Heartwired for Health & Economic Justice

Messaging Recommendations for Persuading & Activating Health System Leaders & Policymakers

wonder for good

Community Catalyst

Table of Contents

These messaging recommendations and research findings are for advocates and communicators who are working to advance **health and economic justice** in the U.S. Whether your work focuses on expanding access to and quality of coverage, reducing the harmful impacts of medical debt, lowering the cost of care, or another key issue area, these insights can be **applied to your messaging for health system leaders and policymakers**.

Project Overview

Project Overview

From September 2025 to April 2026, Community Catalyst convened partners from its medical debt and out-of-pocket affordability cohorts working at the intersection of health and economic justice to advise on the Heartwired for Health and Economic Justice research project. The advisory group was facilitated by Wonder for Good.

Primary Goals

- **Shared Narrative:** Bring together medical debt and out-of-pocket affordability partners to develop a unified narrative that reframes health care affordability and medical debt as systemic failures — not personal misfortunes
- **Capacity Strengthening:** Equip partners working at the intersection of health and economic justice with tools, training, and resources to deploy effective narratives on medical debt and Marketplace affordability

Key Audiences

- Policymakers and health care system leaders (public, state officials, and private) in states represented in the advisory group: AZ, CA, CO, FL, GA, IL, ME, NC, NM, NY, PA, TX, WA
- A mix of somewhat supportive and somewhat opposed to change goals identified by Community Catalyst and the advisory group

Project Outcomes

- Actionable messaging guidance to influence policymakers and health system leaders

Big-picture Vision for Health & Economic Justice

Internal reference point; adapted from big-picture vision articulated by Community Catalyst's Health Justice Narrative: Community of Practice with input from the Heartwired for Health & Economic Justice advisory group to articulate what we hope will be different in the world if our efforts are successful. This vision laid the foundation for our subsequent research, but was not intended to be external-facing messaging.

We envision **health** as a **fundamental human right**—guaranteed to all, no matter **who they are, where they live, whether they work, or any other factor.** Through bold, community-driven action, we **dismantle structural racism** and **heal its generational harms** to individuals, communities, and health systems. Together, we're building a future where **everyone thrives**—free from health disparities, empowered by equity, and supported by systems rooted in dignity and justice. Our vision is a future where:

- **Health care** and **coverage** are **affordable** for everyone. Financial barriers, surprise bills, and life-changing costs do not exist.
- Every person has access to **high-quality**, **culturally responsive care** and **coverage** for every **age**, **life stage**, and **need**.
- Health care systems are **shaped by** and **accountable to the communities they serve**.
- **Economic and social conditions** such as where you live **don't determine your wellbeing or health outcomes**.
- **Communities thrive** because holistic health and well-being are supported in our everyday lives.

Near-Term Change Goals

developed in collaboration with Community Catalyst and advisory group

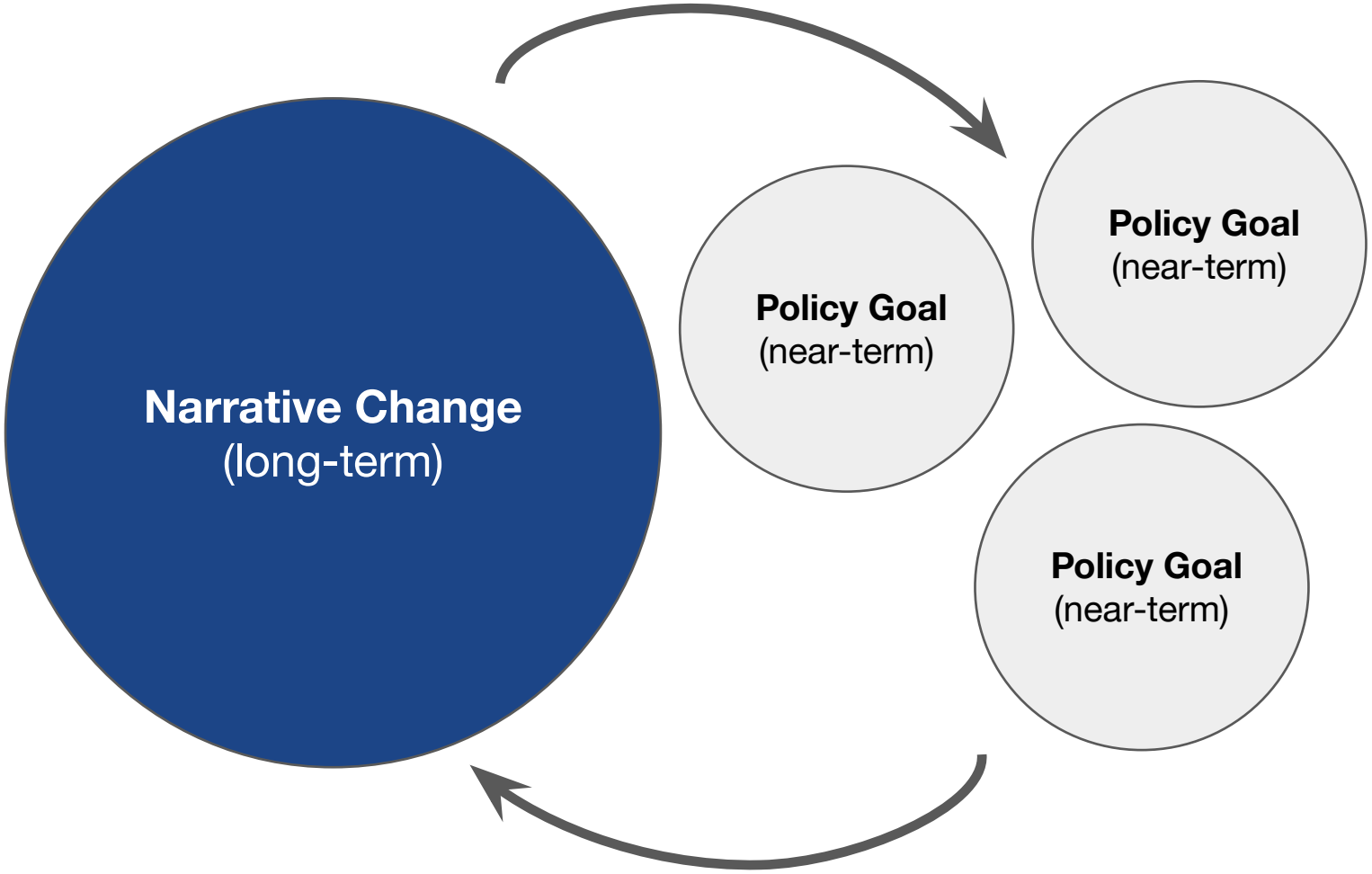
- Lower out-of-pocket costs in the form of copays, deductibles, premiums, and cost-sharing
- Increase access to Marketplace coverage through Special Enrollment Periods, including for people in critical need of health services, tax time enrollment and other enrollment streamlining policies
- Set universal eligibility standards for hospital financial assistance programs, including presumptive eligibility and standardized applications (for example through language access standards)
- Expand the comprehensiveness of health coverage, including through expansions of Essential Health Benefits (EHB) Benchmark Plans
- Strengthen oversight of nonprofit hospitals by enforcing community benefit standards, scrutinizing tax exemption misuse, and regulating healthcare mergers
- Restrict the promotion and use of medical credit cards and other predatory medical payment products
- Provide, maintain and expand state-funded coverage for immigrants (for example by raising state revenue)
- Establish a cap on hospital prices

Policy goals serve as concrete indicators of progress on narrative change.

Choosing these goals does not mean other priorities are unimportant!

Instead, they act as representative markers of your overall work and ensure that the research is rooted in reality.

Long-Term Narrative Change and Shorter-Term Policy Goals



- Success in advancing near-term policy goals is an **indicator** that the narrative is shifting
- Winning near-term policy goals allows us to both **shift** the narrative and **amplify** new and different messages and stories
- Policy wins can also **shape people's lived experiences with issues** — helping people to manage their fears and also nurturing compassion
- When the **narrative starts to shift**, it creates a more **supportive environment** for new and more policy goals

Methodology

The Heartwired Approach

The five Heartwired factors help us understand what's simmering below the surface — how our emotions, values, identities, lived experiences, and beliefs combine and collide around a particular issue. We use that knowledge to influence audience behavior, change policies, and transform cultural narratives.

Emotions

Feelings in response to stimuli. Emotions drive behavior particularly when we feel threatened and need to make split-second decisions.

Lived Experiences

Meaning made from events and relationships that a person experiences in their life.

Identity

How one sees oneself in relation to the world. Identity incorporates many facets and traits.

Values

Ideals held about good and bad, right and wrong. Values influence emotions, beliefs and behaviors and are often shared within a culture or community.

Beliefs

Ideas held to be true. When we have little experience with something, we tend to fill in the knowledge gaps with assumptions.

Project & Process Overview

Change & Audience Phase

What is the big-picture vision we are working towards that is grounding our work on this project?

What indicators can help us measure progress made towards our big-picture vision?

What opportunities and barriers exist in the current health and economic justice landscape?

Mindset Research Phase

In what ways do our health system leaders' and policymakers' Heartwired factors shape their thinking on health and economic justice?

What complex emotional barriers does our messaging need to help these audiences resolve in order to move them to support?

Persuasion & Activation Research Phase

How do health system leaders and policymakers respond to test messages and content?

What words, messages, stories, and messengers are most resonant for these audiences, and effective in building their support and mobilizing action?

Research Participants

Between November 2025 and April 2026, Wonder conducted **26, 60-minute in-depth qualitative interviews** with health system leaders and policymakers in two phases of research (mindset / persuasion & activation).

Audience Category	Number of Interviews
Private Health System Leaders *includes publicly-funded private health systems (e.g., safety net hospitals)*	9*
Public Health System Leaders / State Officials	7**
Policymakers	4

States Represented	Number of Interviews
California	3
Colorado	7
Georgia	1
New Mexico	1
New York	2
Pennsylvania	1
Texas	4
Multi-state	1

**Includes 2 repeat participants*
***Includes 4 repeat participants*

Messaging Objectives: Activation & Persuasion

ACTIVATE

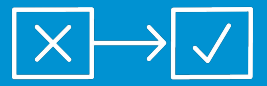
OBJECTIVE

Activate target audiences who are already supportive.

PERSUADE

OBJECTIVE

Persuade target audiences who are conflicted.



NEUTRALIZE

OBJECTIVE

Neutralize those who will never be supportive today.

Persuasion & Activation Research: How did we measure success?

Before and **after** reading the test content, participants were asked to **rate their level of support for or opposition** to each of the following 'ideas', on a scale of -5 to +5 *(where -5 = strongly opposed, 0 = neutral, +5 = strongly support)*:

A. Lower out-of-pocket costs in the form of copays, deductibles, premiums, and cost-sharing

B. Set universal eligibility standards for hospital financial assistance programs, including presumptive eligibility and standardized applications (for example through language access standards)

C. Expand the comprehensiveness of health coverage, including through expansions of Essential Health Benefits (EHB) Benchmark Plans

D. Strengthen oversight of nonprofit hospitals by enforcing community benefit standards, scrutinizing tax exemption misuse, and regulating healthcare mergers

E. Restrict the promotion and use of medical credit cards and other predatory medical payment products

F. [DECOY CHANGE GOAL]: Reduce regulatory barriers that limit insurer competition, including allowing interstate sales of health insurance plans and supporting policies that prevent local provider monopolies

G. [STRETCH GOAL]: Ensure everyone in the United States can access government-funded health insurance (e.g., Medicare for all)

H. Provide, maintain and expand state-funded coverage for immigrants (for example by raising state revenue)

I. Establish a cap on hospital prices

Findings from Research Interviews with Health System Leaders & Policymakers

Summary of Research Findings

1	Everyone agrees: the health care system is broken, unaffordable, and inaccessible.
2	Big, transformative fixes feel like the right answer, but also feel out of reach.
3	Incremental solutions feel more feasible, but support varies – with notable alignment among public health system leaders around hospital accountability.
4	Politics, rising costs, and loss of coverage are creating a sense of urgency to act — and for some, a strategic opening to reconsider potential solutions.
5	Responsibility is tangled in a ‘web’ of obligation, blame, and deference among key players.
6	New and unexpected messengers can boost the credibility of messaging.
7	Framing change as a shared responsibility can inspire hope and motivate action.

1 Everyone agrees: the health care system is broken, unaffordable, and inaccessible.

- Nearly all research participants see the profit-driven nature of the system as the root problem and inherently problematic, though none described it explicitly as “economically unjust.”
- Many pointed to fragmentation, variation, and complexity within the system, as these lead to greater administrative burdens, higher costs for care and coverage, and confusion for patients, providers, and system leaders alike.
- Nearly all research participants described rising costs for care and coverage as deeply concerning, and view them as secondary issues that stem from profit motives built into the system.

1

Everyone agrees: the health care system is broken, unaffordable, and inaccessible.

"The corporatization of medicine, the corporatization of healthcare, insurance companies — their primary objective is to maximize profit. That means maximizing denials, delayed payment. It's gamesmanship towards the goal of profit. Healthcare used to be [...] not driven by profit or ego or personal good, but driven by a mission [...] holding sacred the person that you're serving."
— PRIVATE HEALTH SYSTEM LEADER, RED STATE (PERSUASION & ACTIVATION INTERVIEW)

"Healthcare costs in this country are already astronomically high and continuing to grow unsustainably. The way we've tried to deal with that creates a lot of consumer friction and a lot of consumer pain — whether that's shifting costs to consumers through premiums and deductibles, trying to manage care, or control what healthcare a consumer can use and when they can use it through prior authorization. Consumers often feel that not only is healthcare expensive, if not unaffordable, to them — they have trouble finding the value in it and they feel like the system is unfair and they have to fight and advocate for themselves." — PUBLIC HEALTH SYSTEM LEADER, BLUE STATE (PERSUASION & ACTIVATION INTERVIEW)

"I think nationally our healthcare system is broken. Affordability is a huge issue when it comes to healthcare. Access is a huge issue." — POLICYMAKER, BLUE STATE (PERSUASION & ACTIVATION INTERVIEW)

"The way we deliver care is so fragmented and the way we cover people for that care. And it leads to a lot of administrative burden, a lot of confusion, a lot of people struggling to figure out how to use their coverage and how to get care." — PUBLIC HEALTH SYSTEM LEADER, BLUE STATE (PERSUASION & ACTIVATION INTERVIEW)

1

Everyone agrees: the health care system is broken, unaffordable, and inaccessible.

"The cost that people have to pay for their health insurance and getting care is just out of control. People are taking on a lot of costs themselves right now. It limits access to care. It makes it even more challenging for people to have funding in their budget for food and housing and other necessities where those costs are rising. I really think a top priority in our state and across the nation really needs to be focused on how much individuals, how much of that financial burden individuals are taking on."
— PUBLIC HEALTH SYSTEM LEADER, BLUE STATE (PERSUASION & ACTIVATION INTERVIEW)

"It is a stretch to call it a system [...] it has got a whole lot of problems and a whole lot of gaps and unfairness. It is dominated by for-profit health coverage corporations, which make money by collecting premiums and spending as little of it as possible on actual health care for people. And they have evolved over the years some very effective mechanisms for restricting access to care and saying no to care."
— POLICYMAKER, BLUE STATE (MINDSET INTERVIEW)

"The health care system for me is a very complicated, messy, inefficient system [...] It ranges from frustrating to enraging when you see people and how they get caught up in it, and especially just when you recognize that big parts of this system really aren't thinking about the patient first. [Stakeholders in the health care system] are thinking more about, 'how does everybody get their cut of things', and I think a lot has gone wrong in that framework." — PUBLIC HEALTH SYSTEM LEADER, BLUE STATE (MINDSET INTERVIEW)

"I would argue our biggest weakness is, we allow [...] too much of our [...] gross domestic product spent on healthcare to leave the healthcare ecosystem. [...] There's a lot of waste and duplication, overutilization. And then a lot of for-profit entities that take dollars out of the healthcare system instead of leaving them in." — PRIVATE HEALTH SYSTEM LEADER, MULTI-STATE (MINDSET INTERVIEW)

1 Everyone agrees: the health care system is broken, unaffordable, and inaccessible.

What this means for our messaging:

- Messaging should **move beyond building awareness of problems** related to rising costs, decreasing access to care and coverage, or system complexity — and instead **expose the root causes and clarify pathways for change**.

2 Big, transformative fixes feel like the right answer, but also feel out of reach.

- Ambitious ideas that address profit motives within the current system — most commonly, the idea of universal, single-payer health care — feel compelling to many research participants.
- However, research participants are highly skeptical of the political and practical feasibility of big goals that require buy-in at the federal level, including universal, single-payer health care.
    - The current administration, politicization of health care, and overall political polarization were often cited as primary barriers.
    - For some, skepticism of universal, single-payer health care is also rooted in concerns about decreased quality of care, longer wait times, and other perceived potential drawbacks.
    - Dominant narratives about government ineffectiveness and claims of waste, fraud, and abuse diminish or complicate some research participants' confidence that the government could successfully administer a single-payer or universal health care system.
- Incremental reforms are often viewed as mismatched to the scale of problems and not worth pursuing because they do not address profit motives as the root cause.

2

Big, transformative fixes feel like the right answer, but also feel out of reach.

"We don't have universal coverage. *That's* the problem. I need a magic wand to make [universal] happen. So in the meantime, do you do these incremental things that provide some value, but that don't really address the issues? Yeah, sure. But at the end of the day — whether it's health equity or it's length of your life expectancy, maternal mortality — none of these are going to address that. The only way to do that is to give everybody healthcare." — PRIVATE HEALTH SYSTEM LEADER (PUBLICLY-FUNDED), BLUE STATE (PERSUASION & ACTIVATION INTERVIEW)

"If we had an ideal healthcare system, we would take a lot of the middle people out of the equation. We over the years have had different people insert themselves into that payment process to get their little piece of the pie. And that's what's driven up a lot of healthcare costs. [...] I do think it's important to say that our current system is broken. I'm not sure that the exact answer though is universal government-funded coverage. To turn this over to the government with no framework or guardrails around it, I'm not sure you're going to achieve success." — PRIVATE HEALTH SYSTEM LEADER, RED STATE (PERSUASION & ACTIVATION INTERVIEW)

"I believe healthcare is a right, not a privilege. I don't think somebody should go bankrupt because they get sick. I understand that is probably not feasible. It is just not the way the system is set up."
— POLICYMAKER, BLUE STATE (PERSUASION & ACTIVATION INTERVIEW)

"It feels like we're solving the symptom and not the fundamental mismatch issue of why is care unaffordable. If we really wanted to fix healthcare, we will have to do something that is farther, structurally. Maybe it is a single payer system. All of these [other solutions] feel like they're just on the margins — important, valuable and on the margins." — PRIVATE HEALTH SYSTEM LEADER, BLUE STATE (PERSUASION & ACTIVATION INTERVIEW)

2

Big, transformative fixes feel like the right answer, but also feel out of reach.

"We have had a number of fraud, waste and abuse cases that have been fairly public. What that means is we need fraud, waste and abuse monitoring, which makes the health care system more complicated, which makes and more cumbersome for providers. You have fewer providers that want to take Medicaid, and we lost the money." — PUBLIC HEALTH SYSTEM LEADER, BLUE STATE (PERSUASION & ACTIVATION INTERVIEW)

"We're in this very odd circumstance where I feel like we could lose our democracy. And when you lose a democracy or you lose the legislative branch — you sort of have a Supreme Court and a presidency, and the presidency is not going for a Medicare for All — you've got to stay in the zone of what's possible right now." — PUBLIC HEALTH SYSTEM LEADER, BLUE STATE (PERSUASION & ACTIVATION INTERVIEW)

"Access to government-funded health coverage: that is number one [...] except I would say in this country it is not likely to come at the federal level. It is much more likely — like almost all good legislation in America — it is more likely to begin in a few states and then go national, which is how Canada adopted their single-payer system." — POLICYMAKER, BLUE STATE (MINDSET INTERVIEW)

"Everyone should be on Medicaid. No copays, no deductibles, no co-insurance; let the payers and the providers fight over the cost. It either needs to be run by the feds or the state, so it is Medicare for all, which is run by the feds, or it is a Medicaid for all version. [...] There is no chance during this administration that we are going to make any progress here. But I would certainly hope the next President and the next set of legislators would run on this specifically. There are a lot of people who support it and the people who are going to fight it are [...] the profiteers." — PUBLIC HEALTH SYSTEM LEADER, BLUE STATE (MINDSET INTERVIEW)

2 Big, transformative fixes feel like the right answer, but also feel out of reach.

What this means for our messaging:

- In order to build trust and credibility with this audience, messaging needs to acknowledge the scope of the problem in the health care system as health system leaders and policymakers see it and position incremental solutions as one, among many, necessary reforms.
    - *Without doing so, messaging risks triggering skepticism that incremental changes — including our change goals — can make a meaningful impact.*
- Messaging should aim to address skepticism of government's ability to implement changes of any scale and counter dominant narratives of waste, fraud, and abuse.

3 Incremental solutions feel more feasible, but support varies – with notable alignment among public health system leaders around hospital accountability.

		Policymakers	Public System Leaders	Private System Leaders
A	Lower out-of-pocket costs in the form of copays, deductibles, premiums, and cost-sharing	**High support among most**, but can depend on how it would be achieved		
B	Set universal eligibility standards for hospital financial assistance programs, including presumptive eligibility and standardized applications (for example through language access standards)	Some support among all	**High support among most**	Mixed views
C	Expand the comprehensiveness of health coverage, including through expansion of Essential Health Benefits (EHB) Benchmark Plans	Mixed views	Mixed views	Some support among all
D	Strengthen oversight of nonprofit hospitals by enforcing community benefit standards, scrutinizing tax exemption misuse, and regulating healthcare mergers	Mixed views	**Very high support among all**	Mixed views
E	Restrict the promotion and use of medical credit cards and other predatory medical payment products	Some support among all	Mixed views due to limited knowledge	Mixed views due to limited knowledge
F	*[DECOY]: Reduce regulatory barriers that limit insurer competition, including allowing interstate sales of health insurance plans and supporting policies that prevent local provider monopolies*	*Mixed views ranging from strong support to strong opposition*		
G	[STRETCH GOAL]: Ensure everyone in the United States can access government-funded health insurance (e.g., Medicare for all)	Mixed views	**High support among most**	**High support among most**
H	Provide, maintain and expand state-funded coverage for immigrants (for example by raising state revenue)	Mixed views	**High support among most**	Mixed views
I	Establish a cap on hospital prices	Mixed views	**Very high support among all**	Mixed views

3

Incremental solutions feel more feasible, but support varies – with notable alignment among public health system leaders around hospital accountability.

"Hospital price growth historically has been off the rails and there really aren't any good comprehensive tools that we have to reign in those costs. It's put us on an unsustainable trajectory, and that means businesses are paying higher premiums than they really should. Consumers are paying way more, and that drives up deductible costs then too, which puts care out of reach." — PUBLIC HEALTH SYSTEM LEADER, BLUE STATE (PERSUASION & ACTIVATION INTERVIEW)

"How much are medical credit cards happening? I don't like predatory medical payment products — that all sounds terrible — but I also think that some people who can't pay otherwise might need this. I don't think that this is the problem that we're trying to solve." — PUBLIC HEALTH SYSTEM LEADER, BLUE STATE (PERSUASION & ACTIVATION INTERVIEW)

"I think there is really good evidence that hospital prices are one of the key drivers of cost." — PUBLIC HEALTH SYSTEM LEADER, BLUE STATE (PERSUASION & ACTIVATION INTERVIEW)

"We set expectations that hospitals have these programs, but without more explicit guidance of who should we cover and how they should be notified, it creates a lot of room for variation. It is confusing for patients and it is unequal among hospitals. I think more clarity will help patients and will be more fair, consistent for the hospitals." — PRIVATE HEALTH SYSTEM LEADER (PUBLICLY-FUNDED), RED STATE (PERSUASION & ACTIVATION INTERVIEW)

"I've noticed in healthcare policy in [state] is that there is a heavy focus on hospitals and, look, they are part of the ecosystem. They should be a heavy focus but I don't think it should be the only focus. I think that if we're going to actually have solutions it has to be everyone is going to have to play a role in that." — POLICYMAKER, BLUE STATE (PERSUASION & ACTIVATION INTERVIEW)

3

Incremental solutions feel more feasible, but support varies – with notable alignment among public health system leaders around hospital accountability.

"Some of the issues on medical debt — it's not getting at the heart of the problem. It's still not addressing the prices. They need to lower the freaking prices. The [solutions on medical debt] — I did not see as actually addressing the problem." — PUBLIC HEALTH SYSTEM LEADER, BLUE STATE (PERSUASION & ACTIVATION INTERVIEW)

"Many of [the change goals] are incremental steps in the right direction. [...] Incremental steps in the right direction are always a good thing to do as long as you are mindful that they are incremental steps and that there are really bigger steps that are needed. But it is always a good idea if you can grab a quarter of a loaf or a half of loaf. That is better than none as long as you keep your eye on the bigger picture." — POLICYMAKER, BLUE STATE (MINDSET INTERVIEW)

"I think you need to keep what we have in place today from the infrastructure. You need to keep the expanded coverage in Marketplaces and the Medicaid expansion [...] I don't think it is pragmatic that we would just completely start all over. We know there are value-based models where we actually embrace populations of people and empower them with education and resources, knowledge, and all of the access they need that we can improve health outcomes and lifestyles. We also know there is some waste and abuse in the system [...] There is a lot more room for efficiency in the system." — PRIVATE HEALTH SYSTEM LEADER, PURPLE STATE (MINDSET INTERVIEW)

"I think Medicare for All still is the most controversial. [...] Maybe there is an incremental way to do it that would make a difference; for example, creating your essential health benefit plan that is national, that everybody gets access to primary care. Start there. [...] I can't in my heart say it is not feasible because it has to be. But I do think that is going to be the [idea on this list] that people have the most opposition for and has been the recipient of the most kind of controversial and political attacks." — PUBLIC HEALTH SYSTEM LEADER, BLUE STATE (MINDSET INTERVIEW)

3 Incremental solutions feel more feasible, but support varies – with notable alignment among public health system leaders around hospital accountability.

What this means for our messaging:

- Messaging about solutions news to include both "why this matters" and "how it works" to increase familiarity and strengthen beliefs about feasibility.
- Messaging should be tailored to address unique concerns about solutions from each audience type (policymakers, public health system leaders, and private health system leaders).
- Messaging for public health system leaders should aim to activate existing support for policies that hold hospitals accountable for lowering costs.

4 Politics, rising costs, and loss of coverage are creating a sense of urgency to act — and for some, a strategic opening to reconsider potential solutions.

- Many health care leaders in our research describe operating in a crisis-like environment, navigating recent and anticipated cuts that are affecting operations, staffing, and care delivery. This instability has prompted some to question long-standing constraints and explore reforms that previously felt out of reach.
- However, not all research participants share the same level of openness to structural reforms, and describe organizational risk tolerance, perceived political exposure, and the ability to absorb change as factors that diminish their support or fuel skepticism.
- Despite these challenges, many research participants continue to point to both recent cuts to health care and looming impacts yet to be seen as a strategic opportunity to build momentum for significant systemic transformations.

4

Politics, rising costs, and loss of coverage are creating a sense of urgency to act — and for some, a strategic opening to reconsider potential solutions.

"In the next five years, will single payer be very seriously considered? I think it will. I think anybody who's not getting ready and figuring out which side they're on is missing it. Because these costs are out of control, states cannot afford health insurance. Employers cannot afford health insurance. It's going to cause a very loud outcry when people on Medicaid lose their coverage and all the downstreaming impacts will cause it to come in a major way." — PUBLIC HEALTH SYSTEM LEADER, BLUE STATE (PERSUASION & ACTIVATION INTERVIEW)

"I think this issue of healthcare cost is becoming a more immediate problem for employers than ever before. I do wonder at what point the employers start to exert pressure to change the system. I think the political pressure that big employers can bring to bear is going to be an important lever to effect change at the federal level." — PRIVATE HEALTH SYSTEM LEADER (PUBLICLY-FUNDED), RED STATE (PERSUASION & ACTIVATION INTERVIEW)

"The enhanced premium tax credits went away at the beginning of this year. I think we're going to see in the absence of that a real increased instability both for consumers who won't be able to afford their coverage as well as providers because they will be seeing far more uninsured patients, which obviously is detrimental to them." — PUBLIC HEALTH SYSTEM LEADER, BLUE STATE (PERSUASION & ACTIVATION INTERVIEW)

"I think as policymakers we need to be really conscious at a state level of not making the situation any worse. The healthcare system is like a tinderbox right now with what [the federal government] is doing. The climate and the temperature is hot between the two parties, but it is also getting hot within the parties, which is an interesting dynamic." — POLICYMAKER, BLUE STATE (PERSUASION & ACTIVATION INTERVIEW)

4

Politics, rising costs, and loss of coverage are creating a sense of urgency to act — and for some, a strategic opening to reconsider potential solutions.

"Healthcare — there's just so much to work on all the time, and there's so much to still resolve all the time. And so now we're dealing with federal cuts. I didn't anticipate that, so now that's the big thing." — POLICYMAKER, BLUE STATE (PERSUASION & ACTIVATION INTERVIEW)

"[My ideal health system] would be universal health care, number one. [...] There's too many organizations that are invested in making money [...] Even when the Affordable Care Act was introduced, it took a lot to get healthcare organizations to support it. This profit motive in healthcare, I think, needs to be managed in some way. [...] And now, politics in general, but [especially] politics around healthcare, are so polarizing, I can't imagine. I think we're stuck with the system that we have. I'm absolutely pessimistic about change."
— PUBLIC HEALTH SYSTEM LEADER, BLUE STATE (MINDSET INTERVIEW)

"[Ideally we would have] a common system. [...] It almost doesn't matter whether it is government run, government funded but privately executed, or government insured [...] I hear more than ever before from employers that just can't afford it anymore. [...] I've got to believe at some point the employers are going to wake up and demand something. [...] I don't see that happening with this administration, but in subsequent administrations with strong leadership, because I think there is enough growing level of frustration in the general public that the appetite is growing to do something."
— PRIVATE HEALTH SYSTEM LEADER (PUBLICLY-FUNDED), RED STATE (MINDSET INTERVIEW)

"We are at a tipping point. If people can't afford insurance premiums but the underlings in the industries are laughing all the way to the bank…people like me have to step in and connect the dots for people and what is causing this and what to do about it? [...] The capitalistic system here has driven the health care system, the biggest part of the economy, to its knees. [...] When I say tipping point: it is starting to be time for single payer where the people are going to get hit so hard [...] At some point people go, 'I was not going to entertain that 5 years ago, 10 years ago. I have run out of options.'"
— PUBLIC HEALTH SYSTEM LEADER, BLUE STATE (MINDSET INTERVIEW)

4 Politics, rising costs, and loss of coverage are creating a sense of urgency to act — and for some, a strategic opening to reconsider potential solutions.

What this means for our messaging:

- Messaging should lean into urgency by framing the current instability as an opportunity to rethink what's possible, rather than using only crisis framing.
- Messaging should affirm health system leaders' and policymakers' desire for structural/systemic changes while balancing what's realistic in the short term, offering concrete actions they can take within the limits of their roles.

5 Responsibility is tangled in a ‘web’ of obligation, blame, and deference among key players.

- Research participants often pointed to concerns about **perceived political implications for speaking out** of the bounds of their own role — for example, state agency officials are unwilling to speak out in support of policies their governor has not voiced support for, regardless of their own views.
- Research participants often **assigned responsibility or blame for problems** within the health care system by pointing to key actors or stakeholder groups outside of their own — for example, when it comes to high costs, hospital system leaders tend to blame insurers and “middlemen” like brokers, pharmacy benefit managers, and pharmaceutical companies; state officials tend to blame hospitals and insurers; and policymakers tend to blame union interests.
- Research participants readily name the **political and financial implications of disrupting entrenched interests** — for example, policymakers pointed to union lobbies as standing in the way of changes that would disrupt the employer-based health insurance system.

5

Responsibility is tangled in a 'web' of obligation, blame, and deference among key players.

"Absent a universal solution, different groups are going to feel singled out. If we talk about financial eligibility standards for hospitals, they are going to point to insurance companies, or to government payers. I think the piecemeal approach is important because those are practical things that will impact patients today and so we should absolutely continue to pursue them, but they become difficult because the way that our healthcare system is fragmented. You've got these different entrenched interests that can point to each other and resist universal reform." — PRIVATE HEALTH SYSTEM LEADER (PUBLICLY-FUNDED), RED STATE (PERSUASION & ACTIVATION INTERVIEW)

"Consumers and employers cannot fix the system. Our elected officials are the only ones that are able to do it. And elected officials are swayed by big money that comes from hospital associations, physician associations, and insurance carriers. But there is so little courage at the elected official level." — PUBLIC HEALTH SYSTEM LEADER, BLUE STATE (PERSUASION & ACTIVATION INTERVIEW)

"[Unions] hate that they've negotiated for healthcare and now we would be somehow taking it out of that negotiation. I tried to bring this issue back this year to see whether or not there was any political will, and we received so many more negative memos on it than I could have imagined possible." — POLICYMAKER, BLUE STATE (PERSUASION & ACTIVATION INTERVIEW)

"There are a lot of competing pressures. [Universal health care] is more of a longer term conversation and challenge. I would be limited in the role that I'm in. I am not going to get out ahead of the governor, for example." — PUBLIC HEALTH SYSTEM LEADER, PURPLE STATE (PERSUASION & ACTIVATION INTERVIEW)

5

Responsibility is tangled in a 'web' of obligation, blame, and deference among key players.

"I work for a large healthcare system and so I don't think it is my place to do that [speak out about universal health care] because it might be viewed as speaking for the organization inappropriately." — PRIVATE HEALTH SYSTEM LEADER, BLUE STATE (PERSUASION & ACTIVATION INTERVIEW)

"We are talking about billions and billions of dollars that hospitals and other providers, health insurers have invested in these systems that work this way, and so to make any changes to those systems is going to be costly for one or more or likely all of those three. And so it is really hard to make those kinds of big changes without negative repercussions to the system." — PRIVATE HEALTH SYSTEM LEADER, PURPLE STATE (MINDSET INTERVIEW)

"I always try to think of the consumer first. [...] Secondarily you think of what the impact is on the regulated community from a cost perspective because obviously there needs to be a cost benefit analysis. [...] I don't want to do something that costs the company millions of dollars — because how do they offset their cost? It comes back to the consumer at the end of the day. So there is a balancing act there." — PUBLIC HEALTH SYSTEM LEADER, PURPLE STATE (MINDSET INTERVIEW)

"You can look at how the Affordable Care Act system was implemented over the course of the last 20+ years [...] There has been a lot of backlash along the way. It hasn't been an easy process even though it has, by and large, worked the way that it was intended. But it has been hard for providers. It has been hard for insurers. It has been hard for the general public. And the things that we're talking about are even sort of bigger changes than that." — PRIVATE HEALTH SYSTEM LEADER, PURPLE STATE (MINDSET INTERVIEW)

5 Responsibility is tangled in a ‘web’ of obligation, blame, and deference among key players.

What this means for our messaging:

- Messaging should acknowledge the complexity of problems and solutions without assigning or shifting blame between actors in the system.
- Messaging should avoid naming specific villains, which risks “outgrouping” essential stakeholders and triggering defensiveness that hinders action.
- Messaging should reframe change as a shared responsibility, requiring coordinated action from multiple actors across the system.

6 New and unexpected messengers can boost the credibility of messaging.

- Research participants named that some of the messengers in content we tested were surprising to see included and were compelling to hear from — including employers, medical professionals, and hospital system leaders.
- While health system leaders often hear from patients and consumers, they hear less frequently from physicians with administrative experience and from employers — groups they view as important but underrepresented in current health care discussions.
- Messages were particularly effective when these unexpected messengers described a change-of-heart they have had on a particular solution and what led them to change their position.

6

New and unexpected messengers can boost the credibility of messaging.

"[The op-ed] may gain, perhaps, more credibility by coming from an unlikely source: a health system leader. Health system leaders typically are not going to favor universal public funding or single payer system. Coming from somebody who is within the system advocating that point of view makes it maybe a little bit more trustworthy, believable." — PRIVATE HEALTH SYSTEM LEADER (PUBLICLY-FUNDED), RED STATE (PERSUASION & ACTIVATION INTERVIEW)

"I think the medical establishment has long been on the other side of this for a wide variety of reasons. I think it is compelling to hear from somebody like this who's had a shift in their mindset about it."
— PUBLIC HEALTH SYSTEM LEADER, BLUE STATE (PERSUASION & ACTIVATION INTERVIEW)

"I wonder about [...] letters that come from different audiences. What would be powerful would be to get a number of signatories or people who submit their own letters as patients, providers, EMTs, community members, policymakers, physicians, nurses, executives and payers — from urban areas, from rural areas, from right-leaning areas, from left-leaning areas, from people who voted Independent — to make it harder for someone to dismiss this as this is just one specific issue for a population." — PRIVATE HEALTH SYSTEM LEADER, BLUE STATE (PERSUASION & ACTIVATION INTERVIEW)

6

New and unexpected messengers can boost the credibility of messaging.

"Employers need to be more engaged in this conversation than they are. Because the majority of people in this country get coverage from their employers and employers are often the most resistant to change. One of the reasons that there hasn't been more aggressive changes at the federal level."
— PUBLIC HEALTH SYSTEM LEADER, BLUE STATE (PERSUASION & ACTIVATION INTERVIEW)

"I appreciated that this was a doctor and administrator. I think explaining it from a physician who also was responsible for managing a hospital, I think was a very good choice." — PUBLIC HEALTH SYSTEM LEADER, BLUE STATE (PERSUASION & ACTIVATION INTERVIEW)

"It would be helpful to hear from employers what their experience is, what their employees want, why they can and cannot provide insurance, what's available to them in the market, and what would be a better system for them to support their employees, who they want to be healthy and work."
— PUBLIC HEALTH SYSTEM LEADER, BLUE STATE (PERSUASION & ACTIVATION INTERVIEW)

6 New and unexpected messengers can boost the credibility of messaging.

What this means for our messaging:

- Messaging should be deployed through a diverse set of messengers that includes unexpected actors and stakeholders within the health care system.
- Especially when communicating to hard-to-persuade audiences, messaging should feature a change-of-heart the messenger experienced about an idea or policy.

7 Framing change as a shared responsibility can inspire hope and motivate action.

- Health care leaders consistently refer back to their commitment to patient outcomes as a major factor in decision-making and respond positively to messaging that demonstrates and affirms how proposed solutions are grounded in this shared core value.
- Some research participants expressed high levels of compassion fatigue for the challenges patients and consumers face related to cost and coverage and cynicism about the feasibility of change.
- Research participants recognize the complexity of the problem and, therefore, believe the solutions will require multiple different stakeholders working together.
- Despite the fatigue and complexity, many research participants expressed a sense of optimism after engaging with the test content, suggesting a strong appetite for sources of hope and opportunities to take action amid challenging conditions.

7

Framing change as a shared responsibility can inspire hope and motivate action.

"It's going to take everybody. That includes legislators and hospitals, doctors, community leaders. We need to all sit in a room. It should be non-political. Healthcare should never be political in any shape, form, or fashion — and public health should never be political, but it is. [...] Let's build from what we agree on to try to come up with a solution." — PRIVATE HEALTH SYSTEM LEADER, RED STATE (PERSUASION & ACTIVATION INTERVIEW)

"It makes me feel like sometimes the system is so large, it seems like there's nothing we can do to really make a change. Seeing concrete examples that have worked at the state level helps remind me that we should always be working to make it better and that there are options out there to help. There's a better way to do things." — PUBLIC HEALTH SYSTEM LEADER, BLUE STATE (PERSUASION & ACTIVATION INTERVIEW)

"If you want really broad change, you have a lot of different people with different trusted sources of information that you need to bring in [...] I think it is actually the combination that matters more than any individual — to have a business leader, a consumer, to have a physician leader — that's how you create the movement because some people may roll their eyes at the consumer, but care what the CEO has to say, and some people may roll their eyes at the CEO and care what the consumer has to say."
— PUBLIC HEALTH SYSTEM LEADER, BLUE STATE (PERSUASION & ACTIVATION INTERVIEW)

7

Framing change as a shared responsibility can inspire hope and motivate action.

"There are pressures from all different sides. You have to look at the ecosystem as a whole, if you are going to address cost in the system, access challenges, costs for consumers."— PUBLIC HEALTH SYSTEM LEADER, PURPLE STATE (PERSUASION & ACTIVATION INTERVIEW)

"At the end of the day, for God's sakes, people should have healthcare and if there's a way to do it, period. The shift [in my support] is the reservations related to, well… How practical is it? I think I gave up that concern. I think what's really important is: how do you have a system that supports people getting the care that they need? Nobody should be screwed in this regard or disadvantaged and not have access."
— PRIVATE HEALTH SYSTEM LEADER, RED STATE (PERSUASION & ACTIVATION INTERVIEW)

"Understanding at the end of the day, the patient experience, the human experience — and that a lot of people who are otherwise pretty stable in their lives can be completely destabilized by the way that our healthcare system works. Our healthcare system is pretty broken and it needs a lot of people to fix it. I find constant value in being a part of those solutions."— PUBLIC HEALTH SYSTEM LEADER, BLUE STATE (PERSUASION & ACTIVATION INTERVIEW)

7 Framing change as a shared responsibility can inspire hope and motivate action.

What this means for our messaging:

- Messaging should affirm the values we share with health system leaders and policymakers and ground specific solutions in a hopeful vision for a health care system that better serves patients and consumers.
- Messaging about solutions that have been implemented should highlight how various stakeholders in the health care system worked together to improve the system.

Messaging Recommendations for Persuading & Activating Health System Leaders & Policymakers

Messaging Strategy for Advocates to Persuade & Activate Health System Leaders & Policymakers

1. **Build a portfolio of different types of content to meet different needs.** Consider case studies, patient stories, op-eds, fact sheets, policy briefs, and more, which can be tailored for both activation and persuasion.
2. **Deploy a diverse set of credible and unexpected messengers.** Consider patients, employers, medical professionals, and hospital system leaders — particularly across the spectrum of political ideologies — who are willing to speak out with new perspectives.
3. **Use examples and proof points about what works to reinforce feasibility and legitimacy of solutions.** Consider drawing examples from a range of geographically and politically diverse states.
4. **Segment by audience whenever possible.** Consider how your messaging can focus on one audience's key constraints and concerns.

Heartwired Principles for Messaging

Wonder leads deep audience research to understand what Heartwired factors — emotions, identity, lived experiences, values, or beliefs — might hinder audiences' support. We also use research to learn about the specific elements that make up an effective messaging intervention. Through our decades of experience in progressive social change, we have identified **five principles** that contribute to successful messaging interventions. We define success by the ability of messaging interventions to persuade conflicted audiences, strengthen support for an idea or an issue, and ultimately lead to change.

Together, these five principles are a blueprint for communicating effectively with conflicted audiences — those who experience moral ambivalence and struggle between competing beliefs and values. The principles are important because they meet deeper psychological and emotional needs that conflicted audiences have in arriving at support for an idea or an issue.

#1

Build trust

Establish trust to effectively communicate and connect with your audiences.

#2

Acknowledge complexity

Demonstrate that you understand people's conflict.

#3

Calm concerns

Address the powerful emotions that audiences experience on your issue.

#4

Nurture compassion

Highlight a common sense of humanity and show audiences why they should care.

#5

Activate hope

Spotlight effective solutions to inspire optimism and hope.

How to Build Trust

- Have messengers speak to shared values around health care and name their wholesome motivations for speaking out: care and compassion for patients, constituents, and consumers.

- Affirm health system leaders' and policymakers desire for a better, more functional health care system that proactively meets patients' needs.

- When available, cite well-respected, politically neutral, and trusted sources, such as RAND, KFF, or JAMA to boost credibility.

"Ultimately, I think you are trying to build trust — and trust comes, in my view, from logic, which is often data. It comes from empathy, so the audience feels like you understand them and care about them, and authenticity like you are sharing your own perspective in a consistent way."
—PRIVATE HEALTH SYSTEM LEADER, BLUE STATE (PERSUASION & ACTIVATION INTERVIEW)

How to Acknowledge Complexity

- Name specific structural factors that health system leaders and policymakers already identify as barriers — for example, profit motives, fragmentation, variation across states and systems, and complexity.

- Acknowledge that significant structural changes may not be feasible in the short term.

- Introduce incremental solutions in the context of a longer-term vision for a better system and describe how smaller or shorter-term solutions help us get there.

> "Not surprisingly, there are some people that love the way the system works now because it works in their favor. They're making money. They don't care. They're not policy people in healthcare. They're running a hospital system or they're running a physician group and it's survival of the fittest. There might be some superficial things they do around quality because they have to meet metrics that the government puts out, but they're in their own world. It's kind of like, 'Don't touch my stuff. Don't mess with what I have because I'm pretty happy with it right now.' The system's complicated."
> —PRIVATE HEALTH SYSTEM LEADER (PUBLICLY-FUNDED), BLUE STATE (PERSUASION & ACTIVATION INTERVIEW)

How to Calm Concerns

- Cite a few impactful data points that demonstrate the proven or predicted impact of a solution.
- Clarify how proposed solutions work in practice, including by naming multiple actors in the health system who would need to act and how they would be impacted.
- Position the government as a lever for change. To do so, cite evidence and examples of where and how similar policy changes have been successful through coordinated government action in a range of different levels of government and political contexts.

"What I have seen entirely lacking from the single payer movement is a practical path to the end goal. I don't believe you can just erase and replace. Even if you can get people to agree that our current system is broken and we need a unified financing system, what does that look like and how do you actually get there? What happens to all the people who get coverage from their job and how does what they're going to get compared to what they have today? And how does it change how providers are paid and they've built their lives off of a certain income? And can you change their income? And if so, what does that mean for the economic ripple effects?"
—PUBLIC HEALTH SYSTEM LEADER, BLUE STATE (PERSUASION & ACTIVATION INTERVIEW)

How to Nurture Compassion

- Highlight patient stories, testimonials, or quotes to show how people are impacted, why solutions are needed, and the scope of how many patients will benefit.
- Have messengers — especially peer health system leaders and decision-makers — describe a change of heart they experienced on a solution or idea. Highlight what the messenger learned that changed their perspective in order to model that shift for others to follow.
  - Change-of-heart story formula:
    "I used to think_____,
    but then I learned/experienced _____.
    Now I think _____."

"The patient stories are the most compelling because I think — at the end of the day — what legislators really listen to and respond to in large part are real people and real stories."
—PUBLIC HEALTH SYSTEM LEADER, BLUE STATE (PERSUASION & ACTIVATION INTERVIEW)

"The [article] from the CEO who said, 'Here's what I thought. Here's what I think now.' That's compelling in a way that's just right."
—PRIVATE HEALTH SYSTEM LEADER, RED STATE (PERSUASION & ACTIVATION INTERVIEW)

How to Activate Hope

- Lay out concrete, actionable steps for implementation when advocating for a solution.
- Describe one or two ways your audience can realistically take action within the limits of their role, and highlight similar actions taken by their peers.
- Connect solutions back to values that we share with leaders — like care and compassion for patients — and our vision for a better health care system.

"[In my previous role] it was like, if everybody walked out of the room just a little ticked off, you probably did the right thing, which may sound crazy. You are not going to make everybody happy, but if you can get everybody to come to the table and compromise [...] We need to determine what the outcome needs to be and what we can all agree on and then figure out how we get there."

— POLICYMAKER, BLUE STATE (MINDSET INTERVIEW)

Overview of Test Content

State Policy Brief

DESCRIPTION

A piece from a trusted health care trade publication highlighting real-world examples from across the country that reflect our change goals, showing that policies that reduce patient financial burdens are already feasible, financially responsible, and scalable.

[View the full content here.]

Note: *This content contains fictionalized elements and should not be distributed. Real stories and data were used in the development of the content, but names and details were changed for the purposes of message testing.*

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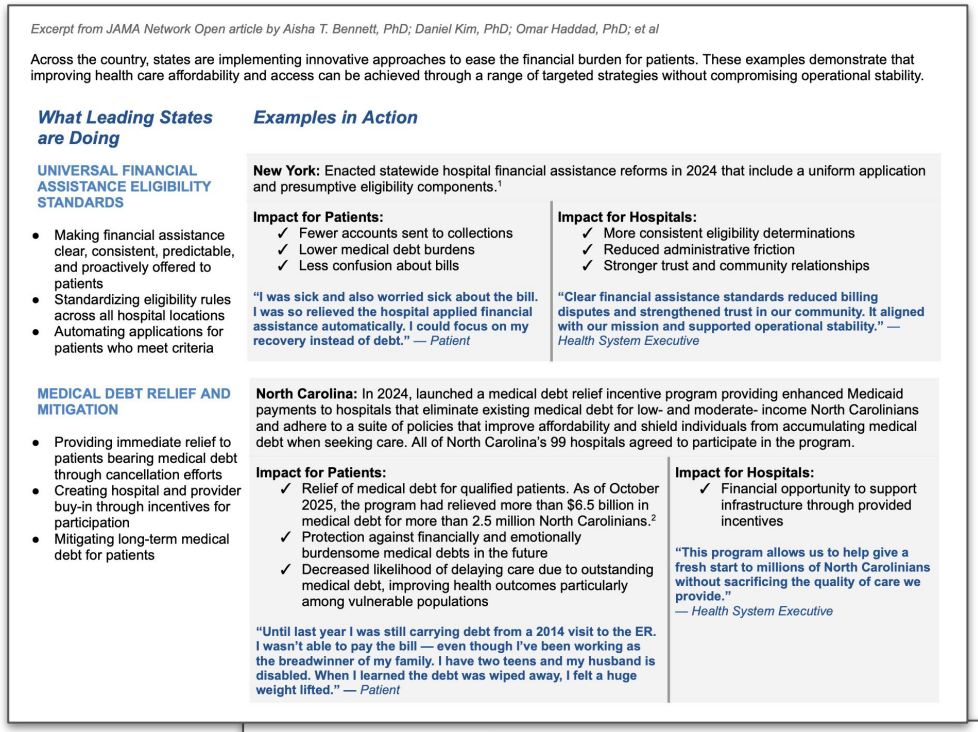
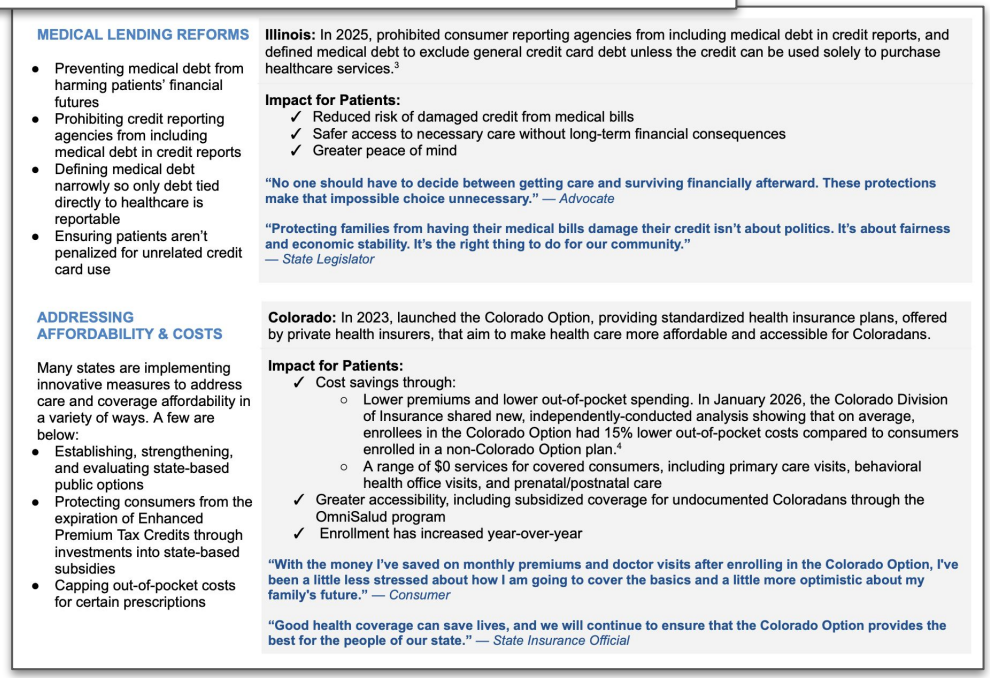


Excerpt from JAMA Network Open article by Aisha T. Bennett, PhD; Daniel Kim, PhD; Omar Haddad, PhD; et al

Across the country, states are implementing innovative approaches to ease the financial burden for patients. These examples demonstrate that improving health care affordability and access can be achieved through a range of targeted strategies without compromising operational stability.

What Leading States are Doing	Examples in Action
UNIVERSAL FINANCIAL ASSISTANCE ELIGIBILITY STANDARDS • Making financial assistance clear, consistent, predictable, and proactively offered to patients • Standardizing eligibility rules across all hospital locations • Automating applications for patients who meet criteria	**New York:** Enacted statewide hospital financial assistance reforms in 2024 that include a uniform application and presumptive eligibility components.[1] **Impact for Patients:** ✓ Fewer accounts sent to collections ✓ Lower medical debt burdens ✓ Less confusion about bills **"I was sick and also worried sick about the bill. I was so relieved the hospital applied financial assistance automatically. I could focus on my recovery instead of debt."** — *Patient* **Impact for Hospitals:** ✓ More consistent eligibility determinations ✓ Reduced administrative friction ✓ Stronger trust and community relationships **"Clear financial assistance standards reduced billing disputes and strengthened trust in our community. It aligned with our mission and supported operational stability."** — *Health System Executive*
MEDICAL DEBT RELIEF AND MITIGATION • Providing immediate relief to patients bearing medical debt through cancellation efforts • Creating hospital and provider buy-in through incentives for participation • Mitigating long-term medical debt for patients	**North Carolina:** In 2024, launched a medical debt relief incentive program providing enhanced Medicaid payments to hospitals that eliminate existing medical debt for low- and moderate- income North Carolinians and adhere to a suite of policies that improve affordability and shield individuals from accumulating medical debt when seeking care. All of North Carolina's 99 hospitals agreed to participate in the program. **Impact for Patients:** ✓ Relief of medical debt for qualified patients. As of October 2025, the program had relieved more than $6.5 billion in medical debt for more than 2.5 million North Carolinians.[2] ✓ Protection against financially and emotionally burdensome medical debts in the future ✓ Decreased likelihood of delaying care due to outstanding medical debt, improving health outcomes particularly among vulnerable populations **"Until last year I was still carrying debt from a 2014 visit to the ER. I wasn't able to pay the bill — even though I've been working as the breadwinner of my family. I have two teens and my husband is disabled. When I learned the debt was wiped away, I felt a huge weight lifted."** — *Patient* **Impact for Hospitals:** ✓ Financial opportunity to support infrastructure through provided incentives **"This program allows us to help give a fresh start to millions of North Carolinians without sacrificing the quality of care we provide."** — *Health System Executive*



MEDICAL LENDING REFORMS • Preventing medical debt from harming patients' financial futures • Prohibiting credit reporting agencies from including medical debt in credit reports • Defining medical debt narrowly so only debt tied directly to healthcare is reportable • Ensuring patients aren't penalized for unrelated credit card use	**Illinois:** In 2025, prohibited consumer reporting agencies from including medical debt in credit reports, and defined medical debt to exclude general credit card debt unless the credit can be used solely to purchase healthcare services.[3] **Impact for Patients:** ✓ Reduced risk of damaged credit from medical bills ✓ Safer access to necessary care without long-term financial consequences ✓ Greater peace of mind **"No one should have to decide between getting care and surviving financially afterward. These protections make that impossible choice unnecessary."** — *Advocate* **"Protecting families from having their medical bills damage their credit isn't about politics. It's about fairness and economic stability. It's the right thing to do for our community."** — *State Legislator*
ADDRESSING AFFORDABILITY & COSTS Many states are implementing innovative measures to address care and coverage affordability in a variety of ways. A few are below: • Establishing, strengthening, and evaluating state-based public options • Protecting consumers from the expiration of Enhanced Premium Tax Credits through investments into state-based subsidies • Capping out-of-pocket costs for certain prescriptions	**Colorado:** In 2023, launched the Colorado Option, providing standardized health insurance plans, offered by private health insurers, that aim to make health care more affordable and accessible for Coloradans. **Impact for Patients:** ✓ Cost savings through: ○ Lower premiums and lower out-of-pocket spending. In January 2026, the Colorado Division of Insurance shared new, independently-conducted analysis showing that on average, enrollees in the Colorado Option had 15% lower out-of-pocket costs compared to consumers enrolled in a non-Colorado Option plan.[4] ○ A range of $0 services for covered consumers, including primary care visits, behavioral health office visits, and prenatal/postnatal care ✓ Greater accessibility, including subsidized coverage for undocumented Coloradans through the OmniSalud program ✓ Enrollment has increased year-over-year **"With the money I've saved on monthly premiums and doctor visits after enrolling in the Colorado Option, I've been a little less stressed about how I am going to cover the basics and a little more optimistic about my family's future."** — *Consumer* **"Good health coverage can save lives, and we will continue to ensure that the Colorado Option provides the best for the people of our state."** — *State Insurance Official*

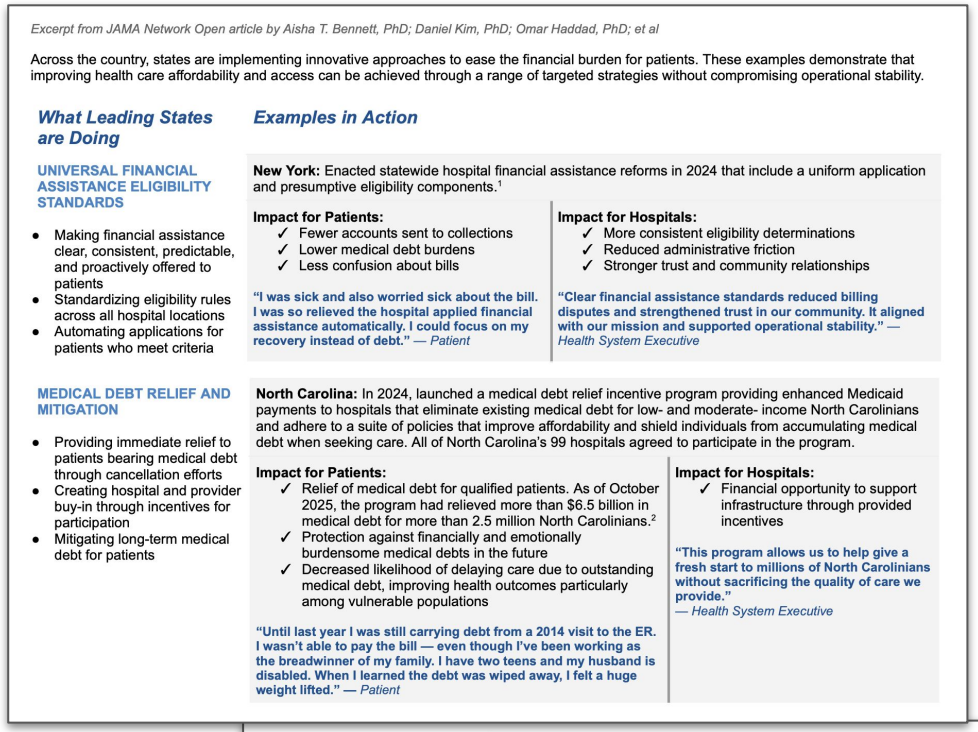
State Policy Brief

WHAT WORKED

- Providing real-life examples of implemented solutions from a range of states, including politically red, blue, and purple states
- Including short testimonials from diverse perspectives
- Featuring trusted sources many are already looking to for the latest research

WHY IT WORKED

- Shows proof (doesn't just tell) that a solution is possible
- Equips audiences already somewhat open to a specific idea to start conversations with others
- Sparks curiosity among those less familiar with or less open to a specific idea



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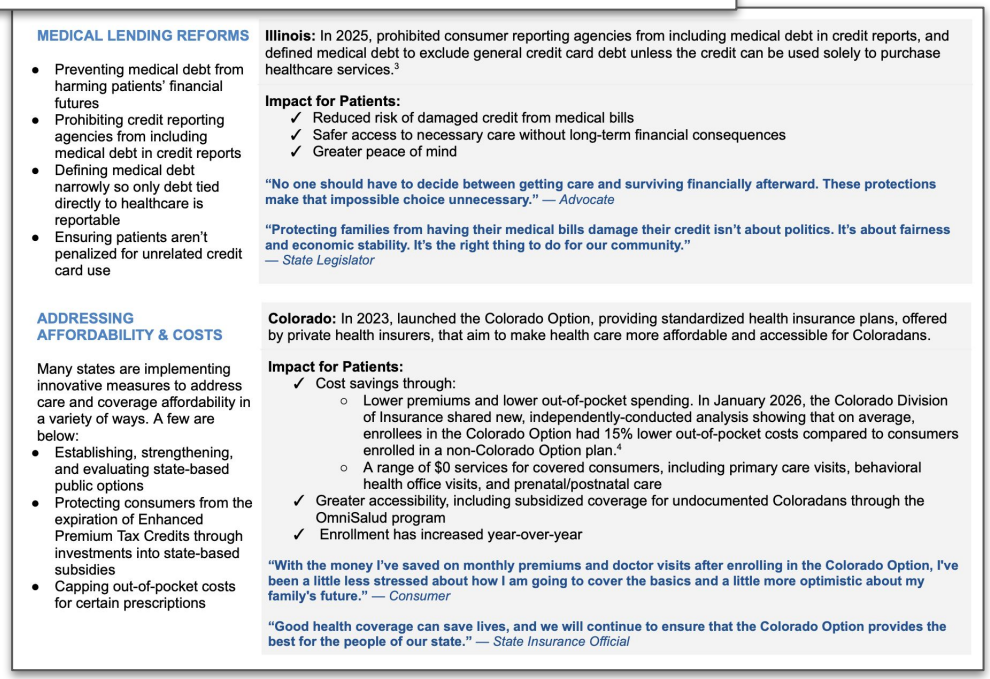

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Reactions to State Policy Brief

"I think they all work well together in the cohesiveness of the approach. I read reports along these lines all the time. It is hard to find reports that are a holistic look at the system. A lot of reports will just focus on one area — like medical debt, or provider costs, or insurance costs — without putting the broader ecosystem on the page. I think that is both the challenge and the opportunity: you have to address everything together to catch all the moving pieces."
— PUBLIC HEALTH SYSTEM LEADER, PURPLE STATE

"It is a combination of states across the political spectrum who are pursuing a broad range of policy options. From the outcomes that are listed here, it looks like to some extent they are all working and achieving their goals. [It makes me think] more states should try and enact more of these policies." — PUBLIC HEALTH SYSTEM LEADER, BLUE STATE

"These kinds of activities are helpful. I think [the North Carolina example] is kind of surprising." — PRIVATE HEALTH SYSTEM LEADER, RED STATE

"What I love about it is that it's all focused on issues directly impacting people and addressing those costs both upfront and downstream, too. And I like that it's centering people's stories and hearing directly from people. It does a really nice job of succinctly putting the problem and solution right next to each other. I thought this was really well done and I really liked the proposals." — PUBLIC HEALTH SYSTEM LEADER, BLUE STATE

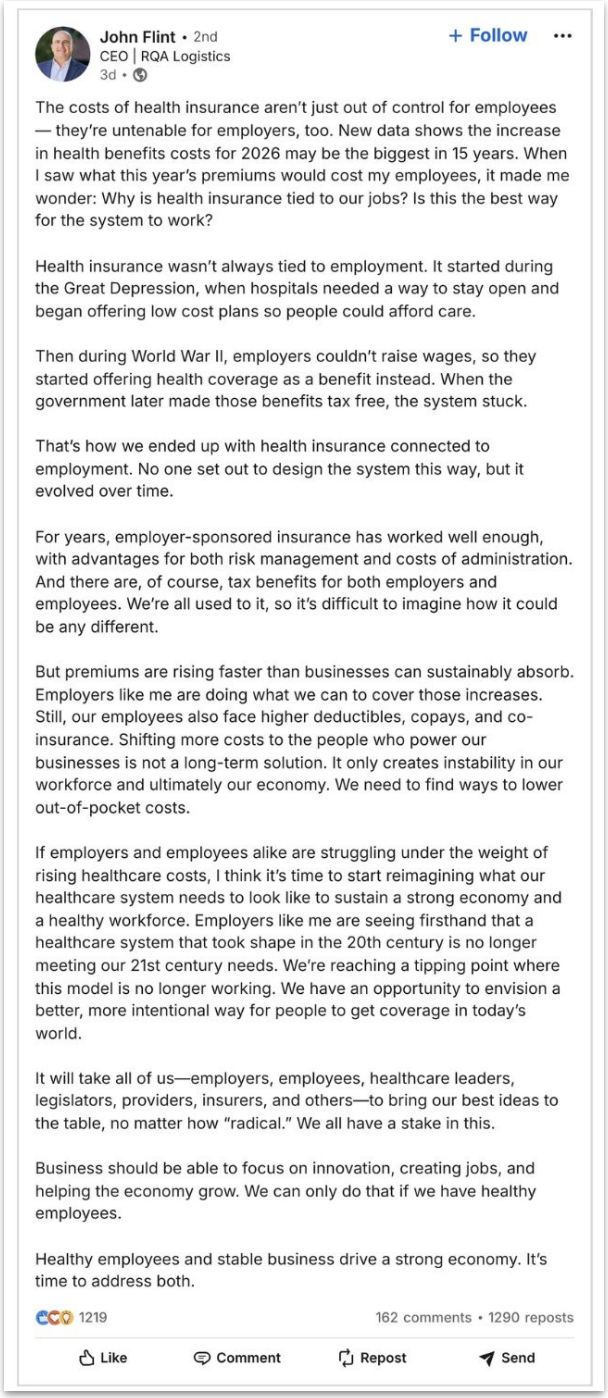
Employer Thought Leadership

DESCRIPTION

Column from an employer's perspective making an economic argument about how tying health coverage to employment creates cost and access challenges for both employees and businesses.

View the full content here.

Note: *This content contains fictionalized elements and should not be distributed. Real stories and data were used in the development of the content, but names and details were changed for the purposes of message testing.*



John Flint • 2nd
CEO | RQA Logistics
3d •
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The costs of health insurance aren't just out of control for employees — they're untenable for employers, too. New data shows the increase in health benefits costs for 2026 may be the biggest in 15 years. When I saw what this year's premiums would cost my employees, it made me wonder: Why is health insurance tied to our jobs? Is this the best way for the system to work?

Health insurance wasn't always tied to employment. It started during the Great Depression, when hospitals needed a way to stay open and began offering low cost plans so people could afford care.

Then during World War II, employers couldn't raise wages, so they started offering health coverage as a benefit instead. When the government later made those benefits tax free, the system stuck.

That's how we ended up with health insurance connected to employment. No one set out to design the system this way, but it evolved over time.

For years, employer-sponsored insurance has worked well enough, with advantages for both risk management and costs of administration. And there are, of course, tax benefits for both employers and employees. We're all used to it, so it's difficult to imagine how it could be any different.

But premiums are rising faster than businesses can sustainably absorb. Employers like me are doing what we can to cover those increases. Still, our employees also face higher deductibles, copays, and co-insurance. Shifting more costs to the people who power our businesses is not a long-term solution. It only creates instability in our workforce and ultimately our economy. We need to find ways to lower out-of-pocket costs.

If employers and employees alike are struggling under the weight of rising healthcare costs, I think it's time to start reimagining what our healthcare system needs to look like to sustain a strong economy and a healthy workforce. Employers like me are seeing firsthand that a healthcare system that took shape in the 20th century is no longer meeting our 21st century needs. We're reaching a tipping point where this model is no longer working. We have an opportunity to envision a better, more intentional way for people to get coverage in today's world.

It will take all of us—employers, employees, healthcare leaders, legislators, providers, insurers, and others—to bring our best ideas to the table, no matter how "radical." We all have a stake in this.

Business should be able to focus on innovation, creating jobs, and helping the economy grow. We can only do that if we have healthy employees.

Healthy employees and stable business drive a strong economy. It's time to address both.

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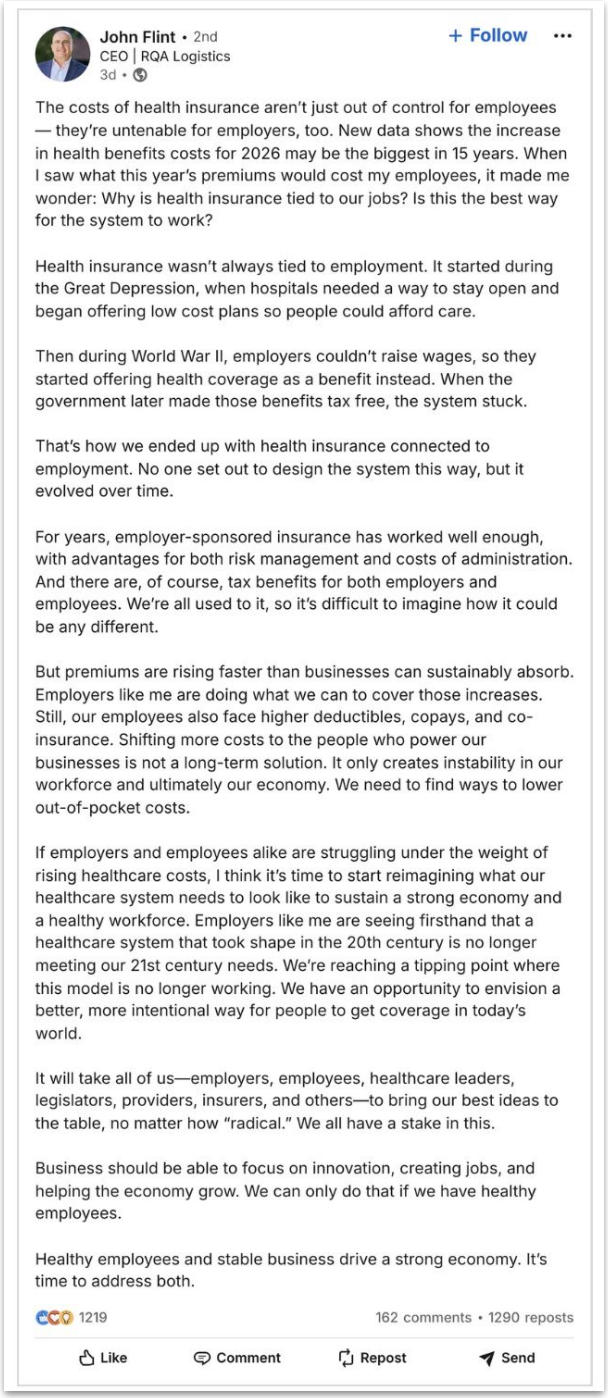
Employer Thought Leadership

WHAT WORKED

- Highlighting an employer voice and perspective that also speaks to employee impacts
- Using economic framing
- Brief historical context, clarifying that employment-based coverage was never an intentional design
- Affirming that we all have a role in building a better system

WHY IT WORKED

- Offers an uncommon perspective from a credible, often unexpected voice in health care discourse
- Moves beyond blame to shared responsibility and problem-solving
- Creates broader pressure for change by engaging employers as influential stakeholders
- Would be even more influential if the specific employer was more well-known



John Flint • 2nd
CEO | RQA Logistics
3d •
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Reactions to Employer Thought Leadership

"It's a really important framing. It provides good historical context without going too deep into the weeds. And I think the question that it raises is one of the most important things that we should be thinking about right now, which is: why are we locked into this system where we have health insurance for a huge portion of the population be tied to their job? It both looked at the employer and employee side of the equation, but I think it could have benefited from even more focusing on the employees who get stuck in jobs because they need the benefits and they don't have a reliable option that's available to everybody. [...] I think that's going to be a really important voice in reform." — PUBLIC HEALTH SYSTEM LEADER, BLUE STATE

"Absolutely. You want healthy employees, you don't want them to have mental health issues or doing drugs or making economic choices around where they work that are based on how much out-of-pocket costs they have. But he didn't give a solution. What he isn't realizing is that he has an economic stake in that he buys health insurance, but he's not a hospital, he's not a doctor, and they could likely oppose a solution that's too radical." — PRIVATE HEALTH SYSTEM LEADER (PUBLICLY-FUNDED), BLUE STATE

"Highlighting that employer-based insurance [...] showed up out of necessity and was kind of forced upon us, is great. I also think that highlighting, 'Hey, this system isn't working for you and it isn't working for me. What are we holding onto?' is great." — PUBLIC HEALTH SYSTEM LEADER, BLUE STATE

Universal Health Care Op-Ed

DESCRIPTION

A “change of heart” story from a medical professional and health system leader making the case that universal coverage is morally, economically, and practically sound.

View the full content here.

Note: *This content contains fictionalized elements and should not be distributed. Real stories and data were used in the development of the content, but names and details were changed for the purposes of message testing.*

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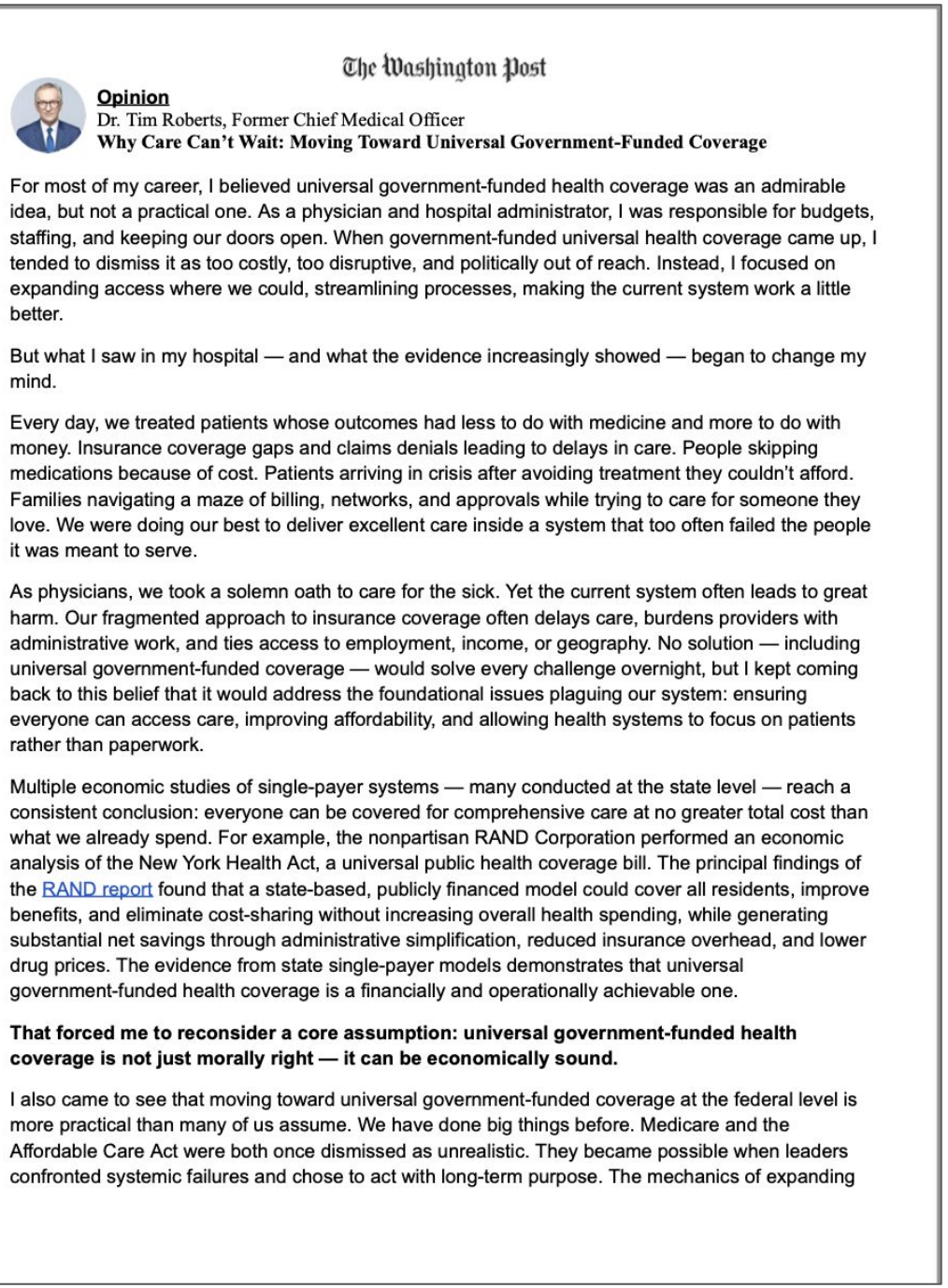

The Washington Post

Opinion

Dr. Tim Roberts, Former Chief Medical Officer

Why Care Can’t Wait: Moving Toward Universal Government-Funded Coverage

For most of my career, I believed universal government-funded health coverage was an admirable idea, but not a practical one. As a physician and hospital administrator, I was responsible for budgets, staffing, and keeping our doors open. When government-funded universal health coverage came up, I tended to dismiss it as too costly, too disruptive, and politically out of reach. Instead, I focused on expanding access where we could, streamlining processes, making the current system work a little better.

But what I saw in my hospital — and what the evidence increasingly showed — began to change my mind.

Every day, we treated patients whose outcomes had less to do with medicine and more to do with money. Insurance coverage gaps and claims denials leading to delays in care. People skipping medications because of cost. Patients arriving in crisis after avoiding treatment they couldn’t afford. Families navigating a maze of billing, networks, and approvals while trying to care for someone they love. We were doing our best to deliver excellent care inside a system that too often failed the people it was meant to serve.

As physicians, we took a solemn oath to care for the sick. Yet the current system often leads to great harm. Our fragmented approach to insurance coverage often delays care, burdens providers with administrative work, and ties access to employment, income, or geography. No solution — including universal government-funded coverage — would solve every challenge overnight, but I kept coming back to this belief that it would address the foundational issues plaguing our system: ensuring everyone can access care, improving affordability, and allowing health systems to focus on patients rather than paperwork.

Multiple economic studies of single-payer systems — many conducted at the state level — reach a consistent conclusion: everyone can be covered for comprehensive care at no greater total cost than what we already spend. For example, the nonpartisan RAND Corporation performed an economic analysis of the New York Health Act, a universal public health coverage bill. The principal findings of the RAND report found that a state-based, publicly financed model could cover all residents, improve benefits, and eliminate cost-sharing without increasing overall health spending, while generating substantial net savings through administrative simplification, reduced insurance overhead, and lower drug prices. The evidence from state single-payer models demonstrates that universal government-funded health coverage is a financially and operationally achievable one.

That forced me to reconsider a core assumption: universal government-funded health coverage is not just morally right — it can be economically sound.

I also came to see that moving toward universal government-funded coverage at the federal level is more practical than many of us assume. We have done big things before. Medicare and the Affordable Care Act were both once dismissed as unrealistic. They became possible when leaders confronted systemic failures and chose to act with long-term purpose. The mechanics of expanding

Universal Health Care Op-Ed

WHAT WORKED

- Featuring a credible messenger with both clinical (physician) and administrative experience
- Including U.S.-based research or examples of what's possible
- Offering a hopeful direction forward

WHY IT WORKED

- Leverages a credible messenger whose experience is grounded in care delivery and informed by system realities, increasing trust across audiences
- Reduces distance or dismissal that can come with international examples or comparisons
- Prompts audiences to imagine alternatives and possibilities, shifting the focus from problems alone to what change could look like
- Would be further strengthened by laying out a feasible path to achieving a single payer system

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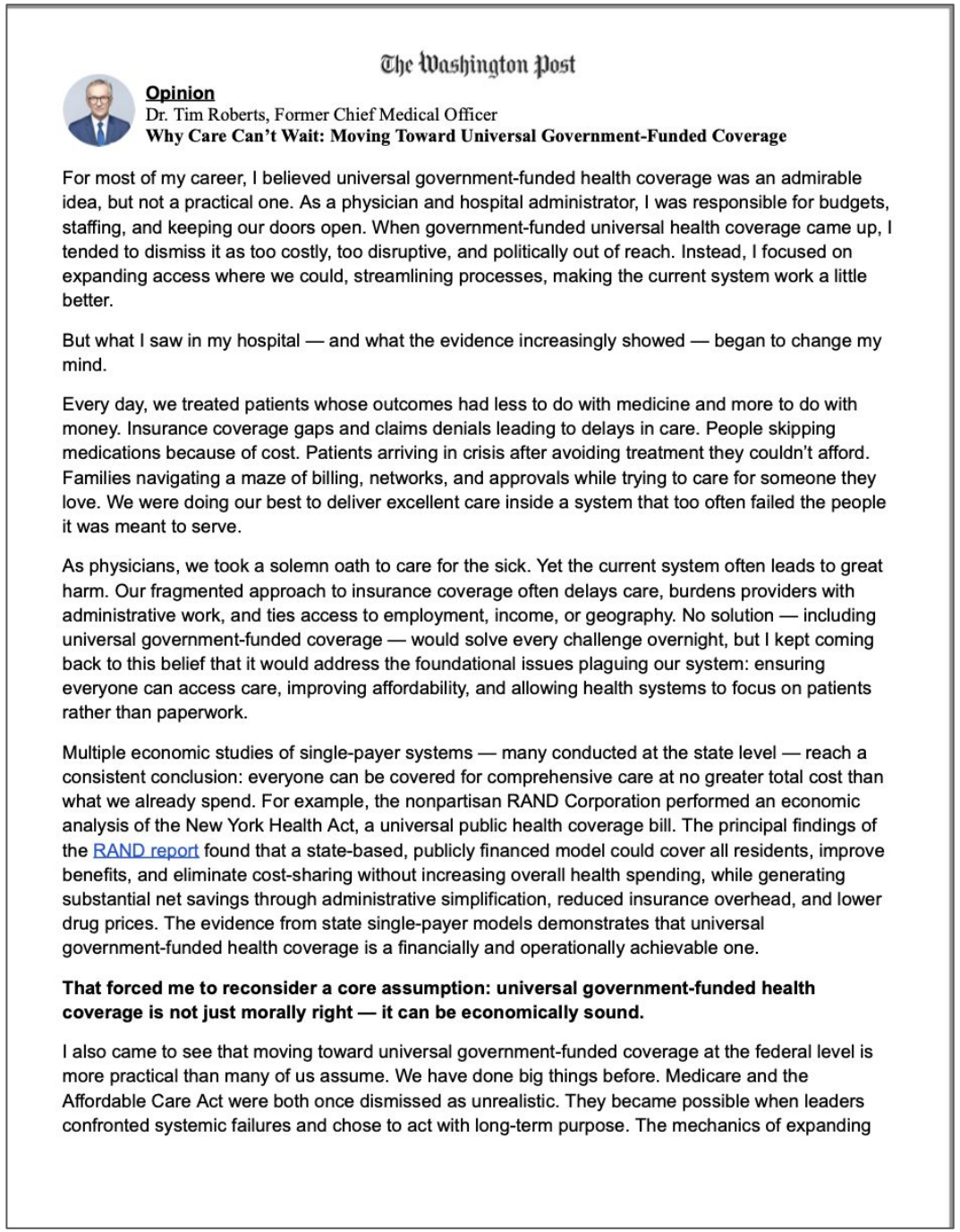

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Reactions to Universal Health Care Op-Ed

"Coming from someone who is a clinician, who has seen some of the core issues manifest in their career, who felt like a structural change felt too far away, but as they have progressed in their career, they have come to realize that maybe the only change that is truly affordable and rational in terms of moving towards, is a single-payer system [...] That resonates with me." — PRIVATE HEALTH SYSTEM LEADER, BLUE STATE

"With him being on the front lines, I think there is a level of credibility. The terminology, and the way he is speaking, speaks to me." — POLICYMAKER, BLUE STATE

"I don't disagree with his conclusion. He knows that people that don't get care are just going to get sicker if they don't have health insurance and then it's going to cost more money. But he did not give a path forward to *how* to get this done. As long as the industries — whether it's pharmaceuticals or hospitals — oppose this, this is just a dream. I admire the passion and I support it, but he didn't give a pathway." — PRIVATE HEALTH SYSTEM LEADER (PUBLICLY-FUNDED), BLUE STATE

"A lot of arguments about single payer focus on other countries. I don't know that Americans respond super well to that. I appreciated that he was able to make the argument without saying this [single-payer approach] worked in Scandinavia. I think that that's important, that we have our own arguments." — PUBLIC HEALTH SYSTEM LEADER, BLUE STATE

Patient Testimonial

DESCRIPTION

An emotional patient story tracing the journey from cancer diagnosis to treatment, highlighting how misaligned financial incentives shape care at each step.

View the full content here and listen to the voiceover here.

Note: *This content contains fictionalized elements and should not be distributed. Real stories and data were used in the development of the content, but names and details were changed for the purposes of message testing.*

My name is Sarah Friedman. I'm a little nervous to share my story today. It's been years since I first found the lump in my breast that turned out to be cancer, but I still remember that day clearly: As I stood in the bathroom feeling the undeniable hard lump, I thought of my toddler napping down the hall, my husband at work, and my elderly father, who lives with us. I knew that cancer wasn't necessarily a death sentence, but as scared as I was of the cancer, I was equally afraid of the financial devastation it could cause my family and our future.

My story is not unique. Millions of Americans face similar challenges. After battling cancer, many of us take pride in identifying as survivors. But simultaneously, in a health care system where people's sickness is what lines the pockets of insurers, pharmaceutical companies, and provider monopolies, we're not just survivors of our illness — we're victims of a system that is designed to extract every dollar possible through any means. Unlike cancer, that's no random tragedy. I'm sharing my story today to say: It simply does not have to be this way.

While patients face rising costs, the seven largest publicly traded U.S. health insurance companies reported a combined $71.3 billion in profits for 2024. Some sources rank health care as a more profitable industry than new cars and commercial real estate. I understand health care is a business. However, health care — unlike new cars and commercial real estate — is not a luxury; it's a fundamental right that allows people to live, work, and care for their families. My family had insurance, but my deductible was $5,000. I think about how many families are out there who have no insurance and face unthinkable but very real costs because they can't even afford coverage or simply don't have access. If the government can figure out how to limit costs on prescription drugs like insulin, what is stopping them from capping costs on all prescription drugs? If some states can put limits on what hospitals can charge their patients, what is stopping other states from ensuring everyone has those same financial protections? As long as financial incentives are the grease that keeps this machine running, our health care system will continue doing what it was apparently designed for: Generating profit for the people at the top, while families like mine have to decide between care or financial ruin.

Today, five years after my breast cancer diagnosis, I'm thankful to be in remission. However, we are still financially unstable because of astronomical medical bills. We sold our house to pay off the credit card debt that helped us cover basic expenses after I had to leave my job because of my treatments. While we used to put away a little money for retirement, we can barely think further than the next paycheck. These days, it's not the chemo making me sick — it's the fear of being one unexpected crisis away from bankruptcy.

There are powerful interests invested in keeping the system this way. At the end of the day, when services are rendered, someone has to pay. But right now, it's patients and families like mine who are paying the most — with our bank accounts and our lives. Through skyrocketing costs, miscoded services, repeated denials and appeals, we are the ones who are jumping through hoops so that CEOs can get fat raises exponentially greater than most of us will make in a lifetime.

I urge all of us — patients like me, policymakers, and leaders in health care — to reject the idea that meaningful, reasonable solutions are out of reach. We've already seen that they are possible. We must act. Our lives depend on it. Thank you.

— Sarah Friedman, California

Patient Testimonial

WHAT WORKED

- Using emotionally compelling storytelling
- Pairing patient story with an exploration of the misaligned financial incentives in the system
- Highlighting the insight that people often think about costs before their cancer or life decisions
- Including curated facts with impact (e.g., $71B in profits)
- Avoiding a single villain by naming a variety of key actors responsible for causing or solving the problem of high health care costs (including hospitals, insurers, pharmaceutical companies, policymakers, etc.)

WHY IT WORKED

- Grounds leaders in real human impact, making the issue immediate and harder to ignore
- Connects individual stories to system-level incentives, clarifying how financial design shapes both health outcomes and behavior
- Makes visible how often cost is part of personal health decisions, shifting how people think about choice in the system
- Adds urgency and credibility through memorable data points that reinforce the stakes
- Would be even more powerful if tied to specific policy solutions or a call-to-action

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— Sarah Friedman, California

Reactions to Patient Testimonial

"She really hit the nail on the head — people that have inserted themselves trying to get their piece of the puzzle. She hit the insurance companies. She hit the pharmacy benefit managers. And then of course, hospitals — and don't me wrong, hospitals can do everything they can to lower cost, but at least she didn't just single out hospitals. She understood the grand scheme. And at the beginning of the article, what really stood out is how she pointed to the $71.3 billion in profits from the publicly traded insurance companies." — PRIVATE HEALTH SYSTEM LEADER, RED STATE

"I think the patient aspect is extremely important. It is one of the reasons I ran for office — to be a voice for my patients. But when we talk about healthcare and we talk about providers and we talk about hospitals, there is an economic component to it too. These are real careers for people — for our nurses, our respiratory therapists, our radiology technicians. It is how they put food on the table and keep a roof over their family's heads." — POLICYMAKER, BLUE STATE

"It is personalized; it is real. It is something most people can relate to either personally, a family member, a friend. So to me [the patient story] seems the most compelling." — PRIVATE HEALTH SYSTEM LEADER (PUBLICLY-FUNDED), RED STATE

Questions? Reach out!

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Community Catalyst