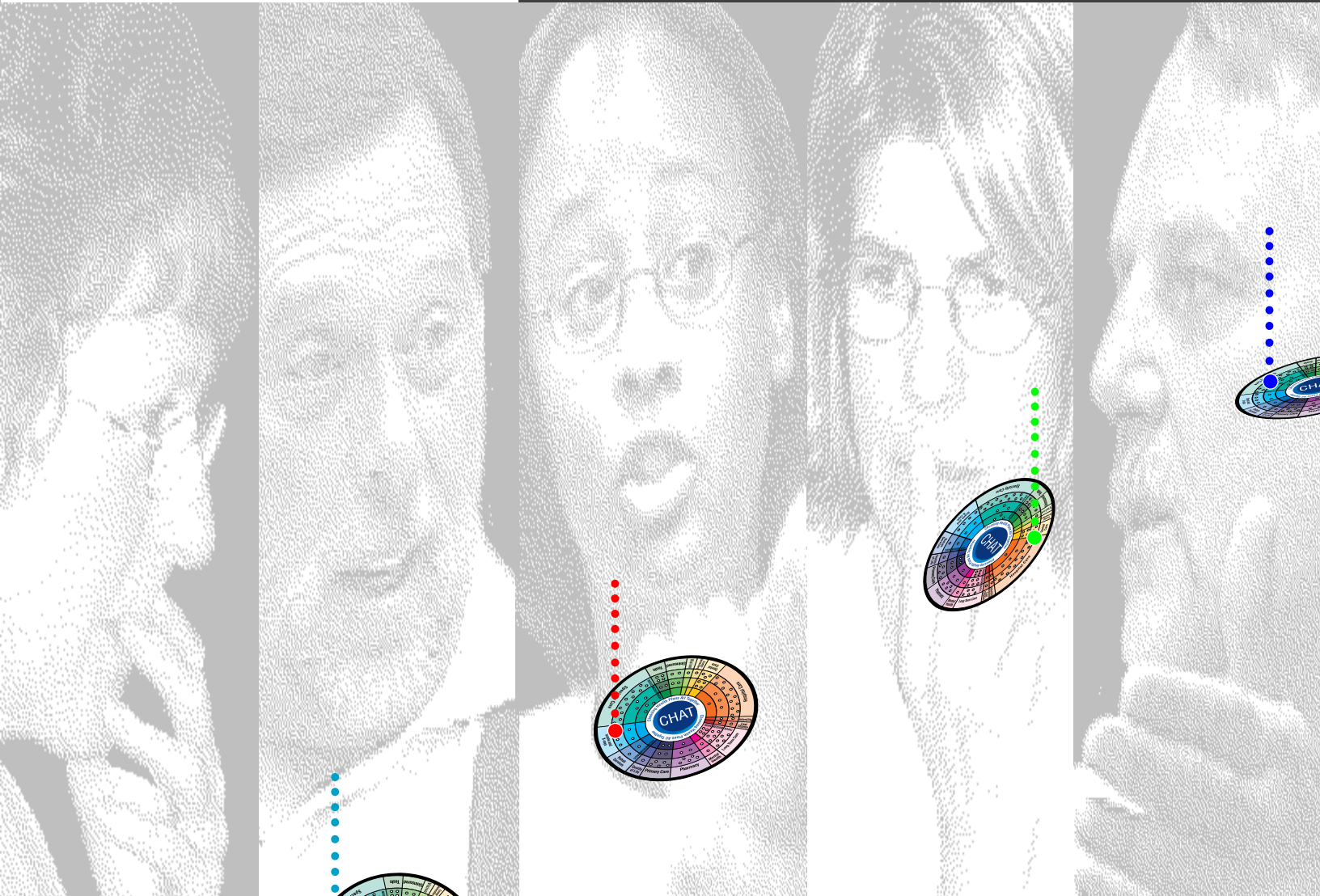


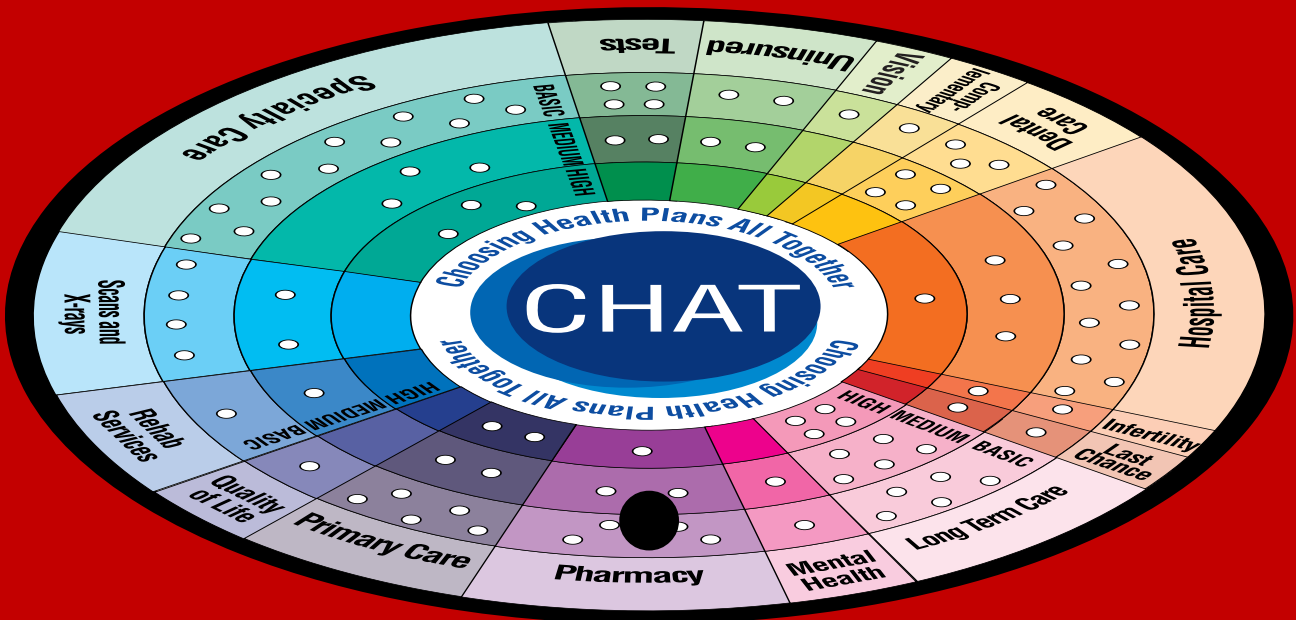
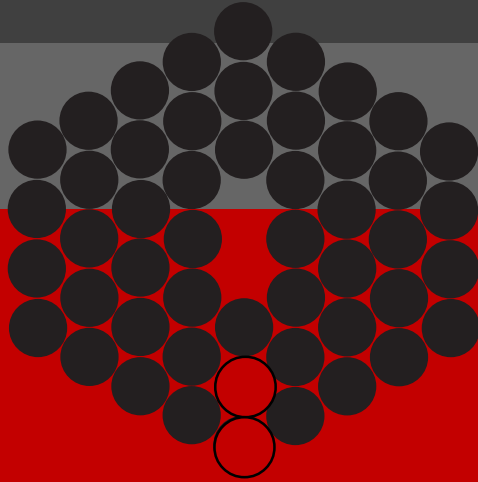
WHEN  
OPTIONS  
EXCEED  
RESOURCES

*Making Trade-Offs in Healthcare Benefits*



*The results of the Capitol Region CHAT Project  
October 2003*

The CHAT  
board challenge:  
50 markers,  
99 marker spaces.



# WHEN OPTIONS EXCEED

## RESOURCES

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*“The person  
you talk to every day  
will not be happy...because  
they want their vision and  
they want their dental, and  
maybe they want their  
chiropractor.”*  
CHAT participant

*“Insurance  
is really to cover the  
dramatic situations that  
not many of us  
run into.”*  
CHAT participant

Sacramento Healthcare Decisions (SHD) is a nonprofit, nonpartisan organization whose purpose is to educate and involve the public in healthcare policy and practice issues. For more information about SHD or CHAT, contact Marge Ginsburg at (916) 851-2828 or [marge.shd@quiknet.com](mailto:marge.shd@quiknet.com).

The Capitol Region CHAT Project was funded by a grant from the California HealthCare Foundation.

The individuals depicted in this report were participants from four of the 72 CHAT sessions.

# 1 EXECUTIVE SUMMARY

Employers and employees alike are worried about the cost of health insurance. In both the public and private sectors, rising premiums are impacting employee benefits packages, and a variety of trade-offs have been implemented or are under consideration: greater cost-sharing by employees, fewer health plan choices or reductions in other compensation. Increased insurance rates have led to growing tensions between what individuals want from the healthcare delivery system and what purchasers are willing or able to spend.

To help shed light on this subject, Sacramento Healthcare Decisions (SHD) conducted the Capitol Region CHAT Project, exploring two aspects of these tensions: 1) what employees consider most important in creating a benefits package when healthcare options exceed resources, and 2) whether participating in the CHAT process leads to better consumer understanding and decisions about healthcare trade-offs.

## *THE CHALLENGES OF CHAT*

CHAT is a game about insurance. In two-hour meetings of 9-12 people, participants designed healthcare benefits packages in four rounds: for themselves and their families (round 1); for all employees in their company (round 2); for all employees in California (round 3); and again for themselves (round 4).

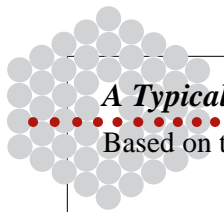
Built into CHAT's design was the need to make trade-offs, reflecting the realities of today's environment:

- CHAT participants had only 50 "markers" to spend among 16 categories of healthcare services, but there were 99 possible places to put them.
- Participants had to weigh various limitations – increased cost-sharing, restricted choice, less convenience and reduced services – as they considered the range of options.
- A Health Event Lottery presented participants with medical scenarios, depicting common and uncommon illnesses and accidents. These events illustrated the services and cost consequences of participants' coverage decisions.
- Each CHAT group had to reach consensus in designing a common benefits package, a process requiring negotiation and compromise.

## *CREATING A STATEWIDE HEALTH PLAN*

CHAT was played by 744 employees from 41 public and private sector groups in the greater Sacramento region, all with employer-sponsored health insurance. While there was variation in participants' individual and statewide plans, a fairly typical pattern emerged. The table on page 3 shows the benefit categories and main characteristics of this composite plan (full descriptions of the benefit categories are included in Appendix B).





***A Typical CHAT Statewide Health Plan***

Based on the decisions of 68 CHAT sessions.

HEALTHCARE CATEGORIES	MAIN CHARACTERISTICS
<b>Primary Care</b>	Includes out-patient visits, preventive care, screening tests and wellness classes. There is limited choice of doctors and several weeks wait for routine appointment. \$15 co-payment for office visits and classes. \$50 for ambulance and ER visit.
<b>Hospital Care</b>	Pays for in-patient hospital bills (except Mental Health). Patients have no choice of which hospital they go to. No co-payment but doctor must discharge patient as soon as possible.
<b>Specialty Care</b>	Pays for visits to specialists, including treatments and procedures. Must be referred by primary care doctor. Use of in-plan specialists only. 45-day wait for routine appointment. \$10 office co-payment.
<b>Pharmacy</b>	Covers medicines prescribed by the doctor but only pays for those that are on the formulary. Only generic are provided if available. \$10 and \$20 co-payments for generic and brand-name, respectively.
<b>Scans and X-rays</b>	Covers x-rays, MRIs and CAT scans. Some require pre-approval by health plan and non-urgent scans will take several weeks to schedule.
<b>Tests</b>	Includes lab tests and other procedures such as EKGs, treadmill tests, etc. Some tests require pre-approval by health plan and non-urgent tests will take several weeks to schedule.
<b>Mental Health</b>	In-patient and out-patient services for nine serious mental health problems. Limited therapists to choose from; \$20 per visit co-payment.
<b>Dental Care</b>	Cleanings and x-rays every 6 months, no co-pay. Limited network of dentists who use only basic materials. Includes emergencies, cavities, oral surgery. 20-50% co-pays required; \$1,000 maximum/year per family member.
<b>Rehabilitation Services</b>	Out-patient physical, speech and occupational therapy plus medical equipment like wheelchairs, hearing aids, artificial limbs. Pre-approval and co-payments are required.
<b>Last Chance</b>	Covers organ transplants when other treatments fail.
<b>Vision</b>	Annual vision test if needed with \$10 co-pay. \$75 towards new glasses or contacts every two years.

To create this benefits package, most groups had to forgo coverage for **Complementary** services, **Long Term Care**, the **Uninsured**, **Quality of Life** services, and **Infertility**.

## ***KEY FINDINGS***

Analysis of the group discussions and participant surveys identified the following:

### **Participants' highest priority for the statewide plan was to include as many benefit categories as possible.**

- When designing a statewide plan, they sacrificed lower cost-sharing, greater choice of provider and more convenience in order to include services that “provided something for everyone.”
- Most participants believed that the average person would not or could not pay out-of-pocket for routine healthcare services, even less expensive ones, unless insurance paid a good portion of the cost.

### **Participants regarded health insurance as guaranteed services, not as pooled resources that must serve diverse groups and various needs.**

- When they had to decide among competing categories, they struggled between the need to cover services that people use frequently and those that cover rare but catastrophic health problems.

### **Participants were influenced by their group's decisions, often reconsidering the coverage choices they made for themselves.**

- In the initial round of CHAT, participants showed little interest in or knowledge about those healthcare services that were outside their experience.
- In the last round, 82% of CHAT participants changed at least one benefit category, coinciding with the decision they made for their statewide plan.

### **Participants accepted the statewide benefits package that they had a role in creating.**

- Eighty-five percent of CHAT participants indicated they were willing to abide by their group's coverage decisions for a statewide health plan.

### **Participants changed their views about the need for limits in healthcare coverage.**

- After participating in CHAT, 72% agreed that it is reasonable to have limits in healthcare coverage, compared with 47% who indicated this at the beginning of CHAT.

## ***IMPLICATIONS FOR EMPLOYERS***

The changing environment of health insurance benefits requires employers to take new and aggressive approaches to educate and involve their employees in the decisions that can affect them so dramatically.

The CHAT results suggest several important actions that employers can take to promote an educated, motivated and involved workforce:

### **Be explicit about resource limitations.**

Employees grasp the concept of opportunity cost (choosing one benefit means that something else will be forgone) when they participate in discussions where resource limitations are visible and specific.

### **Provide creative opportunities for employees to learn.**

Most employees are unfamiliar with the actual costs of services, the amount their employers pay for coverage, and the insurance principle of pooled resources. Employee surveys, interactive problem-solving, and scenarios that illustrate the consequences of their insurance choices may serve to gain employees' interest.

### **Involve employees in decisions about benefits trade-offs.**

On the post-CHAT survey, 59% of participants agreed strongly that it is important for employees to have a role in deciding about healthcare coverage for their company. When difficult decisions are required, shared responsibility can strengthen employees' commitment to finding the best possible options and accepting a mutually-agreeable benefits plan.

# INTRODUCTION

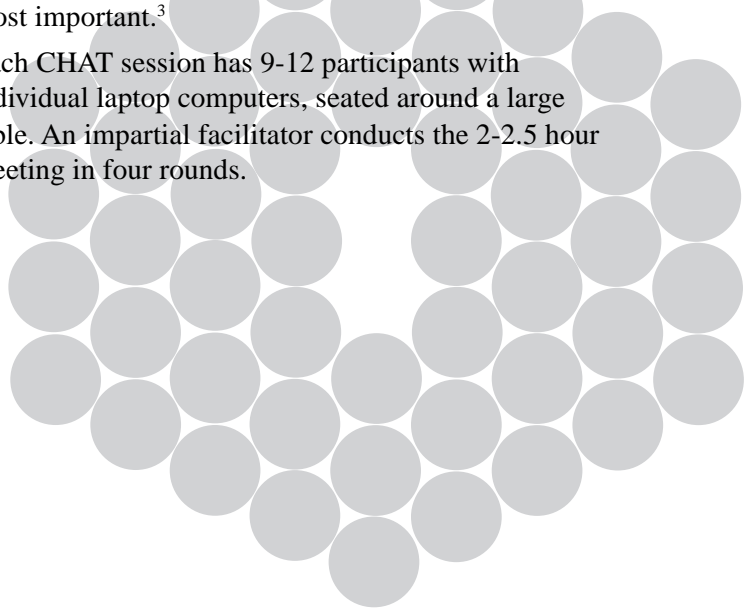
Private and public sector employers, including local, state and federal governments, are facing significant increases in the cost of providing healthcare coverage for their employees. By all accounts, healthcare costs and health plan premiums will continue to see double-digit growth in coming years. The challenge for employers is how to adjust to these higher costs in ways that are fiscally responsible while attempting to meet employee expectations for healthcare coverage. Many employers have had to increase the employee share of cost, reduce benefits, or consider other changes in employee compensation.

Sacramento Healthcare Decisions (SHD), as part of its *Fair Sharing* initiative, conducts consumer-centered projects to address the issue of finite healthcare resources. From May 2002 through July 2003, SHD planned and implemented the Capitol Region CHAT Project<sup>1</sup> to explore how employees might prioritize healthcare benefits when resources are limited. CHAT was developed in 1999 by researchers at the University of Michigan School of Medicine, the National Institutes of Health, and MultiLogue, a game design company.<sup>2</sup>

## HOW CHAT IS PLAYED

CHAT is a game about health insurance. Depicted on a pie chart (see inside front cover), there are 16 *benefit categories* (e.g., Primary Care, Pharmacy, Hospital Care) and one to three *benefit levels* for each category: Basic, Medium and High. The benefit levels address such attributes as choice, cost-sharing, convenience and expanded services. Each of the categories requires a specific number of “markers” in order to include it in a benefits package; if a participant wants a higher level of service than Basic, it costs additional markers. The number of markers required for each category is based on the actual cost of that category. Each participant has 50 markers to spend. Since the CHAT pie chart has 99 possible places to put the markers, participants must decide which categories and benefit levels are most important.<sup>3</sup>

Each CHAT session has 9-12 participants with individual laptop computers, seated around a large table. An impartial facilitator conducts the 2-2.5 hour meeting in four rounds.



<sup>1</sup> CHAT (Choosing Healthplans All Together) is copyrighted by the University of Michigan and licensed to Sacramento Healthcare Decisions.

<sup>2</sup> For additional information on CHAT projects: Danis M, Biddle A, Goold SD. Insurance benefit preferences of the low-income uninsured. *J Gen Intern Med* 2002;17: 125-133. Danis M, Biddle AK, Goold SD. Enrollees choose priorities for Medicare. *The Gerontologist* 2004 (in press).

<sup>3</sup> The number of markers was determined by Milliman USA, a national actuarial firm, based on costs in California as of July 2002. The 50 marker total represents the average amount spent by California employers for a commercial health plan for employees in 2002. For complete descriptions of the benefit categories, benefit levels, and the number of markers each required, see Appendix B.



### ***Round 1: An individual health plan***

After instructions, participants complete a pre-CHAT survey. They then work alone for 15 minutes to design an individual healthcare benefits package for themselves and their immediate family. This plan will be in effect for five years. When everyone is finished, the **Health Event Lottery** (a randomized, computer-generated medical scenario) illustrates for each participant the impact of their plan design. Each person reads the lottery event aloud to the others, with brief discussion. See Appendix C for examples of the lottery scenarios.

### ***Round 2: A health plan for all company employees***

Participants now work in groups of three. Using a new CHAT board (but with the same categories and markers), these small groups now design a coverage plan for all the employees in their company. The three working together must all agree on the benefits package. When everyone is finished, there is one more round of the Health Event Lottery, with groups reading their events (and consequences) to others at the table.

### ***Round 3: A health plan for all employed people in the state***

All the participants close their computers and the facilitator brings up a new CHAT board on a screen in front. For this round, all the participants together must design a uniform benefits package for all employed persons in California who currently have insurance. The facilitator leads the discussion. Different participants nominate categories and benefit levels but anyone can veto the choices of others. Participants discuss and debate which categories are most important and why. Sometimes groups must vote if they cannot come to agreement.

### ***Round 4: A revised health plan for the individual***

Participants use their own computers for the last round. They create a health plan for themselves and family, just like round 1. But now they have learned more about the benefit categories, experienced the Health Event Lottery, heard the views and experiences of others and negotiated to develop a statewide plan. Thus, their choices this time may be different (and more informed) than round 1. When finished, they complete the post-CHAT survey.

## ***THE CAPITOL REGION CHAT PROJECT***

SHD established four project objectives:

- 1.** Engage local public and private sector employees in the challenges and realities of making trade-offs when resources are insufficient to meet all healthcare wants and needs.
- 2.** Demonstrate a process for decision-making that incorporates accurate, unbiased information and interactive consensus-building.
- 3.** Present employers and policymakers with data on consumers' priorities as a basis for future considerations of healthcare benefits and to demonstrate a model process for societal decisions.
- 4.** Contribute to a growing body of knowledge on consumer values related to sharing finite resources.

An Advisory Committee (Appendix F) helped to choose and define the project's benefit categories and benefit levels that would be consistent with state trends, assisted with employer recruitment, and reviewed project results.

Forty-one private and public sector groups participated in CHAT (see Appendix A). These organizations sponsored from one to five CHAT sessions with their employees or colleagues for a total of 72 CHAT sessions.

Participants' health benefits choices were recorded anonymously on individual computers. In addition, participants were asked to respond to two surveys: one prior to the CHAT exercise and one following its completion. Selected demographic data and responses to survey questions are shown in Appendix D. Sutter Institute for Medical Research provided the statistical analysis of the data. The association of many demographic variables with pre- and post-CHAT responses and choices made within the rounds were analyzed and selected results are in Appendix E.



# CHOOSING INDIVIDUAL AND GROUP HEALTHCARE BENEFITS

This section presents the choices that employees made as individuals and group members.

The summary results of CHAT are reported below for 68 CHAT sessions.

- Rounds 1 and 4: Creating an individual healthcare benefits package.
- Round 3: Creating a statewide healthcare benefits package.

Round 2 data are excluded in the analysis. Round 2 represents an intermediary step and is used mainly to give participants more time to learn about the benefits categories and become accustomed to making group decisions.

## INDIVIDUAL CHOICE OF HEALTHCARE BENEFITS

Participants had two opportunities to create their own benefits package: at the very beginning of CHAT (round 1) and then at the end (round 4). Round 4 was an opportunity for participants to change their coverage decisions after exposure to new information and different opinions. The results of these two rounds are shown together in the chart below.

### Creating an Individual Benefits Package<sup>4</sup>

Participants' choices when creating a plan for themselves and their immediate family for a five-year period. (The dark shaded cells mean that the benefit level was not an option for that category).

CATEGORY	ROUND 1: at the start of the CHAT session Individual coverage choices in % (N = 698 participants)				ROUND 4: at the end of the CHAT session Individual coverage choices in %, in order of descending frequency (N = 695 participants)			
	% participants who picked the category	Benefit level chosen			% participants who picked the category	Benefit level chosen		
		BASIC	MED.	HIGH		BASIC	MED.	HIGH
Primary Care	98 %	45 %	47%	6 %	99 %	62 %	36 %	1 %
Pharmacy	98	75	18	5	99	84	14	1
Hospital Care	99	76	19	4	99	91	8	
Specialty Care	92	80	11	1	99	92	7	
Scans & X-rays	91	80	11		97	94	3	
Tests	89	78	11		95	92	3	
Dental Care	87	77	10		87	85	2	
Rehab Services	46	39	7		68	62	6	
Vision	73	73			65	65		
Mental Health	39	34	5		61	47	14	
Last Chance	38	38			60	55	5	
Complementary	25	25			25	25		
Quality of Life	19	19			14	14		
Long Term Care	15	15			13	12	1	
Uninsured	10	10			10	9	1	
Infertility	8	6	2		6	5	1	

<sup>4</sup> Although 72 sessions were conducted, four groups used a slightly different CHAT Board structure. Thus the coverage results shown in this report are for 68 groups (698 participants) rather than 72.

**OBSERVATIONS:** In comparing the individual choices made by participants in rounds 1 and 4, several differences are apparent:

- Participants selected more categories of services in round 4 than round 1 (an average of 10.0 categories vs. 9.3 categories).
- Preferences for three benefit categories increased substantially in round 4. **Rehabilitation Services** increased from 46% choosing it in round 1 to 68% in round 4; **Mental Health** increased from 39% to 61%; and **Last Chance** increased from 38% to 60%.
- In round 4, participants spent far fewer of their markers on Medium and High benefit levels. For example, 23% of participants choose Medium or High **Hospital Care** in round 1; in round 4, only 8% choose those coverage levels.

### GROUP CHOICE OF HEALTHCARE BENEFITS

The climax of CHAT was round 3, when everyone worked together in consensus fashion to create a uniform healthcare benefits package for all employed, insured Californians. During this discussion, everyone had an equal voice and anyone could veto a category proposed by another. About half the groups eventually had to vote on certain categories when agreement was not reached.

**OBSERVATIONS:** Most groups wanted a plan that offered the widest range of benefit categories possible. This required that groups forgo the benefit levels which brought greater choice, more convenience and lower co-payments. Nevertheless, participants felt that covering a broad array of services was the fairest approach for meeting the needs of millions of people.

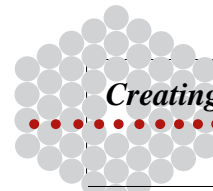
*“You may be willing to take that risk for yourself, but we’re looking after the state of California.”*

The major categories of coverage – Primary Care, Hospital Care, Specialty and Pharmacy – were chosen by all 68 groups. However, there was considerable discussion on how to spend the last 3-5 markers. The choices debated most were:

- Using two markers to cover Medium level **Primary Care** for its better selection of doctors, shorter waiting time and lower co-payments.
- Moving to Medium level **Mental Health** to cover drug and alcohol treatment programs.
- Deciding among the smaller (one marker) categories, e.g., **Last Chance, Vision, and Complementary**, when not all could be chosen.

Two benefit categories – **Long Term Care** and (covering the) **Uninsured** – were frequently the subjects of intense debate even though few groups ultimately included them for coverage.

How participants view and value the various benefit categories is discussed in greater detail in the next section.



### Creating a Statewide Benefits Package

#### ROUND 3

The choices of the CHAT groups when designing a plan for all working people in California, in %, in order of decreasing frequency (N = 68 groups)

CATEGORY	% groups that picked the category	Benefit level chosen		
		BASIC	MED.	HIGH
Primary Care	100 %	78 %	22 %	
Pharmacy	100	96	4	
Hospital Care	100	99	1	
Specialty Care	100	100		
Scans & X-rays	100	100		
Tests	99	97	1	
Mental Health	94	54	40	
Dental Care	91	91		
Rehab Services	88	85	3	
Last Chance	71	66	4	
Vision	69	69		
Complementary	19	19		
Long Term Care	12	12		
Uninsured	10	10		
Quality of Life	3	3		
Infertility	1	1		

# 4 RATIONALE FOR COVERAGE DECISIONS

The reasons for the choices that participants made, as individuals and in groups, are important to understanding how people might respond to future trade-offs. In wrestling with these decisions, participants had two realms of competing priorities:

- 1) Specific restrictions and limitations that differentiated the benefit levels of Basic, Medium, and High.
- 2) The relative importance of different benefit categories when the available markers precluded choosing them all. Selection was also influenced by the number of markers each category cost (e.g., Long Term Care required five markers for Basic while Vision only cost one marker).

## INSURANCE RESTRICTIONS AND LIMITATIONS

With 99 marker spaces and only 50 markers to spend, participants considered four types of health plan limitations.

**Comprehensiveness:** the breadth of categories that could comprise the benefits package.

**Convenience:** the degree to which pre-authorizations or waiting times were required.

**Cost-Sharing:** the amount of the employees' co-payments for covered services.

**Choice:** the variety of providers (physicians, hospitals, therapists) from whom to receive services.

Based on the group discussions and surveys questions, participants responded to these limitations as follows:

**Comprehensiveness.** Of all four factors, comprehensiveness was almost a universal value in designing a healthcare benefits package for all employees in the

state. Every discussion group conveyed the message, *it's important that we give everyone the largest number of covered services possible*. Participants felt that this was what people would want and that it was the fair thing to do when there were diverse needs and interests.

**Convenience.** Interest in Medium benefit levels was almost always focused on shorter waiting times for doctors' appointments, medical tests and procedures. Although groups had less discussion than with comprehensiveness, convenience was the highest priority on questions from the pre- and post-CHAT surveys which asked about features of health insurance (Q.14, Appendix D). On choosing three of eight possible features, the two most selected were "Being able to get doctors' appointments quickly" (chosen by 58%) and "My doctor being able to order tests and medicines without getting approval" (50%).<sup>5</sup>

**Cost-Sharing.** For some, lower co-payments were a critical factor for wanting to move above the Basic benefit level for their own plans. Co-payments were particularly troublesome for the statewide plans, when participants were concerned about the plight of lower-income families. Participants also acknowledged on the survey questions that co-pays were important considerations (Q.14, Appendix D). "Paying as little as possible for my medications or doctors' visits" was a priority for 44% of participants and "Paying as little as possible for my share of the health insurance premium" for 40%. Yet neither ranked as high as convenience features.

**Choice.** This issue emerged most clearly in discussions of Primary Care. Participants felt that the primary care doctor is the mainstay of patient care, and the ability to choose (and change) their doctor was critical to receiving quality care and accessing other services. This concern about choice did not apply as strongly to choice of hospital or specialists. On the CHAT survey, only 19% thought that "being able to see a specialist who is not part of my health plan" was one of the top considerations, and only 19% prioritized "having a choice of which hospital I go to" (Q.14, Appendix D).

<sup>5</sup> Comprehensiveness of services was not included on the list of features in this survey question. In pre-testing the survey, comprehensiveness was included and dominated participants' answers so much that we removed it in order to learn more about the other features.

## **PERCEPTIONS OF SPECIFIC HEALTHCARE SERVICES**

During the round 3 group discussion, some of the 16 benefit categories on the CHAT board elicited considerable discussion and others did not. The following summaries are listed in order of the relative frequency or intensity with which these benefit categories were discussed (coverage choices of the 68 CHAT groups are indicated for each of the categories).

### **Primary Care**

*The votes of 68 groups:*

*No Coverage: 0 Basic: 53 Medium: 15 High: 0*

Primary Care was seen as the entry point to all healthcare services and usually received the most discussion. Aside from Mental Health (which cost fewer markers), Primary Care had the largest number of groups that chose Medium level. Participants felt that having sufficient choice of primary care physician made other restrictions (e.g., pre-authorizations) more palatable.

*“If some things are going to be limited then I want to be able to choose a good doctor that is going to refer me to the things I need.”*

### **Mental Health**

*No Coverage: 4 Basic: 37 Medium: 27*

A frequent debate ensued on coverage for drug and alcohol treatment programs (available only at the Medium level). While acknowledging that substance abuse impacts many people, participants often resented sharing in the cost for conditions they believed to be self-imposed or self-correctable. Participants also perceived that sufficient county and low-cost private services were available. Nevertheless, many groups chose Medium level because they saw substance abuse as a statewide problem, affecting the safety of others and workplace productivity. Those who had no previous experience with Mental Health as a category were often influenced by participants with more knowledge about mental illness.

### **Vision**

*No Coverage: 21 Basic: 47*

This very small benefit category typified a major tension about the role of health insurance – is its first priority to cover services that “everyone uses” (e.g., Vision) or is it to cover care that is life-threatening, very expensive but rare? The actual dollar benefit of Vision care was quite limited and many thought other choices bring greater value. Others argued that almost everyone used the service and that no one would get their eyes checked unless this was subsidized. Many also noted that Vision care had become such a common fringe benefit that people would be very unhappy to have it taken away.

*“We shouldn’t waste a marker. Anyone can get what they need at Wal-Mart for \$99.”*

### **Dental Care**

*No Coverage: 6 Basic: 62 Medium: 0*

While almost all groups covered Dental Care as part of the statewide plan, it was sometimes debated as a service that individuals could pay for themselves. Arguments made against self-pay were that families could not afford it for their children; people would not go to the dentist unless the cost was subsidized; preventive dental care was very cost-effective; and poor dental care led to many other health problems. Most considered this to be an essential component of any system of healthcare coverage.



## Long Term Care (LTC)

*No Coverage: 60 Basic: 8 Medium: 0 High: 0*

In many of the sessions, LTC received extensive discussion. Often one or more participants had family situations where LTC was needed; they became strong advocates and sometimes could persuade their colleagues. When LTC was rejected by the group, it was usually because participants thought that it could (or should) be purchased separately; it cost too many

CHAT markers; and/or too few people would need to use it.

However, most agreed that LTC coverage was important for the well-being of families and society. On the

post-CHAT survey,

LTC was chosen most often as the category participants would add to their benefits package if they had more markers (Q. 16, Appendix D).

*“I also think Long Term Care was important; it just wasn’t worth the five markers. If it was four, I would have grabbed it.”*

## Last Chance (organ transplants)

*No Coverage: 20 Basic: 45 Medium: 3*

This category was commonly debated at the end of the discussion when the group had just a few markers left. Though relatively few people had personal experience or knowledge of organ transplants (the main component of *Last Chance*), if someone mentioned that these are life-saving and prohibitively expensive or had personal knowledge of a successful transplant, the rest of the group was often

convinced. Dissenters felt

*“I have real mixed feelings about it – it’s very expensive and it only happens to a few people, but if it is someone that you care about, it is the biggest deal in the world.”*

that not enough people needed the service and that it often didn’t succeed. Using an additional marker for experimental treatment (Medium level) was usually dismissed. Most thought the treatment was too expensive and not likely to work.

*“It may sound cruel, but I work for this and I need coverage for me first.”*

*“I know everybody is going to disagree with me but I don’t care. I want to pick the Uninsured – that could be me in 5 years, that could be my grandmother, that could be anyone.”*

## Pharmacy

*No Coverage: 0 Basic: 65 Medium: 3 High: 0*

This category sometimes generated extensive discussion if one or more participants had costly co-pays or had personally experienced (and were unhappy about) formulary restrictions. There was also general discussion of the high costs of prescription medication and debate about generic vs. brand name. Nevertheless, most people accepted the pharmacy limitations as the reality of today’s marketplace.

## Uninsured

*No Coverage: 61 Basic: 7 Medium: 0*

Most groups dismissed this category with little discussion. However, when discussed, covering the uninsured generated the highest intensity of debate and disagreement of any category. It was often rejected for different reasons: it was the responsibility of the state (not private employers or employees) to provide coverage; the uninsured could qualify for state-funded programs; people could find coverage if they tried harder; or there were too many benefit categories still not affordable with the limited number of CHAT markers. Yet in some of the CHAT sessions, a participant made a compelling case for including the uninsured, insisting this would reduce the cost of healthcare for everyone; many people couldn’t qualify for state programs; working folks like themselves might need this coverage at some point; and it was the “right thing to do.”

## Hospital Care

*No Coverage: 0 Basic: 67 Medium: 1 High: 0*

While this was one of the two most expensive CHAT categories, the discussion was usually a short one. Many were unhappy about the phrase *no choice of hospital* under Basic level and wanted Medium level to avoid that restriction. Some had experience with a

poor quality hospital but most simply disliked the idea of having no choice.

Participants frequently commented that signing up with a health plan or doctor is equivalent to choosing your hospital.

This likely reflects the fact that Sacramento has a highly

concentrated healthcare delivery

system where four entities own almost all the hospitals in the region.

## Complementary

*No Coverage: 55 Basic: 13*

Discussion of Complementary services, such as acupuncture and chiropractic, usually occurred only when a participant (or one's family member) was an active user. Even then, active users didn't always advocate for coverage; they often agreed that these were costs that could be paid out-of-pocket. An argument that sometimes swayed participants was that alternative medicine users often did not use Primary Care or Pharmacy; thus including Complementary services was an issue of fairness and of supporting the use of lower-cost interventions.

*“Because if I’m paying into this for somebody else to get little glass bottles with the candles in them to put on their back to suck out the evil spirits, then I am against that.”*

## Rehabilitation Services

*No Coverage: 8 Basic: 58 Medium: 2*

This category was usually an afterthought but one that most people felt was worthwhile once they understood what it was

(physical therapy, wheelchairs, etc.) and when it would be needed for an

employed, non-elderly population. It was never chosen at the beginning of the round 3 discussion; while not considered essential like Primary Care or Hospital Care, it was one that most people could agree on with little dissent.

*“What am I going to do when a mom comes to me and says their five year old child lost his leg and now our plan doesn’t cover artificial limbs?”*

## Specialty Care

*No Coverage: 0 Basic: 68 Medium: 0 High: 0*

Specialty Care was the other very expensive category and received even less discussion than Hospital Care. Few people argued for Medium level services (with its greater choice of specialists and without the primary care doctor having to make the referral), and most believed that a good primary care doctor would help in getting good specialty care. Even in round 1 (before participants were influenced by the views of others or by the Health Event Lottery) only 12% chose Medium or High Specialty Care, considerably lower than the 53% who chose Medium or High for Primary Care.

## Infertility

*No Coverage: 67 Basic: 1 Medium: 0*

While every session had some discussion of Infertility coverage, comments were almost always critical, if not derisive, of coverage inclusion. Several sessions had strong advocates but only once were the arguments persuasive enough to result in the category being included. Comments like *let them adopt, the population is too large already, and this is a personal choice issue* were common responses.

Yet this category may be unique because it is one where many people already know that they will never use it (which cannot be said about other categories) and, therefore, may not relate to the plight of those needing it.

*“If I couldn’t get pregnant, that could be something that would be important to me, but I don’t think that my having a baby has a positive effect on the state of California.”*

## Scans & X-rays

*No Coverage: 0 Basic: 68 Medium: 0*

This category (as well as Tests, below) generated little discussion. Participants knew what the services were, used them, and couldn’t imagine themselves or others having to pay for them out-of-pocket. They were always included in the statewide plan and rarely did someone “veto” or even question the coverage selection.

## Tests

*No Coverage: 1 Basic: 66 Medium: 1*

(see description above)

## Quality of Life (QOL)

*No Coverage: 66 Basic: 2*

Defined as services that people often want that are not always medically necessary, this category elicited smiles when the Health Event Lottery gave scenarios about circumcisions, hair growth remedies and weight-loss pills. This category was included in CHAT to see if participants viewed these services differently than more disease-oriented ones. Although only two groups included QOL in their statewide plan, participants did not dismiss the value of these services; in fact, 14% included QOL in their own plan in round 4. Nevertheless, when a plan was for everyone in the state, most people viewed these as personal choices that could not compete with more essential services.

*“Quality of Life does nothing for me. You want Viagra? Buy it yourself.”*



## 5 ENGAGING AND EDUCATING EMPLOYEES

In addition to identifying employee priorities, CHAT was also created to help employees understand that trade-offs are a part of decision-making today and to engage them in this issue as consumers and citizens. The project had several ways to gauge CHAT's impact on participants.

### LIMITING COVERAGE

CHAT is based on the premise that limits in healthcare insurance coverage are inevitable. This premise, however, is rarely acknowledged or debated openly. One measure of CHAT's impact was to assess participants' views on coverage limits prior to CHAT and again at the end of the session.

The following question was included in both the pre-CHAT and post-CHAT surveys.

<b>Agree or Disagree:</b> <i>Given the rising cost of health care today, it is reasonable to limit what is covered by health insurance.</i> (N=737)		
	<i>Pre-CHAT responses</i>	<i>Post-CHAT responses</i>
Agree strongly	12 %	25 %
Agree somewhat	35 %	47 %
Disagree somewhat	26 %	18 %
Disagree strongly	23 %	8 %
Not sure	3 %	1 %

Pre-CHAT, those agreeing (47%) and disagreeing (49%) were evenly divided, with twice as many *disagree strongly* as *agree strongly* (23% vs. 12%). By the end of the session, the *disagree strongly* had fallen to 8% and *agree strongly* increased to 25%. The total in agreement with the statement had increased to 72% and those disagreeing fell to 26%.

**DISCUSSION:** There was a 53% increase in the number of participants who agreed that it is reasonable to limit health insurance coverage. This change in perspective was consistent across all demographic groups and all CHAT sessions. Participants came to this conclusion solely from the experience of building a health plan based on the average amount currently spent by California employers. It is apparent that the CHAT process had a substantive impact on participants' views about limits on health insurance coverage.

### CHANGING COVERAGE CHOICES

CHAT used a consensus-building approach to see if groups could agree through negotiation and compromise on a uniform healthcare benefits package. One potential impact of this group process is that the individual participants learn from each other in ways that enhance their own perspectives about their healthcare coverage needs.

Participants changed their minds in several ways over the course of the CHAT session. Of 698 participants, 82% changed their selection of coverage for at least one of the 16 benefit categories between rounds 1 and 4 to what the group chose in round 3; only 30% changed their selection contrary to the group choice in round 3. (See Appendix E for details on the statistical analyses used in this section).

While some benefit categories were rarely rejected in any CHAT rounds (e.g., Primary Care and Hospital Care), others showed considerable variation. Rehabilitation Services, Last Chance and Mental Health showed the greatest influence of the CHAT process. With Rehab Services, the decisions of 32% of all participants in round 4 were different from their round 1 choice yet congruent with their group



decision in round 3. This compares with only 10% of participants who also made a different Rehab coverage decision in round 4 vs. round 1, but whose decision was inconsistent with the round 3 consensus. With Mental Health, 29% of participants changed their selection to become congruent with round 3 compared with 6% of participants whose selection was inconsistent with round 3. With Last Chance, 28% changed their selection congruent with round 3 while 9% were incongruent. All of these percents were statistically significant ( $z > 2.58$ ,  $p < .01$ ).

**DISCUSSION:** After listening and talking to others, the vast majority of CHAT participants changed the composition of their individual benefits package with selections highly consistent with the group consensus reached in round 3. While participants rarely changed their selections of universally-desired categories (like Primary Care), the categories less well-known to participants were most susceptible to the influence of rounds 2 and 3 discussions.

These findings suggest that the process of free discussion and consensus-building had an educational and persuasive effect on participants. This is an important consideration if employees will be assuming more responsibility for making individual or group decisions about costs and services.

### **RECOGNIZING TRADE-OFFS AND PRIORITIES**

Another measure of CHAT's impact was the discovery, in the words of the participants themselves, of what they learned from and felt about their experience. The last two questions on the post-CHAT survey were open-ended: *What, if anything, surprised you the most in today's CHAT session? What, if anything, did you find most valuable in today's CHAT session?*

Seventy-five percent of participants completed these voluntary questions, and their responses had several common themes.

**What surprised you in CHAT?** The common themes were:

- *How people's priorities or points-of-view are different.*
- *How difficult it was to develop a plan for others or to make trade-offs.*
- *That we can't have everything.*



Typical responses:

- Difficult to pick & choose what's most important – hard to predict the future.
- How difficult it was to make choices when forced to choose between valued services.
- How one person's decision can really make a difference in someone else's pocket.
- The differing ideas of what a "basic" plan covers.
- Some people were more interested in "perks" than basic overall coverage.
- The great discussion that the group had when sharing their views.
- People not wanting to spend money on other people's health problems.
- That we agreed more than we disagreed, and that most individuals were fair in making choices for others.
- The struggle to find a happy medium between everyday costs vs. costs that may be incurred in the future.
- How fast the markers were used up is what surprised me the most.



### What was most valuable about CHAT?

The common themes were:

- *Having to prioritize, understanding there are limitations.*
- *Learning about health insurance, coverage, costs, options.*
- *Hearing from others; group process.*



Typical responses:

- The realization that I can't look at my specific needs when designing a plan for the bigger population.
- Great learning experience about something I don't know a lot about.
- Learned about how random health crisis can be and how unexpected in nature.
- Hearing the various view points and the logic that supported them.
- Teamwork, exchange of ideas, hearing how other people evaluate and make decisions.
- Got a good idea of how difficult it is to propose comprehensive coverage to a group.
- The opportunity to discuss this information with my fellow employees.
- Broader understanding of the difficult coverage decisions employers face daily.
- Made me think about health insurance in ways that I haven't before.
- Feeling what's it's like to have to make these difficult choices.
- There are lots of choices and sometimes you have to forgo some things to get others.
- Re-evaluated what I consider to be BASIC health care needs.
- Made me see how many things I take for granted with my healthcare coverage today.
- Having the opportunity to express my opinion.



The post-CHAT survey also asked participants how they viewed being part of CHAT:

<i>Which statement most closely represents your view about participating in CHAT? (N = 736)</i>	
This will make a difference in the way I consider my health care coverage:	26 %
It's given me something to think about:	63 %
No new information, but it was enjoyable:	9 %
It was not a good use of my time:	1 %

**DISCUSSION:** Participants not only grasped the challenge of priority-setting, they seemed to enjoy the intellectual and interpersonal exchange required to find consensus when there is not a “right” answer.

While many participants came to CHAT knowing little about health costs or health insurance, they were readily engaged and enthusiastically took on the responsibility of creating a statewide plan. While the debates were energetic, often with laughter, the seriousness of the subject was not lost on participants. Said one person: *This is not an easy thing at all. So, if we are uncomfortable with everything here today I absolutely think that is what this exercise was supposed to do.*

For most participants, the challenge of thinking beyond their own needs to those of large numbers of people may have been the greatest value of CHAT.

*“I think when you are designing it for the whole state though, then you have to look at not just individuals but everybody combined.”*

# 6

## SUMMARY OF FINDINGS

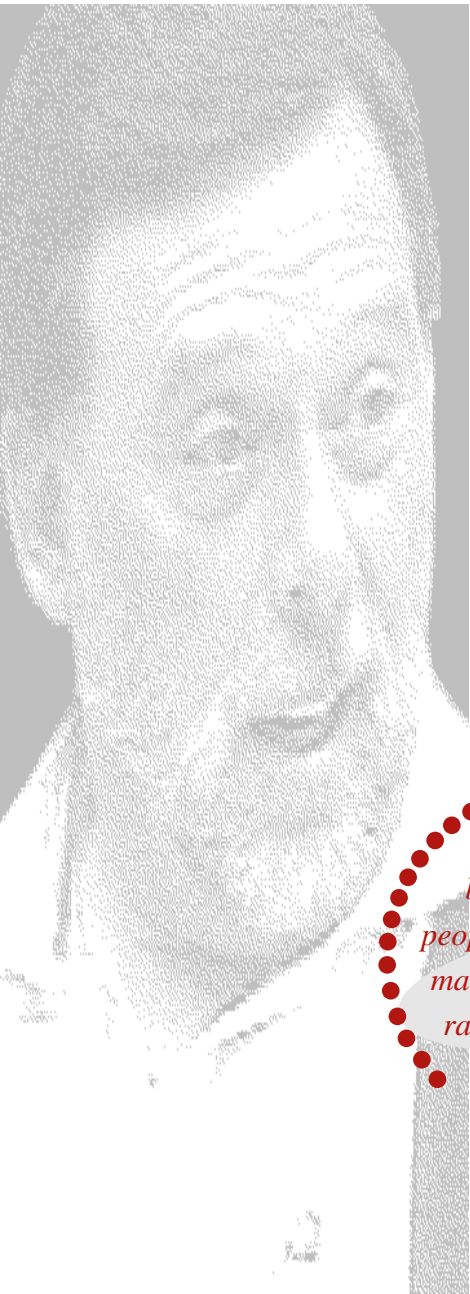
Analysis of the round 3 transcripts, the pre- and post-CHAT surveys, and statistical review of the coverage decisions suggests several conclusions about what most participants believed, what they valued, and how they responded to the challenges of CHAT.

- **Participants initially placed greatest priority on those healthcare services with which they have the most experience.**

Since their healthcare exposure was often limited to primary care, hospital care, pharmacy, dental and vision, participants initially gave little thought to other services that were unfamiliar or addressed future or unexpected needs. For example, in round 1 only 38% of participants included Last Chance but 73% chose Vision care. At the beginning of CHAT, concern about a catastrophic health event was a lower priority than having coverage for services that they knew they would use.

- **Most participants thought of health insurance as guaranteed services, not as pooled resources that all must share.**

The premise of insurance, where many pool their funds so that the unlucky few can be protected from financial disaster, is not the prevailing view of health insurance. While individuals expect insurance to protect them in case of catastrophic medical expenses, they also view it as a set of services that can and should be utilized fully. The contradiction of maximizing use of insurance benefits while minimizing the cost of those benefits wasn't apparent to most participants. Thus, designing a plan with limited resources that met the diverse needs of all California employees was an eye-opener for those who hadn't seen insurance as finite.



*“I think, by and large, most people are interested in a maintenance type thing, rather than looking at the future.”*

*“If you pay for something, then you have that mental thing, like I’m wasting my money if I don’t use it.”*

● **Preventive healthcare services need to be covered benefits or consumers would not use them.**

Many participants believe that the average person would not or could not pay out-of-pocket for routine healthcare services unless insurance pays all or part of the cost. This was especially true for services like Vision, Dental Care or routine healthcare screening exams. Participants often spoke as if no coverage meant no access.

*“No Dental?  
There is going to  
be a lot of people with  
no teeth. Who is  
going to buy me  
dentures?”*

● **Fairness means there should be something for everyone.**

In decisions for “all of California,” the concept of fairness was to cover the broadest possible range of services. This comprehensiveness of services was usually more important than the features of choice, convenience or cost-sharing. However, when presented with services many regarded as marginal (e.g., Infertility, Quality of Life or Complementary), the other features took precedence.

● **Participants are capable of making difficult trade-offs when given the responsibility for doing so.**

While the challenge and novelty of making trade-offs was apparent in participants’ post-CHAT comments (pages 15-16), all the CHAT groups accepted the task with energy and commitment. On the post-CHAT survey, 90% of participants indicated that they were very or somewhat satisfied with the health plan choices made by the whole group (Q. 18, Appendix D).

Some decisions meant giving up desired categories, and others involved accepting categories that were not important to the individual. For example, many resented providing coverage for health problems they regarded as self-imposed. Despite this, 40% of the CHAT groups included coverage for drug and alcohol treatment programs in their state plan, while only 14% did so for their individual plan. Thus, many participants took a broad view of the needs of the state and the impact that problems like substance abuse have on families, workplaces and communities. This coverage decision reinforces the conclusion that participants are able to consider the needs of many – and not just their own needs – when given the responsibility to do so.

*“Nothing we  
choose will satisfy  
everybody, but we’re  
looking at the masses, the  
majority of what people  
need, not necessarily  
what they want.”*

● **Participants accepted for themselves the statewide benefits package that they had a role in creating.**

Eighty-five percent of CHAT participants indicated they were willing to abide by their group’s decision on a statewide health plan, even though 47% of participants felt that their current health benefits were more generous than the CHAT benefits (Q. 19, 20, Appendix D). Participants were also influenced by their group’s decision: their individual choices in round 4 often coincided with those their group made in round 3.

While enthusiastic about group decision-making, many also indicated that they would want to purchase additional coverage if a benefits package was too limiting.

It is important that business leaders understand employees’ perspectives since this is the lens through which many employees will judge the changes to their healthcare coverage. But more important, these findings show that the average person can play a responsible and active role in helping to address the trade-offs facing today’s workplace environment.



# 7 IMPLICATIONS FOR EMPLOYERS

## *LIMITATIONS OF PROJECT DATA*

Business leaders may want to use some of the results of this project – such as the coverage decisions made in rounds 1, 3 and 4 – to help inform their specific decisions regarding healthcare benefits. They should, however, take a cautious approach to viewing these choices as definitive:

- CHAT is a simulation and the trade-offs represented here may not replicate those being considered by a particular company or those available from health plans.
- The individual results for a participating organization may reflect the perspectives of as few as 10 employees.
- The total results reflect the views and choices of employees from more than 40 different organizations who have varying benefits packages, experiences and financial resources.
- What individuals indicate they want in a simulation exercise may not be the same as they would choose in real life.

Despite these caveats, the results of the CHAT process can help employers develop strategies for working with their employees.

## *WORKPLACE STRATEGIES*

Economists are predicting that health insurance premiums will continue to rise significantly in coming years. While policymakers debate various cost-containment strategies, those potential interventions will not affect costs appreciably in the immediate future. Many employers are facing the dilemma of what steps to take if they need to make changes in employees' health benefits package.

The significance of CHAT lies as much, if not more, with its process as with the coverage decisions made by the participants. While the coverage decisions can be discussion-starters, it is the process of employee involvement and ownership in decision-making that are key to developing mutually-agreeable benefits plans. There are several actions employers can take.

**1. Discover what employees know and do not know about healthcare insurance.**

For example, CHAT learned that only 45% of participants indicated that they knew the total cost of their own monthly health insurance premium (Q. 10, Appendix D). People enjoy surveys (especially on computer) and if anonymity is guaranteed, a survey can be an effective way to pique employees' interest, develop baseline information and serve as the foundation for an education program.

**2. Develop interactive seminars on relevant topics.**

Identify interesting or controversial aspects of the CHAT findings – such as trade-offs between coverage of routine services vs. catastrophic care, or healthcare as a “shared resource” – to acquaint employees with current healthcare dilemmas. Adult learning techniques which use individual and group problem-solving skills are particularly valuable when dealing with the details of healthcare coverage that many consider dreary or arcane.

**3. When presenting health insurance options, find a way to show the consequences of insurance features.**

Coverage details as a way to compare various health plan choices do little to stimulate self-learning. By comparison, CHAT's Health Event Lottery uses realistic scenarios to illustrate the impact of individuals' benefits decisions. This same technique could be used to illustrate the pros and cons of different benefit plan designs.

*“I'm just stating why I would want it...we don't have to vote for it but still I just want to be heard.”*

**4. Involve employees directly in corporate decisions about health plan benefits.**

Employees appreciate being involved in corporate decisions, even as they recognize their input alone is not determinative. When asked on the post-CHAT survey, 59% of participants **agreed strongly** that it is important for employees to have a role in deciding about healthcare coverage for their company (Q. 22, Appendix D).

Participants were particularly enthusiastic about CHAT's interactive discussion and decision process where everyone had a chance to contribute. Individuals will negotiate and compromise if given the information, opportunity and responsibility.

**5. Keep employees informed.**

Communicate directly with employees about the rationale for proposed changes in healthcare benefits, coverage or choices. Let employees know how their input was used by the organization.

Involving employees may become even more important as new models of health coverage put greater emphasis on the employee's role as purchaser and decision-maker. Consumer-driven plans and other emerging models will require a higher level of consumer knowledge and foresight. Employers, insurance brokers, purchasing cooperatives and others in leadership roles need to establish creative ways to help employees adjust thoughtfully and realistically to healthcare in the 21<sup>st</sup> century.



## PARTICIPATING BUSINESSES AND ORGANIZATIONS

Totals – 41 groups, 72 meetings, 744 participants

### PRIVATE SECTOR (total meetings = 43)

California Chamber of Commerce  
 California Foundation for Independent Living Centers  
 EDS (3)  
 “Focus group” (2)  
 Golden State Donor Services  
 Health Rights Hotline  
 Hubbert Systems Consulting  
 Kaiser Institute for Health Policy  
 KVIE  
 Leadership Sacramento (2)  
 (Sacramento Metro Chamber of Commerce)  
 Legal Services of Northern California  
 Loaves and Fishes  
 MAAP (Mexican-American Alcoholism Program)  
 Ogilvy Public Relations  
 PRIDE Industries (2)  
 PriMed Consulting (5)  
 PWA Insurance Services  
 Raley’s  
 Sutter Community Benefits Committee  
 Sutter Regional Programs  
 Sacramento Bee (4)  
 Safety Center, Inc.  
 Teichert Corporation (5)  
 VSP (4)  
 Western Contract

### PUBLIC SECTOR (total meetings = 29)

California Department of Health Services, Medi-Cal Operations Division (2)  
 California Senate Fellows Program  
 California Legislative Staff  
 CalPERS  
 Department of Managed Health Care (2)  
 El Dorado County Health Plan Advisory Committee  
 Elk Grove School District (4)  
 Executive Fellowship Program  
 Placer County Health Department  
 Sacramento County  
 Department of Public Works (2)  
 Department of General Services (2)  
 Department of Health and Human Services (3)  
 Department of Human Assistance  
 Department of Workers Compensation  
 IHSS (In Home Supportive Services) Staff  
 IHSS Providers  
 San Juan School District, Administrators Association  
 Yolo County Employees (2)

## CHAT BENEFIT CATEGORIES AND BENEFIT LEVELS

Below are the 16 categories, in alphabetical order, used on the CHAT board for this project. Some categories have one or two benefit levels (Basic, Medium) and others have three levels (Basic, Medium, High) depending on how extensive the services. *In parentheses are the numbers of markers needed to choose each level of each category.* The markers needed are proportional to the cost of the service within a benefits package. There are 99 possible places for markers but only 50 markers to spend.

**COMPLEMENTARY:** *Pays for alternative treatments.*

(1) **BASIC:** Covers acupuncture and acupressure for pain; chiropractor for back or neck problems. You use a network of licensed providers. You pay \$10 per visit for these services. Covers up to 20 visits a year.

**DENTAL CARE:** *Pays for the care of your teeth.*

(3) **BASIC:** Cleanings and x-rays every 6 months at no cost to you. Limited network of dentists who use basic materials. After \$50, basic dental services are 80% covered such as emergencies, cavities, oral surgery. Pays 50% of crowns, bridges. Max. coverage is \$1,000 yr.

(3+4) **MEDIUM:** Same dental services as Basic level, but many dentists to choose from who use more elaborate materials. Your plan pays for 80% of all dental care (50% for dentures) up to max. of \$2,000 yr. Braces are covered at 50% for each family member up to \$1,000 each.

**HOSPITAL CARE:** *Pays for in-patient hospital bills except for mental illness.*

(12) **BASIC:** You have no choice about which hospital you go to. You pay nothing for your hospital stay. Your doctor needs to discharge you as soon as possible.

(12+3) **MEDIUM:** You have a larger selection of hospitals from which to choose. You pay nothing for your hospital stay unless you choose the most expensive ones; then you pay \$50 a day. Your doctor needs to discharge you as soon as possible.

(12+3+1) **HIGH:** You can go to any hospital you choose but you may have to pay up to 10% of the cost (\$2,000 maximum). Your doctor can keep you in the hospital as long as he or she wants.

**INFERTILITY:** *Pays for tests and procedures for a woman having trouble getting pregnant.*

(1) **BASIC:** All types of infertility testing and medical treatments are covered, including surgical procedures to correct problems that prevent pregnancy.

(1+1) **MEDIUM:** In addition to testing and procedures, this includes up to \$30,000 for procedures that may help you (or spouse) get pregnant, such as in vitro fertilization (IVF).

**LAST CHANCE:** *Pays for special treatments in very serious or life-threatening situations when the usual remedies do not work.*

(1) **BASIC:** Your plan covers all the cost of organ transplants.

(1+1) **MEDIUM:** In addition to organ transplants, it also pays for you to take part in research on new treatments that are being tested. This would be an option if you are not getting better with current treatments.

**LONG TERM CARE:** *If you become badly disabled or injured, it pays for extended care in a nursing facility or at home. You must be healthy at the time you apply for this benefit.*

(5) **BASIC:** If you can't eat, dress or go to the bathroom by yourself, your plan pays 70% of the cost of a nursing facility for up to 3 years. There is no inflation protection.

(5+5) **MEDIUM:** If you can't eat, dress or go to the bathroom by yourself, your plan pays 90% of the cost of a nursing facility for as long as you need it. Includes inflation protection. You may separately buy the same coverage for an additional family member — spouse, parent or child.

(5+5+4) **HIGH:** Same as Medium but you can either go to a nursing facility OR receive help in your home. Your plan pays 90% of the nursing facility or about 150 hours a month of in-home care, for as long as you need it.

**MENTAL HEALTH:** *Pays for out-patient and in-patient treatment for mental illnesses; may include alcohol or drug treatment programs.*

(1) **BASIC:** Provides coverage for 9 mental health problems, such as schizophrenia, manic-depressive disorder and anorexia. Unlimited therapists visits; you pay \$20 a visit. Also covers in-patient care for these 9 problems. Choice of therapists and hospitals is limited.

(1+1) **HIGH:** Besides the 9 conditions, this level covers other mental health problems and drug and alcohol treatment programs. It covers 30 visits a year; you pay \$20 a visit. Covers in-patient care for 30 days, at no cost to you. Wider choice of therapists or hospitals.

**PHARMACY:** *Pays for the medicines that your doctor prescribes.*

(5) **BASIC:** Your plan only pays for medicines on its accepted list ("formulary"). A pharmacist must give you the generic, instead of brand-name, if available. You pay \$10 for generic, \$20 for brand-name.

(5+2) **MEDIUM:** If your doctor wants to prescribe a medicine not on the formulary, it must first be approved. Pharmacist may use either generic or brand name drugs for your prescription. You pay \$5 for generic, \$15 for brand name.

(5+2+1) **HIGH:** Your doctor can prescribe any medicine without following a list or getting approval. You pay \$5 for either generic or brand name.



**PRIMARY CARE:** Pays for your primary or family doctor to take care of you, including preventive care, routine screening tests and wellness classes. Includes use of ambulance and emergency room (ER).

(5) **BASIC:** You have few doctors to choose from. You wait several weeks to get a routine visit. Office visits and wellness classes cost you \$15. Screening exams (mammograms, colon tests, etc.) are no cost to you. Ambulance and ER visits cost you \$50.

(5+2) **MEDIUM:** There are more doctors to choose from; you wait a week for a routine visit. Office visits and wellness classes cost you \$5. Screening exams (mammograms, colon tests, etc.) are no cost to you. Ambulance and ER visits cost you \$25.

(5+2+2) **HIGH:** You can go to any doctor you choose and there is very little wait for a routine visit. Office visits and wellness classes, screening exams (mammograms, colon tests, etc.), ambulance and ER visits are all provided at no cost to you.

**QUALITY OF LIFE:** Pays for tests, procedures and medications that may enhance quality of life, even though they may not be “medically necessary.”

(1) **BASIC:** This covers such things as weight-reduction pills, hair growth medications, Viagra, minor acne treatment, circumcision, laser surgery to correct vision, full body scans and others. Your cost ranges from \$20 co-pay to 50% of the cost of laser surgery and scans.

**REHABILITATION SERVICES:** Pays for out-patient physical, speech and occupational therapy, nutritional counseling and equipment such as wheelchairs, hearing aids, artificial limbs and special devices for your home.

(1) **BASIC:** The service or equipment must be ordered by your doctor or therapist and approved by your health plan. Limited number of therapists to choose from. You pay \$15 for each therapy session and 20-50% of the cost of most equipment.

(1+1) **MEDIUM:** If your doctor or therapist orders it, approval by your plan is not required. There are many therapists to choose from. Your plan pays all the cost of services and equipment.

**SCANS AND X-RAYS:** Pays for x-rays and high-tech scans (such as CAT scans and MRIs) that help identify certain medical problems.

(4) **BASIC:** Your doctor needs to have certain tests approved before ordering them. You may need to wait many weeks for a scan if it is not an urgent problem.

(4+2) **MEDIUM:** Your doctor can order any scan or x-ray without getting approval. You may need to wait a week for a scan if it is not an urgent problem.

**SPECIALTY CARE:** Pays for visits with a specialist, including treatments and procedures for complex illnesses or injuries that your primary doctor doesn't handle. This includes doctors who do surgery, treat cancer, heart problems, etc.

(12) **BASIC:** Must have referral from your primary doctor to see an in-plan specialist. You pay \$10 per visit. Choice of specialists is limited. You may wait 45 days for non-urgent visit. If you go to an out-of-plan specialist, you pay for all of it.

(12+3) **MEDIUM:** Do not need a referral from your primary doctor to see an in-plan specialist. You pay \$10 per visit. There are many in-plan specialists available. You may wait 25 days for a non-urgent visit. If you go to an out-of-plan specialist, you pay half the cost.

(12+3+3) **HIGH:** You do not need a referral from a primary care doctor. You can see any specialist in the U.S. for \$30.

**TESTS:** Pays for laboratory tests and other procedures (such as treadmill tests for the heart or an EKG) to help diagnose when a medical problem is suspected. This does not include x-rays or scans.

(4) **BASIC:** For some tests and procedures, your doctor needs approval. You may have to wait several weeks to get the test or procedure if it is not urgent.

(4+2) **MEDIUM:** Your doctor can order any tests without getting approval. There is very little waiting time.

**UNINSURED:** Helps pay for basic health insurance for those who may have lost their job or have no insurance where they work. Although they do not qualify for state programs (like Medi-Cal), they cannot afford to buy insurance without help.

(2) **BASIC:** You contribute to a fund that helps 1 in 8 uninsured Californians buy health insurance at a price they can afford.

(2+2) **MEDIUM:** You contribute to a fund that helps 1 in 4 uninsured Californians buy health insurance at a price they can afford.)

**VISION:** Pays for eye exams, glasses and contact lenses.

(1) **BASIC:** You get an eye exam once a year, if needed. You pay \$10 a visit. You get \$75 towards glasses or contact lenses every 2 years.

## HEALTH EVENT LOTTERY

Randomly-selected computerized lottery cards are used with rounds 1 and 2, after participants have already designed their health plans. With the lottery, participants can see how their benefits package responds when common or uncommon health events occur. The level of benefit that the participant chose for that category (e.g., Basic level Hospital Care) is hi-lighted so the actual coverage is apparent. If the participant didn't choose that category, the lottery card says that all costs must be paid by the individual.

*“Long Term  
Care was something  
we didn't have on our  
group plan and then she  
had that one lottery card  
where I thought, man  
we'd be really up a  
creek.”*

Here are examples of three (of the 90) lottery cards from this CHAT project:

### DENTAL CARE

*You've had a toothache for weeks. You go to the dentist. The tooth, which already has fillings, is cracking and needs a crown.*

**BASIC:** After you pay \$50, your plan pays 80% of fillings and half the cost of a crown. With a total bill of \$1,000, you will pay \$560.

**MEDIUM:** You have many dentists to choose from. It costs \$1,000 for repairs and a crown, of which you pay \$200.

### HOSPITAL CARE

*You have had a heart problem for many years; it has now gotten much worse. Your doctor thinks the best care possible would be at a specialized cardiac center.*

**BASIC:** Your insurance does not cover the cardiac center, so you would have to pay \$27,000 to go there. Instead, you go to an in-plan hospital; insurance pays the entire \$14,000 bill.

**MEDIUM:** Though you have a wide selection of hospitals, the specialized cardiac center is not covered. Your stay at an in-plan hospital cost \$14,000 and is paid by your insurance.

**HIGH:** Your plan will pay \$26,000 for your treatment at the specialized heart center; your co-pay is \$1,000.

### LAST CHANCE

*You developed hepatitis from a tattoo you got at age 21. Now your liver is failing and a liver transplant is the only option left. These transplants cost about \$300,000.*

**BASIC:** Your insurance pays the entire cost of the liver transplant which, with follow-up care, will be at least \$300,000.

**MEDIUM:** Your insurance pays the entire cost of the liver transplant. If it fails, you could enroll in an experimental program testing the use of pigs' livers in humans.

## CHAT PARTICIPANTS: DEMOGRAPHICS AND RESPONSES TO SELECT SURVEY QUESTIONS

Group name: ALL GROUPS  
 Date of CHAT session(s): Sept. 26, 2002 - July 17, 2003  
 Number of participants: 744  
 Number of groups: 72

Results are given in %; totals below or above 100% are due to rounding.

1. Gender: Male: 38 %  
 Female: 62 %

2. Ages: 18 - 29 12 %  
 30 - 39 23 %  
 40 - 49 32 %  
 50 - 59 25 %  
 60 and up 8 %

3. Family status:  
 Single 26 %  
 Single with dependents 10 %  
 Couple 24 %  
 Couple with dependents 39 %

4. Your race or ethnic group (choose all that apply)  
 Asian 8 %  
 Black or African American 8 %  
 Hispanic or Latino 10 %  
 Native American 2 %  
 White 72 %  
 Other 4 %

5. What is the highest grade or level of school that you have completed?  
 8th grade or less 0 %  
 Some high school but did not graduate 0 %  
 High school graduate or GED 8 %  
 Some college or two-year degree 34 %  
 Four-year college degree 35 %  
 Post-graduate degree 22 %

6. Which category describes the total yearly income for your household?

\$0 to less than \$10,000 0 %  
 \$10,000 to less than \$20,000 3 %  
 \$20,000 to less than \$35,000 13 %  
 \$35,000 to less than \$60,000 24 %  
 \$60,000 to \$90,000 23 %  
 More than \$90,000 36 %

7. Generally, would you say your health status is:

Excellent 27 %  
 Very Good 51 %  
 Good 18 %  
 Fair 3 %  
 Poor 0 %

8. Do you or anyone else in your household have a disability or chronic health condition?

Yes 34 %  
 No 64 %  
 Not sure 2 %

9. During the past 12 months, how much did you or your household spend on medical and dental care? (Not including the cost of your health insurance premium)

None 2 %  
 Less than \$200 23 %  
 Between \$200 and \$500 30 %  
 Between \$500 and \$2,000 33 %  
 More than \$2,000 11 %  
 Don't know 1 %

10. Do you know the total cost of your monthly health insurance premium that is paid by your employer AND you?

Do not know 56 %  
 Yes 44 %

11. How much of your monthly health care insurance premium is paid by YOU or YOUR SPOUSE?

Do not know 12 %  
 \$0 (employer pays it all) 24 %  
 \$1 - \$30 11 %  
 \$31 - \$60 13 %  
 \$61 - \$100 12 %  
 \$101 - \$200 13 %  
 More than \$200 11 %  
 I or my spouse pay the entire premium 3 %

12. All health plans have some coverage restrictions. Which best describes how much you know about your health plan restrictions?

I know nothing	6 %
I know a little	42 %
I know a fair amount	37 %
I know a lot	15 %

13. Agree or Disagree: Given the rising cost of health care today, it is reasonable to limit what is covered by health insurance.

	<i>Pre-CHAT responses</i>	<i>Post-CHAT responses</i>
Agree strongly	12 %	25 %
Agree somewhat	35 %	47 %
Disagree somewhat	26 %	18 %
Disagree strongly	23 %	8 %
Not sure	3 %	1 %

14. Of the factors listed below, select the 3 that are MOST important to you in considering your health insurance coverage:

	<i>Pre-CHAT responses</i>	<i>Post-CHAT responses</i>
● Having a choice of which hospital I go to	17 %	19 %
● Paying as little as possible for my share of the health insurance premium	38 %	40 %
● Having a large selection of primary care doctors to choose from	28 %	39 %
● Seeing a specialist without having to be referred by my primary care doctor	40 %	28 %
● Being able to get doctors' appointment quickly	64 %	58 %
● Being able to see a specialist who is not part of my health plan	26 %	19 %
● My doctor being able to order tests and medicines without getting approval	52 %	50 %
● Paying as little as possible for my medicines or doctor's visits	32 %	44 %

**(POST-CHAT QUESTION ONLY)**

15. Of the factors you selected in the last question, which ONE thing is most important?

● Having a choice of which hospital I go to	4 %
● Paying as little as possible for my share of the health insurance premium	21 %
● Having a large selection of primary care doctors to choose from	14 %
● Seeing a specialist without having to be referred by my primary care doctor	7 %
● Being able to get doctors' appointment quickly	24 %
● Being able to see a specialist who is not part of my health plan	4 %
● My doctor being able to order tests and medicines without getting approval	14 %
● Paying as little as possible for my medicines or doctor's visits	11 %

**OTHER POST-CHAT QUESTIONS**

16. If you had more money ("markers") to spend on the last round, which ONE thing would you have spent them on:

● Long Term Care	22 %
● Primary Care	12 %
● Specialty	9 %
● Hospital	9 %
● Pharmacy	8 %
● Dental	8 %
● Mental Health	6 %
● Some other non-CHAT category	5 %
● Uninsured	4 %
● Last Chance	3 %
● Rehabilitation Services	3 %
● Vision	3 %
● Complementary	2 %
● Tests	2 %
● Scans and X-rays	1 %
● Quality of Life	1 %
● Infertility	1 %

17. For me, making decisions on where to put my CHAT markers was

Very easy	17 %
Somewhat easy	38 %
Somewhat difficult	38 %
Very difficult	6 %

18. To what extent were you satisfied with the health plan choices made by the whole group together?

Very satisfied	39 %
Somewhat satisfied	51 %
Somewhat dissatisfied	8 %
Very dissatisfied	1 %

19. If this process today had been real, would you be willing to abide by the group's decision?

Yes, definitely	31 %
Yes, probably	55 %
Probably not	9 %
Definitely not	2 %
Not sure	1 %

20. In general, the health insurance coverage you were able to buy with the CHAT markers seemed (pick one only)....

● Much more generous than what I currently receive	2 %
● Somewhat more generous than what I currently receive	8 %
● About the same as what I currently receive	41 %
● Somewhat less generous than what I currently receive	32 %
● Much less generous than what I currently receive	15 %
● Not sure	2 %

21. To what extent do you Agree or Disagree with this statement: After participating in CHAT today, I want to learn more about my health insurance.

Agree strongly	38 %
Agree somewhat	50 %
Disagree somewhat	6 %
Disagree strongly	1 %
Not Sure	4 %

22. Agree or Disagree: I think it is important for employees to have a role in deciding about health care coverage for their company.

Agree strongly	59 %
Agree somewhat	33 %
Disagree somewhat	5 %
Disagree strongly	1 %
Not Sure	1 %

23. Which statement most closely represents your view about participating in CHAT today:

● This will make a difference in the way I consider my health care coverage.	26 %
● It's given me something to think about.	63 %
● No new information, but it was enjoyable.	9 %
● It was not a good use of my time.	1 %





## STATISTICAL ANALYSES OF SELECT PARTICIPANT RESPONSES

Carol Parise, PhD, research scientist at Sutter Institute for Medical Research, conducted the statistical analyses of CHAT results using SPSS version 11.5.1. The analyses were conducted for several reasons:

- *To determine if there was a relationship between participants' demographic characteristics and how they answered certain pre- and post-CHAT attitudinal questions.*
- *To determine if there was a relationship between demographic characteristics and the benefit categories participants chose in round 4.*
- *To determine if and to what extent participants were influenced by group discussions (rounds 2 and 3) in their subsequent individual decisions in round 4.*

Although the 744 CHAT participants were somewhat over-represented by those with higher education and income, there were a sufficient number of participants at the lower income and education levels for analyses of these groups to be valid.

While most of the demographic characteristics of participants were analyzed, many – education, health status, family status, presence of disability, frequent use of healthcare services – had no statistically significant association with how survey questions were answered or which benefit categories were chosen (categories of ethnicity other than Caucasian did not represent a large enough sample size to analyze).

However, the demographic variables of age, gender, and income were associated with several differences in participants' responses. Comparisons between pre- and post-CHAT results were analyzed as differences between group responses rather than changes between individual responses.

The following are the results of the analyses of survey questions that were central to the project.

<sup>1</sup> Pearson Chi-Square and standardized residuals were used to assess the association and the Test of Independent Proportions was used to examine differences between specific proportions of interest. Logistic regression analysis was used to obtain odds ratios and 95% confidence intervals (CI) around the odds ratios.

## SELECT PRE- AND POST-CHAT SURVEY QUESTIONS

**1. Agree or Disagree: Given the rising cost of health care today, it is reasonable to limit what is covered by health insurance** (asked both pre-CHAT and post-CHAT, Q.13, Appendix D).

In considering just one of the four possible responses, *agree strongly*, participants' views changed markedly: pre-CHAT, 12% of all participants agreed strongly with the statement while post-CHAT, 25% did so ( $z=2.73$ ,  $p < .01$ ). Females, younger age, and lower income people were less likely to agree with this statement pre-CHAT - 9% of women versus 16% of men; 2% of people under age 30 versus 16% of people age 50+; and 8% of participants with income less than \$35K versus 20% of participants with income of \$90K+.

The demographic patterns were similar for this question post-CHAT although all groups showed post-CHAT responses in proportionally similar ways. For example, post-CHAT, 22% of females agreed strongly, increasing from their pre-CHAT of 9%; 13% of people under age 30 agreed strongly, increasing from their pre-CHAT of 2%; and 15% of participants with income less than \$35K agreed strongly, an increase from the 8% who agreed strongly pre-CHAT.

**DISCUSSION:** By asking this question at the beginning and end of CHAT, the change in response was an indicator of whether CHAT participants' views were influenced by their participation. These results show that their views changed in a meaningful way, even among the demographic groups that disagreed about the need for limit-setting at the start of CHAT.

**2. Which statement most closely represents your view about participating in CHAT today?** (Q. 23, Appendix D)

This question was a measure of the impact CHAT had on participants. Twenty-six percent of all participants answered this question with the strongest response, *"this will make a difference in the way I consider my healthcare coverage."* While there was not a large variation in the demographics of those who responded this way, the most significant variable was age: those in the 18-29 age group were 2.2 times (95% CI=1.3, 3.6) more likely than players age 50+ to respond that CHAT will make a difference.

**DISCUSSION:** These results suggest that younger people are more likely to be impacted from the CHAT experience than older people. Perhaps younger employees have less experience with using healthcare benefits and have thought less about healthcare costs and coverage issues.

**3. If this process today had been real, would you be willing to abide by the group's decision?** (Q. 19, Appendix D)

Willingness to abide by a group decision is an important factor in considering CHAT (and other consensus-building efforts) as a tool for making societal decisions. In identifying which groups were more likely to represent the 31% of participants who answered this question *"yes, definitely,"* analyses showed that participants age 40+ were 2.2 times (95% CI=1.3, 3.9) more likely than participants under age 30 to respond *"yes, definitely."*

**DISCUSSION:** Although younger participants are most affected by using CHAT (the previous question), they are less likely than older participants to abide by their group's decision. Perhaps this resistance is related to their skepticism about limit-setting (noted in item #1 above) or that older people are more accustomed to consensus-based decisions.

**4. Do you know the total cost of your monthly health insurance premium that is paid by your employer and you?** (Q. 10, Appendix D)

This was the only "knowledge" question on the survey. Fifty-six percent of participants did not know the total cost and 44% responded that they did know. Men were somewhat more likely than women to know, but the major demographic variable was low income and younger employees. Those aged 18-29 were 66% less likely [OR = .34, 95% CI = (.20, .57)] to know the cost than were those older than 50. Those earning less than \$35K were 61% less likely [OR = .39, 95% CI = (.24, .63)] to know the cost of their premium than were those earning more than \$90K. Age and income were highly correlated. For example, 43% of people earning less than \$35k per year were 30 years old or younger. After adjustment for age, income was still associated with knowledge of premium amount. People earning less than \$35k per year were 49% less likely [OR = .51, 95% CI = (.37, .84)] than participants earning \$90k+ per year to know the cost of their premium.

**DISCUSSION:** As reflected in the analyses of the other questions, lower income and younger participants (two groups that often overlap) may be less involved with healthcare as a workplace issue. While most participants (88%; see Q. 11, Appendix D) knew what they paid for their share of the monthly premium, the knowledge gap about the total cost of health insurance suggests that employers may want to do more to bring this information to their employees.



#### ***PARTICIPANTS' CHOICES IN ROUND 4***

In round 4, participants made their final decisions on what they wanted in their benefits package for themselves and their families. They already completed three earlier rounds of CHAT, heard the arguments of colleagues and had a chance to test their choices via the Health Event Lottery. Thus, round 4 represented their most informed decisions. Since the major benefit categories (e.g., Hospital, Primary Care, etc.) were chosen by almost everyone, the categories of interest were those chosen by some people but not all. Like the survey questions, the most statistically significant differences were related to gender, age, and income.

#### **MENTAL HEALTH**

Sixty-one percent of all participants choose Mental Health in round 4. Among all the demographics, gender was the only variable significantly associated with choosing coverage: 66% percent of women included this in their coverage, compared with 53% of men. Thus, women were 1.7 (95% CI = 1.3, 2.4) times more likely than men to select Mental Health as a covered benefit.

#### **LONG TERM CARE (LTC)**

Thirteen percent of all participants chose Long Term Care coverage and this percentage increased as annual income decreased. Twenty-three percent of participants with household incomes of less than \$35K annually included LTC in their health plan, compared with 11% of participants earning \$60-or more.

#### **VISION**

Sixty-five percent of all participants chose vision coverage. This benefit category was particularly appealing to lower income and younger participants. Seventy-four percent of participants earning less than \$35K chose Vision, while only 55% did of those earning more than \$90K [OR=2.3, (95% CI = 1.4, 3.8)]. Age was similarly associated, with 74% of those aged 18-29 choosing Vision compared with 57% of those aged 50 and older [OR=2.1, (95% CI = 1.2, 3.6)]. The association of income after adjustment for age was not meaningfully different than the unadjusted result.

#### **COMPLEMENTARY**

Increasing age was associated with selecting Complementary care coverage. Thirty percent of people age 50+ chose coverage compared with 18% of people under age 30 with (OR = 2.0, 95% CI = 1.1, 3.7)

#### **QUALITY OF LIFE (QOL)**

Both income and age were associated with this category. Seventeen percent of people earning less than \$35K per year chose QOL compared with 7% of people earning \$90K or more per year. Age was also moderately associated with choosing QOL where 21% of people younger than 30 chose QOL compared with 12% of people aged 50+. However, when income was adjusted for age, neither of these demographics was statistically significantly associated with choosing QOL.

The other discretionary categories – DENTAL and LAST CHANCE – showed only slight variations by demographic groups.

**DISCUSSION:** The paucity of demographic variation among the coverage categories is notable. Perhaps there are so many factors that influence which categories individual participants most value, that identifying single determinants is challenging. Nevertheless, the differences that exist are interesting. Perhaps LTC and QOL coverage being associated with income simply means that high-income participants can afford to purchase LTC policies and QOL services out-of-pocket while low-income individuals cannot. Vision care's greater popularity with low-income and younger participants may be related to their use of the service, or they are more aware of the out-of-pocket cost, or perhaps they do not envision needing some of the other categories that they had to forgo to include Vision.

### ***INFLUENCE OF ROUND 3 DECISIONS ON COVERAGE CHOICES IN ROUND 4***

The following is the statistical basis for the analysis and discussion in the section titled Changing Coverage Choices on page 14.

Assessment of the impact of group decisions on individuals' coverage choices in round 4 was done by classifying participants into four voting patterns. These patterns describe how they voted for each of the coverage categories in rounds 1, 3 and 4 (as noted earlier, we did not track the responses of round 2, regarding that as an intermediary step for participants to become more familiar with the options). These voting patterns were defined as YES or NO. YES meant that participants chose Basic, Medium or High level coverage; NO meant that the category was not chosen. The following are the 4 responses patterns:

#### **PATTERN #1:**

No change in coverage choice for any round (e.g., YES-YES-YES, where participant voted YES for Last Chance in rounds 1 and 4 and was in a group that voted YES in round 3).

#### **PATTERN #2:**

Same coverage in rounds 1 and round 4, but round 4 coverage choice was different from the group decision in round 3 (e.g., YES-NO-YES, where participant voted YES for Last Chance in rounds 1 and 4, but the group decision in round 3 was NO).

#### **PATTERN #3:**

Different coverage in round 1 and round 4 but round 4 coverage choice was the same as the group's choice in round 3 (e.g., YES-NO-NO, where participant voted YES for Last Chance in round 1 and voted NO in round 4; the group decision in round 3 was also NO).

#### **PATTERN #4:**

Different coverage choice in round 1 and round 4 and round 4 coverage choice was the opposite as the groups' choice in round 3 (e.g., YES-YES-NO, where participant voted YES for Last Chance in round 1 and voted NO in round 4; the group decision in round 3 was YES).

Participants were classified in this manner for all coverage choices.

The goal of the analysis was to determine if the discussions that took place between round 1 and 4 appeared to have an influence on coverage choices made in round 4. Therefore, the two response patterns where participants changed their responses between rounds 1 and 4 were compared. Pattern #3 participants appeared to be influenced by the group's decision in round 3 since they changed their coverage choice in round 4 to what their group chose in round 3. Pattern #4 participants changed their coverage in round 4 from round 1 but in the opposite direction from what their group in round 3 chose. The Test of Independent Proportions was used to compare the participants in these two categories.



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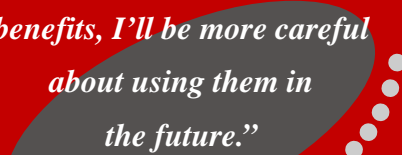
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*“I had  
become desensitized  
to the cost issue. Rather than  
think about how to maximize my  
benefits, I’ll be more careful  
about using them in  
the future.”*



*Post-CHAT interview with participant  
who worked in the Benefits Division of a private  
sector company.*



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