cards. One more thing: The idea that malpractice insurance is the big reason for healthcare costs going up is a smoke-screen. In 2002, a surgeon operated on me the day after he had lasik surgery on his eyes. He cut two major blood vessels during the surgery, and I almost didn't live through it. I checked into suing him with a half dozen attorneys and got the same information. My condition was not bad	WA	2/16/2006 9:09:50 PM

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	Response	**State**	**Date/time received**
	enough for them to take on the fight, because the doctor's insurances put up such a long and rigorous fight. The attorneys said it sure sounded like a strong case, but he proceeds wouldn't be enought to take on the long fight. So, that tells me what I've read about the myth is true. Not very many people who suffered malpractice even file a law suit. Those who do probably deserve their awards. Also, I understand in Washington that the doctors actually own the malpractice insurance company and get kick-backs, so the whole controversy seems suspicious. 0 The cost of healthcare is exacerbated by the outlandish money doctors expect to earn. My surgeon, though gifted, hardly seems deserving of the amount the insurance paid, over $32,000 for about 10 hours of his time. And I will be paying for a long time afterwards on the extra $6,000 he demanded that I pay of the other $32,000 he wanted that the insurance would not pay. It seems the bottom line is that our healthcare system is more about profit and high life styles of doctors than the needs of citizens. So much more could be done in terms of health maintenance with environmental controls, health messages directed to the public, and other techniques to create a culture of health and respect for each other.		
	My college teaching profession has been "Walmartized" into permanent, part-time work without healthcare benefits(across the nation, currently 65+% of all college professors). I have struggled for 8 yrs to pay for my own insurance on less than $25,000 a year wages. The premium cost having risen recently to $3600a yr, I am now forced to give up my coverage this month (2/06), and join the ranks of the uninsured.	CA	2/19/2006 2:34:59 PM
	The company I am employed with recently changed our insurance carrier, we had two choices to choose from. One being Kaiser, and the other a health care plan, we were told that if we selected the healt care plan that nothing would change, which has been proven to be untrue. We are now paying much higher co-pays for prescription drugs and also less coverage for our medical expenses. We also cannot have our same Dr. if he or she is not recognized by the health plan. This has created a problem as I have a cardiologist that is not (I have been seeing him, my husband also, for the last 5 years after every since my heart surgery)and I just received a notification that this Dr. is not a provider with our insurance and therefore I owe this Dr. over $1000.00 since Jan 06. Our prescripions copays have doubled and tripled. I can not beleive how nothing will change has become a nightmare for the employees who are also paying a higher premium per month.	CA	3/22/2006 1:44:14 PM

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Response	State	Date/time received
Poor circulation in the left leg. Two bypasses already, unsuccessful. Took a while to find an orthopedic doc, b/c I had too much surgery. Found one at Temple. He said the leg was so bad I may loose it. I had a 12-hour operation and they saved the leg. He said he still may have to take my toes, but I felt fine. That surgeon helped me walked again. The operation left 280 staples, 26 stitches, and a few stitches that dissolved. This was August. February I got stitches taken out and the stitched my arm bent, causing me to get another surgery to fix the damage. (Five surgeries altogether, 3 in the leg and 2 in the arm). Germantown (Wilacrest) Hospital, I would not recommend to anyone. I had my insurance company move me out. I used Elder Health insurance (they provide transportation). It was covered completely. I need therapy (first bill $420), which is not covered by Elder Health insurance, but I also has Health Partners (under welfare, I have to pay $46 a month) as back up and Medicare. The qualifications to receive free health care are way too low, you have to almost have absolutely nothing, and be dirt poor to get itâ€¦ People straight off the boat get it, and we are born here and have to fight to get it! Donâ€™t go to Germantown Hospital. Food and service is terrible. My insurance company moved her out of that hospital. The emergency there is ok; if you have to stay they send you to Einstein Hospital. When I didnâ€™t have health care I called the manufacturers of the meds and they told me about RX programs and sent me a 3 months supply of meds. My other issues are: The ER will only take care of one problem. It is hard to find a good Family Doc.	PA	5/25/2006 11:52:45 AM
My problem is probably the same a others on Medicare D. Before I joined Medicare D, I was eligable for discounts from manufactors, and received help from the State of North Carolina. Now on Medicare D,I reahed my limit by May 1. What do I do. First, I stopped taking one prescription, next, I asked my doctor to change any of my prescriptions to generic. Only one has a generic. Next, I stopped taking some of my medicine every day, but took it every other day. At the price of my prescriptions, what could I do????? I misunderstood what I had read about Medicare D. OUT OF POCKET, meant my pocket, not the whole cost of the medicine. Sttill I have to pay the insurance company although I am not gettting any service from them. HELP!HELP! I worked until I was 65, had health problems, always paid my taxes and voted.	NC	6/8/2006 9:09:49 AM
all was well until my wife and I became self employed. We pay 1,400 per month for insurnce. age 60 and 55. It is a real burden and drains us financially. I ama Viet Nam vera vet and I was excluded from va healthcare by the Bush Admin as were all section 8 vets. This sucks and demonstrates the mis placed priorities of our government. Make everyone buy insurance on their own and you will see major changes.	SC	7/15/2006 6:41:43 PM

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Response	State	Date/time received
Prescription Drug Advertising.	MN	2/10/2006 4:46:37 PM

Where is the Outrage?

The majority of legislators in Congress simply do not get it! The largest contributing factor in the outrageous cost of prescription drugs is advertising and promotion -- about 37% of the price we pay for those drugs. The cost of research and development (R&D) for new drugs does not even approach that percentage, since a huge part of the research going into the development of new drugs is performed by our National Institutes of Health. About twenty-five billon dollars of taxpayer money goes to the NIH each year, much of which is spent on research for the development of new drugs. It is the pharmaceutical industry's advertising, promotion and excessive profits, not research and development, that drives up the costs of prescription drugs.

The incredible waste of valuable prescription drug resources is appalling. Here's but one example of such waste: There are hundreds of thousands of pharmaceutical company ads that appear in many thousands of magazines and newspapers each year. Most of the major pharmaceutical company ads in magazines usually contain a couple of pages of 'stats' describing the product and its contraindications. These pages are usually set in type so small that they cannot be easily read. And if one were to take the time to read it, the technical language is virtually incomprehensible to almost all readers. Since only a physician may prescribe prescription drugs, such information properly belongs only in medical and professional journals.

Billions of dollars are spent (and wasted) each year on television and print media ads. These enormous costs are reflected in the price of the product. Direct to Consumer (DTC) advertising of prescription drugs should be banned. The United States and New Zealand are the only countries that permit DTC advertising of prescription drugs -- and prescription drugs in New Zealand are heavily subsidized by the government (and, as an indirect result of DTC advertising, so are pharmaceutical companies). Drug prices in most other countries are about half those in the United States.

But the most damnable outrage is the recently-passed Medicare prescription drug legislation language that prohibits Medicare from negotiating Medicare prescription drug prices! You can bet that it was the drug companies that wrote that provision into the bill. The gratuitous 'discounts' that are being offered to low income prescription drug consumers by the pharmaceutical industry are a sham. What good is a 25% discount when the product is 200% overpriced?

The pharmaceutical industry does not need any more protection -- it needs less! It is the drug consumer who needs protection from drug companies. It's time to rein in the pharmaceutical industry drug cartel and their congressional co-conspirators.

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Response	State	Date/time received
MEDICARE PRE$CRIPTION DRUG$ -- EVERYBODY WIN$!	MN	2/10/2006 4:52:49 PM

Now that Congress has passed prescription drug coverage under Medicare, think of all the benefits that senior citizens will come to enjoy. Qualified Medicare enrollees now are given â€˜discount cardsâ€™ by pharmaceutical companies that allow for discounts off of an as-yet-undetermined double-digit annual increase in prices.

Itâ€™s too bad that non-seniors will continue to pay usurious prices for prescription drugs, but then we canâ€™t expect Congress to work all of its miracles at once, can we? At least we can now put a stop to the unlawful re-importation of those dangerous Canadian drugs. Never mind that there has not been a single documented case of death or injury due to drug re-importation. Congress has opted to err on the side of safety. This safety net will assure that U.S. pharmaceutical manufacturers will prosper and we can continue to enjoy those thousands upon thousands of wonderful television and print media ads extolling the virtues of these gratuitous â€˜angels of mercyâ€™.

Hereâ€™s the beauty of it all. There is explicit language in the Act that prohibits Medicare from negotiating prices with drug manufacturers. By allowing drug manufacturers to gouge Medicare according to whatever the market will bear, pharmaceutical stocks will soar in value.

And thereâ€™s an added bonus. Insurance companies and advertising agencies will be taking an even larger slice of the prescription drug benefit. This Thanksgiving â€˜turkeyâ€™ that Congress and the AARP has served up will redound to their benefit -- big time! But there is more good news. After the pharmaceutical, insurance and advertising interests have gobbled up most of the turkey, there might still be enough of the carcass left for the drug consumer to pick on.

Those of us who have millions of dollars in pharmaceutical, insurance and advertising company stocks soon will realize unimaginable gains. In 2002, combined profits for the ten drug companies in the Fortune 500 ($35.9 billion) were more than the profits for all the other 490 businesses put together ($33.7) billion. CEOs of major pharmaceutical companies will no longer have to be content to receive an average $37 million in annual compensation.

With additional growth incentives, such as more tax relief, pharmaceutical company executives will have the financial freedom to further expand their enterprises abroad -- not to mention that their companies wonâ€™t have to pay taxes to the U.S. government. Donâ€™t worry about loss of tax revenue. Those that do pay taxes will pick up the slack; or we can push the inevitable day of reckoning ahead to those who will have to deal with todayâ€™s record-deficit spending tomorrow.

With privatization of Medicare prescription drug benefits now a fait accompli, insurance company involvement has added to the administrative costs of providing benefits. The administrative cost of providing medical benefits under Medicare formerly had been about two percent. According to some experts, involving private insurance carriers could keep administrative costs down to about nine percent.

And letâ€™s not forget the hidden costs of obtaining this prescription drug legislation. Pharmaceutical companies have donated millions of dollars to Senators and Representatives for their election campaigns. Can you just imagine how much President Bushâ€™s campaign had received from a grateful pharmaceutical industry for his support?

Although there are far too many to list here, be sure to remember all those staunch defenders of the free enterprise system when you vote in the next elections.

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Response	State	Date/time received
IT'S ON THE INTERNET!	MN	2/10/2006 4:57:34 PM

A 51-page report by the Office of the Minnesota Attorney General -- a scathing indictment against the pharmaceutical industry and its practices. The report is entitled: "FOLLOW THE MONEY. The Pharmaceutical Industry -- The Other Drug Cartel'.

On September 30, 2003 I attended a meeting with the Minnesota Attorney General, along with about 15 other retired persons, to provide additional input on the outrageous price gouging by the pharmaceutical industry. This meeting was held prior to a press conference at which the Attorney General announced that he had filed a lawsuit against Glaxo-Smith-Kline for alleged conspiracy with other pharmaceutical companies to stop re-importation of drugs from Canada.

Following is the Summary of a 51-page report on the pharmaceutical industry, prepared by the Office of the Minnesota Attorney General and released on September 30, 2003.

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Summary of Report Below

The full report may be viewed by searching the net: FOLLOW THE MONEY. The Pharmaceutical Industry -- The Other Drug Cartel

EXECUTIVE SUMMARY

Section One and Two: Industry Profits
Approaching 15 percent of the gross national product, health care is the fastest growing, and one of the largest, sectors in the American economy. The segment within the health care sector growing fastest is prescription medication, which represents almost 18 percent of the health care dollar. By the end of this decade, the Medicare population alone will likely expend $228 billion on prescription drugs. With a profit margin of 18.6 percent in 1989, the pharmaceutical industry has been the most profitable industry in the United States in each of the past ten years, approximately 5-1/2 times more profitable than the average Fortune 500 company.

Section Three: Research and Development

While the industry justifies its profit margins by claiming that it invests a large percentage of revenue in research and development (R&D), it fights every attempt by the government to verify the extent of R&D investment. In fact, experts estimate that up to 85 percent of R&D funding comes from the National Institutes of Health (NIH), public tax credits, private foundations, and academia. Indeed, one tax credit alone allows a 50 cent credit on tax liability for each dollar spent by a pharmaceutical company on R&D. This tax credit, combined with other tax credits, rewards the pharmaceutical industry with the lowest effective tax bracket of any other industry -- roughly half that of other corporations and half that of the average family.

Section Four: Public Funding of Research and Development

A substantial amount of profit comes from new drugs which are discovered and formulated through public foundations and universities, which then license the drugs to a pharmaceutical company for a small fraction of the company's ultimate profits. For instance, the breast cancer drug Taxol was developed with $32 million in federal funding after approximately 30 years of research. The NIH licensed Taxol to Bristol-Myers Squibb in 1992, which then generated $1 billion of revenue per year on the sale of the product. Bristol-Myers then extended its exclusive control over Taxol by manipulating the U.S. Patent Office with deceptive patent claims, keeping a generic form of Taxol off the market. Other examples of blockbuster medications developed with substantial public funding are Tamoxifan,

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Xalatin, AZT, Zovirax, Capotin, Platinol, and Epogin. Experts indicate that most of the R&D financed by the pharmaceutical industry appears to be directed to "me too" drugs that, for instance, change a molecule of a drug coming off patent so that the company can petition for a new patent on the modified drug which is then marketed as "new and improved".

Section Five: Marketing in the Pharmaceutical Industry

While the extent of the pharmaceutical industry's investment in R&D may be questioned, its commitment to marketing is crystal clear. For each dollar received by the pharmaceutical industry, approximately 37 percent is spent on administration and marketing, almost three times the amount allocated to research and development. According to one study, the industry's marketing staffs increased by 59 percent between 1995 and 2000, while research staffs declined by two percent. One expert concludes that if drug prices were regulated, any reduction in expenditures by the industry would be in marketing, not research and development.

In 1996 the U.S. Food and Drug Administration relaxed regulation of "direct-to-customer" ("DTC") advertising. As a result, the industry spent $2.5 billion in DTC advertising in 2001. Experts believe that DTC advertising unnecessarily drives up the consumption of drugs. One survey found that, if their physicians turned down a request for an advertised drug, approximately 40 percent of patients would attempt to obtain the drug from a different doctor.

Section Six: Industry Dominance

Unlike most other industrialized countries which have laws to regulate the price of prescription drugs, the United States implements laws to protect the industry from competition. Because other countries regulate the price of drugs, Americans find that they can purchase medications in other countries, such as Canada, at approximately 50 percent of the U.S. price. Federal importation laws, however, inhibit the ability of Americans to purchase drugs in Canada. Another law which protects the industry requires the use of the "average wholesale price" in determining amounts paid for drugs by Medicare and Medicaid. These two government agencies are required to purchase medications at a fictitious "average wholesale price" which is reported to them by pharmaceutical companies When the Medicaid or Medicare programs attempted to negotiate the price or utilize an "average wholesale price" established by the Department Justice, Congress intervened and forced these agencies to pay a minimum price at the level reported by the drug manufacturers.

Yet another law which protects the industry is the Hatch-Waxman Act, which allows pharmaceutical companies to extend the life of a drug patent and eliminate competition from generic drug manufacturers, simply by claiming that the drug has been modified or is being used for different treatment.

Section Seven: Political Influence

The political influence of the pharmaceutical industry is unprecedented. The Attorney General's Office surveyed 17 pharmaceutical companies and their industry organization, PhRMA. PhRMA alone is expected to spend $150 million in lobbying, political contributions and issue advertising in 2003. Individual pharmaceutical companies made federal political contributions totaling $27 million in the 2001-2002 election cycle. In addition, PACs sponsored by the 17 companies appear to have spent over $9 million during the 2001-2002 election cycle, two-thirds of which was spent on contributions to other political committees, particularly "Stealth PACs". PhRMA and the 17 pharmaceutical companies also disclosed lobbyist expenditures of approximately $132 million for the 2001-2002 election cycle.

"Stealth PACs" are committees whose names are intended to connote an affiliation

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	Response	**State**	**Date/time received**
	with a particular constituency when the committee's mission is, in fact, adverse to the constituency. Stealth PAC groups include Citizens for a Better Medicare, United Seniors Association, the 60 Plus Association, and the Seniors Coalition. All of these Stealth PACs are funded by pharmaceutical companies. Stealth PACs create the perception of representing senior citizens through "astroturf lobbying", which is high-tech telemarketing masked to look like grassroots lobbying. The Stealth PACs establish telemarketing banks to contact representatives in Congress, state legislators, and thought leaders and represent themselves to be senior citizens who oppose the regulation of pharmaceutical prices. The above Stealth PACs expended over $25 million in lobbying expenses during the 2001-2002 election cycle. Section Eight: Impact on Minnesota The pharmaceutical industry has retained approximately 38 lobbyists in Minnesota to oppose legislation designed to regulate prescription drugs. Last year, the industry was successful in gutting the Fair Drug Pricing Act. Other legislation defeated by the industry included the False Claims Act and a bill that would have required pharmaceutical companies to certify under oath the validity of the average wholesale prices filed with the government. Section Nine: Conclusion The report concludes that the undue influence of the pharmaceutical industry on lawmakers is responsible for the current prescription drug crisis. The inaction of lawmakers, who campaign on pharmaceutical reform but repeatedly fail to implement it, is a scandal that will only be addressed when the media and other public commentators expose the issue.		
	I believe that the government should be much more involved in the health insurance system of this country. I am very tired of hearing how the U.S. health care system is the best in the world. I am also tired of hearing how "socialized" (i.e. government regulated or controlled systems) are inferior to a private, free market system like ours. I've lived in other countries where I had to visit a doctor and/or hospital. In England, I was enrolled in their National Health system. I had to visit an emergency room for a recurring eye infection I always got every Spring. I went into the hospital, told them I had an eye infection, waited aobut 5 minutes and saw a doctor. I told him the name of the antibiotic eyedrops I always got and he wrote me a prescription, I paid one pound (about $1.50) out of pocket for the entire experience. A year later, I was in New York and had no insurance. I got the same eye infection. I visited my parent's doctor who charged me $50 and promptly told me to see an opthomologist. I saw the opthomologist, told him the name of the eye drops I needed...he did a whole series of tests on me and finally wrote me a prescription for the antibiotic eye drops I always got. He charged me $300 and the prescription cost about $10. I did not see how the U.S. system was in any way better than the English system. The English system provided faster, more efficient care for far less money than the U.S. system did. A few years ago, while travelling through Europe, I needed to see a doctor. In Germany, a friend of mine called his doctor to have him see me. I was given an appointment for later that same day. The doctor examined me and gave me a prescription. The doctor's visit cost me 20 Euros (about $20) out of pocket as I was not enrolled in the German National Health system. The prescription cost about the same amount. These amounts were the total cost of the services rendered...the cost that would have been charged to the National Insurance plan, had I been enrolled. Had I been enrolled in the German National Health system, I would have not had to pay out of pocket for these services. The actual costs for this experience were similar to what I would have had to pay out of pocket in the U.S. if I had insurance. The actual costs in the U.S. would	WA	3/24/2006 11:55:08 PM

Question	We all have different experiences getting health insurance or in seeking health care. Sometimes these are good experiences, while other times they are not. We may meet very special providers or encounter new and innovative practices. Other times the American health care system disappoints us. Please tell us what has worked well or hasn't worked well for you or your family.

Response	State	Date/time received
have been substantially more. Again, I do not see how the U.S. system is superior in any way to the German system. Both the German and English systems have significant involvement from the governments of those countries. This involvement resulted in far more cost effective treatment.		
ok	KS	8/7/2006 3:48:26 PM
I represent workers in Ma. the cost of health insurance has increased over 40% in the last few Years. I have a company that is looking to hire a Machinist.Draw back , as i have stated to the company. "we are haveing a problem because of the cost of health care $200.00 per WEEK".Most of the employees are paying in the range of $90 to $100 a week.Wages at times are below the increase of the health care increases.	MA	8/25/2006 7:15:51 AM
We have always had employer-sponsored health care coverage. When my husband first began his position several years ago, his employer paid all the premiums. Over time, as insurance costs increased, we had to pay about $300 out of pocket each month for our insurance premiums. (We did have excellent coverage though.) Even though my husband had several health issues (diabetes, high blood pressure, high cholesterol) we had everything managed well with medication. Then the un-thinkable happened, his liver failed. Facing major surgery and expense (you cannot be on the wait-list without insurance) our only hope was insurance. In June 2005, when he was laid off due to the economy, we were extremely terrified about what would happen. Who else would insure him? His employer graciously agreed to continue to pay his (and mine) insurance premiums in exchange for his consulting services. He was unable to work at that point anyway due to his health detiorating. We were blessed with receiving a life-saving organ in November. Now, as he is still not able to work yet due to slow recovery, we face medication bills of $2000/month if we should loose this insurance. Because of my salary, we do not qualify for Medicaid, nor are we old enough for Medicare. However, we could not afford the medication at all without insurance. I think our answer is nationalized health care. We both grew up military kids and my husband was in the service 12 years. The system can work and does work. If taxes need to be increased some to pay for services, so be it. This is America. We should have the best health care in the country!!! Thank you for your efforts in this daunting task.	CO	2/16/2006 12:46:38 PM

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Response	State	Date/time received
I have osteoarthritis in my back, hips, shoulders, and knees. I cannot walk but maybe 1 city block now. I am also bi-polar. I take 6 different medications every day. I work for a tax preparation company so I am only employed part-time during the summer months. I do not qualify for health insurance because I am a "health risk" and no one wants to cover me, furthermore, I would not be able to afford health insurance premiums because I do not make enough money. I do not qualify for medicaid or medicare because I am not raising children and I am working. Fortunately, I am able to fill out a lot of red tape and get free medications from the companies that make them, however, it costs $45.00 per visit to see a doctor. Heaven forbid should I have to go to the emergency for anything because I would not be able to afford it. I wish someone could help me and others like me that are trying to work and pay the bills on our own get decent medical coverage. I could go on and on. I also found out I am in the early stages of glaucoma and will be starting more medications for my eyes. I honestly do not know what I am going to do. I hope someone can help us in this work.	OK	5/25/2006 12:46:02 PM
Please read my true story. I have worked in the health care system myself since 1965 and helped thousands. About eight years ago while living in *** Texas, I became very ill with hypertension (220/110). I lost my job because of illness and had to seek medical care at the only indigent health care clinic in the County. It was demanded of me to present a Tx. drivers liscence, automobile insurance and a utility bill, which I did. I was flatly and uncompassionately refused treatment because the address on my auto insurance did not match the address on my drivers liscense. I almost lost my life. Meanwhile the majority (approximately 90%) of patients at the clinic were extremely young pregnant women who were in fact illegal aliens and had never paid a dime into the system. I was too sick to do anything but cry at the time. I barely had enough gasoline to make it to an emergency room. It seems as though if a person has the ability to obtain the required documents whether they are forged or not, that person is elegible to be treated at the only indigent taxpayer sponsered clinic in the County. I am a healthcare worker and have been for many years. I have experienced a downhill slide on a steep slope of the healthcare experience. We are all paying for healthcare one way or another. Let's even the field.	TX	6/7/2006 8:25:42 PM
Being able to choose our own physicians is very important to us. Medical care is a service, and when people have choices and competition exists in the free market, better care is available and people will seek it. This is my big fear with nationalized medicine -- these options to patients and incentives to health care professionals will disappear.	CO	2/17/2006 7:02:16 PM
I suspect my wife and I are in the position of the vast majority of people in our age group. We are both 51 years of age. We would like to retire sooner rather than later. we have done a lot of things right, made some investments and own our home. But the one thing that is blocking us from planning that early retirement is affordable health insurance. It is absolutely shameful that the most powerful country on the face of the earth cannot provide affordable health care for its citizens when countries with far less resources have achieved it. Until the people of this great nation rise up and â€œthrow the bums outâ€ and elect people that have actually had â€œrealâ€ jobs and lived in the â€œrealâ€ world, I doubt anything will change.	OR	6/19/2006 11:22:01 AM
I am a 30 year retired teacher without affordable health care insurance. Caught between state retirement programs, I have only private catastrophic insurance. A shameful way to reward those who have given so many years to society!	WA	8/30/2006 3:14:59 PM

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	Response	**State**	**Date/time received**
	I am 67 years old. Do not use drugs, not even asprin. Why should I HAVE TO sign up for part D and pay for something I don't use or need. The politicians and the insurance industry are holding hands and forcing us to sign up. The 1% penalty is not fair. Those that don't want it,let them wait until the next sign up period, should they need it. America is The Land of the Free and we, as adults,should have a choice, without penalty!	FL	4/7/2006 4:01:47 PM
	In July of 2001, at age 58, I found the need to quit my 6-1/2-year position as social worker/grief counselor with a local hospice, to find more time to assist my aging parents, aware that I would lose my work-related health insurance in the process. But I knew I could get coverage under the recently initiated domestic partner health insurance provision at the city-owned hospital where my life-partner works, and did so. I then started a private counseling practice, with the flexible work hours I needed, and all was going fairly well until the newly-elected Colorado Springs mayor and the city council rescinded the domestic partner health insurance provision for city-owned businesses, and I suddenly found myself with no health insurance at all! And realistically, I'm not eligible for the city's indigent medical coverage, either. I tried to get coverage through several avenues as a business owner, but could not afford the high premiums. I was turned down by Blue Cross because I had incurred a dx. of depression and a prescription for an antidepressant when I was simultaneously trying to care for my parents and work at hospice. (My mother died in 2003, and I was faced with moving my father to a care facility, and dealing with their possessions of 60 years' marriage. My depression was actually situational; I'm no longer taking the antidepressant, and am doing quite well.) My prescription medicines cost so much that I couldn't afford them, so I began ordering them from Canada to save money; one of my orders was recently confiscated by our government to "protect" me from drugs not approved by the FDA (the drug was Synthroid, a common thyroid medicine.) They did assure me I had NOT broken any laws, but that my medicine would be returned to the sender anyway. So, although I own a small but growing business, I live in fear of having an accident or serious illness, as I'm still struggling to repay business loans, and could not face another large financial obligation. I'm 62, and will just have to wait until I'm covered by Medicare, praying nothing happens until then! ***	CO	7/21/2006 10:57:16 AM
	Her brother in England has excellent health care. He had surgery and pays for nothing. They have universal health care. Itâ€™s even better for those on welfare and that is the opposite for this country. You have to wait five days to get RX from the Health Center	PA	5/25/2006 12:02:53 PM
	Having private insurance has been easy for me to access good health care and required me to have a certain level of personal responsibility in our health care decisions. I have always worked and have chosen jobs that guaranteed health care coverage. This has been a welcome and reasonable sacrifice for there were times that I could have or needed to work parttime but didn't because I was motivated to maintain insurance for myself and our children. As a general rule, I have received good health care as my children have. Again, it took time, money and energy to do what the health care provider advised and we are all healthy today even with one child surviving cancer. We were able to accomplish this through grace firstly and by commitment to be a contributing member of a free society.	LA	4/12/2006 1:47:32 PM

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Response	State	Date/time received
I am utterly bewieldered by the resistance to a single-payer plan, and by the opposition to management of such a plan by our government, which should be a means by which we protect and advance our collective interests. I am sick and tired of the deference to the profit-driven interests of insurance companies, and I no longer have patience with fraudulent arguments on behalf of "choice" on the part of American citizens. The present system of health-care delivery, so strongly centered on profit for the providers and insurers, denies most of any real choice. The fear of "socialism" is absurd; we seem to be afraid of our own government--maybe because pharmaceutial companies and private insurers have corrupted the present governemnt?	MA	2/17/2006 9:32:42 AM
I have been personally very fortunate, having received mostly excellent health care for a variety of serious problems. These include: insulin-dependent diabetes; kidney failure; kidney and pancreas transplant; diabetic retinopathy with extensive laser surgery; osteopenia and several stress fractures; cancer in hard palate with radiation; recent tooth loss due to the past radiation, with hyperbaric oxygen treatment; a prosthetic device in my mouth to eat and talk properly. The only thing that annoys me is the inablility of my variious doctors to communicate well with each other at times. The thing that causes me fear and makes me angry is that I am an intelligent person, live in a large urban area with excellent health care facilities, work as a nurse myself, and thus understand how to negotiate the "system" and find the best care for myself. I am my own case manager. Too many times, I have seen the outcome for those who do not know how to get good care, who believe the second-rate pratitioners they see, ignore the sysmptoms they have, ignore the advice they do receive and have irreversible complications before they get any competent care at all. Further, I am afraid for all of us who are chronically ill. The current schemes to make patients pay for more of their own care merely penalize the ill, most of whom do not have the money to pay for their own care. This is not insurance. Insurance takes a little bit from all, regardless of the theoretical risk, so that everyone can receive what they need. If you don't need any right now, just wait--your turn will probably come--even if it is 40-50 years from now. The current president thinks people just go to doctors for FUN?? I don't think there are many people who get unneeded care on their own--they are sent for tests and so on by a medical practitioner, often to cover that practitioner's butt from frivolous or imagined lawsuits, or because they can't get the results of the same test done a week ago across town. Please don't let the government programs make things worse for people who are already ill. Most of the time it is not our fault, and even if our own behavior did contribute to it, it is not fair to blame those who already have the problems. Maybe we should make the percapita tax higher for the obese and for smokers in my new universal health care scheme. Maybe everyone who is chronically ill needs their own nurse/case manager.	PA	2/20/2006 11:11:10 AM

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Response	State	Date/time received
When I was expecting our son a little over a year ago, I had to find a new doctor. The doctors at the local hospital (at least the ones that I had dealings with) did not have time for the simplest questions and did not want to explain anything to me. I had no other children, so this being my first child I had lots of questions and conserns. The doctors didn't even want to discuse my being RH-. They just told me I needed shots and that was all I needed to know. That bothered me. So my husband and I looked into it and found out that if his blood was negative too, I wouldn't need shots at all. So at my next doctors visit we requested to have his blood checked and the doctor flat out said no, because she said we are not sure he's the father! This was right infront of my husband!! Needless to say we were done with that doctor. I also was forced into haveing a flu shot that I didn't want when I was pregnant. Because they told me I had to, even when I kept telling them I didn't want it. I just didn't know at the time that I did not have to do anything that I doctor told me I had to do. I sure it was just being young (22 at the time), but I really did not feel that it was right that I was being so poorly informed at such an important time in my life. Not too long after the bad experienced with the doctor, I was talking to someone who gave child birth classes and she said she has a midwife when she has had her children. I had never thought of that before. I am so very glad I looked into it. She took the time (sometime hours an office visit) to talk to my husband and I about anything that we were concerned about. And she had a whole library of books and incouraged us to read, read, read and ask all the questions we could think of at each visit. It was so impowering to know that I had a choice in my own healthcare, I didn't know that it was mine, to except or refuse any type of healthcare service "offered". I felt that no other doctor wanted me to feel like it was a suggestion, but an order. Anyway in May of 2005, we had our son at home with the Midwife. I know that I have never had a child in a hospital so I really can't compare but, I don't ever want to know. Having our son at home just the way we wanted.... it was one of the best choices I have ever made, everything went wonderfully smooth and I felt very aware and informed of what was taking place. I just think that it is so sad that at 22 years of age I had no idea that my healthcare, was mine, no doctor had wanted to tell me that, I was always pushed into doing what they wanted.	WI	3/19/2006 2:34:37 AM
I try hard to avoid using emergency services which are the most expensive, but in my community, the private physician often refers to the emergency room, I believe for the convenience of his office not being clogged with emergent type care and this causes over use of the emergency room as well as many people continuing to use it as a doctor's office thinking their problem is an emergency when it really isn't. Our emergency room is often full and I don't see triage happening in a timely manner.	MS	2/12/2006 8:34:43 PM
We are a retired couple, me through disability. Our Medigap insurance for two costs $684 a month, the last increase of which was quite significant. If such increases continue, we will not be able to afford gap health insurance. There MUST be some caps or controls on costs for medical services and how much insurance companies can charge.	VA	4/11/2006 11:21:29 PM

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Response	State	Date/time received
I am 52, have a bad disc c6/c7 that may require surgery, have no med insur, am laid off, have very low fixed income that is 100% from my own resources (no food stamps, welfare, ssi, etc). I want to pay for my surgery from my IRA. The IRS says they will penalize me for early withdrawel (in the range of $5k for a $40k surgery). I complained it was unfair, they said they don't make the rules, Congress does. I wrote Sen Lugar, Sen Bayh, Rep Carson. All took months to respond. Carson sent form letter back not relating to my subject. Bayh sent letter back with attachment from IRS stating what I already knew. Lugar sent letter back stating he requested Sen Grassley's Senate Finance Comm to keep my issue in mind in the future. I called Grassley's office; they said retirement security was a priority for them and nothing could be done about my issue. All told me to have a nice day after they brushed me aside. What a perfect example of govt neglect and abuse of a citizen trying to pay for their own healthcare and not leach off the system and beg for help. What an example of govt corruption and taxing power over lowly impoverished people trying to show personal responsibility and self reliance, all to fatten their revenue stream for their pork and their earmarks.	IN	5/4/2006 3:34:26 PM
Following is the statement I just made to my Dr.'s billing office for a financial hardship application. Perhaps you will find my situation of interest: I expect that the new Medicare prescription drug coverage effective Jan. 1, 06 will cause a financial hardship for me due to the following reasons: I have a high-cost medical condition: HIV/AIDS. I am considered dual eligible (Medicare/Medi-Cal) with a monthly share-of-cost of $643. I also participate in ADAP (Aids Drug Assistance Program). In the past, I would pick up my prescriptions at the first of the month, and ADAP would pay my share-of-cost, and Medi-Cal would pay the rest, leaving me with a zero share-of-cost when I went to the Dr. for office visits, lab work, etc. Now, since Medicare is the payer for prescription drugs, when I recieve other medical services, I will still have a high share-of-cost to meet. In other words, after Medicare pays their portion of office visits, labs, etc, I would have to pay the portion that Medi-Cal would normally pay, up to $643. I have little to no available funds to pay for such out-of-pocket expenses. It is somewhat unclear to me what this expense could amount to. I see Dr. *** nearly every month, and I suppose the amount would vary due to the nature of services, labs, etc. I have been a patient here for over ten years, beginning with Dr. ***. It is my hope that arrangements can be made so that I can continue my treatment with Dr. *** without having to pay out-of-pocket, as I would be unable to do so. This is the situation as best as I can understand it at this time. Thank you for your consideration. (I did not mention here, that I really don't understand just what exactly ADAP will be doing for me now, other than covering the one drug that the Humana (Medicare) plan will not cover. This is an unresolved issue, and I am looking to AIDS Project Los Angeles for advice. And even they do not have all the answers.)	CA	2/15/2006 8:44:12 PM

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Response	State	Date/time received
I am a CPA/PFS, CFPtm. I assist my clients regularly with retirement and elder care decisions and have made the same within my own family. I know that many in my community do not receive and can not afford adequate health care services. I know that these people do not pay much if any in income taxes. Therefore, a tax credit of any kind is no incentive for them. Recent articles raise the question of quality of care where individuals with HSA accounts postpone care because of a concern that they may spend their account. If a HSA discourages the seeking of reasonable care or discourages someone from such care, then the program does not work as intended. Certainty is needed when seeking medical and health care services. Hospitals need to be able to depend on proper reimbursement. Doctors need to be adequately reimbursed. The government may need to negotiate drug prices to level the playing field for consumers. If everyone seek care services knew that basic care was fully available and the care givers knew that they would receive adequate compensation, I am satisfied that the cost of these services would decline. It may be that community and in rural areas, mobile clinic programs need to be created to bring services to the people in need. Transportation is a problem for many. It is clear to me that our present system does not provide adequate to all of our citizens. The richest nation in the world should be able to solve this problem.	MT	8/25/2006 1:27:51 PM
My husband is an entrepreneur. He has been in and out of the corporate world about 6 times over the last 6 years. Each job change led to a change in health plans. The doctors fortunately remained the same, but I discovered the treatments changed depending on the type of coverage we had. (private vs.company policy, high vs.low deductible or mediocre policy) Strep throat diagosis one time required a test and follow-up visits, another time, tests were eliminated and a follow-up visit was eliminated after the completion of the medicine. Acne treatment on low-deductible plans required shots or expensive medicine. High deductible visits prescribed topical treatments or a lecture about washing your face more often. When I asked why treatments were different than the time before, they usually gave a well reheared speech stating that many tests are unnecessary. When I came in with a better policy they explained that the tests were necessary. At my last high deductible Dr. visit, the Doctor was telling me about the latest in pap smear technology while looking at my chart. When she discovered the high deductible plan, she switched gears and said, "but your history is good, so I think we will use the old system." As she was performing the procedure she made the comment to the nurse, "I have forgotten how to use the old instrument." She also eliminated many of the annual tests that I normally recieved because "My health was good." What this six year experiment has shown me is that when the coverage is good, more tests are ordered and higher priced drugs prescribed. When the coverage is poor or the deductible is high, fewer tests are ordered, and generic drugs are given or "home" remedy is recommended. I would like to think that doctors have my best interests at heart, but I am more and more convinced that doctors make decisions based on money and my health treatment may be compromised. Doctors may complain that insurance companies are making decisions for them but when I offer an alternative solution such as paying cash up front, I realize that Doctors still want the income that the insurance companies provide them. If I have a high deductible plan I always offer to pay cash up front. Most offices refuse. The one time I managed to pay cash,(the person was new) the bill was only $40 verses the usual $150. I discovered my out of pocket was much less expensive when I paid cash. Needless to say they didn't let me do it again. They insisted on filing with the insurance company.	TX	8/30/2006 8:23:50 PM

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	Response	**State**	**Date/time received**
	One last experience I would like to share is when my daughter was diagnosed with Melanoma the first week of college in Minnesota. We live in Texas. We had just taken out a private health insurance policy. I knew it would be temporary because my husband would be joining a company with benefits in 3 months. In order to save money on the private health insurance policy (I was following Bush's directive) I took out a high decuctible plan. Unfortunately, I misinterpreted the technical language and discovered my deductible was $10,000 rather than $5,000 and the fine print limited my understanding that coverage was limited in another state. To add insult to injury, I ended up paying $13,000 even though coverage after $10,000 was paid in full because of pre-existing conditions, waiting periods and exculsions. I honestly felt the insurance company was making the policy up as we went along. The lesson I learned is high deductibles can be very devasating to the family budget and Health Insurance Savings Plans that are being promoted may be ok until you have one expensive series of treatments or operations. In this case, I had only saved $100 for our personal HSA. My bill was $13,000. I am still paying the bill to the tune of $1000 per month, which leaves no money to place into our HSA. Our family budget would be wiped out if we were to have another $10,000 or $5,000 medical expense. We also are at risk of being uninsured because of the pre-existing conditions if we use another private insurance plan. I hear more and more stories of people being in financial ruin or one step away. Our health care system must change because our system of free enterprise is benefiting only the insurance companies and doctors. Our nation is splitting into an ever widening class system. I used to buy into the concept that private/business enterprise was the answer rather than government. I can't buy that anymore. Our bodies have become a "product" rather than humans in which we are ALL treated with dignity and respect.		
	My son is 36 years old. He has had significant health issues for the past 26 years. These have progressively eroded his ability to sustain gainful employment. He has not been able to work full time for almost three years and has been without health insurance for the past sixteen months. He has no job and no money. He is in the process of filing for Social Security Disability. That can be a lengthy process -- and then, once approved, he will have to wait ANOTHER two years to be eligible for Medicare. Meanwhile, he has run heavily into debt to pay for household expenses and medications. If he is approved for disability, the minimum payments on his debt load will greatly exceed the benefits he will receive. Even retroactive benefits at the outset will only be a temporary solution. Medical expenses are now the leading cause of personal bankruptcy. But it looks as though that is where he is headed. And THEN what will he do?	CT	2/7/2006 10:44:07 AM
	My son is 36 years-old; has had serious, chronic heatlh problems for the past 26 years; problems are getting worse; has been without health insurance for the past 18 months; is unemployed; is disabled but not yet approved for SSI or SSDI -- therefore has no recourse to Medicaid or Medicare; is 16 months overdue for at least one critical medical screening that we know of; has debt load that is very deep and getting deeper. Needless to say, we are frantic with worry for him.	CT	3/30/2006 9:35:29 AM

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Response	State	Date/time received
As a registered nurse working in an ER, I see first-hand every time I work what the lack of access to healthcare is doing to my patients. I remember in the 2000 debates when Bush said that people were NOT having to make the choice between paying for medications or buying groceries or heating their homes, etc. Well, guess what? YES, they are having to make those choices. I just took care of a patient the last shift I worked who was bundled up due to the cold who hadn't taken his blood pressure medication for 6 months because he couldn't pay for it! His blood pressure was sky high! He was cold and embarassed to admit it; He said that he had his thermostat turned down to the lowest setting possible. This man and his wife both had jobs but no health benefits. I see this every day. It makes me sick to know that the wealthiest country in the world is allowing it's citizens to go without access to basic healthcare. My patients are getting sicker and sicker and as a result are costing a lot more money to take care of them when they arrive in this condition, rather than providing them with preventative care and health promotion strategies that would be much cheaper for our nation in the long run. Things have gotten much worse in the past 6 years. I'm tired of talking about it-lets get the show on the road!	OH	3/30/2006 12:07:50 AM
Over the years, health care insurance has gotten more expensive - to the point that even the smaller companies have cut benefits or elliminated health insurance to most employees, reducing most employrees to part-time status and making them not elegible for coverage. Now in busines for myself, I am unable to afford health coverage of any kind - even the state sponsored health care is not affordable. So, in recent years, I have turned to alternative solutions to health problems with great success. I have also gone on the offensive with a progresive prevention modality. At 62, I am healthier now than I have been over the past 30 years. I have eliminated severe depresion with a dietary supplement, and removed kidney stones without the need for surgery or pharmacuticle chemistry. ANY HEALTH CARE SYSTEM needs to emphasis prevention with dietary education: after all - "you are what you eat". Symptoms of illness are an indication that something is wrong in the body - treating the symptoms DOES NOT cure the problem!!!!!!!!!!!!!!!!!!!!	WA	2/16/2006 6:43:03 PM
We own a family perated business and we are insured as a small group containing my wife,myself and my son. In 2000 I got cancer and became a macrobiotic, I and my wife are now more healthy than 95% of most americans and tests prove it. However we are being run out of business by the amount it cost us for health care on a monthly basis.It is more than alot of americans make as a living. Soemtimes when business is slow we eat into our personal savings to pay this insurance. It goes up every year on top of this.	IL	4/16/2006 6:17:36 PM

Question	We all have different experiences getting health insurance or in seeking health care. Sometimes these are good experiences, while other times they are not. We may meet very special providers or encounter new and innovative practices. Other times the American health care system disappoints us. Please tell us what has worked well or hasn't worked well for you or your family.

Response	State	Date/time received
My wife and I have been very fortunate that both have had supposedly decent coverage. So what's the problem? The insurance companies routinely deny claims for frivolous (fraudulent) reasons, argue over which company is primary, and are incapable (or unwilling) of working with providers to coordinate benefits. Then, bills that should have been covered are improperly turned over for collections--and this with two policies in effect:double coverage equals no coverage. Opponents of Universal coverage and Single Payer always cite a fear of government bureaucracy. Believe me, governement can't out do what the insurance industry has inflicted on us all. These insurance companies and their bureaucratic ways are estimated to waste 20% or more of every health care dollar v an efficient 3% for administration in Medicare. The insurers won't reform. So the entire system must be reformed over their objections. A single payer systems along the Medicare lines seems the only reasonable way to go. By the way, I lived in Canada for a year and I have relatives who live in Australia. Neither country has the horrific "non-system" (mess) that we have.	TX	6/14/2006 6:26:18 PM
Four experiences of myself and my siblings are relevant to this proposal. My sister, a Canadian, was told by her assigned physician that her melanoma was not yet critical and she would have to wait for quite some time. A friend, who was also an MD, told her not to be a fool, to get on a plane to the states and get it removed immediately. It was a simple office prodedure that allowed her to return to Canada the same day. My brother, a retired U.S. civil servant and Air Force officer, has what is considered to be one of the finest health insurance plans in America. He contracted an agressive form of prostrate cancer. After doing a great deal of research, he decided on treatment other than what was initially offered. What he had been offered would have provided results that did not fit his life style and personal preferences. It also did not take into consideration the latest advances in treating prostate cancer. To be blunt: the doctors lied to him to stay within their treatment guidelines. I have lived most of my 58 years without medical insurance. The last policy I had that actually came close to meeting my needs was in the mid 70's. I purchased the policy through my business for myself and all of my employees. After a few years the State of Colorado mandated that all group insurance include maternity benefits (among other things). Many of my empoyees were single women in a position that required strenuous physical activity and travel. Why would I want to cover the cost of a volutatry condition that would have made them unable to continue working for me? The cost rose dramatically and I dropped the policy. Since then the most common insurance card used by myself, my wife and my children has been Visa or MasterCard. Even the policies offered under the new HSA rules are so burdened with just plain silly mandates that their cost far outweighs their benefits. My former medical provider in Minnesota, Mayo Health Systems, had a virtual monopoly in their geographic area because of state laws. They started to charge more for the few people who paid cash so they could offer discounts to various HMO and government clients. I had to get out of Minnesota. My current	SD	8/30/2006 9:31:35 PM

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	Response	**State**	**Date/time received**
	independent physician in South Dakota offers a discount for cash. I can get the treatment I want when I want it at a reasonable price. In the 90's I took over my parents affairs as their guardian. My experiences with Medicare convinced me that my parents would have been better off if the money that they had paid for Medicare over their working lives and that had been deducted from their Social Security checks had been piled in the street and burned in exchange for Medicare never having been implemented. I had never before dealt with such a completely incompetent system and I had been in the Navy! Medical care will be rationed either by market forces or by politcal considerations. Politics stifles medical advances and results in poorer more costly care. Canadians and many Americans now have such a system. Mandates and regulations DO COST money. They are not free. Mandates and regulations do stifle innovation and inhibit honest discourse between doctors and patients. If many of the recommendations that have been proposed are implemented, I will expect to go to Asia for any significant treatment. We are always less satisfied with the parts of our society that are controlled by political processes. That is the very nature of the political process. The delivery of goods or services by political processes is always more expensive and less efficient. That, too, is the very nature of the political process. It cannot be changed any more than the laws of physics can be repealed. Henry David Thoreau said it quite cogently. "Government never furthered any enterprise but by the alacrity with which it got out of the way." If only FEMA and Ray Nagen had done that one year ago in New Orleans. Don't screw up the American medical market any more. Get out of the way. When I was driven into unemployment for seveal years, I had no health insurance - at all. It made the situation worse. If the government does nothing else, it should guarantee that every single US citizens has access to basic health care - period. Without this guarantee, not much else matters really. Yes, I have had good experiences with professionals and poor ones. Mostly good because I had to pay cash out of pocket for whatever services I received.	UT	3/18/2006 8:26:37 PM
	I work as a professional theapist in the mental health field. The field is hugely inefficient and does not encourage best and innovative practices. The system is antiquated and broken. A terrible mess: underfunded, poor training of theapists, poor organization of services, too expensive modalities of helping people (should use education, skill training and groups much more!)and easier access to theapists when people need to be seen. It shames me to see our health care industry building more and more specialized hospital services year after year and we continue to see our costs go through the roof paying for it all...and more and more people losing their health insurance. It's despicable. We are a pariah in the world's health care. The medical arms race must stop and only an authoritative public entity can stop it. There must be central command of cost containment at the state level or the system will just continue to run out of control. Only governments can establish an infrastructure to contain costs. The paper work, billing and sheer madness of the private health insurance system is appalling. Why we continue this hugely expensive and inefficient system is beyond me...perhaps because some coporpations continue to make huge profits perpetuating this mess. Only government can put a stop to it and set up a financing system that is fair, well funded, efficient and services best practice in health care		

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Response	State	Date/time received
Health care should not be a luxury that only the wealthy can take advantage of. I have been low income most of my life. My family has had to go without proper care since it was formed. I have had to do without to ensure that the rest of my family gets marginal care. I am the main provider for our family so my deteriorating health and my inability to afford to care for myself properly puts my whole family at even more financial risk. We are not proud of being on welfare but we are even though I work fulltime and attend college partime. I have made progress toward getting off the system but as anyone will tell you who has been on the system and gotten off, the loss of benefits devastate your budget and you lose much more than you had when you were being paid hundreds of dollars less. Most employers health plans are so expensive new-hires can't afford their plans and partime workers don't even come close to making enough. For example where I am employed now a partime employee must come up with $700 a month to get on their family health plan. That is over half of their income for the month. The insurance companies and medical professionals are both to blame for this. Several countries have adopted socialized medicine because of this. The main objection to this has been that it will increase taxes but would it take over half of your income? Not if were run properly. Another objection is that the quality of medical professionals would drop. I say this would not be the case. We would have people who were in the medical profession because the want to be healers not because the want to be rich. The propaganda distributed by both the medical profession and the insurance agencies is motivated by greed at the expense of our citizen's health. Why would anyone care to support that? Why have our duly elected officials abandoned us? Do they not know this is going on? Sure there are a few who abuse the system but should the majority be punished because of the few? This shows a lack of leadership seasoned with a dose of indifference. Are our children and the future generations of America doomed? Who will be around to do the grunt work of the rich? Who will be able to support our government? The rich don't pay the majority of the taxes in this country. The working class does. Please help us and our families. Please take away the responsibility of the health of our citizens from the powers that are abusing it. Our nation can only be as strong as its citizens. How can we be strong if our citizens are weak or sick. Other countries know this and have taken steps to ensure the health of all its citizens. What is up with US?	OR	8/31/2006 12:05:40 PM
Medicare has served me very well - as far as it goes. It should be broadened to also cover hearing, dental, and prescription drug costs. The ongoing annual cuts in Medicare budgets are causing doctors to drop Medicare covered patients. One of my doctors stopped taking Medicare patients. This is very worriesome. The new Medicare Rx drug coverage is a vicious joke which I firmly believe is actually designed to enrich the drug companies and destroy Medicare.	WA	2/7/2006 7:25:12 AM

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Response	State	Date/time received
I was diagnosed with esophageal cancer. I work for the Union Pacific Railraod and I am in a union. I recognize the fact that it is the union negotiated health care that I have for now that provided for the excelllent care that I have received. I for now am cancer free. Had I not had health care the bills for my treatments and surgery would be well over $200,000 and I would have to declare bankruptcy.	CO	2/17/2006 9:42:40 AM
My wife and I have recently retired, and moved to our "retirement home" in a new community. I have found it next to impossible to find a primary health care provider-I have one choice within a 75 mile radius and that choice is severely over-booked. The reason given is that the Medicare system reimburses at an unrealistically low level, is far too slow in processing paperwork and demands far too much paper work from participating providers.	CO	2/17/2006 1:55:08 PM
Having just taken your poll, I think it is fair to tell you that it is biased toward an outcome that will be as unsatisfactory as the status quo. What is wrong is the reliance on employers (who are bailing out as rapidly as possible), and the reality that insurance companies run the system. That is wrong, but your survey presumes them. American proopaganda has it that health care is a new, unsolved problem. It is not. Most every other developed country in the world does it better, cheaper, and with universal coverage. For a level playing field at the global level, we need to organize the way other countries do. I personally think that the Scandinavians are among the best. Just watch as GM goes bankrupt...or transfers many jobs to Canada. See this website: http://www.seconnecticut.com/healthcare.htm	CT	5/4/2006 5:24:19 PM
I am 62 years old and retired. I served in the military during the Vietnam war and worked for the same employer for 30 years after. I have always paid for health insurance. No one gave me anything without me paying my fair share. I have never been denied a medication or medical care of any kind. The secret to that is I never relied on the government for my health care. People who want a "guaranteed" medical benefit are implicitley relying on the government for that benefit. They don't want to pay, they don't want to be restricted, they just want. Period. The free market is the only reasonable and efficient way to provide health care, or most anything else for that matter, for the vast majority of people. Keep government out of it or you will have the same medical mediocrity that exits in Canada and other "guarantee" countries.	CA	6/8/2006 5:13:13 PM

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Response	State	Date/time received
I own a little 3 chair barber shop for 40 year. My biggest cost was health insurance. It was hard for me to fine help,because i could not give my the people that work for me any kind of health plans. My wife did child care at home,to help pay for health insurance which was as high as 17,000.00 a year for both of us before we retired.Now we pay about 8,000.00. Are goverment does so much for other nations,with our tax money,but can not do anything for us. I think untill our congress has no health insurance,we will never will have any help in the health insurace.	WI	6/9/2006 6:44:46 AM
I have had a lot of bad experiences within the health care system. The worst was delays in obtaining proper treatment even when it was sought immediately. I was having angina problems while at Cedar Point, went to the doctors right away as I did not know what was happening, he scheduled me for a Stress-echo test two weeks later, then I was sent for a catherization test and was rushed into by-pass surgery and was told this should have never been delayed two weeks for a test as my heart could have and would have stopped at anytime because of blockages. - I went to a dermatologist for treatment for rashes (with blisters) breaking out on me. The Doctor who is a professor at a large Medical University misdiagnosed this as psoriasis and treated it for four years in the same manner with absolutely NO results or improvement. I got permission from HMO to seek another opinion, and was subsequently diagnosed with Dermatitis Herpetiformis, placed on meds and have been outbreak free since then. For 4 years I had been prescribed the wrong meds, prescription compound creams and paid out of pocket for light treatments that would have NEVER worked in the first place as I had been misdiagnosed. These two experiences show that there is a severe lack of expertise within the system that keeps driving up costs needlessly. This is truely wasteful. When a doctor has the credentials to practice and clinical priveleges, his cases need to be supervised more closely to determine whether or not they are delivering appropriate and effective service and should or should not continue to have clinical priveleges. The case of the stress echo was due in part to poor scheduling and underestimating the need, and the case of the misdiagnosed DH was due largely in part to the doctor's lack of expertise and clinical supervision despite his credentials. The shame is that he teaches medical students, but how can someone teach something they can't even do correctly?	MI	2/18/2006 3:14:25 PM
My sister is a widow at age 53 and she is diabetic. She was on her husband's Blue Cross Blue Shield insurance. She was able to keep it for 36 months on a Cobra plan which was so expensive. Once that ran out she was unable to get insurance, because of Pre-existing conditions or they wanted to have a rider about the diabetes or any possible related problems which could be anything under the sun. She was on this insurance for years. We have no way in the country to help our people, unless they have nothing and go on welfare. My daughter who turned 23 and is in college has been on my insurance. Once they turn 23 they are taken off. She has mild Asthma and it's the same problem for insurance. She has friends who are dealing with it to, and some chose to get pregnant and go on welfare and have their schooling paid for and health needs met. What are we doing to our kids. If my State didn't help pay for insurance it would be close to 1000 a month. We need a National Health Care plan for all Americans. I would be willing to pay extra taxes to be sure every person could get help.	WY	6/8/2006 11:11:12 AM

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My opinion is that the 40 million Americans that we hear about who don't have insurance include millions who can't get insurance because they have a pre-existing condition. Our son, who has a pre-existing condition of Inflammatory Bowel Disease (IBD)of Ulcerative Colitis, was covered on our employee policy until he reached 25. Always being on maintenance medication, the costs for it was approximately $210 per month once he was not eligible. Needless to say, the other worry was that he wouldn't have a flareup, another illness or an accident. He was uninsurable. All he wanted to find was affordable insurance for himself until he could get some from his employer. $500 per month isn't affordable. To exclude people with pre-existing conditions from getting the medical care and affordable insurance they need is unethical. Government run healthcare isn't the answer, but the marketplace can structure medical insurance at an affordable price created to suit needs of individual with or without a pre-existing condition.	TX	7/15/2006 2:33:41 PM
I was recently laid off and for September, was advised that my COBRA medical for my husband and I was going to increase from $900 to $1200 with higher co-payments, etc. I was fortunate enough to qualify for Healthly NY as I am unemployed and my husband is a freelancer. I will now pay a little under $400 a month vs. $1200 a month. However, there are certain services and prescriptions that are not covered. We were fortunate to work out an arrangement with one of our physicians for a low monthly fee and he is comfortable with us ordering certain prescriptions from Canada which will save us hundreds of dollars. What we pay in overall tax in NYS is just as high in most countries where people receive healthcare from cradle to grave albeit they pay a portion or not based on their income. This isn't too much to ask our governement to offer healthcare coverage. They already have it in place with Medicare and Medicaid, why not extend these programs?	NY	8/24/2006 4:03:47 PM
check this out for real life experiences with this frustrating topic - it saddens the heart! and in texas, if you have health issues, you cannot buy individual policy and must go to Texas State Pool and pay about $15,000/yr in premiums for two people + $5000 deductibles - this is insane!	TX	3/15/2006 8:53:24 PM
As a single parent raising my 3 sons, even with the union health benifits I recieve from my contract, I have shelled out well over $2500 dollars in expenses for my sons in the last year. No major medical problems to encure this, just standard visits, one adhd child and one athlet. I work my ass off for my boys and this contry should be ashamed at the way we treat out own people. Basic medical covarage is not a privlage, it is a RIGHT as a tax paying citizen. Make it happen or be unemployed as a polotition. It's that simple. Show us the repect we deserve for voting you in office and get it DONE!!!	WA	6/20/2006 5:24:18 PM

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Until citizen get involved on the billing process, health care providers will continue to abuse the programs. Citizens must be the ones billed, they must review and approve the charges before the agency evaluates and pays if proper. Medicare is a generous program, but operates in a vacumn and gets milked by unscrupolous providers.	FL	3/26/2006 12:56:58 PM
I have paid for health insurance for forty one years. During the first three decades I rarely used it. Now that I need it I have to pay over $700 per month 'co-pay' to get heart, arthritis, and dermatology medicines. (That would be if I used my insurance, fortunately, I can use my wife's. But that means that what I pay for is worthless.) I am concerned that, with the way things are going, I will be broke after I retire with a decent retirement income. I teach sociology at a college and have noted to my students for many years that the U.S.A. is the only western country that allows its citizens to be devastated by health care costs. There seems to be a shared naive blief that it won't happen to me'. Or even worse, there seems to be a worse belief that those who are devastated by catostraphic health care maybe weren't right with God.	TX	6/15/2006 3:46:38 PM
It was good to be at the meeting at the seattle center. I have worked at a major university for almost 20 years, in their Information Systems division. I watched health benefits erode for many years.. I left that position in 1998 and paid Corbra Rates for 18 months.. that was rediculous.. but they hook you into it. I went to school full-time. They offer student health insurance -- and they offer grad students a real insurance pgm - a big difference from the regular student insurance. I went to the student health center -- at the front door, you're required to register and give them your insurance info -- or your visa card. The student health plan? Offered little real benefits and when I needed to see a specialist? I had to go to the hospital.. and I incurred a several thousand dollar bill - for several visits. It took several years to pay these bills as a student. I worked part time in several accounting offices around that university and I saw the efforts the administration takes to get their funds and put student education as the last priority. During the Time period 1998-2005, healthcare in Washington State took a huge nosedive.. monthly premiums started up and now you can pay up to 300 a month for Regence Healthcare as a state employee. What happened between 1998 and 2005? The stat abdicated on their promise to employees to keep their staff income and benefits intact. The state said, if we don't raise rates, we have to cut services.. and make state employees pay a larger share of their medical expenses. Today Group health charges 60 dollars a month and regence charges 300 a month for a family. With both of these plans (the low and high).. you have few out-of-pocket expenses. That same specialist visit I mentioned earlier? cost me 10.00 after I was gainfully employed again, as a student it costed several thousands, now only ten dollars. You mentioned that healthcare costs rise with age.. I can say that dental care definitely rises with age too..	WA	3/1/2006 1:57:00 AM

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	Response	**State**	**Date/time received**
	I've faithfully seen a dentist for decades.. and his daughter too.. they put many fillings in my teeth.. now there's more metal than tooth in some of my teeth.. they pushed me to get crowns.. Crowns are one of the most profitable actions for dentists. Some charge 1200 for a porcelin crown. Just ask them what a gold crown costs. A friend if mine got two crowns last year and owes her dentist over two thousand dollars. In 1998, dental insurance was simple, get your cleanings twice a year, get xrays every other year and a filling now and then. Now? It's crowns and more.. and limits on dental coverage in a year? Who dreamed that one up? Did they think we wanted to do more dental work? I'd say that most people get dental work when they need it. So I've Learned in this last year back in the state work force: Group Health Insurance -- Hands Down, the best and the least expensive benefits plan. I'm talking total expenses. Dental Insurance? Willammette Dental - by regence? Offers a Dental HMO program. With free amalgam fillings, cleanings, xrays, etc and crowns for 140 dollars. -- yes 140 dollars for a crown. So I've switched to Willammette dental and I've had my first appt with them.. now I have to wait two months for an opening in their cleaning schedule.. I'd say they are becoming popular too!! I'd like to see a national program modeled on Group Health Coop.. and a dental program like willammette dental too.		
	Damn, I don't want to fill out a long survey answering your questions. I want to tell you!! 1. I was shopping late at a local grocery.. someone behind me in line asked about the 2 pints of ice cream in my hands.. I responded "I run".. she said her doctor forbid her from running because of her back and said he said he would quit as her doctor if she tried to run... I told her to stretch before/after and go for the running.. damn her doctor, she would fire him if she started running.. and continued. So I'd like to see more people running as the weather improves and maybe more of those will continue this fall when the weather worsens again.... I walk the stairs at work/run them too.. and I'd like to see the stairs so busy at work that I'd have to take the elevator... I speak with doctors and other medical experts about how to keep my health.. and fitness and nutrition are near the top -- along with a good additude. My salads have more veggies in them than lettuce and I recently added bean sprouts too.. Find ways to incorparate exercise into your daily regimen.. walk to the store, walk at lunch and for your breaks... Remember that mowing the lawn isn't aerobic exercise.. but walking/running afterwards is.. I've run most of my life and I find running has been and continues to be good for me. I've run a 1/2 marathon and a full marathon.. now I'm preparing for my first	WA	4/14/2006 3:11:14 AM

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	Response	**State**	**Date/time received**
	mountain trail race..		
	group health of washington state would be a good model for a national health system. Regence' Columbia dental system would be a good model for a national dental system. So many people have misconceptions about healthcare, healthcare providers and insurance and the system does it's best to keep participants misinformed. 1. Doctors provide long-term individual Personal care for their patients/family. >>> Doctors keep personal files of each of their patients and review those files before seeing each patient. 2. Doctors provide excellent medical care for their patients.. >> it's up to the patients to care/heal for themselves and for adults, doctors are really advisors for us.. we make our own choices on how we live our lives. 3. Good health is seen as a significant solution to this problem.. If everyone took personal care of their bodies thru exercise and diet.. If our streets and parks were flooded with joggers and bikers... if saturday mornings were mobbed at greenlake.. -- Our office has a fairly large contingent of walkers -- 5%? 3%? or even 1% of the staff will walk on nice days. As washington state employees, we are granted two 15 minute breaks for every 8 hours of work. Washington state has a health initiative, and we encourage physical activities.. but so many choose to stay inside and play card, jigsaw puzzles etc.. or get in their cars and run errands. I'm a lifetime runner, I've had an ability to run since I was?? and I've chosen to run most of my life. I'm a trail runner now and enjoy running in the woods and mountains.. Running has many benefits too.. their are many books written about running by runners too.	WA	8/3/2006 11:03:53 PM

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	Response	**State**	**Date/time received**
	I am an advocate for healthy living.. I've not been sick for many years and my only visits to the doctors have been for running injuries. My health is good, I donate blood regularly and I joined aarp last year.. I seek out those older than I -- to find out what issues they have and what I can to avoid/delay those issues for me. There's no point to living longer, if you don't have your health. Mobility is critical for living and self support, if you can't get up and fix your own dinner, you can't live without help. My running is integral with mobility and trail running also requires agility, balance and dexterity. The uw school of medicine - orthopaedics and sports medicine has an excellent video archive about sports injuries and issues for maturing people. You can find them at www.orthop.washington.edu Look for videos.. Also many people at work have said they can't run/walk due to their knees.. my doctor gave me this website for my use and these exercises will help any runner/walker with kneecap issues: http://familydoctor.org/479.html So no matter what goes on with this initiative, we still must promote physical fitness/exercise/stretching/agility for everyones health and quality of life.		
	The current healthcare system punishes individuals for visiting doctors for just about any complaint. I was turned down for health insurance for various reasons including mild chest pain, which turned out to be anxiety after the death of a parent, a false positive on a liver enzyme test, which upon further testing showed no evidence of liver problems and hemmoroids. And if you choose to treat even mild depression with medication, it is likely you'll be turned down for health insurance should you need to seek coverage on your own. Rather than support someone for going to a doctor to check out a symptom--even if it turns out to be nothing--the system makes you an outcast in the eyes of insurance companies. In the long run, I feel this discourages people from seeking medical treatment. I know it has discouraged me.	FL	3/27/2006 7:54:50 AM
	I have been very fortunate to carry healthcare coverage through my husband's employer the last 18 years. I have even had at many times duel coverage or what we consider Coordination of benefits when I have chosen to elect healthcare coverage through my employer. My concern is for the person who does not have access to Healthcare coverage through their employer either because they do not offer it or they cannot afford it. There is just not enough options out there for these individuals. I can also tell you first hand the number of people without insurance is tremendous as I recently supervised an admitting staff at a local hospital and noticed a trend, people without Healthcare coverage cannot afford to go to a physicians office to be treated and therefore abuse the emergency room at hospitals. Most people know that they cannot be refused treatment (EMTALA law) and so now the hospital is running a free clinic. Something needs to happen in Heatthcare in order for this to stop.	TX	4/18/2006 9:02:20 AM

Question	We all have different experiences getting health insurance or in seeking health care. Sometimes these are good experiences, while other times they are not. We may meet very special providers or encounter new and innovative practices. Other times the American health care system disappoints us. Please tell us what has worked well or hasn't worked well for you or your family.		
	Response	**State**	**Date/time received**
	My daughter has been a diabetic since she was 5 years old. She is presently in college and can not receive health care insurance becasue of a pre-existing condition. I am now paying COBRA insurance but it will soon run out. Insurance companies want a year of insurance premiums paid before they will give her coverage. We can't afford that on top of her regualr medical expenses. Where do we go for insurance coverage? This is very frustrating.	PA	4/23/2006 10:56:11 AM
	I have been a health insurance agent for 26 years. I don't want to pay for people to get insurance at my expense. If businesses are forced to provide their employees with insurance. I will have to pay by paying higher prices for goods. If people would use the HSA system, insurance is less expensive. The reason there are so many uninsured is because their priorities are set for their comfort not their need. They feel if they don't pay, the government(meaning me)will pay. The answer is not government control. People have to get their priorities straight.	FL	6/15/2006 10:12:26 PM
	Need to kill the insurance companies' strong lobby and get politicians off the boards. Health care has gone into the toilet in this country thanks to HMOs. Premier hospitals have all been bought by insurance companies, nurses (small forces) are busy doing data entry, patients are cared for by aides who have had 60-90 days training, every hospital has become a teaching hospital. Patients are released before they are able to be on their own, or are sent to rehab centers (within or out of the hospitals) where the care is offered by aides. You get what you pay for - $7.50/hr minimum wage! Insurance premiums have increased more than the 50% you cite since 2002, more like 150%, while insurance benefits (Medicare and private) have gone down. We have a government that doesn't have oversight on anything that we pay for, nor does it care. That's where the changes must come about - in the government.	CO	2/15/2006 11:53:23 PM
	As the wife of a retired family physician (35 1/2 yrs.) and as his office manager & a retired social worker, I am always concerned about health care. I have had clients who did not get the rx. they needed for lack of funds/insurance. We also have a disabled adult daughter who is on Spend Down Medicaid...what a laugh...the system expects her to pay $343 out of pocket monthly before Medicaid kicks in. How can she do this with an Social Security Disablity monthly check of $760, which is to pay lot rental, food utilities, etc., etc. What happens when the collectors get these bills? Life is hard enough for her without this aggravation.	MI	7/8/2006 8:51:29 PM
	Since 1970 when I moved to Portland/Oregon, I was eligible to belong to the Kaiser Permanente HMO here.I had a choice of M.D.s, and over the years, have been able to make changes within the system either when I didn not like the one I had chosen, or when the M.D. was reassigned. I liked having the pharmacy right there when a prescription was given. I also liked the abiity to go to the emergency clinic on Saturdays, or f rom 6-8 PM weekday PMs without an appointment if I had a problem that I didn't want to wait for an appointment with my regular MD, such as so mething in my eye. I was often seen by M.D. , but also by either a P.A., or RN, or NP when assigned at the triage desk. If in the morning I got up and had an illness or other problem, I called to speak to an Ad vice Nurse, and after telling of the problem, would be set up with an appointment to be seen that day or the next with my Internist. My major problem occurred last year when I went to the dermatologist in May/04 for one problem but asked about a place on my chin that had re-occurred after Internist had "zapped it" in January/03 as had been done by a nurse at another area. The MD should have sent me initially to the derma tologist as it was a skin cancer which the dermatologist diagnosed. I called the advice nurse to ask what date was it that I had gotten zapped, and "by the way, what was the diagnosis". The reply was	OR	2/16/2006 8:24:47 PM

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	Response	**State**	**Date/time received**
	non-cancerous. This was a year later. W hen the skin cancer was removed, I had received 17 stitches. In that elapsed year the cancer had gotten worse.		
	I have had great difficulty in getting health insurance for myself as we are not poor enough for us to receive assistance yet we are not rich enough for me to be able to pay the monthly premiums for health insurance, so I am uninsured and pay out of pocket. Some things that help are some care providers(not a lot) are willing to let people make payments over several months for their care and just recently my doctor's office has finally started where they offer 25% off for self-pay. I have also been fortunate enought to find a good family practice doctor that me, our daughter, and occasionally my husband see for care. She is willing to listen and understands my preference for treating with alternative medicine. She is not knowledgable in that area, but she is not condescending and I also realize that at times alternative medicine may not always do it thus the reason I see a doctor on occasion. My husband is covered through the VA, but the barrier there is recieving care. He has had heart problems over the last several years and it has frequently been difficult to get a doctor to return a call(often takes up to 3 days) or to arrange a visit. I'm not picky over appointment times or days, but if you're going to be given an appointment 3 weeks away for when you're sick - well by that point you'll have either cured yourself or be dead so what good is the appointment. We have been told if they can't give us an appointment then we can just go to the emergency room, but we believe you shouldn't go to an emergency room unless it's an emergency and the things my husband has needed care for could be helped by simply a doctor visit.	NC	2/22/2006 7:21:51 AM
	I belong to an HMO (Group Health Coop of Washington State) and am also on Medicare due to being disabled with Muscular Dystrophy. I've been trying to get a powered standing wheelchair for the past 6 months, as I cannot stand up without pushing myself out of a manual wheelchair using my dining room table. I also have limited walking ability. The doctors I've seen, as well as a physical therapist I've been working, agree I need this piece of equipment. I should not be walking at all due to the amount of weakness in my legs and pushing myself up to a standing position has become almost impossible. Since my HMO manages my Medicare, they say they must abide by Medicare's rules. Request for payment was denied due to Medicare'r rule that they will only cover a power chair if you cannot walk around your home and the seat/lift portion if you can walk once standing. One rule contradicts the other. I now have to go thru the appeals process. I'm told I'm one of those who "fall through the cracks". I live alone, am losing more and more strength, and need this piece of equipment in order to keep my independance. Medicare needs to change their rules to help those of us who "fall through the cracks" get what we need without having to go through a lengthly appeal process. The disabled shouldn't have to fight so hard to get what they need to keep their independance.	WA	6/24/2006 11:10:31 PM

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	Response	**State**	**Date/time received**
	I am a licensed pharmacist of 35 years. I have an essential tremor. I am fortunate to have a medical solution to make it much less severe. I have taken medicine prescribed for me since 1980 in the same original dose as prescribed by the Chief Physician of Motor Movements of Barrows Neurological Center in Phoenix, AZ. and every other physician holding that position since 1980. My drug will lead to seizuress, possible atrial tachycardia, and possibly death if withdrawn or substituted according to the chief physician at Barrows and my own personal primary care provider. Health insurance paid for it since 1980, but the new Medicare Part D will not pay for it, and I have to pay over $400.00 a month for this medication or suffer dire consequences. I retired October 5, 2005, but when Medicare Part D took over January 1, 2006 they refused to pay for it. As a result I had to come out of retirement to pay for my medication. Medicare won't discuss this in medical terms. All insurance plans for seniors won't pay for it if Medicare Part D won't pay for it. They just say denied "by plan design" or "denied Non-Formulary." Medicare has just been totally rude and shouted at me over the telephone when I try to discuss this rationally in medical terms. I am back working to pay for it. It was cheap in the 80's and 90's, but it is now expensive because it is an orphan drug because Ayerst beat McNeill in marketing with a nonsubstitutable alternative drug that at the time was more expensive. I hope my strength holds out, so I can stay alive. Medical ignorance and irresponsibility is being practiced by the governmant and Medicare Part D.	AZ	6/29/2006 3:47:00 PM
	Iam 63, SS widows benefits, part time job. I have been without health care coverage for the past three years. I had been carrying my own insurance from 1991. When the premium went up to 40% of my monthly income, I had to drop it. I am not "old" enough for Medicare and not "quite" poor enough for Medicaid, so, I am in the "forgotten" zone. Hope I can make two more years with no major problems (all though I was told that I may have an aneurysm , can't afford the test to see if I do or not)and it will be interesting to see if the program still exists when I do reach 65. MY knees hurt(very worn cartilage from past work, my hips hurt, same reason, I have a constant hissing in my head(connected to the aneurysm?????). I honestly don't hold much hope for anything to change soon enough to resolve my issues.The presidents current proposals won't do a thing for me. I can't qualify for any policy that would allow me to open a HSA(don't have the income to put money into to it anyway. Don't pay income taxes(do pay taxes on everything else that I buy) so a "tax credit" won't help, and when private insurance costs $8000 to $10,00 a year, a $1000 tax credit is laughable they are going to insist that Employers provide insurance then they should cover all employees, including "part time"(I have been at the same part time job for 7 years, not exactly a "transient" employee.I have relatives in Canada, and they get what they need, when they need it. Billions and Billions are spent on a war that is killing and maiming our children, but we are told we can not afford "affordable health care for all. America may be the richest country in the world, and probably is, but it is becoming the most "selfish" group of people and many of them don't even realize it.	WI	2/17/2006 1:18:05 PM
	... I have a disabled son who is 27 years old. He suffers from a seizure disorder, hip problems, migraine headaches, kidney problems, and takes multiple medicines. While medicare and medicaid pay his medical bills, there is no doctor in this area that will take him as a patient. Consequently, no one oversees the medicines he takes. The only times he sees a doctor are when he is extremely ill. To get medical care, I have to take him to the emergency room. Every time we get a new physician in our area who is taking new patients, I am told that " we don't see medicaid/medicare patients" I know that my son is not the only person in this situation. My question is: How can a nation refuse to provide the medical care that might someday help him to lead a more productive life? How can physicians who have received their educations with federal and state funding ethically refuse to treat the most medically fragile of our population? In an age where every medical insurance system requires that everyone have a primary care physician to oversee their care, why are medicare/medicaid patients denied this right? Thank you.	WA	3/26/2006 9:40:47 AM

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Response	State	Date/time received
Medicare D is not for individuals that qualify for medicaid. Since the Medicare D. our individuals have a co-pay sometimes amounting to over $50.00 a month. Before we had a system in place that paid for their co-pays. There is a simple solution and that is to not require individuals who qualify for medicaid because they recieve a disability ie SSDI to take Medicare D. or to allow medicaid to meet these costs.	IL	5/2/2006 12:16:36 PM
My son is working but at very little income, he is 24 and my daughter in law is not able to work because she is in the last month of pregnancy. Her pregnancy is being covered by medicaid and she is not getting the best care and can't find a pediatrician for the baby when it comes, they don't take medicaid or "are full." My son gets sick and he doesn't go to the doctor since he doesn't have insurance. The ER rooms are "full" with people with no insurance and their illness is not an emergency....	TX	6/14/2006 4:42:29 PM
I am a 54 yr old woman without health insurance. I have some health concerns right now that I can't take care of due to lack of money. I can't work, mostly due to my health problems, and I can't afford to spend the kind of money it would require for tests, medication, and treatments. I'm what you'd call between a rock and a hard spot, I guess. On the one hand, I suspect the longer I go without addressing my health problems, the worse they will get, which I can tell myself, in terms of pain and other symptoms. I expect one day it will get bad enough that I'll be forced to go to the emergency ward, and am afraid that when that day comes, it might be too late. I also have dental problems that I'm sure are affecting my health, as well, and not just by having bad looking teeth. I'm too poor to be able to afford health insurance, I haven't worked at a job that has provided health insurance since the 1970s! Medicaid won't insure me because I have no children under 18, and my 19 yr old son has no health insurance, either. His last job didn't provide it, and none of the jobs he's looking for now provide it, either. There are less and less full time jobs available, and there are virtually no companies that provide healthcare for part time employees - there aren't that many full time jobs anymore that provide insurance, period! So I just suffer, and try to get through each day as best I can. I believe in universal health insurance. I believe that our country should join the rest of the civilized countries that provide some form of universal health insurance to their citizens. Our country pays more in health care for it's citizens now than it would if we had a fully operational universal health care system!!! That's what's so mind-boggling. But what is truly sad is that there is no reason for it other than plain old greed. And you know what the Bible says about greed - that the love of money is the root of all evil. We need to oust the rich politicians and start electing people who can emphathize with the "common" people, and legislate accordingly. Our government was set up "by the people, for the people", and we need to get back to legislating "for the common welfare and good of the majority of the people". The majority of the people in this country are not rich. Therefore, the rich should not rule, and they should not make the laws. That was exactly what our founding fathers wanted to avoid! The aristocracy ruling class!! Anyway, that's about it. I'm just waiting to die, for lack of health insurance, in a nutshell. What a great country. Or was. It's not great anymore. And it should be ashamed of the way it's letting its poorer citizens down. We need another all-out war on poverty. And that includes the cessation of employer-sponsored healthcare and promotion of healthcare for all - regardless of ability to pay.	KY	8/28/2006 2:58:22 PM

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Response	State	Date/time received
I feel like you are not addressing the real issue in health care. The insurance companies and medical places are charging way too much. And the insurance companies tell us what we can do, over our own doctors. If they say I can't get a drug my doctor ordered unless I pay for it by myself then they need to get a license to practice medicine. When a person pays so much money for insurance--just what do we get for it???????????	OH	5/15/2006 4:16:14 PM
When I went in for my yearly check up last year my doctor told me he was using a new and more accurate pap test, but my insurance would not pay for it. My next question was,"How much does this new and improved pap test cost?" The doctor replied, " I don't know, check with one of the girls up front." So I ask the girls up front what the new and improved pap test cost, they all looked at each other and said, "Well we don't know that." So my next plan is to go back to the doctor and ask him to give me the old pap test that the insurance will pay for. I'm sick and tired of paying insurance premiums only to get the run around, and I'm tired of paying taxes, and getting an insane war instead of Universal Health Care.	OH	6/9/2006 1:17:50 PM
I have met with many doctors who meet with me for such a short amount of time and dismiss concerns I have. I think that for the amount of money and time it takes to get to a doctor, this kind of care is unacceptable. I have had negative experiences related to hospital prices. There is virtually no way to know how much care will cost at one hospital versus another and I have been charged a lot more at one hospital than another for the same procedure. And I have no idea whether the care is even better at one or another. E-mailing with a doctor has worked very well for my family in terms of getting test results and for small concerns related to an ongoing illness. I don't think it could replace regular visits, but it supplements them well and is easier than calling on the phone.	MD	3/22/2006 3:13:42 PM
As a health care provider, I have seen many people in my practice alone who have drained the system financially and also exhaust themselves for the time that they have went to doctor after doctor. By the time they finanly make their way into my office and I provide my clinical recommendations and have identified the cause of their health cocerns, then their health care "insurance" won't pick it up and then it becomes a cash patient. Which one is better? I believe incentives for people to staty healthy should be awarded, especially since our health care system really isn't a health care system...it is a "sickness system" and that taking care of your self and not taking medciation is NORMAL. Granted there are medications that are warranted and thank god we have them, but not for daily everyday issues. Less invasive, more effective cheaper means by ways to take care of people are out there and they need to be made aware to the masses. When I saved teh life of the 5 year old child from asthma medciation and ermergency room visits, the parents could not believe the quality of life changes in their son. what a differnce? If everyone had their spine checked as policy, then we would have a healthier society!! Chiropractic care = Healthier bodies. Sincerely	MA	4/10/2006 12:54:02 PM

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Response	State	Date/time received
I attended the U of M discussion. I believe the meeting was very unproductive. I was told after the meeting that there was to be cross discussions with people attending. Therewasn't. The survey was very poor because it was obvious that those in attendance did not have sufficient knowledge to answer the questioms	MI	3/25/2006 9:38:26 AM
I have realatives that are working poor with 2 children. They have health insurance with a $20 copay per visit. One child has epilipsy and required hospitalization. $100 to start with and then 20% of the hospital stay. Office visit to a clinic for diagnosis and treatment $40. There are 2more doctors to visit, medicine to purchase. They delay office visits because of the cost, and delay the purchase of Med because of the copay.	WA	8/30/2006 5:38:32 PM
My husband is a Veteran and gets his meds from the VA. He recently has shingles and was percribed 2 different meds. Because of time constraints we had to pay. Called Walgreens. The price was $89., called Costco. The price was $19.95. Not all people are as savy as we. Who advocates for them?	WA	8/30/2006 5:43:04 PM
I was self-employed thoughout my working life and retired early at age 58 (my husband is 10 years my senior). I had private insurance through an association but shortly before my retirement the plan folded. I found it impossible to get any sort of private insurance at any price at the age of 58. The insurance companies would manufacture non-existent "pre-existing conditions" from odd remarks in the medical history as an excuse to deny covereage and even letters from multiple doctors refuting their claims did not sway them. Gratefully, my state has a high risk pool so I have insurance but I pay an extraordinarily high premium for it. I consider it protection money. I can't risk having to pay for a major illness that would bankrupt our retirement nestegg and leave us paupers. We will be so relieved to be out from underneath this financial burden when I can join Medicare. The cost of my health insurance is our biggest expense and the single biggest threat to our restirement security.	WI	3/19/2006 2:05:14 PM
I work as a patient advocate and what I see majority of time is the addressing of unpaid medical bills. And also the lack of understanding and frustration of dealing with health insurance companies and/or public health programs such as Medicare or Medicaid. Patients are bringing to me hospital bills they have just recently received for services as far back as 2002. What is the delay w/facilities getting medical bills out? Also, communication with health insurance, whether private or public is a major effort. Most patients don't understand what it means to meet a deductible, what prior authorization is, why a service is not a covered benefit. True, patient should take on the resposibility of knowing what benefits they are entitled to, but many are turned off with the multiple forms and statements attached to the health plan, they don't even bother reading any of the materisls - UNTIL they are in a state of crisis or need medical care. Many a times, I spend an hour or more explaining insurance benefits to a patient. The health insurance industry is not consumer friendly - the driving force seems to be the $$!	NM	3/22/2006 3:24:08 PM

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Response	State	Date/time received
This is long, but please read it. I have found out I am not alone in this predicament! I am a 50-year-old married mother of two grown sons. I have been hard working and independent since age 14 and have never requested any form of government assistance. My eyes have recently been opened to how a life can be ruined without health insurance. After 6 years on my last job, I was laid off due to downsizing in the US and Upsizing in India. At the time, I was in physical therapy 3 times per week for degenerative disk disease in my lower back. After losing my health insurance I could no longer afford the physical therapy and my orthopedic specialist dropped me because they don't accept "Cold" patients, who are patients with no insurance. Two of my lower disks are now ruptured and I have severe Sciatica. The pain is so debilitating that I can no longer work or even take care of my husband, my household or myself. I have to go to a pain management doctor each month for pain medications because my family doctor cannot prescribe long term pain medications. I have to use a cane to walk very short distances and can only shop or go out of the house with the use of an electric cart or wheelchair. I have constant unbearable pain so to alleviate the pain I am in a continual pain medication fog and afraid I might become addicted to the medications. I have tried therapeutic massages, a chiropractor and other treatments, but nothing has helped. 3 doctors have told me I need back surgery but I have no health insurance and no money. I called the hospital to see if I could arrange a payment plan but the cost could run between $40,000 to $100,00 and they could only give me up to 3 years to pay it off. Without my income we cannot afford that kind of bill and do not want to ruin our good credit rating by defaulting. We barely get by on my husbandâ€™s income now. We had to get a home equity loan on our â€œnest eggâ€ home to pay for my medical needs and medications including high blood pressure, high cholesterol and depression as well as the back problem. I could be added to my husbandâ€™s group insurance policy but it would cost 25% of his weekly paycheck, which we cannot afford, plus it would not cover any preexisting conditions for the first two years. Private insurance has the same 2-year preexisting condition policy and prohibitive costs. We do not qualify for state medical assistance because we are not within the poverty limits. I have applied for Social Security Disability and been denied twice. I now have an attorney and we have been waiting for a court date for more than 6 months for my last appeal. I applied for Medicare but was denied because I have not been legally declared disabled by Social Security and even when or IF I am awarded Social Security Disability I will not receive Medicare for the first two years. So, because I donâ€™t have health insurance I lie around suffering, feeling useless and hopeless and have declined into a deep depression. We have gone through all of our savings, lost the equity in our home and may have to sell it and buy a small mobile home to afford my medical expenses and our living expenses and we obviously will not have a retirement fund of any kind. Itâ€™s a shame that the big business of health care and our government can allow an otherwise productive American citizen to decline and perish after years of working hard and contributing to the tax system, including the Medicaid tax. We need a National Health care system like Canada has. When I was working, I wouldnâ€™t have noticed a few extra tax dollars out of my paycheck to pay for it, especially if it helped put the brakes on outrageous healthcare costs that prohibit otherwise responsible people to sink low enough to beg for government assistance. In fact, we are now considering moving to Canada and starting a new life all over again without our family so I can get the medical care I need. Thank you for your Citizens' Health CareWorking Group commitment. We need you!	FL	6/8/2006 7:03:02 AM

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	Response	**State**	**Date/time received**
	Sincerely, ...		
	i didn't see this option for narative accounts when i used the 'tell us in your own words' online form twice in the past month or so. before i try to re-relate my experinces as an RN who recently worked at county general in L.A. and a kaiser permanente facility, could you let me know if that input has already been documented? i used ----- in both submissions and gave my contact phone # in the last one the appauling video of a poor mentally ill pt in a hospital gown being dumped at the L.A. mission in her hospital gown yesterday has prompted this effort to make sure that my distressing experiences as an RN at both kaiser and county are known. i dealt specifically with the problem of how alarming it was for me that in both systems i saw patients violated daily (or nightly, i was a noc RN) while the healthcare staff and management were much more preoccuppied with their own financial wellbeing. too much smoozing and denial would make you think this isn't the typical scenario in hospitals today, but in fact every person who enters an acute care system today is COMPLETELY at risk for damaging care. you would not BELIEVE what REALLY goes on at the hands of people who document care they don't give and neglect to document the damging things they do do. that piece of video of "catching kaiser in the act of cruelty" is just the tip of the iceberg.	CA	3/23/2006 11:39:35 AM
	I am a registered nurse of twenty years on the west coast. From my years of practice I have seen that there is a very large need for physicians to discuss end-of-life care and have that discussion early on with patients. Even a public health message would be good. We do the craziest things and spend millions of dollars on procedures on eighty and ninety year old people. Recently I had a 99 yo woman who received a $70,000 pacemaker/defibrillator, and another patient who was in his forties that could not afford a life-saving operation. Doesn't make much sense. I know that most physicians blame lawyers and say that they will get sued if they do not do "everything" for each patient. I think it is time to have discussions on the fact that life is finite and prolonging it with the latest technology when one is in their very advanced years is not a good use of our resources. I am sorry to say that most physicians that I have met in the private sector are only worried about their piece of the pie, not the good of the entire population. Very sad because they have huge lobbies that promote the same old system that is ready to crash. Thanks,....	WA	6/6/2006 10:49:46 AM

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Response	State	Date/time received
I am unable to obtain affordable medical insurance to cover my asthmatic condition because it is pre-existing condition. Today I went to the pharmacist to fill two prescriptions, two out of many I am required to fill each month, the cost was $614.00, which I could not afford. I have been working all my life, but when it comes to health care, I cannot afford it and cannot get assistance. I am just over the poverty level for assistance, but not enough to afford the medical costs. I recently had to go to the emergency room at hospital, the cost for four hours there was over $2,000.00, the hospital forced me to get a loan or sue me, there is no compassion among the health providers, I have been told to give up my job and my home and I can get government assistance, I want to take care of myself, but the health care system in the US is impossible, the government spends millions on other people around the world but when it comes to taking care of the hard workers here in the U.S. they turn a deaf ear. And I am better off than some, I do not know how the elderly and people with families make it. Something has to be done and done now to improve health care and medical provider compassion in the U.S.	IN	3/26/2006 3:06:29 PM
I am an ER RN, and so have an different perspective than many people. I have seen too many people who are uninsured, or under insured who cannot find a doctor to assume primary care, so they use the ER to receive it. They come in, by ambulance for medication refils. that is at the expense of the people who are also struggling to afford health care. We need universal health care, not health insurance. Insurance does not provide treatment, diagnosis or meidications, all it does it take some health care dollar for its own. It is also not a gatekeeper. That is the role of the doctor, who has spent 12 years of his life studying the issue, not for a statistician to decide. People do not overuse health care, we underuse it. We are nearly the least healthy people in the modern world, and we are getting sicker. We the government has a direct stake in the wellness of the people (which it already does, it just does not acknowledge the fact) then we will not be so eager to tell the people that "Market forces" have decreed that a fast food joint embed itself on every corner of America. A society benefits from a healthy and educated population. We are flunking in both areas. We cannot tie health care to employment, that guarentees inequality. And as we witness business after business jettison their health and pension plans, we have to acknowledge that this is a road that is coming to a dead end. Our businesses are having to compete with a global economy, and many of the other countries have universal health care, as well as excellent elder care. We have neither. We cannot expect businesses to shoulder the burden. health care decisions need to be made by the doctor and the patient. Nobody else. If we start limiting those choices to the tried and true we will soon see un fall behind in innovation. We will also see results of tests skewed to meet the current standards. So those kinds of oversights don't work We won't need to see a huge increase in spending for health care to insure that everyone has coverage. When you take away premiums and put those into taxes, and simplify programs, there will be little need to increase taxes. Indeed, health care will be simpler, people won't be wading though reams of unintelligible papers to try to pick a plan, a plan, more over that usually cleverly disguises what it will and won't cover, and the patient doesn't find out until too l ate. Our society is in a shambles, we care for too few, eject too many and pamper the least deserving. Lets fix this today	OR	4/19/2006 3:10:58 PM

Question	We all have different experiences getting health insurance or in seeking health care. Sometimes these are good experiences, while other times they are not. We may meet very special providers or encounter new and innovative practices. Other times the American health care system disappoints us. Please tell us what has worked well or hasn't worked well for you or your family.		
	Response	**State**	**Date/time received**
	In the last 5 years since our son has been born, my husband worked for 2 companies that had to close their doors due to the bad economy. Our son has some health issues and needed eye surgery and surgery for hypospadias (minor issues in the big scheme of things). We had to go on a search for to purchase our own health insurance. What we discovered was that most companies would not even take us on and we had to go through COBRA and pay over $900 a month to get my son through his surgeries. Once COBRA expired, we found that Kaiser Permanente would take my son and I through my small homebased business for around $450/month and my husband went into a Blue Cross major medical only for around $170/month. Still over $600/month. Once my husband secured a job, his company offered Kaiser again. Kaiser has been the best experience we have had with health care in the 18 years we have been married. No run around! Easy to make appointments, very seldom do we have to wait at our appointments for more than 15 min., the Doctors have been extremely attentive and have great follow up. What ever they are doing works quite well. Through my husband's company it runs around $150/month for 3 of us. My son has had 3 surgeries with them and we've never seen a bill. I know there are still issues in a company like Kaiser, but it has been the best experience we have had.	CO	2/16/2006 8:23:23 PM
	I find it challenging to find health care coverage when I need it. The times in my life when I have had coverage have been times when I have been 'low-risk'. I am afraid that the American health care system is turning into a tiered system. Also - none of the plans offering Medicare Plan D benefits in my state cover the medicines that I take. I do not wish to enroll in a program that doesn't meet my needs nor do I wish to be penalized later.	MN	5/15/2006 11:40:31 AM
	Recently I switched jobs and had to change insurance plans. I paid for a more expensive policy in order to keep my doctor. I had a kidney stone over the January 1st holiday and went to the local ER three times in two days. Since I didn't show up in the new plan yet as a member and my old policy had been cancelled my primary care doctor refused to treat me (even though I had been going to the clinic for six years for healthy exams). I had full insurance coverage but was I was still bounced from one hospital to another and ended up being sent home with a shunt in for 3 days while they waited to find my insurace coverage. Only then was I able to see a specialist and have a lithotropsy. Afterwards my new insurance didn't want to cover the ER visits as I hadn't gotten my PCP's approval first and since I went to the wrong hospital when the first one sent me to the second one I had to pay a huge co-pay. I can't fathom what people who really don't have insurance do.	WA	2/23/2006 2:54:55 AM
	I am a retired physician who has worked in both the private sector and in the US Army. I believe that the care in both areas was exemplary but, for the health care workers and patients, the military was superior. We did not have to worry that patients couldn't pay for their medicines, or that they would go back to work too early because they couldn't afford to not work. We didn't have to worry about the horrendous cost of lab or diagnostic studies. We had time to be more compassionate and just take care of patients. I believe that we should have a single payer system - the government. All health care workers would be government employees. Do away with ALL the insurance companies. The money currently spent on bureauocracies and paying off shareholders could easily take care of everyone without any out-of-pocket increases in payment over what our taxes could easily cover. I recently switched insurance coverage - and because I haven't used any services in years I could - to a policy that limits my out of pocket payments to 3500. I still must pay for all my medicines, though. It costs almost $300 per month for my own coverage. My husband is diabetic and his coverage is over $600 A MONTH, with some discount on medicines, a hefty deductible, only 80% covereage of most things, and no limit on out-of-pocket expenses. Because we are both too young for	WA	8/30/2006 3:21:29 PM

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	Response	**State**	**Date/time received**
	Medicare this is as good as we can get. I pray that he doesn't get a prolonged illness before he gets to Medicare age.		
	I am a healthcare worker. Our employer has not been able to provide us with affordable healthcare coverage that covers hospital expenses. As I near retirement age, I keep hoping that nothing serious will happen until I am finally able to sign up for medicare/medicaid, as this is the only way I would be able to afford a hospital stay or extensive tests. And the older we all get, the more likely we are to develope more serious medical problems.	IA	6/24/2006 10:18:54 AM
	I am a 52 year old female working full time in a smoky casino. I seemed to be in perfect health until about 3 years ago. I am a slim, nonsmoker, exercised regularly, had a recent physical, lipid panel numbers normal (except for low HDL) and below normal blood pressure. I had a massive heart attack resulting in 2 stents. I have health insurance through work with high deductibles and co-pays. I would like to get out of this smoky environment that I work in, but I need the health insurance. I am considered uninsurable. I can't start a business of my own and I have to work for someone who provides health insurance. In my hometown, options are limited for employment--a job change would mean a HUGE decrease in income. My 21 year old daughter had aortic valve replacement last year. She will be uninsurable for the rest of her life unless she can be covered by a group policy. She is still covered under her dad's insurance, so he is limited where he can be employed also. When she finishes Cosmetology school, she will have to be covered by Cobra which is cost prohibitive for a young person just starting out in her career and only be employed somewhere that offers health insurance, which is not common in her field. She most likely will have to move out of state and live in a city with larger businesses. So you can see that health care affects not only our quality of health, but impacts where we can be employed and even where we can live. Tax breaks won't help if coverage is not available. We need some kind of national health insurance to increase the risk pool. In South Dakota, we have a small population and small businesses, so health care is expensive and not always available.	SD	6/13/2006 12:27:23 PM
	I am a nurse who has worked very diligently and ethically for many years taking care of others. I became self employed and obtained health insurance allowed by the Federal govt one time per year. Without any notice, this past year, the government discontinued this, and I am stuck in an extremely expensive health care plan that will only continue to rise in cost, and which I will be unable to afford in the next 2 yrs. I am unable to obtain health insurance on my own at this point without any pre-existing condition clause. This is how our government encourages initiative in America.	MD	6/14/2006 6:28:05 PM

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Response	State	Date/time received
I use to have full coverage insurance through my employer. After being laid off, I cannot find full coverage insurance, because my health conditions are excluded from coverage. As an independent insurance seeker, I am offered the opportunity of getting insurance that covers everything else that I do not have. The insurance excludes me from getting covered on my health conditions that I do have. Because I can get insurance and have to pay for whatever they don't cover, this mean I would have to pay double. I have investigated in Medicaid. I do not qualify for Medicaid, because I have too much money in savings. My doctor does not except Medicaid. I have investigated in CHP+. I do not qualify because Survivors Social Security pays the too much. I have investigated in the high risk pool in my state, Colorado. That plan is exorbitant and prohibitive to pay. COBRA was offered, but it is to exorbitant and prohibitive to pay. When insurance and health care coverage is equal to or greater than a mortgage payment, I have to choose which one is more important to pay. I have a â€œDiscountâ€ plan, but it pays very little. On average, it pays 10%, if I don't go to the doctor more than five times a year. This is not health coverage. However, it will provide a card for the hospital if I need to go. Hospitals are now refusing care if you do not have insurance or can pay in full up front. Now I am facing a possible catastrophic event, which could happen at any moment. What am I going to do? Would I need to sell my house? Would I need to move out to the street?	CO	5/24/2006 9:29:58 PM
The problem is not just affordable health care. As long as health coverage is sold on the free market, there is nothing to say that the insurance companies have to sell you a policy, even if you can afford it. I was rejected by a major non-profit insurance company for having acne and allergies! What is more, in my state, being denied coverage even for the most trivial reason, caused me to be ineligible for other types of coverage for seven years. Considering how necessary adequate health insurance is in our society, it is a shame that we have not even formed some sort of minimum coverage level that companies must sell to everyone.	MD	7/31/2006 4:53:15 PM
It would be great to see coverage of wellness programs like yoga, meditation, massage, energy medicine, etc.. vs drugs after one is sick. I would like the option of seeing an acupuncturist or homeopath vs an allopathic doctor who is going to prescribe me pharmaceutical drugs with side effects. I have insurance for emergencies, but use homeopathy to treat myself and family, so I have to put money into a system that does not give much back to me since I do not use western medicine and that approach. I used the health care system for a couple of fractured bones and a case of botulism, the bills were quite high on the second one. I am glad that I can use homeopathy for a fraction of that price and be responsible for my own health.	CA	8/14/2006 2:29:09 PM

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	Response	**State**	**Date/time received**
	What hasn't worked well for me was that I was terminated on trumped up charges because I was working trying to get a Union in and I filed and EEOC claim on my job. I then was without health care my family has seuffered and my husband has high blood presssure and my daughter has asthma, I went to sign up for a health card or medicaid and they gave it to my daughter but not husband, becasue he worked but could not afford the health care plan where he worked. I then read where Canada has free health care, well the United States is bigger and Richer why can't we have free health care. I have since became disabled and then you have to wait 120 days for Social Secuirty which you have paid into to see if you are eligble. America which was buildt buy the hands of our fore fathers you can 't get any help.	OH	6/2/2006 10:53:03 PM
	Being born in Britain and now a US citizen I recently experienced the differences between the US and British healthcare systems. Althouth the British socialized healthcare system appears to have it's cost benefits, which comes from income taxes, it also has some downfalls. If a person has a non-life threatening ailment then they may be required to wait a long period of time just for a doctors appointment. A relative of mine has to wait 13 weeks just for a doctor to assist with arthritis. On the other hand if it is life threatening the system can move fast. Recently, my Uncle had to undergo surgery for brain cancer. A decision was made fairly rapidly and he was rushed into surgery. When the patient leaves the hospital he/she does not have to worry about extensive bills as it is paid by the government. Although the US appears to have a higher quality healthcare system many of the advances are held back due to FDA approval procedures. Other countries do not have the stringent approval process and therefore benefit from advances much sooner. So the conclusion in my mind is a blended system of socialized and insured healthcare. This will have to be determined in time as reform is a necessity in the US.	FL	6/6/2006 2:03:35 PM
	i worked very hard to become a pharmacist. i go to work evey day, trying my best to practice, work, help my patients. i end up doing almost everything BUT pharmacy, as i spend most of my time discussing, addressing, trying to solve insurance problems, dur messages, prior authorizations, substitution issues, lack of coverage issues. all issues that demand most of my time, preventing me from investing time in my education and taking care of patients.this has deteriorated my attitude, and denigrated the caliber of care on a very immediate basis. personally , my insurance policy has been changed, forcibly, so that what was once the best i could afford, now will not pay for my heart and cholesterol medication, my wifes therapy, nor my boy's nasal inhalant. what kind of system do we have ?	PA	1/31/2006 10:49:22 PM
	I am a Teamster with great health care. My wife went in for surgery, to remove an ovarian cyst, they found cancer and had to remove everything because it was all full of cancer. Then she needed chemo and I know that with out the good health care insurance I have this would have been a death sentence for here. The cost will be more than $500,000.00 and we did have to pay for some out of our pocket but less than $2500.00. I know now that being a Teamster has saved my wife and kept my out of debt for the rest of my life. I don't know how our government can say that they are helping, us the people of this nation, when we have so many people in this country that don't have any kind of health care insurance at all. Our elected officals are lining their pockets and putting anchors around our feet to keep us down, while they have the best health care they want and the best doctors. How much does it cost the american tax payers a day for the health care team that follow big fat Dick around all day every day?	WA	2/18/2006 9:52:53 AM

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Response	State	Date/time received
Hello, First, thanks for giving the public a chance to comment on our experiences with the health care system. After being one of the healthiest people I know for 32 years of life, I was diagnosed with Multiple Sclerosis last September. This diagnosis hit me just a few months after my father died of leukemia the previous April. So, I have had ample dealings with the health care system during the past year. Just to set the stage for you, I never smoked, drank or used an illegal drug before my MS diagnosis. I rarely ever used my health insurance provided by my employer and maybe caught one cold per year. My dealings with insurance and health care had been pretty limited prior to myself and my father getting sick and I was very naive about the state of health care in the US. The one thing I've learned for myself and heard many people in the health care industry say repeatedly is that if you're going to get sick in America, you'd better be rich or poor because if you're caught in the middle, you're screwed and you'll end up bankrupt and left without the care you need. What I mean by that if you're poor, you'll get Medicaid and will rarely be billed for anything the Medicaid system won't pay. If you're rich, you'll just write a check for whatever your insurance didn't cover. If you're in the middle, you're either using private insurance or Medicare and will be billed for medical costs that you can't possibly begin to pay and you better hope that you don't need to be admitted to the hospital to which you owe an outstanding bill. I don't know of many middle class people have an extra $10,000 to spend on medical costs that insurance didn't cover after a hospitalization. You could always not pay and wipe your credit history and not be admitted to the hospital to which you owe this bill the next time you need care. I worked in local government and don't make a lot of money. However, I played by the rules, I paid my taxes, I took graduate courses in the evenings to better myself, I never committed a crime and I opted to take the health insurance provided by my employer even though at the time, I had almost no need for it. Now that I'm sick, I struggle to make it to work everyday because I need my insurance and the money to pay the large bills that my insurance doesn't fully cover. I'm on an $18,000 per year drug for the MS. This drug is the only thing keeping me functioning. If I lose my job and insurance, I'll lose that drug. My doctor told me that I need to be on a double dose of this drug but insurance likely won't cover it. I've told my neurologist to give me whatever drugs will prop me up in order to make it to work everyday regardless of the long term consequences because I can't afford to get sick enough not to work. What I mean by that is, if I can't work, my insurance might COBRA long enough to for the two and a half years long enough for Medicare coverage to begin. However, neither my COBRA insurance or Medicare will cover all of my drug or health care costs and the limited amount of money I'll get from SSDI will not be enough to live on let alone pay the medical costs not covered by insurance or Medicare. MS is an expensive disease and what becomes of suckers like me who played by the rules? I'm not married so I have no spouse to put me on her insurance plan should I become too sick to work and my COBRA insurance run out and Medicare not cover everything. Obviously, with MS, I will not be able to obtain an insurance policy on my own without the open enrollment offered by employers and thatâ€˜s only if thereâ€˜s been no gap in coverage. Should I become unable to work, I will be uninsurable and I will not even be able to get Medigap coverage because of the MS. The health insurance industry is one of the few places in American society where discrimination is legal. They can refuse to serve me because of my health situation. A potential employer cannot refuse to offer me a job because of MS but insurance companies can refuse to cover me. I have a friend in Canada who is my age and has MS. She attended college in the	NC	6/4/2006 1:12:44 PM

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Response	State	Date/time received
US and wanted to remain here but was diagnosed with MS while living in the states. Her father, a Canadian physician, actually told her that she can't afford to get sick in the US and to return to Canada where she will at the very least, get the care she needs without fear of how to pay for it. She might have to wait a little longer for appointments but she'll get the care and medicines she needs to stay functional without the added stress of how to pay for being sick. I'll apologize for the rant but this has dominated my thoughts since my diagnosis. My only option other than staying employed is to get completely paralyzed by the MS, shirk my financial responsibilities, become a burden of the state and be sent to a state run nursing home. There is no middle ground with getting sick in the US.		
Medicare RX plan I reached the the "38%" level at the end of April. I was repeatly told by United Health Care representing AARP that I would only have to pay the next 1350 after reaching the 2250 level when I first enrolled. If you were to call today 5 out 10 representatives would still give you that version. The other five would tell you that since I had already paid on my own $878.34 I would need to spend $2721.66 to reach the next level which would put me in the "14%" bracket. Based on the national Walgreen pricing of my drugs with the AARP discount I would pay 5% in the remaining four months. In 2005 I paid for drugs including a compreshive AARP with a drug coverage plan $6450. In 2006 with AARP including both drugs and a greatly reduced AARP supplemental coverage I would pay $4878. The real killer is paying $650 out of pocket for the next four months. The Medicare RX plan is certainly "A WMD" for every senior. http://www.latimes.com/news/local/la-me-medicare18apr18,0,1685565.story	TX	4/21/2006 11:18:43 AM

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Response	State	Date/time received
1. Once I visited a family practice doctor at a small clinic I had used before, to inquire about a persistent condition of the skin of a finger, that looked rather like athlete's foot. I had used numerous standard over-the-counter and alternative treatments, to no avail. He walked in, took a glance, said it was athlete's foot and prescribed a standard over-the-counter treatment that I had used before to no effect. When I tried to tell him this, he said that he had no time and if I wanted him to take a history, which he did not want to do, it would cost extra. He already was charging me about $60 for the few minutes he spent. To my mind, taking a history is a standard part of medical practice and not taking one when it could be relevant would be malpractice. (By the way, thinking he might somehow be right, I used the treatment he prescribed, to no good effect but some ill side-effect.) Something is really wrong with medical education or ethical standards if something like this can go on. 2. I dislocated my shoulder in an athletic event on a Sunday mid-day and it wouldn't go back into place. I went to the closest emergency medical treatment facility, and waited an hour or more for treatment. They took X-rays, gave me a muscle relaxant and pain drug, and the doctor moved it by hand back into place with no problems in a couple of minutes of his time. Then, when I was a little dopey because of the pain drug, they asked if it would be Ok to take more X-rays, to which I assented, though I said it was unnecessary because my shoulder was just fine. During this whole episode, in which I waited quite a bit at various times, so there was plenty of time, no one bothered mentioning to me anything about the cost of any of the procedures. I didn't insist on asking because I had insurance from a University plan that, I thought, would cover such things as normal for students who would often be involved in athletics. I thought the cost might be about $700 (of which I might have to pay 10-20%), since I had heard that emergency room visits were expensive nowadays. If it had been done as an outpatient visit to a doctor, it would have expected it to have been no more than a couple hundred dollars. The doctor only spent a couple of minutes in treatment (and a few minutes beforehand talking with me), the drugs were not expensive, and my use of facilities and equipment was minimal, except for the numerous X-rays, which I hadn't wanted but had assented to because they had wanted to do them. The bill, however, was for $2800, which the insurance company (and I) thought excessive (to put it mildly, in my case). In particular, the insurance company thought there were too many X-rays. What I got out of all this was that the medical system (not the doctor, whose bill was reasonable for an emergency room visit) is in effect rapaciously greedly and does multiple unnecessary tests (X-rays, here) either to pay for their equipment that was unnecessarily expensive for the case at hand or to cover their asses if something should just happen to go wrong in a very straightforward simple case. Please note: you may use this experience on your web site and in your reports, but not if you provide any personally identifying information about me. Thus I indicate "no response" in the checkbox. Also note that the zip code below is not where these things occurred.	IN	2/19/2006 4:25:15 PM

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Response	State	Date/time received
I feel that health insurance companies are running everything giving the consumer and doctors no say in things. For instance, Aultcare is our insurance carrier. I see a doctor 55 minutes away from my home for my fibromyalgia. Twice a month he comes down to an office a mile from my house and they will not cover him as a provider unless I drive the 55 minutes or his office in North Canton. Also, Aultcare will only cover the physical therapy at the Healthplex that is part of our hospital. This place does not have any understanding of how to treat someone like me who lives with chronic pain and needs repeated service during certain seasons when my pain levels go through the roof. So I have to pay more to go to another physical therapy business who has a large clientel of chronic pain patients and are very effective and knowledgeable about chronic pain. They have been trying for 13 years to get into the Aultcare system and many patients have written letters or sent emails or called begging to have them let into the system to no avail. It has been proven that HMOs and PPOs have not lowered the cost of health care and in fact costs have continued to increase by double digits. I think there whould be a law passed that all insurance companies should have to allow any health care provider into their program who is willing to accept their fee schedule. These insurance companies are forming monopolies of power in our area and the doctors as well as the patients are fed up!	OH	4/15/2006 9:35:00 AM
My husband and I are self employed and, thankfully, quite healthy. Yet, we pay nearly $8,000 dollars a year for the most basic insurance coverage that will only help in a catastrophic situation. We think the HSA is the worst and stupidest solution that ONLY benefits the rich. It does nothing for strugglng business owners and tax payers like us, except make us think twice about "Do we really need that mammogram?" "Do we really need that physical?" Even now, I can't tell you how humiliating it is to call the physicians office before an appointment and ask, "Now, how much of that testing, labs, blood work, etc. do you really have to do?" Because every damn penny of it comes out of our pocket. And if it is coming out of my HSA, that is money I may need later. It is a terrible solution. I haven't found anything that works. Our insurance provider has made record profits every year, while we struggle to pay our monthly premium with huge deductibles. As a two-employee firm, we cannot negotiate a "sweetheart deal" with BCBS. I never thought I would be for socialized anything, but these costs are killing us!	TN	4/22/2006 9:55:43 AM
I am a registered nurse and work for the largest HMO in Ca. Because of what I have seen and heard from the members, I have chosen to not be a part of that health care system. When I made the decision I was receiving free, other than co-pays, medical care for myself and spouse. We pay an extremely high monthly premiums for a PSO insurance but feel that it is worth the cost. However, I resent that we must pay this plus our Medicare premiums to obtain the quality of health care that I feel is necessary and that which we, and LEGAL U.S. citizens, deserve.	CA	7/12/2006 10:55:33 AM

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Response	State	Date/time received
Dear Sir, A few years ago, I visited a physician at a large establishment in my city. I explained to her my spiritual views, my views of privacy, and requested that my records not leave her office (in writing). I also told her the only thing I expect is honesty and respect. If it was too difficult for her to work with me due to my views, I would understand, and I would appreciate her honesty. She agreed. About a year and half later I obtained my medical records. She falsified my records, and has made it impossible for me to get any type of objective care within the medical establishment. She twisted my words, left out important information, violated my privacy, prescribed a medication that (by her own words) was not in my best interest, and outright lied in my record and to me in the office. When I was diagnosed with cancer, I could not continue care with the largest medical establishment in my area. Two years after (in writing, on my consent for treatment form) I "thought" I made it a provision of my care, I was told by the establishment, they didn't have to honor my mandate, they, in fact, didn't have to honor anything at all. The physician directed her nurse to leave a message on an answering machine with a male voice with test results (that were also inaccurate). My husband played the message. It created many issues within our household. Again, the medical establishment never apologized. Instead, they put me through "hell" for more than 6 months, writing letters, contacting people, and meeting with hospital personnel. The doctor's boss (with a witness present) approved amendment of my record. However, the legal department informed me that the only way the record could be amended is if the doctor who lied approved. HIPAA not only gives the establishment full access to my records, it also allows others access. I cherish the first amendment, but it doesn't apply within the medical establishment where I sought treatment. (Even though it is stated in their "patient bill of rights") A physician is allowed to create a bias in one's medical record (without the knowledge of the patient, and even lie) that will hinder future medical care. I also cherish the fourth amendment, but that doesn't apply to the medical establishment. If patients want their information shared, it should be respected. However, if a patient does not desire another physician access (even in the same establishment), a patient should have that right!! Didn't people die for our right to privacy? Often a large medical establishment has a monopoly on health care in the area. (This is the case where I live.) Shouldn't spiritual beliefs be respected and not subjected to ridicule? I believe (in order to keep doctors honest) that copies of ALL information placed in a patient's file (especially the doctor's comments) be given to the patient without cost, without hassle, and without retribution. Most people don't know that the person in whom they place their trust, isn't trustworthy. In fact, there really is no doctor-patient confidentiality. (Unless one encounters a physician who puts trust ahead of medical policy) I filed a complaint with the State Medical Board. It was a waste of time. After two years, they dismissed my concerns. I filed with HIPAA officials, but after two years, I have not recieved a reply to my complaint. Hospitals have a lot of money and powerful attorneys. A patient has no chance of fighting their system. I was told their policies were in the best interest of the patient (without the patient's knowledge or permission). Does freedom of choice only extend to a woman's right to choose whether or not to stay pregnant? I believe the first and forth amendment should be extended to the medical community and they should be held to the rights guaranteed to us	OH	8/16/2006 11:34:33 AM

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	Response	**State**	**Date/time received**
	by our constitution.		
	I have always been fortunate to have healthcare...and mostly in past years have been double covered by my previous job and my husband's employment. My husband died last year at the age of 50 and I am self employed now and to cobra his insurance it costs me almost $500. per month. I am a healthy individual, but due to the stress of my loss, I feel locked into this insurance. There is a strong possibility that I will lose my home because of not being able to make ends meet. I am considering getting a job with benefits to reduce my costs, but I know my self employed job would suffer tremendously. All I ask for is reasonable health care costs, of which $500. per month is not. Health care costs are one of the biggest stressor in my life right now.	WA	8/30/2006 2:42:16 PM
	I am a nurse practitioner who found my own thyroid cancer, but because I was in an HMO, I had to convince my provider that I needed to see a surgeon. This took 8 months even though I am used to dealing with the health care system. I am worried this delay increases my risk that my cancer will return. My provider said he was an endocrinologist, but was not board certified--he just had a fellowship in the field. I think we as consumers should have more control over our own health care. This is why I am now in a PPO, and hope never to have to deal with a gate keeper againl	IL	3/6/2006 5:39:13 PM

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I think that one the most disappointing aspects of the present health care system is the attitude of hospitals and the medical establishment toward consumers and toward alternative care providers and institutions. Some examples: 1. Hospitals and physicians are forcing women to have unwanted and unnecessary cesarean sections. This happened to a family member 5 years ago. She was severely traumatized. This trend has continued and gotten worse in the intervening years, even though no evidence supports c-sections as a better choice than vaginal deliveries. C-sections result in a 4 times-higher incidence of maternal death than vaginal deliveries and this unfortunate trend (a 40% increase in recent years) is greatly increasing the costs of maternity care. 2. The incidence of medical errors and hospital-induced infection rates is far too high, and consumers are not provided with sufficient information to avoid risks of incurring such infections and errors. An example from my own life that could have resulted in infection occurred last year. I was hospitalized for asthma and was receiving medications that compromised my immune system. Despite this heightened risk of vulnerability to infection, I was assigned to a room with another patient who, I learned, was suffering from a staph infection of unknown origin. My family and I had to argue with several layers of hospital bureaucracy before they agreed to transfer me to another room. Such carelessness is inexcusable. 3. Another example: I learned recently that one of the medications I take for asthma was deemed by the FDA in November 2005 (4 months ago) to be so risky as to require a "black box warning." The physician who had prescribed it and several other phsicians who knew I was taking it all failed to alert me to the risk I was incurring. I learned about the risk from the media and confronted the prescribing physician, who agreed to prescribe another medication only reluctantly. 4. Hospitals and the medical establishment refuse to cooperate with integrative providers, even when it puts the patient's health at risk to do so. An acquaintance of mine was recently transferred from an freestanding birthing center to a hospital when she decided she wanted medicated pain relief. The hospital nursing and medical staff were rude, condescending, and verbally abusive toward her and her midwife and refused to permit the midwife to even remain with her in the labor room. This hospital refused to enter into a transfer agreement with the birthing center, which is nationally- accredited, even though it is routine for transfers to take place between and among hospitals of different levels. Another patient of my acquiantance, from this same birthing center, was transferred to the hospital when it was determined that a c-section was necessary. The on-call physician, when he learned that a birthing center patient was coming in and needed a c-section, left the hospital and refused to answer his pager. The surgery was delayed for 90 minutes and the baby had to spend several days in the ICU. 5. Vaccinations with thimerosol, which contains mercury, are routinely provided to children and babies. Parents are not given truly informed consent about this risk and are not even told that this preservative is in the vaccine. 6. Most managed care and other health plans will not pay for most alternative and integrative care health professionals, such as midwives or chiropractors or independent nurse practitioners. i, my friends, and my family members experience this problem frequently. Most health plans require these providers to bill through a physician, if they cover their services at all. Both government and private payors in this country are locked into the AMA-designed and -controlled CPT coding system, which does not adequately cover services provided by these other providers. The vast majority of holistic, preventive services provided by integrative health care professionals are simply not recognized by the CPT codes. As a nation, we are wasting enormous sums of money by being locked in to the AMA CPT codes and by being limited to services provided by or "supervised" by physicians. Providing a level playing field for all health professionals would greatly increase competition, providing lower cost care and greater access to services and improvements in quality of care. However, the hospital/medical establishment have created barriers	DC	3/22/2006 1:00:36 AM

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	Response	**State**	**Date/time received**
	to entry for other health professionals and barriers to receiving care on the part of Americans.		
	I am an ambulatory disabled individual, under age 50, with several serious chronic illnesses and dependent on medicines for my survival. I am enrolled in Medicare as well as covered by a health care plan at the company I worked for. Here's what happened to me when Medicare Part D was implemented: For many years, my medication costs were about $20 per month, on average, because the pharmacy benefits had reasonable and fixed co-pays. So despite my limited and fixed disability income, I could afford my medicine and other necessities of life. Because of the provision in the Medicare D program that gives grants to corporations for every retiree they keep on their own rolls (to keep from dumping us all en masse into the Medicare Part D program), my company cancelled the retired employee's participation in the pharmacy benefits I had been enrolled in. We were then placed into a newly devised program that is supposed to be roughly equal to the basic Medicare D plan. This new plan involves a complicated co-pay schedule (Imagine a multi-dimensional matrix involving 25% to 50% copay, formulary and non-formulary, name brand and generic, etc. etc. etc.) As a result, the monthly costs for my medicines soared from about $20 to over $1200. This happened just when my endocrinologist had finally, after more than three years of lab tests, fine-tuning, and other efforts, succeeded in titrating up the correct level of one of the endocrine drugs I need (without which I'd be dead in weeks). So as a result of the Medicare D provisions and implementation, I have to make more doctor visits now for re-titration with an affordable (and a less reliable) generic, which is not working as well for me as the original medicine. So in addition to having to start an arduous titration process over, I now have to decide each month whether to pay for medicine or for food; when sickness and pain and desperation allow medicine to come out on top that month, even the mortgage gets paid late. My life is in increasing disarray and unravelment; I'm losing the gains I'd made in my health--and I fear that I'll never get physically well enough to work again. Despite free samples from my doctors, changing to cheap generics, I can't afford my medicines (not all of them have generic equivalents; most can't be halved with a pill-splitter). I'm just a few dollars too "rich" to qualify for most readily available state and private programs that help people get access to drugs. I'm thinking of selling my house to get money to pay for medicine. Somehow, I do not think that this is what Medicare Part D was supposed to do. I remember when Medicare beneficiaries first demanded a pharmacy benefit. They were buying prescriptions from Canada and Mexico, cutting pills in half, trying	NY	4/9/2006 8:09:57 AM

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	to decide between paying for medicine or paying for food. The Medicare Part D plan simply changed the people suffering and laboring under heavy medicine costs from one group to another. Was that progress?		
	I take care of my 89 year old mother's health care bills. She is covered by an insurance plan from the government, based on my father's employment. Every month, every single month, she is overbilled by health care providers. I have written letters to the providers, explaining how they are overbilling her, which result in that particular bill being fixed. The next month, the same thing, by the same provider, happens all over again. I have written to the government, which explained in the nicest possible way that as long as the health care providers are not trying to cheat them (the government) they really don't look into attempts to fleece the elderly. I had to fight for months to get the insurance to pay for a procedure (vertebroplasty) without which my mother would have been bed-ridden and in agonizing pain after she fractured a vertebra. The insurance company said there was "no treatment" for this, even though vertebroplasties have been done for decades. We finally won. Why is it so much time and effort and work? If we had a single payer system, all of this paperwork and cheating would go away.	MA	5/13/2006 10:34:19 AM
	... Iâ€™m a member of Acts of Art. I am a poet, screenwriter and actress. At the present moment, I have a day job and insurance. But for many years, I worked part time at coffee shop and paid for all my health care out of pocket. I could not afford the monthly rates that health insurance cost. At this time, I was performing as an actress in various downtown theatres, including a community street theatre throughout the boroughs, as well as participating in and organizing poetry readings. My small, radio theatre company produced an award winning radio drama which we performed, edited, and distributed. The hours I spent beyond my part time job, in rehearsals, on the phone planning rehearsals, gathering actors, generating material, talking with kids after shows, and just plain writing, exceeded a full time job hourly schedule without the pay or benefits. I passionately loved and still love every moment I can dedicate to acting or writing. These arts have crafted me into a person who is a caring, thinking, and active member of the community. One summer I found a lump in my breast. For several months, I tried to pretend it wasnâ€™t there. But a lump doesnâ€™t go away on its own. I was terrified and in denial. I had no insurance and feared the cost of a hospital visit. Not going to the hospital was not for lack of knowledge. I knew that I should go.	NY	6/22/2006 2:46:08 PM

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	Several years previous to this summer, my mother died of breast cancer. I knew a lot about lumps. I watched her for six years as she not only battled the cancer, but battled insurance companies and hospital bills. I didnâ€™t have a lot of faith in health insurance. Basically, health insurance and hospitals seemed both out of my reach and what I was trying desperately to avoid. Eventually, I couldnâ€™t avoid the reality anymore. I got very lucky. I met a doctor who severely negotiated his price and a rich relative paid for the hospital bill. And most of all, the lump was not cancerous; but if it had been, I would have missed a very important opportunity for preventative treatment. I donâ€™t think we can afford to leave the fate of our health up to luck â€“ the body wonâ€™t always thrive against the odds. A recent study â€œfound that the uninsured were over twice as likely to forego treatment for serious symptoms, even those for which care was thought necessary. While this does not necessarily reflect on the health status of artists as a whole, it does indicate that uninsured workers may face increased health care needs due to lack of coverage and resulting poorer health status.â€ The creative imagination is responsible for inventing solutions, for remembering beauty, for communicating and contemplating our very existance. If we want a culture which values the imagination and therefore reaps the benefits of doing so â€“ then we need to value the facilitators of the imagination; we need to invest in those who stand guard over the imagination â€“ the artists, the dreamers, the creators. I have a vision. Based on three things I believe to be true. 1) The imagination is our most valuable resource. 2) Everyone deserves health care. 3) And every one is an artist. When we care for the artist, we are caring for an element of ourselves and communities which clarifies the meaning of our lives. Although an act of art can transcend its artist, the artist must still reckon with its personhood. Health care is a form of deeply personal praise for the body and soul. And from that praise, the body responds with gifts of song, dance, and inspiration.		
	In my 20s and 30s, I thought I was doing my part to keep healthcare costs down by seeing a nurse practitioner instead of a doctor for yearly exams and other relatively minor things. Imagine my surprise when I found out my insurance was billed the same amount for each visit as if it had been with a doctor. There should be lower cost alternatives...maybe there are now with all these "minute clinics", I'm at a point where I need to see mostly specialists, so my opportunity for lower cost visits is now gone.	MN	6/6/2006 10:31:58 PM

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I haven't a clue where this fits but my experience spans 20 years in the health care profession as a nurse. To me many of the reason's for escalating cost is moronic beurocratic regulations that have little bearing upon the quality and greed driven ferriferous law suites. Beurocratic rules, complicated payee systems, every thing in triplicate paper poop take up personnel man hours thus increase administrative cost while inhibiting patient care. Frivols law suites are the reason for increase mal-practice premium cost which are passed on. I knew an OBGYN who paid as much for his malpractice in a "quarter" than I did my house over 15 years . . .that is why seeing a doctor cost $120.00 for ten minutes! Paper work is drastically decreasing nursing time with patients especially in the long term care settings. Yes procedures should be documented but the more times some thing is repeated the higher the chance for providing inconsistent (worse conflicting) information. I went into nursing for people not paper. Over half my time at work is consumed by redundant paper work in an efficient and archaic system. Much of this paper work is generated my Medicare requirements, insurerâ€™s looking for loop holes to get out of paying, and law suites. It is a sad day when facilities are more worried about covering their asses than patient care. More emphasis is placed upon the business aspect of health care than in people compassion. That is what health care is today all about covering your butt because health care professionals can be suited even if they do nothing wrong. . .how many people would tolerate being in constant fear of being sued or hassled by your licensing board . . . . You can be investigated by a licensing board a process that can take years. The innocent are weighed down while the guilty are continuing to practice. I go to work every day knowing as a nurse I can be sued even if I do every thing right . . .God help me if I make a mistake. As a bonus the insurance companies, litigation lawyers, and clueless government policy makers, pile on paper, polices, rules which can be time consuming and confusing therefore actually increase the chances of error. You think health care is confusing on the patient end you should try it from the nursing side. I belong to a nursing magazine and they published a study that indicated many nurses are leaving the profession due to the stress filled environment created by impossible demands constant shortage of staff zero support and an aggressive fear of litigation environment. Now in my opinion the high cost of health care and the reason behind the nursing shortage are caused by the same problems- .	TX	8/1/2006 3:58:35 AM
Since my family lost its medical insurance when my husband was fired, I feel like every flu season is like Russian Roulette. I do everything preventive I can think of (e.g. healthy diet, vitamins and supplements and do not smoke), but I still live in fear of losing our house to a disease.	CA	2/15/2006 9:42:31 PM

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Response	State	Date/time received
Last Saturday at 3am I got a call from my 21 year-old daughter. She was crying and in obvious pain. Walking home with a friend, she'd been goofing off and fallen on her face on the sidewalk. Her chin was cut to the bone and she had broken at least 2 teeth. Despite the pain and the profuse bleeding, what she feared most was going to the emergency room with no health insurance. My 23 year-old son (also with no health insurance) worked on ski patrol at a resort this past winter. His first call was to aid a snowboarder who'd hit a tree. On arriving at the scene he found that it was a friend his age and she was in terrible pain with a back injury. Despite her pain and the potential seriousness of her injury, the young woman begged them not to call an ambulance because she had no health insurance. By far the largest group of uninsured in America are those between 18 and 24 years of age. While 16% of all Americans have no health insurance coverage, 28% of those between 18 and 24 years of age are totally without coverage. That is almost 1 in 3 of our children. This group is also the fastest growing of those without health insurance. Too old to be covered by their parents' policies, our children are learning that fewer and fewer employees can afford to cover new hires. The result is a rapidly expanding bulge in the uninsured (the second largest group of uninsured is between 25 and 35 years of age). And I'm not even talking about the poor or the indigent. My kids are typical middle-class kids, who went to the dentist every six months while growing up and to the doctor at least once a year. Now there is no preventive medical care for them. When my daughter went to the dentist to have her teeth fixed, he found that she had 2 cavities. Thanks to preventive care as a child, they were the first two cavities of her life. If she hadn't fallen, she wouldn't have had them fixed until she was in unbearable pain, and the result would have been much more serious and expensive treatment. I think we owe it to our children, who are expected to bear the brunt of national defense and to repay our mounting national debt, to provide them with basic health insurance. To my mind this means a comprehensive national health plan. We can no longer afford to pay private insurance companies 40% of our national health care dollar to shuffle paper when medicare (A & B) operates at a 2% overhead. It's good that we take care of the old, but we need to take care of the young as well. After all, they will soon be taking care of us, and we might stop and think about what we're expecting from them.	WI	4/18/2006 9:39:38 AM
My perspective is a little different. I am a toxics researcher and immersed in issues respecting our lack of health as a society , specifically the representations of the reletively recent body burden studies, the red cross' neo natal merconium studies, the prevalence of pesticides, herbicides POP's and pharmaseuticals in our waterways, oceans and air. Then a toxic dyes, the high fructose corn syrups, aspatame and the genetically engineered corn, soybeans and wheat that iare at a minimum affecting our response to antibiotics and one can almost feel that we are sabotaging our chances for health regardless of the system. What did the recent Commonwealth club of SF say it is a Gross National Problem. But since this is YES magazine let me add a positive obsevation. My research indicates for example that if one additional very important incentive for nationql health care beside the fact that it is after all our tax dollars and shoulfd be our priority is that National health Care systems have an additiona; incentive to take imporatant precautionery steps to protect theri citizens that are not there when indibviduals bear the burden.For example women exposed to certain chemicals are likely have children that to develop health problems(say proximity to chemical plants ot nuclear power plants).Some countries with universal health are instigating programs to relocate these women. THanks for listening.This is important work and will facilitate the transparency needed in a number of health arenas. Sincerely,	CA	8/26/2006 5:16:23 PM

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	We have had the best experience with preventative medicine with our Naturopathic physicians, and the most amazing birth experiences with both of our kids born at home with licensed midwives. We found that midwifery care was both more complete and more helpful than our care with an OB. The OB, for example, had no way of resolving my serious headaches throughout pregnancy. My midwife changed my diet and my headaches disappeared. Many other instances of similar situations occurred during our first pregnancy. Out of hospital births with licensed midwives should be the standard of care (see the British Medical Journal Article, which demonstrates the safety of this option as compared to hospital births), which would save the health care consumers a tremendous amount of money.	WA	3/28/2006 1:21:08 AM
	hello Let me begin with my experience with the new Medicare Pharm-D program. I am a dual eligible recipient of both Medicare and Medicaid. In November of 2005 I enrolled in, (with confirmation) a New Pharm D plan and elected to stay in a free standing Medicare program. In January I was passively enrolled in a medicare HMO without my knowledge or permission. Boy has this come back to haunt me. I utilize the healthcare system for many Illnesses, including the many ramifications for a bothched cancer treatment. I have found that since January 1st that none of my bills have been paid by anybody because each plan thinks that the other one is responsible. My case manager and I have spent many hours on the phone trying to straighten this out and have found that the people you call don`t even have a clue as to how to deal with this situation. You just get bounced from one person to the next until you reach a number to call and you get a mail box and never get a reply. Everday I get letters requesting the proper information of my exact coverage, I fill them out and they fall on deaf ears. I have spent countless hours trying to explain to Medicare that they need to correct the wrong information and four months later its as messed up as ever. I call and am promised that the situation will be cleared up and it goes nowhere. I am now receiving all my bills at home demanding payment. I survive on a modest Disibility check with very limited resourses. The entire healthcare system is collapsing before our eyes and we have only Congress to thank. And why should they care they have excellent Healthcare coverage. I look forward to this rountable and hope to find a way for people to get busy with fixing this bloated,inept system in the richest country in the world. See you there!	PA	3/29/2006 8:27:28 AM
	Through personal experience I find, Hospital & Doctor care is as good as the quality of your present coverage. The amount of paper work to see how your insurance provider physcians/hospitals can diminish or increase the amount of medical service paid on your behalf is scandulous.	na	2/16/2006 12:25:38 AM

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	I have experienced private sector healthcare and government healthcare. The private sector healthcare has been in Colorado, Texas and Iowa. The government healthcare has been in Virginia, Texas and Colorado. My government healthcare experiences are full of long waits and rarely seeing the same provider. I would have to go through my background and history of the current condition each time I saw a provider. Most didn't care if I was there. They knew there were 20 more just like me in the waiting room. The worst example was the time I had an appointment with a pediatrician for my 2 year old with an ear infection. I waited an hour and asked at the desk how much longer it would be. I was told that everyone was going to lunch and I could come back in an hour if I still wanted to be seen. When I had my first child the hospital told me that I could not get anesthesia because the doctor was asleep. They finally called him and told me that I had to take the shot because he got up just for me. When the baby was about to come out the nurse told me I had to stop pushing because the doctors were changing shifts. It was 7 am and the next doctor had not arrived yet but the current doctor was leaving. My private sector healthcare has been self-pay and through health insurance. There were times I declined government coverage and paid for my own care because I could be seen faster and ask questions. I have had health insurance through large companies and smaller ones. My current employer is self insured. I have had the same doctor for 10 years. If I am not happy with how he treats me I know I can go to another doctor. I also know that if I choose not follow the rules of the health plan I can get care on my own and pay for it myself. All of my worst experiences were when I had government health care. If this group is recommending I be forced to accept government health care my response is thanks but no thanks. I have paid for my own care by choice in my poorest times and eating ramen every day. My choice, my reponsibility.	IA	6/5/2006 9:55:09 PM
	My family is rationed out of health care because health care coverage is not universal and guaranteed by my government to which I pay taxes. This is outrageous since we are the richest country in the world, and we have paid $400 billion for an illegal war and countless billions for corporate welfare and tax cuts to the wealthy! This rationing of healthcare to the insured worsens my health and the health of my 6 yo son becasue we cannot count on the meds we need and the care we need, since we cannot bcount on being insured at any given time. This is a national crime. It's time for universal access, single payer care, like most other industrialized countries provide.	NM	3/20/2006 3:14:13 PM

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Important: feel free to use or post any/all of my commments below, however, DO NOT POST MY NAME, ADDRESS, OR STATE OR EMAIL ADDRESS; this could literally cause us to be uninsurable, as I have no doubt insurance companies are studying these postings. ========== Here is how our current system works: The health insurance company carefully evaluates your medical needs and provides you with a plan that specifically excludes all of them. This is called the â€œpre-existing condition clauseâ€ ; it is immoral, it is unethical, and it should be illegal, because it makes the entire system dysfunctional. Those who actually are in serious need of healthcare receive NONE! My experience with several different health insurance companies have ALL been nothing short of a NIGHTMARE!!! They do NOT give a ratâ€™s ass about your health; their ONLY concern is raking in maximum premiums and paying out as little as possible, so as to maximize their profits. The profit motive, which is great for most of Americaâ€™s businesses, creates financial incentives for insurers which are counter to their primary purpose, and work to the detriment of those they are obligated to serve. Iâ€™m going to share with you some of the horrible experiences I have had: Mutual of Omaha: This company literally blackmailed us! Many years ago, my wife had to have her tonsils out. They deemed it an outpatient procedure and would not pay for an overnight in the hospital. The doctor forced the issue because he knew it was not an outpatient procedure. Several months later, the company sent an arrogant representative out to our home; he reminded me of a mafia thug. He pointed out that when I took out the policy, I was assigned to some environmental group. He said the policy required that I renew my membership in this group each year. I was not told about this and was not aware of it. He threatened that if we did not cancel our insurance with Mutual of Omaha, they would bill me for additional punitive back premiums for the past several years, for the period I was not officially a member of stated organization. He enforced a ludicrous technicality which had nothing to do with the health insurance, which no policy member would have been aware of, just to get rid of us, because we were costing them too much money. Subsequently, I applied with Anthem Blue Cross. Over the next decade, the premiums started going up and up and up and up. It was getting prohibitively expensive. Note: there are apparently NO regulations on the premiums these companies can charge; they can literally get rid of you by raising your premiums sky high until you are forced to drop the policy. Obviously this is wrong and unethical â€“ but it is perfectly legal (where is Congress when we desperately NEED a regulation preventing this?). I had no choice but to look for a different policy; I tried Golden Rule. Golden Rule: Spent at least 40 hours digging through records to fill out their application. [This is another reason we need to get rid of the insurance companies. Who has this kind of time to analyze insurance plans and fill out reams of application paperwork. No one should have to do this; most people with full time jobs and children just donâ€™t have this kind of extra time.] They took my money, and sent me the approved policy, but didnâ€™t tell me ahead of time: they specifically excluded one of our daughters because she had been in psychotherapy. I called Golden Rule, and I canâ€™t repeat here what I said to the representative (in a not very nice way I told them what they could do with the policy); suffice it to say that I have never been so angry in my entire life. The stress of this and knowing that I had just wasted over 40 hours of my time, re-activated a previously dormant stomach ulcer. Now, an insurance company has CAUSED a health problem! I think this is contrary to their purpose?	CO	6/8/2006 1:28:55 AM

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Anthem Blue Cross: I subsequently started all over and filled out a new application for a NEW healthcare plan with the company I was already with (still had not cancelled the previous plan that I had for a decade). Again, countless hours wasted on more applications. They accepted us and our daughters into a new low premium/high deductible plan, however, they wrote in a LIFETIME exclusion on the only two things that I might require healthcare for: migraine headaches and stomach ulcers. This, after I have already been with them for a decade, and this minor ulcer had not been causing problems for years (I thought it had completely healed) until the Golden Rule Company temporarily re-activated it, causing me to go on Prilosec (Nexium is way too expensive) for about six months. The U.S. must have a single payer system, and completely get rid of all health insurance companies; and I have NO sympathy for them if they all go bankrupt â€“ none whatsoever! I have heard that some other industrialized countries have a line on their federal tax return where every citizen is required to pay some pre-determined amount (possibly on a sliding scale) to fund basic healthcare. And, in return every citizen is guaranteed basic essential healthcare. The money is dispersed by an agency of the government, in the same way as health insurance companies disperse money; only there is no â€œprofitâ€ , no â€œpre-existing condition exclusionsâ€ , and citizens donâ€™t have to worry about losing their home and life savings should they contract some rare disease or have a bad accident. Most personal bankruptcies today are a result of huge medical bills which cannot be paid; this should not happen and is unacceptable. Also, who tied health coverage to your employer? This makes no sense at all. Businesses should not be saddled with this responsibility. Taking this out of the lap of businesses will allow them to be more financially competitive in the global market. Businesses in other countries donâ€™t have to provide employees with healthcare. Healthcare plans should have nothing to do with your employment, and businesses should not be required to finance them. Summary of my recommendations: **Single payer system, through an agency of the federal government, for basic essential healthcare (physicians â€“ of your choice, accidents, illnesses, diseases, surgeries, hospitals, prescriptions), without preventing consumers from seeking out and privately paying for â€œotherâ€ medical procedures (elective cosmetic surgery, fancy expensive specialty clinics for those with lots of $ to incinerate), if they choose. Reasonable cost controls should be built into such a system. **U.S. business must compete in an ever more competitive global market. They should have NO responsibility for providing healthcare to anyone. You must take this responsibility out of the lap of all U.S. businesses. A single payer system will accomplish this.		
The high deductibles for my 20-something daughter's health insurance prevented her from attending to a condition she developed in the Winter. Fortunately, she eventually got the care she needed. But,I fear that her generation's health care will be inferior to my own and my parent's generation. Many are in middle-class jobs with access to low-income health care as they work for small businesses that cannot afford the current high costs of insuring their employees.	NM	6/9/2006 3:26:31 PM
Our experience with Medicare and Tri Care has been generally very good though we have been dissappointed in the failure of Medicare to follow up on charges for services not received but billed by a hospital. Our problem as seniors has been with the high cost of dental care, vision care and hearing aids These problems are no less important to the quality of life than other medical problems	IN	3/12/2006 3:32:20 PM

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	When a grand niece, who had no insurance, had to go to the hospital, they charged her much more than they would have charged an insurance company or Medicaid or Medicare. We have found doctors who will not accept Medicare patients.	FL	3/21/2006 12:44:12 PM
	The company I am working for almost 24 yrs. has always had a PPO and is self insured they contract an out side company to administer it and it has worked very well. But my cost has started to go up. Money is withheld from my check each week for Ins. My up front deductible has increased about30% and I pay a very small copay.Prescriptions costs have tripled in the last 2 years so we use generic as much as we can.	PA	3/21/2006 8:00:01 PM
	When my wife and myself made the decision to both become self-employed, working out of our home, it suddenly became very difficult to find a health care plan that was affordable and comprehensive -- i.e. one that included basic care, hosplitalization, disability, presecription drugs, vision care and cancer screening). In addition, though I am slightly overweight (though successfully working to reduce that weight)I had a clean bill of health from a recent comprehensive physical exam (including blood tests) Yet I was unfairly penalized with inflated health care insurance premiums, or worse, being denied coverage outright. This has to change.	CO	2/16/2006 12:55:46 PM
	I am a family physician in northern Michigan. The daily stories of financial hard-ship, the inability to access medications, studies or specialists creates constant suffering for many of my patients. These are hard working folks and their loss of dignity appalls me in this great nation. This is for everyone from the disabled, the working poor, the middle class, and the elderly. We must and can do better.	MI	3/30/2006 11:22:51 AM
	I have seen medicare work wonderfully for aged relatives. Why can't everyone have medicare so we can eliminate health insurance companies. The government is way more efficient than the private sector. Almost every private insurance plan I have ever seen is terrible. Premiums are extremely high, service is inconsistent and dealing with the insurance company is a bureaucratic nightmare. All citizens should have free and equal access to health care and it should not be rationed out by insurance companies.	OH	4/23/2006 10:08:40 PM
	My husband and I are fortunate enough to have a decent health ,dental,and vision insurance policy from his employer. I also receive a health care fund reimbursement from my employer. I happen to be a Nurse Practitioner, and am angered at how many times our practice loses business because even though we can accept insurance payments from an HMO, such as Priority Health, they will not list us as primary care providers. They only would have to reimburse us at 85% of what a physician receives, saving millions of dollars for consumers in their premiums alone. Instead, they insist that we contract with a physician who will state that they are the PCP, then they reimburse us at 100%-and we have to send him a check for the 15%-which to me is FRAUD. Our waiting room time is usually only a few minutes, and we spend much more time with our patients in a typical visit. We do not do conveyor belt medicine, and try to limit ourselves to no more than 15-20 patients a day. Obviously we are not getting rich at that amount, be we provide high quality, compassionate care, in an atmosphere that is relaxed for our patients and the providers. We also are not allowed to accept Medicaid patients because we do not have a supervising physician. I can't say that this breaks my heart because of the poor reimbursement, but we would certainly see a certain percentage if it was allowed by the government. Independent Nurse Practitioners are also not promoted with our local hospital. Our names are listed in a provider directory, but staff is instructed to only refer new patients to physicians, not NPs. In	MI	2/14/2006 2:48:11 PM

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	MI, we have prescriptive authority for Schedules III-V, yet we still have to have a "collaborative agreement" with a physician (that charges handsomely for that "privelige")in order to conduct our practice. NPs liability insurance is low-and for good reason-we are careful, and do not over step our scope of practice. Physician's however, is extremely high due to lawsuits.I could go on and on forever, but I will shorten my tirade. I really appreciate the opportunity express this, and appreciate your forum for health care change.		
	My Boyfriends Family all had cancer. Now he is 53 and refuses to go for a check up because he knows that even if they find something, we cannot afford to go on with the expensive tests and treatments to stop it. So we just wait and wonder and pray that nothing goes wrong. I know that there are millions of men out there that feel the same way. they do not want to burden there family with the high expences and the chance of looseing there home so they just dont go to the Doctor.	FL	5/13/2006 11:13:19 AM
	My niece is 18 months old. When she was about 8 months old we had to take her to the hospital in Farmington, NM because she was having breathing problems. They didn't know what was wrong with her so they flew her to Albquerque, NM where she stayed for about a month. They still did not know what was wrong with her and wanted to send her to Children's Hospital in Denver but couldn't send her until she was declared disabled and but on Medcaid. This took over two weeks to get this done. They then sent her in an Ambulance to Denver, Co where they treated her with in a week and sent her home. She was diagnosed with Pulmonary Hypertension. She is now 20 months old takes viagra every day to keep her veins open to pump blood through her body. She is also on oxygen 24hrs a day. The saddiest part is that Her mom (my sister) is 20yrs old and unable to work because medicaid will not pay for a respit nurse to come in and take care of my niece so that my sister can finish her education and get a job. My niece is still considered disabled so therefore my sister gets a $500.00 a month. She is expected to support her and her daughter on $500.00 a month. She would like to work but us unable to because of the inadquete health care. This a continous battle for our family. Something has to change.	NM	6/3/2006 2:42:01 PM
	My story is basically of my family. Today I am the head of my household. My husband has become mentally ill and has not worked in over 4 years. We have gone through many set backs including almost divorcing. He served in the Military for 16 years and retired from the Alabama National Guard. He would have gone to Iraq but his knees were bad, and he could not pass the physical. Today he has no health insurance and we are trying to get him help through the VA. He needs a knee replacement both knees and most of mental health services. I can't afforded to put him on my insurance because the difference is for the employee ($15.00 per pay) to ($300.00 family) I make less than 27,000 per year. I hate being in this situation but we also need a home, car and bills paid. He is trying to get disability and even when that happens there will be a 2 year wait before Medicare. Even with our problems we still have the chance for VA services for him. Many do not have that option. I feel that he should have something in terms of Health Care he worked for many decades and served his country. Now, He has to find all his medical records for his years of service. He has to write for them and we only hope that they can be found. In the mean time I try to make him comfortable and live in guilt because when he was able to work he made sure his children and wife were insured.	AL	5/12/2006 5:22:32 PM

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Response	State	Date/time received
I was laid off my job because of tax cuts and right now have $50 a month core major medical insurance. I would like to buy this insurance after my cobra runs out. Please offer it. Along with a health clinic, I can survive.	CA	7/20/2006 4:23:08 PM
Every citizen should have full access and choice in medical care, at government expense. Ordinary working people should not be paying the hourly rates of physicians or the costs of diagnostics and treatments - especially when there is no satisfaction guarantee. One form of satisfaction is accurate diagnosis, and getting even that can be costly and time-consuming. My husband and I have received both excellent and disgraceful medical care. Now we receive none, as we have no insurance and a $10.75 hourly income is too high to qualify for horrible care at the Placer County Medical Clinic. We can go to the emergency room, but my husband never has after seeing how I was treated there. In our 10 years together, I have visited the ER approximately 3 times in a two month period. A nurse made it clear to me that I should not go there for my "chronic" conditions, and that I must go to a doctor. I made it clear that we have no access to medical care outside of ER. We are both afraid to go back. Examples of this terrible system: When my husband was making $8.75 hourly, we had to pay to use the Placer County Medical Clinic. He was very ill and needed antibiotics in order to be able to continue working. He was prescribed erytabs, a drug (form) that is well known to cause side effects. A respected patient would get Zithromax, Biaxin or even Keflex, but we paid the clinic both for the visit and for those horrible drugs. The drugs made my husband vomit blood. He discontinued the drugs and we could not return to the clinic because we could not pay yet again. Thankfully for us, he managed to continue to work in food service so that we could continue to have a place to live, and he eventually got well. He caught the sickness at work, of course, from others in the same predicament. The effects of depriving the citizenry are contagious, and even those whose needs are met are subject to the consequences. After my ER visit, I called the county clinic to ask if it was okay to take ibuprofen with an aspirin a day. The male nurse, upon hearing my symptoms, said I should come in for an office visit. I told him I could not pay. He told me to "make it available". I did not go. I went to the county clinic for a "free" mammogram. It was done at a separate, legitimate facility. But I was billed nearly $900 for it. I'm not going to pay it, but apparently free mammograms are not necessarily paid for by programs that claim to pay for them. And I also wonder what good it does to give free mammograms to women who have no medical coverage for the treatment of breast cancer. I have had proper medical care and coverage in the past. My husband had some good care once through the county, but outside of that has not had medical or dental care. Both of us need medical and dental care. I think this is enough to say at this point, although I could certainly go on at length.	CA	7/25/2006 12:48:40 AM

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	Response	**State**	**Date/time received**
	The main problem with American healthcare is that it is a for-profit system. If it were a non-profit venture, people would be able to afford the cost of healthcare. Pharmaceuticals should not cost the outrageous amounts they currently do. Let's face it: a lot of our current pharmaceuticals are nothing more than weeds that get "cooked down" into pill forms. These processes are not expensive and neither are these "weeds". Working and impoverished Americans should not be overpaying for pills just to cover some overpaid CEO's salary. The exact same thing is happening at hospitals and doctor's offices. The entire system needs an overhaul. I am willing to pay for the services I recieve, as long as it is at a reasonable cost. It is incredibly ridiculous to pay $500.00 for a prescription drug or a doctor's visit. I would not spend that much on entertainment or a one day vacation. Not every American is earning a thousand dollars a day. Some of us aren't even earning $500.00 per week. Great thought must be given to this crisis and everyone's salary must be taken into consideration.	MI	6/13/2006 3:02:47 PM
	In 1988, I had to sign a waiver agreeing not to be in the insurance pool so that the other employees could get coverage. In about 1990, an insurance agent assured me that his company would cover me; I gave him a check; a few days later his employer called to tell me that they were returning my check that as soon as I said I had diabetes the agent should have said I could not get coverage. WHENEVER I HAVE EMPLOYER SPONSORED INSURANCE, MY EXPERIENCES WITH THE MIDICAL SYSTEM ARE POSITIVE. In 2002 I became disabled. My CORBRA payments were around $500 a month. My CORBRA expired. By January 8, 2006 my individual insurance premium was $961 per month with a $2500 deductible and 30 percent thereafter.	GA	4/11/2006 2:47:22 PM
	The shortage of healthcare workers is what is making the cost of healthcare so high. We need to expand healthcare programs in our colleges so that more students can study nursing, x-ray tech, med lab tech, etc., and we also need to expand enrollments in physicians' medical schools. The shortage of healthcare workers is not only allowing those who work in the health care field to charge whatever price they want for their services, but the shortage is also allowing mediocre and poor-performing healthcare workers to remain in the field of healthcare, and the general attitude has become "Let the buyer beware". I was born with the health condition hydrocephalus in 1959. I had a very good neurosurgeon during my childhood, and after 6 surgeries before the age of 9, I was able to live a normal life until age 38. At age 38, I again needed hydrocephalic surgery, but my previous neurosurgeon had retired from doing surgery, and the new neurosurgeon I went to was unable to diagnose what my problem was, and almost made a vegetable out of me because he mis-diagnosed me so badly. When I finally sought the opinion of a totally different neurosurgeon in a totally different geographical area, my problem was surgically corrected immediately. However, by that time, I had received a letter from my boss at work telling me I'd been permanently replaced (I'd only recently started that job, but it made me angry because I had a number of years of previous experience in that occupational field and my replacement had no previous experience). Then, even though he knew that I'd lost my job, the neurosurgeon who had been unable to diagnose my problem threatened to turn me over to a collection agency if I didn't pay him $800 (which I owed him due to the deductible on my insurance policy). I went to a lawyer, but was told I couldn't sue the incompetent neurosurgeon because I had completely recovered my health. I then turned my case over to the Dept. of Professional Regulation in the state where I live, but the incompetent neurosurgeon didn't get punished, and apparently continued in business as if nothing had happened. Today, I believe he practices in a college town, where many unsuspecting college students may encounter him some day. I am very grateful that I am still "in one piece" after encountering this neurosurgeon.	IL	5/15/2006 9:21:28 PM

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	Response	**State**	**Date/time received**
	This comment is in regards to Lee Memorial Health System - Trauma Center in Ft. Myers, Florida and the day they saved my daughter's life. This is the only trauma center on Florida's Gulf Coast between Tampa and Miami and there are more than 1 million residents in the Lee County Trauma Services District. Since the Florida Legislature created the state's first trauma legislation in 1982, no consistent and sustained funding source for the trauma centers has been established on the state level. It's expensive saving people's lives - expensive equipment, helicopters, staffing trauma surgeons and other specialists 24 hours a day, liability insurances and losses due to inadequate Medicare coverage and uninsured patients. Luckily it's still open! My only daughter at 19 years old daughter needed them on New Years Eve 2003 after a severe collision. She suffered from internal bleeding, brain injury, two tears in her aorta, crushed left pelvis and rib cage and collar bones, a broken leg and ankle, and a face laceration with subsequent nerve damage. This wonderful man http://www.leememorial.org/trauma/medicalstaff_dr_ybanez.asp , Dr. Manuel Ybanez saved my daughter's life that night and has been an inspiration to us and many other families I've met. What would we do without these doctors standing by every night waiting for our sons and daughters? But we are also part of the problem. My daughter was insured all of her life, then she turned 18 and had a job that offered benefits so she switched over. Then about 2 months prior to her accident she changed jobs and didn't get a temporary health policy. She was waiting it out, she had one more month until the new policy went into effect. Alot of young adults find themselves in this situation, they feel invincible. About 54 percent of 18-to-24-year-olds are uninsured as stated in USNews article featuring my daughter and others in her situation http://www.usnews.com/usnews/health/articles/040510/10trauma_3.htm). After six major surgeries and two helicopter flights, the bill was huge, almost $400,000 which will take a long time for us to pay off. We are so fortunate to have received the level of care needed to save her. Every single doctor and nurse we met exceeded our expectations My father is a surgeon and my mother an ICU nurse and due to this experience my daughter will begin school to become a Physical Therapist in the fall. They saved her life in so many ways, we are forever grateful.	FL	5/16/2006 10:46:48 PM
	We currently have a PPO that does work...I have been able to get some specialize care at Duke University Medical System and I live out of Durham....but have a special autoimmune disease that manifests itself on my skin. I am now enrolled in a special study, which is being paid for by the pharmacy company...or else I could not afford this particular medication. I have also been able to find doctors within our network of doctors. I have a huge problem finding coverage for mental health coverage that is accessable and affordable. Our plans are limited to a certain amount of visits per year and lifetime. We have been fortunate in having a good choice of physicians within our network...and that works.	NC	3/22/2006 8:01:00 PM

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After having health care insurance through a company plan, my husband and I were both self employed. Never had a hospital stay or serious illness. For condition such as hyper tension, we were both turned down for medical insurance. Both of our conditioned control by drugs. Now we pay $900 a month with a $5,000 deductable, goes up every year, I am 58 my husband 60. How high will it go, can we ever think about retirement or will we have to work just to pay health care premiums. Something has to be done, and NOW.	UT	5/4/2006 2:04:11 PM
I had just startied to work at my company and my health insurance coverage was not in effect. At my company we have a six month probationary period before you receive any benefits. I became very ill with some sort of virus. I had to rushed to the county hospital in my area with a temp. of 104 and my throat closed, i could not breath because of the infection in my throat. I was in the emergency room waiting area for only 10 to 15 minutes after the triage because the infection was so severe. I was in the hospital for 5 hours. It cost me over $3000.00. I don't make that much money and cannot pay for the visit. The bill is now in collections. I don't qualify for Medical or welfare because I don't have children. I am going to try to pay the bill by giving them $25.00 per month. Oh did I mention that the doctor and lab and x-rays are entirely separate from the $3000.00 bill?	CA	2/22/2006 1:41:13 PM
I think that Doctors prescribe too many drugs. At one time I was on 6 prescriptions (2 for High Blood Pressure, 2 for diabetes and 2 anti-depressent). But I was told to lose weight and that would help me. However, the side effects for three of these drugs were weight gain, sleeplessness and depression. So I took myself off all of the drugs and in one year I have lost 50 lbs. Feel better, sleep better and am more active less depressed. I have lost almost all of my respect for the medical profession.	NV	4/3/2006 11:14:17 AM
My husband's company changed insurance from a deductible insurance policy with a prescription card to an HSA insurance policy. The company gave us $500 and then said there you go, you will have to supplement the rest out of weekly deductions. Thus, for the family it is $59 a week. The HSA is not an insurance plan for the middle class, but for the rich. In essence, the company has diverted all of the insurance responsibility onto the individual. Many, including my family, are trying to find alternative medicine (herbal)-- we are on maintenance medication-- between my husband and I, medicine would run over $300 a month. If we used the insurance for medicine on a monthly basis we would have nothing left by the end of the year -- to begin the new year. At this moment, I feel that the HSA, in its current state, empties the pocketbook of the individuals and fills the pocketbook of corporations -- (at least in my families situation). It could be at least tolerable if, in my case, the company would outlay at least half the amount of the outlay example($1625) at the beginning of each year. We do not go to the doctor, unless we truly have too -- we ask how much the medicine will cost, will reject procedures because we cannot afford it, and deal with a situation longer, because we know how much we have in our plan-- to work with. I'm beginning to wonder where corporate responsibility begins and ends?	IA	4/9/2006 11:44:52 AM

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Hello, I am 24 years old. A year and a half ago I started experiencing a very bad headache which did not go away for 2 weeks. I had recently started a new job and hadnt received benefits from them yet when this began. The headaches were so severe I was forced to quit my job and try to solve this health problem of mine. The emergency room was my only option and all they are willing to do there was a cat scan which came up negative. They gave me a prescription and sent me with a reccomendation to see my primary care physician. I had none and no money. I decided I had to go to social services to see what could be done. I received Maryland Primary Care, who I went to see as my symptoms got worse and worse. They told me that there was nothing I could do and that the wait for the public neurologist was 6 months!!!, and there were people having seizures who still had to wait that time. Furious as I was I decided there was no way I could live with this pain for 6 months, so I went to apply to medicaid. Now in order to get approved for medicaid (the only way to get your healthcare paid for) you must be found disabled. So the paperwork has to go through for a month or 2 then I am sure they have some kind of interview to see wheather or not you qualify as disabled. For 1 thing the time it takes to see if you are even eligible for medicaid is unnaceptable as sick people do not have the luxury of time for red tape, especially if their only hope is medicaid in which most people are rejected anyway due to the severe requirements. Ok so my application for medicaid is still pending after 2 months and I begged a relative to pay for my health insurance because I am in severe pain, am having reaction to all pain medicine which Ive never had in the past and cannot go on like this. So I decide to apply for health insurance. Now on my application for an HMO I was asked many questions about my health. I had applied for this insurancee company in the past and because I mentioned being diagnosed with depression and being on prozac, I was rejected, obviously because I am not a profitable enough person for insurance. Well now I am applying again with this same company and I had to lie about my health and claim it was perfect so as to not be denied as I am in such pain I can not be without a doctor much more as the headache has been constant for 4 months now and getting more severe at times feeling life threatening when my entire head feels ice cold. This strange symptoms I cannot be without a doctor so I lied abot my condition on the application and said I was in perfect health. No citizen should have to do this. I like to be an honest person and only in what I feel is a life threatening circumstance would i falsify any information. NOw I was accepted to my HMO but when it came to seeing the doctor I felt very troubled abot lying about when my symptoms started, I wanted to give the full picture so they could treat me more accurately. I did so and am awaiting to see a neurologist on march 9th. There is a possibility that the informatiuon I gave may negate my policy as I didnt mention the headaches then. What will I do then???? My health is deteriorating and I am now getting symptoms of weakness in one side of my body along with my headaches and to be without a doctor like this should not be possible in a country as rich as ours. I can only imagine people worse off than me who couldnt afford insurance who must wait these exhaustive months just to see a doctor that is paid for by the state. This is unacceptable. I am persoanlly willing to dedicate my time to advancing the cause of affordable quality healthcare for all because until this happened to me I didnt realize how bad the problem is. NO one should have to wait months to see a doctor, no one should have to wait months just to see if they are accepted qand eligible for medicaid, majority of which will be rejected. IN the richest country in the world, we can definately do better. I only wonder what I will do if my nsurance cuts me off for having an unmentioned pre-existing condition. I wll be royally screwed. Our health insurance companies have become like casinos, where games are only offered with the odds in their favor. Health insurance must absolutely not be allowed to be continued as a profitable business, because the sick are always unequitable for these companies and we can not leave our own sick people to die simply because they are unprofitable to the only means of getting healthcare, the insurance company. Change must be made. I have been like this now for about a year and a half, have been unable to work since that time and cannot function normally. I am pretty	MD	2/20/2006 10:37:58 PM

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	much housebound and constantly in pain unnecessarily I feel as Im sure a visit to a specialit couldve figure dthis out. I await my March 9th appt and hope whatever illness inside me has not progressed to the point of being able to be cured. Allin all too much time has been wasted just to try and get healthcare. Its time to change things		
	Some medical care providers/pharmacutical companies need to due a better job keeping prescription expenses down. They need to openly communicate with doctors regarding the care of patients, lower cost alternative medicines. If a client's prescriptions change, this should be coordinated with the doctors to provide low cost, effective treatment. Use their history base to facilitate the above, to make certain the revision is warranted.	FL	4/8/2006 8:03:24 PM
	AS en Emergency physician over the past 30 years I have seen firsthand every day the hardships and porr medical care our fragmented and expensive health care non-system has caused. It is a national shame that we do not have a single payor tax supported universal basic health care coverage for all who live in our country as does all other developed countries in the world. We spend 40-50% more per capita on health care than any other nation with 31% of our dollars going to special interests profit and overhead. This system must be fixed since it is adout to implode.	CO	2/20/2006 6:41:40 PM
	working with tecknowledgy was and is currently helping make a terrible experience better. with the help of a hospital base test system i found that i was able to monitor my mom who suffered demenia alyheimer for a longer time at home with less help and more crediable information and also less visits to the hospital emergency room. now i remain active with the technowledgy and use it in ass't living to keep her from a nursing home. nothing is perfect but it helps not only the caregiver but dignity to the patient while the doctors get credible information.	NJ	6/2/2006 8:59:37 PM
	My experience is not personal but professional...in Washtenaw County, Michigan we have successfully embedded community mental health professionals into 4 primary care clinics and written a Manual for providers on this process that is available via the National Council of Community Behavioral Healthcare. This project provides for'one stop shopping' for the vulnerable population in our county. We're excited about it and want to share a local option program with others.	MI	6/7/2006 10:50:18 AM

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I have always had health insurance. What has changed is that from health care being an insignificant part of my budget, it is now the major household expense with co-pays and deductibles sharply higher along with premiums. The question is starting to become can I afford any health care. Out of pocket, including the insurance premiums is now running from $19,000 to $25,000 each year. We have a brief respite only because my wife got a temporary job and we could drop our retiree plan for an active employee plan for 18 months. What is needed is some percentage of MONTHLY INCOME that is the maximum take for health care. I would be happy to pay the first 10% myself if I knew anything in excess of that would be 100% covered. The other main problem is that government science searches for treatments for medical conditions and rarely ever cures. We need some multi-billion dollar prizes for cures.	WA	2/22/2006 9:03:41 PM
I HAD FOR SEVERAL YEARS PROVIDED GOOD HEALTH INS. COVERAGE FOR EACH EMPLOYEE. SOMETIMES THE EMPLOYEES SPOUSE'S BENEFITS WERE MORE FOR LESS, SO I COMPENSATED MY EMPLOYEE. NOW THAT WE HAVE AGED AND HAD CLAIMS ON OUR GROUP COVERAGE, THE COST HAS HAD 30-40% ANNUAL INCREASES AND WE HAVE TO RETAIN AT LEAST TWO EMPLOYEES UNDER THE GROUP COVERAGE. OF COURSE THESE TWO ARE GOING TO BE US OLDER FOLK WITH PRE-EXISTING CONDITIONS. I GAVE THE YOUNGER EMPLOYEES A WAGE INCREASE IN AN AMOUNT GENEROUS ENOUGH TO MORE THAN COVER THE COST OF PREMIUMS TO GET THEIR COVERAGE ON THEIR OWN, WHICH THEY DID. BUT I FOUND THE FOLLOWING MONTH, WHEN MY GRANDSON WENT IN FOR AN EMERGENCY OPERATION @ $7,000. THAT MY SON HAD OPTED TO SAVE A FEW BUCKS WITH THE $10,000. DEDUCTABLE PLAN.	IA	2/16/2006 4:42:23 PM
11 years ago when we bought our first house my husbands job changed unexpectedly. After trying for 3 years to make things work we were forced to go bankrupt. Just a few weeks after the bankruptcy was finalized I was diagnosed with MS. We spent the next 7 years paying for the tests that were required for diagnosis. I was "lucky: enough to get medicaid to pay for my $800+ per month treatments but we struggled to pay off the hospital bills and to keep our heads above water since I could not work any longer. I 've been waiting for 3 years to get a tooth fixed because I cannot afford it and we have no insurance except my medicaid which does not cover teeth. I also cannot get glasses which were prescribed 2 years ago because I can't afford them. We just got insurance in November finally BUT they won't fix my teeth for a year and they don't cover glasses. Thank God they WILL cover my MS medications. It doesn't do as much as it should but it's better than nothing I guess.	VT	2/16/2006 1:02:15 AM

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My partner and I both have HIV and I have Hepatitis C (HVC), as well. My partner is on disability and has Medicare. I, on the other hand am self-employed part time. I had health insurance, for which I paid for years. When I was diagnosed, I found that my prescription benefit only covered 25% of the cost of non-generic drugs and 100% of generic drugs. None of the HIV or HVC are available as generics in this country. The monthly cost of my HIV Medication alone was over $1200 per month. After paying my $500 deductible each year, my insurance paid for 25% of the cost on my medication for about three months before total yearly benefit was used up, leaving me to pay for the other 75% out of pocket. The other nine months of the year, I had to pay 100% of the cost of my medication out of pocket. Not being independently wealthy, clearly that was far beyond my means. I was forced to drop my private insurance and throw myself on the mercy of state and private programs like, ADAP, Ryan White, and UNM CARES to pay for my medical expenses. While my partner and I are receiving excellent health care now, we are forced to live in virtual poverty in order to qualify for our health care. While my partner might be able to work part time, he can't earn over $800 per year or he would lose his disability, and I cannot earn more than $150 per week or I will no longer quality for my medical assistance. We do not receive any food stamps, rent or heating assistance, clothing allowances, transportation, to get by. It is only by the grace of God, and help from friends and family that we are not homeless, naked, and starving in an alley! The United States is the richest country on the planet, but it is the only major Western, industrialized Democracy that doesn't have government health care for all of it's citizens. The emergency rooms of public hospitals are being crushed by the weight of the indigent and people who cannot afford health insurance, who must use them for their primary medical care. Meanwhile private health care networks, insurance company run HMO's, and pharmaceutical corps are raking in obscene profits for their shareholders each year. It is not just ridiculous, but criminal, and an untenable situation.	NM	6/26/2006 4:35:15 PM
It's too much for me to type here.If you would like to hear about what I've dealt with and my thoughts, see my comments to your polls and feedback already sent in 2/15/06. I would think you would find me very helpful to your/our cause.	NH	2/15/2006 11:56:18 PM
I worked for a non-profit in NJ for more than a decade, and it provided health care through different providers, none of which kept the coverage for more than two years. Presumably because we had an aging work force they wanted to drop us or charge new rates that were not affordable to the NGO income ability. My home medical folder weighed about ten pounds due to the ritural of plans that dropped our non-profit. That's why I have concluded that the American business model should not be applied to health insurance. The private sector wants young healthy people; older people who need more care have greater human needs - the values and needs are divergent. When I am 65, and wake up in a hospital after a serious illness, I want to see people with a Quaker or Catholic religious order disposition, or secular people who entered medicine and nursing because of their humanitarian ideals, not their desire to make a lot of money, looking over me. I don't want to see the likes of Donald Rumsfeld, Donald Trump or Dick Cheney in white coats telling me to hurry up and get better or that I'm using up bed space. Last year I moved to the Metro, DC area, to look for work in my field. I was on my wife's policy, but it was based in a Massachusett's HMO, where she stayed to work. The same HMO, Blue Cross and Blue Shield, said her policy would not cover me in Maryland, they were entirely different organizations. So no portability. The Maryland HMO also slapped a 6-9 month waiting period on me - meaning they wouldn't cover me for the two reasons I logically would most need coverage for - until after that period was up. I turned them done because I strongly disagree with that type of decision: based on their bottom line, not my medical needs. It was outrageous. These are the two chief reasons why we need a single payer universal system not	MD	3/25/2006 6:49:48 PM

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	run for profit or on the pure free market "race to the bottom" business model.		
	We always think that the goverment is so smart but this part D. I think thy could have done a better job. This donut hole does not make any sense. Why could they not fix it so we paid the some and not have the donut hole. The people that do not get much money this works for them. But me in the middle class. it is going to be hard for me when I get to the donut hole and still have to pay the premium, with no benifit.The people in Washington make lots of money so it is not a hard ship on them.They never think of us middle class people? Texas. Thank you for letting me air my thought. Not that it will do any good.	TX	5/30/2006 1:27:57 PM
	I am a single woman on disability and not a Senior for another 20 years. I have Medicare due to having an asset: $3k in a Roth IRA and a paid off old vehicle. Since being unemployable I can neither add to it (Roth IRA) or get rid of it in order to qualify for Medicaid. I would lose the benefits I have AND my apartment which has income restrictions, being partly funded when built by Federal Funding in 1998. The Part B payment made for me due eligibility at only $719 a month before Jan's cost of living increase (only like $20: how does this help with everything going up including rent when Section 8 has been closed five years ago-the waiting list-before I became disabled?) allowed me to get a studio apt. at $475 a month which is over 50% of my $839 disability check. I have credit card debt of $6k due to this and scrips out of pocket not covered by my Part D plan or before in effect...and other bills...coming out of a domestically violent marriage in divorce where advised to accept nothing in order to not jeopardize my benefits and housing as is/keep my abuser away from me who has threatened me with a weapon before I left him. Now I'm told that the $20 increase where I had no copays for my medical care is now, as of 3/31/06, having me pay 20% on every doctor visit or ER visit and frankly what do I have left after car insurance, new plates and license in a new state (even though I rarely drive as cannot afford to park where I LIVE: $95 more a month in my building!), utilities and the usual items that are necessities not covered as food items on my $150 per month EBT Food Stamp card? One alone of my meds not covered by Part D is outrageous as a GENERIC! My PCP says I need it but I am trying to wean off it and it's an awful experience since it has to be hurried since there was no warning by Medicare and it's plans for Part D contractors! In fact, Medicare told my plan paid for this med and then I find out that in my state my plan CANNOT pay as it's illegal? It was the only plan paying for this medication and others in its classification. I don't know how I can live...have a landline phone, and internet connection to keep in touch with family...can't afford l-d but am forced to have it as of this week, due to extenuating circumstances, courtesy my now ex-husband at present, and out of pocket medical care fees and my prescription copays plus all other things mentioned without living in unsafe project housing and staying in my very safe	OR	4/6/2006 11:50:33 PM

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$475 downtown apartment with no bedroom and added laundromat expenses? I can't live on my disability check! If services were not taken away, I might be able to make it but this is not what happened. My Disabililities caseworker says it's unfair re the aftermath of a lousy cost in living "raise" that bumps me out of needed medical benefits and care and may see me staying on disability if I cannot afford care that would help me get off of it, if at all possible with my disabilites being as they are. I signed a petition re Medicare budget cuts as advised by caseworker. In any case, I should be able to live in dignity and without the constant duress of living in horrible poverty save my apartment. As it is, I "make too much" for any kind of counseling and fear any rehabilitation will end up the same way once I am ready for it, physically. I don't have enough left over to pay for a discounted bus pass (a good deal but I cannot afford it) nor any mental health type services. If President Bush's family and all of his congressmen had to live as I do...I think they would sing a different tune. Instead they have cut Medicare and other assistance programs to include Section 8 housing vouchers.		