Statement of Richard G. Frank, Vice Chair
Citizens' Health Care Working Group

Hearing on Health Care Reform and Health Insurance Coverage

March 14, 2007

United States Senate Committee on Finance

Statement of Patricia A. Maryland, Chair
Citizens' Health Care Working Group

United States Senate Committee on Finance

March 14, 2007

Mr. Chairman and members of the Committee, thank you for the opportunity to share with you the experience of the Citizens' Health Care Working Group, which originated in bipartisan legislation sponsored by Senators Wyden and Hatch, and was created to engage the public in a nationwide discussion about how to improve health care in the United States. The fourteen citizen members of the Working Group represented an informed cross-section of the American people, in addition to the Secretary of Health and Human Services. It was my privilege to serve as the Vice Chair of the Working Group. My statement reports on what we learned and offers the Working Group's recommendations.

OVERVIEW

The unpleasant reality is that the health care system that captures vast amounts of America's resources, employs many of its most talented citizens, and promises to both promote health as well as relieve the burdens of illness is failing far too many of us.

On last report, the number of uninsured Americans has grown to 47 million, rising by more than one million a year. Tens of millions more are underinsured and at immediate risk of financial ruin if they are seriously ill or injured. Individuals, families, employers, and every level of government are feeling the financial pressure of rising health care costs. More often than not, people do not receive the best care that science has to offer. Many are bewildered by the complexity of health care and insurance coverage. As one citizen voiced to us, you cannot "*navigate the health care system without luck, a relationship, money and perseverance*." The need for change is clear, but transforming health care so that it works for all Americans is a daunting prospect. It will involve difficult decisions about how health care is organized, delivered, and financed. Years of stalemate on health reform prompted a bipartisan call to go back to the American people, to explore their values and aspirations for the health care system, and to provide the energy needed to sustain real health reform.

The Citizens' Health Care Working Group was established by Congress to "*engage in an informed national public debate to make choices about the services they want covered, what health care coverage they want, and how they are willing to pay for coverage*."

What we heard was that many Americans believe that public policy designed to address the growing crisis in health care cannot succeed unless all Americans are able to get the health care they need, when they need it.

PUBLIC DIALOGUE

Following six regional hearings held in 2005 with experts, stakeholders, scholars, and public officials, the Working Group issued *The Health Report to the American People*, a report intended to facilitate a national dialogue on health care reform. In addition, the Working Group has made the presentations from its hearings available to the public via the Internet, at www.CitizensHealthCare.gov.

The Working Group then initiated an extraordinary effort to reach out to diverse communities representing a full spectrum of the American public. This began with a review of over 100 public opinion polls taken between 1991 and 2006. It also included a review and analysis of policy and research literature, surveys, and special analyses of health data; live one-on-one conversations and community meetings; expert research; and mass communications through the Internet and press. Over nearly eighteen months, the Working Group directly engaged thousands of Americans, including:

- About 6,650 people attending 84 community meetings across the nation as well as meetings organized by individual Working Group Members and other organizations by the end of May, 2006, and input from over 700 people attending 14 meetings after the Interim Recommendations were published on June 2nd.
- Over 14,000 responses to the Working Group Internet poll; and another 6,000 sets of responses to open-ended questions about health care in America
- Over 500 descriptions of experiences with the health care system submitted via the Internet or on paper, and about 400 e-mail letters, handwritten notes, letters, essays, and copies of reports that people sent to the Working Group.
- About 7,300 individual e-mail and written comments on the Working Group's Interim Recommendations

The Working Group recognized that many people attending the meetings or providing input in writing are likely to be especially interested in health care. Because of this, the Working Group held a variety of special topic meetings, some in collaboration with partner organizations, and also worked with a range of organizations to encourage their members to complete the Working Group poll or to write in comments. Among these were meetings organized by, or with the help of, groups including local Chambers of Commerce, The National Association of Realtors, The Consolidated Tribal Health Council, a consortium of Big Ten Universities, local chapters of the League of Women Voters, professional nursing associations, organizations serving homeless persons, unemployed persons, people with disabilities, and elderly persons. Several national corporations and national labor unions encouraged members to attend meetings and provide input via the Internet, and both the Catholic Health Association and the United Church of Christ were particularly active in eliciting input to the Working Group.

The remarkable consistency of findings from national polls, community meetings, poll data from the Working Group Internet site, and the University Town Hall Survey give us confidence that we heard the views of a broad segment of the American people. We do not claim that we know, with complete certainty, the health care values and preferences of all Americans. Rather, we based our deliberations on a careful assessment of input from as many sources as feasible, including tens of thousands of people from all across the United States, taking into account the gaps or biases that may be reflected in individual sources of data.

WHAT WE HEARD

In every venue, we heard from Americans who are deeply concerned about access to health care, and the rising costs of care and insurance. While Americans recognize that health care costs are a major problem for businesses, industry, and government as well as families, many believe that the huge sums now being spent on health care should be enough to ensure access to quality care for everyone, if these resources were allocated more sensibly. At the same time, people consistently emphasized the importance of shared responsibility and fairness – a clear willingness to pay a fair share, to try to do a better job of taking care of themselves, and to accept limits on coverage if based on good medical evidence. Many believe that health coverage should be comprehensive enough to ensure people can get the care they need, when they need it, without having to negotiate or hurdle complicated administrative barriers. They told us they want health care to be available where people need it, in their communities. Finally, people told us that they want interactions with health providers to be based on mutual trust and respect.

The Working Group heard a variety of views regarding how a national system of health care should be organized -- from support for an entirely federal system with no private health insurance at all, to state-based single payer systems, to private sector participation in a system with established standards for benefits, coverage, and cost with minimum government involvement in day-to-day operations, to entirely free-market approaches. There was, however, overwhelming support for a plan that covered all Americans. In addition, there was considerable discussion at many meetings about interim reforms that could increase coverage until comprehensive changes could be made.

Opinions about incremental reforms were sharply divided and varied considerably from community to community. The overriding message, however, was consistent across every venue we explored:

> ***Americans should have a health care system where everyone participates, regardless of their financial resources or health status, with benefits that are sufficiently comprehensive to ensure access to appropriate, high-quality care without endangering individual or family financial security.***

People also conveyed a sense of urgency and wanted changes to start immediately.

VALUES AND PRINCIPLES

In developing recommendations, the Citizens' Health Care Working Group believes that reform of the health care system should be guided by principles that reflect the values of the American people:

- Health and health care are fundamental to the well-being and security of the American people.

- Health care is a shared social responsibility. This is defined as, on the one hand, the nation or community's responsibility for the health and security of its people, and on the other hand, the individual's responsibility to be a good steward of health care resources.

- All Americans should have access to a set of core health care services across the continuum of care that includes wellness and preventive services. This defined set of benefits should be guaranteed for all, across their lifespan, in a simple and seamless manner. These benefits should be portable and independent of health status, working status, age, income or other categorical factors that might otherwise affect health-insurance status.

- Health care spending needs to be considered in the context of other societal needs and responsibilities. Because resources for health care spending are not unlimited, the efficient use of public and private resources is critical.

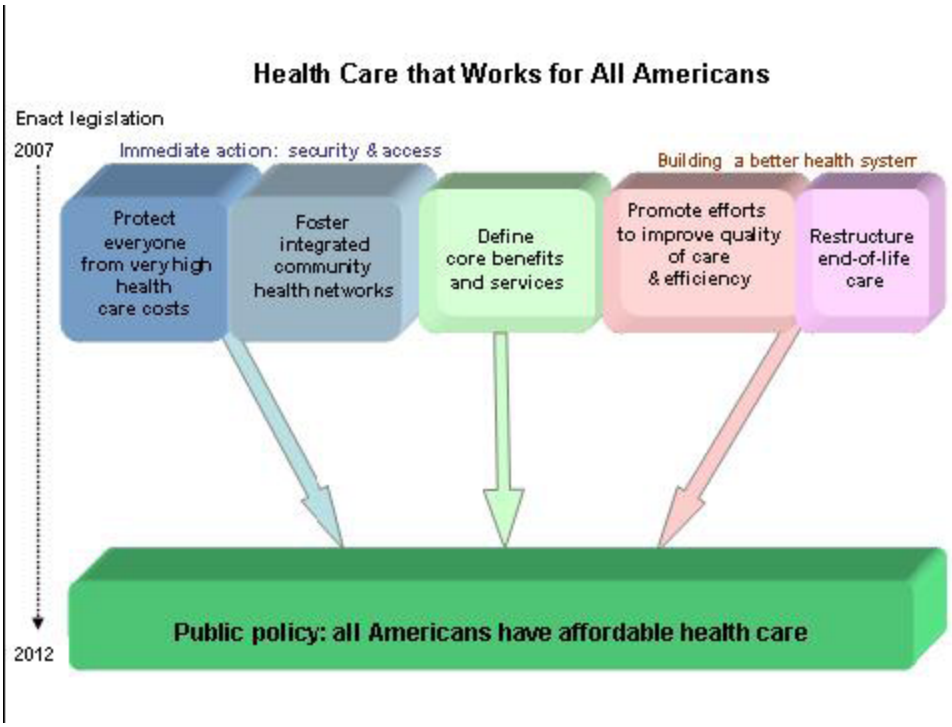
RECOMMENDATIONS

Based on these values and principles, the Working Group proposes six recommendations–organized into three sets–to accomplish its central goal, stated in Recommendation 1.

1. Establish public policy that all Americans have affordable health care. A clear majority of participants in community meetings, as well as those who responded to a numerous national polls conducted over the past few years, are in favor of universal coverage. However, "universal coverage" means different things to different people. The values and preferences being expressed did not lead the Working Group to conclude that there was only one particular model for ensuring that all Americans have access to high quality health care. Several approaches need to be analyzed and debated.

Also clear is that all Americans want a health care system that is easy to navigate. They want to have stable coverage when circumstances change, such as when they change jobs, get married, or move to a different state. People want decisions about what is and what is not covered to be made in a participatory process that is transparent and accountable. It should draw on best practices, resulting in a clearly defined set of benefits guaranteed for all Americans. The overwhelming majority of Americans that the

Working Group heard from also want health care system change to begin now. The Working Group is therefore recommending immediate action with a target of 2012 for ensuring a core set of benefits and services for all Americans. A five-year transition is recommended, with the immediate first step being to address serious threats to health security: very high costs, and gaps in access to basic health care, preventive services, and health education at the community level.



STEP ONE: Immediate action to improve security and access

2. Guarantee financial protection against very high health care costs. The program the Working Group is recommending would provide some level of immediate protection for everyone, and also has the potential to stabilize existing employer-based health insurance markets and expand the private individual and small group health insurance markets to more Americans. More important, it will establish the principle of universal coverage and provide the foundation for providing core benefits and services to all Americans as called for in Recommendation 1. This program could be structured in a number of ways, using market-based or public social insurance models.

3. Foster innovative integrated community health networks. We heard concerns across the country related to a lack of primary-care providers; the inability to access specialty care; and, difficulties in navigating a complicated system, especially for those with chronic conditions. Citizens in multiple locations spoke highly of the continuity of care and easy access to needed services they receive from comprehensive delivery systems. The goal is to help communities build programs of a similar nature, where

health care providers at the local level are brought together to ensure that more people can have access to primary, mental health, and dental health care, and improve the effectiveness and efficiency of health care delivery. This step would immediately provide low income Americans with access to a comprehensive set of health care services that would move the delivery system towards one that is more likely to efficiently supply quality care.

STEP TWO: Define Core Benefits and Services for All Americans

4. Defining the core benefits and services that will be assured to all Americans. The conversations in each and every community meeting demonstrated how difficult the task of defining basic health care coverage will be for policymakers. Many people expressed concerns about what they view as the arbitrary exclusion of benefits or services from coverage. As was the case in many deliberations, the public was aware of the political challenges involved in making such decisions and the virtues of independent commissions in helping policymakers with such choices.

To define core benefits and services for all Americans, the best methods must be applied in a transparent process. Consumer participation is critical to ensuring public trust in the process and essential for ensuring that personal values and preferences are taken into consideration in coverage decisions. The group making decisions should be established as a public/private entity to insulate it from both political and financial influence. The group should be an ongoing entity with stable funding, to guarantee its independence and to assure that the benefits continue to reflect advances in medical research and practice. Evidence used to make decisions about coverage can contribute to improvements in the overall efficiency of health care delivery and help patients and providers make informed decisions. Identifying core benefits can help make all health care more effective and efficient, helping to control health care costs overall.

STEP THREE: Build a Better Health System

5. Continue to Promote efforts to improve quality of care and efficiency. A message that resonated throughout the public discourse centered on how America could do a better job with its $2 trillion a year spending on health by achieving greater efficiency and improving quality.

Concerted efforts in some integrated health care systems have demonstrated how care can be improved and waste dramatically reduced. Continuous improvement methods have reduced costs by managing chronic conditions, providing tools for informed decision-making, reducing preventable care-associated patient injuries, and designing coordinated systems of care delivery that reduce hassle and the need to redo tests and procedures. However, continuous improvement efforts rest on fundamental changes in medical practice and culture – a difficult, long-term, proposition. Widespread improvement will require a much better understanding of how to “do it better” (investment in health care delivery research), restructured training programs, significant

organizational restructuring, and investment in aligned health information technologies and systems.

The federal government is a dominant purchaser of health care. It also plays a significant role in the research and evaluation of the delivery of health care services. It is well positioned to provide leadership in these areas. A variety of federal programs could be used for development, demonstration, and dissemination. Federal health programs run the full range of design possibilities, making them particularly useful for new ideas.

6. End-of-life care should be fundamentally restructured so that people of all ages have increased access to these services in the environment they choose. Many end-of-life issues are intertwined with effectiveness, quality of care, clinical decision-making, and patient education addressed in Recommendation 5. The concerned and thoughtful attention to end-of-life issues that emerged through its public dialogue made clear to the Working Group that change is needed.

Currently, the policy development is hampered by a lack of useful information about patients' needs and use of services. The development and use of standardized instruments for collecting demographic, epidemiological, and clinical information, careful evaluation of emerging care models, and the dissemination of best practices are all needed to improve care for the dying. The Working Group acknowledges that end-of-life issues are often difficult, painful, and complicated and thus not conducive to quick or easy fixes. This recommendation seeks to better define, communicate, and make available at individual, family, community, and societal levels the support needed and wanted in one's last days. Public and private payers should integrate evidence-based science, expert consensus, and linguistically appropriate and culturally sensitive end-of-life care models so that health services and community-based care can better handle the clinical realities and actual needs of patients of any age and their families.

FINANCING

No plan to address the serious shortcomings in today's health care system would be complete without considering how to pay for it. After considering the discussions at community meetings, citizens' comments received in its web-based polls, public opinion expressed in national polls, along with proposals put forth by government agencies, think tanks, and scholars, the Working Group arrived at three guiding principles to financing new initiatives:

- The financing methods should be fair. Financing methods should not have the effect of creating a disproportionate increase in the financial burden on the sick; responsibility for financing of health care should be related to a household's ability to pay; and all segments of society should contribute to paying for health care.
- The financing methods should increase incentives for economic efficiency in the health sector and the larger economy.
- The methods should be able to realize sufficient funds to pay for the recommended actions.

The Working Group believes that a number of the recommendations made in this report force a difficult choice of finding sources to pay for these actions or contributing to sizable budget deficits. Some of its proposed actions would result in opportunities to reallocate existing funds spent by state and federal governments. These would include payments by Medicaid under disproportionate share hospital (DSH) provisions, high-cost risk pools, and uncompensated care payment programs.

Some of the actions proposed in this report may also yield savings to the health care system in the long term, but based on the evidence and conversations with experts, the Working Group has concluded it is unlikely that health system improvements will yield sufficient savings over the next few years to pay for all of the reforms recommended in this document. In addition to reallocating existing funds and harnessing savings, a third source of financing would stem from making changes in existing government subsidy programs that are at once inefficient and unfair. Based on recent reviews of federal subsidy programs by the Congressional Budget Office, the President's Commission on Tax Reform and independent scholars from across the political spectrum, the Working Group believes that significant funds would be available by altering such public subsidy programs in a way that improves both economic efficiency and fairness. Finally, if these sources were not sufficient to address the funding requirements of the six recommendations presented, new revenues would have to be considered. The Working Group strongly believes that in order to gain the confidence of the American public, it is critical that funds obtained from reallocations, savings, changes in subsidy arrangements, or new revenues be specifically dedicated to health care coverage.

Based on a review of national polls, the Working Group's own Internet polls and discussions at community meetings, it is clear that a large segment of the American people believe there are sufficient funds associated with American health care to pay for health care that works for all Americans. As a result, there is a strong sense in the public that reallocation of existing public funds, changes in subsidy programs, and increased efficiency should take priority in funding the recommended actions. Yet when posed questions about the possible need for new revenues, we found that the majority of people were willing to pay some more to ensure that all Americans are covered. This has also been found consistently in national polls.

CONCLUSION

Adopting these strategies simultaneously enables the American health care delivery and financing systems to take several important steps toward universality. It sets in motion a plan that responds to overwhelming public support for a new dynamic in American health care where everyone is protected, not just select portions of the population.

If the United States Congress decides that fundamental change in health care is either too disruptive to the economy, too complex, or too controversial and defers further action at this time, the Working Group fears that the cost of this inaction to American

families goes beyond dollars and cents. The problem of medical providers charging the insured more to cover costs of the uninsured will become even more prevalent. Public budgets will continue to feel the pressure of both the growing numbers of uninsured people and of the aging population, as long-term care costs consume an even greater share of Medicaid funds. Additionally, uncompensated care costs—now estimated to be more than $40 billion annually—will continue to rise, placing huge burdens on hospital providers and even forcing many safety net providers to close.

Furthermore, health care premiums will continue to rise. These increases will make it more difficult for many businesses to continue coverage for their workers and retirees; they will continue paring down coverage and shifting costs to employees. Individuals and families will find it more difficult to purchase coverage from their employers or the individual market and may not be eligible for public programs. States will continue to explore ways to provide coverage to their residents, but finding the revenue to pay for these programs could threaten budgets or lead states to raise revenues in ways that drive out businesses. The uninsured will continue to receive less care and less timely care, to sustain more financial risk and to live, on average, shorter lives. The ramifications of the changes above will reach to every facet of American society, fundamentally altering the economy from what it is today.

This predictable tragedy must be avoided. Doing nothing to address a failing health care system will surely cost us more tomorrow than will acting today. The Citizens' Health Care Working Group urges timely action on these recommendations for making health care work for all Americans.