Health Coverage for All Arizonans
A Report on Citizen and Stakeholder Dialogues

Project Sponsor:
St. Luke's Health Initiatives

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HEALTH COVERAGE FOR ALL ARIZONANS

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VIEWPOINT LEARNING, INC.

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Executive Summary

In Fall 2005, Viewpoint Learning and St. Luke's Health Initiatives embarked on a research project designed to provide decision-makers with insight into what sorts of health care reforms the public in Arizona is and is not likely to accept, and to lay the groundwork for an effort to engage the broader public on how to address the state's health care crisis.

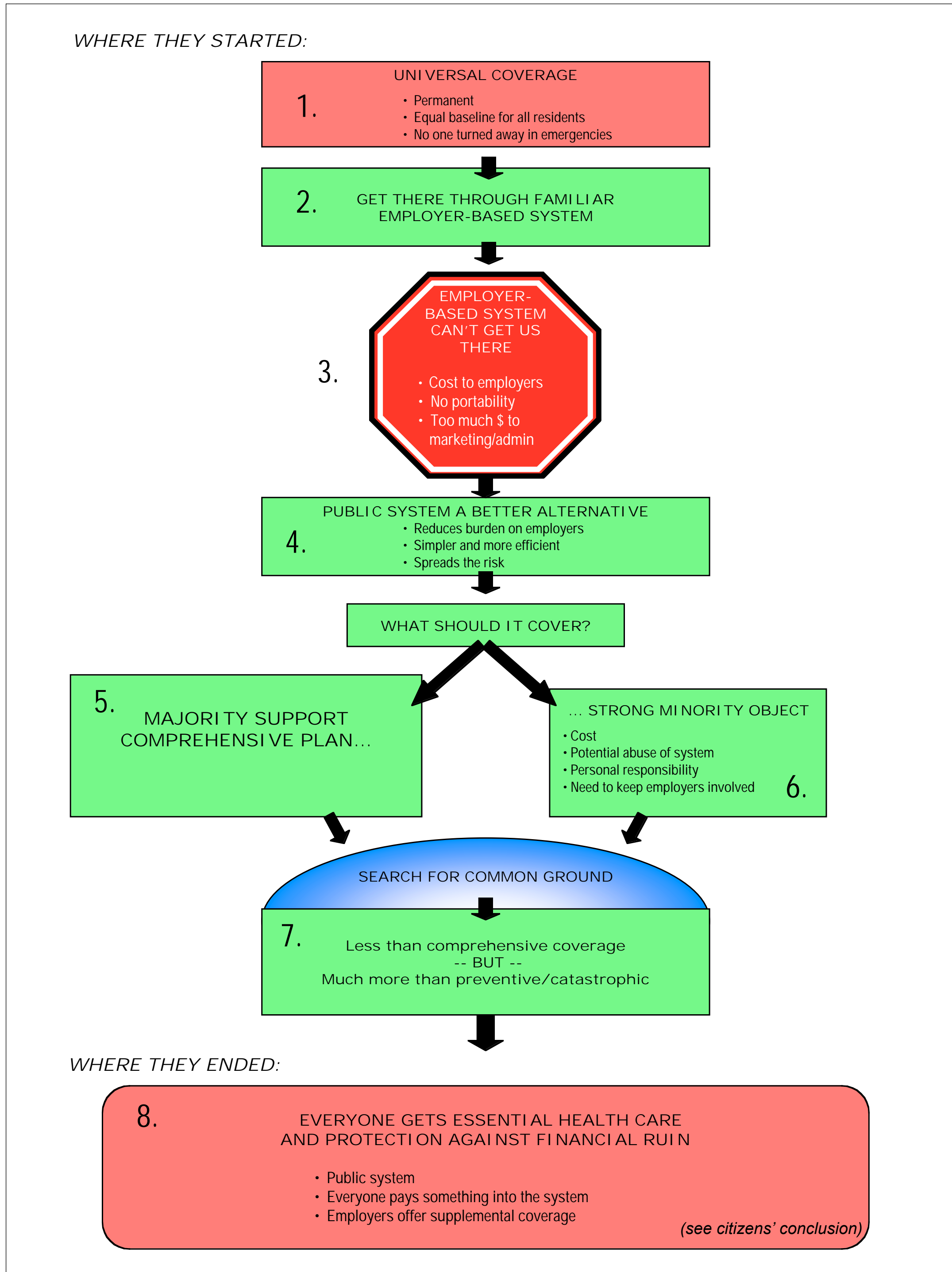
The project consisted of two closely related components:

1. *ChoiceDialogues on Health Coverage for All Arizonans*. A series of three daylong dialogues with representative samples of Arizonans (30-40 per session). These dialogues explored the question of what kind health of care system Arizonans want to see in the future and what tradeoffs they are prepared to support to achieve their vision.
2. *Stakeholder Dialogue*. A "Stakeholder Dialogue" that brought together some citizens from the earlier ChoiceDialogues with government officials and civic leaders. Participants looked for common ground between the vision the citizens defined in the ChoiceDialogues and the realities and future the leaders see. They worked together to identify high leverage steps to move closer to that vision.

General Findings

Surprising possibilities emerged in these dialogues. As diverse groups of citizens talked through four possible scenarios for moving to a universal health care system and their pros and cons, participants discovered a remarkable amount of common ground, and a consistent pattern of values and priorities emerged. In particular, given the opportunity to work through the issues, there was stronger support for universal health coverage and a greater openness to a public system than polls might indicate. Each of the dialogues reached very similar conclusions following essentially the same sequence of steps, illustrated in the following chart:

Thinking It Through: How Citizens Reached their Conclusions



1. Most participants entered the conversation open to universal coverage. In defining what a universal system must entail, they identified three critical components: permanence (coverage that cannot be taken away for any reason); equity

(coverage that provides an equal baseline for all Arizonans); and scope (all legal residents covered in full, but no one turned away for urgently needed care.)

2. To create such universal coverage, they initially favored building on the familiar employer based system.
3. But they quickly concluded that there were significant problems with this system as a way to provide universal coverage. Of particular concern were the high costs it would impose on employers, the lack of portability (e.g. the need to change insurers and providers when changing jobs and the possible loss of coverage altogether), and the proportion of health care dollars that go to administration, marketing and profit.
4. As they began to consider alternatives to the employer-based system, several factors pushed them towards a public system; in particular the permanence and portability of the coverage it would offer, the financial and administrative relief it would provide for business, the increased simplicity and efficiency such a system could provide.
5. They then considered what level of coverage such a public system should provide. Most participants began by favoring comprehensive coverage.
6. But a strong minority voiced concerns about an "everything for everybody" approach. Their concerns centered on the need to promote personal responsibility and healthy behaviors, and on the potential for abuse of the system. They also argued for keeping employers involved, not only as a counter-balance to reservations about a completely public system, but also to keep some of the employer-provided dollars in the system and as an expression of employers' responsibility toward employees and the community.
7. To find common ground between these viewpoints, participants agreed to adjust the level of coverage provided under the public system — opting for less coverage than a fully comprehensive plan, but still covering a wide range of health care services. This was designed to ensure that individuals would be responsible for paying more of their health care costs than under the comprehensive plan, and that employers would have more room to provide supplemental coverage.
8. The citizens' conclusions called for a public system that would ensure everyone gets health coverage for a wide range of medical services, while protecting everyone from financial ruin due to health care expenses (catastrophic coverage). A key condition was that everyone MUST pay something into the system, and that employers or individuals should able to purchase supplemental coverage over and above the coverage provided through the public system. Employers would be able to offer supplemental coverage, and many called for additional steps that would ensure employers continued to do so. In all of the dialogues, participants were prepared to pay for a system that met these conditions. A fuller statement of these Citizens Conclusions can be found on page 25 of the report.

Meeting with leaders

Some of the citizens who had participated in the ChoiceDialogues then met with health care leaders, government officials and other key stakeholders in a second daylong dialogue. This Stakeholder Dialogue was an experiment designed to produce two outcomes:

1. To build on the citizens' vision for the future of health care in Arizona established in the ChoiceDialogues, and to find the common ground between that vision and the future that leaders see as both desirable and feasible.
2. To identify a small number of high-priority, high leverage goals that, if achieved, would move the state closer to this shared vision.

In most cases the vision defined in the stakeholder dialogues dovetailed with the vision created in the citizen dialogues, including support for a universal public system of health care, providing a continuing role for employers and private insurers, and promoting personal responsibility and healthy lifestyles. The one significant difference was that participants in the stakeholder session ended up supporting a more comprehensive benefits package than the ChoiceDialogue groups (for reasons detailed in the report).

Stakeholder dialogue participants then identified three high priority goals, and a series of related steps, to realize their vision:

a. Engage the public directly in efforts to shape a universal system
b. Phase in a single universal system
c. Reform the state's system of training medical professionals/care providers.

Overall, the Stakeholder dialogue left participants, even those who had spent decades in the trenches on health care reform, feeling more optimistic about the possibilities for significant reform and the ability of the public to move past raw opinion and wishful thinking to a more considered judgment.

Implications for Action

The depth of public concern about health care coverage, and citizens' openness to considering significant change, indicate that the time is ripe to move beyond patchwork fixes and take bolder steps. In Arizona and nationwide, momentum on this issue is beginning to build. It is quite likely that health care issues will be on the agenda in upcoming elections, and the public's hunger for workable solutions is growing harder to ignore.

This series of dialogues reveals a clear set of implications for decision makers who wish to lead a public learning process around health care reform. Perhaps the most important message is the need for such a process, because the findings described above and detailed in the full report reflect the views citizens arrived at only after thoughtful consideration. Polls of the general public would likely yield results similar to those the participants themselves expressed at the beginning of their dialogues. These findings indicate where

people *can* go, given the opportunity to work through the choices and the leadership to help guide the process.

Getting the public to such a point cannot be accomplished with top-down education and spin; it requires authentic public engagement and an effort to discover common priorities and build mutual trust and understanding. Leaders hoping to promote a solution need to respect the public's process of connecting the dots and resolving contradictions.

To resolve this gridlock issue, leaders and the public need to search for and build on common ground. This is a departure from the way business is too often done in politics, which is to build constituencies around wedge issues. That won't help Arizona. Wedge issues only create and reinforce gridlock. A far more promising direction is to build on the surprising and powerful common ground we found among citizens (and stakeholders). By following this path, Arizona's leaders and citizens alike are far more likely to create sustainable reform and a healthier future for all Arizonans.

HEALTH COVERAGE FOR ALL ARIZONANS

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VIEWPOINT LEARNING, INC.

I: INTRODUCTION

Around the country there is growing agreement that the American health care system is in need of major reform, and Arizona is no exception. Nearly 1 million Arizonans are uninsured. At the same time, health care costs are rising at double-digit rates, making it ever more difficult for employers and individuals to afford the cost of coverage. The results are evident across the state, from increasing rates of personal bankruptcy resulting from medical bills to overflowing emergency rooms.

Most Arizonans agree that something must be done. 63% believe that state government should provide insurance to the uninsured, while 55% say the government should do this even if it means raising state taxes.[1] However, while these polls indicate that people support the idea of universal health coverage, many crucial questions remain unanswered. How should this insurance be provided – by government, by employers or by individuals? What exactly should be covered? How should the cost be distributed? Each of these questions touches on fundamental values concerning health care – issues of access, equity, and responsibility – but how the public resolves these questions remains largely a matter of conjecture.

At the same time many people, experts and ordinary citizens alike, are increasingly frustrated and hopeless. Attempts at reform ranging from the ill-fated Clinton plan to the recent troubles with Medicare's prescription drug benefit seem to confirm that the woes of the health care system are just too big, too complex and intractable to be fixed. Wary of this new "third rail" of American politics, many political leaders have fallen back on incremental solutions, and those in the trenches see little opportunity for meaningful change.

A critical step in breaking free of this stalemate and finding solutions that can work is to find ways to develop deeper insight into the views, underlying assumptions and values of unorganized citizens – whose support is essential to any sustainable reform. Such insight cannot be provided by interest groups, which by definition do not represent the views of unorganized citizens. Nor can they be fully provided by polls and focus groups, which can be misleading when citizens have not made up their minds. Under these conditions people's surface opinions are highly unstable. Polls and focus groups (which take snapshots of opinions) provide little sense of how those opinions are likely to evolve as people learn, or of the kind of leadership initiatives that can help accelerate this learning process.

ChoiceDialogues™ were developed to deal with issues where people have not yet made up their minds – to engage citizens in working through their views on complex, gridlock

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[1] These poll findings are borne out nationally as well. Two-thirds of Americans support universal health coverage, even if it means raising taxes (Pew 2003).

issues. They provide an innovative and tested way to compress the "working through" process, in which dialogue participants come to understand the pros and cons of various reform options, struggle with the necessary trade-offs of each, and come to a considered judgment – all in the course of a single eight-hour day. ChoiceDialogues offer unprecedented insight into how and why people's minds change as they learn. And when conducted with a representative sample, they provide both a basis for anticipating how the broader public will resolve issues once they have the opportunity to come to grips with them, and insight on how best to lead such a learning process on a larger scale. (For additional detail on the ChoiceDialogue methodology, see Appendix A.)

Project Overview:

In Fall 2005, Viewpoint Learning and St. Luke's Health Initiatives embarked on a research project designed to:

- Determine what Arizonans mean by "universal" coverage and how they resolve the difficult tradeoffs required to put any universal system in place.
- Provide decision-makers with insight into what sorts of health care reforms the public is and is not likely to accept.
- Lay the groundwork for an effort to engage the broader public in a thoughtful discussion of how to address the state's health care crisis.

The project consisted of two closely related components:

3. *ChoiceDialogues on Health Coverage for All Arizonans.* Viewpoint Learning conducted a series of three ChoiceDialogues with representative samples of Arizonans (30-40 per session). These dialogues explored the question of what kind health of care system Arizonans want to see in the future and what tradeoffs they are prepared to support to achieve their vision.
4. *Stakeholder Dialogues.* The ChoiceDialogues were followed by a "Stakeholder Dialogue" that brought together some citizens from the earlier dialogues with government officials and civic leaders. Participants looked for common ground between the vision and tradeoffs the citizens defined and the realities and future the leaders see, and they worked together to identify high leverage steps to move closer to that vision.

II: CHOICEDIALOGUE IN ARIZONA

A total of 3 ChoiceDialogues were conducted, one each in Phoenix, Flagstaff and Tucson. Each ChoiceDialogue brought together 30-40 randomly selected participants representing a cross section of the public in the area, and each group represented a wide range of socio-economic circumstance, ethnic backgrounds, and political leanings. In all three sessions, citizens spent the morning crafting a vision for the future of health care in Arizona and setting their priorities, while in the afternoon they worked to determine what sort of tradeoffs they were and were not willing to accept to make that vision a reality.

As a starting point, participants used a specially designed workbook constructed around

four distinct scenarios or choices for getting to universal health coverage – all represented from a citizen's rather than an expert's perspective. Two of these scenarios expanded the current employer-based system, and two created a public system. In each of these categories (employer-based and public), one scenario offered limited coverage, and the other offered comprehensive coverage. These scenarios did not encompass any changes in Medicare; however, all four were designed to cover all Arizonans under age 65 regardless of age, income, employment or health status (including those currently covered by AHCCCS.)

The four scenarios can be envisioned as a matrix (below):

	Employer-based	Public
Comprehensive	**SCENARIO 1: Expanded employer-based system: full coverage for all**	**SCENARIO 2: Arizona Medicare for all**
Limited	**SCENARIO 3: Expanded employer-based system: limited coverage for all**	**SCENARIO 4: The state provides the basics: the rest is up to you**

Complete descriptions of the four scenarios can be found in Appendix C.

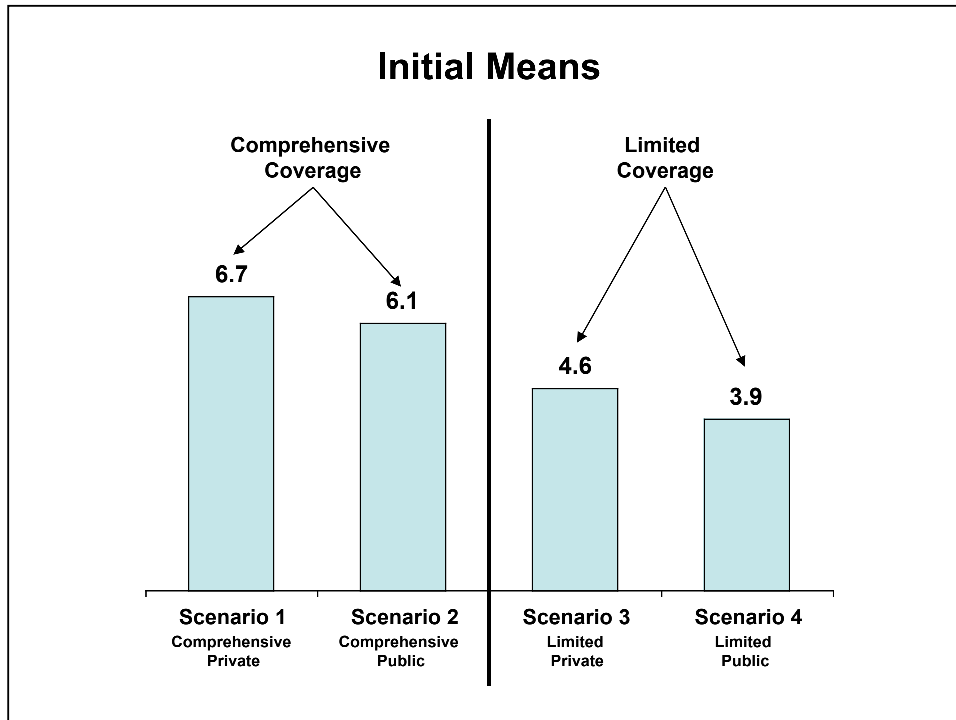
The scenarios were a starting point for discussion – participants were encouraged to adapt and change them.

General Findings

In their initial responses to the issue, participants gravitated towards the two scenarios that would provide all Arizonans with comprehensive coverage. Their first preference was an employer-based system resembling the one in place today, but with the difference that every Arizonan would be covered and all employers would pay into the system. All three groups rated Scenario 1 (comprehensive employer-based coverage) highest of the four scenarios initially, with an average rating of 6.7 points out of 10.[2] Scenario 2 (a comprehensive public system) was consistently rated second, averaging 6.1 points out of 10. The limited coverage scenarios were much less popular at the beginning of the day, with participants rating Scenario 3 (a limited employer-based system) at 4.6 out of 10 and Scenario 4 (a limited public system) at 3.9 out of 10. (See Figure 1.)

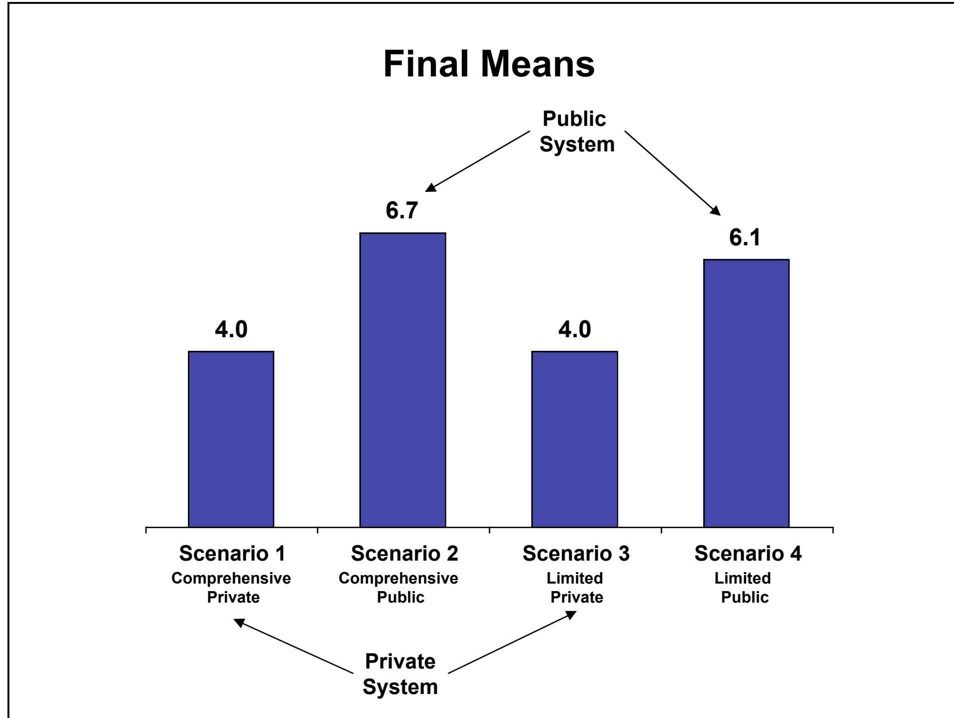
[2] In each ChoiceDialogue, participants were surveyed twice, once at the beginning of the day and again at the end. They were asked to rate their response to each scenario independently on a scale of 1 to 10, 10 being totally positive and 1 being totally negative. The initial mean for each scenario indicates participants' average rating of the choice in the morning; the final mean represents participants' average rating of the same scenario at the end of the dialogue. At the end of the day, they also were asked a series of further questions relating to health insurance. Complete quantitative results can be found in Appendix B.

Figure 1: Initial Means



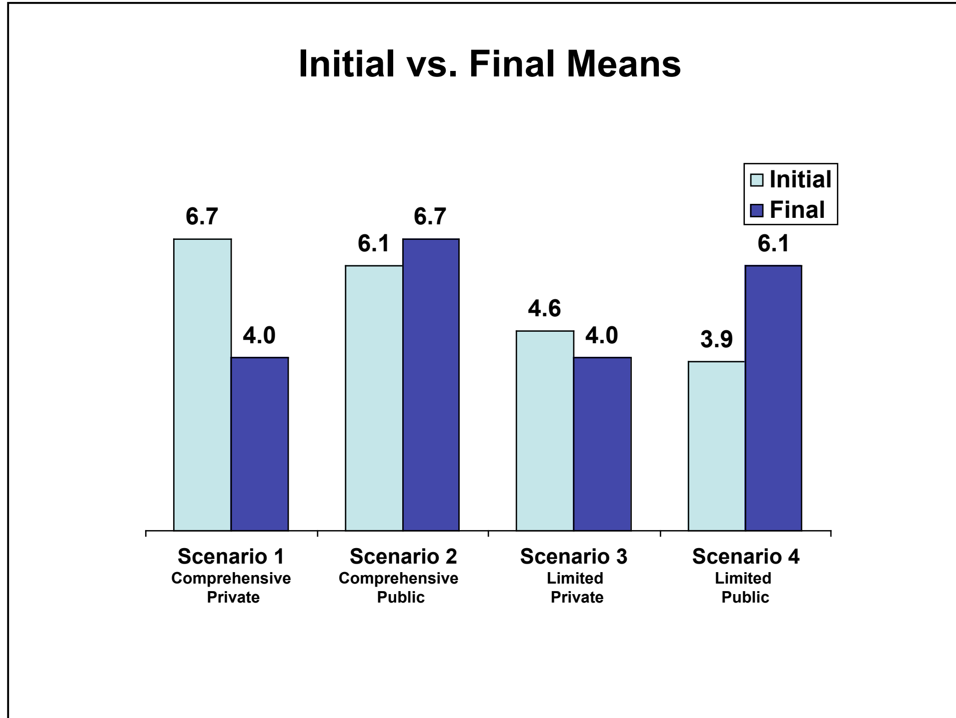
Over the course of the dialogue, however, participants' opinions underwent a significant shift. By the end of the day, the two public insurance scenarios had emerged as strong favorites, while the two employer-based scenarios declined in popularity. In the final questionnaire, participants rated Scenario 2 (a comprehensive public system that started off the day fairly high) highest at 6.7, and Scenario 4 (a limited public system) second at 6.1. The two employer-based scenarios both ended the day considerably, finishing at 4.0 points out of 10. (See Figure 2.)

Figure 2: Final Means



Two of these shifts were notably significant. Scenario 1 (a comprehensive employer-based system), which was most popular in participants' initial assessment (rated 6.7 out of 10), dropped to last place in the afternoon (4.0 out of 10). And Scenario 4 (a limited public system), which was least popular in the morning (3.9) rose dramatically to finish the day at 6.1, only slightly behind the comprehensive public scenario (Scenario 2). (See Figure 3.)

Figure 3: Initial vs. Final Means



In part, these shifts indicating openness towards a public system and possibly a more limited form of coverage were the result of participants' reframing of the issue and their search for common ground. From an initial perspective that prioritized what should be covered (comprehensive vs. limited coverage), participants shifted to view the issue in terms of how insurance should be provided (a public system vs. a private system). In the process they also shifted from a focus on how a given system applied to their own situation to considering what would create the most workable and equitable health insurance system for the state – one in which no one is left out, and everyone pays a fair share.

They reached this conclusion by following a series of steps:

Getting from here to there:

Participants brought a wide variety of perspectives to the discussion: they included business owners, retirees, parents, part time workers, students, healthy people, chronically ill, insured, uninsured, and underinsured. For all their differences, most participants agreed from the outset that the current health care system is not working well. Many spoke powerfully about their difficulty getting or maintaining health coverage. All were concerned about the rising cost of premiums, co-pays and services, and many feared that their health and that of their families was suffering as a result.

> *I don't have insurance right now. I had a stroke a year ago and I owe $12,000 to Maricopa County.*
>
> *My husband and I are small business owners. We can't afford health care for ourselves … and we can't afford to provide it for the people that work for us.*

As they talked, participants quickly built on each others' experiences to paint a portrait of

an extremely complex issue; one for which any solution will require serious tradeoffs.

A: The meaning of "universal" coverage

Before even considering the specific scenarios, participants began to create a working definition of "universal coverage." As they worked through this question, they identified three primary facets of "universality": permanence, equity, and scope.

- *Universal coverage should never be taken away :* Most participants quickly agreed that health coverage should never be taken away because of an individual's age, employment or health status. This conclusion was further reinforced in the final questionnaire, in which an overwhelming 94% of participants said that having insurance that can "never be cancelled because of changes in health" was "absolutely essential" or "very important."

> *Each person should pay for things that they might not necessarily use at a certain point in time. Someone might say that that's not fair because you're paying for the same amount of care that someone that has a chronic illness would be paying for, but our feeling is that you never know when you're going to be that person.*

- *Universal coverage should create an equal baseline of coverage for all Arizonans:* The almost immediate agreement on a universal system opened the door to a discussion of equity. Most participants began from the position that it is essential to provide for and protect those most in need (especially the very young, the very old and the disabled). However, as they discussed the issue many came to feel that while the current system aims to do that, it does so in a way that is fundamentally unfair – because it leaves too many deserving people out in the cold.

> *We think that everybody should be treated the same if they have low income, if they're rich, no matter what – they should be treated the same and have the same treatment from the doctors as they come in.*

> *AHCCCS kind of rewards people not to work. I can't understand that. People that do work are penalized and I don't see where this is fair to anybody.*
>
> *The thing I didn't like about [being on] AHCCCS was that you never saw the same doctor two times in a row. You go into the clinic, you see a doctor one time, you go back, who knows who you're going to see. They don't have no reference to you, they don't know you, they just talk to you for a few minutes, write your prescription or send you off to somebody else.*

As the dialogue progressed, most participants concluded that the only fair system was for everyone – young or old, rich or poor – to start with the same basic level of coverage. They agreed that people who want something better than that basic package should be able to "buy up," but participants felt strongly that every Arizonan should receive the same basic benefit. **Rather than relying on a safety net that catches people only when they have fallen into poverty, most participants supported raising the "floor" so that everyone – including hard working low-income families – has the essentials.**

- *Who should be included in a universal system?:* The next question was where to draw the boundaries between those with coverage and those without. This raised some significant differences. Some participants viewed health care as a human right that should be extended to any person in the state, regardless of citizenship or residency status. Other participants argued that health insurance was not a right but a benefit of being an Arizonan – and as such it should be restricted to citizens, legal residents and their children. After a great deal of discussion, participants arrived at common ground – all legal residents of Arizona should be covered by whatever system was adopted, while others (including illegal immigrants, tourists and residents of other states) should have access to emergency care but not the full range of benefits.

> *I think one of the problems that we're having here is we're still looking at health care as a benefit when health care should be a right. It should be something that we should all get, everyone in the state should receive it.*

> *I believe that illegal immigration is bleeding our system. When you go into an emergency care … there are too many illegal immigrants going in for basic health care, rather than emergency care and they walk out without paying their bill and therefore the citizens of Arizona are paying their bill*
>
> *If you're not a citizen of the state then you shouldn't be getting services on a regular basis. If it's an emergency, yes, go ahead and take care of them.*

B: What kind of system? Public vs. Private

Groups then turned to the question of how this insurance should be provided.

At the outset, most participants leaned toward supporting a system that resembled the current employer-based one. Many elements of the current (and most familiar) system had strong appeal. People who had decent coverage or good long-standing relationships with their doctors didn't want to risk having to change it. Many felt that private market involvement was the best mechanism for keeping costs down. Several participants pointed out that offering benefits allowed employers to compete for the best employees, and many also felt that employers have a responsibility to help provide for their workers' well-being. Most important of all, participants saw an employer-based system as offering a powerful incentive to work.

> *You need to give people an incentive to keep working and if they have better care if they are employed then they'll keep working. If you don't have to do anything [and] you're going to get all the medical care in the world, why work? Why care?*

As they considered the two employer-based scenarios further, however, several factors emerged that led participants to feel that a universal employer-based health insurance system was untenable. Some of these factors "pushed" people away from an employer-based system while others "pulled" people towards something different and perhaps better.

"Push factors": Drawbacks of an employer-based system

- **Cost.** Many participants, themselves business owners, spoke powerfully of the costs imposed by the current system. They feared that the economic and administrative burden of providing insurance for all Arizonans would force them to lay off workers or close their doors altogether. Employees, for their part, were concerned about the impact that these scenarios would have on wages and hiring.

> *If you make the employers pay, you're going to have employers leaving this state by the droves. You're going to have small employers go out of business. Right now when they offer insurance it's a benefit…. But to make them do it…. Companies are going to leave the state to save money if they're forced to pay this. They're going to go somewhere else.*

- **Lack of portability and choice.** Participants expressed frustration with having to change insurers and providers when they change jobs or when their employer switches insurance plans. They felt that the employer-based scenarios would do little or nothing to change this situation, because they did not address the issue of portability or preserving the individual's right to see the doctor of his or her choice.

- **Profit.** Finally, many participants felt that it was inappropriate for Arizonans' health care to be driven by profit. In part this arose from a mistrust of business; many participants felt businesses regularly put profit ahead of employees well-being. In addition, many participants expressed concern (and some resentment) at the amount of money private insurance companies channel into administration, marketing and profit, all at the expense of patients.

> *I worked for 30 years for the steel industry and then the steel industry turned sour and went bankrupt on us, and the first thing that we lost was our health coverage. You also now have airlines going back to people and saying, you've been retired for 10 years, you're no longer part of the force, you no longer belong on our insurance plan. Whether you work for a company for 10 days or 30 years, they can stick it to you real quick. I opt for public all the way.*
>
> *With a profit-based private insurance company, [their] main interest is profiting themselves by handling your insurance and paying their executives millions of dollars.*

"Pull factors": Advantages of a public system

In addition to these "push" factors, there were several "pull" factors that drew participants toward a public system.

> *If [employers] are totally out of the picture they can reduce their costs, perhaps reduce the cost of goods and services, maybe even increase your net pay so that you can afford the income tax and the sales tax to pay for this coverage. We think it would attract employers to Arizona if they knew they didn't have to mess around with health care anymore. It would be an attraction for them to come here.*

- **Benefits to business.** Participants felt that a switch to a publicly run system would relieve business of much of the burden of paying for insurance and administering benefits, and most participants came to agree that the many businesses would be eager to move to a state where that was the case.

> *We all agreed that we want a single system that's state run because we feel like there will be more efficiency versus an employer run system. We also felt like people would have a better understanding of what they're getting because right now there's too many options out there and it gets really confusing.*

- **Simplicity and efficiency.** Participants felt that a public system would be a simpler, more efficient way to ensure that everyone gets coverage, regardless of their age or employment status. This aspect was especially appealing to small business owners and the self-employed, who currently must wrestle with a complex and time-consuming bureaucracy.

- **Other advantages.** Participants also were drawn to other advantages of a single payer model. First, that it would remove the profit motive from health insurance. Second, they felt it made sense to make the insurance pool as broad as possible to distribute risk across the widest possible range, thereby keeping costs relatively low for everyone.

> *In order to get the largest pool of contributors into the insurance program, we felt that it was most beneficial to go with a public system. For most [small] companies, what we have now is a very high-cost system, and one outlier has a big impact on the overall cost. So [a public system] has the best benefit in general.*
>
> *Maybe a public-based [system] would have some inefficiencies – as any large company would – but they would probably put more money back into care and into education and the things we want rather than incentivizing their officers to cut costs and make more profits.*

Persistent reservations. However, participants voiced several persistent reservations about a publicly run insurance system:

- **We need to give people an incentive to work.** Many participants came in to the dialogue believing that most of the uninsured were not working, and therefore a state-run system would discourage people from working. This concern was dramatically reduced when participants learned that the vast majority of uninsured Arizonans (80%) live in families with at least one worker. In each of the dialogues, people shared their stories of working 1, 2 or 3 jobs and still not being able to afford coverage. This led many to re-examine their assumptions about the uninsured: many concluded that if the uninsured are for the most part employed, then breaking the link between insurance and employment would not amount to "rewarding the lazy" – it would improve the lives of Arizona's working people. This was a key turning point for many people in coming to view the health insurance crisis not as a problem for the poor and lazy, but as a structural and systemic problem.

> *[I had thought], that the uninsured were people that were not working. But if 80% are working and it's simply the fact that they don't make enough money or they work for businesses that can't afford it, then [an employer-based] system won't work.*

- **Government run systems are expensive and inefficient.** A more tenacious concern was the belief that a publicly-run insurance system would be expensive, bureaucratic and inefficient – that it would embody all the worst aspects of "socialized medicine." For some participants, this concern was enough for them to resist the idea of public insurance even when it seemed to be in their own interest.

> *If you look at other countries that socialize their health care you don't see what they have to deal with. They have to deal with long lines, bad service. You may think about the money but you're not going to think about how long you're going to have to wait when you go for a checkup. If you go to an emergency, how long are you going to wait and type of service are you going to get?*

One exchange between two participants brought this dilemma vividly to life:

Participant A: We can't afford the $800 a month [we pay now on COBRA] and I don't know that we could afford $200 a month.

Participant B: But wouldn't it be worth it to your mental state to have blanket coverage for $200 a month?

A: It would be, yes. It definitely would.

B: Then why are you against it?

A: Because I don't believe the figures. I mean, every time that they have tried to present things like this, and almost every government program that they present ends up costing three or four times more than they originally estimate.

…

I would [accept the idea of public health insurance] except… I don't know, my experience with the government has been so negative to this point that I'm not sold on it.

While most participants ultimately agreed that a publicly-run insurance system made the most sense, a significant minority voiced serious concerns that a shift to an entirely public system might create more problems than it would solve.. They did, however agree that in truly universal system would require a major role for government. They then set about to describe conditions for a public system that would satisfy most of the participants, including those with reservations.

- **One solution: keep employers in the game.** These persistent reservations about a publicly-run system led many participants to advocate keeping employers in the game to some degree. Many felt that providing benefits for employees was an important part of the employer's responsibility and that it is in their interest to do so in order to keep productivity high, attract good people and be seen as a good corporate citizen. Just as importantly they wanted to find a way to keep some of the employer-provided dollars in the health care system, and came to feel that the appropriate role for employers was to provide some sort of supplemental insurance.

Most participants felt that businesses would find it in their self-interest to offer supplemental insurance as a means of competing for the best employees. However, some were more skeptical and predicted that with another system in place businesses would simply pocket the windfall for C.E.O.'s and shareholders. These participants saw business leaders as primarily interested in their own bottom line; they did not believe that

> *Theoretically, if the employers are taking the dollars that they're saving and putting it back into income then I wouldn't have a problem at all. But I don't know that that would happen. That's what worries me – with this I now have the same salary, a bigger income tax and the employers are going "yee-ha!" because now they have all this money – because they're about profit which is why they're buying cheap.*

businesses would choose to provide supplemental coverage nor did they think they would they pass along any cost savings in the form of increased wages if they were relieved of the burden of providing health insurance. They wanted more assurance that businesses' savings would be returned to workers and the broader community – and some suggested making an employer contribution mandatory in the form of an employer-paid tax if not direct provision of health care.

Ultimately, participants discovered a great deal of common ground on the issue of public vs. private insurance: they concluded that the main system for providing insurance to Arizonans should be publicly run, offering a single basic package. However, they strongly believed that employers should continue to play a role in health care to keep the dollars in the system, incent employees and provide a check for what might otherwise be a too big government bureaucracy. This belief led them to consider the possibility of businesses offering some kind of supplemental coverage to employees and their families as a benefit. But what, exactly, should that supplemental coverage include? This opened the door to a discussion of what should be covered by the public system.

C: What should be covered? Limited vs. Comprehensive Coverage.

Most participants started the day leaning towards a vision of comprehensive coverage for all Arizonans, and the comprehensive public system gained ground over the course of the dialogues. Many were reluctant to say that any services short of elective cosmetic surgery should not be covered, especially as participants began to share personal experiences of having been helped by specific therapies or treatments. Participants who might have initially resisted the idea of including (for instance) chiropractic care in the basic insurance package found it difficult to maintain that position when faced with someone who had been helped by it.

As they came to grips with what a comprehensive statewide system would actually entail, those inclined to more comprehensive coverage listened to the concerns of those who were less comfortable with the idea of publicly funded "Cadillac coverage" for all. Those concerns focused on questions of cost, personal responsibility (including concerns about possible misuse of the system and the need to promote healthy behaviors), and the need to keep employers involved.

Appeal of limited coverage:

- **Cost:** Initially participants who advocated more limited coverage were moved by the issue of cost. As they realized that they as taxpayers would have to finance the system many voiced concern about the expense of providing comprehensive coverage to every Arizonan. The materials provided cost estimates for each scenario, however, and once they had reviewed the estimates participants did not spend a great deal of time focused on specific costs. All were considered to be within the realm of possibility, and it became clear that the difference in a comprehensive versus a limited system was less dramatic that the difference between a public versus a private system and all of its accompanying administrative and profit dollars. In fact, when looking over the materials many participants noted that comprehensive coverage cost only a little bit more than limited, and none of the cost estimates were cause for significant concern.

> *The average cost for a teeth cleaning anywhere in the state of Arizona is $94. You're going take four million people times $94 to have two teeth cleanings a year, you're going to add to your bottom dollar. Are you willing to pick up that cost in your income taxes? I realize that people are concerned about their coverage but there has to be some individual responsibility here. Individuals have to pick up their portion because if we continue to add to the [baseline services] that will hurt all of us in the long run.*

- **The bottom line: personal responsibility:** The discussion revealed that many participants' focus on cost was fueled by the concern that giving people comprehensive coverage (what some participants saw as "everything for everybody") would result in abuse of the system and provide no incentive for people to take personal responsibility for their health.

    - *Abuse of the system:* Many pointed to instances they felt demonstrated that such abuse was already taking place, ranging from frivolous emergency room visits to "freeloaders" moving state to state in search of the most generous state-sponsored care. Participants who supported limited coverage maintained that such a system would encourage personal responsibility by requiring people to be accountable for a larger share of their own health care – either by paying for it out of pocket or by buying supplemental insurance.

> *A lot of people, even people who are on AHCCCS … if their child gets a scratch they run to the emergency room. They run there for ridiculous, silly little things and I think that helps push up the cost of health care for everybody.*
>
> *We did not want to overburden the system by making everything accessible to everybody at all times – [we want] to prevent people from going to the doctor too much.*
>
> *I work in the health department here in Flagstaff. People are coming to our facilities … who basically go from state to state shopping for health care, and they upset me. Our clinic offers dental care for AHCCCS patients and it's pretty limited. They tell me, "Well I can get more in Oregon or in Texas they'll do this or in New Mexico they have this or that…" It's frustrating that you have to pay taxes for … people who don't even contribute to our state.*

- *Promoting healthy behaviors:* Many participants extended this notion of taking financial responsibility for one's own care to encompass more fundamental lifestyle choices. Across the board, groups agreed that preventive medicine did far more to improve people's health than the current focus on treating problems after they arise, and that a focus on prevention would save money in the long run. Participants expressed unwavering support for immunizations and screenings as well as broad-based education in how to live a healthy lifestyle.

> *When you go to the doctor they treat the symptoms, not the cause. They need to do a lot more preventative maintenance*
>
> *Health care is not preventively oriented but really is kind of jumping in after the fact.*
>
> *Preventative care is good because if you can catch the illness before it gets too bad, you can take care of it and it costs less. If you can stay healthy and exercise and you go through all the tests and you get the basic preventative care then you won't get sick in the first place. Hopefully.*

> *People who may smoke or choose to drink alcohol, choose to have some bad living habits, they get sick or they get cancer, and I'm going to pay for it out of my premiums? I have a very serious concern about the fairness of that.*

However, this raised the question of how far an insurance system should go in promoting and rewarding healthy behaviors – for example encouraging people to quit smoking, lose weight or practice safe sex. While participants agreed that Arizona would be healthier if everyone made such lifestyle changes, the groups were sharply divided on whether the health system should offer incentives and if so what would be appropriate.

Many participants (including many who supported incentives for healthy behaviors) were deeply uneasy about how such determinations would be made and who would sit in judgment. As they discussed the issue further, they concluded that most medical conditions had extremely complicated causes, including behavior, genetics and environment, which made the question of "responsibility" far murkier than they had initially supposed. Nonetheless, they held to the basic principle that people should be encouraged to live healthy lives as much as possible.

> *I think we need to be really careful about how we define "healthy lifestyle." Many people have many different definitions of that. I think it's great to have the overall view of, yes, we want to promote and encourage healthy lifestyles, but we need to be careful not to define that too specifically – it has to fit everyone.*

- **A desire to keep employers involved:** As noted above, participants felt there was value in keeping employers involved, not only as a counter-balance to their reservations about a completely publicly-run system, but also to keep some of the employer-provided dollars in the system and as an expression of the employers' responsibility to employees and the community.

These concerns were strong arguments against a comprehensive system for many. These participants felt that by offering more limited coverage, Arizona could establish a minimum standard of care that would be adequate for most people – in fact significantly

> *I don't think that necessarily everyone would feel that they had to have full coverage. I don't have insurance right now and I wouldn't mind having just a limited plan…. Just limited would be a grade up and I think most people would feel that way.*

better than what many people have now. At the same time, a limited system would give Arizonans a strong incentive to take care of themselves and would help avoid overburdening the system while keeping employers involved. Faced with those strongly stated concerns and wanting to find common ground, those largely in favor of comprehensive coverage moved some distance toward a more limited plan.

Their next task was to see how much common ground they could establish between these two perspectives. Since all agreed that they wanted a system that provided at least limited coverage, they turned to the question of what exactly such a limited plan should include – what must be covered in any minimally acceptable plan.

What level of coverage is essential? Most participants agreed that the limited coverage described in the scenarios was too restricted.[3] The notion of "comprehensive" however struck some of them as too generous in concept for the reasons listed above, and they devoted considerable attention to defining the services they felt must be covered in any acceptable plan. As they worked, participants acknowledged that any addition to the list of covered services would make the system more expensive, and they agreed that they were willing to pay these additional costs. In addition to the basic services outlined in the limited plan, participants also wanted to see **– and were willing to pay for –** the following:

- Comprehensive care for children and pregnant women. Almost unanimously, participants agreed that this was essential, and all the groups added maternity care to the list of services that should be covered under a limited care scenario.

> *If you prevent these moms from having maternity care, then … they have children with poor health and that puts a strain on the system in the future. I think it's better to do the preventative care with the maternity care.*

- Preventive care. As already noted, participants placed a strong emphasis on preventive care, and they were willing to pay more to improve and expand access to preventive measures if it meant that more people would be healthier.

- Hospitalization. In addition, participants wanted some coverage for hospitalization below the 10% threshold. They felt that the risk of hospitalization was one of the key reasons for having insurance in the first place. Put simply, covering hospital costs was what insurance was *for*.

- More coverage for prescription drugs. Participants also agreed a limit of 8 prescription fills a year was unrealistic, especially for people with chronic conditions like arteriosclerosis or diabetes.

[3] A chart outlining the comprehensive vs. limited coverage scenarios can be found in Appendix D.

- <u>More help for chronic conditions</u>. As with preventive care, participants felt it was far more cost effective to spend more helping people manage chronic conditions than to deny that help only to have people get sicker and require more costly treatment.

> *When it comes to education about healthy lifestyles we mean things like diabetic education for newly diagnosed diabetics, cancer education for people who newly diagnosed with cancer, learning how to live and manage what the illness is in order to prevent further costs. I think those definitely are some of the preventative and educational programs that can be put into place that really have a minimal cost to the system and have maximum benefit to the overall health of the people that are part of that system.*

By the end of the day, participants had found common ground around a plan that was distinctly more generous than the limited coverage presented in the original scenarios, but still met concerns about cost, encouraging personal responsibility, discouraging overuse of the system and keeping employers involved.

D: Who pays and how?

Finally, participants turned to the issue of how Arizona should pay for a universal health care system. Most quickly saw that they, as residents of the state, would ultimately pay for health care – whether through premiums and co-pays, increased taxes, lower wages or higher costs for goods and services – and most were willing to make that sacrifice in order to ensure that all Arizonans have coverage. Their primary aim was to determine what way of distributing the cost would be most equitable.

As noted earlier, participants agreed that placing the burden on employers would be both economically damaging and inefficient.

Two inter-related elements guided this discussion: protecting people from excessive risk and ensuring that everyone pays a fair share into the system.

- **Protection from catastrophe.** Participants agreed that while people needed to bear some of the risk of illness or injury, no one should ever be forced into bankruptcy by it. In their final questionnaires, 91% of participants said that providing "full coverage for the high cost of serious accidents or major illnesses" was either essential or very important in a health plan. Most participants felt that the scalable deductible was an ideal mechanism for providing this kind of protection.

> *The state should pay for the catastrophic coverage, the kidney transplant, leukemia, that kind of stuff and not so much of the "I've got a hangnail, please take me to the ER."*

- **No free rides.** Similarly, while participants insisted that all Arizonans should have access to care regardless of income or employment status, they felt very strongly that every Arizonan, even the poorest, should pay something into the system.
  - <u>Income tax.</u> Most participants agreed that a progressive tax like the income tax was the fairest and most efficient way of paying for the state-wide system.
  - <u>Sales tax.</u> However, since some Arizonans earn too little to pay income tax,

participants also felt that a sales tax was an appropriate way to ensure that everyone who spends money in the state contributes in some way to the plan. In particular, a sales tax would ensure that illegal immigrants and tourists (especially winter visitors) pay something into the system.

- Sin tax. Many participants supported imposing additional taxes on products with unhealthy consequences like tobacco and alcohol.

The extent of the common ground established by ChoiceDialogue participants can be seen in the following box (Citizens' Conclusions).

Citizens' Conclusion

All Arizonans should have at least basic health insurance: preventive care, catastrophic coverage, and essential medical services. No Arizonan should have to choose between health care and necessities like food and shelter, and no one should be bankrupted by catastrophic illness or injury. We believe that the best way to make that happen is through a **single public insurance agency.** Only the state has the ability to make sure that essential care is available to all. Employers and individuals will be able to supplement basic coverage provided by the state with private insurance plans that fit their budget and lifestyle.

In addition, we all must take more responsibility for our own health, with a greater emphasis on prevention and healthy living. In order to make sure people do this, financial incentives for healthy behaviors must be built in to the state plan.

More specifically….

- **Who's covered?** All Arizonans will automatically receive the same basic level of insurance. Coverage will not be tied to employment, and everyone will be covered regardless of age, income or health status. Non-residents (like tourists or undocumented immigrants) will not be entitled to the same level of coverage that legal residents receive, but those who require urgent medical care will not be turned away.
- **How do you get your insurance?** All Arizonans under age 65 will get their basic health insurance through a single public agency. Many working Arizonans will receive private supplemental coverage through their employers, and anyone will be able to purchase it individually.
- **What's covered?** At a minimum, everyone will receive preventive and essential medical care at no or very low cost under this plan. In addition, every Arizonan will be protected against catastrophic health care expenses. This coverage will kick in when total medical expenses reach 10% of household income, not according to a flat dollar deductible. In addition to preventive and catastrophic care, we agree that some services must be covered: pre-natal and maternity care, children's health, hospitalization, and prescription drugs for serious illness or chronic conditions. We generally agree that limiting coverage to these essential services makes financial sense, encourages healthy behaviors and prevents overuse of the system by making people think twice about seeking medical treatment for every cold, cough or minor ailment. In addition, it is extremely important that people have some choice of providers under this system.
- **Who pays and how?** If Arizona is to stay competitive and businesses both small and large are to thrive, we do not think business should be forced to continue to bear the burden of paying for health care, nor do we believe it makes for an efficient system. Individuals should pay for this system through taxes and fees. We agree that an income tax should be a key source of funding for this system. However we believe all individuals should have to pay something for this system; no one gets a free ride. Therefore we believe that other consumption taxes, such as sales tax or a sin tax should also be included so that anyone spending money in Arizona (and who might require care) is also contributing. We believe that a limited public system leaves room for employers to supplement the public coverage as a benefit of employment. We reviewed the costs of providing this coverage, and we are prepared to pay for it, provided that accountability measures are put in place.

ChoiceDialogue participants ended their dialogues surprised and exhilarated about the amount of common ground they were able to establish. For many, their initial pessimism about the state's health system and the possibility of fixing it had shifted into a growing

sense that solutions were possible, and might even come to pass.

> *Before I came into this focus group, my thought was basically we shouldn't have overall coverage for every single person, but the ideas I heard opened up my mind that it is possible, that it is fair for people to be healthy and get that coverage. This day changed my view.*
>
> *I was very surprised that the overwhelming majority of people here said they would accept higher costs, higher taxes to provide services for everybody in the state. That's an amazing surprise to me, and that's a message that should get to the state officials.*
>
> *I was surprised to find how many people are open to the concept of government managing our insurance program. Not everybody seems to have bought into the extreme downsizing that we've lectured about in the last few years, and that really did surprise me. My message to decision-makers is that we want a compassionate but affordable system. It is doable, from what we've seen today*
>
> *A message to decision-makers: if 50 people in this room can come up with the conclusions we've come up with and we never saw each other before, you ought to be able handle it.*
>
> *I've learned today that a really diverse group of people can be civilized and have a common caring conversation with one another about important issues.*
>
> *It was refreshing to me too to see that people with so many different ideas could come to a consensus on a lot of things. Maybe there is hope for us to work out something to change the system.*

III: Stakeholder Dialogues – A Two-way Learning Process

In December 2005, Viewpoint Learning conducted a daylong "Stakeholder Dialogue" with some of the Arizona residents who had participated in the previous ChoiceDialogues, along with officials, civic and business leaders, advocates and health care professionals. The Stakeholder Dialogue was an experiment designed to produce two outcomes:

3. To build on the common ground established in the citizens' vision for the future and to blend it with other stakeholders' vision of what reforms would be both desirable and feasible.
4. To identify a small number of high priority, high leverage goals that, if achieved, would move the state closer to this shared vision.

Like the ChoiceDialogues, the Stakeholder session was highly structured and based on dialogue, not debate. By focusing on common ground that all participants shared – citizens, government officials, advocates and business leaders alike – these dialogues worked to break through gridlock and highlight new ways forward.

A: Trends shaping the current situation

Participants began by identifying factors or trends that had contributed to the current crisis. Several themes stood out in their analysis:

- **Demographics:** Participants noted that not only has Arizona's population increased dramatically in recent years, the population has also aged. In addition, the state has experienced an influx of immigrants, both from other states and from Mexico and Central America. All these factors have shifted the amount and the type of care that Arizonans need.

> *Beyond the inevitable aging of the population, there are also increasing chronic disease trends … that are going to create incredible pressures on the healthcare system.*

- **Economic trends:** Participants also noted that Arizona's economic landscape has shifted in recent decades, with lower-wage service jobs playing a larger role and fewer employers offering health care to their workers. Many believed that globalization had pushed companies to focus intensely on cost control and the bottom line. Participants also noted a widening gap between rich and poor in the state, exacerbated by a tax structure that disproportionately burdens the poor.

> *There is just a huge burden on the bottom third [of the income scale] in terms of their financial capacity to meet the requirements of a modern society.*

- **Trends specific to health care:** In addition to the overall economic trends, participants singled out several trends specific to health care.
    - Most important of these was the skyrocketing cost of medical treatments, especially prescription drugs, a sore spot for most participants. Participants suggested several factors driving this rise, including advancing technology, fear of litigation leading to an emphasis on "defensive medicine" and a regulatory climate that places few restrictions on suppliers' prices and profits.
    - Several participants also pointed to factors on the demand side of the equation, in particular consumers' increased expectations and growing sense of entitlement when it comes to health care.

> *Everybody thinks about healthcare as doctors and hospitals. You forget about the drug companies and the guys who make the hip implants, and the insurance companies. Those … companies have made windfall record profits over the last several decades. And there is no control on that industry.*

- **Changing social contract in the workplace:** Finally, participants pointed to an overall change in the social contract. On the economic front, participants saw a breakdown in the traditional contract between employers and employees: as companies became more competitive (and often larger and more impersonal), many participants felt their focus was increasingly on the bottom line. As a result, employers felt less obligation to the well-being of employees, and employees felt less loyalty to the company and less trust that the company would look out for its employees' best interests.

> *I think there's been a growth of me-ism in our society – I've got it, you don't, and I don't care. It's a breakdown of the social contract between employer and employees. Some of it's due to globalization and increased competition on so many different fronts. It's like I used to care about you, but now I don't feel like I can, so you're on your own.*

Participants all agreed that unless significant changes are made, the future for health care in Arizona looks bleak.

- On the economic side, they foresaw a rise in both corporate and individual bankruptcies, as well as an overall a downturn in the state's economic climate. Many feared that companies would be less willing to locate in Arizona, and that others would leave the state.
- In health care, they expected to see an intensified shortage of providers and a lower doctor/patient ratio. The aging of the state's population would put increased pressure on Medicare, while the widening gap between rich and poor would result in increased pressure on AHCCCS as well. Overall, participants felt, continuing along the same path would result in Arizona becoming a less healthy place.

> *[If nothing changes,] it will begin to have a really dramatic economic impact on the overall health of the state. Arizona will become a less attractive place for people to want to live, move to, develop a life around.*

This shared understanding of the current situation and its likely outcomes provided the jumping off point for the rest of the day's dialogue.

B: Creating a shared vision

In most instances, the conclusions reached in the Stakeholder dialogues dovetailed with those reached in the ChoiceDialogues. In particular, Stakeholder Dialogue participants agreed on the following points:

- **Universal public system**: Like ChoiceDialogue participants, Stakeholder Dialogue participants strongly supported creating a universal public system that ensured continuity of coverage and offered relief to employers. In addition to the rationales cited in the earlier dialogues, Stakeholder Dialogue participants felt that a universal system would be significantly simpler and more efficient than the current patchwork. They were less concerned than ChoiceDialogue participants with illegal immigrants and winter visitors taking advantage of the system, viewing this as a relatively minor factor in the overall picture. Instead, they focused their attention on covering Arizonans who are currently falling through the cracks.
    - Continued role for employers and private insurers: Participants liked the idea of employers continuing to offer some supplemental coverage, and many supported keeping significant private market involvement in the system through competitive bidding for service delivery.

> *We do like the idea of having a less complex government system. The less the tracking, the less eligibility restrictions you have, the better it will be because it will drive costs down.*

- **Personal responsibility/limits on care:** Participants agreed that a universal system should offer incentives for healthy behavior. They also went further than ChoiceDialogue participants in how to establishing some limits on care. Several participants drew a distinction between treatments that are possible and those that are necessary or desirable, and they called for the state to begin a dialogue on whether, when and how to integrate new technology and treatments into patient care.

> *If you could figure out a way to cut off a head from one body and move it to another body, it would be the most complex thing that could be done in health care. But just because it could be done doesn't mean that it should be done. We have to create a dialogue to start to talk about some limits.*

- **Comprehensive coverage:** The only significant difference between the Stakeholder Dialogue conclusions and those reached in the ChoiceDialogues was in the common ground established around comprehensive coverage. In the Stakeholder Dialogue, citizens and leaders alike went farther in the direction of comprehensive coverage – including citizen participants from the ChoiceDialogues who had spoken strongly in favor of limited coverage during the earlier sessions. Many of the concerns that had led ChoiceDialogue participants to favor more limited coverage were answered in the Stakeholder session, while other reasons to favor more comprehensive coverage were added:
    - A comprehensive plan would be more **cost**-effective, since the money saved by offering only limited coverage would largely be offset by the administrative cost of tracking eligibility.
    - A comprehensive system can support **personal responsibility** even more powerfully than a limited system because it gives people tools they need to take steps to get and stay healthy (education and preventive care) and especially to effectively manage illnesses so that they do not become more serious.
    - A simplified and more unified system that offered a wide range of providers (MD's, nurse-practitioners, home health aides, etc.) would cut down on **misuse of the system** by making it easier for people to get the care they need from the right person. If patients have easy access to a clinic or a nurse practitioner, for instance, they would not be forced to turn to the emergency room and the attending physician for basic care. In addition, a more comprehensive system would provide more effective ways to establish responsible limits on care (determining what treatments are appropriate under what circumstances).
    - Even under a more comprehensive system there would still be opportunities to **involve employers** in providing supplementary coverage.
    - Arizonans would be healthier under a more comprehensive plan, since there would be fewer barriers and financial disincentives to getting care.

> *Comprehensive coverage is a real positive…. That way, there's no disincentive for employees to get care. The poorest people historically say if there's premiums or deductibles they cannot get care. With [comprehensive coverage] you don't have that disincentive.*

Overall, support for more comprehensive coverage grew over the course of the day, as citizens (and some skeptical leaders) became more convinced that a system with more comprehensive coverage could be designed in ways that met their concerns and would be workable. This latter point was likely reinforced by the experience of being engaged in respectful dialogue with some of the very people who might actually be running such a system.

A more comprehensive system that includes all preventive, all primary care, all prenatal, maternal health coverage – that has incentives for healthy behaviors. Something like the dental plans where if you do the prophylactics then all other services are covered for you. Something like that really promotes healthy behaviors for a healthier society.

C: High-Leverage Goals

In the second half of the day, participants worked to identify a small number of "high leverage" steps that would move the state towards the common-ground vision of the future. Participants considered what needed to be done, who would do it, and by when. They also noted likely roadblocks and thought through ways to overcome them. In the end, three clear goals emerged as key to a solution that would provide high-quality health coverage for all Arizonans:

- **Engage the public directly in efforts to shape a universal system**
- **Phase in a single universal system**
- **Reform the state's system of training medical professionals/care providers**

These goals were highly interconnected.

- **Engage the public directly in efforts to shape a universal system.** Participants felt strongly that direct public engagement would be essential to any sustainable reform. Several expressed frustration with recent attempts to address health reform through the legislature: in their view the issue has become so politically untouchable that relying on government to take the initiative will result in a patchwork of incremental fixes at best and stalemate at worst. Participants agreed that a far more effective approach was to go directly to the public and the business community, build a consensus for change and engage them in the task of building a workable solution that reflects their values and priorities.
- **Phase in a universal system.** Participants agreed that this new system should be phased in to cover the most vulnerable Arizonans first: children, pregnant women, the disabled and those with chronic conditions. Participants cited two reasons for phasing in coverage in this way: first, politically this is relatively straightforward, since the public has repeatedly indicated that covering children is a high priority; and second, the cost is relatively modest, and could even be covered by Arizona's current budget surplus.

We could cover every child in Arizona today. Based on the number of children and using actual AHCCCS rates it costs only about $300 million and at the current match rate of Medicaid, that's $100 million worth of state money – and currently the state has a $600 million surplus. This is actually doable.

Ultimately participants wanted to see a comprehensive publicly-administered health insurance system. This system would have several key features: it should be simplified, with fewer barriers between different modes of care. In addition, it should maintain a role for private insurers through competitive bidding. And it should rely more extensively on paraprofessionals like physicians' assistants or home health aides in order to make most effective use of the state's health care dollars.

- **Reform the state's system of training medical professionals/care providers.** Participants agreed that the state's system for recruiting and training health professionals must be overhauled if it is to meet the state's needs under a new public system, especially if it increases reliance on providers with lower levels of certification. Key steps to achieving this goal included:
  - Boosting education funding and medical residency programs in state to increase the number of MD's in more specialties to Arizona.
  - Reforming liability practices that make it impractical for providers to move from state to state to encourage providers to choose to practice in Arizona
  - Increasing training programs for all types of care providers, especially paraprofessional certifications, so appropriate care is available without always having to see an MD.

> *To me the nursing shortage is one of the biggest crises this state is facing. The schools did just get $4 million from our state Legislature but they weren't forced to sit in a room and come up with really creative strategies to deal with the crisis. There are lots of ways that they could do it. They could hold three sessions a day, they could hold sessions through summer, they could do all kinds of creative things that they haven't been forced to do to deal with it.*

IV: IMPLICATIONS FOR DECISION-MAKERS

This series of dialogues reveals a clear set of implications for decision-makers who wish to lead a public learning process around health coverage and health care reform. The common-ground conclusions reached by citizen participants show the conditions under which Arizonans are prepared to accept change. Given the opportunity to work through the issues:

- The public believes that all Arizonans are entitled to basic health coverage. This coverage has three characteristics:
  - Permanence: It cannot be taken away regardless of employment, income or health.
  - Equity: All Arizonans should have an equal baseline of coverage. Those who want and can afford additional coverage beyond the baseline should be able to purchase it.
  - Scope: All citizens get the baseline coverage, and non-residents get something more limited.
- Arizonans are willing to support a shift from an employer-based to a publicly run insurance system in order to ensure coverage for all Arizonans without placing an

undue burden on employers. Their support stems from several key benefits that believe would result from a public system; increased simplicity and cost effectiveness, portability and choice of provider. They are willing to pay the increased taxes required for such a system IF certain conditions are met:

- All Arizonans – even the poorest – must contribute something towards their own coverage and care.
- The system must encourage personal responsibility and healthy behaviors.
- Coverage must include:
  - Basic, preventive and catastrophic care
  - Hospitalization, management of chronic disease and essential prescription drugs
  - Preventive coverage to ensure that the most vulnerable (children, pregnant women, the disabled and those with chronic conditions) get the care they need.
- Individuals should pay for this new system primarily through income taxes and fees, supplemented by sales taxes and "sin taxes."

It is important to remember that these findings do not reflect the general public's views today. Polls of the general public would likely yield results similar to those the participants themselves expressed at the beginning of their dialogues. Rather, these findings indicate where people *can* go, given the opportunity to work through the choices and the leadership to help guide the process.

Getting the public to such a point cannot be accomplished with top-down education and spin; it requires authentic public engagement and an effort to discover common priorities and build mutual trust and understanding. Leaders hoping to promote a solution must respect the public's process of connecting the dots and resolving contradictions.

- For example, participants in both the citizen and the stakeholder dialogues subscribed to two basic ideas: no one should be left out by the insurance system, and everyone should contribute to the system in some way. In the stakeholder dialogues, however, participants emphasized the first point (making sure that no one is left out), and they focused on removing barriers to access for the most vulnerable populations. However in the citizen dialogues, participants emphasized the second idea (no free rides), and they focused on ways of structuring the system that ensured that everyone contributes (e.g. through sales taxes, co-pays).

  Decision-makers hoping to gain public support for reform must keep such a distinction in mind. Focusing on "helping the neediest" as a key benefit of a new policy will not resonate with the public unless the plan does so in a way that satisfies their concerns about freeloaders. Ways to address this concern first involve making clear that most of the uninsured are workers and ensuring that everyone pays something through sales tax or by other means.

A cause for optimism: Overall, these dialogues represent a real cause for hope. Participants in these dialogues – citizens and leaders alike – expressed surprise and delight at the amount of common ground they discovered over the course of the dialogue, and this optimism fuelled their eagerness to extend the conversation to a broader community.

Leaders and experts were particularly impressed at the quality of the conversation and the valuable insights that citizen participants provided. Many said in their final comments that they had been "buoyed" by the day's dialogue and participants' openness to change – at the end of the day initially pessimistic participants expressed renewed hope that Arizona might be able to make a dent in this intractable issue. For their part, citizen participants were pleased that their voices had been heard and taken seriously, and many were encouraged that it might be possible to make even more significant reforms than they'd originally thought. Many said that they were looking forward to continuing involvement in this issue and that they had renewed faith in the ability of private citizens to act as agents of change.

> *I was shocked when we went around the first time, I continue to be shocked as we finish up the day and very much invigorated. I am heartened by how much common wisdom there is on these issues…. Many of us have been through this issue before and been discouraged because we couldn't get traction, we couldn't get it going. Maybe this is the tipping point.*
>
> *I think I was most surprised by both the citizens' conclusions and then our own consensus here today in general… I've been doing this a while, and I'm really kind of buoyed by today. This gives me a little staying power.*

The depth of public concern about health care coverage, and citizens' openness to considering significant change, indicate that the time is ripe to move beyond patchwork fixes and take bolder steps. In Arizona and nationwide, momentum on this issue is beginning to build. It is quite likely that health care issues will be on the agenda in upcoming elections, and the public's hunger for workable solutions is growing harder to ignore.

But to bring such a solution to pass, leaders and the public must search for and build on common ground. This is a departure from the way business is too often done in politics, which is to build constituencies around wedge issues. That won't help Arizona. Wedge issues only create and reinforce gridlock. A far more promising direction is to build on the surprising and powerful common ground we found among citizens (and stakeholders.) By following this path, Arizona's leaders and citizens alike are far more likely to create sustainable reform and a healthier future for all Arizona.

> *What I found most surprising is the vastness and complexity of this problem. I'm hoping that I will continue to learn and be able to a spokesperson out there to talk to people when there's a need…. I think the best thing of all is that I love my state of Arizona and I've never seen so much public outreach before … your voice is heard here, and I think that's a great start. (Citizen)*

Appendix A

ChoiceDialogue™: The Methodology

ChoiceDialogue methodology differs from polls and focus groups in its ***purpose, advance preparation, and depth of inquiry***.

- **Purpose.** ChoiceDialogues are designed to do what polls and focus groups cannot do and were never developed to do. While polls and focus groups provide an accurate snapshot of people's current thinking, ChoiceDialogues are designed to predict the future direction of people's views on important issues where they have not completely up their minds, or where changed circumstances create new challenges that need to be recognized and addressed. Under these conditions (which apply to most major issues), people's top-of-mind opinions are highly unstable, and polls and focus groups can be very misleading. ChoiceDialogues enable people to develop their own fully worked-through views on such issues (in dialogue with their peers) even if they previously have not given it much thought. By engaging representative samples of the population in this way, ChoiceDialogues provide unique insight into how people's views change as they learn, and can be used to identify areas of potential public support where leaders can successfully implement policies consonant with people's core values.
- **Advance Preparation.** ChoiceDialogues require highly trained facilitators and (above all) the preparation of special workbooks that brief people on the issues. These workbooks formulate a manageable number of research-based scenarios, which are presented as a series of values-based choices, and they lay out the pros and cons of each scenario in a manner that allows participants to work though how they really think and feel about each one. This tested workbook format enables people to absorb and apply complex information quickly.
- **Depth of Inquiry**. Polls and focus groups avoid changing people's minds, while ChoiceDialogues are designed to explore how and why people's minds change as they learn. While little or no learning on the part of the participants occurs in the course of conducting a poll or focus group, ChoiceDialogues are characterized by a huge amount of learning. ChoiceDialogues are day-long, highly structured dialogues – 24 times as long as the average poll and 4 times as long as the average focus group. Typically, participants spend the morning familiarizing themselves with the scenarios and their pros and cons and developing (in dialogue with each other) their vision of what they would like to have happen in the future. They spend the afternoons testing their preferences against the hard and often painful tradeoffs they would need to make to realize their values. To encourage learning, the ChoiceDialogue methodology is based on dialogue rather than debate – this is how public opinion really forms, by people talking with friends, neighbors and co-workers. These 8-hour sessions allow intense social learning, and both quantitative and qualitative measures are used to determine how and why people's views change as they learn.

Steps in a ChoiceDialogue Project

1) Archival analysis of polls (or conducting a special one) and other research to provide a baseline reading on what stage of development public opinion has reached;

2) The identification of critical choices and choice scenarios on the issue and their most important pros and cons, and the preparation of a workbook built around those scenarios in a tested format for use in the dialogues;

3) A series of one-day dialogue sessions with representative cross-sections of the population. Each dialogue involves about 40 participants, lasts one full day and is videotaped. A typical one-day session includes the following:

    - Initial orientation (including the purpose of the dialogue and the use to be made of the results, the nature of dialogue and ground-rules for the session, introduction of the issue and some basic facts about it);
    - Introduction of the choice scenarios on the issue, and a questionnaire to measure participants' initial views;
    - Dialogue among participants (in smaller groups and in plenary) on the likely good and bad results that would occur as a consequence of each choice if it were adopted, and constructing a vision of the future they would prefer to see;
    - A second, more intensive round of dialogue among the participants (again both in smaller groups and in plenary) working through the concrete choices and tradeoffs they would make or support to realize their vision;
    - Concluding comments from each participant on how their views have changed in the course of the day (and why), and a questionnaire designed to measure those changes.

4) An analysis of how people's positions evolve during the dialogues. We take before and after readings on how and to what extent people's positions have shifted on each choice as a result of the dialogue. This analysis is both quantitative and qualitative.

5) A briefing to leaders to make sense of the results. The briefing summarizes what matters most to people on the issue, how positions are likely to evolve as surface opinion matures into more considered judgment, the underlying assumptions and values that shape that evolution, and the opportunities for leadership this creates.

Appendix B

Quantitative Findings

At the beginning of the dialogue, participants were asked to rate each scenario on a scale of 1-10, with 1 being negative and 10 being positive. They were asked to rate the same scenarios again at the end of the day. The initial and final means represent the mean rating for each scenario before and after dialogue.

Assessment of the four scenarios

N = 119	initial mean	final mean
Scenario 1: Expanded employer-based system: full coverage for all	**6.7**	**4.0**
Scenario 2: Arizona Medicare for all	**6.1**	**6.7**
Scenario 3: Expanded employer-based system: limited coverage for all	**4.6**	**4.0**
Scenario 4: The state provides the basics: the rest is up to you	**3.9**	**6.1**

Additional Questions

At the end of the dialogue several additional questions were asked to provide further insight into values and attitudes that might influence participants' judgments.

The questions concerned values on entitlement to health care and responsibility for the costs of serious illness and satisfaction with the current health care system and their own health insurance, if they had it. Participants were also asked to identify how important various elements were in a health plan.

Value questions

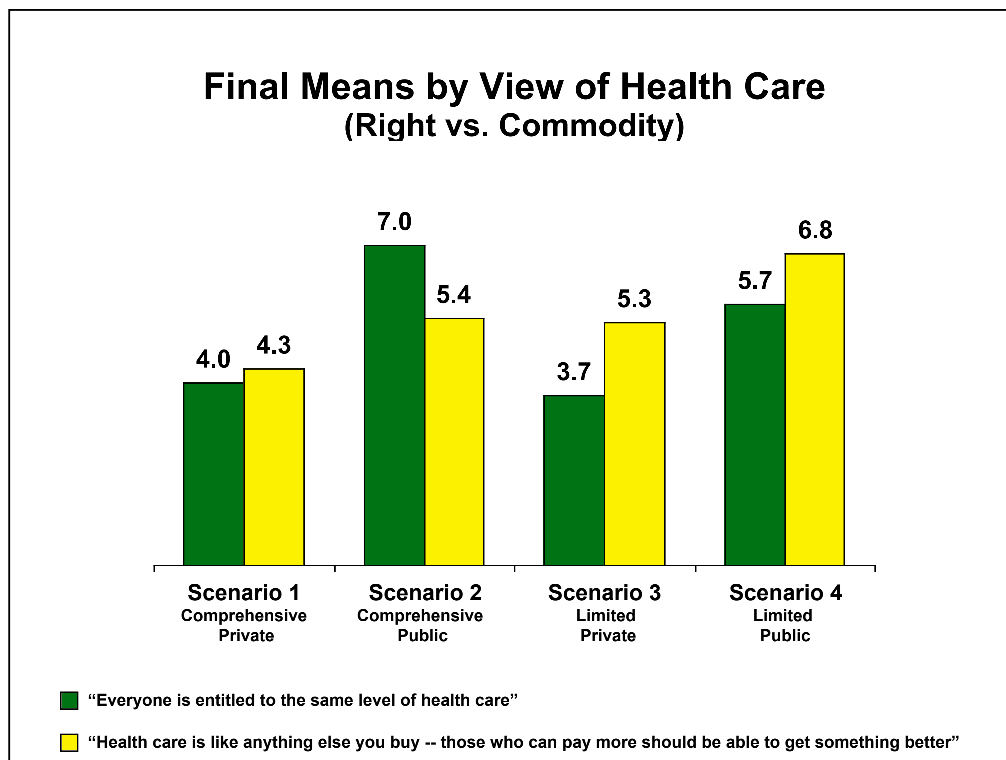
There was overwhelming consensus that "no one should be forced into financial ruin because of the high medical expenses," as shown in the following table. Nine out of ten supported this point of view.

Q: Which comes closer to your point of view?	(%)
A: People have the responsibility to be prepared for the high cost of serious illness or injury	**10**
B: No one should be forced into financial ruin because of high medical expenses	**90**

In contrast, another question flagged differences in values. While three out of four supported the principle that "everybody is entitled to the same level of health care," a minority saw health care more as a commodity, with those able to pay more getting better care.

Q: Which comes closer to your point of view?	(%)
A: Everybody is entitled to the same level of health care	**76**
B: Medical care is like anything else you buy – those who can pay more should be able to get something better	**21**

This attitude clearly influenced responses to the scenarios – in their final judgments, participants who took the "commodity" point of view were more likely to favor limited health plans, whether public or private, and less likely to favor the public comprehensive health coverage scenario. As might be expected, the wealthiest respondents were more likely to favor this point of view. Nearly half (42%) of the participants with incomes of $75,000 or more had a "pay more/get more" view of health care, rather than seeing it as something everyone should receive equally.



Ratings of health care

As in most national surveys, there was a high level of dissatisfaction with the current health care system in America today. Two-thirds rated the U.S. health care system "fair" or "poor." Younger participants (under 50) were more critical of the current health care system than older respondents.

Q: How would you rate the health care system in America today?	(%)
Excellent	2
Very good	9
Good	22
Fair	36
Poor	30
No answer	1

In contrast to the views of the health care system in general, people were much more satisfied with their own health care insurance. The majority (52%) said they were "extremely" or "very" satisfied with their current insurance and only 13% were clearly dissatisfied. (87% had some form of insurance, including Medicaid.)

Q: Overall, how satisfied are you with your current health insurance plan?	(%)
Extremely satisfied	21
Very satisfied	31
Somewhat satisfied	34
Not too satisfied	10
Not satisfied at all	3
N/A	2
Q: What is the source of your primary insurance coverage?	
Your employer or union	38
Spouse/parent's employer or union	21
Medicare	14
Medicaid	4
A plan you bought yourself	7
Other	12
N/A	3

Base = 104 (participants with health insurance; 87% of total sample)

It is not surprising that those who are most satisfied with their current health insurance are less critical of the health care system in general. Nearly half (47%) of the participants who are "extremely" or "very" satisfied with their own health insurance rate the current health care system as good to excellent. This suggests that a high level of satisfaction with current health care services should be considered as a potential obstacle to making changes in the current system.

What is important in a health care plan

Participants were asked to rate how essential they felt a number of possible elements were to a health plan for themselves. Rated most essential was a policy that couldn't be cancelled because of changes in health and full coverage for serious accidents or major illnesses. About two-thirds thought these were "absolutely essential" elements and more that nine out of ten regarded them as highly important.

Nearly half considered coverage for the cost of prescription drugs and freedom in choice of doctors and hospitals "absolutely essential" In addition to concerns about cost issues (premiums, out-of –pocket costs and lifetime dollar caps), participants also considered no charge preventive care and lower costs for people who have a healthy life style important elements in a health care system. There was surprisingly little concern about waiting time for less urgent operations like hip replacements – the majority rated it of low importance.

Q: How important is each of these to you in a health plan?

	High Importance (%)			**Low Importance (%)**		
	Total	Absolutely essential (%)	Very important (%)	Total	Somewhat important (%)	Not very important (%)
Policy that cannot ever be cancelled because of changes in health	**94**	61	33	**6**	4	2
Full coverage for the high cost of serious accidents or major illnesses	**91**	67	24	**8**	7	1
Covers the cost of prescription drugs	**84**	48	36	**15**	14	1
Low monthly premium	**84**	34	50	**15**	14	1
Complete freedom to choose doctors and hospitals	**82**	48	34	**17**	17	0
No dollar cap on total covered expenses in your lifetime	**80**	38	42	**18**	13	5
***No charge for preventive care** like checkups, shots, mammograms*	**79**	40	39	**21**	13	8
***Lower costs for people who have a healthy lifestyle** (non-smokers, not overweight, etc.)*	**73**	34	39	**27**	19	8
Minimal out-of-pocket expenses	**67**	29	38	**31**	28	3
Little or no waiting time for appointments	**67**	17	50	**33**	32	1
No need for approvals or referrals to see a specialist	**63**	21	42	**36**	28	8
Little or no paperwork	**47**	11	36	**53**	40	13
***No waiting time for less urgent operations** like hip replacements or cataract surgery*	**44**	18	26	**56**	44	12

Demographic Information

N = 119

Gender	%
male	49
female	51

Age	%
18-29	17
30-49	45
50-65	22
over 65	14
N/A	2

Highest level of schooling completed	%
less than high school	5
high school graduate	11
some college	45
college degree	18
graduate study/degree	18
N/A	3

Annual household income	%
under 20K	17
20-29K	18
30-49K	20
50-74K	23
75-99K	12
100K or more	8
N/A	3

Appendix C

Four Scenarios

ChoiceDialogue participants used the following four scenarios as a jumping off point for their dialogue.

<table>
<tr><th></th><th>Employer-based</th><th>Public</th></tr>
<tr><td>Comprehensive</td><td>SCENARIO 1:
Expanded employer-based system:
full coverage for all
• All Arizonans will get health insurance from employers or through a pool of private insurance companies offering a wide range of plans, including low-cost options.
• Coverage will be comprehensive: it will include all needed doctor visits, drugs, hospital stays and tests. As with today's plans, choice of doctor or hospital may be limited.
• Employers that do not offer insurance will pay a payroll tax that will be used to cover most of the cost of plans purchased through the insurance pools. Individuals will pay premiums, co-pays and deductibles. The state will subsidize premiums for those who cannot afford them on their own.
• People will be able to buy supplemental coverage to help pay for deductibles or co-payments, or to provide extra services like private hospital rooms.</td><td>SCENARIO 2:
Arizona Medicare for all
• All Arizonans will get health insurance through a single public insurance agency, in a Medicare-like program.
• Coverage will be comprehensive: it will include all needed doctor visits, drugs, hospital stays and tests. All providers in the state will be included.
• This program will be funded by income taxes and by individual co-payments and deductibles.
• People will be able to buy supplemental coverage to help pay for deductibles or co-payments, or to provide extra services like private hospital rooms.</td></tr>
<tr><td>Limited</td><td>SCENARIO 3:
Expanded employer-based system:
limited coverage for all
• All Arizonans will get health insurance from employers or through a pool of private insurance companies offering a wide range of plans, including low-cost options.
• Coverage will be limited: it will cover preventive care, 4 primary care visits and 8 prescriptions per year. It will not cover anything further until a household's medical expenses exceed 10% of household income for the year. After that, essential health care expenses only will be covered in full.
• Employers that do not offer insurance will pay a payroll tax that will be used to cover most of the cost of plans purchased through the insurance pools. Individuals will pay small premiums, plus all health care expenses above the basic services up to the point when those costs add up to more than 10% of household income.
• People will be able to buy supplemental insurance to pay for uncovered health care expenses below the 10% threshold as well as those services not included in the plan at all (dental, vision, hospice).</td><td>SCENARIO 4:
The state provides the basics:
the rest is up to you
• All Arizonans will get health insurance from a single public insurance agency.
• Coverage will be limited: it will cover preventive care, 4 primary care visits and 8 prescriptions per year. It will not cover anything further until a household's medical expenses exceed 10% of household income for the year. After that, essential health care expenses only will be covered in full.
• The limited coverage will be funded by income taxes. Individuals will pay for all health care expenses above the basic services up to the point when those costs add up to more than 10% of household income.
• People will be able to buy supplemental insurance to pay for uncovered health care expenses below the 10% threshold as well as those services not included in the plan at all (dental, vision, hospice.)</td></tr>
</table>

Appendix D

Comprehensive vs. Limited Coverage

ChoiceDialogue participants used the following chart as a starting point for their discussion of what a state health plan should cover.

COMPREHENSIVE COVERAGE			LIMITED COVERAGE
Wellness (screenings, checkups, well-baby)	✓	✓	***Wellness (screenings, checkups, well-baby)***
Lab tests (preventive)	✓	✓	***Lab tests (preventive)***
Primary care (Doctor visits)	✓	**limited**	***Primary care (Doctor visits):*** 4 visits, then no coverage until 10% threshold
Drugs (generic)	✓	**limited**	***Drugs (generic):*** 8 prescriptions, then no coverage until 10% threshold
Drugs (brand name)	✓	**limited**	***Drugs (brand name):*** Covered only after 10% threshold
Surgery (in-patient and out-patient)	✓	**limited**	***Surgery (in –patient and out-patient):*** Covered only after 10% threshold
Emergency room, Hospitalization Lab tests (diagnostic), Medical equipment (wheelchairs, prosthetics)	✓	**limited**	***Emergency room, Hospitalization, Lab tests (diagnostic) Medical equipment (wheelchairs, prosthetics):*** Covered only after 10% threshold
Behavioral/Mental health	✓	**limited**	***Behavioral/Mental health:*** Covered only after 10% threshold
Maternity	✓	**Not covered**	***Maternity***
Dental, Vision	✓	**Not covered**	***Dental, Vision***
Skilled nursing, home health, hospice	✓	**Not covered**	***Skilled nursing, home health, hospice***
Podiatry, chiropractic, physical therapy	✓	**Not covered**	***Podiatry, chiropractic, physical therapy***
People can purchase private supplemental insurance to pay for: • lower co-pays and deductibles • extras like private hospital rooms.			People can purchase private supplemental insurance to pay for: • uncovered services below the 10% catastrophic threshold • services not included in the limited plan. (e.g. hospice, dental, maternity)