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BALANCING ACT: CREATING A SUSTAINABLE HEALTH CARE BENEFITS PACKAGE

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EXECUTIVE SUMMARY

Stakeholders of all stripes are at near-consensus on the importance of adequate health care coverage for all Americans. To date, steadily rising costs and the expanding ranks of the uninsured have led policymakers to concentrate on how to finance universal coverage. Communities and states that have succeeded in developing a workable financing structure are now faced with the equally challenging task of constructing a benefits package that is fair, affordable, and sustainable.

In order to create viable coverage models, we must examine certain assumptions: that all health care has value and must be covered; that insurance is to pay for services rather than to meet agreed-upon health care needs; and that the priorities of the individual trump the priorities of society. It is unlikely that expanded coverage plans—whether at the community, state, or national level—will be sustainable without questioning these widely held assumptions.

There are four key strategies for developing a benefits package in an era of health reform. Each can be considered independently or in various combinations.

Targeted cost sharing. Asking individuals to pay more for coverage—by contributing higher premium payments, co-payments, co-insurance, or deductibles—is often the first step that employers take to reduce their own cost burden. However, for lower-income individuals (who are most likely to be the target of coverage expansion plans), high cost sharing limits access to services; if used indiscriminately, this approach can render insurance coverage meaningless. Some organizations now incorporate creative cost sharing arrangements that encourage the efficient use of services and health-promoting behaviors and discourage the use of high-cost, low-value interventions.

Efficient providers. Better coordination of care, more selective use of specialists, and restricting choice can yield meaningful cost savings without sacrificing quality. In developing an affordable benefits package, policymakers can assess the efficiency and quality of local providers, be selective about which providers are used, establish treatment standards, and create mechanisms to monitor care delivery.

Treatment value. Medical treatment is frequently provided despite insufficient benefit to the patient. Scarce resources can be allocated more efficiently by adhering to evidence-based medical practices and by incorporating cost-effectiveness as a criterion for coverage.

Prioritizing needs. Health care coverage has become increasingly comprehensive as medical science has extended its reach into ever more aspects of the human condition. To prioritize needs is to differentiate between health care that supports the most essential aspects of human functioning and that which serves to enhance an individual's quality of life. If societal resources are limited, we must ask ourselves which health care needs must be met for everyone and which must be the responsibility of the individual.

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The task for policymakers is to find the appropriate mix of these four strategies commensurate with population-based needs, finite resources, and community values. While the question of public values has not been a routine part of the health debate, some communities have used citizen engagement tools to help define the specifics of coverage. Small group interactive methods like CHAT® transcend the limitations of public opinion surveys to help us understand what people value and why.

While medical science has a seemingly boundless capacity to offer improvements in health care, society does not have a boundless capacity to pay. The task of expanding coverage responsibly and fairly requires policymakers to make decisions that take into account the voices of those who will benefit from the coverage and the larger society that will finance it.

This paper discusses benefits design as an essential element of health care reform and as indispensable to achieving cost containment. It presents various strategies for crafting less costly high-value coverage, cites examples of health plans that have done so, and proposes a process that can build consensus for creating sustainable benefits packages.

INTRODUCTION

Hardly a week goes by without a governor or a presidential candidate announcing a plan for achieving universal health care. While there are many creative proposals for how we will foot the bill for universal coverage, there is less evidence of creativity when it comes to designing a fair and sustainable benefits package.

In its 2007 report on the progress made by the individual states in expanding health care coverage, AcademyHealth, a national policy research organization, concluded that the states have had little success in addressing the underlying costs of health care and that reaching agreement on what services would be covered has proven to be particularly difficult.¹ Ignoring these challenges is no longer an option. Families, employers, and government cannot sustain the steadily rising costs of our current health care system. At the same time, the public is unhappy that more and more Americans are uninsured. If we are to move forward on expanding coverage, we must devise a politically acceptable process for designing a benefits package that acknowledges that our resources are finite.

CONTROLLING THE PREMIUM

The average employer-based health insurance premium is now \$4,242 per person per year.² This cost is influenced by three factors:

1. The prevalence of illness, disease, and disability. Current cost drivers include obesity, diabetes, and other chronic conditions that are increasingly prevalent among Americans of all ages.³
2. The cost of treating illness, diseases, and disability. This includes the price tag of medical technologies, treatments, and providers; inefficiencies in the health care system; unnecessary medical treatments; and the under-use of effective care.⁴
3. The inclusions and limitations of the benefits package. This is the primary means by which society can decide how its health care dollars are spent.

In the best of all worlds, the prevalence of illness and disease would be lower and treatment costs would be better controlled, minimizing the need to adjust benefits. However, achieving major reductions in the prevalence of disease and the cost of treatment is a long-term endeavor. Dramatic cost-containment steps (such as instituting strict price controls, putting all physicians on salary, or restricting expenditures through a budget process) are not likely to pass political muster in the near future. Nor are states going to be able to afford \$4,242 per person to expand coverage. Therefore, they will need to take a critical look at what constitutes essential health care coverage.

Carefully executed benefits design can be an effective backdoor approach to reducing prevalence and cost. For example, individuals whose health care plan includes a financial incentive to maintain normal cholesterol levels may be more likely to do so and thereby reduce their risk of stroke (thus impacting prevalence). A benefits package requiring stricter evidence-based criteria for coverage of expensive diagnostic tests (such as MRI scans) could help reduce the cost of medical care.

Yet benefits design will also need to confront societal assumptions about medical care and the purpose of health insurance. Our seemingly unlimited capacity for innovation in medical science produces a steady stream of new and costly interventions and has expanded our concept of what constitutes illness.⁵ In short, there seem to be no limits to the frailties of the human condition that medical science will seek to remedy. These developments have expanded the boundaries of medically necessary care and the obligations of health care insurers. It is not enough to ask: How do we cover everyone? We must also ask: What should everyone be covered for?

THE CHALLENGES OF BENEFITS DESIGN

Most states attempting to expand coverage develop financing mechanisms before they address benefits design. Neither task is easy, and it is logical to try to gain momentum and stakeholder support for the first level of commitment before tackling the next. Whenever benefits design is undertaken, prevailing American views about health care may preclude ready answers. Those views include:

All health care has potential value. Since comprehensive coverage has been the norm for most employer-based coverage, it is not surprising that many individuals assume that all medical problems should be covered by health insurance. Nor is it surprising that providers often agree. This perspective was evident in 2003 when, as part of its initiative to encourage universal health care in California, the Blue Shield of California Foundation undertook its Essential Health Benefits project.⁶ Dozens of expert physicians from a variety of clinical and administrative positions were asked to develop a list of prioritized essential benefits. According to the foundation, what they came up with was “closer to a comprehensive package than a minimum.” The experts were neither bound by budget constraints nor offered guidelines for assessing the relative importance of health care services or treatments. Thus, virtually everything in the medical toolkit was considered to be essential.

If the Foundation’s project was intended to help determine how to allocate finite resources, its experts should also have been asked to consider societal priorities. This balancing of societal and clinical perspectives is essential to the task of allocating resources.

Coverage is defined as services provided. A typical health care plan defines benefits under such categories as hospital care, specialty care, and prescription drugs. While this is the easiest way to describe and determine the cost of a benefits package, it may not be the best way to make decisions on how our health care dollars are used.

For example, in 2004 hospital services represented about 30 percent of the total cost of health care in the United States.⁷ But as a category, this does not specify the reason someone requires a hospital stay. The patient may be getting cardiac by-pass surgery for heart disease, gastric by-pass surgery for morbid obesity, a knee repair to help a weekend athlete resume running marathons, or a fallopian tube repair to enable a woman to become pregnant. All of these are problems that medicine tries to remedy, but they may not be of equal significance.

We should first ask ourselves what we want our health care system to achieve—rather than what we want insurance to pay for.

The individual’s needs are foremost. The patient recovering her fallopian tube function is likely to regard this surgery just as essential as any other medically appropriate treatment. Yet, as policy leaders and the public face trade-offs regarding comprehensiveness and affordability, many may question the rationale for optimizing each person’s health status if more basic health care needs are not being met for a significant portion of the population. This is not a new problem. Fifteen years ago, as the Clinton administration began its attempt to expand coverage, health economist Victor Fuchs noted, “The divergence between what is beneficial for the individual and what is beneficial to the society as a whole is the key element in the current health care debate.”⁸

This is still key to the current debate. Since universal coverage must be supported by communal dollars (public and/or private), we must ask: What is it that those communal dollars will provide for all members of our society, and what is it that individuals will need to provide for themselves? The challenge is to develop a fair means for answering those questions.

STRATEGIES FOR AFFORDABLE BENEFITS DESIGN

There are four promising strategies for reducing the cost of a benefits package, which can be applied or linked together in a variety of ways.

Targeted Cost Sharing

In recent years, the default strategy for most employer-based plans has been to have employees and their families absorb a greater share of the cost of the insurance premium or of the care they receive. This varies from the simplest approach (e.g., the employee pays for dependent coverage) to arcane combinations of co-payments, deductibles, co-insurance, and caps. Offering high-deductible plans is a convenient and uncomplicated way to take some of the cost burden off the sponsors (businesses and government). However, when faced with substantial out-of-pocket costs, individuals are as likely to forego necessary care as unnecessary care.⁹ Moreover, as costs continue to rise, there are limits to what consumers can absorb, resulting in a cost burden that renders them essentially uninsured. This is particularly the case for middle- and lower-income individuals whose underinsurance leaves them vulnerable to personal bankruptcy.¹⁰

While high-deductible plans may be appealing to healthy, higher-income individuals, lower-income individuals have a very low threshold for what they think they can afford and will discontinue care when that threshold is reached.¹¹ Thus, other cost sharing arrangements may be more effective and equitable.

Lower co-payments for choosing generic over brand-name drugs are now common. This concept could also be applied to encourage the use of effective, but less costly, tests and procedures, the use of urgent care centers instead of emergency rooms, and healthy behavior, such as getting preventative care or joining a fitness club. Another possibility would be to tailor a cost sharing program to the individual's income level and/or to the degree of risk to his or her health. For example, a patient with a difficult chronic condition might be fully covered for the medications that will keep him stable. One study demonstrated that eliminating co-payments for high-risk patients on cholesterol-lowering therapy reduced the use and cost of hospital and emergency care.¹² Waiving or reducing co-payments is not simply an act of charity; it is a way to avoid the costly repercussions of a patient failing to comply with his medical regimen because he cannot afford to pay his share.

Efficient Providers

Research has shown that health care costs less, with no sacrifice of quality, when it is provided by well-run managed care organizations rather than through fee-for-service arrangements.¹³ Integrated medical groups with their closed panels of salaried physicians have been shown to outperform independent medical associations (whose physicians are only loosely affiliated with each other) when it comes to quality-of-care measurements.¹⁴ There is also evidence that more care is not necessarily better care and that specialty care is often overused.¹⁵

While the data suggest that using more efficient providers is an area with great potential for cost savings, it is also a subject that generates public disquiet. Choosing one's own doctor is a value that Americans hold dear. The managed care backlash of the late 1990s dealt a blow to health plans that employed restrictive networks and heavy-handed pre-approval processes. Although consumers have been generally satisfied with managed care plans that now have fewer restrictions, this freedom has been accompanied by higher costs and increases in insurance premiums.¹⁶

Interest in "high-performance" provider networks is growing among purchasers and health plans as they scrutinize physicians' practice patterns. A number of health plans use tiered co-payments to encourage the use of the most efficient providers, i.e., those with proven track records for delivering high-quality care at lower costs.¹⁷ Pitney Bowes, a large employer with a leadership role in health care cost containment, saved \$12 million in 1996 when it charged lower premiums to employees who used more cost-efficient providers.¹⁸ Researchers at Milliman,

Inc, a health care consulting firm, have calculated that the development of provider networks with no excess physician capacity, tightly controlled referrals to specialists, and physician “extenders” (such as nurse practitioners) could significantly reduce health care costs.¹⁹

Although using these high-performance networks could mean significant cost savings, a shortage of primary care physicians and the likely resistance of organized medicine may limit this strategy. Interestingly, the public may now be more willing to compromise on the issue of physician choice. In a study conducted several years ago, researchers found that two-thirds of lower-income adults would accept limits on provider choice in exchange for lower out-of-pocket costs.²⁰ Higher-income adults were less willing to do so.

Treatment Value

Stricter standards for determining when medical interventions (such as prescription drugs, tests, or procedures) are covered could also lead to lower costs. Such standards encompass two discrete categories.

Proven effective. In recent years, the quality of medical care has become a major focus of U.S. health care leaders and researchers. The RAND Corporation, which has been studying the question of appropriate care for many years, has concluded that a third or more of all health care procedures performed in the United States are of questionable benefit.²¹ One way to deal with this problem would be to move toward the practice of evidence-based medicine (EBM), requiring providers to adhere to medical interventions whose effectiveness has been demonstrated in clinical trials.

Effectiveness standards are still lacking in many clinical areas, but these gaps are shrinking. The bigger problem may be resistance on the part of physicians and other health care providers to establishing, monitoring, and maintaining high EBM standards.²² For example, while research has shown that an MRI scan is not an effective tool for diagnosing the cause of isolated acute low back pain,²³ physicians still commonly prescribe the procedure for this purpose. Patient demand also helps drive the overuse of many procedures.

EBM is also useful in assessing new medical technologies. According to a report prepared for The Commonwealth Fund, “One-half to two-thirds of the long-term [health care] spending growth is because of the so-called march of science.”²⁴ New prescription drugs, surgical devices, and diagnostic tools are often introduced so quickly into clinical practice that little is known about their relative effectiveness and impact on health outcomes. Technology assessment studies are becoming more common and some health plans or medical groups use the results for treatment or coverage decisions. There is growing interest in developing a national center where uniform, objective, and transparent analyses can be conducted and the results used with confidence.²⁵

Tying cost sharing to evidence of effectiveness could reduce the use of less effective treatments without imposing inflexible standards of coverage. If a patient with low back pain were required to pay half of the \$1,000 cost of an MRI scan, he might think twice about insisting on a procedure whose diagnostic value is low. In an era when patients are encouraged to take an active role in their treatment decisions (and to take more financial responsibility for those decisions), basing co-payments or co-insurance on demonstrated clinical effectiveness is one way to encourage “good value” decisions.

Sufficient worth. Whereas EBM standards are intended to discourage the use of interventions that have not been proven effective or are less effective than other approaches, cost-effectiveness analysis (CEA) compares the effectiveness of an intervention relative to its cost. An example of this is a cancer drug that costs \$50,000 and would likely give a patient only six more weeks of life.

Cost-effectiveness analysis sounds like a topic that only an economist can love. It is in fact an approach that needs the perspective of the general public. Consider the cancer patient referred to above. Clinical experts know which medical interventions (e.g., drugs, surgery, radiation) are available for particular stages of the disease; the extent that treatments may impact the course of the disease; and the possible burden to the patient, such as uncomfortable side effects or a shortened life span. These assessments are the purview of clinical experts. But the question of whether society should pay for a high-cost, marginally beneficial treatment should incorporate societal views on what constitutes good value.

By all accounts, policymakers assume that the public would reject cost-effectiveness analysis as a factor in coverage decisions. However, recent studies conducted in New York and California showed that most consumers support the idea.²⁶ In the California project, 80 percent of the respondents to a post-discussion survey said that they thought using cost-effectiveness standards were appropriate in some or most situations. And when the participants in this study were asked to rank their receptivity to the use of cost-effectiveness standards when compared with other actions to control costs, they ranked it among the top three.

FIGURE 1. Sacramento Healthcare Decisions. *Getting Good Value* project, post-discussion survey, 2006.

There are different ways that we may control the cost of health care, though most experts agree that it will take a variety of actions to do this. Of those listed below, which ones do you support (check all that apply):	
(N = 296) (listed in order of response)	
Put more dollars into prevention to reduce expensive care later	75%
Price controls on expensive drugs and profit-making aspects of health care	67%
Use cost-effectiveness standards like those discussed in this exercise	56%
Increase government oversight to reduce waste, greed, and abuse	49%
Reduce high administrative costs by financing health care through government	46%
Reduce amount paid to doctors, hospitals, and other providers	22%
Establish annual health care budget and stick to it	22%
Have consumers pay more so they are careful about services they use	20%
Other	8%
Disagree: should not try to control rising costs; too valuable to reduce	5%

Source: See http://www.sachealthdecisions.org/docs/ggv_report.pdf

Although the United States lags well behind other Western countries in using cost-effectiveness analysis as a tool for allocating resources, interest is growing. Many believe that applying CEA standards is the only way to control the impact of the cost of new technologies.²⁷ A comprehensive report was recently submitted to the U.S. Agency for Healthcare Research and Quality with recommendations for incorporating cost-effectiveness analysis in health care policy.²⁸ While this report ultimately envisions a strong federal role in establishing CEA policy, leadership at the state and private sector levels is critical to creating the conditions for change. Local and state interest may well provide the impetus for national action.

Prioritized Needs

Restricting coverage of certain health care categories or needs, as opposed to restricting coverage of specific interventions, is another approach to cost containment. Apart from cost sharing, the most common practice of lower-cost plans is to eliminate whole categories of services, such as prescription drug coverage and behavioral health services. Modifications of this approach include setting limits on the number of medical “encounters” that are covered during a calendar year (for example, the number of prescriptions that can be filled), or by capping the dollar amount available for specific services. Like high-deductible health plans, these limitations can be very blunt instruments if coverage of critical services is indiscriminately disallowed.

An alternative approach is to consider the various needs that health coverage addresses, rather than the services it pays for. If limits on available resources preclude doing everything that is medically possible, then society should be explicit about the goals of health care that it deems most important. Such an approach is used in Sweden, where the first step in establishing coverage guidelines is creating priority groupings for clinical care.

FIGURE 2. Priority Groupings for Clinical Care in Sweden (Ninth Futures Forum, World Health Organization, 2006)²⁹

Priority group	Content of care
IA	Care of life-threatening acute diseases and diseases that, if left untreated, will lead to permanent disability or premature death.
IB	Care of severe chronic diseases. Palliative terminal care. Care of people with reduced autonomy.
II	Individual disease prevention in contacts with medical services. Rehabilitation as defined in the Health and Medical Services Act.
III	Care of less severe acute and chronic diseases.
IV	Borderline cases.
V	Care for reasons other than disease or injury.

Sweden has many more steps to its process for coverage decisions, but this is a simple example of categorization by magnitude of medical problems.

In the United States, infertility treatment is usually one of the first items that lower-cost plans drop from coverage. While the rationale for doing so is rarely explained, infertility is, after all, not life threatening, will not prevent a person from being employed, is not likely to lead to bankruptcy, and there are other ways to have a family. But if we are to establish acceptable parameters for affordable coverage, we need a process that allows individuals and communities to articulate why coverage is justified for some interventions and not for others.

There is also a bright line between treatment value and prioritized needs. Take the drug Viagra for treating erectile dysfunction. The medication passes all the tests of treatment value: it is effective and meets evidence-based criteria. It is also cost-effective, in that the benefit that individuals derive from the drug is well worth its modest cost. Nevertheless, when the public is asked to design a basic benefits package, the drug is often excluded because the problem it addresses is not considered to be as important as other medical needs. In this case, the significance of the need is the determining feature, not how well the treatment works or how much it costs.

APPLYING THESE STRATEGIES TO BENEFITS DESIGN

A system of sustainable coverage will likely employ all four of these approaches to benefits design. The key will be deciding what emphasis to place on each and how to promote and sustain a delivery system that is able to implement them effectively.

To illustrate how these strategies can be applied, below are brief descriptions of how two communities with finite resources developed expanded coverage programs. The primary focus here is on how these plans used the concepts of treatment value and prioritized needs to help define their coverage and how they involved the community at large in developing their benefits packages.

The Oregon Health Plan

In the late 1980s, the state of Oregon made the first serious attempt to define basic benefits in this country. Then state senator John Kitzhaber worked with the Oregon legislature for several years to develop a universal coverage plan. The first phase involved increasing the number of low-income residents enrolled in the state's Medicaid program.³⁰ Kitzhaber believed that by eliminating coverage of unnecessary or marginally beneficial care and the treatment of less critical problems, Oregon could bring more low-income people under Medicaid without necessarily spending more money.³¹

The process for establishing the Oregon Health Plan (OHP) benefits package was unusual in many ways. The Oregon Health Services Commission (which included physicians, other health professionals, and consumer representatives) ranked the relative efficacy of medical interventions and categorized them according to their impact on individual and societal well-being. The final result was a listing in rank order of more than 700 pairs of medical conditions and treatments. Depending on the available funding, the OHP would cover conditions and

treatments as far down the list as possible. As of early 2007, funding was available through item number 530.³² The list is reviewed periodically to incorporate new research and medical advances and to keep it current with available funding.

While the OHP also has systems requirements (for example, whenever possible, contracts are established with managed care organizations to economize on the cost of provider services), the plan's unique aspect is its emphasis on eliminating coverage for treatments that do not demonstrate a sufficient level of effectiveness and for treatment of conditions whose impact on the individual or on society does not rise to a certain level of importance. To illustrate how these criteria are applied, the plan currently excludes treatment of low back pain that has no neurological involvement (rationale: there is conflicting evidence on the benefit of treatment) and cancer treatments when there is less than a 5 percent chance that the patient will live more than five years (rationale: the likelihood that the treatment will be effective is small).³³

It may be surprising that a potentially helpful treatment would be denied to a person with an otherwise fatal condition. The OHP creators, who were required to make some difficult trade-offs, relied on population-based criteria to establish the rules for coverage. They also did not leave it entirely up to physicians to figure out for themselves what constituted appropriate care: the list of condition/treatment pairs clearly specified what would be covered. While some physicians objected to ceding autonomy for treatment/coverage decisions, others appreciated not being put in the position of denying an intervention of dubious benefit to a patient who wanted it.³⁴

At its peak, this expansion program enrolled 125,000 more low-income residents than it had under its previous Medicaid program. However, revenue shortfalls have devastated the program, requiring selective cost sharing on the part of some enrollees and a reduction in the number of participants. When the OHP was devised, it was intended that coverage along the prioritized list would fluctuate with available funding. However, the federal government has greatly restricted how much Oregon can reduce the list of funded condition/treatment pairs. This has led the state to make significant reductions in optional Medicaid services provided in its expansion program. This less-generous benefits package, coupled with increased cost sharing requirements and declining funding for the program, has seen the number of people enrolled in the expansion portion of the plan reduced to a current level of 22,000.³⁵

Oregon's Senate Bill 27 of 1989 required the Health Services Commission to "actively solicit public input through a community meetings process to build a consensus on the values to be used in guiding health resource allocation decisions."³⁶ In community discussion groups throughout the state, facilitators used different scenarios to learn about individuals' health care priorities and the rationale for the health care decisions they made. A key finding was the high priority that community members placed on disease prevention, a concern that was reflected in the development of the condition/treatment pairs. The creators of the Oregon Health Plan used a variety of other tools to gain public input, but it was the discussion groups that were particularly relevant to the prioritization process.

Muskegon's Access Health Plan

In Michigan, Muskegon's three-share plan (funded jointly by the community, employers, and employees) was initiated in 1999 and has become a model for other communities wishing to expand coverage to the working uninsured. Access Health has a number of distinguishing characteristics: it is still thriving after eight years; its monthly premium has increased by only about 5 percent per year and is still less than \$200 per person per month; and attrition of employers and employees is very low. The plan enrolls between 1,200 and 1,500 individuals each year, its growth being limited by the amount of the community share. For the purpose of this paper, it is Muskegon's benefits package that is of particular interest.³⁷

Although the plan contracts with virtually all the physicians in the region (which was a condition of their support), there are many mechanisms in place to assure high-quality, effective care. The plan incorporates various managed care principles, including pre-authorizations for certain procedures, an assigned primary care provider (PCP), and an ambitious case management program. There are also some uncommon requirements for plan members: they must sign a contract agreeing to meet with their PCP upon enrollment, complete a health assessment, and follow a preventive care schedule.

Prioritizing needs is a significant component of the plan's design. While many of the typical exclusions of other lower-cost plans are in force here (e.g., no coverage for dental, vision, hearing, chiropractic, sexual dysfunction, substance abuse, and infertility services), the plan also excludes from coverage:

- Any health care needs that could be provided for by another entity, such as mental health problems that could be treated in existing community-based programs; workplace injuries covered by workers compensation; injuries from automobile accidents that should be covered by automobile insurance; and prenatal care that might be available through an existing public-sector program.
- Medical problems caused by a failure to use standard safety equipment, high-risk activities like skydiving and bungee jumping, or the chronic abuse of alcohol or a controlled substance.
- Services that do not address an actual medical problem, such as vaccinations required for foreign travel or physicals required for employment.

The W. K. Kellogg Foundation, which provided the support to get Access Health off the ground, made it clear that community members had to be involved in devising the plan. During the development process, hundreds of potential enrollees, including businesses and employees, were interviewed. Ultimately, a 40-person working group—a cross-section of the community—provided direction regarding the plan's details.

Muskegon is only one of many places that have developed creative benefit plans tailored to the needs, characteristics, and resources of the local community.³⁸ Like the Oregon plan, Muskegon's Access Health was developed slowly and carefully with the active participation of every stakeholder group and a committed leadership. Since participation by employers and employees is voluntary, creating a benefits plan that both groups approved was essential. While many other "skinny" plans have had difficulty attracting enrollees, Muskegon's has not because local leaders kept a close eye on what purchasers regarded as reasonable.

THE PUBLIC'S ROLE

Both Oregon and Muskegon developed coverage plans that included the perspectives of community members. The leaders of programs that have not engaged the public in discussions of trade-offs may not have known of effective tools for doing so or may not have realized that benefits packages might be adjusted to reflect local needs. Slavish attention to laws and regulations on coverage mandates can also be a deterrent to creativity; a priority setting exercise is an opportunity (theoretically) to throw away all the rules and start from scratch.

One important aspect of any public engagement process is to ask people to consider decisions from their perspective as citizens, not as patients. Health care coverage, whether through public or private insurance plans, is a collective resource; deciding what will be covered should be based on collective values. The differences between what individuals desire for health care coverage and what communities prioritize means that some hard choices must be made if we are to have a just and sustainable system.

PRIORITY SETTING USING CHAT®

Medical ethicists have been considering the implications of finite health care resources for many years. In 1998, two physician ethicists from the University of Michigan and the National Institutes of Health, respectively, developed CHAT (Choosing Healthplans All Together), an exercise requiring participants to make choices among competing health care priorities.³⁹ Its purpose is to educate individuals, to learn how and why people decide what is most important to them, and to facilitate public participation in priority setting.

The paper version of CHAT appeared in 2000, and in 2002 it became available on CD-ROM. At that point Sacramento Healthcare Decisions (SHD) began using the computer-based CHAT version for projects in California with public and private sector employees and then with Medicaid beneficiaries.⁴⁰ CHAT has also been used by groups in other states, as well as in India, New Zealand, and South Africa. Recently a web-based version has been developed.⁴¹

THE JUST COVERAGE PROJECT

Using the CHAT program, SHD developed the Just Coverage project in 2005 in response to growing political and public interest in covering the uninsured and the frequent reference to the undefined term, “basic” health care. This project was not a precursor to a specific health plan; the intention was to show policy makers how citizens think about basic coverage.⁴²

Just Coverage assessed how the public responded to the four approaches to benefits design presented in this paper. In 2005–06, nearly 800 Northern Californians met in 71 small group sessions to design a benefits package with only two-thirds of the dollars normally spent on employer-based health insurance. With more coverage options than resources, the participants were asked to create a health plan based on the question, “As citizens, what is the minimum coverage that you think everyone should have?”

The CHAT software is written to allow project sponsors to customize the available options. For Just Coverage, SHD used 14 categories and switched from the more common services approach (hospital care, prescription drug coverage, etc.) to a needs-based approach, using such categories as episodic care, chronic illness, end-of-life care, and catastrophic illness. There were up to three tiers of coverage for each category; the higher the tier, the better the coverage and the greater the cost. Participants were given markers to “spend” and Milliman, Inc. provided the actuarial basis for estimating the value (the number of markers required) for each tier in every category.

Led by an experienced facilitator, participants designed coverage plans in several rounds—individually, in small groups, and with a group of 10–15 people. Hearing the experiences and perspectives of other participants added an important dimension to this exercise. Additionally, the group discussions from all 71 sessions were tape recorded and transcribed, providing substantive insight on the reasoning behind participants’ choices.

Strategies for affordable benefits design—cost sharing, efficient providers, treatment value, and prioritized needs—were all components considered by participants in designing their “basic” benefits packages. The trade-offs were explicit since the pie chart that showed all the coverage choices had 76 marker spaces to choose from but there were only 50 markers to spend. A number of themes emerged from the choices participants made in designing their theoretical model:⁴³

1. On cost sharing: The plan must be affordable for middle- and lower-income families. Participants kept the share of premium and co-payments low enough to encourage the use of health care services but not so low as to promote frivolous use.
2. On the choice of providers: Most groups opted, albeit reluctantly, for the most restrictive provider network (emphasizing primary care and the highly controlled use of specialty care) in order to use the available funds to cover higher tiers of health care needs. They were adamant, however, that medical care had to be high quality and that access to care could not be restricted.
3. On treatment value: Participants eliminated coverage of low-value medical treatments, that is, where the cost was great and the benefit very small or where there was little evidence of effectiveness. For most this was not a difficult choice to make compared with other trade-offs. To illustrate, participants had an option under the “Maintenance” category (for uncomplicated chronic illness) to spend one additional marker so that a “doctor can order any tests, procedures, and drugs that he thinks will help the patient, without having to follow established guidelines.” None of the 71 groups chose this option, and less than 2 percent of individuals did so.
4. On prioritized needs: Participants did not consider all health care needs to be of equal importance. While they thought that a broad spectrum of coverage was highly desirable, they also thought it was more important to cover health care needs related to fundamental human activity (the ability to carry out the basic functions of daily life, the ability to work and be a productive member of society) than other health care needs.

In addition to being an effective tool for gathering input on benefits design, the CHAT process also had an impact on those who engaged in the exercise. Participants’ attitudes regarding the role of health insurance changed

demonstrably between the start and the end of the session. This change was evident by their responses to the following pre- and post-CHAT survey question:

FIGURE 3. Sacramento Healthcare Decisions’ Just Coverage Project, 2006.

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

	Pre-CHAT response (n=369)	Post-CHAT response (n=353)
Strongly agree	9%	27%
Agree	44%	49%
Not sure	20%	9%
Disagree	21%	12%
Strongly disagree	6%	3%

Source: see http://www.sachealthdecisions.org/docs/jc_report.pdf

An interesting dynamic of the CHAT process was how individuals adapted to the role of making decisions that would affect everyone. Most participants began the exercise focusing on their own health care needs. By the time they finished negotiating with their fellow participants, they had begun to appreciate their role as citizens serving the broader needs of the community. For example, they often seemed resentful about spending resources on treatment for substance abuse (personal responsibility usually loomed large). However, as citizens responsible for a plan that served the state well, they wanted coverage for health care needs that promoted a healthy work force and minimized the detrimental influence that substance abuse has on the community. And while participants were troubled by the prospect of having to limit choice, most concluded that they could not justify the high expense associated with a broad provider network. This did not mean that the participants no longer valued choice, but that other aspects of health coverage were more important. Said one insured participant, “This isn’t the level I would choose for myself, but it is better than not being covered for the care people really need.”

THE MASSACHUSETTS TELEPHONE SURVEY

There are other methods for capturing citizens’ perspectives on health care coverage. Though most public engagement efforts use a discussion group format, the Center for Survey Research at the University of Massachusetts constructed a research project in 1989 based on telephone interviews.⁴⁴ The researchers created 64 vignettes, depicting a variety of conditions and treatment situations, ranging from the ordinary to the catastrophic. In one, a 40-year-old woman has had a cough for a week and now has a temperature of 102 and chills. The woman goes to see a doctor for an examination and medication. In another, a man who has had severe diabetes and kidney failure for many years is close to death. A special form of dialysis offers the hope that he may be kept alive for a few more weeks, or perhaps longer. Cure is not possible.

The telephone interviews were conducted with 206 randomly chosen individuals, each one being asked to answer the same two questions regarding 20 different vignettes: 1) If you were designing a health insurance plan, what priority, on a scale of 1 to 10, would you give the medical service for the problem described? 2) Given that the more an insurance plan covers, the higher the cost of the premium, would you want to be part of a plan that covers the cost of this care? The results of the survey demonstrated the ability of the public to establish priorities:

- Respondents did not rank all health care services as equally desirable for inclusion in an insurance plan.
- There was almost a perfect correlation between what they thought should be included in a health plan and their acceptance of that plan for themselves.
- The highest rated vignettes were those that depicted serious illness or injury: someone injured in an automobile accident, someone with a birth defect, a suicidal patient, someone with HIV-AIDS from a blood transfusion.

- The lowest rated vignettes were those that involved the removal of a birthmark on the arm, an office visit for scraped knee, in vitro fertilization and fertility testing.
- The personal circumstances of the respondents had virtually no relationship to the priority ratings; even those in poor health or with lower incomes were discriminating in what they included for coverage.

Telephone surveys have the advantage of producing large amounts of data quickly and easily. Their greatest disadvantage is that researchers are unable to elicit the participants' rationale for their responses. Even so, such surveys could play a valuable role in providing policymakers at the state and national levels with quantitative data to validate the priorities identified in more qualitative approaches.

MOVING FORWARD

The four strategies discussed here for developing an affordable benefits package—targeted cost sharing, efficient providers, treatment value, and prioritized needs—can be approached in many different ways, depending on political realities and community values. It is the role of policy leaders to find the right balance that will assure fair, affordable, and sustainable coverage for all Americans. The following summarizes some of the the key issues:

Cost sharing. Americans think that cost sharing is unacceptable if it precludes reasonable access to health care services or leads to bankruptcy.⁴⁵ Thus stakeholders need to ask: What is the fairest approach to distributing the burden of cost sharing? What role should incentives or penalties play in motivating consumers to adopt healthier life styles? How can cost sharing be used to encourage the appropriate use of health care services?

Efficient providers. While the inefficiencies of our current health care delivery system are legendary, more economical, high-quality models do exist—from safety net clinics to the Veterans Administration system. Some community-based health care plans (such as Muskegon's Access Health) exert control by contracting only with providers in their immediate geographical region. In other communities, market-based approaches (where consumers pay lower premiums when using more efficient providers) may be the most feasible approach. A primary care model for Medicaid beneficiaries in North Carolina provides, among other things, 24-hour access to a "medical home" and disease management programs; in this instance, a \$10.2 million investment reaped \$244 million in savings.⁴⁶ Improving the efficiency of providers is among the most challenging tasks we face. However, coverage expansion programs can be an opportunity to evaluate existing provider systems with respect to quality and efficiency and to develop other options if necessary.

Treatment value. For this approach to have teeth, authority must be established (as it was in Oregon and Muskegon) to improve adherence to evidence-based medical practices. While more research is needed to fill the gaps in our knowledge, provider organizations must commit themselves to higher standards of clinical care. There is a difference between respecting the professional authority of the physician and tolerating deviant practice in the name of autonomy. Patients are usually very trusting of their physicians and assume that what they recommend is worthwhile. If premiums are to be affordable, payers must be far less tolerant of marginal medical practices. There is growing interest in adopting comparative-effectiveness and cost-effectiveness approaches, and this is an opportune time for states to consider how these approaches could help in the design of affordable coverage expansion programs. In the long term, action on the national level may be needed, but now is the time for states to experiment with new ways of getting the best value for their health care resources.

Prioritizing needs. More so than the other strategies discussed here this approach relies on an engaged and responsible citizenry to help articulate the health care needs that must be met with communal funds. The challenge is to determine our priorities. Those tasked with designing an affordable benefits package might start with a collaborative values-based process to determine what the public sees as "critical" and "not critical." Such an effort seems more suited to deliberation on the local or state level than at the national level. Geographic and cultural boundaries may influence public values related to personal responsibility, social obligations, and the significance of individual fulfillment—all of which might affect community views of what is critical and what is not.

Whether they use the CHAT format or other priority-setting tools to elicit public opinion, political leaders must decide which issues are most important for public deliberation. California's Just Coverage project paid particular attention to the four strategies described here, but there may be different cost-reduction strategies that would work better elsewhere.

The public's values cannot alone be determinative. Yet public values should not be ignored; what may seem reasonable and logical to a policymaker or health care leader may not resonate at all with community members. Equally important, citizens must have ownership of policies that may ask them to contribute more or live with less. Ownership comes from having had a voice in the making of such policies.

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