Health Care That Works For All Americans

Dialogue With The American People

Citizens' Health Care Working Group

HEALTH CARE
THAT WORKS FOR ALL
AMERICANS

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How We Did Our Work

Hearings

In the summer and early fall of 2005, the Working Group held hearings in Crystal City, Virginia; Jackson, Mississippi; Salt Lake City, Utah; Houston, Texas; Boston, Massachusetts; and Portland, Oregon to learn about the nation's health care system. At the first hearings, health policy experts provided a common foundation on topics including employer-based and other private insurance, public programs including Medicare and Medicaid, health care costs, and public and private initiatives to control costs and expand insurance coverage. At the subsequent hearings topics included: the uninsured and underserved, health care quality, geographic variation in health care utilization, health information technology, rural health issues, mental health, health care disparities, long-term care, end-of-life care, community-based care, and Oregon's experience in public engagement on health care issues.

We also heard of many private and public programs trying to expand access to care, improve quality, and reduce costs. Some of the programs we heard about were state and local programs to expand health insurance coverage; employees and employers working together to expand access by holding costs down and getting the right care at a good price; using health care technology to reduce medical errors, monitor patient care, and choose the most appropriate care for patients; providing more information to providers and patients for making choices about health care; encouraging people to use less expensive but equally effective care such as generic drugs; adjusting payments to doctors, hospitals, and other health care providers based on the quality of care they provide; and improving people's access to care and insurance coverage through more effective use of current programs or new programs that will allow small business and self-employed individuals to obtain coverage.

Many of the programs are new, so we don't know yet how well they will work over the long term. And, because these programs were designed to work in particular places, we don't know whether the programs would fit, or work successfully, in other locations or settings. However, the hearings reinforced our conclusion, as stated in the *Health Report to the American People*, that we need to address the entire health care system, not just specific problems in cost, quality, or access, no matter how urgent they may seem from our different perspectives. Ideally, savings gained from improving efficiency and quality in the system could be used to make other needed changes. Some of the proposed health care initiatives could help to keep the amount and type of some health care services we receive the same, while controlling costs and improving quality. But we also concluded that none of the initiatives that we reviewed could provide all the answers to our health care system's problems. Rather, the hearings helped lay the groundwork for the search for solutions described in this report.

A complete list and brief description of the 61 presentations made by experts at these hearings is found in Appendix E.

Public Dialogue

The Working Group conducted community meetings throughout the United States to hear from, and begin a dialogue with, the American people. As stated in the statute, these meetings constitute the primary source of input that the Working Group has used in developing its preliminary recommendations. In addition, however, a variety of complementary forms of input (described below) have been important. These different types of input were designed to engage a broad segment of the American public in an informed discussion, using formats that allowed both

- free expression of all views, and
- sufficient structure to allow the Working Group to characterize and compare different views in order to reach conclusions based on the dialogue.

Working Group Community Meetings

The Working Group conducted 31 Community Meetings in 28 states between January and May 2006 (see Appendix A). These meetings ranged in size from about 35 to approximately 500 participants. At least one Working Group Member attended each meeting. Each meeting was organized using one of a set of formats designed for meetings of different lengths, but all were based on discussion of the four questions to the American people posed in the legislation. The discussion guides, as well as other background materials developed for the meetings (videos, slides, etc.), were all based on the analysis of issues confronting the American health care system presented in the Working Group's publication, *The Health Report to the American People*, with some updated facts and figures. Audience generation for the community meetings consisted of outreach through both earned and paid media, involvement of national and local organizations, associations, and other groups, and the participation of various leaders and government officials at the local, state and national levels. Professional meeting facilitators led the meetings.

The basic structure of the meetings involved discussion among participants sitting in small groups, and a structured process for reporting the views of the groups. At the 31 Community Meetings, electronic devices allowed individuals to provide responses to all or some of the same questions included in the poll posted on the Working Group Internet site (see Appendix C), and used in other polls and surveys. The responses to each question were then displayed on a screen, providing immediate feedback to the participants. As discussed in "The Dialogue" (below), there was some variation in the wording of the "standard" questions from meeting to meeting, in response to the preferences of the groups. The format therefore allowed participants to alter the discussion when they felt it was important to do so, while providing enough consistency to allow for comparisons on key issues. Attendees were also encouraged to provide written comments, and many did so. Staff of the Working Group also considered these comments in their review of the meetings.

Additional Meetings

Another important set of discussions took place at the University town hall meeting sponsored by the Big Ten Conference and the Association of Schools of Public Health, and hosted by the University of Michigan on March 22, 2006 (see Appendix D). This virtual town hall provided a forum for individuals gathered at 22 separate public meetings organized by the participating universities, along with the webcast of the meeting from the University of Michigan, as well as people viewing the live webcast across the country. Interactive technology allowed various locations to call in with questions and comments, and individuals submitted their feedback about health care in America through e-mail to be read to participants during the live event.

Still other meetings organized by individual Working Group Members and staff in collaboration with community based health, advocacy, and business groups provided additional insights and opportunities to hear from people with perspectives that might not have been well represented at the other community meetings (see below). Some of these were directly related to issues that were raised in the hearings held by the Working Group (see Appendix E). These special meetings included sessions focusing on mental health, health care at the end of life, chronic illness and disability, a series of meetings in rural areas of Mississippi, a meeting co-hosted with Native American organizations, and a meeting organized by a national association representing realtors.

The Working Group also reviewed data from additional meetings that members as well as other people throughout the country conducted on their own, using materials developed by the Working Group and made available to the public in the "Community Meeting Kit" available on the web site. A listing of meetings that have provided data to the Working Group is included at the end of this section. Other organizations have also provided us with information. Among these are: The National Health Care for the Homeless Council (NHCHC), which conducted a nationwide outreach effort to gather the input of homeless persons; data from the responses of 446 homeless persons in 12 cities were provided to the Working Group.

Other Direct Citizen Input

The Working Group solicited input from people across the country via the Internet, at www.citizenshealthcare.gov, and by mail.

The Working Group Public Comment Center on its web site solicited both structured and unstructured comments from the public.

- "What's Important to You" sought responses to four broad questions about people's concerns about health care in America, views on changing the way health care is delivered or paid for, trade-offs that people would be willing to make to improve health care, and recommendations that people would make to improve health care for all Americans. The responses submitted by over 4,600 people from across the United States were coded into response categories and

analyzed. The full text of close to 2,200 hand written responses was also provided to the Working Group for review. The United Church of Christ provided us with about 1,500 hand-written responses from people in about 10 percent of its 5,700 churches across the country to the open-ended questions posted on our Internet site; these are included in our analysis.

- Close to 600 people wrote to the Working Group, via the CHCWG Internet "Share Your Experience" page or in handwritten letters, to tell us about their own stories. Many of these described problems obtaining or paying for adequate health insurance or quality health care; some described very positive experiences with the health care system.
- The Health Care Poll posted on the web site drew over 13,000 responses from January through August 31 (see Appendix C). The Catholic Health Association (CHA) also provided over 1,000 poll responses that were submitted directly to CHA's web site. These are included in the analysis of poll data; the responses are also presented in Appendix C. A number of organizations, including Communication Workers of America (CWA), Starbucks Coffee Company, The National Health Law Program, the National Assembly on School Based Health Care, Wheaton Franciscan HealthCare, and the American Nurses Association also provided information and links to encourage people to provide input to the Working Group. Many people affiliated with these groups participated in community meetings and via the Internet. More than 500 members of the CWA responded to the Internet poll (see Appendix C). Additionally, many of the organizations that conducted their own meetings sent us paper polls. The Area Agency on Aging in Florida provided about 50 poll responses from seniors in Florida. Written input mailed to the Working Group was coded and analyzed using the same protocols as the electronic data submitted over the Internet.

Analysis of the Data

Methods

The Working Group reviewed summaries of all the sources described above. The Community Meetings were considered, for analytical purposes, as case studies. In addition to the data on demographics and the votes recorded at each meeting, staff reviewed background information on each location and, in the course of planning each meeting, obtained a great deal of information on the health care, resources, and policy issues in each community. Senior staff members who attended the meetings used a structured format when preparing the meeting reports. The individual reports, including the data recorded at each meeting, are being made available to the public on www.citizenshealthcare.gov. The Working Group compared data across meetings only when it was truly comparable, that is, questions were asked in the same context during the meetings, in the same form. (See Appendix B for more information.)

Staff coded and analyzed data from open-ended, on-line polls, and Interim Recommendation responses using standard statistical software. The Working Group reviewed summary data, as well as the results of analyses that reflected possible

differences in response patterns related to demographic differences. The Working Group also reviewed data from relevant national polls and surveys.

Public Comments

The Interim Recommendations posted on the web site received over 8,000 responses, mostly via the Internet, but also by mail, from June 1 through August 31. These public comments were classified into response categories and analyzed; comments were also posted on the web site. Official feedback from advocacy organizations and professional associations were reviewed by the Working Group members as well as staff, and posted on the Working Group web site. A summary of the comments and the Working Group's response to the comments is presented in Appendix G.

Limitations

People attending the Working Group Community Meetings or providing input in writing are more likely than others to be especially interested in health care, either because they, or their family members, have had concerns about their health care or insurance coverage, or because they work in the health care field. The people we heard from were, on average, more likely to be female and in or on the edges of the Baby Boom generation (age 45-64), and the proportion having bachelor degrees or advanced graduate degrees was much higher than in the population as a whole. And, while participation in Community Meetings by minority group members was fairly close to national percentages, representation of people who identified themselves as Latino or as African American among those submitting comments or poll data was lower. The proportion of people who were not covered by any form of health insurance, and the proportion receiving benefits through Medicaid, was also lower than the nation as a whole. Some of these limitations were addressed by holding meetings specifically designed to reach underrepresented populations (see above). And, as noted above, analysis of the data was performed to assess the extent to which demographic factors may have accounted for some of the findings.

A more serious issue is the inability to ensure that people providing input represent the full spectrum of views of all Americans, given that people who are sufficiently interested or motivated to provide input on health care and policy issues may not be typical of the population as a whole. The consistency of findings across many communities and between the poll data obtained through both the Working Group Internet site and the community meetings provides support for the view that we have heard from a significant segment of the American people. The consistency between findings from recent national polls and surveys provides even stronger support for the findings. However, the meetings, as well as the www.citizenshealthcare.gov data were designed to offer information to help frame discussion and responses to questions, whereas national polls and surveys generally do not serve this purpose. Therefore, the responses we have analyzed are not exactly comparable to other national poll data, even when the same, or very similar, questions are asked. Consequently, we do not claim that we know, with great certainty, the values and preferences of all Americans. Rather, we are basing our recommendations

on a careful assessment of input from as many sources as feasible, from tens of thousands of people from all across the United States, taking into account the gaps or biases that may be reflected in the data to the best of our ability.

Citizens' Health Care Working Group Meetings through August 31, 2006

Working Group Community Meetings

Kansas City, MO	January 17, 2006
Orlando, FL	January 24, 2006
Baton Rouge, LA	January 26, 2006
Memphis, TN	February 11, 2006
Charlotte, NC	February 18, 2006
Jackson, MS	February 22, 2006
Seattle, WA	February 25, 2006
Denver, CO	February 27, 2006
Los Angeles, CA	March 4, 2006
Providence, RI	March 6, 2006
Miami, FL	March 9, 2006
Indianapolis, IN	March 11, 2006
Detroit, MI	March 18, 2006
Albuquerque, NM	March 20, 2006
Phoenix, AZ	March 25, 2006
Hartford, CT	April 6, 2006
Des Moines, IA	April 8, 2006
Philadelphia, PA	April 10, 2006
Las Vegas, NV	April 11, 2006
Eugene, OR	April 18, 2006
Sacramento, CA	April 19, 2006
San Antonio, TX	April 19, 2006
Billings, MT	April 21, 2006
Fargo, ND	April 22, 2006
New York, NY	April 22, 2006
Lexington, KY	April 25, 2006
Cincinnati, OH	April 29, 2006
Little Rock, AR	April 29, 2006
Tucson, AZ	May 4, 2006
Sioux Falls, SD	May 6, 2006
Salt Lake City, UT	May 6, 2006

University Town Hall Meeting, March 22, 2006

Participating Institutions*

Boston University	Boston, MA
Drexel University	Philadelphia, PA
Emory University	Atlanta, GA
George Washington University	Washington, DC
Indiana University	Indianapolis, IN
Johns Hopkins University	Baltimore, MD
Louisiana State University	Baton Rouge, LA
Michigan State University	East Lansing, MI
Northwestern University	Evanston, IL
Ohio State University	Columbus, OH
Penn State University	Harrisburg, PA
Purdue University	West Lafayette, IN
Tulane University	New Orleans, LA
University at Albany	Albany, NY
University of Arkansas	Fayetteville, AR
University of Illinois	Urbana, IL
University of Iowa	Iowa City, IA
University of Louisville	Louisville, KY
University of Michigan (Host)	***Ann Arbor, MI***
University of Minnesota	Minneapolis, MN
University of South Carolina	Columbia, SC
University of Wisconsin	Madison, WI

* Not all meetings took place at main campuses.

Special Topic Community Meetings

Hanover, NH	Last Days	March 31, 2006
Redwood Valley, CA	Native Americans	April 20, 2006
Washington, DC	National Association of Realtors	May 16, 2006
Atlanta, GA	Mental Health	May 22, 2006

Meetings Organized/Facilitated by Individual Members

Washington, DC	Ascension Health CEOs	December 5, 2005
Daytona Beach, FL	Bethune-Cookman College	March 26, 2006
Deltona, FL	Florida CHAIN (Community Health Action Information Network) and MS-keteers Multiple Sclerosis Support Group	May 6, 2006
Palm Beach Gardens, FL	Area Agency on Aging	May 10, 2006
Boca Raton, FL	Area Agency on Aging	May 11, 2006
Lake Worth, FL	Area Agency on Aging	May 12, 2006
Thousand Oaks, CA	City of Thousand Oaks Conejo Recreation and Park District	May 18, 2006
Miami, FL	The Alliance for Human Services, The Human Services Coalition, Florida CHAIN, Miami-Dade County Health Department, Health Foundation of South Florida	August 22, 2006

Self-Initiated Meetings

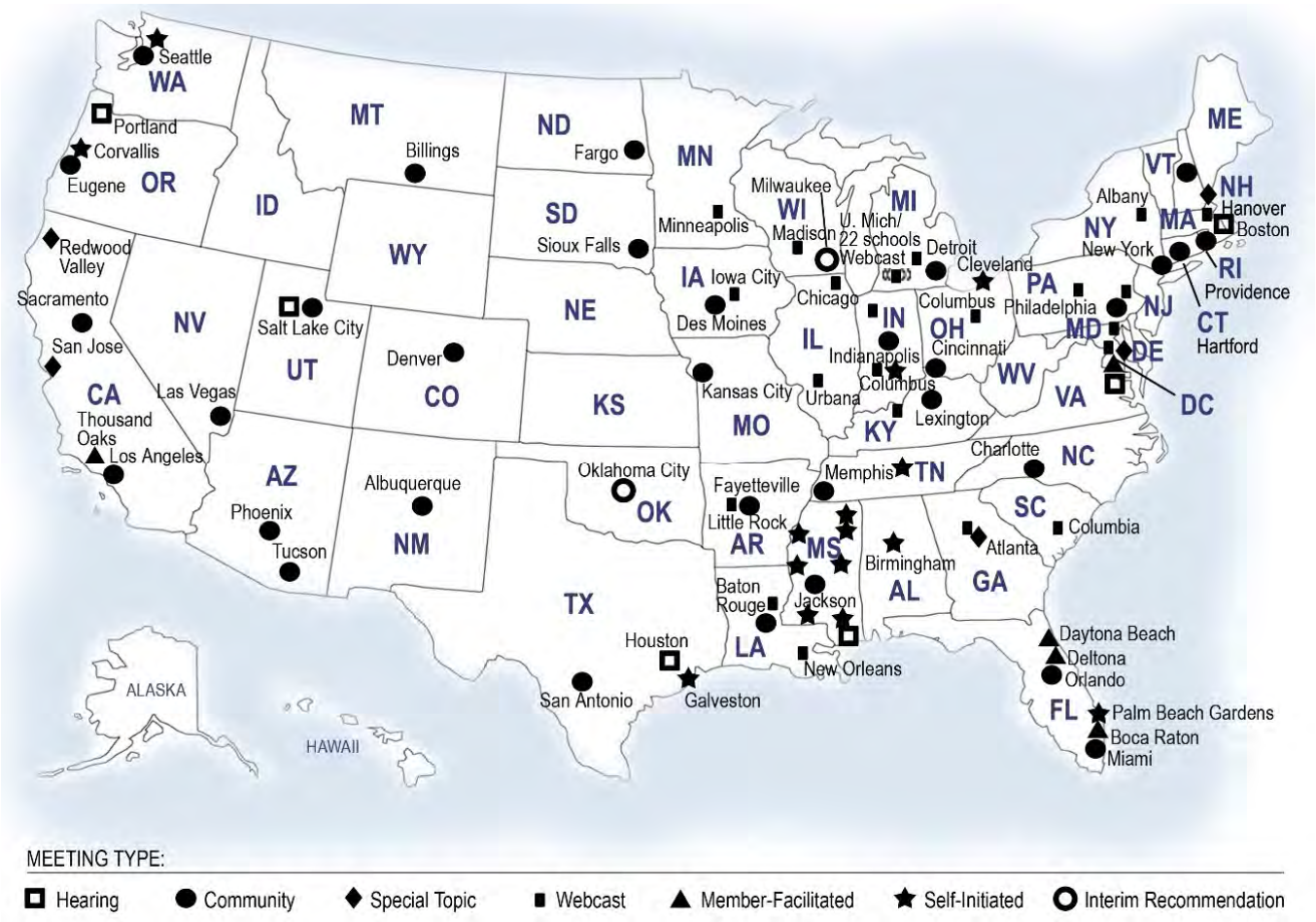
Crossville, TN	The Learning Community	January-March, 2006
Galena, IL	League of Women Voters	February 23, 2006
Starkville, MS	MSU Extension	March 21, 2006*
Verona, MS	MSU Extension	March 27, 2006*
Wesson, MS	MSU Extension	March 29, 2006*
Hattiesburg, MS	MSU Extension	March 30, 2006*
Clarksdale, MS	MSU Extension	April 11, 2006*
Palm Beach Gardens, FL	Human Resource Association of Palm Beach County	April 11, 2006
Greenville, MS	MSU Extension	April 18, 2006*
Newton, MS	MSU Extension	April 20, 2006*
Cloverdale, CA	United Church of Cloverdale	April 23, 2006
Eau Claire, WI	Chippewa Valley Technical College	April 29, 2006
Seattle, WA	Association of Advanced Practice Psychiatric Nursing	April 29, 2006
Alpena, MI	League of Women Voters	May 1, 2006
Galveston, TX	Center to Eliminate Health Disparities, University of Texas Medical Branch	May 1-3, 2006
Boulder, CO	Individuals	May 3, 2006
McKeesport, PA	Mon Valley Unemployed Committee	May 11, 2006
Muncie, IN	BMH Foundation and Partners for Community Impact	June 2, 2006
Birmingham, AL	Greater Birmingham PDA/DFA, UFCW Local 1657	June 22, 2006
Corvallis, OR	Mid Valley Health Care Advocates	July 20, 2006
Birmingham, AL	Birmingham Friends Meeting	July 16, 2006
Jackson, MS	MSU Extension	August 22, 2006*
Hattiesburg, MS	MSU Extension	August 23, 2006*
Greenville, MS	MSU Extension	August 24, 2006*
Cleveland, OH	North East Ohio Voices for Health Care	August 24, 2006
Columbus, IN	Columbus Regional Hospital Foundation (2)	August 29, 2006

* Held under the auspices of the Mississippi State University Extension Service.

Community Meetings on Interim Recommendations

San Jose, CA eBay/PayPal	July 20, 2006
Oklahoma City, OK	August 1, 2006
Milwaukee, WI	August 12, 2006

Locations of Community Meetings Across the United States



The Dialogue

This chapter highlights public input on the four questions Congress specified that the Citizens' Health Care Working Group ask the American people. The Working Group has reviewed all input it has received from community and other meetings, by Internet, by mail, in person, or by phone. Particular emphasis in this section has been given to information gathered in community meetings held throughout the nation, which Congress directed the Working Group to conduct before preparing its Interim Recommendations. Other survey data sources are discussed throughout this section, and they will also be highlighted in the Final Recommendations to Congress.

This chapter follows the organization of the "typical" meeting, which always began with a discussion of participants' underlying values. The 31 community meetings varied slightly from site to site, reflecting differences in the participants' interests and preferences. While the general structure of the meetings was similar, it evolved over time as the Working Group attempted to find more effective ways to gather the desired information. Meetings varied in length, with most meetings either three or four hours long, although some were shorter and a few longer. At all these meetings, discussions centered on the four legislatively mandated questions:

I. What health care benefits and services should be provided?

II. How does the American public want health care delivered?

III. How should health care coverage be financed?

IV. What trade-offs are the American public willing to make in either benefits or financing to ensure access to affordable, high-quality health care coverage and services?

Summary of Findings

The following common themes emerged from the community meetings and other sources of information collected from the American public by the Working Group:

Values

- Underlying the discussion of the four legislative questions is the belief by virtually everyone in attendance at each community meeting that the health care system has at least some serious problems.
- Over 90 percent of participants at community meetings and respondents to the Working Group's poll believed that it should be public policy that all Americans have affordable coverage.

I. What health care benefits and services should be provided?

- A clear majority of participants preferred that *all* Americans receive health care coverage for a defined level of services.
- People at the community meetings frequently expressed strong support for increased focus on wellness and prevention services as part of "basic" coverage, rather than focusing only on treating sickness.
- Participants at meetings continually emphasized the importance of a strong education component in health care and the management of health.
- Individuals voiced support for a fairly comprehensive basic benefit design.
- Although many participants recognized the need to do more to ensure that the health care provided is appropriate and delivered efficiently, they were also concerned about arbitrary limits on coverage and were not comfortable with bare-bones benefit packages.
- Despite the reluctance of many to limit benefits, participants at meetings supported limiting coverage to services that have proven medical effectiveness.
- Participants expressed some level of support for the idea that some people could pay for additional services outside the basic benefit package.
- People wanted consumers to play an important role in deciding what should go into a basic benefit package.
- Participants in some meeting sites discussed a potential role for a local board or other quasi-governmental entity in defining the basic level of services.
- Participants expressed the desire to be involved in the management of their own health care and were willing to accept some responsibility for their medical decision-making.

II. How does the American public want health care delivered?

- At the community meetings, individuals asked for a delivery system that is secure, transparent, easy to navigate, and treats the "whole person."
- Affordability of care is a primary concern among participants.
- Participants were troubled that many people did not have access to the health care they need.

- Many participants cited complexity of the system as a contributing factor to the problems with the health care system.
- Linked to confusion about the health care system was the lack of useful information to help individuals navigate the health care system.
- Participants mentioned that they or others were not always treated with respect or dignity.
- Participants frequently cited barriers to care related to their insurance coverage.
- Participants told the Working Group that they want to feel secure knowing that when they or their families need care, they can get it without becoming impoverished.
- Participants wanted all Americans to be able to get the right health care, at the right time, in a respectful manner.
- Participants noted that being able to choose and maintain a stable, long-term relationship with a personal health care provider was critical.

III. How should health care coverage be financed?

- Although the results differed across meeting sites, a majority of participants (ranging from 55 percent to 88 percent in the community meetings) believed that everyone should be required to enroll in either private or public "basic" health care coverage.
- In almost every community meeting, a majority of participants supported the notion that some individuals should be responsible for paying more for health care than others. The most commonly mentioned criterion for paying more was income, but varying payment by income was supported by the majority of participants in fewer than half of the meetings where this question was discussed.
- Views about employer-based coverage did not generally reflect a deep distrust of employers, but instead were intertwined with broader concepts of health reform.
- At most meetings, participants stressed the importance of preventive care to reduce health care costs.
- Participants at most meetings believed that individuals have a responsibility to manage their own care and use of services.
- In many meetings, participants mentioned that individuals have a social responsibility to pay a fair share for health care.
- Participants frequently stated that the problems of high costs rest with "price setters"—namely, prescription drug companies, insurers, and for-profit providers.
- A commonly expressed view was that a simpler system would result in lower administrative costs.
- Some support exists for investment by providers and the private sector in health information technology to increase system efficiency.
- Participants expressed general support for individuals playing their part in controlling utilization and costs.
- Individuals would like information about how to use health care better and more effectively.
- At some meetings, participants supported providing incentives to patients to engage in healthy behaviors.
- Participants expressed preferences for using medical evidence to decide which services are covered and provided.

- There was general support for controlling prescription drug costs by limiting direct-to-consumer advertising of prescription drugs and using more generic drugs, when medically appropriate.
- Support also existed for limiting expensive yet "futile" end-of-life care and instead providing palliative care.
- In almost all community meetings, participants expressed the belief that changing the culture from sick care to well care—namely, by focusing on prevention, wellness, and education (in general, and health education in particular)—will reduce health care costs.
- A commonly expressed view was that better use of advanced practice nurses and other non-physicians could save money and improve quality.
- Participants believed that investing in public health would pay dividends in terms of reducing health care costs.
- Support for limits on malpractice was expressed at some community meetings.

IV. What trade-offs are the American public willing to make in either benefits or financing to ensure access to affordable, high-quality health care coverage and services?

- In most meetings as well as on the Working Group poll, a majority of participants expressed a willingness to pay more to ensure that everyone has access to affordable, high-quality health care. Overall, about one in three (28.6 percent of poll participants) said they were willing to pay $300 or more per year.
- When asked to rank or choose among competing priorities for public spending on health, individuals—with few exceptions—were most likely to rank "*Guaranteeing that all Americans have health coverage/insurance*" as the highest priority.
- When asked to evaluate different proposals for ensuring access to affordable, high-quality health care coverage and services for all Americans, individuals at all but four meetings ranked "*Create a national health insurance program, financed by taxpayers, in which all Americans would get their insurance*" the highest. Three other options generally ranked in the top four choices at the community meeting locations: "*Expand neighborhood health clinics*"; "*Open up enrollment in national federal programs like Medicare or the federal employees' health benefits program*"; and "*Require that all Americans enroll in basic health care coverage, either private or public*."

Detailed Description of Findings

Values

Before focusing on the four legislative questions, all meetings began with a discussion of individuals' underlying values and perceptions that generally centered on three questions:

- When asked how they would describe the U.S. health care system today, 97 percent of attendees across all community meetings selected "*It is in a state of crisis*" (64 percent) or "*It has major problems*" (33 percent). In each of the 31 community meetings, at least 88 percent selected one of these options. Overall, only two percent said "*It has minor problems*," and one percent either said "*It does not have any problems*" or had no opinion. **Underlying the discussion of the four legislative questions is the belief by virtually everyone in attendance at each community meeting that the health care system has at least some serious problems.** This same concern has also surfaced in national polls. A January 2006 New York Times/CBS poll found that 90 percent of respondents said that our health care system needs fundamental changes or to be completely rebuilt (56 percent and 34 percent, respectively).[1] This finding has been fairly consistent over the past 15 years. However, the Employee Benefit Research Institute's annual Health Confidencet Survey has found from 1998 to 2004 the percent of respondents rating our health care system as poor has doubled from 15 percent to 30 percent. [2]

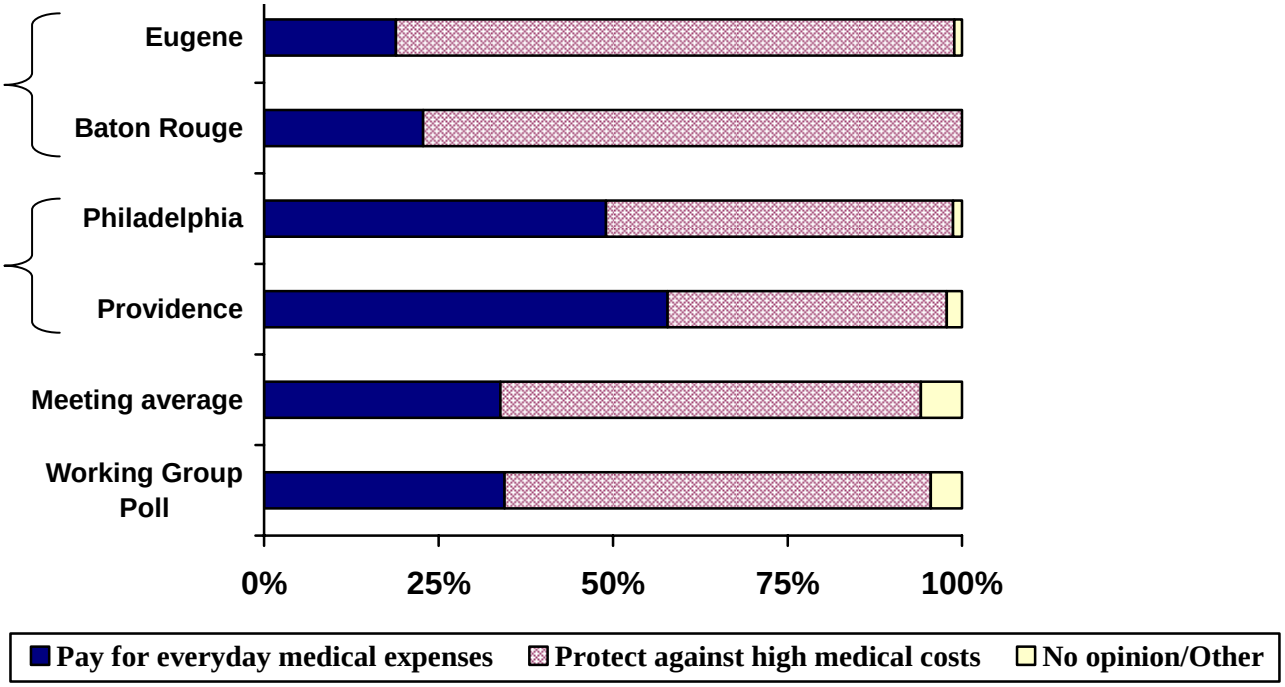
- When meeting participants at all meetings were asked, "Should it be public policy that all Americans have affordable health care coverage?", 94 percent overall said "yes." Similarly, in the Working Group's poll, 92 percent either strongly agreed (79 percent) or agreed (13 percent) with this statement. **Over 90 percent of participants at community meetings and respondents to the Working Group's poll believed that it should be public policy that all Americans have affordable coverage.** As stated by participants in the Orlando community meeting, "Health care is a right and not a privilege." Seattle, Denver, and Philadelphia meeting participants, among other locations, desired "cradle to grave" access to health care.

- At many of the community meetings, participants were asked what they believed was the most important reason to have health insurance. Although the results varied by meeting site, individuals were more likely to choose the response "To protect against high costs" than they were to choose the response, "To pay for everyday medical expenses."

Figure 1 illustrates how participants' responses varied across community meeting sites and the Working Group poll.

Figure 1:

Which do you think is the most important reason to have health insurance? (Lowest and highest rankings at community meetings, average, and Internet ranking)



Note: This question was not asked in Los Angeles, Albuquerque, Hartford, Las Vegas, San Antonio, Fargo, Lexington, Little Rock, or Sioux Falls. Eugene and Baton Rouge were the meeting sites where "Pay for everyday medical expenses" ranked as the lowest among the cities where the question was asked, while Philadelphia and Providence were the meeting sites where that option ranked as the highest. The meeting average reflects a weighted average of all meetings where this question was asked.

I. What health care benefits and services should be provided?

Some common themes have emerged from the community meetings regarding what health care benefits and services should be provided. In the community meetings, discussion of this question generally revolved around three core questions.

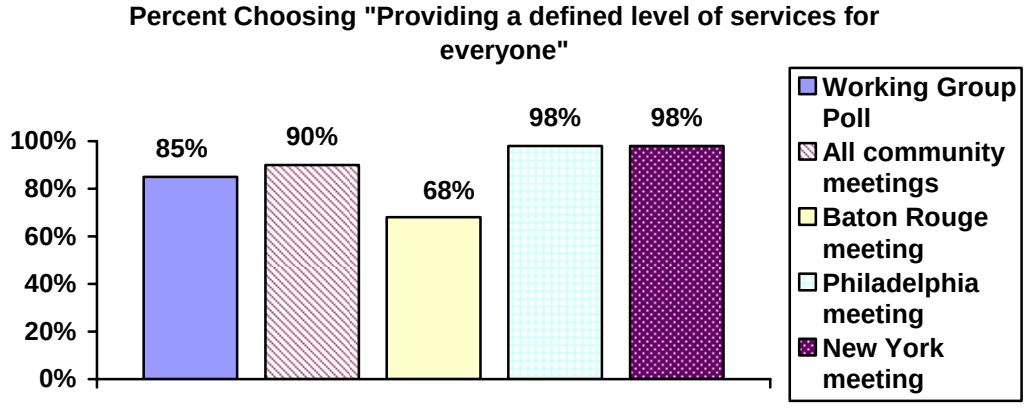
The first of these questions is discussed below:

"Health care coverage can be organized in different ways. Two different models are: (1) Providing coverage for particular groups of people (e.g., employees, elderly, low-income) as is the case now; (2) Providing a defined level of services for everyone (either by expanding the current system or creating a new system). Which of the following most accurately reflects your views?"

In response to this question, a strong preference emerged:

- **A clear majority of participants preferred that all Americans receive health care coverage for a defined level of services**. In response to the question, the vast majority (between 68 percent and 98 percent) of participants at all community meetings have said that we should provide a defined level of services for everyone. The highest level of support for a defined set of services was in the community meetings that were held in Philadelphia and New York, and the lowest in the Baton Rouge meeting (See Figure 2).

Figure 2:
Which statement best describes your views on how health care coverage should be organized?



In the Working Group poll, 84 percent of participants answered the question this way. These findings are also consistent with the results of other national polls asking similar questions. In surveys conducted by other organizations, a clear majority have expressed

the opinion that all Americans should have health insurance. For example, a *Wall Street Journal* poll regarding public support for a range of health practices in September 2005 found that 75 percent of U.S. adults somewhat favored (23 percent) or strongly favored (52 percent) universal health insurance.[3] More recently, a New York Times/CBS poll conducted in January 2006 found that 62 percent said that they think the federal government should guarantee health insurance for Americans; 31 percent said this was not the responsibility of the federal government, and 7 percent said they do not know.[4]

Discussions at community meetings teased out variations in how people conceptualize health coverage. For example, some participants indicated that it was hard to make a choice between the answers without knowing *who* was providing the coverage, or what would be covered. Many tended to view access to health care as a basic right, and they conveyed a willingness to contribute to the success of a system that would facilitate health care for all.

- In the Baton Rouge community meeting, where the smallest percentage of people opted for providing a defined level of services for everyone, participants still concluded that a defined level of services for everyone was "more fair and equitable" in the face of the current system that was "failing."

- In the Detroit community meeting, some participants worried that the issue of discrimination needed to be addressed, regardless of the system design. Just like the current system of providing coverage for particular groups of people (such as Medicare or Medicaid for elderly, disabled persons or low-income populations, or group coverage organized through employment), a system providing a basic level of care for everyone ran the risk of not providing sufficient levels of care for all. Participants expressed concern that any system reform must avoid creating different levels of care for different subsets of the population.

- At the two largest community meetings in Los Angeles and Cincinnati, fewer than 10 percent of participants favored the current system that provides coverage according to a person's affiliation with a particular group. These participants, like those at the other meetings, cited problems with the current system, including:

    - It excludes the unemployed and others who are not part of a particular group
    - The system is high cost, complex, and not uniform across groups
    - Mobility and flexibility are a problem.

- About 90 percent of participants supported the option of providing a defined level of benefits for everyone, rather than the current system of coverage for certain groups. The virtues of implementing a system of coverage for all that were mentioned included:

    - Reduced overall and administrative costs
    - Decreased hospitalization and emergency room use
    - Access for all

- Covered prevention and immunization, and
- Improved level of national health care.

However, participants also expressed potential concerns about such a system, such as: What is the defined level of services? Who will be denied access to care if costs are too high, and who will make these decisions? Who will pay?

- At all locations, participants emphasized the importance of involving consumers in the development of a basic benefit package. Because consumers can articulate what services are necessary at various stages of life, their participation in the development of the plan could help contain costs. In the Phoenix community meeting, for example, participants wanted a basic plan that would vary based on age and gender, and that could be added to if desired. Participants at most meetings recognized that the current system does work for some, and allows for a richer benefit than might be available otherwise, but that it does not work for everyone. They expressed a desire to build upon the current system, changing it into something that is more inclusive and provides a level of care for all Americans. Everyone would contribute to this system based on their ability to pay. However, for those people who are unable to afford the cost, government subsidies should be provided to allow access to a basic package.

- In the San Antonio community meeting, participants expressed interest in an approach that would provide a basic level of care for everyone combined with personal responsibility.

- In a number of community meetings, including Lexington, Eugene, Sioux Falls, and Cincinnati, participants commented that the United States should learn from other countries that have covered all or most of their citizens.

The second structured question delved into how to define the specific level of benefits:

"It would be difficult to define a level of services for everyone. A health plan that many people view as 'typical' now covers these types of benefits, many of which are subject to co-payments and deductibles: preventive care, physicians' care, chiropractic care, maternity care, prescription drugs, hospital/facility care, physical, occupational, and speech therapy, and mental health and substance abuse. How would a basic package compare to this 'typical' plan? Are there benefits that you would add or would take out?"

Although the discussion differed by meeting location, some common themes emerged:

- **People at the community meetings frequently expressed strong support for increased focus on wellness and prevention services as part of "basic" coverage, rather than focusing only on treating sickness**. According to participants at meetings throughout the country, individuals have a responsibility to be good stewards of their health and health care resources (preventive care/screenings/use of services). They also viewed an emphasis on wellness and prevention services as a

way to reduce health care costs, as discussed in the Financing section. According to these participants, disease management should also be a part of the focus. In the Working Group poll, over 90 percent of respondents indicated that annual physicals and preventive care should be part of a "basic" or "essential" benefits package, a level of support that was similar to that for hospital stays, prescription drugs, and lab tests.

- **Participants at meetings continually emphasized the importance of a strong education component in health care and the management of health**. To be good stewards of their health, individuals need to be educated about wellness and prevention. People thought information about how to use health care better and more effectively was important, but not information on cost. Broader issues of general education also came up in some meetings. Participants talked about the importance of beginning early, in grade school, to focus on basic skills that are prerequisites to literacy and health literacy. Fargo meeting participants expressed a preference for "school-based health promotion programs" for those in kindergarten through grade 12.

- **Individuals voiced support for a fairly comprehensive basic benefit design.** Benefits that a number of participants in meetings throughout the country viewed as important components of a basic benefit package included—but were not limited to—dental care, vision, hearing, care by non-physician providers such as nurse practitioners, long-term care, mental health, and hospice care. Some meeting participants also desired coverage of complementary and alternative medicine (for example, acupuncture).

- **Although many participants recognized the need to do more to ensure that the health care provided is appropriate and delivered efficiently, they were also concerned about arbitrary limits on coverage and were not comfortable with bare-bones benefit packages**. A participant in the Eugene community meeting made the point, "There's a need for definition because we can't afford it all." Still, when pressed to make decisions about what services to drop from basic coverage, many respondents told the Working Group "None," which was the most popular response in some locations.

"All people should have the same coverage that the President, Vice President, and Congress have…"
(Phoenix meeting)

"We agree that there should be a basic level of services for everyone-everyone has a right to that care. But our concern is that neither of those--what we have now, or a basic plan for everyone-- will work until it's a consumer-driven choice and not a corporate solution that values profits above everything else. The consumer should be driving the choices, not like the way the culture is now. There should be more of a balance."
(Charlotte meeting)

"Every citizen has a basic right to have basic health care, and it can't be based on the type of job they have."
(Salt Lake City meeting)

- **Despite the reluctance of many to limit benefits, participants at meetings supported limiting coverage to services to those that have proven medical effectiveness**. They expressed a certain level of comfort with decisions that could affect utilization, if they were based on medical evidence. Just over half of the Working Group poll respondents agreed (36 percent) or strongly agreed (14 percent) that health plans or insurers should not pay for high-cost medical technologies or treatments that have not been proven to be safe and medically effective, and nearly a quarter were neutral on the subject; responses in the March University town hall meeting were similar (see text box below), with 58 percent agreeing (36 percent) or strongly agreeing (22 percent).

University Virtual Town Hall Meeting:
"A National Conversation on Health Care"

On March 22, 2006, 22 universities participated in a simultaneous discussion on health care. Sponsored by the Big Ten Conference and the Association of Schools of Public Health, and hosted by the University of Michigan, this virtual town hall meeting provided a forum for individuals across the country to voice their opinions on health care.

Broadcast via satellite from the University of Michigan, individuals participated in this event either by gathering at various university sites, or by logging onto the forum through the Internet. Interactive technology allowed various locations to call in with questions and comments, and individuals submitted their feedback through e-mail to be read during the live event. The 21 simultaneous meetings held in addition to the host meeting were organized by their respective university communities, and followed the same format. Participants at these meetings received the standard Community Meeting Discussion Guide and a Health Care Poll, specific to this event, which included the majority of questions asked on the Working Group's own Internet poll (as well as in many of the Working Group Community Meetings). The separate meetings also had access to a local faculty expert who assisted in sending comments and questions to the national coordinator at the University of Michigan. After the event, the completed Health Care Polls were coded (772 from 22 of the webcast sites) and entered into a data set that was made available to the Working Group for analysis (See Appendix D for a complete summary of the results). Participating schools were:

Boston University
Drexel University
Emory University
George Washington University
Indiana University
Johns Hopkins University
Louisiana State University
Michigan State University
Northwestern University
Ohio State University
Penn State University
Purdue University
Tulane University
University at Albany
University of Arkansas
University of Illinois
University of Iowa
University of Louisville
University of Michigan
University of Minnesota
University of South Carolina
University of Wisconsin

- **Participants expressed some level of support for the idea that some people could pay for additional services outside the basic benefit package**. For example, in Kansas City, participants favored allowing individuals to purchase additional coverage of chiropractic care or fertility treatments. Charlotte participants were willing to pay more for an "a la carte" plan that would allow people to add services to the basic plan, which could vary by life phases and would be most cost effective for each age group. At virtually every meeting, attendees expressed concern about coverage for "futile" care at the end of life.

Results of the Working Group poll question about the importance of including each of 23 specific benefits can be found in Appendix C (Question 4 of the Working Group poll).

The next question in this section of the community meetings asked participants for their views on who should decide which benefits would go into the basic benefit package:

"How much input should each of the following groups have in deciding what is in a basic benefit package (federal government, state and/or local government, medical professionals, insurance companies, employers, consumers)?"

Some common themes emerged in response to this question:

- **People wanted consumers to play an important role in deciding what should go into a basic benefit package**. In meetings throughout the country, the majority of participants consistently answered that a combination of consumers, medical professionals, federal government, state and local governments—generally in that order—should be responsible for having input into these decisions. Some participants indicated that employers and insurance companies should also play a role, but one that is more limited.

  In the majority of meetings, participants were asked, "*On a scale of 1 (no input) to 10 (exclusive input), how much input should each of the following have in deciding what is in a basic benefit package?*" When participants were asked the question in this way, the highest rating was *always* for input from consumers, and it was *always* followed by "medical professionals."

> *"Some new entity or process needs to be created that includes all the relevant stakeholders, the foremost of which would be the consumer."*
>
> *"[There should be] a 'quasi-governmental' entity representing all groups, including us, the people."*
>
> *"One way to organize this would be to create an entity very much like the Federal Reserve Board with appointed individuals who are professionals in their field and whose activities are generally public so it has to come under the federal government but wouldn't be the government as we generally think of it."*
>
> (Orlando meeting)

Responses to this question are illustrated in Figure 3. In some meetings and on the Working Group poll, individuals were asked which party or parties they would prefer to make the decision regarding what services are covered in the basic health insurance plan. At least 60 percent of Working Group poll respondents and participants in the half dozen community meetings in which the question was asked this way chose the "some combination" option (of consumers, employers, government, insurance companies, and medical providers; the question did not identify which specific combination people preferred).

In the Sioux Falls meeting, participants were also asked to rate the "degree of involvement" government, medical professionals, insurance companies, employers, and citizens should each have in determining what is included in a basic health care package using the scale: major role, minor role, and no role. Consistent with other findings, 88 percent of participants voted that citizens should have a "major role," and 73 percent indicated that medical professionals should have a "major role." Participants generally believed that government (72 percent) and employers (64 percent) should play a "minor role;" insurance companies received a mixed response, with 55 percent saying they should play a "minor role" and 42 percent saying they should play "no role."

Figure 3:
On a scale of 1 (no input) to 10 (exclusive input), how much input should each of the following have in deciding what is in a basic benefit package?

Location	Federal Government	State/Local Government	Medical Professionals	Insurance Companies	Employers	Consumers
Jackson	3.6	3.0	5.7	1.8	3.6	7.8
Seattle	4.3	4.0	5.9	1.6	2.3	7.3
Denver	4.2	4.0	6.4	2.5	3.8	6.8
Providence	4.1	3.8	6.8	2.3	2.8	8.0
Miami	5.0	4.5	5.5	2.3	3.0	6.9
Indianapolis	4.9	3.9	6.1	2.2	3.3	7.6
Detroit	3.5	3.7	6.8	1.4	2.4	7.6
Phoenix	3.9	3.7	5.2	2.0	3.4	7.7
Des Moines	5.0	4.7	5.4	2.2	2.6	6.7
Philadelphia	4.4	4.4	6.0	1.5	3.1	6.7
Sacramento	3.8	3.8	6.4	2.5	2.9	7.4
Billings	5.1	4.7	6.0	2.4	4.0	6.3
New York	5.2	4.1	6.7	1.4	2.1	7.7
Tucson	3.9	3.4	6.2	2.6	3.2	6.6
Salt Lake City	4.6	4.7	4.9	2.6	3.1	6.8
Average	**4.4**	**4.0**	**6.0**	**2.1**	**3.0**	**7.2**

- **Participants in some meeting sites discussed a potential role for a local board or other quasi-governmental entity in defining the basic level of services**. For example, participants in the Memphis community meeting strongly supported the concept of defining the basic level of service using a "grass roots" method

through regional or state boards. In these discussions, participants emphasized the need for a publicly accountable body.

- **Participants expressed the desire to be involved in the management of their own health care and were willing to accept some responsibility for their medical decision-making**. Meeting participants felt that consumers played an important role in decision-making. This opinion was expressed both by individuals who sought a larger role for government and those who preferred that government have a limited role.

Mental Health Meeting

At its Boston meeting in August 2005, the Citizens' Health Care Working Group heard from a panel made up of the Director of Mental Health Services for Massachusetts, a representative from a managed behavioral health care plan and an advocate for the mentally ill. As members of the Working Group attended community meetings, they heard that access to mental health services was a significant issue to many participants. In order to delve more deeply into issues related to mental health, the Working Group sponsored a meeting focused on this topic in Atlanta, Georgia on May 22, 2006, at Skyland Trail, a mental health facility which offers long- and short-term residential care and community-based therapy, with the National Mental Health Association of Georgia as a host.

The participants at this meeting were knowledgeable about mental health. They included providers and consumers of mental health services, family members and advocates for the mentally ill and other health care providers. The meeting format was a mix of questions used at other community meetings and questions specific to mental health.

Attendees believed that the value most fundamental to a health care system "that works for all Americans" is universal access, with health care as a right. Other important values are affordability and equal quality of care for all. In considering what was most important to the delivery of mental health care services, universal access was also the most important value, accompanied by integration of mental health into primary health care, parity for mental health care and eliminating the stigma attached to mental health.

The issue participants believed most important to address in getting mental health care services is the lack of parity in insurance treatment of mental illness. Other problems that are priorities for action include the need for more funding for mental health services, the stigma associated with mental health conditions, continuity of care and the need for education to help people "know what is wrong and where to go for help." The inappropriate criminalization of mental health behaviors was also identified as a problem.

When asked about the delivery of mental health services within the overall health care system, a majority of attendees embraced this vision which was developed by one table of participants:

> A comprehensive delivery system through primary care to include addictive disease, mental illness and all other physical illnesses with:
>
> - Education for all providers on mental illness
> - A robust referral system. and
> - Access to services driven by consumer choice.

Ultimately, attendees wanted a system of "any door" access to services where dollars follow the consumer, and there is a focus on wellness recovery and resiliency.

II. How does the American public want health care delivered?

In general, community meeting discussions of how the public wants health care delivered have been structured around two central questions. The first is discussed below:

"What kinds of difficulties have you had in getting access to health care services?"

Individuals at the community meetings discussed a number of problems they or their family members have had in getting access to health care services. Some common themes emerged that are summarized below.

> *"When you change insurance, you should be able to keep your doctor."*
>
> *"Primary care doctor—I like that relationship and I don't want to see that go away."*
>
> (Charlotte meeting)
>
> *"It is an accident of history that medical insurance is attached to the place of employment, only to be lost or changed if jobs change or are lost."*
>
> (Comments submitted to CHCWG Internet "What's Important to You?")

- **At the community meetings, individuals asked for a delivery system that is secure, transparent, easy to navigate, and treats the "whole person."** Having a continuing relationship with a personal physician is just one component of a stable system, according to the participants. Confidentiality of medical records was mentioned as another important component of a good health care system. Individuals expressed a desire for a system that is holistic, treating the whole person rather than just treating "a bundle of symptoms," as described in the Denver community meeting.

- **Affordability of care is a primary concern among participants**. At meetings throughout the country, individuals discussed how costs had prevented them or others from getting needed care. Costs of care generally referred to *their* (or their family's) costs, including co-payments, deductibles, and health insurance premiums, rather than system-wide costs. Participants in different cities indicated that the high costs of prescription drugs were a particular concern. Participants in the Salt Lake City meeting discussed how "people are being priced out."

  National polls have shown that the cost of health care overshadows concerns about quality. In fact, almost three-quarters (73 percent) of those surveyed in a 2005 Gallup Poll said they were greatly concerned

> *"More than anything at our table we have been talking about the cost of the health care – cost is keeping people from getting the care."*
>
> (Phoenix meeting)
>
> *"We want health care delivered equitably at the community level by people we trust."*
>
> (Memphis meeting)
>
> *"We have rural areas here in Indiana where you can't even get a paramedic."*
>
> *"We have lost time-intensive care. Providers right now don't have time to spend with us! You only get two minutes with your doctor."*
>
> (Indianapolis meeting)

about cost; less than half rated other items such as medical errors or avoidable complications, privacy of health information, or availability and access to services as great concerns.[5] The EBRI 2004 Health Confidence Survey found that 34 percent of respondents were not at all confident (23 percent) or not too confident (11 percent) in their ability to afford health care today. The figure rose to 44 percent (25 percent not at all confident and 19 percent not too confident) when the respondents were asked about being able to afford care ten years out.[6] For the last twenty years, a variety of survey findings consistently showed that approximately one in four Americans reported problems paying medical bills in the previous year.[7] Surveys have continued to describe that burden Americans are feeling as it relates to the costs of medical care. According to a 2006 CBS/New York Times Poll, 61 percent of adults said they were concerned a lot about the health care costs they are facing now or will face in the future,[8] A Pew Center for the People and the Press Survey found that 54 percent of U.S. adults reported that the costs of paying for a major illness was a major problem and 38 percent said even routine care was a major problem. Moreover, 70 percent of respondents said that the government spends too little on health care, while 65 percent thought that the average American spends too much.[9]

"Culturally competent care-funding to encourage more minority physicians and providers. If I want an African American dermatologist, I have to search high and low."
(Indianapolis meeting)

"You can't get through this system without luck, a relationship, money, and perseverance."
(Salt Lake City Meeting)

"Care should be delivered at the most local level possible."
(New York Meeting)

- **Participants were troubled that many people did not have access to the health care they need**. Access to care includes access to both facilities and health care providers, including specialists. Participants in community meetings nationwide highlighted problems with access to health care in rural areas, including lack of transportation to providers or facilities located far away. The lack of public transportation was brought up as an issue not only for rural areas, but for urban areas as well. Others described problems finding an accessible provider who was willing to accept their insurance, particularly Medicaid. Providers and facilities tend to be concentrated in suburbs and more populated areas. For example, in the Phoenix community meeting, individuals noted that most providers and specialists were concentrated in the Phoenix area, and it was difficult to access care in other areas of the state. According to a national Wall Street Journal/Harris Interactive survey 56 percent of adults agree that people who are unemployed and poor should be able to get the same amount and quality of medical services as people who have good jobs and are paying substantial taxes.[10]

Consolidated Tribal Health Project, Redwood Valley, California

"I don't have money to get my kids milk and you want me to take them to the dentist?"

"Society preaches prevention—but a doctor isn't going to see this young lady's kids for preventive care. She might get in at a walk-in clinic, but what's the quality of care? Is the waiting room safe? Is the provider credentialed? Are they culturally sensitive to your needs? We get referred to the outside world where they assume you can read and write and just have you signing forms and don't take the time to explain it to you."

Native Americans (both tribal and non-tribal members) met in Redwood Valley on April 20, 2006, at the Consolidated Tribal Health Project to provide an open, honest, and often emotional insight into the barriers they face in accessing even basic primary medical, mental and dental health care. Participants expressed their desire for everyone to have access to health care, both in terms of geographic distance and ability to access providers.

They felt that "health care is not a privilege, it's a right and we don't receive that right…not only as Native Americans, but as rural citizens." Individuals addressed the issue of access as a multi-pronged problem. One woman said, "When they can afford to purchase gasoline, their tires are in good shape, and they aren't in too much pain, they can make the long drive for care." If the primary care reveals a need for specialty services, they face an even greater hurdle.

Individuals talked about how they valued culturally competent care with providers who took the time to explain medical terminology and did not assume literacy. One person noted that "[health] professional people are so professional that they don't know how to relate to us nobodies. They don't know how to tell us the simple things." Participants at this meeting emphasized the importance of the government recognizing its duty to the Native American population and honoring the trust relationship that is established in law.

Mississippi Listening Sessions

Eleven listening sessions organized by faculty of the Mississippi State University Extension Service were conducted between March 21, 2006 and April 20, 2006. These sessions were held across the rural areas of the state and included a diverse mix of geographies and cultures. Altogether, 138 people participated in the sessions. The majority of participants were college graduates, many with post-graduate education, and most had some form of health coverage. Many of the participants were health care providers or administrators, or business people actively involved in their communities, and most were knowledgeable about the problems facing low-income and underserved rural Mississippi communities. A major thought expressed across the rural sessions was that many problems with the health care system in rural areas are distinct from those found in more urbanized areas. Lack of physicians and other health care professionals, distances to services, transportation issues, high cost, and lack of insurance were strongly recurring themes across the state.

Across the sessions, values regarding affordability and quality of care ranked highest among participants. Accessibility ranked third in urgency, but the total number of specific issues related to this concept dominated the discussion. Choice of care rounded out the list of values articulated at the sessions.

Those observing the sessions noted that there were marked differences in the views expressed in the meetings, reflecting at least in part, differences in culture, but also the recent major devastation caused by Hurricane Katrina. Participants from the state's southern regions, hardest hit by the storm, talked about problems they still face getting health care. Doctors left and patient records were destroyed or disappeared. And when some doctors attempt to return, they are finding that their patient base is scattered and possibly gone for good. Concerns were also expressed in the other regions of the state focused on the influx of Katrina and Rita evacuees (many of these evacuees are either uninsured or are covered by Medicaid) and the accessibility barriers that these people faced. Other storm concerns involved the lack of generators for respirators and difficulty accessing medication. One person who became the guardian after the storm of a 3-year old child who is covered by Medicaid seemed overwhelmed: "I don't know what to do or how to access the system." Another left the same session highly distressed contending that, in light of this system's inability to quickly respond to Katrina, we had no business focusing on health care issues that will take years to address, and that we should instead focus our attention on the possibility of other natural disasters, a potential pandemic, or a bioterrorist attack.

In other sessions, people talked about more pervasive problems, including delays in the ability to schedule an appointment, and physicians who are unwilling to accept Medicaid or Medicare patients. Problems related to communicating with the system led one participant to advocate the establishment of patient navigators. One session in Hattiesburg focused on small businesses' and independent contractors' inability to secure reasonable group rates; it was mentioned that 28 percent of National Association of Realtors members have no health care coverage.

Most participants (78 percent) agreed with the statement, "It should be public policy that all Americans have affordable health care." Compared to other meetings, however, participants expressed a stronger interest in focusing on personal responsibility (including taking advantage of educational opportunities) to improve health care and control health care costs, investing in public health infrastructure, and expanding safety net programs in order to ensure access to care. There was also a greater emphasis on expanding existing public programs and bolstering the employer-based health care system to address gaps in coverage, rather than initiating new programs or making fundamental changes to the health care system. The most resounding dialogue the group facilitators recalled at all the sessions focused on the availability of health care services.

- **Many participants cited complexity of the system as a contributing factor to the problems with the health care system**. A number of issues related to complexity were discussed. Some participants noted that a lack of transparency in insurance coverage and reimbursement policies contributed to the problems. In the Memphis community meeting, the discussion of the complexity of the insurance system emphasized the problems created by multiple payers. Related to the concept of multiple payers, participants in the Denver community meeting discussed how the "labyrinthine scheme of Medicare and Medicaid" sets up a system especially hard to navigate by or on behalf of elderly patients. In the Providence, Philadelphia, and Sacramento community meetings, the new Medicare prescription drug benefit (Part D) was cited as an example of the complexity of the health care system.

  > *"It's so complex. You wake up one day and your contract has been renegotiated, your numbers have changed, and your providers have changed. There are too many rules and too much bureaucracy."*

- **Linked to confusion about the health care system was the lack of useful information to help individuals navigate the health care system**. Individuals wanted to have access to understandable medical information to help them make educated decisions about their health care. Many participants discussed their desire to partner with their health care provider in making health care decisions. Participants noted that sometimes it was very hard to find any information, although we also heard from some participants that information was available if one knew where to look. People often were not sure where to go to find what they needed. The desire for information is not unique to Working Group community meeting participants. According to a 2005 Gallup Poll, a slim majority (51 percent) of individuals said they do not have enough information about hospitals and other health care facilities to make educated choices for health care services.[11]

- **Participants mentioned that they or others were not always treated with respect or dignity.** Examples of problems people encountered included a lack of effective communication, discrimination by race or ethnicity, long wait times, and overcrowded emergency rooms. In a number of locations, meeting participants discussed how they had encountered or knew of barriers due to race or ethnicity, language, lack of cultural sensitivity, and lack of health insurance.

- **Participants frequently cited barriers to care related to their insurance coverage**. People in community meetings mentioned that they have experienced problems getting care due to health insurance rules. For example, some services were not covered due to pre-existing conditions. Participants also discussed problems related to needing to go through an insurer's gatekeeping requirements to receive referrals that sometimes were denied. A number of participants spoke of problems with the portability of health insurance under the current system.

Within the employer-based health insurance system, someone who changes jobs might be forced to switch insurance and could lose access to their health care provider if that provider is not in the new network. Participants in the Billings community meeting noted that limited provider networks created access problems in Montana, a large but lightly populated state. In the Baton Rouge community meeting, participants noted that the experience from the hurricanes in the summer of 2005 brought to the forefront the need for major emergency preparedness in all aspects of the health care system, including among insurance providers.

> *"It's often more stressful to deal with the insurance company than it is to deal with the disease."* (Des Moines meeting)
>
> *"There should be no waiting period before becoming eligible for coverage."* (Lexington meeting)

The second question asked of community meeting participants about health care delivery relates to their priorities for getting needed care:

"In getting health care (choosing a physician, health care provider, or health plan), what's most important to you?"

The responses to this question built on the answers to the previous question about problems getting care. The primary themes related to affordability, accessibility, and forming mutually respectful relationships with providers.

- **Participants told the Working Group that they want to feel secure knowing that when they or their families need care, they can get it without becoming impoverished**. Discussants frequently mentioned that it was important that their out-of-pocket costs for health care not be unreasonably high. Participants said people should have to pay some amount, but they generally also said that patients of all income levels should be able to receive needed care without costs being a barrier.

  > *"I feel like we are only as good as our weakest link, and so many people can't afford care."* (Fargo meeting)

- **Participants wanted all Americans to be able to get the right health care, at the right time, in a respectful manner**. Access for everyone emerged as a common theme across meeting sites. Some meeting participants said that receiving "the right health care" meant that medical decisions would not be based on factors such as a person's age. Many participants decried making medical decisions on the basis of cost rather than medical need, but did want the care they receive to be delivered in a cost-effective manner. Participants expressed the need to have care received in a coordinated and timely manner. Among other factors, getting the right care in a respectful manner involved having a provider who was courteous and could communicate well. As stated in meetings from

Charlotte to Seattle, participants believed that care should be sensitive to the needs of different cultures. The desire to be treated with respect has also been shown to be highly valued in other national surveys. A 2004 Wall Street Journal/Harris Interactive poll asked what qualities people believed were extremely important from the doctors who treat them; some of the most popular responses related to the medical provider's interpersonal skills—such as being respectful (85 percent) and listening carefully to health care concerns and questions (84 percent).[12]

- **Participants noted that being able to choose and maintain a stable, long-term relationship with a personal health care provider was critical**. Individuals at meetings throughout the nation reiterated the importance of the provider-patient relationship that they believed should not be affected by whether a person switches jobs or changes health insurance. In the Phoenix community meeting, participants valued being able to choose a provider that would listen to them and provide "true" care, rather than just writing out a prescription. They wanted to be able to keep their health care provider even if they changed insurance carrier. In a number of locations (such as at the meetings in Orlando and Detroit), participants also discussed the importance of choosing a specialist. Participants at the community meetings told the Working Group that they placed a high value on having a "medical home" in which they can spend individual time with a provider. On the other hand, some participants at other meetings, such as San Antonio, expressed a willingness to forego some choice of primary care physician in exchange for lower costs or higher quality care.

III. How should health care coverage be financed?

Community meetings tended to devote a substantial amount of time to questions related to financing health care and controlling health care costs. The first of five questions that were commonly used in community meetings asks participants their opinion on whether everyone should be required to enroll in basic health care coverage:

"Should everyone be required to enroll in basic health care coverage, either private or public?"

Meeting participants had interesting discussions in response to this question:

- **Although the results differed across meeting sites, a majority of participants (ranging from 55 percent to 88 percent in the community meetings) believed that everyone should be required to enroll in either private or public "basic" health care coverage**. Support for some form of mandated coverage is displayed in Figure 4. Fewer than half (47 percent) of the Working Group poll respondents agreed or strongly agreed with requiring everyone to enroll in health coverage, and another 21 percent said they were "neutral." Over 80 percent in the University town hall meeting said everyone should be required to enroll in basic (public or private) health care coverage.

Figure 4:
Should everyone be required to enroll in basic health care coverage, either private or public?

Percent Saying "Yes":		
Less than 70%	**70-79%**	**80% or More**
Kansas City (60%)	Orlando (74%)	Memphis (83%)
Baton Rouge (65%)	Jackson (74%)	Charlotte (80%)
Albuquerque (62%)	Seattle (77%)	Indianapolis (88%)
Des Moines (55%)	Denver (75%)	Philadelphia (82%)
Las Vegas (56%)	Providence (76%)	Sacramento (81%)
Eugene (65%)	Miami (75%)	Lexington (80%)
	Detroit (75%)	Cincinnati (86%)
	Phoenix (79%)	Little Rock (85%)
	San Antonio (73%)	Tucson (88%)
	Billings (74%)	Sioux Falls (82%)
	Fargo (74%)	Salt Lake City (81%)

Note: Los Angeles, New York, and Hartford are not included in this table. In the Los Angeles meeting, the responses were modified based on participants' comments in the meeting. As a result, only 16 percent answered "yes" to the question, while 78 percent of the participants chose a third option that was offered by participants—that everyone automatically would have coverage under a national system, so, according to participants, the question was not applicable. For the same reason, the question was not completed in the New York meeting. In the Hartford meeting, the majority of participants abstained.

Several common themes emerged when individuals discussed why they supported requiring everyone to have health care coverage. Some participants expressed the opinion that those who are able should pay their fair share. At meeting sites throughout the country, individuals made the analogy to the law that requires everyone who drives to have automobile insurance. They believed that health coverage should be treated similarly since everyone uses health services. Additional analogies included laws requiring seat belt use and vaccinations, as expressed by meeting participants in Miami. Participants in community meetings in places such as Jackson and Denver that supported an "individual mandate" (in other words, a law requiring all individuals to have health insurance coverage) said it would be consistent with the philosophy of individual responsibility.

"Enrolling everyone in a single pool would spread costs and yield savings."

(Providence meeting)

"There should be progressive rates for health care, based on ability to pay, through income taxes, as part of a single- payer system."

(Hartford meeting)

"*All individuals should carry their own health insurance as they do for car and property. Insurance companies should be forced to insure individuals rather than corporate entities and employer groups*."

(Comments submitted to CHCWG Internet "What's Important to You?")

Younger Americans Weigh in on the Issues

Over 100 students in an undergraduate public health class at Purdue University participated in the University town hall meeting as part of a class assignment. They completed the University town hall poll, and explained their responses to questions about policy options in essay questions.

Compared to older respondents, the students were less likely to describe the health care system as being in a state of crisis (6 percent) or having major problems (61 percent). Most (88 percent) agreed or strongly agreed that it should be public policy that all Americans have affordable health care insurance or other coverage, and most (72 percent) said coverage should be provided for everyone, for a defined level of benefits. The students also opted, by a majority of 70 percent, for mandatory enrollment in some form of public or private coverage.

The majority (57 percent) thought some people should be responsible for paying more for coverage than others, with respondents most likely to state that the criteria for paying more should be either health behaviors or income. The most important priorities identified by the students for public spending on health and health care in America were guaranteeing that all Americans get health care when they need it through some sort of private or public program and investing in public health programs to prevent disease, promote healthy lifestyles, and protect the public during epidemics and disasters.

Although strong support for an "individual mandate" was found at each of the meetings, some participants disagreed. Others objected to the way the question was worded since they said it assumed implicitly that a national health care system would not exist. In fact, at the community meeting in Los Angeles, the vast majority of participants supported a new "third" option: that everyone automatically would have health coverage and access to care under a new national system. Participants who disagreed with the individual mandate concept expressed concerns that it would give greater power to the government and would undermine concepts of individual freedom. Someone at the Billings meeting noted, "[Montanans] don't like to be told what to do." Meeting participants also expressed uncertainty about how undocumented persons or non-citizens would be treated in the individual mandate system, with some saying these individuals should receive care, others maintaining that non-citizens should not be entitled to coverage.

The next commonly asked question related to whether people should pay more for health care and, if so, whether the amount they should be required to pay should be influenced by income or other factors:

"Should some people be responsible for paying more than others? What criteria should be used for making some people pay more?"

- **In almost every community meeting, a majority of participants supported the notion that some individuals should be responsible for paying more for health care than others**. The most commonly mentioned criterion for paying more was income, but varying payment by income was supported by the majority of participants in fewer than half of the meetings where this question was discussed. (See Figure 5.)

However, in many community meetings, no consensus emerged regarding who should pay more, as shown in Figure 6.

- The most popular choice of criteria was *income*. In other words, those with higher incomes should pay more than those with lower incomes. Some participants argued that those with very low incomes should not have to pay anything for their care. A July 2006 Wall Street Journal Online/Harris Interactive Poll found that 39 percent of adults agree that the higher someone's income is, the more he or she should expect to pay in taxes to cover the cost of people who are less well off and are heavy users of medical services.[13]

- The next most popular criterion often was health behaviors. Such a system could be structured either by reducing health insurance costs for those who practice healthy lifestyles (for example, exercising regularly, not smoking, wearing seat belts, etc.), or by increasing health care co-payments or premiums for those who practice unhealthy behaviors, such as smoking. (*In three of the community meetings, the choice "other" was changed to "other/combination of factors,"*

which could include both income and health behaviors, as well as other factors.) According to a Wall Street Journal Online/Harris Interactive Poll conducted in July 2006, more than one in three agreed (35 percent) but another 35 percent disagreed that it is unfair to require the majority of people who are healthy to pay for most of the cost of treating those who are sick and heavy users of hospitals and doctors.[14]

Figure 5:
Should some people be responsible for paying more than others?

Percent Saying "Yes":		
Less than 60%	**60-69%**	**70% or More**
Indianapolis (58%) Sacramento (43%)	Orlando (64%) Baton Rouge (60%) Memphis (66%) Jackson (60%) Denver (66%) Miami (63%) Phoenix (65%) Tucson (61%)	Kansas City (72%) Charlotte (72%) Seattle (77%) Providence (79%) Detroit (81%) Des Moines (73%) Philadelphia (83%) Billings (76%) Salt Lake City (80%)

Note: This question was asked only in the above cities. In most meetings where this question was asked, participants were also asked which criteria should be used. In some meetings, however, *only* the question about criteria was asked. See the next question below.

Over 80 percent of respondents in the University town hall meeting said that some people should be responsible for paying more for coverage than others, and about 71 percent said income should be used as a criterion for making people pay more.

Figure 6:
What criteria should be used for requiring some people to pay more?

Location	None—everyone should pay same	Vary by Family size	Vary by health behaviors	Vary by income	Other	Other/ Combination
Orlando	21%	6%	15%	41%	17%	Not asked
Baton Rouge	6%	15%	27%	44%	8%	Not asked
Memphis	15%	3%	11%	58%	14%	Not asked
Charlotte	12%	1%	27%	32%	27%	Not asked
Jackson	26%	4%	19%	38%	13%	Not asked
Denver	16%	4%	16%	57%	8%	Not asked
Los Angeles	20%	4%	11%	51%	15%	Not asked
Providence	20%	2%	27%	45%	6%	Not asked
Indianapolis	16%	4%	29%	47%	5%	Not asked
Detroit	12%	7%	7%	69%	7%	Not asked
Phoenix	26%	2%	12%	52%	8%	Not asked
Des Moines	17%	4%	16%	61%	3%	Not asked
Philadelphia	8%	5%	7%	70%	10%	Not asked
Billings	12%	7%	29%	44%	8%	Not asked
Fargo	6%	1%	11%	21%	--	61%
Little Rock	11%	5%	6%	15%	--	62%
Tucson	18%	0%	18%	50%	13%	Not asked
Sioux Falls	13%	3%	23%	10%	--	52%
Salt Lake City	9%	4%	23%	59%	6%	Not asked

Note: Figures may not add up to 100 percent due to rounding. Question was not asked in Kansas City, Seattle, Miami, Albuquerque, Hartford, Las Vegas, Eugene, Sacramento, San Antonio, New York, Lexington, or Cincinnati.

On the Working Group poll, there were multiple questions about how higher income people might pay more for coverage. About 40 percent (38 percent) of respondents agreed or agreed strongly that everyone should pay the same for health insurance, while **44 percent disagreed or strongly disagreed**. When asked whether people with higher incomes should pay higher premiums for employer-sponsored health insurance, 37 percent agreed or strongly agreed, while **43 percent** of respondents **disagreed or strongly disagreed**. Moreover, about one-third (34 percent) of respondents agreed or strongly agreed that higher income people should pay higher premiums for health insurance they buy themselves, compared to 45 percent who disagreed or strongly disagreed.

The level of support for higher-income people paying more for health insurance they purchase themselves was similar across education levels of the people responding to the Working Group poll. A **large share of respondents disagreed or strongly disagreed.** These findings may reflect the view, also heard at many meetings and in comments submitted via the Working Group poll, that there is some support for higher contributions from higher-income people, but there is less support for direct income-related cost-

sharing or premiums than there is for contributions to a national coverage system through some form of progressive tax, as discussed below.

According to a recent Los Angeles Times/Bloomberg survey 34 percent of adults believe that it is the government's responsibility to ensure that all citizens have health insurance and income for retirement, while 28 percent believe that it is the employer's responsibility and 28 percent believe that it is the individual's responsibility. [15]

The following question generated substantial debate at many of the meetings:

"Should public policy continue to use tax rules to encourage employer-based health insurance?"

As shown in Figure 7, the percent of individuals who agreed with this question varied greatly from meeting site to meeting site. In the Detroit community meeting, only 23 percent of participants supported a continuation of the use of tax rules to encourage employer-based health insurance, while 87 percent of those at the Baton Rouge community meeting agreed with the policy. In a number of meetings, some participants abstained from answering the question, in many cases because of frustration with the way the question was worded, as was the case with the previous two questions. In five of the community meetings, an "abstain" option was provided to participants.

A different question, focusing on whether employers should be given additional incentives to *expand* coverage, was asked in both the Working Group's poll and the University Internet town hall meeting. Support for tax incentives for employer-sponsored coverage as a means of expanding coverage was relatively high. Almost 70 percent (69 percent) of Working Group poll respondents and 61 percent of University town hall meeting respondents agreed or strongly agreed with the strategy.

Figure 7:
Should public policy continue to use tax rules to encourage employer-based health insurance?

Percent Saying "Yes":		
Less than 30%	**30-49%**	**50% or More**
Memphis (29%)	Kansas City (36%)	Orlando (60%)
Providence (27%)	Seattle (32%)	Baton Rouge (87%)
Detroit (23%)	Denver (39%)	Charlotte (62%)
Hartford* (15%; 41% abstained)	Los Angeles (37%)	Jackson (72%)
Des Moines (24%)	Indianapolis (31%)	Miami (67%)
Las Vegas (25%)	Albuquerque (39%)	Phoenix (53%)
San Antonio* (14%; 48% abstained)	Philadelphia (32%)	Lexington* (63%; 18% abstained)
	Eugene (32%)	
	Billings (46%)	Cincinnati (50%)
	Fargo* (44%; 27% abstained)	Tucson (50%)
	Little Rock* (42%; 23% abstained)	Salt Lake City (53%)

Note: Question was not asked in Sacramento, New York, or Sioux Falls. * "Abstain" option provided.

- **Views about employer-based coverage did not generally reflect a deep distrust of employers, but instead were intertwined with broader concepts of health reform**. The extent to which participants at a meeting may have been more heavily focused on fundamental reform, like a single-payer system, affected the group discussions about employer-based coverage. An analysis of Internet and mailed-in, open-ended responses to the question about changing the way health care is financed, as well as comments from participants at some community meetings, revealed at least four—sometimes overlapping—categories of responses.

- ***"The current system should be maintained or bolstered, either on an ongoing basis or as part of a more comprehensive system***." Some meeting participants supported a clear role for employers and a continuation of the current tax rules for employers. Some participants who supported retention of these tax rules argued that they needed to be applied fairly, with small businesses needing additional incentives. Meeting participants who supported comprehensive reform through some type of national plan told the Working Group that, in the absence of a national plan, employers would need to be responsible, with tax breaks provided to assist small businesses. Without a national plan, participants worried that people across the country would lose coverage through employers dropping insurance. In the community meeting in Los Angeles, participants who supported continuing the current tax system did so because they believed it encourages employers to provide

"I do believe all employers large and small should give their workers insurance. There should be programs or better tax cuts for those employers."

"[Expand] tax incentives for companies that provide health care benefits for their employees. Small companies should be able to join together to take advantage of group rates. Corporations like Wal-Mart should be penalized for not providing decent health care benefits for its employees."

"If employers are to continue to provide coverage, all employers must participate, nationwide."

"I think that placing the burden of health care on employers makes American businesses less competitive in the global market. At the same time, I think that placing the burden of paying for health care on individuals will ultimately drive up the cost of care by forcing the poor and middle-income among us to rely on costly emergency services that hospitals cannot ethically deny based on inability to pay, rather than cheaper preventive care which they can."

"We must sever the relationship between health insurance and employment. Employers should not bear the cost; it is impacting our competitiveness in the global market and it leaves huge gaps in which persons not employed in a company providing health insurance, are forced to bear huge costs of non-group insurance or, most likely, go without insurance at all. The rising percentage of uninsured is a tragedy in itself because these people frequently go without needed health care until they reach crisis. In addition, we all pay for the uninsured through higher and higher insurance premiums. Our system must be completely overhauled and redesigned to provide universal coverage with buy-in by all who have the means and a safety-net for those who can not."

(Comments submitted to CHCWG "What's Important to You?")

coverage that they might otherwise not have an incentive to provide. They also felt that the system leads to higher employer productivity and helps promote shared responsibility.

- ***"Employer-based insurance is not sustainable and is too expensive."*** Many participants felt the nation should move away from current tax rules that favor employer-sponsored coverage. Even with the current tax breaks, health care costs continue to rise rapidly, and both businesses and employees are footing ever larger and unsustainable expenditures. Some meeting participants believed that the system of employer-based health insurance needs to be replaced to make U.S. industries more competitive. At least one person noted that the employer subsidies were invisible to the average citizen, unlike Medicare or Medicaid, whose costs are frequently cited. Other participants noted that they were afraid to leave their jobs because of fear of losing health insurance or paying higher premiums. Those who opposed the current tax breaks cited a lack of equity in the current employer-based insurance system, a system that, as long as it exists, means that health care, as stated by someone at the Indianapolis meeting, will be, "an imperfect patchwork full of gaps."

- ***"The whole system should be changed fundamentally, but employers should contribute through some form of taxation or contributions to a pool."*** Other participants indicated an interest in a non-employer based system, but one in which the employers are still involved. For example, in the Des Moines community meeting, a participant referred to the employment-based system as "…outdated and the money saved from not having an employer-based system could go towards higher salaries and/or taxes to create a new system." Some participants at different meetings supported fundamental change to the system, but believed that a transition period should be implemented during which employers would still contribute to the system.

> *"We need to have one single pool of Americans who are insured. This would help spread their risk and everyone could be covered. Employers could contribute to the costs, but individuals should be able to contribute on their own."*
>
> (Comments submitted to CHCWG Internet "What's Important to You?")

- ***"Employer-based insurance is unfair, inequitable, and inadequate."*** A number of participants discussed other aspects of the employer-based system that were not working. For example, participants brought up the fact that some employers are going around the current tax system by hiring only part time employees, to whom they are not required to offer full benefits. In the Los Angeles meeting, many participants supported a government-run universal health care system because they felt that the current employer-based system is unfair. They expressed concerns that it excludes self-employed, unemployed, and part-time workers, and favors large corporations. These participants supported replacing the employer tax

> *"Employer-sponsored insurance worked when it was a perk, an extra offered by employers. But now coverage is a necessity, not a privilege."*
>
> (Billings meeting)

incentive with another type of tax (such as an income or payroll tax). At several meetings and in Internet comments, some called for a national value added tax[1] or national sales tax. A large number of participants expressed the opinion that access to care should not be tied to insurance coverage.

At some meetings, participants were asked what the responsibilities of individuals and families should be in a health care system. Although some of these topics will be discussed under the next question typically asked in community meetings ("What can be done to slow the growth of health care costs?"), the following section provides a brief summary of three of the most common responses to the question:

"What should the responsibilities of individuals and families be in the health care system?"

Three of the most common answers heard by the Working Group in response to this question were the following:

- **At most meetings, participants stressed the importance of preventive care to reduce health care costs**. Preventive care includes getting important screenings, exercising regularly if possible, and following a healthy diet. Some individuals said that practicing preventive care would lower health care costs.

- **Participants at most meetings believed that individuals have a responsibility to manage their own care and use of services**. Participants told the Working Group that doing so involves educating oneself, possibly through attending health education classes. It also involves being proactive in seeking better care and becoming wise, informed consumers of health care services and following treatment regimens. However, a number of participants noted that some people are better equipped to be informed consumers than others.

- **In many meetings, participants mentioned that individuals have a social responsibility to pay a fair share for health care**. Participants in the Memphis and Las Vegas meetings, among others, mentioned that, in a universal health system, this would include paying appropriate and possibly additional taxes.

The Working Group poll also shows some support for strategies that focus attention on the costs and appropriate use of health care. A majority of respondents either agreed (37 percent) or strongly agreed (19 percent) that we should all pay for part of our health care costs so that we will be more careful about how we use health care services.

[1] A value added tax is a tax, levied at each stage of production, on the added value in each stage as firms produce goods or services. It is similar in some respects to a sales tax. Many industrialized nation employ various types of value added taxes. (See Bickley, James M. CRS Report for Congress Value-Added Tax: A New U.S. Revenue Source? Washington D.C: Congressional Research Service, August 22, 2006. Accessed at http://opencrs.cdt.org/rpts/RL33619.pdf.)

Hearing from self-employed small business owners

The National Association of Realtors hosted a community meeting during their annual legislative conference on May 16, 2006, in Washington, DC, to enable the Citizens' Health Care Working Group to hear from these self-employed small business owners from around the country. Participants at this meeting sought to identify solutions for the problems specific to self-employed small business owners. They recognized that more than one in four of the nation's 1.2 million realtors have no health care coverage, while many others are only a single health incident away from having their livelihood destroyed by high health care costs.

Recurring themes in this meeting included a desire to have protection from financial ruin, having access to affordable care, and increasing the information available for patients on cost and quality to enhance their decision-making capabilities. They emphasized the need for a level of security in the health care system, saying that "we need something that ensures that if we become very ill, it doesn't take away our livelihood or what we've worked so hard to earn all our lives." While most participants agreed that everyone should have access to basic health care services, they were rather evenly divided on whether or not people should be required to have health care coverage. One participant said that "at first I was going to say no (to a requirement), but then I thought, if they aren't required to sign up for it then the only time they will get in the system is when there is emergency care and that will cost us more." Desiring to keep health care "in the competitive arena," participants talked about the need to have greater transparency in costs, standardization of forms, and understandable information to enable them to be better patients. There was a clear sentiment at this meeting to limit government involvement, with participants asking "has it ever improved anything if the government gets involved and standardizes it?"

The next "typical" meeting question asked participants about ideas for reducing the growth of health care costs in this country:

"What can be done to slow the growth of health care costs in America?"

Participants had a variety of ideas about how they would slow the growth of health care costs. Throughout the meetings, common themes emerged:

- **Participants frequently stated that the problems of high costs rest with "price setters"—namely, prescription drug companies, insurers, and for-profit providers**. In meetings throughout the country, participants mentioned the desire to limit profits in the health care sector. Some participants also noted that allowing the government broader authority to negotiate prices with pharmaceutical companies would reduce Medicare costs. The Working Group poll showed strong support for government setting limits on prices for health care products such as prescription drugs or medical devices; just over 70 percent of respondents strongly agreed (39 percent) or agreed (32 percent) with these

government-set limits. The general lack of trust of for-profit health care expressed in the community meetings is consistent with other national survey findings. For example, a December 2003 Wall Street Journal Online Health Care Poll found that most of the public do not view health care as a business that should be driven by the profit motive, and only 22 percent would prefer that for-profit insurance provide most health insurance; the findings indicated a preference for government (31 percent) or non-profit organizations (25 percent).[16]

- **A commonly expressed view was that a simpler system would result in lower administrative costs**. Participants believed that a more straightforward health care system would reduce administrative costs by eliminating duplication of services. At a number of meetings throughout the country, many individuals advocated a single-payer system to eliminate the middleman, possibly one structured like Medicare or similar to the public school system. Under this type of system, everyone would pay taxes to support the system, even though, as with education, they might not use the services. Participants advocating the single payer concept said it would be the most efficient way to organize health care.

> *"I paid over $12,000 in expenses (not including legal fees) to collect $12,500 in medical expenses because insurers were arguing about who was responsible. Everyone wants to avoid paying. It would be vastly cheaper to adopt any of the European systems."*
>
> *"I think we'll finally, inevitably, follow the lead of every other Westernized nation and institute some form of extensive public health care system – I think it's the most efficient system, and the one that gives the best care to the most people. The biggest problem I see with the system as it now stands is that we as a society spend a huge amount of money putting a profit in the pockets of the 'middleman' in the system—the insurance companies. That's why we spend 50% more of our GNP on health care than other nations do while getting worse care, and it's absurd."*
>
> (Comments submitted to CHCWG Internet "What's Important to You?")

- **Some support exists for investment by providers and the private sector in health information technology to increase system efficiency**. At a number of meetings, participants supported increasing the availability of electronic medical records. Greater investment in health information technology and moving to an integrated system of electronic medical records could improve administration and treatment and reduce medical errors, according to views commonly expressed at the meetings. More than 70 percent (71 percent) of respondents to the Working Group poll supported more investment by doctors, hospitals, and other providers in health information technologies as a means to improve quality and increase administrative efficiency. (By comparison, a 2005 Wall Street Journal Online/Harris Interactive poll found that 78 percent of the public supported doctors' use of electronic medical records.)[17]

A concern discussed at some meetings was privacy of the electronic medical records, which is highlighted in recent national surveys. For example, a 2005 Harris Interactive poll found that 70 percent of Americans are very or somewhat concerned that personal medical information might be leaked due to weak data security, and the public was evenly divided on whether the potential benefits of electronic medical records outweigh the potential risks to privacy.[18]

Public investment in health information technology was not identified as among the priorities for public spending on health and health care by most Internet poll respondents (see Appendix C).

- **Participants expressed general support for individuals playing their part in controlling utilization and costs**. Individuals have a responsibility to be informed health care consumers and comply with recommended treatments. To this end, participants suggested several related ideas:
    - **Individuals would like information about how to use health care better and more effectively**. For example, those with chronic diseases could use more information to properly manage their treatments.
    - **At some meetings, participants supported providing incentives to patients to engage in healthy behaviors.** Some participants supported the idea of rewarding people who practice healthy behaviors (for example, not smoking, or getting recommended health screenings). On occasion, participants also discussed the notion of penalizing people who engage in unhealthy lifestyles. The type of unhealthy behavior in question affected participants' opinions, consistent with other national surveys. According to a 2005 Wall Street Journal Online/Harris Interactive poll, the majority of Americans supported the idea of smokers, those who do not wear seat belts, and those who drink alcohol heavily paying more in health insurance costs; however, the same poll found strong opposition for charging more to those who are overweight or who do not exercise regularly.[19] According to a 2006 Wall Street Journal Online/Harris Interactive poll that compared results from the same poll in 2003 to the results in from the 2006 poll, in 2006 53 percent of adults agreed that it is fair to ask people with unhealthy lifestyles to pay higher insurance premiums than people with healthy lifestyles; while in 2003 only 37 percent of adults agreed. [20]
    - **Participants expressed preferences for using medical evidence to decide which services are covered and provided.** Many participants discussed the importance of focusing on evidence-based medicine.
    - **There was general support for controlling prescription drug costs by limiting direct-to-consumer advertising of prescription drugs and using more generic drugs, when medically appropriate.** Participants at many meetings expressed the desire to limit or prohibit direct-to-consumer advertising of prescription drugs, which could reduce the over-use of heavily-advertised drugs and slow the growth of health care costs. Some people mentioned ideas to make generic drugs available more quickly in

the market; for example, Orlando community meeting participants suggested reducing the length of time of the exclusive patent rights of pharmaceutical companies.

- **Support also existed for limiting expensive yet "futile" end-of-life care and instead providing palliative care.** Participants at meetings generally recognized the high costs associated with certain end-of-life services, some providing little value to the patient despite their high costs. At the same time, they stressed the importance of pain management, hospice care, and other support services to improve the quality of the last days of life. Better communication with patients near the end of life was considered to be an important step in controlling these costs. Participants in some meetings stressed the importance of living wills and medical directives that detailed people's wishes for treatment if they were too ill to communicate. At many meetings, similar concerns were expressed about the effectiveness and costs of care for very fragile newborns.

> "*We should have the decency to honor end of life by not pumping millions into the last days but rather encouraging high quality comfort care."*
> (Sioux Falls meeting)

- **In almost all community meetings, participants expressed the belief that changing the culture from sick care to well care—namely, by focusing on prevention, wellness, and education (in general, and health education in particular)—will reduce health care costs**. Participants broadly supported greater emphasis on prevention as part of a "culture of wellness" in the health care system. A number of participants in community meetings across the nation (including Des Moines, Fargo, Salt Lake City, Las Vegas, and others) emphasized the need for education of both children and adults to make this culture possible.

> "*If we want to bring the cost of health care down, then ultimately, we need to reduce the burden of disease. We need to reduce the need to spend money rather than figuring out how to redistribute the money. Otherwise the system will remain broken regardless of how we want to pay for it."*
> (Indianapolis meeting)

- **A commonly expressed view was that better use of advanced practice nurses and other non-physicians could save money and improve quality**. In some meetings, participants supported the increased use of care provided by health professionals other than physicians including greater use of home-based care.

- **Participants believed that investing in public health would pay dividends in terms of reducing health care costs.** Some people discussed providing more funding for community health centers and for public health more generally. They believed that doing so could reduce racial differences or disparities in health care, and could effectively reduce overall system costs.

- **Support for limits on malpractice was expressed at some community meetings.** Some participants discussed decreasing malpractice costs.

End-of-life care has surfaced at virtually every community meeting as an issue that encapsulates many of the frustrations with health care in America. Sometimes meeting attendees discussed the need for hospice care in the basic benefit package. Sometimes participants talked about exchanging expensive measures of questionable efficacy for the dying for general improvements in access to care. Usually, the speaker raising the issue has been a bit tentative. "I'm not sure how to phrase this…" or "This sounds clumsy…" Death is a difficult topic among family and friends; it's also difficult in a policy context.

At its Boston hearing, the Working Group heard a panel of experts on end-of-life care. This discussion was compelling, and members asked that a community meeting be held on the topic (information on the presentation can be found in Appendix E). This special topic meeting was held March 31, 2006 in Hanover, New Hampshire. About 120 people attended. "Living Well through the End-of-Life" was the theme of the meeting. The last chapter of many people's lives requires support and assistance, but often what is needed to live well is not medical in nature. Transportation, personal care, and help with meals and cooking are all needed. What people attending the meeting feared most about their final days (or those of someone close to them) were intractable pain, "prolongation of death," and losing personal control. They identified potential challenges related to "getting the system to work for you when you are dying" or "graceful surrender." What people wanted most from the medical system was to have their choices honored, good pain relief, and respect from health professionals so they could maintain their dignity.

The majority believed that family and friends are the primary sources of such help, but that some paid assistance should also be available. People would like respite services for the principal care provider and a contact person for coordination of community help. "Care has to be taken out of the medical system and accommodate what happens in the community." Most people (69 percent) wanted to die at home. Close to 85 percent believed that other choices could be acceptable if certain elements of care were well managed.

When asked what policy advice they'd give their Senators, participants had many specific suggestions, such as realigning financial incentives so that physicians could be encouraged to spend more time talking to patients and a request to revisit Medicare hospice payment practices. However, suggestions quickly began to mirror what has been heard in other meetings. *"As a health care consumer, I want appropriate, timely, comprehensive care from conception to death and I would be willing to pay an additional modest percentage of income across my working life to achieve this.*"

IV. What trade-offs are the American public willing to make in either benefits or financing to ensure access to affordable, high-quality health care coverage and services?

The last of the four questions that the legislation directed the Working Group to ask the American people is about trade-offs they are willing to make so that everyone has access to affordable, high-quality care. In community meetings, the "typical" structure was to ask participants to discuss their willingness to pay to achieve this goal, evaluate the most important priorities for public spending on health care, consider specific trade-offs the public would be willing to make, and then to evaluate potential approaches for improving access to affordable, high quality health care for all Americans. In many meetings, time constraints or the desire by participants to reiterate their support for broad system reform precluded discussion of some of these questions.

Many comments submitted to the Working Group via the poll provide additional context for understanding what we heard about trade-offs. Although worded in a variety of ways, the single most common response to the question about trade-offs can be summarized as "no trade-offs." The discussions at the community meetings provided context for what people really were saying, which is far more complicated.

The discussion at meetings was divided into several parts. One set of deliberations at the meetings focused specifically on paying for expanded coverage.

"*That is too broad a question. There is the wealthy American public who have lots of options right now. There is the less wealthy American public who have enough income to take some of the available options. There is the working American public who can just barely afford any available options. And there is the American public who can not afford any of today's health care options. And each group will have very different ideas about what they are willing to give up or 'trade-off' to get affordable, good quality health care. Even the concept of 'quality' health care is a relative term -- any reasonably trained and mostly competent doctor looks good when your choice is that doctor or no treatment at all. What all Americans should want is at least the quality and availability of care that countries like Canada, France, England, etc. offer.*"

(Comments submitted to CHCWG "What's Important to You?")

"Eliminate profits in the health care system to pay for universal coverage."

(New York City meeting)

"Eliminate medical middlemen (insurance companies) and direct-to-consumer advertising by pharmaceutical companies in exchange for universal health care."

(Hartford meeting)

"How much MORE would you be willing to pay (taxes, premiums, co-payments, or deductibles) in a year to support efforts that would result in every American having access to affordable, high quality health care coverage and services?"

- **In most meetings as well as on the Working Group poll, a majority of participants expressed a willingness to pay more to assure that everyone had access to affordable, high quality health care. Overall, about one in three (29 percent) said they were willing to pay $300 or more per year.** Sizable shares of participants expressed a willingness to contribute *some* additional amount each year toward the stated goal. (See Figure 8.) Although the size of the groups varied, some participants at all meetings said they would be willing to pay an additional $1,000 or more in a year. The Working Group poll indicated that 12 percent would be willing to pay $1,000 or more per year (in taxes, premiums, or deductibles) to support efforts that would result in access to affordable, high-quality health care services and coverage for all, and 17 percent would be willing to pay an additional $300 to $999. Another 19 percent said they did not know, and 13 percent said they would not be willing to pay anything extra.

"For those that already have health care, I believe many are willing to pay a little more for that benefit if they can be guaranteed that the extra would be put towards providing health care for those less fortunate; most of us have been in the position of having no health care at one time or another in our lives. For those that don't currently have health care, there can't be much they can trade".

"I think that most people would be willing to accept a national value added or national sales tax to fund a nationalized medical system that treats all legal citizens fairly and equally, without financial or any other kind of discrimination."
"Phase it in. Universalize a small sector of health care--for example, preventive care--before trying to redo the entire system. If the public learns to trust a small sector of tax-financed health care, it will be more open to greater change."
"It should be underwritten by the government, with sliding scale of payments made by individuals through taxes - people who make the most should pay the most to insure that health care is available for all; employers should also contribute through the taxes they pay."
Comments submitted to CHCWG "What's Important to You?")

In the Working Group poll, the amount they were willing to pay was fairly consistent across age; however, persons with the highest levels of education (those with graduate degrees) were more likely to be willing to pay $1,000 or more than those with less education, a finding that could indicate that those likely to have more money are willing to pay more. It may also reflect that those with higher levels of education typically have richer employer-sponsored insurance packages, face lower out-of-pocket payments, and therefore have not already reached their limit in terms of willingness to pay. At the meeting with realtors (see "Hearing from self-employed small business owners**"** text box

presented earlier), where few have any employer-sponsored insurance and face high premiums in the individual market, a large percentage were not willing to pay anything more, even though they earn relatively high incomes. Even so, in the 28 meetings where the question was asked, at least 43 percent of participants indicated some willingness to pay more to achieve this goal.

Figure 8:
Amount Willing To Pay in a Year So That Every American Has Access to Affordable, High-Quality Health Care

Location	$0	$1-$99	$100-$299	$300-$999	$1,000+	Don't Know
Kansas City	7%	12%	19%	24%	25%	14%
Orlando	18%	11%	20%	15%	17%	20%
Baton Rouge	9%	20%	20%	26%	20%	7%
Memphis	31%	2%	4%	13%	31%	19%
Charlotte	45%	8%	11%	10%	16%	11%
Jackson	34%	16%	15%	13%	5%	18%
Denver	12%	16%	17%	24%	25%	6%
Los Angeles	38%	14%	9%	10%	11%	19%
Providence	24%	8%	21%	16%	24%	8%
Indianapolis	12%	15%	15%	16%	22%	20%
Detroit	10%	13%	15%	21%	33%	8%
Albuquerque	22%	8%	18%	18%	24%	10%
Phoenix	19%	15%	20%	19%	20%	7%
Hartford	20%	10%	13%	27%	22%	8%
Des Moines	14%	12%	15%	31%	20%	9%
Philadelphia	9%	12%	12%	13%	28%	25%
Las Vegas	15%	18%	21%	20%	16%	11%
Eugene	13%	12%	12%	18%	33%	12%
San Antonio	8%	15%	23%	20%	19%	15%
Billings	15%	16%	19%	19%	21%	10%
Fargo	11%	16%	30%	16%	13%	14%
New York	25%	3%	6%	13%	36%	16%
Lexington	11%	15%	18%	29%	20%	6%
Cincinnati	24%	19%	15%	10%	12%	19%
Little Rock	14%	26%	23%	18%	7%	12%
Tucson	23%	19%	0%	29%	13%	16%
Sioux Falls	6%	16%	16%	25%	28%	9%
Salt Lake City	23%	14%	20%	25%	11%	6%
AVERAGE	**19%**	**14%**	**16%**	**17%**	**19%**	**14%**
Working Group Poll	***13%***	***17%***	***21%***	***17%***	***12%***	***20%***

Notes: Figures may not add up to 100 percent due to rounding. The "don't know" data for the Working Group poll includes the one percent that did not respond. Question was not asked in the Seattle, Miami, or Sacramento community meetings.

The next question asked the public about its views on what should be the most important priority for public spending for health care:

"Considering the rising cost of health care, which of the following should be the most important priority for public spending to reach the goal of health care that works for all Americans?"

At community meetings throughout the country, participants were asked to consider a list of possible priorities for public spending to reach the goal of health care that works for all Americans. In some of the meetings, participants were asked to give the most important priority of those listed, while in other meetings participants were asked to rate each priority on a scale from 1 (low) to 10 (high). The list presented at the meetings generally included the following items: guaranteeing that there are enough health care providers, especially in areas such as inner cities and rural areas; investing in public health programs to prevent disease, promote healthy lifestyles, and protect the public in the event of epidemics or disasters; guaranteeing that all Americans have health insurance; funding the development of computerized health information; funding programs that eliminate problems in access to or quality of care for minorities; funding biomedical and technological research; guaranteeing that all Americans get health care when they need it, through some form of public or private program, including "safety net" programs for those who cannot afford care otherwise; and preserving Medicare and Medicaid.

Although the phrasing of the question and the options given were not exactly the same across the community meeting sites and the Working Group poll, the top priorities were consistent:

- **When asked to rank or choose among competing priorities for public spending on health, meeting participants—with few exceptions—were most likely to rank *"Guaranteeing that all Americans have health coverage/insurance"* at the top of the list.** In the Working Group poll, 64.6 percent chose this as among the top three priorities for public spending on health.
- Other spending priorities in the list that tended to score high included:
    - Investing in public health programs to prevent disease, promote healthy lifestyles, and protect the public in the event of epidemics or disasters
    - Guaranteeing that all Americans get health care when they need it, through some form of public or private program, including "safety net" programs for those who cannot afford care otherwise
    - Guaranteeing that there are enough health care providers, especially in areas such as inner cities and rural areas , and
    - Funding programs that eliminate problems in access to or quality of care for minorities.

It is important to note that each of the eight options provided by the Working Group likely would receive support from the public if polled separately, even if it did not rank as the *highest* priority among the group. For example, "funding the development of computerized health information" and "funding biomedical and technological research" generally did not rank among the highest priorities, though discussions at Working Group meetings frequently emphasized their importance. Similarly, individuals selecting other options as most important (such as "guaranteeing that all Americans have health

insurance") would likely be in favor of strengthening Medicare and Medicaid as part of the broader health care structure that would cover all Americans.

It is also important to note that support for *any* of the particular proposals could change dramatically when the list of potential priorities was modified, as occurred in two meetings. In the Hartford meeting, where participants were asked, "Which is your first priority?" discussants there added a ninth priority to the list: "*Guaranteeing that all Americans have quality health care*." When this option was included in the list of options, a full 80 percent of participants selected it rather than the options ranked highly elsewhere. For example, although the option, "Guaranteeing that all Americans have health coverage" ranked as the second highest priority in the list, it was selected by only 8 percent of participants. "Guaranteeing that all Americans get health care when they need it" also was selected by 8 percent of respondents, and no other option generated more than one vote. Similarly, in the Billings meeting, audience members requested a word change of one of the choices to include "*Guaranteeing that all Americans have health care*." In this meeting, participants were asked to rate each priority on a scale from 1 (low) to 10 (high). When this option was added, it ranked higher than any other option.

Paying More Taxes for Health Care for All:
Evidence from Other National Polls

- A poll conducted in December 2004 by The Pew Research Center for the People and the Press found that 65 percent of Americans favor or strongly favor the U.S. government guaranteeing health insurance for all citizens, even if it meant raising taxes (Pew); an earlier poll conducted in August 2003 also by Pew from the same polling group also found that 67 percent favored guaranteeing health insurance to all citizens even if it meant raising taxes.[21]
- A 2003 CBS News/New York Times poll showed that 81 percent of respondents favored using potential tax cut money to ensure all Americans have access to health insurance, whereas 14 percent indicated a tax cut should be a higher priority.[22]
- A 2003 poll found that 79 percent of Americans believed it is more important to provide health care coverage for all Americans, than to hold down taxes. (ABC/Washington Post).[23]

The next question often asked at community meetings was met with resistance at most meetings, sometimes by many of the participants:

"Some believe that fixing the health care system will require trade-offs from everyone—for example, hospitals, employers, insurers, consumers, government agencies. By 'trade-off' we mean reducing or eliminating something to get more of something else. On a scale from 1 (strongly oppose) to 10 (strongly support), please rate your support of each of the following trade-offs. What are some other examples of trade-offs that you would support?"

In many of the meetings, the Working Group provided a list of specific trade-offs for participants to evaluate:

- Accepting a significant wait time for non-critical care to obtain a 10 percent reduction in health care costs
- Paying a higher deductible in your insurance for more choice of physicians and hospitals (or paying a lower deductible with less choice)
- Paying more in taxes to have health care coverage for all. This could mean limiting coverage to high deductible/ catastrophic care or, if you were willing to pay more, a more comprehensive package
- Expanding federal programs to cover more people, but providing fewer services to those currently covered in those programs
- Limiting coverage for certain end-of-life care of questionable value in order to provide more at-home and comfort care for the dying
- Having government define benefits and set prices versus relying on free market competition by doctors, hospitals, other health care providers, and insurance companies.

> *"I would be more willing to pay more in taxes to assure that everyone has access to good healthcare if I could be assured that the medical care system was based on fair practices and was not influencing politics. I would be thrilled to see Americans embrace a healthier lifestyle. That is a trade-off that doesn't cost much. People seem to believe that they can just take a pill or wait for some breakthrough to solve their health problems. Public schools need to bring back physical education and increase activity, cities need to become more pedestrian/bicycle-friendly. This country can help provide the opportunity to MAINTAIN good health instead of fixing the problems of poor health; - it would be a lot cheaper. I'd be willing to pay more in taxes for things like that."*
>
> (Comments submitted to CHCWG "What's Important to You?")

In a number of meetings, participants voiced support for limiting coverage for end-of-life care of questionable value in order to provide more at-home and comfort care for the dying. This option received strong support in both the Working Group poll and the University town hall meeting—59 percent and 63 percent, respectively, agreed or strongly agreed with the proposal. The proposal generally receiving the lowest level of support was "expanding federal programs to cover more people, but provide fewer services to persons currently covered by those programs." In the Working Group poll, for example, only 17 percent of respondents agreed or strongly agreed with this proposal. In the University town hall meeting, 24 percent agreed or strongly agreed.

Individuals at many, if not all, community meetings argued that there were enough resources in the system already to achieve a goal of health care that works for all Americans, that resources just need to be redistributed. Most, however, did not think that the resources needed to be redistributed away from services provided to them; rather, they wanted to see reductions in waste, fraud, and (unnecessary) profit. In other cases,

participants thought that the trade-offs should come from outside the health arena. For example, at the Los Angeles community meeting, participants developed and voted on their own list of specific trade-offs they would be willing to support. The only two choices that garnered majority support were: (1) No trade-offs—the American people already pay more than enough to fully fund a single-payer universal plan; and (2) Trade war for health care—cut from defense and homeland security budgets. In Las Vegas, the participants opted for "re-evaluating federal spending priorities."

Despite the resistance to this particular question, the meeting participants did discuss various trade-offs (without using that term) in previous sections of the meeting. For example, as noted above, many participants expressed a willingness to pay more so that everyone had care. Many participants also told the Working Group that individuals should play a larger role in their health and health care. More than one in three people filling out the Working Group's Internet poll said they would be willing to pay a higher deductible in exchange for more choice of providers and services. This level of support for a trade-off of out-of-pocket costs for choice was actually slightly higher than the 2004 National Opinion Research Center at the University of Chicago (NORC) national survey finding that 27 percent of respondents would be willing to accept a higher deductible in exchange for fewer restrictions on use. The NORC results varied by income: 40 percent of Americans with household income of $75,000 or more would accept a higher deductible, compared with 23 percent with income below $25,000.[24] The Working Group was not able to analyze the relationship of income to its participants' responses.

The final substantive question at meetings asked people for their opinions on a range of fairly specific yet broad proposals for ensuring access to affordable, high quality health care coverage and services for all Americans:

"If you believe it is important to ensure access to affordable, high-quality health care coverage and services for all Americans, which of these proposals would you suggest for doing this?"

As with the previous question, participants at the community meetings were asked to evaluate a list of proposals. In this case, participants were asked to evaluate ten proposals on a scale from 1 (low) to 10 (high). Proposals included: offer uninsured Americans income tax deductions, credits, or other financial assistance to help them purchase private health insurance on their own; expand state government programs for low-income people, such as Medicaid and the State Children's Health Insurance Program (SCHIP), to provide coverage for more people without health insurance; rely on free-market competition among doctors, hospitals, other health care providers, and insurance companies rather than having government define benefits and set prices; open up enrollment in national federal programs like Medicare or the federal employees' health benefits program; expand current tax incentives available to employers and their employees to encourage employers to offer insurance to more workers and families; require businesses to offer health insurance to their employees; expand neighborhood health clinics; create a national health insurance program, financed by taxpayers, in which all Americans would

get their insurance; require that all Americans enroll in basic health care coverage, either private or public; and increase flexibility afforded states in how they use federal funds for state programs—such as Medicaid and SCHIP—to maximize coverage.

As with the question on priorities for public spending, preferences varied somewhat in different meetings and on the Working Group poll. Once again, however, a clear consensus emerged among these options:

- **When asked to evaluate different proposals for ensuring access to affordable, high-quality health care coverage and services for all Americans, individuals at all but four meetings ranked "*Create a national health insurance program, financed by taxpayers, in which all Americans would get their insurance*" the highest.**
- Three other options almost consistently ranked in the top four choices:
    - Expand neighborhood health clinics
    - Open up enrollment in national federal programs like Medicare or the federal employees' health benefits program, and
    - Require that all Americans enroll in basic health care coverage, either private or public.

These options received high levels of support, in the community meetings as well as the Working Group poll. The support for neighborhood health clinics and for opening up enrollment in Medicare or the federal employees' health benefits program was consistently high and in line with the strong support for the Medicare program that was expressed in meetings across the country. The responses to both the Working Group poll and the University town hall meeting were similar to each other, as shown in Figure 9 below. There was, however, stronger support for expanding state programs such as Medicaid or SCHIP in the poll and the University town hall meeting than in the 31 community meetings. The level of support in the Working Group poll and University town hall meeting for opening enrollment in national programs such as Medicare or the federal employees' health benefits program was in line with a 2005 national survey by the Employee Benefit Research Institute that found 76 percent strongly or somewhat favor allowing uninsured people to buy into government programs such as Medicare and Medicaid, or into the one in which members of Congress participate.[25]

In the community meetings, the individual mandate (in other words, requiring that all Americans enroll in basic health care coverage, either private or public) was included as one of the options. Regardless of when in the meeting the question was asked, this option had a fairly high level of support, although the explanation of the concept differed from discussion to discussion. This option ranked third in popularity in the University town hall meeting and, in several community meetings, it ranked higher than all other options. However, its support in the Working Group Internet poll was below 50 percent.

Figure 9:
Responses to Trade-off Questions on Working Group Poll and from University Internet Town Hall Meeting

How much do you agree or disagree with the following options to assure coverage for all Americans? % who "Agree" or "Strongly Agree"	Working Group Poll	University Town Hall Meeting
Offer uninsured Americans income tax deductions, credits, or other financial assistance to help them purchase private health insurance on their own	42%	35%
Expand state government programs for low-income people, such as Medicaid and the State Children's Health Insurance Program, to provide coverage for more people without health insurance	68%	71%
Rely on free market competition among doctors, hospitals, other health care providers and insurance companies, rather than having government define benefits and set prices	23%	16%
Open up enrollment in national federal programs like Medicare or the federal employees' health benefit program	64%	63%
Require businesses to offer health insurance to their employees	56%	47%
Expand neighborhood health clinics	73%	79%
Create a national health plan, financed by taxpayers, in which all Americans would get their health insurance	70%	78%
Require that all Americans enroll in basic health care coverage, either private or public	47%	74%
Increase flexibility given states in how they use federal funds (such as Medicaid and the State Children's Health Insurance Program) to maximize coverage	55%	58%
Expand current tax incentives available to employers and their employees to encourage them to offer insurance to more workers and their families	69%	61%

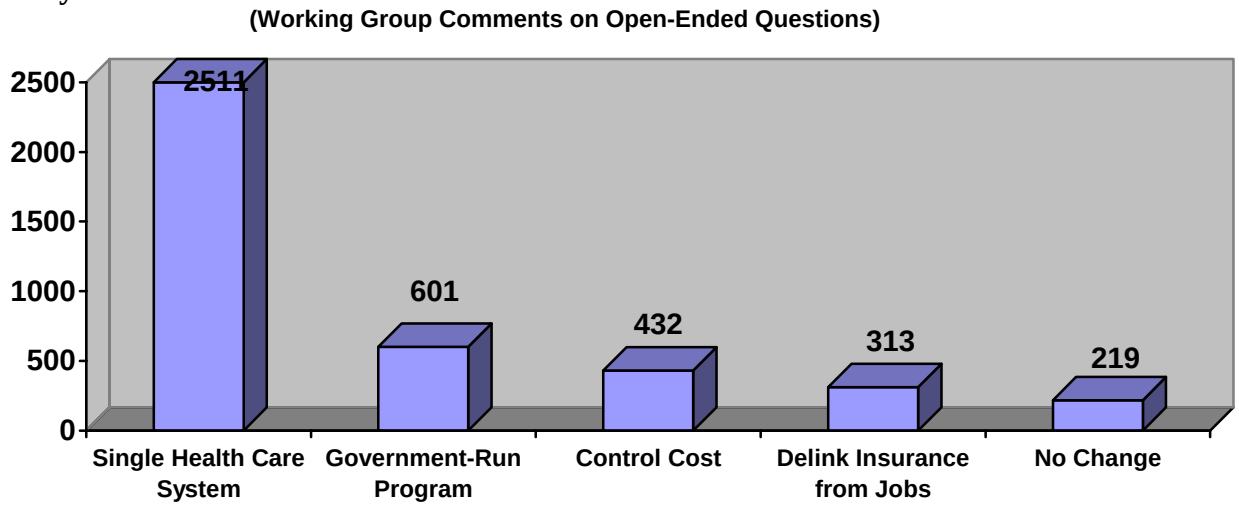
The open-ended comments submitted to the Working Group provide some additional insight into how people view the health care system, how they want it changed, and what trade-offs they are willing to make. More than 6,000 people (6,224) wrote responses, sometimes fairly long, to the general questions on both the Internet as well as on paper forms sent to the Working Group.

In general, responses to the open ended question about paying for health care were very similar to responses to the questions regarding trade-offs and recommendations. There are comments from a small number of individuals who are strongly opposed to major changes to the current system or to any changes that would increase the government's role in health care, but these were not the typical comments we received or what we heard in meetings or from the Internet poll.

As illustrated in Figure 10, analysis of the comments shows that when asked about what kinds of changes should be made to the way we currently pay for care, most wrote about the need for a single health care system. We know from the comments submitted as well as the discussions at the meetings that the notion of a single health care system means a number of different things to different people. For some, the most important issue clearly was the need for a government-run program. For others, it was an administratively

simple program that would be available to everyone but provided in the public and private arenas. Among the 2,511 respondents who wrote about the need for a single health care system in response to an open-ended question about how health care should be financed, 43 percent recommended a single-payer system, while 24 percent discussed national health care and 18 percent discussed universal health care. The remainder discussed the ideas of universal Medicare, universal coverage, universal basic care, or universal access.

Figure 10:
Our current way of paying for health care includes payments by individuals, employers, and government. Are there any changes you think should be made to this system?

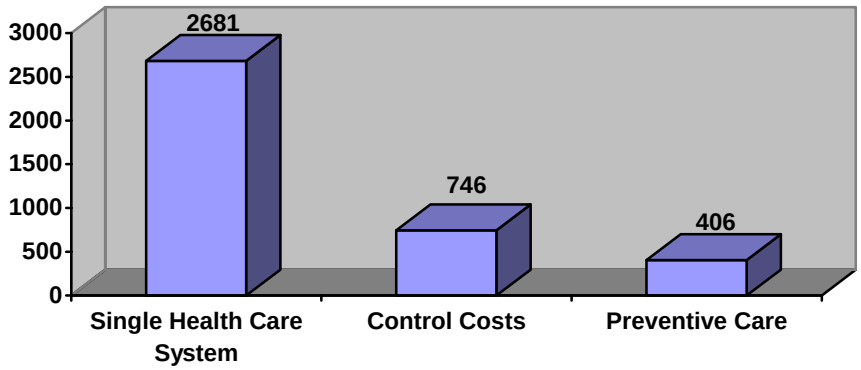


And, while a minority expressed the view that market reforms and advancements in technology could help to control costs and lead to better access to care, most of the people we heard from want more fundamental change.

The same notion—the need for a single national health care system—dominated the responses to the final question that asked people for the single most important recommendation for improving health care for all Americans. See Figure 11.

Figure 11:
What is your single most important recommendation to make to improve health care for all Americans?

(Working Group Comments on Open-Ended Questions)



There is a great deal of diversity in the ways people envision a reformed system. They believe this can be accomplished, and most believe that the resources are already there in our current system to achieve this goal. A selection of sample comments is provided below.

The Working Group Heard Many Views about How to Make Health Care Work for All Americans: Examples

"We need a single-payer system to control costs and promote efficiency, and it has to be universal."

"I think the only thing that will work is creating a system that includes everyone at a basic level of care with significant incentives for preventive care. It could be done through a system of clinics located near grocery stores (or WalMart-type stores), in schools and community heath centers."

"Let's just do Medicare for everyone. And establish a universal standard of electronic record keeping. Then everybody can go to the doctor of their choice, when they need to, and nobody falls through the cracks. And our health care system can focus on getting the right treatment to people the best way, and the health care database can track what treatments work best for whom, in the most cost effective way. Until we have a system that guarantees universal, complete coverage, we will never be able to track what basic, effective health care really costs or establish mechanisms --or even rationing (which I don't think we need)-- that does what is best for all;"

"Everyone pays a fair share, everyone has health care benefits."

"A non-profit single payer system that covered everyone would be the best solution. This would save billions in the total cost of health care in America. This plan could buy drugs with huge bulk discounts like Medicare & congressional, & veterans plans do."

"Require all Americans to choose a health care option and allow health care choices. Then let the free market reduce the costs. The default option is a free Medicaid type program that only provides emergency and preventative care."

Examples (Continued)

"I believe if Americans see that financing is more fair (rich paying more than the poor, the young contributing to the care of the elderly, the healthy paying for the sick) and all according to their level of income, this would be the first step in Americans accepting financial trade-offs. If the financing is not transparent and fair, there will be perpetual resistance. Second, I believe there must be set up a public infrastructure for setting standards of coverage and the availability of services that we are willing to fund. Such a public commission would include both citizens and representatives of all health care professions meeting apart from state or federal government. Such commission governance should be on the state, not federal, level so that local management is undergirding the system. Health resource management is local. When American citizens see that a public entity is taking the time and expertise to decide transparently what should and will be covered according to some stated ethic and philosophy of health care goals, trade-offs become more easily acceptable because the public is involved (not private corporations or remote federal agencies making such decisions). And finally, the public and local health care professionals should have the right and access to express their opinions and desires to such a public commission. There is a decision-making infrastructure that carries real authority and control but that is also permeable and open to citizen and professional input."

"All insurance should be tax deductible whether employer provided or individually purchased, as well as health expenses should be deductible below the 7.5 percent threshold. More transparency in both quality and cost so that people can truly become health care consumers. Government plans need to provide BASIC coverage and support care through community health centers as most efficient way for free care to be administered."

"I believe people should have a choice in selecting and paying for their healthcare. However, I believe the government should provide catastrophic coverage for all people. It will pay for itself in reduced neglect and dependency on government welfare and other programs."

"Put everyone in one risk pool and have a publicly financed, privately delivered system instead of paying high administrative costs for private insurance companies."

"Develop a coordinated system through the government that assures access for all, including focusing on preventive care. Health care should be regulated -- like utilities are regulated. The private sector system is not working for the US. Every other developed country has figured out a system; why can't we?"

"A single-payer system with a massive investment in information technology that provides universal access to patients as well as providers."

"Enact a single payer system of national health insurance with national standards and a global budget in which inequalities in health care delivery would be monitored and reported by race, ethnicity, income, and disability status at the state and community levels to identify inefficiencies that could be reduced by incorporating non-discrimination standards into the regulatory structure at the federal and state levels."

Examples (Continued)

"We need to set up a system like Social Security, where all working people pay into it, but all get equal coverage. We also need to tax not-for-profit institutions and systems that are currently acting very much like for-profit systems to cover insurance costs for the uninsured, the elderly, and disabled. If these systems are competing with one another, and they are, they must contribute to the community need through tax dollars, since they are duplicating services and keep building facilities that are not needed."

"Medicare and the VA are and have been working. They are cheaper than other options already in place and are more efficient in administrative costs than many other options."

"A non-mandatory, semi-private, semi-government run health insurance/free (or at least affordable, possibly based on income levels) health care program to everyone in the country. A health care program completely run by the government wouldn't work, but neither would one that was privately run - something comparable in theory to the FEHBP. And it should be either free service (paid for by taxes) for the patron, or be priced according to income and possibly 'risky' behaviors."

"In addition, we need a system where health care is provided by those best able to do it most efficiently including the highest quality. There is too much reliance on physician specialists and not enough on family physicians and nurse practitioners, nurse-midwives, nurse anesthetists, etc."

"I like the idea of the health savings accounts -- but the people that need the help can't afford the cost of the high deductible insurance, so how can they afford to put $2500 or so a year in the savings portions? Paying medical expenses from an account that they manage, might make people monitor their health care costs. I do believe that people on SSI - Medicaid overuse the system. But -- how can they not. They don't have any experience with the health care system, having put off all but the most critical care all of their lives. They only know the emergency room, because they have only sought medical care in extreme emergency in the past. To make the health savings account work, I think the government should put the $2500 into the health savings account, for all individuals below a certain income level."

"Create a system that seamlessly covers individuals from birth to death. Health care is about the individual, not whether they work, or have a disability, or fall within a certain age range. We keep everything in this country piecemeal and segregated by false categorization and because of that ensure a fragmented system with lots of individuals falling through the cracks. Get rid of the fractured system based on the private market. It doesn't work. It is costly and creates too many gaps in care."

"There needs to be some combination of these things to allow coverage for all Americans. Maybe we could expand Medicare/Medicaid, or allow people without coverage to enroll in the federal employees' plan, with a premium based on a sliding fee scale, so all pay something."

Endnotes

[1] The New York Times/CBS News Poll of 1,229 adults, conducted January 20-25, 2006.
[2] Employee Benefit Research Institute and Mathew Greenwald & Associates, Inc. 1998-2004 Health Confidence Surveys. "Public Attitudes on the U.S. Health Care System: Findings from the Health Confidence Survey" EBRI Issue Brief No. 275. November 2004. See Figure 5: Rating of Health Care System in America Today, 1998-2004.
[3] Wall Street Journal Online/Harris Interactive Poll of 2,242 U.S. adults, conducted online by Harris Interactive September 6-12, 2005. See The Wall Street Journal Online (October 20, 2005), "Poll Shows Strong Public Support For Range of Health Practices."
[4] The New York Times/CBS News Poll of 1,229 adults, conducted January 20-25, 2006.
[5] Gallup Poll of national random sample of 1,010 U.S. adults age 18+, conducted in September 2005. See The Gallup Poll (November 1, 2005), "Healthcare Panel: Costs More Troubling Than Quality."
[6] Employee Benefit Research Institute and Mathew Greenwald & Associates, Inc. 1998-2004 Health Confidence Surveys. "Public Attitudes on the U.S. Health Care System: Findings from the Health Confidence Survey" EBRI Issue Brief No. 275. November 2004. See Figure 19: Confident in Selected Aspects of the Health Care System, 2004.
[7] USA Today/Kaiser Family Foundation/Harvard School of Public Health: Health Care Costs Survey (August 2005) conducted by telephone by ICR/Harvard University between April 25 and June 9, 2005, with 1,531 adults age 18 and over responding. See Chart 6: Trends in Ability to Pay for Health Care. Additional survey sources include The Gallup Organization and Pew Research Center.
[8] The New York Times/CBS News Poll of 1,229 adults, conducted January 20-25, 2006.
[9] The Pew Research Center for the People and The Press Poll of 1,405 U.S. adults from March 8-12, 2006. "March 2006 News Interest Index."
[10] Wall Street Journal/Harris Interactive Health-Care Poll of 2,325 U.S. adults conducted by Harris Interactive between July 11 and 13, 2006. See the Wall Street Journal Online (July 31, 2006), "Higher Premiums for Those with Unhealthy Lifestyles Supported by 53 Percent of U.S. Adults."
[11] Gallup Poll of national random sample of 1,010 U.S. adults age 18+, conducted in September 2005. See The Gallup Poll (November 22, 2005), "Healthcare Panel: More Information, Stat."
[12] Wall Street Journal Online/Harris Interactive Health-Care Poll of 2,267 U.S. adults conducted online by Harris Interactive between September 21 and 23, 2004. See The Wall Street Journal Online (October 1, 2004), "Doctors' Interpersonal Skills Valued More than Their Training or Being Up-to-Date."
[13] Wall Street Journal/Harris Interactive Health-Care Poll of 2,325 U.S. adults conducted by Harris Interactive between July 11 and 13, 2006. See The Wall Street Journal Online (July 31, 2006), "Higher Premiums for Those with Unhealthy Lifestyles Supported by 53 Percent of U.S. Adults."
[14] Wall Street Journal/Harris Interactive Health-Care Poll of 2,325 U.S. adults conducted by Harris Interactive between July 11 and 13, 2006. See The Wall Street Journal Online (July 31, 2006), "Higher Premiums for Those with Unhealthy Lifestyles Supported by 53 Percent of U.S. Adults."
[15] Los Angeles Times/Bloomberg Press of 2,563 adults conducted by Roper Center for Public Opinion Research between February 24 and March 5, 2006.
[16] Wall Street Journal Online/Harris Interactive Health-Care Poll of 2,587 U.S. adults conducted online by Harris Interactive between November 13 and 17, 2003. See The Wall Street Journal Online (December 4, 2003), "Most People Uncomfortable with Profit Motive in Health Care."
[17] Wall Street Journal Online/Harris Interactive Health Care Poll of 2,048 adults conducted online by Harris Interactive between September 30 and October 4, 2005. See The Wall Street Journal Online (October 7, 2005), "Poll Indicates Strong Support for New Medical Technologies."
[18] Harris Interactive telephone survey of 1,012 Americans age 18+ between February 8-13, 2005. See Alan F. Westin testimony at the hearing on privacy and health information technology (February 23, 2005) www.patientprivacyrights.org, under News Room.
[19] Wall Street Journal Online/Harris Interactive Health-Care Poll of 2,007 U.S. adults conducted online by Harris Interactive between December 12-14, 2005. See The Wall Street Journal Online (January 6, 2006), "Kicking a Bad Habit Could Pay Off."

[20] Wall Street Journal/Harris Interactive Health-Care Poll of 2,325 U.S. adults conducted by Harris Interactive between July 11 and 13, 2006. See The Wall Street Journal Online (July 31, 2006), "Higher Premiums for Those with Unhealthy Lifestyles Supported by 53 Percent of U.S. Adults."
[21] The Pew Research Center for the People and the Press (May 10, 2005) "Beyond Red vs. Blue." The 2005 Political Typology Survey is a national telephone interview sample of 2,000 adults age 18 and over. The Typology Callback Survey conducted in March 2005 obtained 1,090 respondents from the initial December 2004 survey. The national sample of 1,284 adults in the 2003 survey was conducted by Princeton Survey Research Associates between July 14 and August 3, 2003.
[22] The New York Times/CBS News Poll of 1,229 adults, conducted January 20-25, 2006. See CBS News Online (May 13, 2004) "Poll: Economy Remains Top Priority."
[23] ABC News/Washington Post Poll, with a national sample of 1,000 adults, was conducted from October 9-13, 2003.
[24] NORC at the University of Chicago survey, implemented by International Communications Research (ICR), with random sample of 2,024 respondents between August 4-10, 2004. Schur, CL, Berk, ML, and Yegian, JM. (November 10, 2004), "Public Perceptions Of Cost Containment Strategies: Mixed Signals For Managed Care." *Health Affairs* Web Exclusive: W4-516 – W4-525.
[25] Employee Benefit Research Institute and Mathew Greenwald & Associates, Inc. (August 9, 2005) "2005 Health Confidence Survey: Wave VIII, June 30-August 6, 2005."

Appendix A:
Local Demographics and Health Resources:
Citizens' Health Care Working Group Community Meetings

Table of Contents

Introduction

The Citizens' Health Care Working Group held meetings across the country to hear what people had to say about health care. A core set of 31 Community Meetings were held between January and May 2006. These were structured similarly, and each included the use of electronic devices allowing individuals to provide responses to questions that were the same as, or very similar to, questions also asked on the Working Group's Internet Poll. In addition to these meetings, about 40 other meetings, organized either by the Working Group, individual members, or other groups across the United States, provided input to the Working Group.[1]

Because the structure of the 31 Community Meetings allows us, with appropriate cautions, to compare what we heard from meeting to meeting, the meetings were the focal point of the Working Group's efforts to engage in a national dialogue. The main criterion for selecting locations for these meetings was reaching as wide a spectrum of communities as possible in the time available. This Appendix provides profiles of these communities to illustrate diversity amongst them. The measures included are population demographics, population health status, and the availability of various health resources. The data represent the Metropolitan Statistical Area (MSA), except where such level of analysis would be inappropriate. For readability, data are summarized and highs and lows are presented. The source of the data is the 2005 Area Resource File data set provided by the Health Resources and Services Administration, Department of Health and Human Services, unless noted otherwise.

• Albuquerque, New Mexico	• Little Rock, Arkansas
• Baton Rouge, Louisiana	• Los Angeles, California
• Billings, Montana	• Memphis, Tennessee
• Charlotte, North Carolina	• Miami, Florida
• Cincinnati, Ohio	• New York, New York
• Denver, Colorado	• Orlando, Florida
• Des Moines, Iowa	• Philadelphia, Pennsylvania
• Detroit, Michigan	• Phoenix, Arizona
• Eugene, Oregon	• Providence, Rhode Island
• Fargo, North Dakota	• Sacramento, California
• Hartford, Connecticut	• Salt Lake City, Utah
• Indianapolis, Indiana	• San Antonio, Texas
• Jackson, Mississippi	• Seattle, Washington
• Kansas City, Missouri	• Sioux Falls, South Dakota
• Las Vegas, Nevada	• Tucson, Arizona
• Lexington, Kentucky	

[1] In addition to these meetings, several other types of meetings expanded the scope of the Working Group's outreach. Special Topic Community meetings were held to explore several issues of special concern, and a national webcast hosted by the University of Michigan included town hall meetings held at 22 participating universities; members conducted meetings; and a variety of organizations held their own meeting using materials developed by the Working Group.

Population Characteristics

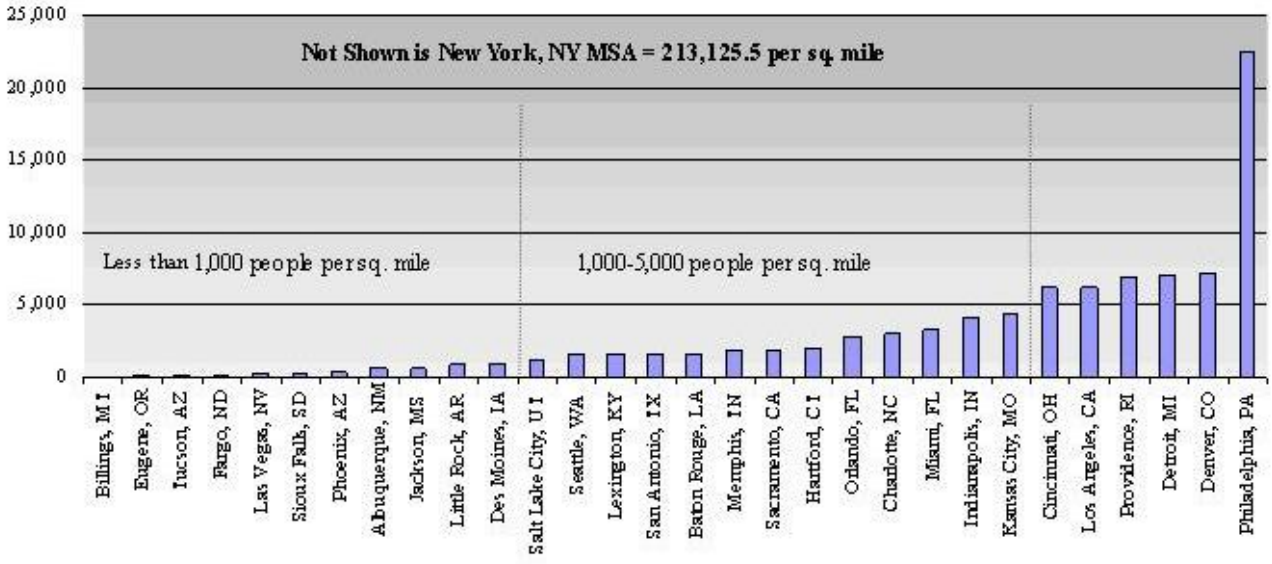
The meeting sites were diverse on several measures, including their population size, rural populations, racial composition, and population age. The following figures provide some insight on these and other characteristics of the communities visited. Just as there is no "typical" U.S. community, there was no "typical" site for a community meeting.

Population Size and Population Density

– The areas visited ranged in size from 144,472 in Billings, MT to over 18 million in the New York metropolitan statistical area (MSA). Of the 31 areas visited, 11 had fewer than one million people, 16 had between one and five million people, and four had over five million people.

– In 2004, the population per square mile also had a tremendous range, from 55.9 people per square mile in Billings, MT to 213,125.5 people per square mile in the New York, NY MSA. As shown in Figure A1, 11 of the areas visited had population densities less than 1,000 people per square mile. Thirteen areas had between 1,000 and 4,999 people per square mile, and seven areas had 5,000 or more people per square mile.

Figure A1:
Population Per Square Mile for Meeting Sites, 2004



Source: Citizens' Health Care Working Group analysis of 2005 Area Resource File (ARF), Health Resources and Services Administration.

– The meeting sites included both rural and urban MSAs. Five areas had more than 20 percent of its population living in rural areas (Baton Rouge, LA, Billings, MT, Jackson, MS, Little Rock, AR, and Sioux Falls, SD). Six areas had less than 5 percent of their population in rural areas, including Los Angeles, CA, New York, NY, Miami, FL, Las Vegas, NV, Salt Lake City, UT, and Phoenix, AZ.

Racial and Ethnic Diversity

– In 2000, 75 percent of the U.S. population was White, 12 percent was Black/African-American, and 13 percent was of another race or combination of races. Of the 31 meeting sites, five had Black/African-American populations greater than 20 percent (see Figure A2), nine had between

10 and 20 percent of the population as Black/African-American, and 17 had 10 percent or less of this population group.

Figure A2:
Prevalence of Black/African-American Populations in Meeting Sites, 2000

MSAs with Black/African-Americans as a Share of the Population:			
Less than 10%		**10-20%**	**More than 20%**
Albuquerque, NM	Phoenix, AZ	Charlotte, NC	Baton Rouge, LA
Billings, MT	Providence, RI	Cincinnati, OH	Detroit, MI
Denver, CO	Sacramento, CA	Indianapolis, IN	Jackson, MS
Des Moines, IA	Salt Lake City, UT	Kansas City, MO	Little Rock, AR
Eugene, OR	San Antonio, TX	Lexington, KY	Memphis, TN
Fargo, ND	Seattle, WA	Miami, FL	
Hartford, CT	Sioux Falls, ND	New York, NY	
Las Vegas, NV	Tucson, AZ	Orlando, FL	
Los Angeles, CA		Philadelphia, PA	

Source: Citizens' Health Care Working Group analysis of 2005 Area Resource File (ARF), Health Resources and Services Administration.

– Of the 31 areas visited, 11 had Hispanic populations (of any race) greater than the U.S. average of 12.5 percent in 2000 (see Figure A3). In San Antonio, TX half of the population was of Hispanic or Latino descent while Albuquerque, NM and Los Angeles, CA both had populations of 41 percent Hispanic.

Figure A3:
Prevalence of Hispanic Populations in Meeting Sites, 2000

MSAs with Persons of Hispanic/Latino Origin as a Share of the Population:			
Less than U.S. Share (12.5%)		**12.5-20%**	**More than 20%**
Baton Rouge, LA	Jackson, MS	Denver, CO	Albuquerque, NM
Billings, MT	Kansas City, MO	New York, NY	Las Vegas, NV
Charlotte, NC	Lexington, KY	Orlando, FL	Los Angeles, CA
Cincinnati, OH	Little Rock, AR	Sacramento, CA	Miami, FL
Des Moines, IA	Memphis, TN		Phoenix, AZ
Detroit, MI	Philadelphia, PA		San Antonio, TX
Eugene, OR	Providence, RI		Tucson, AZ
Fargo, ND	Salt Lake City, UT		
Hartford, CT	Seattle, WA		
Indianapolis, IN	Sioux Falls, SD		

Source: Citizens' Health Care Working Group analysis of 2005 Area Resource File (ARF), Health Resources and Services Administration.

Age and Gender

– The age distributions of the areas visited varied. Salt Lake City, UT had the largest proportion of persons under age 25 (43.3 percent); Miami, FL had the smallest percent (31.5 percent). In Indianapolis, IN, 17.3 percent were age 65 and older while in Salt Lake City, UT only 8 percent were seniors. Figure A4 gives examples of age distributions for nine small, medium, and large communities visited by the Working Group.

Figure A4:
Summary of Age Distributions, by Population Size, 2000

MSA	2000 Population	Percent Age 0-24	Percent Age 25-44	Percent Age 45-64	Percent Age 65+
Fargo, ND	174,367	40.2%	29.7%	19.5%	10.6%
Eugene, OR	322,959	34.8%	27.5%	24.4%	13.3%
Des Moines, IA	481,394	35.1%	31.5%	21.8%	11.5%
Little Rock, AR	610,518	35.5%	30.7%	22.4%	11.3%
Salt Lake City, UT	968,858	43.3%	30.7%	18.1%	8.0%
Charlotte, NC	1,328,839	34.7%	35.2%	20.3%	15.0%
Indianapolis, IN	1,524,707	35.5%	32.9%	21.0%	17.3%
Miami, FL	5,007,564	31.5%	30.2%	21.8%	16.4%
New York, NY	18,323,002	33.4%	31.7%	22.3%	12.6%
U.S.	281,421,906	35.3%	30.2%	22.0%	12.4%

Source: Citizens' Health Care Working Group analysis of 2005 Area Resource File (ARF), Health Resources and Services Administration.

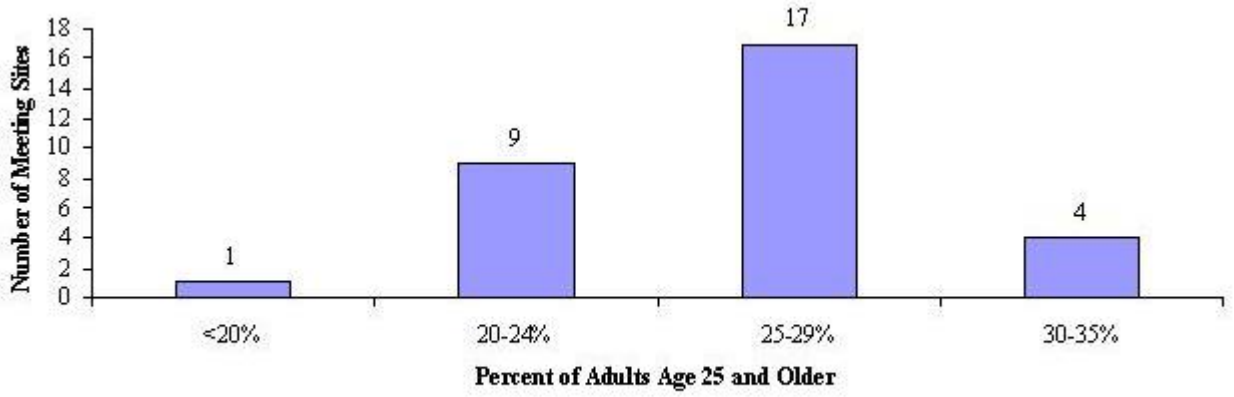
– For the most part, the meeting sites were evenly split in terms of the percentages of men and women, just like the U.S. as a whole (49.1 percent men in 2000). Jackson, MS had the lowest percentage of men (47.7 percent); Las Vegas, NV had the largest (50.9 percent).

Education and Employment

– In 2000, the majority of adults age 25 and older in each of the communities had achieved at least a high school diploma, although there was some variation across geographic areas. In the Los Angeles, CA area, 72.2 percent of adults had completed at least high school while in the Fargo, ND area, 89.7 percent had completed high school education or above that level. In the U.S. as a whole, 80.4 percent of adults age 25 and older had at least a high school diploma.

– As shown in Figure A5, in 21 of the meeting sites, more than 25 percent of adults age 25 or older had completed four or more years of college in 2000. In the United States, 24.4 percent had completed four or more years of college.

Figure A5:
Adults Age 25 and Older with 4 or More Years of College, 2000



Source: Citizens' Health Care Working Group analysis of 2005 Area Resource File (ARF), Health Resources and Services Administration.

– Unemployment rates also varied across sites. While the unemployment rate in the Sioux Falls, SD area was 2.8 percent in 2000, Los Angeles, CA faced unemployment of 7.4 percent. The national unemployment rate in 2000 was somewhere in between, at 5.8 percent. The Working Group visited 12 places with unemployment rates of 5.8 percent or higher and 19 with rates lower than the national average.

– In 2004, 8.4 percent of the U.S. population were veterans of the military. Of the 31 sites hosting Community Meetings, the Charlotte, NC area had the largest portion of veterans (22.5 percent), while Los Angeles, CA had the smallest percentage (4.7 percent). Twenty-one of the meeting sites reported veteran populations less than 10 percent of their populations. The other 10 areas had veteran populations of 10 percent or higher.

Income and Poverty

Per Capita Income

– In 2003, the per capita income for the U.S. was $31,472.[2] Of the 31 MSAs visited, 14 had per capita incomes less than the U.S. average, 17 had per capita incomes greater than the U.S. figure. Per capita incomes in the meeting sites ranged from $25,853 in Tucson, AZ to $40,963 in the New York, NY MSA (see Figure A6).

[2] The Area Resource File uses income data from the U.S. Department of Commerce, Bureau of Economic Analysis. Income figures from this source differ from those reported by the U.S. Bureau of Census.

Figure A6:
Per Capita Income for Meeting Sites, 2003

MSAs with Per Capita Income *Less* Than U.S. Average $31,472		MSAs with Per Capita Income *More* Than U.S. Average $31,472	
MSA	**2003 Per Capita Income**	**MSA**	**2003 Per Capita Income**
Tucson, AZ	$25,853	Memphis, TN	$31,665
Eugene, OR	$26,316	Providence, RI	$31,742
Baton Rouge, LA	$26,878	Lexington, KY	$32,012
San Antonio, TX	$27,315	Cincinnati, OH	$32,974
Orlando, FL	$28,103	Miami, FL	$33,023
Jackson, MS	$28,143	Sioux Falls, SD	$33,272
Albuquerque, NM	$28,584	Charlotte, NC	$33,289
Billings, MT	$29,181	Los Angeles, CA	$33,324
Phoenix, AZ	$29,589	Kansas City, MO	$33,356
Salt Lake City, UT	$29,779	Des Moines, IA	$33,695
Little Rock, AR	$29,975	Indianapolis, IN	$33,732
Fargo, ND	$30,767	Detroit, MI	$36,000
Las Vegas, NV	$30,938	Philadelphia, PA	$37,055
Sacramento, CA	$31,436	Hartford, CT	$38,196
		Seattle, WA	$39,012
		Denver, CO	$39,215
		New York, NY	$40,963

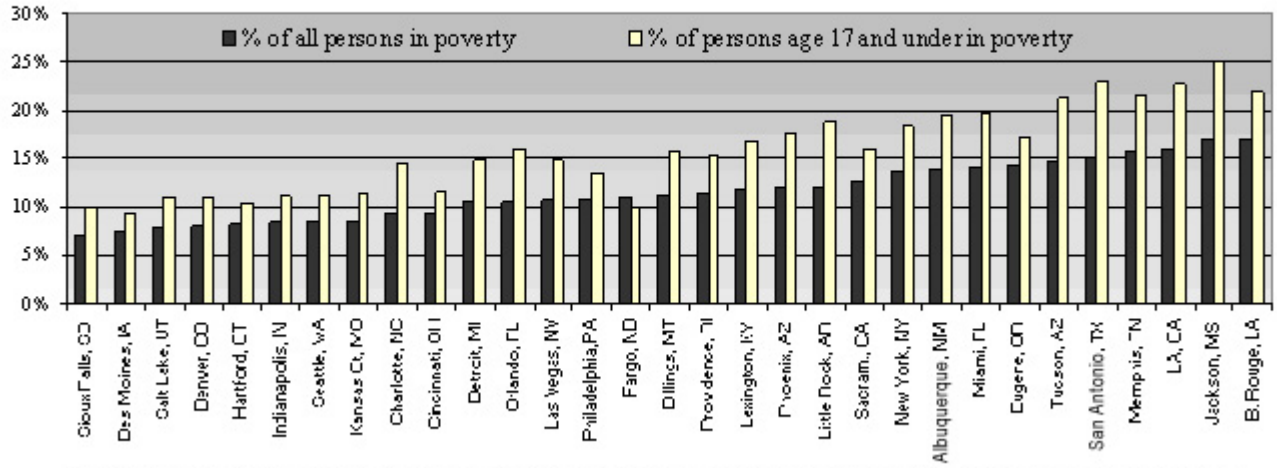
Source: Citizens' Health Care Working Group analysis of 2005 Area Resource File (ARF), Health Resources and Services Administration. Note: The Area Resource File uses income data from the U.S. Department of Commerce, Bureau of Economic Analysis. Income figures from this source differ from those reported by the U.S. Bureau of Census.

Poverty

– The percentage of persons living with incomes below the federal poverty level (FPL) in 1999 ranged from 7.1 percent in Sioux Falls, SD to 17.1 percent in Baton Rouge, LA (see Figure A7). Twenty-two areas had 12.7 percent of the population (the national average) or less living in poverty.

– For children age 17 and under, the percentage living with incomes below poverty ranged from 9.3 percent in Des Moines, IA to 25 percent in Jackson, MS.

Figure A7:
Percent of All Persons and Those Age 17 and Under Living in Poverty, 1999



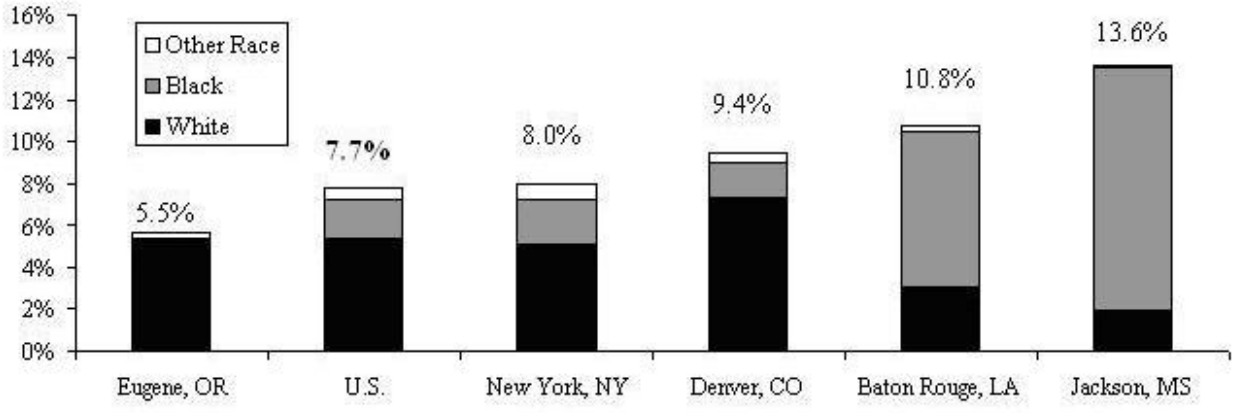
Source: Citizens' Health Care Working Group analysis of 2005 Area Resource File (ARF), Health Resources and Services Administration.

Health Status

Births

– Figure A8 shows a summary of the average percentage of births for 2000-2002 that were low birth weight by race of the birth mother. Eugene, OR had the smallest proportion of low-weight births with 5.5 percent, and Jackson, MS had the largest proportion with 13.6 percent. The other counties highlighted show the variation for highly populated areas like New York, NY as well as smaller areas like Baton Rouge, LA. The counties of the community meetings also showed diversity in the percent of births receiving early prenatal care. On average in the U.S., 81.5 percent of births got early prenatal care between 2000 and 2002. Philadelphia, PA had the lowest percentage of births for early prenatal care (67.2 percent), Des Moines, IA the highest (89.3 percent).

Figure A8:
Summary of Low Birth Weight Percentages for Meeting Site Counties, by Race, 2000-2002

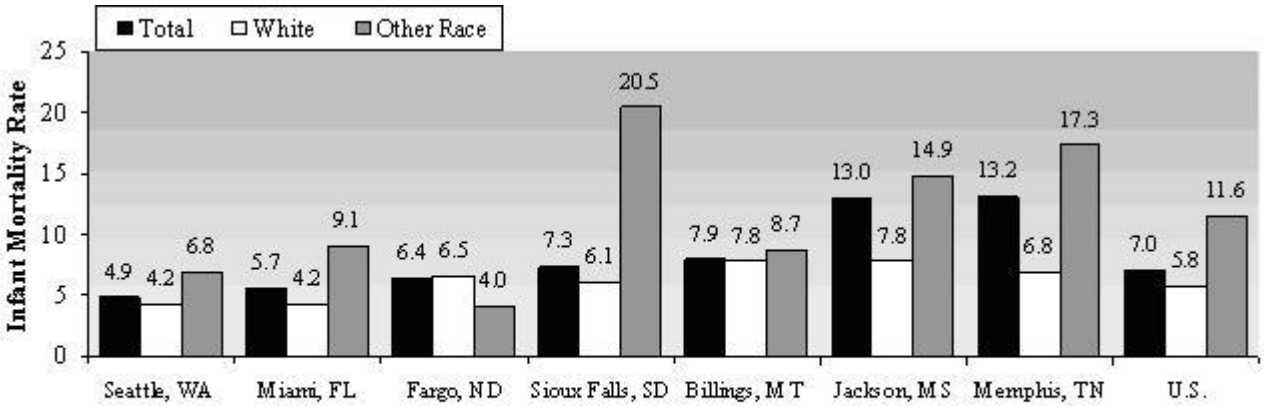


Source: Citizens' Health Care Working Group analysis of 2005 Area Resource File (ARF), Health Resources and Services Administration.

Deaths

– The infant mortality rates (infant deaths per 1,000 births) in the counties visited ranged from 4.9 in Seattle, WA to 13.2 in Memphis, TN (average for 1998-2002). Racial disparity for infant mortality is also evident across the counties visited. The infant mortality rates for births to White mothers ranged from 4.2 in Miami, FL and Seattle, WA to 7.8 in Billings, MT and Jackson, MS. In contrast, the range in mortality rates for births to mothers of other races was 4.0 in Fargo, ND to 20.5 in Sioux Falls, SD. Figure A9 summarizes the infant mortality rates for the counties with highest and lowest rates for each racial category.

Figure A9:
Summary of Average Infant Mortality Rates in Meeting Site Counties, by Race, 1998-2002



Source: Citizens' Health Care Working Group analysis of 2005 Area Resource File (ARF), Health Resources and Services Administration.

– For most counties visited, close to half of all deaths were due to one of four major diseases—heart disease, cancer, chronic lower respiratory diseases, or diabetes, on average between 2000 and 2002. Four counties had less than 45 percent of deaths from these major diseases (with the lowest being 38 percent in Salt Lake City, UT), 22 counties had 45 to 55 percent of deaths from these diseases, and five counties had more than 55 percent of deaths due to major disease (with the highest being 57 percent in Providence, RI).

Figure A10:
Percentage of Deaths Due to Major Disease in Meeting Site Counties, 2000-2002

Percentage of Deaths from Heart Disease, Cancer, Chronic Respiratory Disease, or Diabetes				
Less than 45%	**45-55%**			**More than 55%**
Charlotte, NC	Albuquerque, NM	Indianapolis, IN	Philadelphia, PA	Des Moines, IA
Denver, CO	Baton Rouge, LA	Kansas City, MO	Phoenix, AZ	Los Angeles, CA
Jackson, MS	Billings, MT	Las Vegas, NV	Sacramento, CA	Miami, FL
Salt Lake City, UT	Cincinnati, OH	Lexington, KY	San Antonio, TX	New York, NY
	Detroit, MI	Little Rock, AR	Seattle, WA	Providence, RI
	Eugene, OR	Memphis, TN	Sioux Falls, SD	
	Fargo, ND	Orlando, FL	Tucson, AZ	
	Hartford, CT			

Source: Citizens' Health Care Working Group analysis of 2005 Area Resource File (ARF), Health Resources and Services Administration.

Resources Available

Physicians

– In 2004, there were over 760,000 nonfederal physicians who were actively practicing in the U.S. This figure averages to about 26 physicians per 10,000 people. Of the 31 areas visited, nine MSAs had 26 or fewer nonfederal active physicians per 10,000, and 22 areas had more than 26 physicians per 10,000 people. The highest ratio of physicians was in Lexington, KY, where there were 48 physicians per 10,000 people. The smallest ratio was in Las Vegas, NV, where there were 17 physicians per 10,000 residents.

– The vast majority of physicians in almost every MSA visited were specialists. In 2004, the range of general practitioners, including general practice, general family medicine, and family medicine subspecialties, was from two per 10,000 residents in eight different meeting sites to six per 10,000 in Sioux Falls, SD. In contrast, the range of all types of specialists was between 14 per 10,000 residents (in Las Vegas, NV) and 36 per 10,000 residents (in New York, NY).

Hospitals and Other Health Care Facilities

– Figure A11 gives a snapshot of the diversity in hospital resources available in a few of the MSAs visited. The sites chosen demonstrate the often noted relationship between the size of the area and the number of short-term general hospitals, ambulatory surgery centers, and hospices. Larger areas tend to have more of these types of facilities. However, population size is less related to the number of rural health clinics, community mental health centers, and federally qualified health centers.

– Veterans Administration (VA) hospitals were present in 24 of the MSAs visited. Twenty areas had one VA hospital. Figure A11 shows the four areas that had more than one VA hospital available—Miami, FL, Philadelphia, PA, Los Angeles, CA, and New York, NY.

Figure A11:
Summary of Number of Hospitals and Other Health Facilities in Meeting Sites

MSA	Population (2004)	Short-Term General Hospitals (2003)	Veterans' Hospitals (2003)	Ambulatory Surgery Centers (2004)	Hospices (2004)	Rural Health Clinics (2004)	Community Mental Health Centers (2004)	Federally Qualified Health Centers (2004)
Billings, MT	144,472	3	0	4	2	1	0	2
Sioux Falls, SD	203,324	7	1	3	3	7	0	2
Eugene, OR	331,594	4	0	9	3	5	1	3
Salt Lake City, UT	1,018,826	10	1	16	13	2	1	8
Cincinnati, OH	2,058,221	21	1	26	11	2	3	24
Detroit, MI	4,493,165	37	1	23	16	0	1	8
Miami, FL	5,361,723	54	2	61	11	4	68	31
Philadelphia, PA	5,800,614	58	3	66	45	0	14	34
Los Angeles, CA	12,925,330	117	2	229	59	0	3	40
New York, NY	18,709,802	143	5	151	56	1	22	63

Source: Citizens' Health Care Working Group analysis of 2005 Area Resource File (ARF), Health Resources and Services Administration.

Medicaid

– Each state had its own income thresholds for Medicaid eligibility for working parents. In 2005 it ranged from 19 percent of the federal poverty level (FPL) in Arkansas to 200 percent of the FPL in Arizona. About half (15) of the areas visited had state-wide income eligibility levels for working parents that were below the national average (67 percent of FPL), eight areas had state levels at or above 100 percent of the FPL.[3]

– State residents may also enroll in Medicaid if they qualify for Supplemental Security Income (SSI). Again, each state sets its own levels for being eligible for SSI. Over half of the areas visited (19) were in states that established SSI eligibility at 73.8 percent of the FPL. The two areas visited in California (Los Angeles and Sacramento) had SSI eligibility of 100.2 percent of the FPL.[4]

Medicare

– The federal Medicare program provides vital health coverage for seniors age 65 and over and certain disabled workers under the age of 65. The percentage of the non-elderly population eligible for Medicare because of disability, 14.7 percent of the U.S. Medicare population in 2003, varied considerably. In Miami, FL, 9.9 percent of Medicare beneficiaries were disabled beneficiaries, while in Kansas City, MO, 14.6 percent were disabled and in Jackson, MS and Little Rock, AR, over one-fifth were disabled (22.0 percent and 20.5 percent, respectively).

– Medicare adjusted average per capita costs (AAPCC) for aged beneficiaries serve as an additional marker of the diversity in the areas of the community meetings. Three counties had the lowest AAPCC of the sites visited—$555.42; fifteen counties were at $613.89; and seven counties had rates above $700. The highest payment rate was $904.51 in Miami, FL. While the average per capita costs reflects differences in the prices of services, it also reflects variation in the amount of services and the intensity of care used.

Uninsured

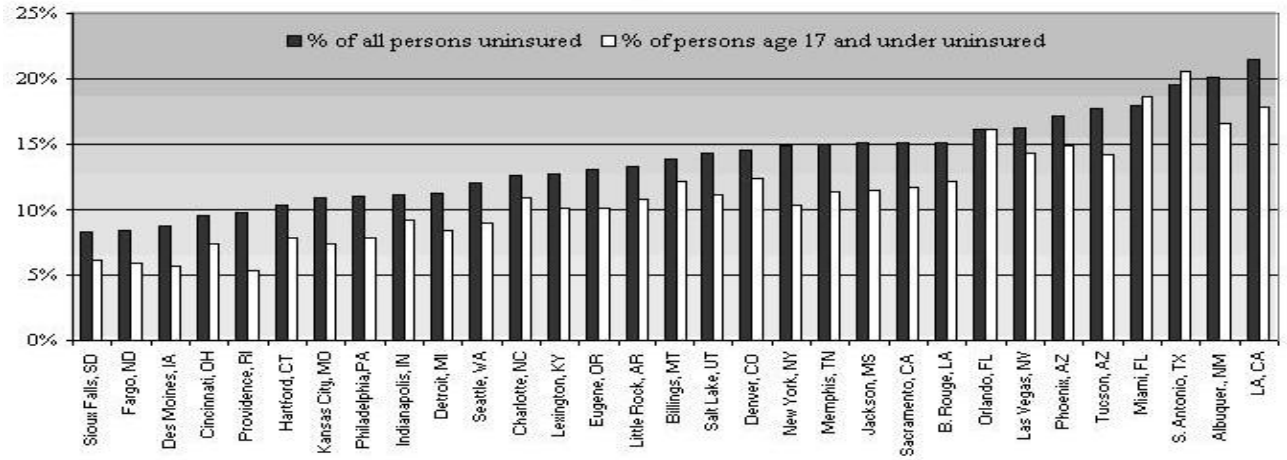
– In 2000, 14.2 percent of the U.S. population did not have health insurance. About half of the areas visited (16) had uninsured rates less than the national average. Sioux Falls, SD had the smallest percent of uninsured persons (8.2 percent) and Los Angeles, CA had the largest percentage (21.5 percent).

– Figure A12 below shows that in all but three areas (Orlando and Miami, FL and San Antonio, TX), a larger percentage of children age 17 and under were uninsured, compared with the percentages for all people.

[3] Kaiser Family Foundation website www.statehealthfacts.org.

[4] Lynda Flowers, Leigh Gross, Patricia Kuo, Shelly-Ann Sinclair, *State Profiles: Reforming the Health Care System 2005*, AARP Public Policy Institute, Washington, DC, February 2006.

Figure A12:
Percent of All Persons and Those Age 17 and Under Without Health Insurance, 2000



Source: Citizens' Health Care Working Group analysis of 2005 Area Resource File (ARF), Health Resources and Services Administration.

Use of Services

– The areas visited by the Working Group also show variation in the rates of utilization of medical care services. In 2003, the rate of inpatient hospital visits in short-term general hospitals (per 1,000 persons) ranged from 404 in Eugene, OR to 1,378 in Sioux Falls, SD. Four meeting sites had inpatient visits rates of over 1,000—Billings, MT, Jackson, MS, Little Rock, AR, and Sioux Falls, SD.

– In 2003, the number of short-term general hospital outpatient visits per 1,000 persons ranged from 931 in Eugene, OR to 7,902 in Billings, MT.

– Emergency department visits in 2003 in short-term general hospitals ranged from 193 per 1,000 people in Sacramento, CA to 576 per 1,000 people in Jackson, MS. Figure A13 below summarizes the highs and lows for inpatient, outpatient, and ED visits.

Figure A13:
Summary of Visits per 1,000 Populations in Meeting Sites, 2003

MSA (Sorted by Inpatient Visits)	Inpatient visits per 1,000 pop.	Outpatient visits per 1,000 pop.	Short-Term General ED visits per 1,000 pop.
Sioux Falls, SD	1,378	2,887	276
Jackson, MS	1,317	2,163	576
Billings, MT	1,237	7,902	321
Little Rock, AR	1,194	2746	441
New York, NY	896	2,049	361
Philadelphia,PA	795	1,862	368
Detroit, MI	610	2,135	362
Los Angeles,CA	542	1,189	250
Sacramento, CA	462	1,183	193
Salt Lake City, UT	437	2,494	323
Eugene, OR	404	931	306

Source: Citizens' Health Care Working Group analysis of 2005 Area Resource File (ARF), Health Resources and Services Administration.

Appendix B: Summary of Community Meeting Data

Demographic Characteristics (N=*Total Number of Respondents*)	Weighted Averages[1]: % of Meeting Attendees
Gender (N=*3,775*):	
Male	37.7%
Female	62.3%
Age in years (N=*3,824*):	
Under 25	6.0%
25-44	25.5%
45-64	53.2%
65+	15.3%
Hispanic Origin (N=*3,805*):	
Yes	9.1%
No	87.6%
Declined to answer[2]	3.3%
Race[3] (N=*3,810*):	
White	69.5%
Black/African-American	16.9%
Asian	2.6%
Native Hawaiian/Pacific Islander	0.2%
American Indian/Alaska Native	1.7%
Multiple races	1.8%
Other	3.8%
Declined to answer[2]	3.6%
Education (N=*3,856*):	
Elementary	0.9%
Some High School	1.3%
High School Graduate/GED	6.7%
Some College	17.1%
Associate's Degree	6.5%
Bachelor's Degree	23.9%
Graduate/Professional Degree	43.3%
Declined to answer	0.5%
Source of Coverage[4] (N=*3,662*):	
Employer	64.5%
Self-purchased	8.3%
Veterans' Administration	1.1%
Medicare	12.6%
Medicaid	2.6%
Other	3.6%
Uninsured	6.6%
Not Sure	0.7%
Employment[5] (N=*3,776*):	
Self-employed	11.6%
Full-time	50.2%
Part-time	8.1%
Looking for work	4.7%
Homemaker	1.7%
Other/retired	18.9%

[1] The weighted average was calculated as the total number of individuals providing a particular response to a question across all meetings divided by the total number of individuals who answered that question at all the meetings.
[2] The "decline to answer" option was not provided at all meetings.
[3] Classifications of race varied between meeting sites. In some meetings, the question of race was limited to one answer, whereas in other meetings, attendees were permitted to answer "multiple races." Also, attendees were allowed to decline to respond.
[4] The question on source of health coverage was not asked in two meetings.
[5] The question on employment was not asked in one meeting; the categories of full-time and part-time were combined in another.

% Who View The Health Care System as Being in Crisis or Major Problem		% that Believe Health Care Should:			% Who Think Affordable Health Care Should be Public Policy		% Who Believe that Health Care Should Cover:		
Meeting Sites Sorted from Lowest to Highest		**Meeting Sites Sorted by "Everyday Costs"**	**Pay Everyday Costs**	**Protect from High Costs**	**Meeting Sites Sorted from Lowest to Highest**		**Meeting Sites Sorted by Percent Answering "Certain Groups"**	**Certain Groups**	**A Level of Benefits for All**
Fargo, ND	87.5%	Eugene, OR	18.9%	80.0%[1]	Salt Lake City, UT	77.2%	Philadelphia, PA	2.0%	98.0%
Billings, MT	90.2%	Baton Rouge, LA	22.8%	77.2%	Baton Rouge, LA	85.5%	New York, NY	2.1%	97.9%
Little Rock, AR	90.8%	Salt Lake City, UT	25.6%	72.1%[1]	Las Vegas, NV	87.4%	Phoenix, AZ	2.8%	97.2%
Jackson, MS	93.5%	Billings, MT	26.4%	70.8%[1]	Fargo, ND	89.4%	Hartford, CT	3.2%	96.8%
Tucson, AZ	94.1%	Des Moines, IA	26.9%	71.0%[1]	Billings, MT	90.2%	Little Rock, AR	4.2%	95.8%
Salt Lake City, UT	94.5%	Seattle, WA	27.1%	36.2%[1]	Orlando, FL	90.4%	Eugene, OR	4.4%	95.6%
Lexington, KY	94.5%	Memphis, TN	27.5%	71.3%[1]	Albuquerque, NM	90.4%	Detroit, MI	4.8%	95.2%
Des Moines, IA	94.9%	Denver, CO	28.0%	71.1%[1]	Kansas City, MO	90.7%	Orlando, FL	4.9%	81.1%[1]
Orlando, FL	95.1%	Phoenix, AZ	28.0%	70.0%[1]	Eugene, OR	91.2%	Denver, CO	5.0%	95.0%
Las Vegas, NV	95.2%	Charlotte, NC	28.6%	70.2%[1]	Jackson, MS	91.4%	Seattle, WA	6.8%	93.2%
Providence, RI	95.9%	Miami, FL	29.4%	70.6%	Phoenix, AZ	91.5%	Tucson, AZ	6.8%	93.2%
Charlotte, NC	95.9%	Orlando, FL	30.1%	68.3%[1]	Miami, FL	91.7%	San Antonio, TX	7.1%	92.9%
Memphis, TN	96.1%	Tucson, AZ	31.1%	68.9%	Charlotte, NC	92.0%	Lexington, KY	7.2%	92.8%
Miami, FL	96.2%	Kansas City, MO	31.7%	57.4%[1]	Des Moines, IA	92.5%	Des Moines, IA	7.4%	92.6%
Kansas City, MO	96.8%	New York, NY	35.2%	46.6%[1]	Denver, CO	92.9%	Indianapolis, IN	7.5%	92.5%
San Antonio, TX	96.9%	Sacramento, CA	35.6%	62.2%[1]	Tucson, AZ	93.2%	Jackson, MS	8.3%	91.7%
Phoenix, AZ	97.0%	Indianapolis, IN	36.4%	62.1%[1]	Providence, RI	93.5%	Sacramento, CA	9.0%	91.0%
Sioux Falls, SD	97.0%	Jackson, MS	42.1%	57.9%	Lexington, KY	93.6%	Memphis, TN	9.6%	90.4%
Indianapolis, IN	97.5%	Cincinnati, OH	43.8%	48.0%[1]	Indianapolis, IN	94.9%	Kansas City, MO	9.7%	80.6%[1]
Baton Rouge, LA	98.2%	Detroit, MI	44.9%	50.0%[1]	Los Angeles, CA	95.4%	Cincinnati, OH	9.7%	90.3%
Eugene, OR	98.2%	Philadelphia, PA	49.0%	49.7%[1]	San Antonio, TX	95.5%	Los Angeles, CA	9.9%	90.1%
Sacramento, CA	98.4%	Providence, RI	57.8%	40.0%[1]	Memphis, TN	95.9%	Miami, FL	10.0%	78.9%[1]
Denver, CO	98.6%	Los Angeles, CA	NA	NA	Little Rock, AR	96.8%	Albuquerque, NM	11.0%	89.0%
Cincinnati, OH	98.9%	Albuquerque, NM	NA	NA	Sioux Falls, SD	97.0%	Billings, MT	13.0%	87.0%
Detroit, MI	99.0%	Hartford, CT	NA	NA	Seattle, WA	97.1%	Providence, RI	17.4%	82.6%
Albuquerque, NM	99.0%	Las Vegas, NV	NA	NA	New York, NY	97.1%	Salt Lake City, UT	18.7%	81.3%
Los Angeles, CA	100.0%	San Antonio, TX	NA	NA	Sacramento, CA	97.6%	Charlotte, NC	18.9%	81.1%
New York, NY	100.0%	Fargo, ND	NA	NA	Cincinnati, OH	98.2%	Baton Rouge, LA	19.6%	67.9%[1]
Hartford, CT	100.0%	Lexington, KY	NA	NA	Detroit, MI	98.7%	Las Vegas, NV	22.5%	77.5%
Philadelphia, PA	100.0%	Little Rock, AR	NA	NA	Philadelphia, PA	99.3%	Sioux Falls, SD	22.6%	77.4%
Seattle, WA	100.0%	Sioux Falls, SD	NA	NA	Hartford, CT	100.0%	Fargo, ND	23.3%	76.7%
Weighted average	**96.8%**	**Weighted average**	**33.9%**	**60.3%**[1]	**Weighted average**	**94.1%**	**Weighted average**	**8.9%**	**89.9%**[1]

[1] Some respondents selected "Other," "Unsure" or "No opinion," so the numbers shown here do not add up to 100 percent.

Who ought to decide what is in a basic benefits package? (SELECT ONE.)

Meeting Site	Consumers	Medical Professionals	Government	Employers	Insurance Companies	Some Combination
Baton Rouge, LA	19.0%	8.6%	5.2%	1.7%	0.0%	65.5%
Charlotte, NC	23.5%	3.7%	1.2%	1.2%	1.2%	69.1%
Cincinnati, OH	25.8%	7.9%	3.6%	1.0%	0.5%	61.2%
Los Angeles, CA	20.6%	15.4%	2.6%	0.4%	0.4%	60.7%
Memphis, TN	28.4%	6.2%	4.9%	0.0%	0.0%	60.5%
Weighted Average	**23.8%**	**9.7%**	**3.3%**	**0.8%**	**0.5%**	**62.0%**

On a scale of 1 (no input) to 10 (exclusive input), how much input should each of the following have in deciding what is in a basic benefit package?

Meeting Site	Consumers	Medical Professionals	Federal Government	State/Local Government	Employers	Insurance Companies
Billings, MT	6.3	6.0	5.1	4.7	4.0	2.4
Denver, CO	6.8	6.4	4.2	4.0	3.8	2.5
Des Moines, IA	6.7	5.4	5.0	4.7	2.6	2.2
Detroit, MI	7.6	6.8	3.5	3.7	2.4	1.4
Indianapolis, IN	7.6	6.1	4.9	3.9	3.3	2.2
Jackson, MS	7.8	5.7	3.6	3.0	3.6	1.8
Miami, FL	6.9	5.5	5.0	4.5	3.0	2.3
New York, NY	7.7	6.7	5.2	4.1	2.1	1.4
Philadelphia, PA	6.7	6.0	4.4	4.4	3.1	1.5
Phoenix, AZ	7.7	5.2	3.9	3.7	3.4	2.0
Providence, RI	8.0	6.8	4.1	3.8	2.8	2.3
Sacramento, CA	7.4	6.4	3.8	3.8	2.9	2.5
Salt Lake City, UT	6.8	4.9	4.6	4.7	3.1	2.6
Seattle, WA	7.3	5.9	4.3	4.0	2.3	1.6
Tucson, AZ	6.6	6.2	3.9	3.4	3.2	2.6
Meeting Average	**7.2**	**6.0**	**4.4**	**4.0**	**3.0**	**2.1**

Note: Not included are community meeting data from Kansas City, Albuquerque, Hartford, Las Vegas, Eugene, San Antonio, Fargo, Lexington, Little Rock, and Sioux Falls because participants did not answer a comparable question. In the Orlando community meeting, participants grouped responses into categories that were not comparable with the other meetings.

Should some people be responsible for paying more than others?		What criteria should be used for making some people pay more?						Should public policy continue to use tax rules to encourage employer-based health insurance?		
Meeting Sites Sorted from Lowest to Highest	**Yes**	**All pay same**	**Family size**	**Health Behaviors**	**Income**	**Other**	**Other or some combination**	**Meeting Sites**	**Yes**	**Abstain**
Sacramento, CA	43.0%	NA	NA	NA	NA	NA	NA	Albuquerque, NM	39.3%	NA
Indianapolis, IN	58.4%	15.5%	3.6%	29.0%	47.2%	4.7%	NA	Baton Rouge, LA	86.8%	NA
Baton Rouge, LA	59.6%	6.3%	14.6%	27.1%	43.8%	8.3%	NA	Billings, MT	45.8%	NA
Jackson, MS	60.3%	25.5%	4.3%	19.1%	38.3%	12.8%	NA	Charlotte, NC	61.8%	NA
Tucson, AZ	61.0%	18.4%	0.0%	18.4%	50.0%	13.2%	NA	Cincinnati, OH	50.4%	NA
Miami, FL	63.0%	NA	NA	NA	NA	NA	NA	Denver, CO	38.5%	NA
Orlando, FL	63.9%	20.9%	6.2%	14.7%	41.1%	17.1%	NA	Des Moines, IA	23.9%	NA
Phoenix, AZ	64.6%	26.0%	2.0%	12.0%	52.0%	8.0%	NA	Detroit, MI	23.1%	NA
Denver, CO	66.0%	15.6%	4.4%	15.6%	56.6%	7.8%	NA	Eugene, OR	31.6%	NA
Memphis, TN	66.2%	15.1%	2.7%	11.0%	57.5%	13.7%	NA	Fargo, ND	44.2%	26.9%
Kansas City, MO	72.2%	NA	NA	NA	NA	NA	NA	Hartford, CT	14.9%	41.4%
Charlotte, NC	72.4%	11.9%	1.2%	27.4%	32.1%	27.4%	NA	Indianapolis, IN	30.8%	NA
Des Moines, IA	73.4%	16.9%	4.2%	15.5%	60.6%	2.8%	NA	Jackson, MS	72.1%	NA
Billings, MT	76.3%	11.9%	7.1%	28.6%	44.0%	8.3%	NA	Kansas City, MO	36.3%	NA
Seattle, WA	77.0%	NA	NA	NA	NA	NA	NA	Las Vegas, NV	24.7%	NA
Providence, RI	79.2%	20.4%	2.0%	26.5%	44.9%	6.1%	NA	Lexington, KY	63.2%	17.9%
Salt Lake City, UT	80.0%	8.5%	4.2%	22.5%	59.2%	5.6%	NA	Little Rock, AR	41.6%	23.0%
Detroit, MI	81.1%	11.7%	6.5%	6.5%	68.8%	6.5%	NA	Los Angeles, CA	37.4%	NA
Philadelphia, PA	82.5%	7.9%	5.3%	7.0%	70.2%	9.6%	NA	Memphis, TN	29.3%	NA
Fargo, ND	NA	5.7%	0.9%	11.3%	20.8%	NA	61.3%	Miami, FL	67.4%	NA
Little Rock, AR	NA	11.1%	5.1%	6.0%	15.4%	NA	62.4%	New York, NY	NA	NA
Sioux Falls, SD	NA	12.9%	3.2%	22.6%	9.7%	NA	51.6%	Orlando, FL	60.2%	NA
Los Angeles, CA	NA	19.8%	4.1%	10.6%	50.5%	15.0%	NA	Philadelphia, PA	32.1%	NA
Albuquerque, NM	NA	NA	NA	NA	NA	NA	NA	Phoenix, AZ	53.1%	NA
Hartford, CT	NA	NA	NA	NA	NA	NA	NA	Providence, RI	26.5%	NA
Las Vegas, NV	NA	NA	NA	NA	NA	NA	NA	Sacramento, CA	NA	NA
Eugene, OR	NA	NA	NA	NA	NA	NA	NA	Salt Lake City, UT	52.8%	NA
San Antonio, TX	NA	NA	NA	NA	NA	NA	NA	San Antonio, TX	13.7%	48.4%
New York, NY	NA	NA	NA	NA	NA	NA	NA	Seattle, WA	32.2%	NA
Lexington, KY	NA	NA	NA	NA	NA	NA	NA	Sioux Falls, SD	NA	NA
Cincinnati, OH	NA	NA	NA	NA	NA	NA	NA	Tucson, AZ	50.0%	NA
Weighted average	67.7%	15.3%	4.2%	16.2%	47.0%	9.3%	8.0%	**Weighted average**	**41.4%**	**5.6%**

How much more would you personally be willing to pay in a year (in premiums, taxes, or through other means) to support efforts that would result in every American having access to affordable, high quality health care coverage and services?

Meeting Site	$0	$1-99	$100-299	$300-999	$1000+	Don't Know
Albuquerque, NM	21.7%	7.5%	18.3%	18.3%	24.2%	10.0%
Baton Rouge, LA	8.7%	19.6%	19.6%	26.1%	19.6%	6.5%
Billings, MT	15.0%	16.3%	18.8%	18.8%	21.3%	10.0%
Charlotte, NC	44.6%	8.1%	10.8%	9.5%	16.2%	10.8%
Cincinnati, OH	24.2%	19.2%	15.2%	10.1%	11.8%	19.4%
Denver, CO	11.9%	15.7%	16.7%	24.3%	25.2%	6.2%
Des Moines, IA	13.6%	11.9%	15.3%	30.5%	20.3%	8.5%
Detroit, MI	9.7%	12.5%	15.3%	20.8%	33.3%	8.3%
Eugene, OR	13.4%	11.9%	11.9%	17.9%	32.8%	11.9%
Fargo, ND	11.0%	16.0%	30.0%	16.0%	13.0%	14.0%
Hartford, CT	20.0%	10.0%	13.3%	26.7%	21.7%	8.3%
Indianapolis, IN	11.6%	14.9%	14.9%	16.0%	22.1%	20.4%
Jackson, MS	33.9%	16.1%	14.5%	12.9%	4.8%	17.7%
Kansas City, MO	6.7%	12.4%	19.1%	23.6%	24.7%	13.5%
Las Vegas, NV	14.5%	18.4%	21.1%	19.7%	15.8%	10.5%
Lexington, KY	11.2%	15.3%	18.4%	28.6%	20.4%	6.1%
Little Rock, AR	14.0%	26.3%	22.8%	17.5%	7.0%	12.3%
Los Angeles, CA	37.7%	14.4%	8.5%	9.7%	10.6%	19.1%
Memphis, TN	30.9%	1.5%	4.4%	13.2%	30.9%	19.1%
New York, NY	25.4%	3.0%	6.0%	13.4%	35.8%	16.4%
Orlando, FL	17.5%	10.7%	20.4%	14.6%	16.5%	20.4%
Philadelphia, PA	9.0%	12.3%	12.3%	13.1%	27.9%	25.4%
Phoenix, AZ	18.8%	15.3%	20.0%	18.8%	20.0%	7.1%
Providence, RI	23.7%	7.9%	21.1%	15.8%	23.7%	7.9%
Salt Lake City, UT	22.8%	13.9%	20.3%	25.3%	11.4%	6.3%
San Antonio, TX	8.4%	15.0%	23.4%	19.6%	18.7%	15.0%
Sioux Falls, SD	6.3%	15.6%	15.6%	25.0%	28.1%	9.4%
Tucson, AZ	22.6%	19.4%	0.0%	29.0%	12.9%	16.1%
Weighted average	**18.9%**	**14.4%**	**16.1%**	**17.4%**	**19.1%**	**14.1%**

Note: Participants in the Sacramento, CA, Miami, FL and Seattle, WA community meetings did not respond to a comparable question.

Please rate each of the following public spending priorities to reach the goal of health care that works for all Americans. (RANKINGS FROM EACH MEETING WHERE QUESTION WAS ASKED THIS WAY)

Meeting Site	Guarantee Enough Providers	Invest in Public Health	Guarantee Health Insurance for All	Develop Health Information Technology	Improve Minority Access	Biomedical and Technological Research	Ensure Health Care for All, including Safety Net Programs for Poor	Preserve Medicare and Medicaid
Billings, MT	4th	1st	5th	3rd	8th	6th	2nd	7th
Charlotte, NC	5th	1st	4th	8th	7th	6th	2nd	3rd
Cincinnati, OH	4th	2nd	1st	8th	7th	6th	3rd	5th
Denver, CO	6th	4th	1st	8th	5th	7th	2nd	3rd
Des Moines, IA	3rd	2nd	1st	6th	5th	4th	7th	8th
Detroit, MI	3rd	2nd	1st	7th	4th	6th	8th	5th
Eugene, OR	5th	2nd	1st	7th	4th	8th	3rd	6th
Indianapolis, IN	3rd	2nd	1st	8th	5th	7th	4th	6th
Jackson, MS	3rd	5th	2nd	8th	4th	7th	1st	6th
Miami, FL	7th	4th	1st	8th	6th	5th	2nd	3rd
Phoenix, AZ	4th	2nd	1st	6th	3rd	5th	8th	7th
Providence, RI	5th	3rd	1st	7th	2nd	8th	4th	6th
Salt Lake City, UT	4th	1st	5th	6th-T	8th	6th-T	3rd	2nd
Seattle, WA	2nd	3rd	1st	8th	4th	7th	6th	5th

Considering the rising cost of health care, which of the following should be the MOST important priority for public spending to reach the goal of health care that works for all Americans? (SELECT ONE)

Meeting Site	Guarantee Enough Providers	Invest in Public Health	Guarantee Health Insurance[1] for All	Develop Health Information Technology	Improve Minority Access	Biomedical and Technological Research	Ensure Health Care for All, including Safety Net Programs for Poor	Preserve Medicare and Medicaid
Albuquerque, NM	8.4%	12.2%	58.8%	1.5%	1.5%	0.8%	12.2%	4.6%
Baton Rouge, LA	6.5%	23.9%	37.0%	8.7%	0.0%	2.2%	17.4%	4.3%
Fargo, ND	6.3%	28.1%	42.7%	1.0%	1.0%	4.2%	13.5%	3.1%
Kansas City, MO	3.1%	18.4%	40.8%	1.0%	2.0%	1.0%	33.7%	NA
Las Vegas, NV	9.7%	20.8%	37.5%	2.8%	6.9%	2.8%	12.5%	6.9%
Lexington, KY	5.8%	23.3%	51.5%	2.9%	1.9%	1.0%	10.7%	2.9%
Little Rock, AR	7.4%	22.3%	48.9%	1.1%	1.1%	0.0%	14.9%	4.3%
Los Angeles, CA	9.4%	8.3%	70.7%	0.6%	3.3%	0.0%	5.0%	2.8%
Orlando, FL	3.0%	17.0%	33.0%	3.0%	2.0%	0.0%	31.0%	11.0%
San Antonio, TX	0.9%	23.4%	47.7%	0.9%	0.9%	0.9%	16.8%	8.4%
Sioux Falls, SD	6.3%	21.9%	46.9%	3.1%	0.0%	0.0%	18.8%	3.1%
Weighted average	**6.2%**	**18.5%**	**49.8%**	**1.9%**	**2.1%**	**1.0%**	**15.8%**	**4.6%**

[1]In the Hartford community meeting, which is not included in the above table, participants changed the categories to include "Guarantee high quality care for everyone." This option was selected by 80% of participants. Note: Participants in the Memphis, Philadelphia, Sacramento, New York, and Tucson community meetings did not answer a comparable question.

If you believe it is important to ensure access to affordable, high quality health care coverage and services for all Americans, which is most important to you? (SELECT ONE)

Meeting Site	Individual Tax Incentives	Expand State Medicaid, SCHIP, etc.	Rely on Free Market	Expand Medicare/ FEHBP	Expand Employer Tax Incentives	Employer Insurance Mandate	Expand Neighborhood Health clinics	Create a National Health Program	Individual Insurance Mandate	Increase State Program Flexibility
Albuquerque, NM	11.1%	2.5%	2.5%	3.7%	2.5%	8.6%	4.9%	56.8%	6.2%	1.2%
Cincinnati, OH	7.8%	11.6%	6.0%	6.6%	3.9%	4.5%	2.4%	39.7%	17.0%	0.6%
Fargo, ND	9.9%	7.7%	7.7%	5.5%	12.1%	4.4%	3.3%	34.1%	9.9%	5.5%
Hartford, CT	0.0%	3.7%	0.0%	3.7%	3.7%	3.7%	5.6%	74.1%	5.6%	0.0%
Las Vegas, NV	5.8%	7.2%	0.0%	8.7%	1.4%	2.9%	2.9%	44.9%	20.3%	5.8%
Lexington, KY	6.3%	5.3%	3.2%	2.1%	2.1%	8.4%	1.1%	54.7%	16.8%	0.0%
Little Rock, AR	11.9%	9.9%	1.0%	11.9%	5.0%	1.0%	5.0%	25.7%	27.7%	1.0%
Los Angeles, CA	6.2%	6.2%	2.6%	7.2%	2.1%	4.1%	6.7%	59.5%	3.6%	1.5%
San Antonio, TX	1.9%	4.9%	4.9%	5.8%	3.9%	1.9%	1.0%	54.4%	19.4%	1.9%
Sioux Falls, SD	7.7%	11.5%	0.0%	15.4%	3.8%	3.8%	0.0%	30.8%	23.1%	3.8%

If you believe it is important to ensure access to affordable, high quality health care coverage and services for all Americans, which of these proposals would you suggest for doing this? (RANKINGS FROM EACH MEETING WHERE QUESTION WAS ASKED THIS WAY)

Billings, MT	8th	6th	10th	3rd	7th	9th	2nd	1st	4th	5th
Charlotte, NC	6th	10th	9th	3rd	4th	8th	2nd	5th	1st	7th
Denver, CO	9th	6th	10th	3rd	8th	7th	2nd	1st	4th	5th
Des Moines, IA	7th	6th	10th	2nd	8th	9th	3rd	1st	4th	5th
Detroit, MI	9th	6th	10th	3rd	8th	4th	2nd	1st	5th	7th
Eugene, OR	9th	6th	10th	5th	8th	7th	2nd	1st	4th	3rd
Indianapolis, IN	5th	6th	10th	4th	9th	8th	3rd	1st	2nd	7th
Jackson, MS	9th	7th	10th	3rd	4th	6th	2nd	1st	5th	8th
Kansas City, MO	7th	4th	NA	3rd	5th	9th	2nd	1st	6th	8th
Memphis, TN	7th	5th	10th	3rd	9th	6th	2nd	1st	4th	8th
Miami, FL	9th	4th	10th	3rd	6th	7th	2nd	1st	5th	8th
New York, NY	9th	4th	10th	2nd	8th	6th	3rd	1st	5th	7th
Philadelphia, PA	9th	7th	10th	3rd	8th	5th	2nd	1st	4th	6th
Phoenix, AZ	7th	9th	10th	5th	6th	4th	2nd	1st	3rd	8th
Providence, RI	9th	8th	10th	4th	7th	6th	2nd	1st	3rd	5th
Sacramento, CA	8th	7th	10th	3rd	9th	6th	2nd	1st	4th	5th
Salt Lake City, UT	6th	7th	9th	5th	8th	10th	2nd	3rd	1st	4th
Seattle, WA	9th	7th	10th	4th	8th	6th	2nd	1st	3rd	5th
Tucson, AZ	7th	5th	10th	4th	8th	9th	3rd	2nd	1st	6th

Note: Participants in the Orlando and Baton Rouge community meetings did not answer a comparable question.

Appendix C:
Working Group Health Care Poll

Total poll responses (internet, Catholic Health Association, and paper) as of August 31, 2006 (14,165) Including:

- **Paper polls added to the CHCWG poll (n = 641).**
- **Catholic Health Association (CHA) posting of the CHCWG poll. These responses were forwarded to the CHCWG from CHA (n = 1,079).**
- **Responses submitted by members of the Communication Workers of America (CWA) to the CHCWG Internet Poll (n = 505).**

1. How much do you agree or disagree with the following statement about health insurance coverage and public policy in the United States? By public policy, we mean a public goal set out in federal or state law.

It should be public policy (that is, a public goal set out in federal or state law) that all Americans have affordable health care insurance or other coverage.

	Total Poll responses	Paper Polls	CHA	CWA
Strongly agree	**78.5%**	77.8%	60.5%	89.7%
Agree	**13.1%**	17.5%	30.1%	6.5%
Neutral	**2.0%**	2.3%	4.3%	0.8%
Disagree	**2.1%**	0.6%	2.6%	0.4%
Strongly disagree	**3.5%**	0.6%	1.7%	1.4%
Not applicable/No response	**0.9%**	0.6%	0.8%	1.2%

2. Which one of the following do you think is the MOST important reason to have health insurance?

	Total Poll responses	Paper Polls	CHA	CWA
To pay for everyday medical expenses	**34.5%**	35.6%	35.3%	25.5%
To protect against high medical costs	**61.0%**	60.4%	61.7%	48.5%
No opinion	**3.7%**	2.2%	2.6%	25.4%
No response	**0.9%**	1.9%	0.4%	0.6%

3. Health insurance coverage can be organized in different ways. Which statement best describes your views on how health care coverage should be organized?

	Total Poll responses	Paper Polls	CHA	CWA
Provide coverage for particular groups of people (for example, employees, people who are elderly or cannot work because of disability, or people with very low incomes) as is the case now.	**11.5%**	12.0%	19.4%	5.15%
Provide coverage for everyone, for	**84.5%**	83.0%	75.1%	92.5%

***Note: Percentages may not add up to 100% due to rounding.**

a defined level of benefits, (either by expanding the current system or by creating a new system).				
No opinion	**2.9%**	3.4%	4.5%	1.4%
No response	**1.2%**	1.6%	1.0%	1.0%

4. Some health insurance models are designed to provide "basic" or "essential" services. When you think about the different kinds of health care that people use, which of the following services do you believe need to be included in BASIC insurance coverage for you and your family? Check all that apply.

	Total Poll responses	**Paper Polls**	**CHA**	**CWA**
Annual Physicals & Preventive Care	**93.5%**	93.2%	95.9%	96.6%
Chiropractic Care	**36.5%**	32.6%	36.8%	52.7%
Community-based Care Services (for people with disabilities)	**70.4%**	67.9%	61.5%	75.3%
Complementary and Alternative Medicine (such as acupuncture)	**36.1%**	31.5%	24.6%	44.2%
Dental Care	**81.7%**	85.5%	82.7%	91.7%
Doctor's Office Visits	**87.5%**	85.2%	90.4%	94.3%
Elective Surgery (such as plastic surgery)	**6.0%**	11.7%	6.8%	12.7%
Emergency Room Visits	**89.6%**	84.7%	85.7%	95.5%
Family Planning	**65.9%**	64.1%	53.5%	66.3%
Hearing Aids	**63.2%**	58.5%	53.8%	75.6%
Home Health Care	**70.6%**	68.6%	66.4%	79.6%
Hospice and Other Palliative Care (pain management)	**77.7%**	72.0%	73.8%	83.0%
Hospital Stays (including surgery)	**92.1%**	88.9%	90.0%	94.7%
Imaging Tests (MRI, CAT, X-ray)	**89.5%**	83.9%	84.1%	93.9%
Lab Tests	**92.5%**	89.6%	91.8%	94.3%
Medical Equipment (such as wheelchairs, prosthetics)	**73.5%**	66.3%	66.2%	81.6%
Mental Health Care	**81.2%**	76.9%	79.2%	84.8%
Nursing Home Care	**65.6%**	61.0%	61.9%	78.6%
Outpatient Surgery	**86.0%**	81.9%	83.8%	91.5%
Physical, Occupational & Speech Therapy	**76.6%**	68.6%	78.3%	84.8%
Prescription Drugs	**90.7%**	90.2%	91.1%	96.0%
Substance Abuse Treatment	**61.7%**	53.7%	58.9%	70.3%
Vision/Eye Care	**79.2%**	83.2%	77.4%	91.3%

***Note: Percentages may not add up to 100% due to rounding.**

5. Who should decide what services are covered in "basic" health insurance?

	Total Poll responses	Paper Polls	CHA	CWA
Consumers	**26.9%**	15.5%	15.1%	51.5%
Employers	**0.6%**	0.5%	1.5%	0.4%
Government	**3.5%**	3.0%	1.9%	1.4%
Insurance Companies	**0.5%**	0.0%	0.6%	0.0%
Medical Providers	**4.7%**	2.5%	5.5%	3.0%
Some combination of the above	**61.6%**	75.5%	72.0%	42.2%
Not sure	**1.6%**	2.3%	3.1%	1.4%
No response	**0.7%**	0.8%	0.3%	0.2%

6a. People may have different views about what is most important to them and their families when it comes to getting health care. Which of the following would be MOST important to you and your family if you have an opportunity to choose health care coverage?

	Total Poll responses	Paper Polls	CHA	CWA
Protecting the privacy and confidentiality of my medical history and treatment information	**4.0%**	4.7%	3.6%	2.6%
Not having to deal with paperwork and bills	**2.7%**	2.5%	1.4%	3.0%
Keeping down the cost of my insurance premiums	**23.2%**	18.9%	21.2%	38.4%
Keeping down out-of-pocket costs for visits, drugs, or other supplies	**23.2%**	18.9%	33.1%	27.5%
Convenience and waiting times for appointments and services	**1.6%**	6.9%	5.6%	0.8%
Being able to get information about the quality of health care services I need in order to make informed decisions about care for my family and me	**11.4%**	1.6%	0.6%	8.1%
Being able to get information about the costs of health care services I need in order to make informed decisions about care for my family and me	**6.1%**	14.4%	12.7%	3.4%
Having health care providers who are respectful and communicate well	**4.7%**	4.2%	4.4%	1.6%
Being able to choose which hospital to go to	**1.1%**	2.5%	1.7%	0.8%
Being able to choose my own personal physician	**17.0%**	21.5%	13.1%	11.5%
Being able to choose my own medical specialist	**4.1%**	3.3%	2.4%	2.2%
No response	**0.9%**	0.8%	0.2%	0.2%

***Note: Percentages may not add up to 100% due to rounding.**

6b. Which would be the NEXT MOST important?

	Total Poll responses	Paper Polls	CHA	CWA
Protecting the privacy and confidentiality of my medical history and treatment information	**4.7%**	4.8%	3.7%	2.6%
Not having to deal with paperwork and bills	**4.7%**	5.5%	1.4%	3.0%
Keeping down the cost of my insurance premiums	**18.7%**	16.5%	21.2%	38.4%
Keeping down out-of-pocket costs for visits, drugs, or other supplies	**21.4%**	15.3%	33.1%	27.5%
Convenience and waiting times for appointments and services	**2.8%**	6.6%	5.6%	0.8%
Being able to get information about the quality of health care services I need in order to make informed decisions about care for my family and me	**9.0%**	4.5%	0.6%	8.1%
Being able to get information about the costs of health care services I need in order to make informed decisions about care for my family and me	**7.3%**	10.4%	12.7%	3.4%
Having health care providers who are respectful and communicate well	**5.9%**	5.3%	4.4%	1.6%
Being able to choose which hospital to go to	**4.1%**	4.2%	1.7%	0.8%
Being able to choose my own personal physician	**14.7%**	15.6%	13.1%	11.5%
Being able to choose my own medical specialist	**5.3%**	8.1%	2.4%	2.2%
No response	**1.5%**	3.1%	0.2%	0.2%

7. One way or another, we all pay for the increasing costs of health care through increased insurance premiums, taxes, or consumer prices. How much do you agree or disagree with the following statements about paying for health care?

a. We should all be responsible for setting aside enough money to pay for most of our health care expenses.

	Total Poll responses	Paper Polls	CHA	CWA
Strongly agree	**7.2%**	6.2%	5.5%	4.8%
Agree	**14.7%**	18.1%	24.0%	5.4%
Neutral	**14.6%**	14.8%	21.1%	11.5%
Disagree	**29.7%**	30.1%	34.1%	20.0%
Strongly disagree	**30.9%**	25.7%	13.8%	56.8%
Not applicable/No response	**2.8%**	5.0%	1.5%	1.5%

b. We should all pay for part of our health care costs so we will be more careful about how we use health care

***Note: Percentages may not add up to 100% due to rounding.**

services.

	Total Poll responses	Paper Polls	CHA	CWA
Strongly agree	**19.2%**	21.7%	20.3%	4.2%
Agree	**37.2%**	39.5%	50.2%	20.2%
Neutral	**12.2%**	10.8%	9.8%	10.5%
Disagree	**16.4%**	13.1%	14.3%	43.6%
Strongly disagree	**12.9%**	11.7%	4.4%	20.2%
Not applicable/No response	**2.1%**	3.2%	0.9%	1.3%

c. People with health problems, who use more health services, should have to pay higher insurance premiums.

	Total Poll responses	Paper Polls	CHA	CWA
Strongly agree	**5.3%**	2.5%	6.1%	2.0%
Agree	**11.0%**	10.6%	14.7%	5.0%
Neutral	**12.5%**	15.0%	18.5%	5.7%
Disagree	**34.9%**	35.3%	41.5%	30.5%
Strongly disagree	**34.0%**	30.7%	17.9%	55.8%
Not applicable/No response	**2.4%**	5.8%	1.2%	1.0%

d. People with higher incomes should pay higher premiums for employer-sponsored health insurance.

	Total Poll responses	Paper Polls	CHA	CWA
Strongly agree	**15.0%**	14.0%	8.1%	33.3%
Agree	**21.7%**	23.6%	18.2%	16.0%
Neutral	**17.1%**	17.3%	18.0%	15.5%
Disagree	**27.1%**	23.9%	40.4%	22.0%
Strongly disagree	**16.1%**	14.5%	13.9%	12.1%
Not applicable/No response	**3.0%**	7.9%	1.5%	1.2%

e. People with higher incomes should pay more for health insurance they buy for themselves from insurance companies.

	Total Poll responses	Paper Polls	CHA	CWA
Strongly agree	**14.4%**	12.6%	6.8%	34.1%
Agree	**19.3%**	21.8%	15.9%	15.7%
Neutral	**17.9%**	18.1%	20.1%	14.5%
Disagree	**28.0%**	24.6%	41.6%	22.0%
Strongly disagree	**17.1%**	14.5%	13.9%	12.1%
Not applicable/No response	**3.3%**	8.2%	1.7%	1.8%

***Note: Percentages may not add up to 100% due to rounding.**

f. Everyone should pay the same amount for health insurance.

	Total Poll responses	Paper Polls	CHA	CWA
Strongly agree	**19.8%**	17.2%	14.5%	16.2%
Agree	**18.6%**	17.8%	26.7%	14.3%
Neutral	**14.1%**	14.3%	18.5%	11.7%
Disagree	**27.1%**	25.4%	29.2%	18.6%
Strongly disagree	**17.1%**	15.9%	9.7%	36.4%
Not applicable	**3.2%**	9.4%	1.5%	2.8%

8. How much do you agree or disagree with the following statements about controlling the rising costs of health care in America?

a. Health plans/insurers should use financial incentives (such as higher payments) to hospitals and doctors that provide efficient, high-quality care.

	Total Poll responses	Paper Polls	CHA	CWA
Strongly agree	**14.2%**	10.0%	11.0%	13.3%
Agree	**40.3%**	30.1%	43.0%	51.9%
Neutral	**17.8%**	18.9%	19.2%	16.0%
Disagree	**16.2%**	23.1%	19.3%	8.7%
Strongly disagree	**8.4%**	10.6%	5.5%	6.5%
Not applicable	**3.2%**	6.5%	2.9%	3.6%

b. Health plans/insurers should not pay for high-cost technologies or treatments that have not been proven to be safe and medically effective.

	Total Poll responses	Paper Polls	CHA	CWA
Strongly agree	**14.3%**	14.0%	12.9%	6.5%
Agree	**36.3%**	43.1%	44.5%	23.8%
Neutral	**23.7%**	17.8%	20.1%	43.4%
Disagree	**17.1%**	15.3%	16.3%	15.3%
Strongly disagree	**6.1%**	6.6%	3.9%	4.4%
Not applicable	**2.5%**	3.3%	1.5%	6.6%

c. Health plans/insurers should not pay for high-cost technologies or treatments even if they have been proven to be safe and medically effective, if less expensive yet equally safe and medically effective technologies or treatments are available.

	Total Poll responses	Paper Polls	CHA	CWA
Strongly agree	**13.3%**	9.7%	11.0%	5.7%
Agree	**36.9%**	35.9%	41.6%	23.2%
Neutral	**14.3%**	11.5%	14.7%	28.7%
Disagree	**20.7%**	16.2%	22.8%	27.5%
Strongly disagree	**11.7%**	10.0%	8.4%	12.3%
Not applicable	**3.0%**	16.7%	1.4%	2.6%

***Note: Percentages may not add up to 100% due to rounding.**

d. Health plans/insurers should use financial incentives (such as adjusting premiums and copayments) to encourage consumers to use more efficient and high-quality providers.

	Total Poll responses	Paper Polls	CHA	CWA
Strongly agree	**13.5%**	10.0%	12.2%	5.9%
Agree	**41.6%**	40.9%	52.9%	29.1%
Neutral	**18.3%**	17.6%	17.6%	32.5%
Disagree	**15.7%**	17.9%	12.6%	21.2%
Strongly disagree	**7.9%**	7.3%	3.2%	7.5%
Not applicable	**3.0%**	6.2%	1.5%	3.8%

e. Governments should set limits on prices for health care products, such as prescription drugs or medical devices.

	Total Poll responses	Paper Polls	CHA	CWA
Strongly agree	**39.0%**	33.9%	29.8%	37.4%
Agree	**32.4%**	34.5%	38.4%	45.0%
Neutral	**9.2%**	11.4%	11.9%	5.9%
Disagree	**9.5%**	11.9%	12.6%	5.5%
Strongly disagree	**7.7%**	5.2%	6.1%	3.6%
Not applicable	**2.1%**	3.2%	1.3%	2.6%

f. Governments should make it harder to qualify for enrollment in their programs that provide health coverage or health care services.

	Total Poll responses	Paper Polls	CHA	CWA
Strongly agree	**3.4%**	2.0%	5.3%	4.2%
Agree	**5.0%**	3.6%	9.6%	3.2%
Neutral	**9.6%**	8.9%	17.7%	6.9%
Disagree	**31.0%**	37.0%	38.6%	24.0%
Strongly disagree	**46.6%**	43.7%	25.5%	56.0%
Not applicable	**4.4%**	4.8%	3.2%	5.8%

g. Governments should improve the administration and efficiency of their health care programs.

	Total Poll responses	Paper Polls	CHA	CWA
Strongly agree	**56.0%**	50.4%	47.2%	41.0%
Agree	**30.0%**	36.0%	39.6%	29.5%
Neutral	**7.4%**	7.2%	7.7%	23.2%
Disagree	**2.0%**	1.7%	1.9%	2.2%
Strongly disagree	**1.9%**	0.8%	1.5%	0.6%
Not applicable	**2.8%**	4.9%	1.1%	3.6%

***Note: Percentages may not add up to 100% due to rounding.**

h. The private sector should increase efforts to improve the efficiency of health care providers that are paid through private insurance.

	Total Poll responses	Paper Polls	CHA	CWA
Strongly agree	**34.6%**	28.9%	20.8%	49.5%
Agree	**37.7%**	40.1%	44.5%	32.3%
Neutral	**15.8%**	16.5%	25.4%	11.5%
Disagree	**4.9%**	5.0%	5.9%	3.0%
Strongly disagree	**2.9%**	3.1%	2.0%	1.4%
Not applicable	**4.1%**	6.4%	1.5%	2.4%

i. Doctors, hospitals, and other health care providers should invest more in computerized information systems to monitor and improve health care quality, reduce errors, and improve administrative efficiencies.

	Total Poll responses	Paper Polls	CHA	CWA
Strongly agree	**32.7%**	24.2%	20.8%	49.5%
Agree	**38.0%**	44.0%	44.5%	32.3%
Neutral	**20.3%**	18.6%	25.4%	11.5%
Disagree	**4.3%**	7.2%	5.9%	3.0%
Strongly disagree	**1.8%**	2.5%	2.0%	1.4%
Not applicable	**2.8%**	3.6%	1.5%	2.4%

9. How much MORE would you be willing to pay (taxes, premiums, copayments, or deductibles) in a year to support efforts that would result in every American having access to affordable, high quality health care coverage and services?

	Total Poll responses	Paper Polls	CHA	CWA
$0	**12.8%**	10.6%	17.0%	12.9%
$1-$99	**17.1%**	15.6%	26.2%	13.5%
$100-$299	**21.3%**	19.3%	20.7%	14.1%
$300-$999	**16.9%**	14.5%	11.1%	9.7%
$1,000 or more	**11.7%**	12.8%	3.3%	4.2%
Don't know	**18.9%**	22.9%	21.0%	44.2%
No response	**1.3%**	4.2%	0.6%	1.6%

10. Considering the rising cost of health care, which of the following should be the MOST important priorities for public spending on health and health care in America? Choose up to 3.

	Total Poll responses	Paper Polls	CHA	CWA
Guaranteeing that there are enough health care providers, especially in inner cities and rural areas	**24.1%**	30.9%	21.3%	20.8%
Investing in public health programs to prevent disease, promote healthy lifestyles, and protect the public during epidemics or disasters	**49.7%**	48.2%	54.6%	34.5%

***Note: Percentages may not add up to 100% due to rounding.**

Guaranteeing that all Americans have health insurance	**64.6%**	63.5%	58.2%	82.4%
Funding the development of computerized health information to improve quality and efficiency of health care	**11.4%**	9.1%	10.8%	7.9%
Funding medical education to ensure that we have enough high quality medical professionals and health care workers	**16.6%**	19.8%	19.3%	14.1%
Funding programs that help eliminate problems in access to or quality of care for minorities	**10.6%**	10.3%	6.7%	5.5%
Funding biomedical and technological research	**10.5%**	8.6%	7.7%	9.7%
Guaranteeing that all Americans get health care when they need it, through some form of private or public program, including "safety net" programs for those who cannot afford care otherwise	**69.8%**	67.4%	76.3%	80.8%

11. Many people believe that fixing our health care system will require trade-offs by everyone (such as consumers, employers, government agencies, insurers, and providers). By trade-offs, we mean reducing or eliminating something to get more of something else. How much do you agree or disagree with the following possible trade-offs?

a. Accepting a significant waiting time for non-critical care to get a 10 percent reduction in health care costs.

	Total Poll responses	**Paper Polls**	**CHA**	**CWA**
Strongly agree	**9.4%**	21.5%	7.0%	3.0%
Agree	**35.8%**	39.3%	32.9%	21.6%
Neutral	**16.1%**	12.5%	20.5%	14.3%
Disagree	**24.2%**	12.5%	25.7%	20.8%
Strongly disagree	**9.8%**	8.6%	11.6%	8.9%
Not applicable	**4.8%**	5.0%	2.4%	31.5%

b. Paying a higher deductible in your insurance for more choice of doctors and hospitals

	Total Poll responses	**Paper Polls**	**CHA**	**CWA**
Strongly agree	**6.4%**	21.5%	3.9%	1.2%
Agree	**29.2%**	39.3%	32.9%	11.3%
Neutral	**15.7%**	12.5%	16.7%	13.7%
Disagree	**30.2%**	12.5%	33.4%	27.7%
Strongly disagree	**13.6%**	8.6%	11.0%	15.3%
Not applicable	**4.8%**	5.0%	2.0%	30.9%

***Note: Percentages may not add up to 100% due to rounding.**

c. Paying more in taxes to have basic health insurance coverage for all

	Total Poll responses	Paper Polls	CHA	CWA
Strongly agree	**26.2%**	21.5%	7.0%	9.7%
Agree	**36.9%**	39.3%	32.9%	27.9%
Neutral	**10.5%**	12.5%	20.5%	9.1%
Disagree	**11.5%**	12.5%	25.7%	11.9%
Strongly disagree	**11.3%**	8.6%	11.6%	11.9%
Not applicable	**3.7%**	5.0%	2.4%	29.5%

d. Expanding federal programs to cover more people, but provide fewer services to persons currently covered by those programs.

	Total Poll responses	Paper Polls	CHA	CWA
Strongly agree	**3.3%**	3.6%	2.2%	1.4%
Agree	**13.7%**	13.9%	19.9%	6.5%
Neutral	**16.9%**	16.2%	24.4%	10.3%
Disagree	**38.9%**	34.5%	38.0%	32.3%
Strongly disagree	**22.4%**	21.4%	13.4%	19.2%
Not applicable	**4.9%**	10.4%	2.0%	30.3%

e. Limiting coverage for certain end-of-life care services of questionable value in order to provide more at-home and comfort care for the dying.

	Total Poll responses	Paper Polls	CHA	CWA
Strongly agree	**23.6%**	20.8%	16.0%	9.5%
Agree	**35.8%**	34.6%	37.8%	25.7%
Neutral	**16.6%**	15.6%	21.0%	15.1%
Disagree	**11.1%**	10.8%	15.6%	8.3%
Strongly disagree	**8.3%**	10.0%	7.4%	10.1%
Not applicable	**4.5%**	8.2%	2.3%	31.3%

12. There are different ways to assure coverage for all Americans. Remembering that we all pay for the cost of health care through insurance premiums, taxes, or consumer prices, how much do you agree or disagree with the following options?

a. Offer uninsured Americans income tax deductions, credits, or other financial assistance to help them purchase private health insurance on their own.

	Total Poll responses	Paper Polls	CHA	CWA
Strongly agree	**12.3%**	8.3%	7.9%	6.0%
Agree	**29.7%**	32.0%	41.5%	20.2%
Neutral	**13.6%**	12.2%	17.2%	11.7%
Disagree	**23.9%**	23.7%	23.2%	45.0%
Strongly disagree	**16.9%**	15.1%	8.1%	14.7%
Not applicable	**3.6%**	8.7%	2.3%	2.6%

***Note: Percentages may not add up to 100% due to rounding.**

b. Expand state government programs for low-income people, such as Medicaid and the State Children's Health Insurance Program, to provide coverage for more people without health insurance.

	Total Poll responses	Paper Polls	CHA	CWA
Strongly agree	**23.8%**	21.5%	10.5%	16.0%
Agree	**43.9%**	46.0%	46.6%	55.0%
Neutral	**12.0%**	10.8%	17.6%	17.4%
Disagree	**10.8%**	10.0%	18.5%	5.5%
Strongly disagree	**6.4%**	3.3%	4.5%	2.6%
Not applicable	**3.2%**	8.4%	2.2%	3.6%

c. Rely on free market competition among doctors, hospitals, other health care providers and insurance companies, rather than having government define benefits and set prices.

	Total Poll responses	Paper Polls	CHA	CWA
Strongly agree	**10.1%**	5.0%	6.5%	4.4%
Agree	**13.0%**	15.3%	23.5%	10.5%
Neutral	**14.1%**	14.0%	25.5%	11.5%
Disagree	**25.8%**	29.3%	28.3%	28.1%
Strongly disagree	**33.7%**	28.0%	13.8%	42.0%
Not applicable	**3.2%**	8.3%	2.3%	3.6%

d. Open up enrollment in national federal programs like Medicare or the federal employees' health benefit program.

	Total Poll responses	Paper Polls	CHA	CWA
Strongly agree	**24.2%**	20.9%	7.5%	18.8%
Agree	**40.1%**	40.6%	39.1%	58.4%
Neutral	**19.2%**	19.3%	32.6%	12.9%
Disagree	**7.8%**	8.1%	13.5%	5.0%
Strongly disagree	**5.8%**	2.5%	4.7%	1.4%
Not applicable	**3.0%**	8.6%	2.6%	3.6%

e. Require businesses to offer health insurance to their employees.

	Total Poll responses	Paper Polls	CHA	CWA
Strongly agree	**23.3%**	20.0%	17.2%	29.3%
Agree	**32.3%**	37.0%	46.3%	52.9%
Neutral	**17.5%**	17.3%	17.7%	8.9%
Disagree	**13.6%**	12.5%	11.7%	2.6%
Strongly disagree	**9.9%**	4.8%	4.9%	1.6%
Not applicable	**3.3%**	8.4%	2.3%	4.8%

***Note: Percentages may not add up to 100% due to rounding.**

f. Expand neighborhood health clinics.

	Total Poll responses	Paper Polls	CHA	CWA
Strongly agree	**27.2%**	25.1%	12.3%	19.8%
Agree	**45.9%**	48.7%	50.4%	51.7%
Neutral	**18.1%**	14.2%	26.3%	23.0%
Disagree	**3.6%**	2.3%	8.0%	1.6%
Strongly disagree	**2.0%**	1.6%	0.8%	0.4%
Not applicable	**3.2%**	8.1%	2.2%	3.6%

g. Create a national health plan, financed by taxpayers, in which all Americans would get their health insurance.

	Total Poll responses	Paper Polls	CHA	CWA
Strongly agree	**47.5%**	41.3%	16.3%	55.1%
Agree	**22.8%**	26.8%	30.3%	25.0%
Neutral	**10.1%**	12.5%	23.2%	7.5%
Disagree	**7.0%**	6.7%	16.4%	4.8%
Strongly disagree	**10.2%**	6.2%	10.4%	4.8%
Not applicable	**2.3%**	6.4%	3.3%	3.0%

h. Require that all Americans enroll in basic health care coverage, either private or public.

	Total Poll responses	Paper Polls	CHA	CWA
Strongly agree	**19.2%**	20.8%	12.0%	11.1%
Agree	**28.0%**	28.7%	40.9%	21.4%
Neutral	**21.4%**	22.2%	22.8%	16.4%
Disagree	**16.0%**	13.3%	15.3%	35.4%
Strongly disagree	**11.7%**	6.2%	5.8%	11.3%
Not applicable	**3.9%**	8.9%	3.2%	4.2%

i. Increase flexibility given states in how they use federal funds (such as Medicaid and the State Children's Health Insurance Program) to maximize coverage.

	Total Poll responses	Paper Polls	CHA	CWA
Strongly agree	**15.6%**	15.9%	9.7%	7.7%
Agree	**39.3%**	40.1%	44.6%	24.0%
Neutral	**23.4%**	17.8%	28.4%	19.8%
Disagree	**11.5%**	10.8%	10.5%	34.1%
Strongly disagree	**6.8%**	7.5%	3.4%	10.3%
Not applicable	**3.5%**	8.0%	2.9%	4.2%

***Note: Percentages may not add up to 100% due to rounding.**

j. Expand current tax incentives available to employers and their employees to encourage them to offer insurance to more workers and their families.

	Total Poll responses	Paper Polls	CHA	CWA
Strongly agree	**26.7%**	23.4%	23.2%	20.0%
Agree	**42.5%**	43.4%	57.7%	25.7%
Neutral	**13.0%**	11.2%	12.1%	11.7%
Disagree	**8.3%**	8.1%	3.2%	30.9%
Strongly disagree	**6.1%**	6.6%	0.9%	7.9%
Not applicable	**3.5%**	7.3%	2.9%	3.8%

We have a few final questions just to help us better understand who our respondents are.

13. Are you male or female?

	Total Poll responses	Paper Polls	CHA	CWA
Male	**36.0%**	27.0%	17.8%	52.9%
Female	**61.7%**	69.6%	80.5%	44.4%
Decline to answer/No response	**2.3%**	3.4%	1.7%	2.8%

14. How old are you?

	Total Poll responses	Paper Polls	CHA	CWA
Under 25	**3.2%**	3.9%	2.7%	0.0%
25 to 44	**27.7%**	15.8%	36.2%	18.0%
45 to 64	**54.5%**	45.25%	55.8%	71.3%
65 and over	**12.3%**	31.5%	3.2%	7.9%
Decline to answer	**2.3%**	4.0%	2.0%	2.8%

15. Are you Hispanic or Latino?

	Total Poll responses	Paper Polls	CHA	CWA
Yes	**2.7%**	4.5%	1.2%	3.6%
No	**90.0%**	88.1%	93.6%	84.8%
Decline to answer/No response	**7.3%**	7.2%	5.2%	10.5%

16. Which of these groups best represents your race?

	Total Poll responses	Paper Polls	CHA	CWA
White	**84.1%**	82.0%	92.4%	74.7%
Black or African American	**2.2%**	6.1%	0.5%	4.4%
Asian	**1.0%**	0.6%	0.8%	0.8%
Native Hawaiian or Pacific Islander	**0.1%**	0.0%	0.2%	0.2%
American Indian or Alaska Native	**0.5%**	0.9%	0.2%	1.0%
Other	**1.8%**	1.7%	0.5%	2.8%
2 or more of the above	**1.7%**	2.0%	0.4%	3.0%
Decline to answer/no response	**8.6%**	6.7%	5.0%	13.3%

***Note: Percentages may not add up to 100% due to rounding.**

17. What is the highest grade or year of school you completed?

	Total Poll responses	Paper Polls	CHA	CWA
Elementary (grades 1 to 8) or less	**0.1%**	1.4%	0.0%	0.%
Some high school	**0.4%**	1.4%	0.2%	0.2%
High school graduate or GED	**6.1%**	8.7%	11.5%	13.9%
Some college	**17.7%**	14.5%	21.0%	37.6%
Associate Degree	**8.5%**	8.9%	18.1%	14.5%
Bachelor's Degree	**29.3%**	24.2%	28.4%	21.8%
Graduate degree	**35.7%**	37.9%	18.7%	9.5%
Decline to answer/no response	**2.3%**	3.0%	2.3%	2.6%

18. Do you have any kind of health care coverage, including health insurance, prepaid plans such as HMOs, or government plans such as Medicare or Medicaid?

	Total Poll responses	Paper Polls	CHA	CWA
Yes	**91.1%**	90.3%	96.3%	95.3%
No	**7.7%**	6.6%	3.0%	3.4%
Not sure/no response	**1.3%**	3.1%	0.7%	1.4%

19. Have you attended any community meetings on the American health care system?

	Total Poll responses	Paper Polls	CHA	CWA
Yes	**22.9%**	45.9%	14.3%	17.6%
No	**75.7%**	50.9%	85.4%	80.6%
Not sure/no response	**1.4%**	3.3%	0.4%	1.6%

20. Have you participated in any web casts on the American health care system?

	Total Poll responses	Paper Polls	CHA	CWA
Yes	**9.9%**	7.6%	5.8%	12.9%
No	**87.9%**	75.7%	93.0%	85.4%
Not sure/no response	**2.2%**	16.7%	1.3%	1.8%

21. Have you read The Health Report to the American People and other material available on our web site?

	Total Poll responses	Paper Polls	CHA	CWA
Yes	**21.1%**	13.9%	9.1%	19.8%
No	**76.8%**	69.3%	90.0%	78.2%
Not sure/no response	**2.1%**	16.9%	0.9%	2.0%

***Note: Percentages may not add up to 100% due to rounding.**

Appendix D: University Town Hall Survey

March 22, 2006 (All Universities Combined)

NOTE: TOTAL NUMBER OF RESPONDENTS = 772.

D1. Are you male or female?

Male	40.7%
Female	59.1
No response	0.3

D2. Are you Hispanic or Latino?

Yes	4.2%
No	95.0
No response	0.9

D3. How old are you?

Under 25	17.0%
25-44	35.2
45-64	36.1
65 and over	11.5
No response	0.1

D4. Which of these groups best represents your race? (Check all that apply.)
(NOTE: THE PERCENTAGES ARE AMONG PEOPLE WHO PROVIDED A RESPONSE TO AT LEAST ONE RACE: N=759 OUT OF 772.)

Race	**Yes**	**No response**
White	80.9%	19.1%
Black or African American	6.3	93.7
Asian	9.1	90.9
Native Hawaiian or Pacific Islander	0.5	99.5
American Indian or Alaska Native	0.5	99.5
Other	4.2	95.8

D5. What is the highest grade or year of school you completed?

Elementary (grades 1-8) or less	0.4%
Some high school	0.3
High school graduate or GED	0.9
Some college	10.8
Associate Degree	1.6
Bachelor's Degree	31.6
Master's Degree	31.1
Doctoral Degree	22.8
No response	0.7

D6. What is your primary source of health insurance?

Employer-based insurance	65.8%
Self-purchased insurance	10.6
Medicare	9.1
Medicaid	0.5
Veteran's	1.3
Other	7.4
None	4.0
Not sure	0.8
No response	0.5

D7. What is your employment status?

Self-employed	5.2%
Employed, working full-time	46.0
Employed, working part-time	17.5
Not employed currently/looking for work	5.2
Homemaker	1.3
Retired	9.3
Other	14.9
No response	0.7

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1. Which one of these statements do you think **BEST** describes the U.S. health care system today?

It is in a state of crisis	47.9%
It has major problems	48.6
It has minor problems	3.0
It does not have any problems	--
No response	0.5

2. Which one of the following do you think is the **MOST** important reason to have health insurance?

To pay for everyday medical expenses	30.7%
To protect against high medical costs	63.1
No opinion	1.6
No response	1.2
Other	3.5

3. How much do you agree or disagree with the following statement about health insurance coverage and public policy in the United States? By public policy, we mean a public goal set out in federal or

state law. "It should be public policy (that is, a public goal set out in federal or state law) that all Americans have affordable health care insurance or other coverage."

Strongly Agree	77.2%
Agree	17.8
Neutral	1.6
Disagree	0.7
Strongly Disagree	2.1
No response	0.8

4. Health insurance coverage can be organized in different ways. Which statement best describes your views on how health care coverage should be organized?

Provide coverage for particular groups of people (for example, employees, people who are elderly or cannot work because of disability, or people with very low incomes) as the case is now	7.5%
Provide coverage for everyone, for a defined level of benefits (either by expanding the current system or by creating a new system)	90.0
No response	1.9
Other	0.5

5. Should everyone be required to enroll in basic health care coverage, either private or public?

Yes	82.4%
No	15.0
No response	2.5
Other	0.1

6. Should some people be responsible for paying more than others?

Yes	81.2%
No	15.2
No response	3.4
Other	0.3

7. What criteria should be used for making some people pay more?

(NOTE: THE PERCENTAGES ARE AMONG PEOPLE WHO PROVIDED A RESPONSE TO AT LEAST ONE REASON: N=754 OUT OF 772.)

Q	**Reason**	**Yes**	**No response**	**Not/Applicable**
7_a	None-everyone should pay the same	12.3%	87.7%	--%
7_b	Family size	--	--	100.0
7_c	Health behaviors	42.7	57.3	--
7_d	Income	70.7	29.3	--
7_e	Other	--	--	100.0
7_f	Age	6.8	93.2	--
7_g	Prior or current health conditions	7.6	92.4	--

8. How much do you agree or disagree with the following statements about controlling the rising costs of health care in America? (NOTE: THE PERCENTAGES ARE AMONG PEOPLE WHO PROVIDED A RESPONSE TO AT LEAST ONE STATEMENT: N=686 OUT OF 772.)

Q	Statement (**S**trongly **A**gree**, A**gree**, N**eutra**l, D**isagree**, S**trongly **D**isagree	SA (5)	A (4)	N (3)	D (2)	SD (1)	Other
8_a	Health plans/insurers should use financial incentives (such as higher payments) to hospitals and doctors that provide efficient, high-quality care.	23.8%	46.9%	15.3%	10.4%	3.6%	--
8_b	Health plans/insurers should not pay for high-cost technologies or treatments that have not been proven to be safe and medically effective.	22.3	35.7	20.6	18.5	2.9	--
8_c	Health plans/insurers should not pay for high-cost technologies or treatments even if they have been proven to be safe and medically effective if less expensive yet equally safe and medically effective technologies or treatments are available.	22.7	39.4	15.3	15.7	6.9	--
8_d	Health plans/insurers should use financial incentives (such as adjusting premiums and copayments) to encourage consumers to use more efficient and high-quality providers.	16.6	43.6	20.0	13.4	6.4	--
8_e	Health plans/insurers should use financial incentives to encourage consumers to pursue healthy lifestyles and prevention.	43.6	38.6	10.5	4.5	2.8	--
8_f	Governments should set limits on prices for health care products, such as prescription drugs or medical devices.	33.7	34.1	14.4	11.7	6.0	0.2
8_g	Governments should make it harder to qualify for enrollment in their programs that provide health coverage or health care services.	1.6	3.4	13.7	34.8	46.5	--
8_h	Governments should improve the administration and efficiency of their health care programs.	53.6	35.1	7.6	2.0	1.6	--
8_i	The private sector should increase efforts to improve the efficiency of health care providers that are paid through private insurance.	32.7	41.6	18.5	5.4	1.9	--
8_j	Doctors, hospitals, and other health care providers should invest more in computerized information systems to monitor and improve health care quality, reduce errors, and improve administrative efficiencies.	41.6	42.1	12.0	2.8	1.6	--

8_k. Do you have a preferred solution?
If there is a comment, write the specific response here.
{OPEN-ENDED RESPONSES}

9. There are different ways to assure coverage for all Americans. Remembering that we all pay for the cost of health care through insurance premiums, taxes, or consumer prices, how much do you agree or disagree with the following options?

Q	Statement	SA (5)	A (4)	N (3)	D (2)	SD (1)	Other
9_a	Offer uninsured Americans income tax deductions, credits, or other financial assistance to help them purchase private health insurance on their own	10.4%	24.7%	17.7%	31.1%	15.9%	0.2%
9_b	Expand state government programs for low-income people, such as Medicaid and the State Children's Health Insurance Program, to provide coverage for more people without health insurance	26.5	45.0	12.9	11.1	4.5	--
9_c	Rely on free market competition among doctors, hospitals, other health care providers and insurance companies, rather than having government define benefits and set prices	4.8	11.0	14.9	34.9	34.4	--
9_d	Open up enrollment in national federal programs like Medicare or the federal employees' health benefit program	22.1	41.2	23.0	10.2	3.5	--
9_e	Require businesses to offer health insurance to their employees	18.3	28.5	21.1	23.8	8.3	--
9_f	Expand neighborhood health clinics	34.4	44.3	15.8	3.4	2.2	--
9_g	Create a national health plan, financed by taxpayers, in which all Americans would get their health insurance	51.5	26.6	9.1	7.0	5.9	--
9_h	Require that all Americans enroll in basic health care coverage, either private or public	37.7	35.8	12.7	9.7	4.1	--
9_i	Increase flexibility given states in how they use federal funds (such as Medicaid and the State Children's Health Insurance Program) to maximize coverage	15.5	42.7	22.2	13.5	6.1	--
9_j	Expand current tax incentives available to employers and their employees to encourage them to offer insurance to more workers and their families	19.7	40.8	18.0	14.8	6.7	--

10. OPTIONAL: Considering the rising cost of health care, which of the following should be the MOST important priorities for public spending on health and health care in America? Choose up to 3. NOTE: 626 RESPONDENTS ANSWERED AT LEAST ONE OF THE QUESTIONS BELOW. THE PERCENTAGES ARE ONLY OF THOSE 626 RESPONDENTS.

		Yes	No Response
10_a	Guaranteeing that there are enough health care providers, especially in inner cities and rural areas	23.5%	76.5%
10_b	Investing in public health programs to prevent disease, promote healthy lifestyles, and protect the public during epidemics or disasters	71.8	28.2
10_c	Guaranteeing that all Americans have health insurance	60.3	39.7
10_d	Funding the development of computerized health information to improve the quality and efficiency of health care	20.3	79.8
10_e	Funding medical education to ensure that we have enough high-quality medical professionals and health care workers	13.9	86.1
10_f	Funding programs that help eliminate problems in access to or quality of care for minorities	20.3	79.8
10_g	Funding biomedical and technological research	11.2	88.8
10_h	Guaranteeing that all Americans get health care when they need it, through some form of private or public program, including "safety net" programs for those who cannot afford care otherwise	65.3	34.7

11. OPTIONAL: How much do you agree or disagree with the following possible trade-off? NOTE: 621 RESPONDENTS ANSWERED AT LEAST ONE OF THE QUESTIONS BELOW. THE PERCENTAGES ARE ONLY OF THOSE 621 RESPONDENTS.

Q	Statement	SA (5)	A (4)	N (3)	D (2)	SD (1)	No response	Other
11_a	Accepting a significant waiting time for non-critical care to get a 10% reduction in health care costs	9.9%	36.7%	21.6%	22.7%	6.6%	2.4%	0.2%
11_b	Paying a higher deductible in your insurance for more choice of doctors and hospitals	8.9	35.3	22.4	24.0	7.7	1.7	--
11_c	Paying more in taxes to have basic health insurance coverage for all	35.0	39.8	9.4	10.7	4.1	1.1	--
11_d	Expanding federal programs to cover more people, but provide fewer services to persons currently covered by those programs	5.2	19.1	23.7	38.9	10.8	2.4	--
11_e	Limiting coverage for certain end-of-life care services of questionable value in order to provide more at-home and comfort care for the dying	27.7	35.3	20.2	11.3	3.3	2.2	--

Number of Surveys, by University

University Name	Number of Responses	Percent
Boston University	33	4.3%
Drexel University	34	4.4
Emory University	14	1.8
George Washington University	18	2.3
Indiana University	43	5.6
Louisiana State University/Tulane University	27	3.5
Michigan State	39	5.1
Northwestern University	23	3.0
Ohio State University	42	5.4
Penn State University	44	5.7
Purdue University	63	8.2
University of Illinois	26	3.4
University of Iowa	27	3.5
University of Michigan	87	11.3
University of Minnesota	99	12.8
University of Wisconsin	46	6.0
University at Albany	18	2.3
University of Arkansas	10	1.3
University of Louisville	18	2.3
University of South Carolina	10	1.3
Johns Hopkins University	34	4.4
Grey Panthers—Huron Valley	17	2.2

Appendix E: Health Care Presentations

Invited experts, stakeholders, and citizens have given presentations to the Citizens' Health Care Working Group on a wide array of health care subjects. What follows is a list of those presentations, organized chronologically in order of presentation to the Working Group.

Underlined text denotes a link to an electronic document on our website that contains the presentation, biographical information, or meeting summary.

Wednesday, May 11, 2005; Crystal City, VA

Overview of the American Health Care System

- "America's Thinning Social Contract," John Iglehart, Project Hope. (See summary for 5/11/2005.) Provides description of American health care system and health expenditures. Asserts that the United States provides a lower rate of health care coverage than other industrialized countries. Many of the uninsured are employed full time. Health care expenditure growth has been outstripping the rates of increase in wages and non health expenditures. Among 30 countries belonging to the Organization for Economic Development and Cooperation, tax receipts are lowest in the United States, but our expenditures for health care are highest.

Public Insurance Programs: Medicare, Medicaid and SCHIP

- "Overview of Medicare, Medicaid and State Children's Health Insurance Program," Bill Scanlon, Health Policy R&D. (See summary for 5/11/2005.) Describes the three major publicly-funded federal and state health care financing programs.

The Uninsured

- "The Uninsured in America," Peter Cunningham, Center for Studying Health System Change. (See summary for 5/11/2005.) Provides fundamental background information about the uninsured in America and the difficulties in addressing their needs.

Thursday, May 12, 2005; Crystal City, VA

Private Health Insurance: Employer-Based Insurance and the Individual Market

- "Employment-Based Health Benefits Among Mid-Sized and Large Employers," Paul Fronstin, Employee Benefit Research Institute. (See summary for 5/12/2005.) Describes the status of employer-sponsored health insurance and changes taking place that are weakening this form of coverage.

- "Small-Group and Individual Coverage," Deborah Chollet, Mathematica Policy Research. (See summary for 5/12/2005.) Describes features of the small group and individual insurance markets

Public Sector Initiatives to Expand Coverage

- "State Strategies To Expand or Maintain Health Care Coverage," Linda Bilheimer, Robert Wood Johnson Foundation. (See summary for 5/12/2005.) Identifies numerous state initiatives in process or under consideration tailored to expand or maintain coverage and to constrain costs in State Medicaid programs.

- *National Governors' Association (NGA) Reform Proposal*, Matt Salo, NGA (See summary for 5/12/2005.) Describes challenges facing state Medicaid programs from the perspective of the

States and offers some suggestions for change, such as updating federal cost sharing rules, which have not been changed since 1982.

- "Communities in Charge: Financing and Delivering Health Care to the Uninsured: Lessons from Community-Based Initiatives to Expand Coverage and Improve Care Delivery," Terry Stoller, Medimetrix. (See summary for 5/12/2005.) Describes a four-year Robert Wood Johnson Foundation-funded effort to develop comprehensive community-based health care services for the uninsured and the underinsured.

Private Sector Initiatives to Expand Coverage

- "National Health Access," Ken Sperling, CIGNA. (See summary for 5/12/2005.) Describes an initiative promoted by the Human Resources Policy Association to address the health care coverage needs of the working uninsured; an effort scheduled to be implemented in 2005 at many U.S. corporations.

- "Private Initiatives to Expand Coverage," Anthony Tersigni, Ascension Health. (See summary for 5/12/2005.) Describes Ascension Health's efforts to improve health care for underserved members of their communities, including underlying principles and a model for change at the community level. Includes description of some efforts in communities where Ascension Health facilities are located.

Friday, May 13, 2005; Crystal City, VA

Health Care Costs

- "Building the Foundation: Health Care Costs," Jennifer Jenson, Congressional Research Service. (See summary for 5/13/2005.) Provides a broad overview of the large issues and fiscal facts regarding health care in the United States and the relative roles of government and the private sector.

- "National Health Expenditure Accounts," Rick Foster and Stephen Heffler, Centers for Medicare and Medicaid Services. (See summary for 5/13/2005.) Reviews the continuing growth in national health care expenditures in absolute value terms and as a proportion of all national expenditures.

Public Sector Initiatives to Control Costs

- "Controlling Costs in Medicare," Jack Hoadley, Georgetown University. (See summary for 5/13/2005.) Describes ways in which Medicare currently constrains costs and additional options for the future, which include adjustments to the payment system, innovative approaches to purchasing services in the fee-for-service market, and increased enrollment in managed care.

- "Public Sector Initiatives To Control Costs: Medicaid," Jim Verdier, Mathematica Policy Research. (See summary for 5/13/2005.) Describes major direct cost control mechanisms including: limiting eligibility or benefits covered, increasing copayments and deductibles, implementing disease management programs, instituting mechanisms for controlling pharmacy costs, and limiting possibility of fraud.

- "Public Sector Initiatives to Control Costs: The State Children's Health Insurance Program," Genevieve Kenney, Urban Institute. (See summary for 5/13/2005.) Describes some methods that states have used to constrain costs under the program, including enrollment caps and eligibility cutbacks, premium increases, and reduced outreach efforts.

Private Sector Initiatives to Control Costs

- "Private Sector Initiatives to Control Costs Presentation to Citizens' Health Care Working Group," Alice Rosenblatt, WellPoint. (See summary for 5/13/2005.) Describes WellPoint's initiatives to

control costs and provide better information to its health care consumers. Also describes WellPoint's Pay for Performance, pharmacy management, and behavioral health initiatives.

- "Private Sector Initiatives: Controlling Costs and Empowering Consumers," Helen Darling, Washington Business Group on Health. (See summary for 5/13/2005.) Describes employers' efforts to address the growing unsustainability of health care costs, including the introduction and implementation of decision support systems, chronic care management, quality and patient safety efforts, and Health Savings Accounts.

Wednesday, June 8, 2005; Jackson, MS

Access, Safety Net, Health Disparities

- *Rural Health Disparities,* Dr. Dan Jones, Dean and Vice Chancellor, University of Mississippi Medical Center. (See summary for 6/8/2005.) Describes the problem of health disparities in the United States, especially for the poor, and how limited access to care is a major cause of this problem. Describes impact of uninsured on his facility and the financial challenges institutions like his face.

- *Mississippi Health Shortages,* Roy Mitchell, Executive Director, Mississippi Health Advocacy Program (See summary for 6/8/2005.) Describes widespread uninsured and under-served rural public health conditions, the significant adverse impact any reductions in Medicaid or SCHIP would have on the poor, and the importance of improving the health care safety net in Mississippi.

- *Prevention and Insurance Needed,* Dr. Herman Taylor, Director of the Jackson Heart Study, University of Mississippi Medical Center (6/8/2005.) (See summary for 6/8/2005.) Illustrates racial/ethnic health care disparities for cardiovascular disease and other health conditions. He argues for access to preventive care for the nation's 46 million uninsured to lessen "downstream" adverse impacts.

The Reality of Being Uninsured

- *Employer Exclusions and Health Care Needs*, Georgia Rucker. (See summary for 6/8/2005.) Narrates personal story of struggling with health care problems and an employer who enforced a restrictive employment clause to deny health care insurance coverage. Ms. Rucker is currently dependent on her family and church for support.

- *Experiencing Uninsured Status*, Richard Dye. (See summary for 6/8/2005.) Describes his personal experience of being uninsured and how the help of family and friends sustained him.

Local Access Initiatives

- *Coverage Plans for Small Employers*, Bill Croswell, Chamber Plus, Metro Jackson Chamber of Commerce. (See summary for 6/8/2005.) Describes activities of Chamber Plus, a subsidiary of the Chamber of Commerce formed in 1996 in response to the need for a health insurance product for employees of small businesses. Chamber Plus now provides group health insurance coverage for 20,000 employees of small firms in the greater Jackson area. Many other chambers of commerce in Mississippi have also adopted this product.

- "Initiatives at the Community Health Center Level," (PDF version) Dr. Janice Bacon, G.A. Carmichael Community Health Center. (See summary for 6/8/2005.) Briefly summarizes her work at a local community health center and the center's efforts to address chronic conditions such as asthma and diabetes.

- "The Jackson Medical Mall Foundation," Primus Wheeler, Executive Director, Jackson Medical Mall Foundation. (See summary for 6/8/2005.) Focuses on the key elements that allowed the establishment of a central health care facility to work in Jackson, MS. A key factor was the collaboration and cooperation of many individuals who were held together by the shared vision

and active leadership of Dr. Aaron Shirley, an early advocate for and promoter of community health centers.

Friday, July 22, 2005; Salt Lake City, UT

Health Care Challenges: The Federal Perspective

- "21st Century Health Care Challenges: Unsustainable Trends Necessitate Reforms to Control Spending and Improve Value," (as PDF document) David M. Walker, Comptroller General of the United States. (See summary for 7/22/2005.) Explains the unsustainability of current cost trends in Medicare and Medicaid, which now represent the fastest growing components of the federal budget, the implications of these rising costs for the future of the federal budget, and potential areas of inquiry to address interrelated problems of cost, access, and quality.

Health Care Quality

- *Comments on "Crossing the Quality Chasm,"* Donald M. Berwick, MD, MPP (by telephone), President and CEO, Institute for Healthcare Improvement. (See summary for 7/22/2005.) Describes the "quality chasm," the gap between the health care quality we have and what we could have, and its six dimensions: safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity. To get to better quality, three areas must be addressed: emphasizing knowledge-based care, establishing patient-centered care, and enhancing cooperation.

- "Unwarranted Variations in Health Care," Part 1, Part 2", John E. Wennberg, M.D., M.P.H., Dartmouth Medical School. (See summary for 7/22/2005.) Describes the existence of geographic and institutional variations in the use of health care services that are unrelated to severity of illness or any demographic variations and that do not result in improved outcomes. Addressing these variations would have important consequences for health care costs and quality.

Health Information Technology Panel

- "IT Session: Citizens' Health Care Working Group," Stanley M. Huff, M.D. Senior Medical Informaticist, Intermountain Healthcare. (See summary for 7/22/2005.) Describes the clinical information system in use at Intermountain, an integrated health care system in Utah, lessons learned from use of this system and potential directions for future work in health information technology.

- *"Information Technology in Service of Health Care Providers,"* Eric Pan, M.D., Internist, Center for Information Technology Leadership (See summary for 7/22/2005.) Presents findings from a study "The Value of Health Care Information Exchange and Interoperability," including estimates of annual potential cost savings of $77 billion to the nation's health care system from the standardization of health care information exchange.

- "Health Information Technology," Scott Williams, M.D., Vice President for Health Affairs, HealthInsight, the Quality Improvement Organization (QIO) for Utah and Nevada. (See summary for 7/22/2005.) Describes the key components of health information technology (electronic medical records, health information exchange, and clinical support for decision-making); lays out many of the issues related to the provider level business case for implementing different forms of health information technology and explores potential federal roles in health information technology.

Employer/Employee Initiatives

- "Purchasers' Path to Promoting Higher Value in Health Care," Peter Lee, Pacific Business Group on Health. (See summary for 7/22/2005.) Explains how cost increases and issues of quality can be addressed by purchasers through better information, evaluation, and financial incentives for

both consumers and providers. Examples include consumer support for hospital choice and provider pay for performance mechanisms.

- "Transforming the Health Insurance Delivery Business Model – A Labor-Management Initiative to Manage Care and Targeting Quality," David Blitzstein, United Food and Commercial Workers International Union. (See summary for 7/22/2005.) Describes how improved information collection systems, analysis of costs and outcomes, and making information and results of value analyses available to individuals and organizations can support improved health care service selection.

- "Controlling Healthcare Costs A New Approach," Elizabeth Gilbertson, Hotel Employees and Restaurant Employees International Union Welfare Fund. (See summary for 7/22/2005.) Explains how her organization, working in the context of an extended health care network (with 1,800 physicians), monitors physician cost and care patterns and how such monitoring can lead to reduced costs, better quality of care, maintaining benefit levels, and higher wages.

Tuesday, July 26, 2005; Houston, TX

Hispanic Health Issues

- "Health Disparities," Adela S. Valdez, MD, Valley Baptist Health System. (PowerPoint slides) (See summary for 7/26/2005.) Describes high levels of uninsurance among Hispanics in Texas and the need for more investment in tobacco cessation, nutrition, and encouraging physical activity. The last two health behaviors are especially relevant to reducing the negative consequences of diabetes and obesity. Hispanics have disproportionately high rates of diabetes. In 2004 five of the nation's "fattest" cities were in Texas. She advocated for increased investments in education as the single most important thing to do to reduce health disparities.

- "Hispanic Health and Health Care Issues in Texas and the United States," Karl Eschbach, University of Texas Medical Branch at Galveston. (See summary for 7/26/2005.) Describes Hispanic population trends in the United States and Texas and presents the "Hispanic paradox," a finding of low age-specific mortality rates for the Hispanic population of the United States compared to the non-Hispanic white population, despite the socioeconomic disadvantages of Hispanics. Hispanics have lower heart disease and cancer mortality; and birth outcomes are similar to whites. The Hispanic "advantage" is larger for immigrants than it is for natives and may be attributed to better health habits and selective migration.

Rural Health

- "Rural and Community Health in Texas," Patti Patterson, Vice President for Rural and Community Health, Texas Tech University Health Sciences Center, Lubbock. (See summary for 7/26/2005.) Describes the realities of large distances in rural Texas and the added difficulties that this introduces when trying to assure that individuals have the health care services they need, or that their health doesn't suffer directly from their isolation. She also describes strategies for recruiting and retaining health care providers in rural areas.

- "Fast Facts About Rural Texas," (PDF document) Ernest R. Parisi, Administrator and Chief Executive Officer, East Texas Medical Center, Quitman. (See summary for 7/26/2005.) Describes the challenges of operating a small hospital and local community health network in rural Texas, their dependence upon major public health financing programs such as Medicare and Medicaid, and the impact of the uninsured on these facilities.

- *"Federally Qualified Health Centers,"* Rachel Gonzales-Hanson, Chief Executive Officer, Community Health Development, Inc., Uvalde (See summary for 7/26/2005.) Describes the critical role that community health centers play in the health safety net, the need for continued funding, and the increasing challenges they must address, especially in rural areas.

Long-Term Care, Home and Community Options

- "Long-Term Care: Care for Elders," Nancy Wilson, Huffington Center on Aging, Baylor College of Medicine. (See summary for 7/26/2005.) Describes key issues in long-term care, including lifetime risk, costs, the benefits of community versus institutional care, and other issues of concern. She also gave examples of community-based approaches to long-term care and noted that addressing long-term care needs will involve collaboration, strategic planning, and involvement of consumers, providers, and health agencies.

- "Long-Term Care: A Community Based Approach," Lanette Gonzales, Sheltering Arms, Houston. (See summary for 7/26/2005.) Describes a community-based initiative in Houston, efforts they have made to recruit and retain staff, and the impact of demographic and other trends and their implications for the future.

Retiree Health Care

- "Addressing the Growing Gap in Retiree Health Coverage," Paul Dennett, American Benefits Council. (See summary for 7/26/2005.) Describes the growing number of retirees without employer-sponsored health insurance and the growing percent of health care costs that retirees have to pay themselves. Recommends several actions, including improving care quality and lowering health care costs.

- "Health Coverage in Retirement," Gerry Smolka, AARP. (See summary for 7/26/2005.) Describes trends in retirement and retirement health insurance coverage as well as the special problems faced by early retirees (i.e., those younger than 65) in finding and affording health insurance coverage.

- "US Family Health Plan: Providing High Quality, Cost Effective Healthcare to Military Beneficiaries," Marshall Bolyard, U.S. Family Health Plan. (See summary for 7/26/2005.) Describes a plan available to, and well received by, military beneficiaries, including military retirees.

Wednesday, August 17, 2005; Boston, MA

Mental Health

- "Department of Mental Health: Commonwealth of Massachusetts," Elizabeth Childs, M.D., Commissioner, Massachusetts Department of Mental Health. (See summary for 8/17/2005.) Describes the work of the Massachusetts Department of Mental Health, giving key statistics about the department and its beneficiaries. She also describes three current initiatives and the department's efforts to address stigma as the chief barrier to individuals receiving mental health treatment.

- "Beacon Health Strategies, LLC," Deborah Nelson, Ph.D., Beacon Health Strategies. (See summary for 8/17/2005.) Describes this managed behavioral health plan and the challenges it faces in providing mental health services.

- "The State of Mental Health Services in Massachusetts: The Impact of Inadequate Funding," Toby Fisher, Executive Director, National Alliance for the Mentally Ill. (See summary for 8/17/2005.) Describes some of the difficulties that result from inadequate funding, which include long waits for services, especially troubling when children must wait, and inadequate pharmaceutical benefits. He also described the successful integration of federal, state, and local policies and initiatives from the perspective of a grass roots, advocacy organization.

State, County, and Local Initiatives

- "Cost, Quality And Access: A System Approach," Trish Riley, Director, Governor's Office of Health Policy and Finance, Maine. (See summary for 8/17/2005.) Describes efforts in Maine to

address cost, quality, and access with a special focus on Dirigo Health Care, an effort to expand health insurance coverage to low-income people in Maine.

- "Access Health: Closing the Gap Between Public and Private Insurance Coverage," Vondie Woodbury, Director, Muskegon Community Health, MI. (See summary for 8/17/2005.) Describes a local county program designed to provide health care coverage to those who would otherwise not have it. The program is targeted at small businesses in particular. The premium costs are shared by the employee (30 percent), employer (30 percent) and the community (40 percent).

End of Life

- "Dying in America: A Generation's Crisis and Opportunity," Ira Byock, M.D., Director of Palliative Medicine, Dartmouth Hitchcock Center, NH. (See summary for 8/17/2005.) Describes trends in aging in America, the shrinking pool of caregivers, and the need to shift services for those approaching death away from institutions and toward care in the home. Most people want to live and die at home, not in institutions. For this to happen, there needs to be an emphasis on palliative, rather than on life-extending, but not enhancing, aggressive medical intervention. Hospices can help in reaching this objective and more caretakers will be needed.

- *"Research Findings About End of Life,"* Nicholas Christakis, M.D., Harvard Medical School. (See summary for 8/17/2005.) Describes the components of a "good" death: individuals want to know what to expect, as well as freedom from pain, not being a burden to their families, having a doctor who listens, and the ability to choose to die at home.

- "Defining and Reforming 'End of Life' Care," Joanne Lynn, M.D., Rand, Washington DC. (See summary for 8/17/2005.) Proposes a model of care for the ill that gradually decreases "curative" care while increasing "palliative" care proportionately. The timing of these changes should be based on the predicted life duration, even though it is difficult to forecast exactly when a person will die. More support for family caregivers is essential.

Employer Initiatives: Leapfrog and Bridges to Excellence

- "Bridges to Excellence" (Part 1) and "The Leapfrog Group" (Part 2), Jeffrey R. Hanson, Regional Healthcare Manager, Verizon Communications. (See summary for 8/17/2005.) Describes two employer-based initiatives for improving health care quality. Bridges to Excellence is a system of rewarding high quality performance of providers and encouraging consumers to purchase high quality care. The initial efforts have focused on diabetes and cardiovascular disease. Leapfrog is an initiative of over 150 purchasers that has focused on identifying specific actions that can result in improved care delivery and on setting up a system of rewards for top performers.

Friday, September 23, 2005; Portland, OR

The Oregon Health Plan

- "White Paper distributed at Citizens' Health Care Working Group hearing" (PDF version), John Kitzhaber, M.D., Center for Evidence Based Policy, Oregon Health & Science University, former Governor of Oregon. (See summary for 9/23/05.) Sets forth his belief in the need to change the health care system from one that rations people to one that rations care. He asserts that major change is needed, incremental change will not suffice.

- "Oregon Health Decisions: Community Meetings Process," Michael J. Garland, D. Sc. Rel., Oregon Health & Science University. (See summary for 9/23/05.) Describes the efforts by a variety of individuals in Oregon to conduct public discussions, formulate a new system for organizing care, and pursue it through to partial enactment and implementation within the state. .

- *[No title or slides]*, Ralph Crawshaw, Co-founder Oregon Health Decisions (Co-presented with M. Garland - See summary for 9/23/05.) Describes the process they went through to hold community level meetings in developing the Oregon Health Plan and the impact of these meetings on developing the plan and on the meeting participants.

The Health Services Commission: Prioritizing Benefits

- "The Work of the Health Services Commission – Prioritizing Benefits," Alison S. Little, M.D., Oregon Health Services Commission. (See summary for 9/23/05.) Describes the process the Commission used to develop a prioritized list of benefits that formed the core of the Oregon health plan.
- "White paper distributed at Citizens' Health Care Working Group hearing" (PDF version), Ellen C. Lowe, Oregon Health Services Commission. (See summary for 9/23/05.) Offers a personal perspective on Oregon's outreach efforts to develop the Oregon Health Plan, based on her experiences as the citizen member of the Oregon Health Services Commission.
- *[No title or slides]*, Diane Lovell, Oregon Public Employees Benefit Board and Oregon Health and Sciences University Employee Benefits Council. (See summary for 9/23/05.) Describes the open, public, and transparent process employed in Oregon in developing the Oregon Health Plan and emphasizes the importance of these characteristics.
- "Methods for Comparative Evidence Reviews," Dr. Marian McDonagh, Oregon Evidence-based Practice Center for the Drug Effectiveness Review Project. (See summary for 9/23/05.) Describes the technical process of review and decision-making regarding selection of pharmaceuticals that are covered by Medicaid. The methodology is intended to be transparent, systematic, and unchallengeable. Participants in the process make sure that the information is very readable. Oregon wants to make sure that its researchers have high standards and are impartial in their evaluation of what constituted equivalent drugs for treatments.
- *"Lessons Learned from the Oregon Experience,"* Bruce Goldberg, M.D., Oregon Office for Health Policy and Research. (See summary for 9/23/05.) Summarizes the lessons learned from the effort in Oregon to develop an alternative approach to providing insurance coverage.

Lessons Learned

- "White paper distributed at Citizens' Health Care Working Group hearing " (PDF version), John Santa, M.D., M.P.H., Center for Evidence-based Policy, Oregon Health & Sciences University. Attachment to paper - M. Gold article (PDF only); see also related article online. (See summary for 9/23/05.) Describes the values and central priorities that continue to motivate those seeking to further the purposes of the Oregon Health Plan, including equity, transparency, value, explicit decision-making, and local control.
- *[No title or slides]*, Mark Ganz, President and CEO, the Regence Group (See summary for 9/23/05.) Describes some of the activities his firm is undertaking, including efforts to develop an electronic health record for the group's members.

Public Sector/Private Sector Perspectives

- "Lessons Learned from Health Care Reform," Jean I. Thorne, Oregon Public Employees' Benefit Board. (See summary for 9/23/05.) Former Oregon Medicaid Director reviews the process that Oregon followed and candidly describes the successes and failures of the state's efforts.

Appendix F: National Health Care Polls and Survey Reports Related to the Working Group Analyses

Polling Organization	Date	Survey
ABC News/Washington Post Poll	**October 2003**	A national survey of a sample of 1,000 adults was conducted from October 9-13, 2003; the survey field work was managed by TNS Intersearch. http://webapp.icpsr.umich.edu/cocoon/ICPSR-STUDY/03942.xml
America's Health Insurance Plans: Post Election Health Care Priorities Survey	**November 2004**	This survey was conducted by Ayres, McHenry & Associates, from November 3 – 4, 2004. It was based on telephone interviews with adults who voted in the 2004 presidential election national sample of 1,000. http://www.ahip.org/content/default.aspx?bc=39%7C4176
Americans for Health Care and Center for American Progress	**November 2005**	This national survey was conducted November 15-22, 2005, there were 1,104 adult respondents. http://www.americanprogress.org/atf/cf/%7BE9245FE4-9A2B-43C7-A521-5D6FF2E06E03%7D/HEALTHCARE_TOPLINES.PDF
By the People: National Deliberative Poll	**November 2005**	This poll was conducted by Stanford University's Center for Deliberative Democracy. 981 adult Americans completed pre and post experiment questionnaires. For a summary of the survey results use the following link: http://cdd.stanford.edu/polls/btp/2005/btp-poll-results.pdf ; for more information regarding the Deliberative Poll questions use the following link http://www.pbs.org/newshour/btp/pdfs/onlinepollsignificantchanges.pdf
California Healthcare Foundation: National Consumer Health Privacy Survey	**November 2005**	This survey was a collaboration between Forrester Research and the California Healthcare Foundation. Forrester surveyed 2,100 U.S. adults; the final survey included 1,000 national respondents and an additional 1,000 oversampled California residents. http://www.chcf.org/topics/view.cfm?itemID=115694
CBS News/New York Times	**January 26, 2006**	Poll: "Bush's Approval Remains Low: Heading into the State of the Union, Just 42 Percent Approve of President." This survey was conducted January 20 – 25, 2006. There were 1229 respondents nationwide. http://www.cbsnews.com/stories/2006/01/26/opinion/polls/main1243679.shtml
CBS News/New York Times Poll	**June 17, 2005**	Survey of 1,111 adults, conducted June 10 – 15, 2005. http://www.nytimes.com/packages/html/politics/20050617_poll/20050617_poll_results.pdf
CBS News/New York Times	**May 13, 2003**	See CBS News online (May 13, 2003), "Poll: Economy Remains Top Priority." This poll was conducted by CBS News and the New York Times from May 9 – 12, 2003. It was based on telephone interviews with a national sample of 910 adults. http://www.cbsnews.com/stories/2003/05/13/opinion/polls/main553730.shtml
CBS News/New York Times Poll	**March 1993**	This was a survey conducted by CBS News and the New York Times from March 28 – 31, 1993. It was based on telephone interviews with a national adult sample of 1,368.
Center for Studying Health System Change, Issue Brief No 95	**May 2005**	"An Update on Americans' Access to Prescription Drugs." Findings from the 2001 and 2003 HSC CTS Household Survey. The 2001 survey had a response rate of 59 percent and contains information from more than 46,400 persons 18 years or older. The 2003 survey, with a 57 percent response rate, includes data from more than 36,500 adults. http://www.hschange.com/CONTENT/738/
Center for Studying Health System Change, Issue Brief No 94	**March 2005**	"More Americans Willing to Limit Physician-Hospital Choice for Lower Medical Costs." Findings are based on the CTS Household Survey, a nationally representative telephone survey conducted in 1996-97, 1998-99, 2000-01 and 2003. http://www.hschange.com/CONTENT/735/
Center for Studying Health System Change (HSC), Issue Brief No 85	**June 2004**	"Tough Trade-offs: Medical Bills, Family Finances and Access to Care." Findings from the 2003 HSC Community Tracking Study (CTS). The survey contains information on about 25,400 families and 46,600 persons, and the response rate was 57 percent. http://www.hschange.com/CONTENT/689/

Commonwealth Fund/Harris Interactive Poll, Public Views on Shaping the Future of the U.S. Health Care System	**August 2006**	Survey of 1,023 adults conducted by Harris Interactive. "Public Views on Shaping the Future of the U.S. Health Care System." http://www.cmwf.org/usr_doc/Schoen_publicviewsfuturehltsystem_948.pdf
Commonwealth Fund 2005 International Survey on Sicker Adults	**November 3, 2005**	"Taking the Pulse of Health Care Systems: Experiences of Patients with Health Problems In Six Countries." Article in Health Affairs – Web Exclusive: Patients' Experiences by Schoen, Osborn, Huynh, Doty, Zapert, Peugh, and Davis. Includes 700-750 adults in Australia, Canada and New Zealand; and 1,500 or more in the United Kingdom, United States, and Germany. Interviews were conducted by telephone between May 9 and May 17, 2005 in the five English speaking countries and between May 9 and June 12, 2005 in Germany. The margin of sample error was approximately plus or minus 4 percent. http://www.cmwf.org/Publications/publications_show.htm?doc_id=313012
Commonwealth Fund 2001 Health Insurance Survey	**April – July 2001**	This survey was conducted by Princeton Survey Research Associates from April 27 through July 29, 2001. It consisted of 25 minute telephone interviews of a national sample of 3,508 adults; the margin of sampling error was plus or minus 2.0 percentage points. http://www.cmwf.org/surveys/surveys_show.htm?doc_id=230522
Democratic Leadership Council Poll	**July 2002**	This survey was conducted by Penn, Schoen & Berland Associates between July 13 – July 15, 2002 and was based on interviews with a sample of 800 adults. http://www.kaisernetwork.org/health_poll/hpoll_index.cfm
Employee Benefit Research Institute: 2000 – 1998 Health Confidence Surveys	**November 2000, September 1999, April 1998**	The 2000 Survey was conducted between April 26 and May 28, 2000 with 1,001 individuals; the 1999 survey was conducted May 13 and June 14, 1999 with 1,001 individuals; the 1998 survey was conducted February 1998 with 1,002 individuals. Each survey incorporated twenty-minute telephone interviews with adults ages 21 and older. http://www.ebri.org/surveys/hcs/
Employee Benefit Research Institute: 2001 Health Confidence Survey	**October 9, 2001**	"Americans' Satisfaction With Health Care Rises, But Pessimism About Future Remains." This survey was conducted between April 17 and May 27, through 20-minute telephone interviews with 1,001 individuals 21 and older. http://www.ebri.org/surveys/hcs/2001/
Employee Benefit Research Institute: 2002 Health Confidence Survey	**September 25, 2002**	"Confidence & Satisfaction in Health Care System Show Little Change Over Time, But Americans Still Worry Abgout Its Future." This survey was conducted between April 18 and May 19, 2002, through 20-minute telephone interviews with 1,000 individuals ages 21 and older. Random digit dialing was used to obtain a representative cross section of the U.S. population. http://www.ebri.org/surveys/hcs/2002/
Employee Benefit Research Institute: 2003 Health Confidence Survey	**September 29, 2003**	"Workers Worry About Losing Job Health Coverage; Express Growing Enthusiasm for Government Plan." This survey was conducted between April 24 and May 24, 2003, through 20 minute telephone interviews with 1,002 individuals age 21 and older. http://www.ebri.org/surveys/hcs/2003/
Employee Benefit Research Institute: 2004 Health Confidence Survey	**October 28, 2004**	"Americans Cut Savings To Pay Rising Health Bills, Fears Future Cost, Access Problems," The survey was conducted between June 21 and July 23, 2004, through 20-minute telephone interviews with 1,203 individuals ages 21 and older. http://www.ebri.org/surveys/hcs/2004/
Employee Benefit Research Institute: Issue Briefs #275	**November 2004**	"Public Attitudes on the U.S. Health Care System: Findings From the Health Confidence Survey." The findings from the 2004 Health Confidence Survey (HCS), which focuses on Americans' satisfaction with the health care system today and their confidence in the system's future. The survey examines Americans' attitudes about employment-based health benefits, health savings accounts, and benefits in the work place. The Issue Brief also looks at long-term trends in satisfaction and confidence with the health care system since the first HCS was conducted in 1998. http://www.ebri.org/publications/ib/index.cfm?fa=ibDisp&content_id=3507

Employee Benefit Research Institute: 2005 Health Confidence Survey	**October 18, 2005**	"Most Americans Satisfied With Quality of Health Care But the Public Does Not Link Cost to Quality." This poll was conducted from June 21 to Aug, 6, 2005 through 20-minute telephone interviews with 1,003 individuals age 21 and older. http://www.ebri.org/surveys/hcs/2005/
Employee Benefit Research Institute: Issue Briefs #288	**December 2005**	"Early Experience With High-Deductible and Consumer-Driven Health Plans: Findings From the EBRI/Commonwealth Fund Consumerism in Health Care Survey" this survey was conducted between September 28 and October 19, 2005 through an 18-minute internet survey. The base sample was randomly drawn from Harris Poll Online; slightly more than 1,200 adults were in the sample. http://www.ebri.org/publications/ib/index.cfm?fa=ibDisp&content_id=3606
Gallup Poll, Tuesday Briefing	**June 28, 2005**	Rick Blizzard, "Safety, Security Flatline with Patients: Medical Error Initiatives Fail to Make Patients Feel Safer" http://www.galluppoll.com/content/?ci=17125&pg=1.
Gallup Poll	**November 7-10, 2005**	This poll is the most recent of the annual polls conducted by Gallup that asks Americans, without prompting to name the most urgent health problem facing the country at the present time. The 2005 survey included 1,011 adults nationwide. http://www.galluppoll.com/content/default.aspx?ci=20032
Gallup Poll: Healthcare Panel: More Information…	**November 22, 2005**	Gallup Poll of national random sample of 1,010 U.S. adults age 18 and older conducted in September 2005. http://www.galluppoll.com/content/?ci=19555&pg=1
Gallup Poll: Healthcare Panel: Costs More Troubling Than Quality	**November 1, 2005**	Same poll as above.
Gallup Poll: Healthcare Panel: How Do People Choose Hospitals	**October 25, 2005**	Same poll as above.
Gallup/CNN/USA Today Poll	**January 2000**	This survey was conducted for the Cable News Network in conjunction with USA Today. The survey was conducted by the Gallup organization January 13 – 16, 2000. It was based on telephone interviews with a national adult sample of 1,027. http://www.kaisernetwork.org/health_poll/hpoll_index.cfm
Gallup/Newsweek Poll	**March 1993**	This was a survey by Newsweek, conducted by the Gallup Organization, March 25 – 26, 1993 and based on telephone interviews with a national adult sample of 755. http://www.kaisernetwork.org/health_poll/hpoll_index.cfm
Harris Interactive Poll, Health Care News	**February 23, 2005**	A telephone survey of 1,012 Americans ages 18 and older conducted between February 8-13, 2005. See Alan F. Westin testimony at the hearing on privacy and health information technology www.patientprivacyrights.org, under News Room. Survey Summary at http://www.harrisinteractive.com/news/allnewsbydate.asp?NewsID=894
Harris Interactive Poll: Health Care News	**August 10, 2004**	"Two in Five Adults Keep Personal or Family Health Records and Almost Everybody Thinks This Is a Good Idea." This survey was conducted online within the United States between July 12 and 18, 2004 among a nationwide cross section of 2,242 adults ages 18 and over. http://www.harrisinteractive.com/news/allnewsbydate.asp?NewsID=832
Harvard School of Public Health and Robert Wood Johnson Foundation: Health & Healthcare Priorities Survey	**April 2001**	This survey was done by Harvard School of Public Health and the Robert Wood Johnson Foundation. It was conducted by the ICR/International Communications Research from April 25 – May 20, 2001. It was based on telephone interviews with a national adult sample of 1,210. Use http://www.kaisernetwork.org/health_poll/hpoll_index.cfm
Health Affairs Data Watch Managed Care Web Exclusive	**November 10, 2004**	"Public Perceptions of Cost Containment Strategies: Mixed Signals for Managed Care," by Schur, Berk, and Yegian. The survey was organized by International Communications Research (ICR). Telephone interviews were conducted from 4–10 August 2004. A random-digit-dialing approach was used by surveyors to interview 2,024 respondents. http://content.healthaffairs.org/cgi/content/full/hlthaff.w4.516/DC1

Health Affairs Data Watch Children and Elderly Web Exclusive	**September 14, 2004**	"Americans' Views About the Adequacy of Health Care for Children and the Elderly," by Berk, Schur, Chang, Knight, and Kleinman. The survey was managed by International Communications Research (ICR). Telephone interviews were conducted 4–18 June 2004. A random-digit-dialing approach was used to contact the 2,013 respondents. http://content.healthaffairs.org/cgi/content/full/hlthaff.w4.446/DC1
Health Affairs Data Watch Chronic Care Policies	**July/August 2002**	A telephone survey of 51 questions was given to a national sample of 1,663 adults between March and November 2000. The complete article is in *Health Affairs*, Vol 21, Issue 4, 264-270, can be found using the following links: http://www.healthaffairs.org/RWJ/Thamer.pdf or http://content.healthaffairs.org/cgi/reprint/21/4/264.pdf
Health Affairs Health Tracking Market Watch	**March/April 2001**	"Patients' Attitudes Toward Cost Control Bonuses For Managed Care Physicians," by Gallagher, St. Peter, Chesney, and Lo, *Health Affairs*, Volume 20, Number 2, pages 186-192. The survey was conducted the summer of 1998 with a random sample of 3,784 phone numbers, 1,050 people were interviewed. http://content.healthaffairs.org/cgi/reprint/20/2/186.pdf or http://content.healthaffairs.org/cgi/content/abstract/20/2/186
Insurance Newscast, Wednesday, 10/12/2005, Ceasefire on Health Care Event	**October 12, 2005**	Former Senator John Breaux Reveals 'What Americans Want in Health Care Reform," Working with Bill McInturff and Geoffrey Garin, http://www.insurancebroadcasting.com/101205-6.htm
International Journal for Quality in Health Care and Oxford University Press	**2002**	"Satisfaction with Quality and Access to Health Care Among People with Disabling Conditions," article by Lezzoni, Dave, Soukup, and O'Day: Volume 14 Number 5 pages 369 – 381. http://intqhc.oxfordjournals.org/cgi/content/abstract/14/5/369; for PDF version use: http://intqhc.oxfordjournals.org/cgi/reprint/14/5/369.pdf
Kaiser Public Opinion Spotlight: Health Care Costs	**August 2005**	Public Opinion on Health Care Costs: http://www.kff.org/spotlight/healthcosts/index.cfm
Kaiser Family Foundation: May/June 2005 Health Poll Report Survey	**June 2005**	This was a survey by the Kaiser Family Foundation conducted by the Princeton Survey Research Associates International between June 2 and June 5, 2005 through telephone interviews of 1,202 adults, ages 18 years and older. http://www.kff.org/kaiserpolls/upload/May-June-2005-Kaiser-Health-Poll-Report-Toplines.pdf
Kaiser Family Foundation: National Survey of the Public's Views About Medicaid	**June 2005**	This was a Kaiser Family Foundation survey conducted by the Princeton Survey Research Associates International. The results were based on the telephone interviews of 1,201 adults between April 1 and May 1, 2005. http://www.kff.org/medicaid/upload/National-Survey-of-the-Public-s-Views-About-Medicaid-Chartpack.pdf
Kaiser Family Foundation/Harvard School of Public Health: Health Care Agenda for the New Congress Survey	**November 2004**	This survey was conducted by ICR-International Communications Research, November 4 – November 28, 2004 and based on telephone interviews with a national adult sample of 1,396. http://www.kaisernetwork.org/health_poll/hpoll_index.cfmor for a PDF file http://www.kff.org/kaiserpolls/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=50263#search=%22Kaiser%20Family%20Foundation%2C%20Harvard%20School%20of%20Public%20Health%2C%20November%202004%22
Kaiser Family Foundation: HealthPoll Report	**September/ October 2004**	Kaiser Family Foundation: HealthPoll Report: Public's Expectations of Health Insurance and Attitudes Towards Potential New Insurance Options. Source data from the Kaiser Family Foundation Health Insurance Survey, 2003, conducted April 30 – July 20, 2003 among 2,507 adults ages 18-64. http://www.kff.org/healthpollreport/Oct_2004/index.cfm
Kaiser Family Foundation Survey: January/February 2004 Health Poll Report Survey	**February 2004**	This survey fieldwork was conducted by Princeton Survey Research Associates International, February 5 – February 8, 2004, with 1,201 respondents 18 and older. The margin of error was plus or minus 3 percentage points. http://www.kff.org/kaiserpolls/upload/Kaiser-Health-Poll-Report-Survey-Toplines.pdf#search=%22health%20poll%20report%20february%202004%20%22

Kaiser Family Foundation Survey: Health Insurance Survey	**April 2003**	The survey was conducted by Princeton Survey Research Associates International, April 30 – July 20, 2003 and based on telephone interviews with a national adult age 18-64 sample of 2,507. http://www.kaisernetwork.org/health_poll/hpoll_index.cfm
Kaiser Family Foundation: Clinton Health Care Reform Plan Survey	**March 1993**	This survey was sponsored by the Kaiser Foundation and was conducted by Louis Harris & Associates between March 3 and March 10, 1993. It was based on telephone interviews with a national adult sample of 1,255. http://www.kaisernetwork.org/health_poll/hpoll_index.cfm to find the survey questions and results.
Lake Snell Perry & Associates	**March 1, 2003**	A national poll of 1,002 adults conducted August 30 – September 1, 2002 for Robert Wood Johnson Foundation "Last Acts" initiative. See Journal of Pain & Palliative Care Pharmacotherapy, Vol. 17(2). 2003. http://www.haworthpress.com/store/E-Text/View_EText.asp?a=3&fn=J354v17n02_11&i=2&s=J354&v=17
Los Angeles Times/Bloomberg Poll	**April 16, 2006**	The Los Angeles Times/Bloomberg Poll contacted 1,357 adults nationwide by telephone April 8 through April 11, 2006; this sample included 1,234 registered voters. The margin of sampling error is plus or minus 3 percentage points.
Los Angeles Times/Bloomberg Press	**March 2005**	Survey of 2,563 adults contacted by telephone February 25 – March 5, 2006. Los Angeles Times/Bloomberg News http://www.sscnet.ucla.edu/issr/da/index/techinfo/M11001.HTM
Los Angeles Time Poll	**July 1994**	Survey was conducted by Los Angeles Times, July 23 – July 26, 1994 and based on telephone interviews with a national adult sample of 1,515. Use http://www.kaisernetwork.org/health_poll/hpoll_index.cfm to find the survey questions and results.
NBC News/Wall Street Journal Survey	**July 2006**	This survey was conducted by Hart/McInturff between July 21 – 24, 2006. 1,010 adults were interviewed. http://www.pos.org/latestnumbers/wsjjune2006.pdf
NBC News/Wall Street Journal Survey	**April 2006**	This survey was conducted by Hart/McIntruff between April 21 – 24, 2006, interviews were held for 1,109 adults including a national sample of 1,005 plus and an oversample of 104 Hispanics. http://www.pos.org/latestnumbers/wsjapr2006.pdf
NBC News/Wall Street Journal Survey	**March 2006**	This survey was conducted by Hart/McIntruff between March 10 and March 13, 2006. 1,005 adults were interviewed. http://www.pos.org/latestnumbers/wsjmar2006.pdf
NBC News/Wall Street Journal Survey	**January 2006**	This survey was conducted by Hart/McIntruff from January 26 – 29, 2006, 1, 011 adults were interviewed. http://www.pos.org/latestnumbers/wsjjan2006.pdf
NBC News/Wall Street Journal Survey	**February 2005**	The survey was conducted by Hart/McIntruff, February 10 – 14, 2005, 1,008 adults were interviewed. http://www.pos.org/latestnumbers/wsjfeb2005.pdf
NBC News/Wall Street Journal Survey	**October 2004**	This survey was conducted by Hart/McIntruff, October 16 – 18, 2004. 1,004 adults were interviewed. http://www.pos.org/latestnumbers/wsjoct2004.pdf
NBC News/Wall Street Journal Poll	**June 1991**	This was a survey by NBC News in conjunction with the Wall Street Journal conducted by Hart and Teeter Research Companies from June 22 – 25, 1991. It was based on telephone interviews with a sample of 1,006. http://www.kaisernetwork.org/health_poll/hpoll_index.cfm
National Public Radio (NPR)/Kaiser/ Kennedy School Health Care Study	**March – May 2002**	This survey was a partnership between NPR, Kaiser Family Foundation, and Kennedy School. It was conducted by International Communication Research. It was based on telephone interviews with a random representative sample of 1,205. http://www.npr.org/news/specials/healthcarepoll/results.pdf
Pew HispanicCenter/Kaiser Family Foundation	**April 2004**	Pew/Kaiser 2004 Latinos Politics and Civic Engagement Survey, conducted by ICR – International Communications Research, April 21 – June 9, 2004. It was based on telephone interviews with a national adult Hispanics sample of 2,288. http://www.kaisernetwork.org/health_poll/hpoll_index.cfm to find the survey questions and results.

Pew Research Center for the People and the Press, March 2006 News Interest Index	**March 15, 2006**	Princeton Survey Research Associates International conducted telephone interviews with a national sample of 1,405 adults, March 8 – 12, 2006. http://people-press.org/reports/display.php3?ReportID=271
The Pew Research Center for the People and the Press	**May 10, 2005**	"Beyond Red vs. Blue." The 2005 Political Typology Survey is a national telephone interview sample of 2,000 adults age 18 and over. The Typology Callback Survey conducted in March 2005 obtained 1,090 respondents from the initial December 2004 survey. The national sample of 1,284 adults in the 2003 survey was conducted by Princeton Survey Research Associates between July 14 and August 3, 2003.
Pew Research Center for the People and the Press	**August 7, 2003**	The national sample of 1,284 adults in the 2003 survey was conducted by Princeton Survey Research Associates International between July 14 and August 3, 2003. http://people-press.org/reports/pdf/190.pdf
Princeton Survey Research Associate: Newsweek Poll	**August 1994**	Princeton Survey Research Associate conducted this survey between August 4 and August 5, 1994. The survey is based on telephone interviews with a national adult sample of 750. http://www.kaisernetwork.org/health_poll/hpoll_index.cfm
Princeton Survey Research Associate: Newsweek Poll	**June 1994**	Princeton Survey Research Associates conducted this survey on June 17, 1994. The survey was based on telephone interviews with a national adult sample of 499. http://www.kaisernetwork.org/health_poll/hpoll_index.cfm
Public Agenda: Bills and Proposals	**November 2004**	"Half of Americans Say the Healthcare System Has Major Problems, and Most Say It Needs Fundamental Changes To Be Completely Rebuilt." Survey sources included: Gallup Organization 11/04: telephone survey of 1,016 adults, November 7-10, 2004. CBS News/New York Times 2/05: telephone survey of 1,111 adults, February 24 – 28, 2005. http://www.publicagenda.org/issues/major_proposals_detail2.cfm?issue_type=healthcare&proposal_graphic=majprophealthfundamental.jpg
Public Agenda: Bills and Proposals	**November 2004**	"Nearly Two-Thirds of Americans Say the Federal Government Should Guarantee Health Insurance for All Americans, But Half Say They Would Not Be Willing To Pay Higher Premiums or Higher Taxes." Gallup Organization 11/04: 508 adults surveyed between November 7 – 10, 2004. Kaiser/Harvard 11/04: 1,396 adults surveyed between November 4 – November 28, 2004. The margin of error is plus or minus 4 percent. http://www.publicagenda.org/issues/major_proposals_detail.cfm?issue_type=healthcare&list=2
Public Agenda: People's Chief Concerns	**November 2004**	"Americans Are Far More Likely To Rate Their Own Health Care and Coverage as 'Excellent' or 'Good' Than They Are the Quality of Health Care and Coverage in the U.S." Gallup Organization: 1,016 adults surveyed via telephone interviews from November 7 – 10, 2004. http://www.publicagenda.org/issues/pcc_detail.cfm?issue_type=healthcare&list=4
Public Agenda: People's Chief Concerns	**March 2005**	"Six in 10 Americans Say They Worry "a Great Deal" about the Availability of Health Care" Gallup Organization: Telephone interviews conducted March 7 – 10, 2005. There was a sample of 1,004 adults. http://www.publicagenda.org/issues/pcc_detail.cfm?issue_type=healthcare&list=6
Public Opinion Strategies Poll for The Markle Foundation	**October 2005**	"Attitudes of Americans Regarding Personal Health Records and Nationwide Electronic Health Information Exchange." Public Opinion Strategies conducted two national surveys for the Markle Foundation: the first was conducted September 20 – 22, 2005 among 800 adults; the second September 28 – October 2, 2005 among 800 registered voters; the margin of sample error was plus or minus 3.46 percentage points. http://www.phrconference.org/assets/research_release_101105.pdf

Research!America An Alliance for Discoveries in Health: Charlton Research Company National Survey 2005	**2005**	The source is a national survey conducted in 2005, by the Charlton Research Company for Research!America. http://www.researchamerica.org/polldata/2005/healthservices05.pdf
Research!America Polling in JAMA: Public Attitudes and Perceptions About Health-Related Research	**September 21, 2005**	This article is by Woolley, Mary and Propst, Stacie, *JAMA.* 2005;294:1380-1384. The article can be found at the following link: http://jama.ama-assn.org/cgi/content/abstract/294/11/1380
Research!America: An Alliance for Discoveries in Health	**November 2004**	Research!America/APHA National Poll on Americans' Attitude Toward Public Health, Results presented at the 132nd Annual American Public Health Association Annual Meeting. http://www.researchamerica.org/polldata/2004/apha2004.pdf
Stony Brook University – Health Pulse of America	**February 18 – March 8, 2004**	Stony Brook University Center for Survey and Research conducted this poll between February 18 and March 8, 2004. It was based on a nationally representative sample of telephone numbers drawn from blocks with at least one-listed residential number. There were 863 adults interviewed from across the nation. http://sunysb.edu/surveys/HPAMarch04.htm
The New York Times/CBS News Poll	**January 27, 2006**	This was a survey of 1,229 adults, conducted January 20 – 25, 2006. Use the following link for more information: http://www.nytimes.com/packages/pdf/politics/20060127_poll_results.pdf
Time/CNN/Yankelovic Partners Poll	**March 1994**	This survey was by done for Time in coordination with the Cable News Network. Yankelovich Partners conducted this survey from March 2 - 3, 1994. It was based on telephone interviews with a national adult sample of 600. http://www.kaisernetwork.org/health_poll/hpoll_index.cfm to find the survey questions and results.
Time/CNN/Yankelovic Partners Poll	**June 1993**	This survey was conducted by Yankelovich Partners, June 17 – June 21, 1993 and based on telephone interviews with a national adult sample of 901. An oversample of 364 adults who voted for Ross Perot for President was also taken. http://www.kaisernetwork.org/health_poll/hpoll_index.cfm to find the survey questions and results.
Towers Perrin HR Services: Thought Leadership	**September 28, 2005**	"Employee Health Care Decisions are Fueled by Fear and Insecurity." This is a Towers Perrin survey of 1,400 employees. http://www.towersperrin.com/tp/getwebcachedoc?webc=HRS/USA/2005/200509/PO_decisions.pdf
U.S. News and World Report Survey	**January 1994**	The Tarrance Group and Mellman, Lazarus & Lake conducted this survey on January 17 and January 18, 1994. It is based on telephone interviews with a national sample of 1,000 registered voters. http://www.kaisernetwork.org/health_poll/hpoll_index.cfm .
USA Today/Kaiser Family Foundation/Harvard School of Public Health: Health Care Costs Survey	**August 2005**	ICR/Harvard University conducted this telephone survey between April 25 and June 9, 2005, with 1,531 adults ages 18 and over responding. http://www.kff.org/newsmedia/upload/7372.pdf#search=%22USA%20Today%2FKaiser%20Family%20Foundation%2FHarvard%20School%20of%20Public%20Health%3A%20Health%20Care%20Costs%20Survey%2C%20%20August%202005%22
Wall Street Journal/Harris Interactive Health-Care Poll	**July 31, 2006**	"Higher Premiums for Those with Unhealthy Lifestyles Supported by 53 Percent of U.S. Adults." Harris Interactive conducted this survey of 2,325 U.S. adults between July 11 and 13, 2006. http://www.harrisinteractive.com/news/newsletters/wsjhealthnews/WSJOnline_HI_Health-CarePoll2006vol5_iss12.pdf

Wall Street Journal Online/Harris Interactive Health-Care Poll	**April 4, 2006**	"Many U.S. Adults Believe Health Care Quality Care be Fairly Assessed, but Few Willing to Pay Significantly Higher Premiums for Superior Care." Harris Interactive conducted this survey online of 2123 American adults between March 20 and 22, 2006. http://www.harrisinteractive.com/news/newsletters/wsjhealthnews/WSJOnline_HI_Health-CarePoll2006vol5_iss06.pdf
Wall Street Journal Online/Harris Interactive Health-Care Poll	**January 2006**	"Kicking a Bad Habit Could Pay Off." This survey of 2,007 U.S. adults was conducted online by Harris Interactive between December 12 and December 14, 2005. See The Wall Street Journal online (January 6, 2006). http://www.harrisinteractive.com/news/newsletters/wsjhealthnews/WSJOnline_HI_Health-CarePoll2006vol5_iss01.pdf
Wall Street Journal Online/Harris Interactive Poll	**October 20, 2005**	"Poll Shows Strong Public Support For Range of Health Practices." Harris Interactive conducted this survey of 2,242 U.S. adults online from September 6 to 12, 2005. http://online.wsj.com/public/article/SB112973460667273222-7Jjp4Ckx_LsV4gI5rjzrENNIcAQ_20061020.html?mod=blogs
Wall Street Journal Online/Harris Interactive Health Care Poll, The Wall Street Journal Online	**October 7, 2005**	"Poll Indicates Strong Support for New Medical Technologies." This is a Harris Interactive online survey of 2,048 adults conducted between September 30 and October 4, 2005. The overall results have a sampling error of plus or minus 3 percentage points. http://online.wsj.com/public/article_print/SB112862766275261910-6zvnFPlXTEOE7jFI3fGQPoAnHm8_20061008.html
Wall Street Journal Online/Harris Interactive Health-Care Poll, News Room	**September 16, 2005**	"Considerable Concern Exists Among U.S. Adults About the Frequency of Unnecessary or Overly Aggressive Medical Treatment." Harris Interactive conducted this survey of 2,286 U.S. adults between August 31 and September 2, 2005. http://www.harrisinteractive.com/news/allnewsbydate.asp?NewsID=970
Wall Street Journal Online/Harris Interactive Health Care Poll, News Room	**July 21, 2005**	"Majority of U.S. Adults Think it is a Good Idea to Forbid Direct-to-Consumer Advertising for New Prescription Drugs When They First Come to Market." Harris Interactive conducted this online survey of 2,207 U.S. adults between July 6 and 8, 2005. http://www.harrisinteractive.com/news/allnewsbydate.asp?NewsID=947
Wall Street Journal Online/Harris Interactive Health-Care Poll	**May 24, 2005**	"Public Interest in the Use of Quality Metrics in Healthcare is Mixed – Unless It Allows Them to Reduce Their Health Insurance Costs." This survey was conducted online between May 11 and 13, 2005 with a national sample of 2,129 adults. http://www.harrisinteractive.com/NEWS/allnewsbydate.asp?NewsID=931
Wall Street Journal Online/Harris Interactive Health-Care Poll	**March 2, 2005**	"Many Nationwide Believe in the Potential Benefit of Electronic Medical Records and are Interested in Online Communications with Physicians." Harris Interactive conducted this online survey of 2,638 U.S. adults between February 17 and 21, 2005. http://www.harrisinteractive.com/news/allnewsbydate.asp?NewsID=895
Wall Street Journal Online/Harris Interactive Health Care Poll	**February 24, 2005**	**"**Health Information Privacy (HIPAA) Notices Have Improved Public's Confidence That Their Medical Information Is Being Handled Properly." This was a nationwide Harris Poll of 1,012 U.S. adults surveyed by telephone between February 8 and 13, 2005 by Harris Interactive. http://www.harrisinteractive.com/news/allnewsbydate.asp?NewsID=894
Wall Street Journal Online/Harris Interactive Health-Care Poll	**October 1, 2004**	"Doctors' Interpersonal Skills Valued More than Their Training or Being Up-to-Date." Harris Interactive conducted this survey of 2,267 U.S. adults online between September 21 and 23, 2004. http://www.harrisinteractive.com/news/newsletters/wsjhealthnews/WSJOnline_HI_Health-CarePoll2004vol3_iss19.pdf
Wall Street Journal/Harris Interactive Health Care Poll	**July 20, 2004**	"Americans Are Concerned About Hospital-Based Medical and Surgical Errors." Harris Interactive conducted this survey between July 8 and July 12, 2004 with a sample size of 2,847 U.S. adults. http://www.harrisinteractive.com/NEWS/allnewsbydate.asp?NewsID=825

Wall Street Journal Online/Harris Interactive Health-Care Poll	**December 4, 2003**	"Most People Uncomfortable with Profit Motive in Health Care." Harris Interactive conducted this survey of 2,587 U.S. adults conducted online between November 13 and 17, 2003. http://www.harrisinteractive.com/news/newsletters/wsjhealthnews/WSJOnline_HI_Health-CarePoll2003vol2_iss12.pdf
Wall Street Journal Online/Harris Interactive Health Care Poll	**November 13, 2003**	"No Consensus on Personal Responsibility for Health Care." This survey of 2,231 US adults nationwide was conducted between October 30 and November 3, 2003. http://www.harrisinteractive.com/NEWS/allnewsbydate.asp?NewsID=708
Wall Street Journal Online/Harris Interactive Health Care Poll	**August 14, 2003**	"National Survey Reveals Top Indicators of Quality of Medical Care." This online survey was conducted between July 24 and 28, 2003, with a national sample of 2,687. http://www.harrisinteractive.com/news/newsletters/wsjhealthnews/WSJOnline_HI_Health-CarePoll2003vol2_iss4.pdf
Wall Street Journal Online/Harris Interactive Health Care Poll	**August 7, 2003**	"Many Want Quality Health Care, But Few Think They Should Pay for It." This survey was conducted online between July 8 and 10, 2003, with a national sample of 2,357 adults. http://www.harrisinteractive.com/NEWS/allnewsbydate.asp?NewsID=661
Washington Post/Kaiser Family Foundation/Harvard University, A Generational Look at the Public: Politics and Policy	**October 2002**	This survey was a partnership between the Washington Post, Kaiser Family Foundation, and Harvard University. The survey was conducted by telephone August 2 – September 1, 2002 with a nationally representative sample of 2,886 randomly selected respondents ages 18 and older. http://www.kff.org/kaiserpolls/3273-index.cfm
Winston Group: New Models National Brand Poll	**November 23, 2004**	This survey was conducted by Winston Group, November 23 – 24, 2004 and based on telephone interviews with a national sample of 1,000 adults. http://www.kaisernetwork.org/health_poll/hpoll_index.cfm, *The Uninsured and Health Insurance Coverage/Access* then *The Uninsured* to find the survey questions and results.
Yankelovich Partners:/Time, Cable News Network	**July 1998**	This survey was conduct by Yankelovich Partners July 1998 with a sample size of 1,024 adults.
Yankelovich Partners: Time/Cable News Network	**August 1991**	This survey was conducted by Yankelovich Clancy Shulman, August 27 – August 28, 1991, based on telephone interviews with a national adult sample of 1,000. http://www.kaisernetwork.org/health_poll/hpoll_index.cfm
Zogby International: In the Media	**October 27, 2005**	"Zogby Survey Reveals Wide Gap Between Consumer Perception and Reality on Health Coverage." A sample of 1,049 privately insured adults were surveyed between September 27 and October 4, 2005; the margin of error is plus or minus 3.1 percent. http://www.zogby.com/news/ReadNews.dbm?ID=1032
Zogby International: In the Media	**April 19, 2005**	"Americans Worry About Losing Their Prescription Drug Coverage More Than The Loss of a Job or Home." Zogby International conducted this survey with interviews of 1,001 adults chosen at random nationwide, the margin of error is plus or minus 3.2 percent. http://www.zogby.com/news/ReadNews.dbm?ID=985
Zogby International Poll for The Galen Institute	**June 2003**	"Medicare vs. Private Health Care Plans." Zogby International conducted this survey on June 18 – June 21, 2003, based on telephone interviews with a sample of 1.007 adults. http://www.kaisernetwork.org/health_poll/hpoll_index.cfm

Appendix G: Response to Comments on the Interim Recommendations

Overview of changes

As a result of comments from the public and its own deliberations, the Citizens' Health Care Working Group has made several modifications to its Interim Recommendation report. These changes were made to clarify the Working Group's intent, provide additional details, and better convey the urgent need for reform that the Working Group has heard from the American public.

First and foremost, the Working Group has restructured its report to make emphatic its major message: to achieve "Health Care that Works for All Americans," it should be public policy, enacted in law, that all Americans have affordable health care. The revised report stresses the goal of affordable health care for all, explains how the individual recommendations work together as a package leading to that goal, sets a target date of 2012 for full implementation, and acknowledges the need for new revenues. The graphic at the start of our report illustrates the relationships among the recommendations and the timeline for their implementation. To further convey the need for immediate action, the report explains what will result if nothing is done.

- Establish Public Policy that All Americans Have Affordable Health Care

In this section of the report, The Working Group makes clear its vision for the health care system, a system which is easy to navigate and in which everyone participates. Its services and benefits are determined through a transparent and accountable process that draws on best practices and these benefits and services are available regardless of changing personal circumstances. These concepts were included in the earlier draft but are emphasized here as is the date for full implementation—2012. There are differing views as to the role government would play in this system: over the comment period we heard from many individuals and groups who advocated for a government-managed health care system financed by taxes. At the same time, we heard from others reluctant to assign additional responsibilities to government. The Working Group does not propose a specific model for achieving what it heard the American people want. While there is great agreement on the ultimate destination, how to get there needs to be determined through ongoing dialogue and action by the Congress and the Administration.

- Guarantee Financial Protection Against Very High Health Care Costs

This recommendation was listed first in the revised materials posted on the Working Group's web site on July 18. This was a concern to many readers who believed beginning the report with the ultimate goal was important. As noted above, the order of recommendations was revised, and additional language was added to make it clear that protection from very high costs was an initial step toward core benefits and services for all. To address the many questions the Working Group received about how this program would work, this report offers two illustrative examples for consideration. The first is a market-based approach; the second is federally-run program based on a social insurance model. The principles, that everyone participates and government

funded subsidies are available based on need, remain unchanged. We have also added language to better explain the relationship we see between this recommendation and the integrated community health network recommendation which follows. The Working Group sees these two proposals—protection against very high health care costs and reforming the health care delivery at the local level—as building blocks for an improved health care system and key steps that can be taken immediately.

- Foster Innovative Integrated Community Health Networks

In the revision of the discussion of this recommendation, the Working Group makes it clear that the networks it envisions are meant for anyone in the community. While the Working Group sees these networks as a sound way to improve care in localities where need is great, it does not see these networks as a form of second-tier care for low-income people, as some writers suggested. To make our intentions more clear, this revision includes more detail on the Working Group's vision for these networks. The discussion provided here places a stronger emphasis on prevention than the earlier draft.

We received many comments from individual community health centers and their associations asking us to remove the proposal to "expand and modify the Federally Qualified Health Center concept" to allow additional providers to qualify for some of the benefits now limited to community health centers and certain other providers. Most of these letters focused on the important role of these centers' citizen governing boards. By statute, at least 50 percent of the members of these boards must be users of the centers' services. We have, however, retained the proposal. The Working Group acknowledges the valuable contributions the community health center program has made in providing care to low-income people over its 40-year history and the central role of community governance in the program. In no way does this recommendation seek to undercut either the program or its structure. The Working Group notes, however, that the organization of health services at the local level varies from community to community. Other successful models of care delivery can be found in many localities. To the extent that these providers are doing similar work for groups of people much like those served by community health centers, they should be encouraged through federal incentives.

- Define Core Benefits and Services for All Americans

The Working Group has expanded the discussion in this section to clarify that core benefits and services would be determined through an open, participatory consensus process. Decisions on inclusion would be based on demonstrated medical effectiveness as well as impact on individual and community health. Additional discussion is provided on the interrelationship of core benefits, evidence-based practice, and incentives that can increase the efficiency of health care delivery. This section also now addresses some important implications of a core set of benefits and services for current coverage in public and private insurance programs.

- Promote Efforts to Improve Quality of Care and Efficiency

This recommendation is fundamentally unchanged. Its accompanying narrative has been expanded to add supporting data and examples of efforts now underway in the public and private sectors.

- Fundamentally Restructure the Way End-of-Life Services Are Financed and Provided

The Working Group added a discussion of professional and family caregivers to the narrative accompanying this recommendation. The narrative now also puts more emphasis on best practices and the need for better demographic, clinical, and epidemiological data to inform policy-making.

- Paying for Health Care for All Americans

The Working Group has expanded its discussion of financing and now places it in a separate section. The final report offers a set of principles it believes must guide sources of financing for these recommendations. First, financing methods must be fair: they should not place undue burdens on the sick; responsibility for financing should be related to a household's ability to pay; and all segments of society should contribute to paying for health care. Second, financing methods should increase incentives for economic efficiency in the health sector and the larger economy. Finally, the methods should be able to generate funds sufficient to pay for the recommendations. The report discusses potential ways its recommendations could be financed, beginning with savings recovered from better management of existing resources. A second source would be the curtailment of subsidies in the current tax code that do not meet the fairness test. If after these two approaches have been taken and additional funds are still needed, this section offers brief examples of policy options for generating new revenues that were mentioned at Working Group meetings or in its online comments.

Summary of Comments

- **Individuals submitting written comments: Internet and paper**

We received about 7,500 comments from individuals on the interim recommendations, including about 3,400 comments from June 2 through July 18, 2006, and over 2,600 through the end of the public comment period on August 31 submitted via the Internet. In addition, about 350 people sent comments via email, and over 100 on paper, including complete versions of the online evaluation form, as well as letters, notes, and postcards. We have also received and reviewed comments on the Interim Recommendations from about 1,000 people who responded directly to the Catholic Health Association web site. An additional 80 individual letters were sent to the Working Group by members of The American Federation of State, County and Municipal Employees. Several other organizations also submitted sets of comments on recommendations

or petitions from individuals affiliated with local chapters, including the Universal Health Care Action Network (North Carolina) and Grass Roots Organizing (Missouri).

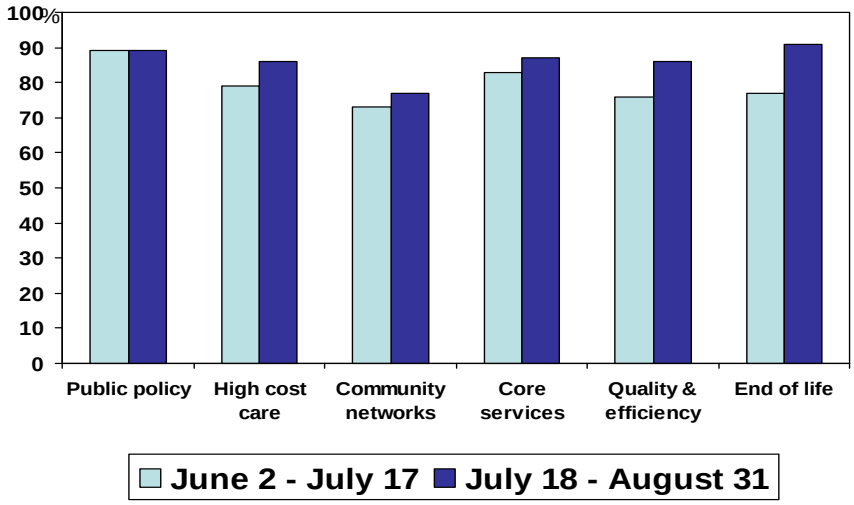
The comments were grouped into two sets, because the additional text was posted on July 18 and the order of the recommendations listed on the Internet was changed. Because the additional material may have altered the way the public viewed the recommendations, we compared responses from each time period separately. Our analysis included a review of a sample of all the comments, but a particular focus on the comments of those who expressed disagreement with the recommendations. We also analyzed a representative sample of all the comments on discussion issues of financing included in the Interim Recommendations.

Overall, the comments reflected the same perspectives and concerns that the Working Group has heard in the community meetings and in the comments and poll results over the past nine months. More than three in four people who provided written comments on each of the six recommendations expressed agreement with the recommendations.

The proportion of people agreeing with the recommendations did not change markedly after July 18, but a slightly higher proportion of individuals providing comments via the Internet indicated agreement with several of the recommendations (Figure G-1). The additional discussion posted on the Working Group web site may have been a factor in this change. A minor format change may have also affected how people provided input. After July 18, the comment page included a one-click box where individuals could indicate whether they agreed or disagreed with each interim recommendation, in addition to the free text area for comments. In the pre-July 18 period, only the free text fields were provided, and agreement was determined by Working Group staff who read the responses in full. After July 18, about two-thirds of those who indicated whether they agreed or disagreed with the Interim Recommendations also provided explanations of their views in the free text fields.

Individuals who provided input via the Catholic Health Association indicated strong levels of support for the recommendations. The letter from the members of the American Federation of State, County and Municipal Employees stated support for most of the recommendations, but also raised some concerns, similar to many others we heard, about "not going far enough."

Percent of Internet Comments Stating Agreement
with Citizens' Health Care Working Group Interim Recommendations



The major points raised by those commenting on the individual Interim Recommendations reflected some common themes, reflecting views about the role of government and social and personal responsibility:

Establish Public Policy that All Americans Have Affordable Health Care

– Of those that agreed, over one-fourth of those commenting want to see the recommendation be explicit – including questions about the structure of the reform, and calls for moving to a single payer system, with a clear commitment to the right to comprehensive coverage for all.

– Among those disagreeing, the principal reasons cited were that people should be responsible for their own health care (about one in four who disagreed); the recommendation involved too much government; market solutions were preferable; or that it would cost too much. About one in 10 disagreeing said the recommendation should specifically call for a government-run system.

Guarantee Financial Protection Against Very High Health Care Costs

– Among those agreeing with the recommendation, just under half provided additional comments or expressed concerns. These included that the recommendation does not go far enough, either because the commenter believes there should be more comprehensive reforms, or concerns that the coverage will be too limited, or more specific concerns about the role of insurers or how the coverage would be financed, or questions about how the policy would actually work. There were also some comments about the need to focus on prevention.

– Close to a third of those who disagreed with the recommendation said they wanted more comprehensive universal health. Others said it was the wrong policy, some citing concerns about too much government, crowding out market-based coverage, or costs. About one in seven disagreeing with the recommendation indicated that people should be responsible for their own health care costs.

- Foster Innovative Integrated Community Health Networks

– More than half of those agreeing with the recommendation cited some concerns, including questions about how the reform would be implemented, a preference for more comprehensive reform, concern about building a "2-tiered" system, and questions about accountability, including the roles of local communities and states in oversight, the need to emphasize prevention services, and how for-profit entities would be involved**.**

– Of those disagreeing after July 18, most cited concerns about too much government/bureaucracy; over one-third of those commenting before July 18 also expressed concerns about bureaucracy. About a fifth of those disagreeing with the recommendation after July said that a more comprehensive universal system should be the goal rather than targeted reforms. Before July 18, a greater percentage of those disagreeing said they want comprehensive rather than incremental reforms.

- Define a Core Benefit Package for All Americans

– About a third of those agreeing with the recommendation also had concerns about particular benefits that should be covered, such as mental health or preventive services. After July 18, about one in five said that the role of insurers in any process of defining covered services or benefits should be limited, or that they should not be included at all.

– The most frequent reasons for disagreeing with the recommendation were distrust of government involvement; a preference for tying benefits to personal behavior or responsibility; and a rejection of the concept altogether among people stating the need for a comprehensive universal health care system.

- Promote Efforts to Improve Quality of Care and Efficiency

– About one in five of those agreeing expressed concerns about focusing on efficiency, accountability, and the role of for-profit health care.

– After July 18, most of those disagreeing are opposed to additional government involvement in health care or government bureaucracy. About one in ten disagreeing wrote that the goal should be comprehensive national health care, rather than any incremental reforms.

- Fundamentally Restructure the Way End-of-Life Services Are Financed and Provided

– Before July 18, most who agreed with the recommendations did not raise additional concerns.

– After July 18, about half of those disagreeing cited objections to too much government or bureaucracy. About one in five in the same time period focused on issues of personal responsibility and choice.

– Comments on financing and broader concerns

Comments addressed a range of issues, including health care costs, the role of government, the type of system that should be put in place, and how reforms should be financed.

Among those commenting on the type of system that should be put in place, most of those commenting favored a single health care system, Medicare for all, or another form of government-organized system that included public and employer-based health care coverage.

- The most commonly-mentioned sources for financing health care for all are income taxes or other forms of public funding, and changing public spending priorities. Others cited a need for greater efficiency or concerns about for-profit health care.

- An analysis of all written comments submitted in one 3-week period found that close to 150 people of about 800 who actually composed and submitted written comments on the Internet had used the term "universal" in one or more recommendations, nine in 10 of those using the term indicated support for some form of universal care system.

- The term "responsibility" was mentioned by a fairly large number of people commenting on the recommendations.
  - About one-third of the comments focused on placing primary importance on personal responsibility:
  - One third advocated public/government responsibility to ensure access to health care for all: and
  - The remainder raised issues of shared responsibility among individuals, employers, and government for ensuring health care for all.

Community Meetings

Fourteen community meetings were held during the comment period on the Working Group's interim recommendations, which began June 2, 2006. They varied in size, sponsorship, and direct Working Group involvement. Three of the meetings were formally organized by the Working Group: two public meetings in Oklahoma City and Milwaukee, and a meeting held at the PayPal campus in San Jose, California for employees of eBay and PayPal. The Mississippi Extension Service, out of Mississippi State University, which earlier in the year had organized meetings across that state, and held meetings on the interim recommendations in Jackson, Hattiesburg, and Greenville which were facilitated by a Working Group staff member. The Dade County Health Department and the Health Foundation of South Florida organized a meeting in Miami that a Working Group member facilitated. Finally, in Muncie, Indiana; Corvallis, Oregon; Cleveland, Ohio; Columbus, Indiana; and Birmingham, Alabama, local groups

organized meetings. Two meetings were held in both Columbus and Birmingham. In all, over 700 people attended these meetings.

While a few of these meetings used the structure of the earlier community meetings and were organized around the four congressional questions, the vast majority focused exclusively on the Working Group's Interim Recommendations. The participants in the meetings varied: attendance at some meetings was dominated by people who work in health care. In general, as at the Working Group's earlier community meetings, many attendees were well-educated, middle-aged women. The Oklahoma City meeting was notable for its over 300 participants and diversity of views.

Public reaction to the interim recommendations from these meetings was consistent with the messages it received on the internet and in the mail. The sentiment among participants was that the American health care system is in trouble and needs change. Some participants saw health care as a global issue, where we have much to learn from other countries. In general, there was strong support for the recommendations, individually and as a package, but a common reaction among participants was that while they agreed with the recommendations, they did not go far enough. A significant percentage of participants, averaging around 20 percent at some meetings, did not support the recommendations, while others were not sure.

At most of these meetings, there was vocal endorsement of "universal health care," which was often coupled with support for a single payer system. At many meetings, there was also an articulate minority concerned about current costs and the damage that failure to address these costs could inflict on American competitiveness.

At many meetings participants had trouble with the recommendation proposing protection against high health care costs and wondered why the Working Group had this limited focus. The Working Group saw this measure as an immediate first step toward the availability of a core set of services for all in 2012, and has clarified both the recommendation on protection against high health care costs and its relationship to the ultimate goal in its final report.

At the well-attended Oklahoma City meeting, the Working Group member and staff were gratified by participants' unexpectedly enthusiastic reaction to two recommendations, Integrated Community Networks and Restructuring End-of-Life Care. Each of these recommendations calls for a rethinking of the status quo with a focus, in major part, on better integration of services at the local level. The response in Oklahoma City suggests the reservoir of energy, imagination and expertise that exists in communities across the country that can be brought to bear on these two recommendations in particular.

Comments from Organizations

The Working Group received over 100 comments on its Interim Recommendations during the public comment period from organizations. Collectively these organizations spoke on behalf of consumers, health care and other professionals, health care organizations, business, labor, insurers, and religious groups. The city of Philadelphia and the Cherokee Nation provided

comments. David Walker, Comptroller General of the United States, also provided comments. Several organizations who advocate for low-income people commented, as did groups that have been formed to pursue health system change. Some organizations provided detailed critiques of each recommendation; others focused on one or two. Some of these organizations represent thousands, even millions of individuals. In some cases local chapters of organizations reiterated or expanded upon the views of their national organization. Some organizations compared the Working Group's recommendations to their own established positions, sometimes enclosing documents spelling out their views.

A summary of individual comments received from organizations follows. The individual letters can be viewed on the Working Group's website www.citizenshealthcare.gov.

The general response to the Working Group's recommendations was positive, and when organizations were critical, more often than not, it was because the writers believed that the recommendations could have gone further. Several organizations questioned the reordering of the recommendations that took place on the Working Group's website about halfway through the comment period. In that revision of the recommendations, to make clear the sequence of implementation steps, the Working Group made the "Guarantee Protection against Very High Health Care Costs" its first recommendation because it could take place relatively quickly. Commenters believed that this move led to a loss of focus on the Working Group's call for affordable health care for all by 2012.

About one in four of the comments from organizations were submitted by federally-funded Community Health Centers or state or national membership organizations representing these centers. These comments were generally supportive of the Working Group's Interim Recommendations with one significant exception. These organizations opposed the proposal to "Expand and modify the Federally Qualified Health Center concept to accommodate other community-based health centers and practices." They noted that community-based, user-dominated governance has been a hallmark of the Community Health Center program since its inception forty years ago and a source of patient empowerment unique in the health care system which should not be modified.

Of comments received from organizations, about one-quarter focused on advocating for universal comprehensive health care. Some praised the Working Group's recommendations as a "strong call for health care coverage for all" but more frequently commenters believed that the recommendations did not go far enough. In all over one-fifth of the organizations commenting called for some form of a national comprehensive tax-payer financed health care system. Many of these commenters cited the Working Group's polls and community meetings to support their views and voiced the belief that the Working Group's recommendations did not accurately reflect public input.

In contrast to these comments, the Working Group received four comments that were very critical of its Interim Recommendation because of the increased emphasis they perceived in them on government's role in health care and lack of emphasis on market-based approaches. One of these organizations challenged the Working Group's findings because its public outreach efforts

did not reach “a representative cross section of the public” and failed to capture the views of the middle class.

A number of comments were received from professional associations representing various types of health care provider or service. In addition to making more general comments, they often argued for adequate attention to their particular interests, such as the health care needs of children, reproductive health, dental health, mental health services, palliative care and HIV care.

Summary of Organization Feedback on Interim Recommendations
Common Themes

- Community health center advocates expressed concern about expanding and modifying the Federally Qualified Health Center concept.
- Many advocacy organizations were disappointed that the recommendations emphasized protection from high cost care rather than access to high quality care for all.
- These same advocacy organizations criticized the recommendations for not going far enough in recommending universal comprehensive health care coverage for all.
- Other groups emphasized the need for free market health care reforms and did not support increased government involvement in health care.
- Groups representing specific populations highlighted the needs of the people they represent and urged inclusion of provisions that would specifically address their concerns.
- Various professional associations who work within the health care system advised including specific health services or references to specific providers in the recommendations.

ORGANIZATION	COMMENTS
Common theme: focus on integrated community health networks	
Access to Care Westchester, Illinois	• Strongly agrees with community networks recommendation to broaden the FQHC concept to include community-based health centers and programs serving under-served populations • Advocates consideration of their model of care which uses private physicians in their own clinics rather than designated public health clinics
Numerous Community Health Centers and related organizations (see list of commenting organizations at right following summary of comments)	• Expresses concern with proposal on expanding and modifying FQHC concept • Argues that patient-dominated health clinic boards are a unique and important feature of the successful Community Health Center program • Urges retention of current FQHC legislation and seeks independent provisions for expanding providers in community networks • Argues that the community networks recommendation does not reflect the majority sentiment expressed in Working Group community meetings Commenting Community Health Centers and related organizations**:** **Allen Hospital, Iowa Health System**, Waterloo, Iowa **Association for Utah Community Health**, Salt Lake City, Utah **Avis Goodwin Community Health Center**, Rochester, New Hampshire **Bi-State Primary Care Association**, Concord, New Hampshire **Colorado Community Health Network**, Denver, Colorado **Community Health Center of Burlington, Inc.,** Burlington, Vermont **Community Health Care Association of New York State**, Albany, New York **Community Health Center of Rutland Region**, Bomoseen, Vermont **Community Healthcare Network**, New York, New York **Coos County Family Health Services**, Berlin, New Hampshire **Decatur County Community Services**, Leon, Iowa **The Georgia Association for Primary Health C**are, Decatur, Georgia **Community Health Centers of Southern Iowa**, Leon, Iowa **Hometown Health Centers, Schenectady Family Health Services**, Schenectady, New York **Hudson River Healthcare**, Peekskill, New York **The Institute for Urban Family Health**, New York, New York **Lamprey Health Care**, Newmarket, New Hampshire **Lutheran Family Health Centers**, Brooklyn, New York **National Association of Community Health Centers, Inc.**, Washington, D.C. **New Jersey Primary Care Association**, Princeton, New Jersey **Oak Orchard Community Health Center**, Brockport, New York **One World Community Health Center, Inc.**, Omaha, Nebraska **Oregon Primary Care Association**, Portland, Oregon

	People's Community Health Clinic, Waterloo, Iowa **River Hills Community Health Center**, Ottumwa, Iowa **William Ryan Community Health Center**, New York, New York **United Community Health Center**, Storm Lake, Iowa **Whitney Young Jr. Health Services**, Albany, New York
National Assembly on School-Based Health Care Washington, D.C.	• Advocates for integrating school-based health care into national health care and education systems • Advises securing a consistent funding stream for school health centers by authorizing school health centers as part of the health care safety net and ensuring that the public health insurance program reimburse SBHC services
Common theme: advocating for universal comprehensive health care	
American Federation of State, County, and Municipal Employees Washington, D.C.	• Argues consideration of different language in the catastrophic coverage recommendation to prevent employers from shifting costs of mandating insurance onto employees • Urges Working Group fulfill its mandate and provide a stronger endorsement of a comprehensive national health care system to reflect the majority public opinion from community meetings and polls • Requests exploration of public catastrophic coverage • Argues that quality and efficiency recommendation uses too broad a definition of fraud and waste, urges specifying "*fraud, waste, and abuse in the system as a whole as it relates especially to for-profit providers of prescription drugs and health care*" • Argues that report should include explicit language to support government's use of purchasing and regulatory powers to rationalize prescription drug prices and control profits of insurance companies and other corporate entities
Catholic Health Association of United States Washington, D.C.	• Strongly supports universal health care for all Americans, but must include non-citizens as well • Urges Working Group to define "*affordable,*" in relative terms • Asks clarification of definitions of palliative, chronic, hospice, and end-of-life care • Advocates for explicit language in the report condemning physician-assisted suicide
Center for Medicare Advocacy, Inc. Washington, D.C.	• Advocates for a universal single payer health care system • Asserts that high deductible coverage is only a stop gap measure and leads to the "doughnut hole" effect
Coalition for Democracy of Central New York Bovina Center, New York	• Argues that recommendations were too vague and need to include provisions for simplifying the health care delivery and financing • Advocates for a health care system that mirrors the Canadian one
United States Conference of Catholic Bishops: Department of Social Development and World Peace Washington, D.C.	• Praises inclusion of a strong call for universal health care coverage with access to a core set of services and financial protection against high health care costs • Observes that the most striking outcome from the Working Group's outreach efforts is that 90 percent of the public who responded to the Internet poll and/or participated in community meetings agreed that affordable health care for all should be public policy • Urges that procedures such as abortion and euthanasia, that they describe as morally objectionable, be excluded • Reaffirms their position that *"health care is a fundamental human right and reform of the nation's health care system must be rooted in values that respect human dignity, protect human life, and meet the needs…*[of the poor]."
Family Planning Advocates Albany, New York	• Advocates for universal single-payer health care for all, including non-citizens living in U.S. • Urges Working Group to expressly advocate for comprehensive reproductive health services • Asserts that "affordable" health care needs to be more explicitly defined • Argues for increasing reimbursement rates for neighborhood clinics • Says report should explicitly address high profit margins of health insurance companies and drug companies • Urges inclusion of abortion services

Health Care for All/NJ Hoboken, New Jersey	• Argues interim recommendations do not accurately reflect citizen feedback from the public at community meetings • Asserts that congressionally mandated questions were biased — leading respondents to discuss the need for "core" rather than comprehensive coverage • Believes recommendations should advocate explicitly for a national, universal single-payer health care system to accurately reflect citizen feedback
Health Care for All/Washington Seattle, Washington	• Argues interim recommendations do not accurately reflect citizen input at community meeting and advocates for comprehensive national health care for all
Institute of Social Medicine and Community Health Washington, D.C.	• Argues recommendations be revised to reflect public feedback and advocate for a comprehensive health care package for all as soon as possible • Supports a civil rights approach to health care processes • Urges clarification of process for arriving at universal health care
International Association of Machinists and Aerospace Workers Upper Marlboro, Maryland	• Asserts that affordable health care for all Americans should be the first recommendation • Argues for adding *"to not harm"* to the core values and principles section • Asserts that core benefits package should be broadened to include comprehensive benefits • Urges explicitly clarifying that protection against high costs is an incremental step toward health care for all • Expresses concern that the public-private partnerships discussed in the community networks recommendation will lead to for-profit entities misusing tax dollars
League of Women Voters Health Care Working Group Medfield, Massachusetts	• Urges reordering of recommendations so that public policy recommendation is first — reflecting community feedback and support • Argues for stronger endorsement in the report for national health care plan, financed by taxpayers, that gives all residents equal quality of care
National Coalition of Mental Health Professionals and Consumers Commack, New York	• Advocates ensuring that mental and substance abuse services are not relegated to a low priority in the recommendations • Argues that the interim recommendations do not reflect public sentiment from community meetings and poll results • Asserts the common message was for a universal, comprehensive system • Argues that rising costs in the health care industry come from high prices for care, administrative costs, and too many basic services performed in a clinical setting
Michigan Legal Services Detroit, Michigan	• Asserts that focus of recommendations should shift from covering high-cost care to providing universal comprehensive health care coverage • Advises keeping the basic structure of federally funded health care centers • Argues for focus on reducing administrative costs and highlighting preventative services and primary care and focusing on the delivery system instead of financing
Michigan Universal Health Care Access Network Detroit, Michigan	• Argues interim recommendations do not go far enough and should include rating criteria for judging a new health care system • Advocates for reducing health care administrative costs and inefficiencies • Argues for financing health care through a new progressive income tax rather than the current fragmented payment system • Argues for a need to address how our current system decreases nation's global economic competitiveness • Asserts that health care should be viewed as a public good • **Follow-up letter**: Asserts frustration that recommendations do not advocate for a progressive tax to finance publicly a national health care program; emphasizing protection against high health care costs will be costly and inefficient but applauds Working Group's commitment to comprehensive health care for all
Midwives Alliance of North America Fairfax, California	• Argues that report needs to reflect citizen feedback at community meetings and advocate for universal national, single-payer health care for all — financed partially by taxpayers • Agrees with promotion of evidence-based medicine, expansion of community health

	clinics, and emphasis on home-based end-of-life care • Argues for inclusion of midwifery services in core package of services
National Association of Free Clinics Washington, D.C.	• Urges inclusion of a definition of "high out of pocket costs" • Argues that the report does not tackle non-citizens' need for health care • Advocates for including vision and hearing services in the core benefits package • Expresses a strong need to make a distinction between free clinics and federally funded health care centers and offers suggestions aimed specifically at free clinics • Argues that health care reform needs also to address potential public health crisis crises (e.g. New Orleans after Hurricane Katrina)
National Advocacy Center, Sisters of the Good Shepherd Silver Spring, Maryland	• Praises Working Group recommending affordable health care for all Americans by 2012 • Advocates reordering the recommendations so that this recommendation comes first
NETWORK Washington, D.C.	• Advocates for affordable and accessible health care for all by 2012—calls for a transformation in health care based on social justice
Public Citizen Washington, D.C.	• Argues that Working Group needs to expressly advocate for a single-payer system in the recommendations • Provides arguments on benefits of single-payer national health care model
Philadelphia Area Committee to Defend Health Care Philadelphia, Pennsylvania	• Argues that interim recommendations do not reflect public sentiment at community meetings because they do not advocate for a single payer universal national health care system • Urges Working Group to draft stronger recommendations that reflect majority opinion at the community meetings
Universal Health Care Action Network Cleveland, Ohio	• Divides critiques into three broad categories: how the recommendations are framed, concern about how accurately they reflect public feedback, and a set of comments on the feasibility of individual recommendations • Argues that recommendations are inter-related and need to be debated as a comprehensive reform package rather than separately • Asserts that American health care system is not a system but is a "collection of loosely linked systems" • Argues that interim recommendations do not accurately reflect the majority who provided feedback to the Working Group and asked for a national health plan, financed by tax payers.
Universal Health Care Action Network of Ohio Columbus, Ohio	• Advocates for changing the order of the recommendations so that Affordable Health Care for all recommendation comes first • Argues that protection against high health care costs should be broadened to include nominal costs for low income persons • Asserts that integrated community health networks should be available to all • Urges more aggressive measures to curtail waste • Argues for eliminating tax cuts for the wealthy
Reach Out America Great Neck, New York	• Disagrees with protection against high health care costs, affordable health care, and a core benefits package in lieu of a universal, publicly financed system of health care
RESULTS Washington, D.C.	• Advocates reordering recommendations to place affordable health care for all as number one • Argues that the timeline needs to be added to spur Congress and the Executive Branch to act
The Workmen's Circle New York, New York	• Disagrees with the revised order of the recommendations and advocates for retaining affordable health care for all as the first recommendation • Argues that the integrated community health network recommendation fails to address the current two-tier system of health care • Disagrees with including "core" benefits package and protection against high health care cost recommendations as they deflects from the ultimate goal of providing comprehensive health care for all

Washington State Ad-Hoc Coalition on the Citizens Health Care Working Group	• Urges shortening the Values and Principles section to the first three bullets • Argues first recommendation should be *"It should be public policy that all Americans have affordable health care"* • Advocates second recommendation should read, *"There should be a national health plan, financed by taxpayers, in which all Americans would get their health insurances"* • Argues third recommendation should read, *"A sufficiently comprehensive benefits packages for all Americans should be defined"* • Proposes additional changes to other recommendations • **Follow up letter:** argues for removing "core" and replacing it with "comprehensive" benefit package • Advocates for not allowing insurance companies and employers to be decision makers in creating the core benefits package • Reiterates Working Group should advocate for comprehensive health care in response to public response through surveys and community meetings
Common theme: Promote a free market health care system	
Association of American Physicians and Surgeons Tucson, Arizona	• Disagrees with the interim recommendations in favor of private market approaches and believes that universal coverage leads to restricted access to care
ERISA Industry Committee Washington, D.C.	• Argues that Working Group should differentiate health care from health insurance arguing that Americans already have access to free health care • Asserts that free health care insurance for all would place an undue burden on taxpayers and lead to rationing • Asserts that a tax-payer system will lead to moral hazard • Argues for restricting unnecessary medical liability lawsuits • Urges Working Group to promote incentives for providers who provide high quality and efficient care
Health Care America Washington, D.C.	• Asserts that the Working Group report is not practical because it does not discuss how to implement the recommendations • Argues that report implicitly calls for increase in the government's role in national health care coupled with a tax increase, which they assert most Americans do not support • Suggests community meetings failed to capture a representative sample of America's middle class • Argues that greater health care coverage does not imply greater access to care • Supports market competition between health plans and packages as the best approach for consumers to enjoy choice in health care • Advocates for four solutions to limit increases in health care costs, including: redirecting non-emergency care to more appropriate locations, enacting medical liability reform, encouraging electronic health records, and introducing pay-for-performance incentives to reward providers for high quality services • Argues that recommendation for integrated community health networks is not notably different from the current system
Institute for Health Freedom Washington, D.C.	• Uses Medicare as a case study to argue that universal, single-payer national health care is not effective in improving health indicators, poverty rates, provider choice, and health privacy
Common theme: all have a special focus	
American Academy of Actuaries Washington, D.C.	• Asks the Working Group refer to their publications as resources for information on a variety of health care issues • *Special focus:*: Argues that actuaries provide unique expertise and perspective on issues related to risk and contingent events
American Academy of Pediatrics Elk Grove Village, Illinois	• *Special focus::* Focus on unique health needs of children • Advocates for increasing Medicaid reimbursements for pediatric services • Argues that integrated community networks recommendation should explicitly refer to children and promote the "child medical home" • Urges development of specific pediatric care quality measures

American Chiropractic Association Arlington, Virginia	• Concludes that health care system needs to shift focus from caring for the seriously ill to disease prevention, early disease detection, and positive lifestyle changes • *Special focus:* Argues chiropractic care is a major component of efficient quality health care and should be fully integrated into the medical delivery system
American Dental Association Washington, D.C.	• Strongly supports inclusion of dental services in definition of core health services • *Special focus:* Argues oral health is an important component of health
American Hospital Association Washington, D.C.	• Presents results from its own independent "listening sessions" held to discuss health care reform with key stakeholders resulting in 10 principles that typify what healthcare should be in America. • *Special focus*: Concludes its vision of health care reform is parallel to the Working Group's interim recommendations
American Psychological Association Washington, D.C.	• *Special focus:* Concerned that the core benefits package will not include adequate mental health services • Argues that "evidence-base care" in benefits section needs to reflect different diagnostic approach for mental health services • Recommends replacing the term "medical" with "clinical" to be more inclusive in treatment by both physicians and non-physicians
Association of Clinicians for the Underserved Tysons Corner , Virginia	• *Special focus:* Advocates for health care reforms that increase underserved community access to care • Encourages greater financial incentives for clinicians to provide preventative care and health education services
Ascension Health Saint Louis, Missouri	• *Special focus:* Praises recommendations and provides a strong endorsement for affordable health care, integrated community health networks, and restructuring end-of-life care
Seton Healthcare Network Austin, Texas	• *Special focus:* Reiterates Ascension Health's comments
Associations of Professional Chaplains Schaumburg, Illinois	• *Special focus:* Argues for greater emphasis on mental, emotional, and spiritual health elements of health care
California Pan-Ethnic Health Network Oakland, California	• Encourages Working Group to add a new recommendation addressing racial disparities in health • *Special focus:* Endorses recommendations but argues for greater emphasis on communities of color
Catholics for a Free Choice Washington, D.C.	• Concurs with finding that the health care system is in desperate need of overhaul • *Special focus:* Argues that core benefits package should include services and medicines based on the needs of the patient not the ideological beliefs of the hospital or provider
Cherokee Nation Tahlequah, Oklahoma	• Argues that the unique relationships with tribes must be honored, Indian Health Service, Tribal Programs, and Urban Indian Clinics (I/T/U) system remain intact and federal funds be used to cover health care expenses imposed on eligible American Indians and Alaskan Natives • Advocates that community health networks include health care services for Indian country • Argues that the I/T/U system should be a critical focus in a new initiative to improve quality and efficiency • *Special focus:*: Carefully take into account how proposed health care reforms will impact the current American Indian and Alaska Native health care system and ensure that any changes have a positive effect on Native Americans and Alaskan Natives
Clinical Social Work Association Seattle, Washington	• *Special focus*: Argues to include physical, mental, dental services in the defined core benefits package

Clinical Social Work Guild Arlington, Virginia	• *Special focus:* Advocates for benefits parity for *mental* and physical services and incorporating language that emphasizes importance of psychosocial aspects of mental and physical health
Congreso de Latinos Unidos Philadelphia, Pennsylvania	• *Special focus:* Argues community-based organizations should be considered as potential outpatient and health and wellness providers/educators especially in communities that frequently encounter obstacles to health care due to language and cultural barriers
Consumers Union Washington, D.C.	• Praises interim recommendations • *Special focus:* Emphasizes need for evidence-based medicine
End-of-Life Nursing Education Consortium Washington, D.C.	• *Special focus*: Suggests integrating end-of-life and palliative care issues throughout all recommendations rather than addressing the issue in a separate recommendation
HIV Medicare and Medicaid Working Group On behalf of 32 organizations from across the country	• Argues that the "core" benefits package should meet the needs of people living with HIV and AIDS • Advocates for explicit measures to protect against high cost out-of-pocket expenses • Strongly supports integrating health networks, including HIV centers of excellence, and ensuring patients have more choice over their end-of-life care, treatment, and environment • *Special focus:* Strongly supports the CHCWG interim recommendations and its call for all Americans regardless of income to have affordable and comprehensive health care
Lourdes (Ascension Health) Binghamton, New York	• *Special focus*: Suggests clarifying high cost in relation to income, otherwise generally supports the recommendations
National Athletic Trainers' Association Dallas, Texas	• *Special focus*: Advocates for supporting policies that enhance injury and illness prevention and preventative care • Argues for policies that address the shortage of health care workers
National Association of Dental Plans Dallas, Texas	• *Special focus:* Argues dental benefits companies are the most effective entities to provide dental coverage with input from dental providers
National Association of Health Underwriters Arlington, Virginia	• Advises Working Group to address high health care costs with the private marketplace subsidizing individual policies and increasing federal subsidies for high risk pools • Urges Working Group to encourage Americans to purchase long term care insurance in their report • *Special focus:* Advocates for retaining the national private health care insurance market
National Association of REALTORS Washington, D.C.	• *Special focus:* Urges support for federal legislation that would authorize the creation of small business health plans through trade organizations • Suggests the small business community be represented on any independent, non-partisan, private-public group called for in the final report
National Committee for Quality Assurance Washington, D.C.	• Recommends supporting pay-for-performance programs for prevention and chronic conditions • Supports recommendation that enhances patient education opportunities • Recommends making organizations who provide the core benefits package responsible for measuring and reporting quality measures • *Special focus:* Supports recommendation on improving quality and efficiency in health care
National Consensus Project for Quality Palliative Care Pittsburgh, Pennsylvania	• Argues that palliative care should be explicitly included as a core benefit • Urges health care policymakers to focus more attention on palliative care to ensure higher quality and more efficiently in care • *Special focus:* Advocates for placing greater emphasis on palliative care
Planned Parenthood Federation of America New York, New York	• *Special focus:* Advocates for CHCWG to address the need to increase funding for public programs that provide low-income women with comprehensive reproductive health services, as well as pre- and post-natal care services

Provena Central Illinois Region United Samaritans Med. Ctr., Danville, Illinois; and Covenant Med. Ctr., Urbana, Illinois	• *Special focus:* Supports recommendations to provide protection against high health care costs, making affordable health care public policy, and reforming end-of-life care to support the wishes of the patient
Providence Hospital (Ascension Health) Mobile, Alabama	• *Special focus*: Generally supports recommendations
Religious Coalition for Reproductive Choice Washington, D.C.	• *Special focus:* Concerned that the content of the core benefit package may be determined by ideological factors and not respect diverse beliefs • Argues for addressing the inequities in medical care and coverage within the system • Advocates for including comprehensive reproductive services and pre-post natal care in the core benefits package
St. Vincent Health (Ascension Health) Indianapolis, Indiana	• *Special focus:* Praises recommendations, placing particular emphasis on protection against high health care costs, integrated community health networks, and improving the quality of care
Supportive Care Coalition Portland, Oregon	• Concerned that emphasis on preventative care will force Americans living with chronic illness to be fully responsible for their own care • Advises the CHCWG to include spiritual and bereavement services in core benefits package • *Special focus:* Urges CHCWG to integrate end-of-life services into the other recommendations, where appropriate
United University Church Los Angeles, California	• *Special focus:* Concerned that delivery of controversial core services such as HIV prevention education, abortion, emergency contraception, condom distribution will be hindered at faith-based medical facilities
Vista Care Scottsdale, Arizona	• *Special focus:* Agrees wholeheartedly with recommendations, especially end-of-life
Common theme: Comprehensive comments on recommendations	
American Academy of Physician Assistants (AAPA) Alexandria, Virginia	• Supports health care delivered by qualified providers in physician-lead teams that are accountable to high professional standards • Advocates for incentives to control costs through optimal use of primary care (e.g. health promotion and disease prevention), reducing administrative costs, eliminate cost shifting, and creating greater incentives for providers to give patients appropriate care • Argues that fair and comprehensive medical liability reform is needed • Endorses system reform that enhances the patient-provider relationship— and when appropriate—defer to the patient's family to make decisions regarding patient care
American College of Physicians Washington, D.C.	• Agrees with recommendations on moving toward universal access to care, creating a non-partisan, public-private group to create the core benefits package • Argues for the need to identify target populations that are the most in need of health care coverage, access, and care • Urges inclusion of explicit language on how to make prescription drugs more affordable • Emphasizes need to make reimbursement levels for covered services fair and appropriate • Argues for including explicit provisions on eliminating disparities in health care based on social, ethnic, racial, gender, sexual orientation and demographic differences • Advocates for stronger emphasis on basic consumer protection rights, including rights to information • Argues for ongoing evaluations of health care reforms • Asserts need to respect individual choice of providers

AFL-CIO Washington, D.C.	• Strongly supports end-of-life, integrated community networks, and public policy recommendations • Argues that $4,000 deductible for high health care cost protection is still too high for poor Americans and would discourage necessary care • Advocates for stronger language on greater transparency for insurance "purchasers" not just "consumers" • Argues for quality and efficiency recommendation to *endorse payment systems to reward high quality care and improvements in care"* • Strongly endorses the core benefits package and argues the recommendation is in contrast to the model of care implicit in the high deductible plan
American Medical Association Chicago, Illinois	• Argues that the best method of expanding health care coverage is to cap or revoke the subsidy of employment-based coverage with the addition of a federal tax credit or premium subsidy for the uninsured • Supports legislation to allow individuals to "buy in" to state employee purchasing pools • Argues that emphasis on safety net in community health networks recommendation will undermine proposal to expand coverage to the uninsured • Supports price transparency, health information technology improvements and a greater emphasis on community-based and home health alternatives for end-of-life and long term care • Disagrees with defining a core benefit package and instead argues that benefit mandates should be minimized to allow markets to permit a wide choice of coverage options
American Medical Student Association Reston, Virginia	• Asserts that recommendations would be strengthened if they included financial and long-term outcome projections • Argues that high cost recommendation implies every American needs catastrophic coverage, when what they need is comprehensive care including the preventative and chronic care management health care service noted in the community network recommendation • Argues that if federally funded health care centers are expanded to include new providers, they should be required to meet current federal guidelines • Advocates for including all providers—not just federally subsidized programs—in provisions to improve quality and efficiency and increasing Medicare funding to address demographic changes in aging • Advocates for single payer system to finance comprehensive national health care • Stresses that the core benefits package recommendation must include a continuing evaluation component to review/revise benefits as necessary
American Nurses Association Silver Spring, Maryland	• Praises Working Group support for affordable, quality health care for all • Urges acknowledgement of discrepancies between community meeting input and the recommendations • Argues the recommendations should have more explicit language on health care as a right for all—citizens and residents • Advocates including more explicit language on controlling long term costs through emphasis on primary care and health maintenance • Asks CHCWG to clarify whether protection against high care costs includes long term care • Asserts that the community health networks need to be integrated with social services • Advises against consumer-driven healthcare because of underlying assumption that patients are able to make the appropriate medical choices • Urges integration of end-of-life services throughout the recommendations • Advocates for explicit language on chronic pain management within section on palliative care • Asks recommendation on affordable health care policy to include language on "removing financial barriers to care" • Requests the CHCWG make a clear distinction between health services and health insurance

	• Advocates including specific mention of "single payer" as a preferred path to financing reform • Requests that insurers not play a role in defining the core benefits package as reflected in public feedback
American Osteopathic Association Washington, D.C.	• Advocates for the creation of a national data bank that evaluates adverse medical events to improve quality of healthcare • Advocates for focusing more on long-term impact of medical interventions on the patient's quality of life as opposed to controlling costs • Disagrees with the core benefits package, arguing it is not feasible
American Public Health Association Washington, D.C.	• Advocates for guaranteeing basic health coverage rather than *protection against very high health care costs* • Stresses including guaranteed Medicaid funding to federally funded health care centers in integrated community network recommendation • Recommends changing current Medicare payment policy for hospice care • Argues that data and specific details are needed to support the recommendation on affordable health care • Requests more specifics on expert group who establishes core benefit package
Cincinnati USA Regional Chamber Cincinnati, Ohio	• Urges CHCWG to quantify affordable health care and clarify who is calling for this recommendation • Argues for more explicit language for each of the recommendations
City of Philadelphia Department of Public Health And additional letter endorsed by 17 organizations and 39 individuals	• Argues highlighting the importance of state and local government, business and labor, faith-based groups, payer organizations, and representatives for the public in defining a core benefits package • Suggests using Philadelphia's Health Leadership Partnership (HLP) as a model for building and integrating community health networks • **Second letter:** Reiterates City's support of community networks recommendation and urges use of HLP as a national model
General Accountability Office (GAO) Washington, D.C.	• Urges Working Group to explicitly explain their method of incorporating public feedback and expert opinion when developing recommendations • Critiques public policy recommendation for not addressing implicit fiscal challenge of charge • Argues that recommendations need to make clear whether core benefits package will replace Medicare and Medicaid • Advocates for separating the core benefit package into two levels of benefits—one universal, government basic coverage (preventative, some wellness, and catastrophic coverage) and the other— supplemental, private insurance to cover non-essential services • Argues for using Medicare/Medicaid as explicit "prototypes" when promoting affordable health care • Advocates for establishing national 'medical best practices'
Health Care Leadership Council Washington, D.C.	• Encourages greater emphasis on consumer education and outreach • Advocates for government-financed private sector health Information technology investment to spur innovation • Encourages Working Group to argue for medical liability reforms
Independent Living Resource Center San Francisco San Francisco, California	• Disagrees with any recommendation using income as a determinant policy because that promotes a two-tiered system • Concerned that the public/private partnerships discussed in the community networks recommendation will lead to corrupt and wasteful government contracts • Proposes offering free tuition in exchange for M.D.s working in low resource locations • Argues that greater emphasis in the report needs to be placed on independent living for people with disabilities • Argues that consumers need options in a core benefits package that fit their needs

Mid-Valley Health Care Advocates Corvallis, Oregon	• Urges recommendations to emphasize protection from high health care costs for all citizens, not just low-income families • Disagrees with new order of recommendations • Concerned that the integrated community network will create a two-tiered system of healthcare
National Coalition on Health Care Washington, D.C.	• Advocates for inclusion of language specifying all Americans should have access to health care insurance and timely access to care • Argues that rising healthcare costs need to be reduced to the annual increase in GDP per capita through limits on increases in insurance premiums for core benefit coverage and rates for reimbursing providers • Supports a $1 billion federal investment in improving national health care quality and efficiency • Urges combining high cost care and affordable health care for all recommendations into one
National Health Law Program Los Angeles, California	• Advocates for clarifying values and principles, explaining how the recommendations will be implemented, and resolving potential inconsistencies between the terms "medically" effective and "evidence-based" • Supports inclusion of comprehensive women's health and language services • Urges recommendation to protect low-income individuals during the transition to health care reform • Advocates for broadly defining the standards and evidence that will be acceptable to determine core benefits • Argues for a financing system in which the government is the single payer • Advocates for financing strategies that consider low-income individuals' existing tax contributions and relative burdens • Urges replacement of all references to "citizens" with "Americans" with "Americans" defined to include immigrants • Argues that report should state that health is a human right • Advocates for spending what is necessary to attain the highest standard of health for everyone • Asks for clarification that "right care at the right time" means that low-income individuals can receive medically necessary services at no cost without delay without cost-sharing • Urges a distinction between "define set of benefits" and the "set of core health services" • Argues that recommendations should explicitly state coverage of health service will not be linked to health status or behavior • Suggests adding "quality" to the principle of affordability to guarantee "quality, affordable health care coverage" • Urges clarification of the appointment process for the private-public group to minimize political influences • Argues for coupling the proposal to expand health centers with the commitment to provide sufficient resources for the task • Advocates for maintaining the requirement that patients occupy a majority of seats on an organization's governing board as a condition of Federal funding • Suggests the Working Group define length and scope of end-of-life services expansively with full funding by the federal government • Argues for prioritizing the collection of racial, ethnic, and language data as the new health information systems are implemented
National Small Business Association Washington, D.C.	• Argues for requiring that everyone have healthcare coverage and providing federal subsidies for low income individuals and • Advocates for pay for performance incentives for health care providers based on outcomes rather than procedures • Suggests the individual tax exclusion for health insurance coverage should be limited to the value of a basic benefits package • Argues health services to be added to the core benefits package undergo cost/benefit analysis

Schuylkill Alliance for Health Care Access, Inc. Pottsville, Pennsylvania	• Advocates for patient incentives to induce healthier lifestyles • Argues patient out-of-pocket expenses should be based on a sliding scale • Advises using sin taxes for financing • Argues government health agencies need to improve coordination
Service Employees International Union Washington, D.C.	• Asserts importance of retaining 2012 timeline for implementing recommendations • Argues that more attention in the recommendations needs to be given to protecting Americans from high health care costs • Advocates for including preventative services, long term care, and provider choice in the core benefits package