Designing Coverage: Uninsured Californians Weigh the Options

California HealthCare Foundation

ISSUE BRIEF

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Introduction

In California, as in many other states, a serious debate is under way about expanding access to affordable health care and coverage. The conversation often focuses first on who will be covered and how coverage will be financed, but another question logically follows: What should coverage include? Resources for expansion, whether paid through public budgets or by private employers and consumers, are limited. Examining how uninsured Californians approach coverage design trade-offs—among covered services, consumer costs, and access to providers—is an important step in assuring the best value for societal and personal resources.

In that context, the California HealthCare Foundation asked Sacramento Healthcare Decisions (SHD), a nonprofit, nonpartisan organization that seeks public input on complex health policy issues, to explore how groups of uninsured Californians would design a health plan if the benefits were constrained by finite resources. SHD completed a similar project in 2006, eliciting the views of northern Californians on the characteristics of basic coverage.[1] With some modifications, the same process was used with 121 uninsured Californians in six communities from Ukiah to San Diego. Participants had been uninsured for at least one year and had income levels between 100 percent and 300 percent of the federal poverty level. These individuals were chosen because they were the most likely to be subsidized by the state, and might also be required to contribute to the cost of coverage. This issue brief offers insights on the values and coverage priorities held by a subset of uninsured Californians who might be directly affected by coverage expansion policy proposals.

The Priority-setting Tool

SHD used a computer process called Choosing Healthplans All Together (CHAT)® as the basis for understanding what was important to people.[2] This tool provided individuals with multiple health coverage options, allowing them to mix and match to specify the characteristics of coverage they valued most. The concept of limits and trade-offs was unambiguous since CHAT required participants to make explicit and visible choices among desirable coverage categories. The options that participants debated addressed three aspects of benefits design: 1) amount of patient cost sharing; 2) extent of provider choice; and 3) coverage of various health care needs. The CHAT process is described in the sidebar on p. 2.

Project Participants

SHD contracted with several focus-group organizations to recruit participants who were uninsured, with varied demographic characteristics of age, gender, ethnicity, and education. Table 1 provides the key characteristics of project participants.

Table 1. Demographic Characteristics of Participants
N=121 Unless noted otherwise, percentages greater or less than 100% are due to rounding.

Age	
18-29	28%
30-39	25%
40-49	26%
50-59	18%
60 and up	3%
Gender	
Male	50%
Female	50%
Ethnicity	
Asian	2%
Black or African American	13%
Latino	36%
Native American	7%
White	45%
Other	4%
(does not total 100%; could select more than one category)	
Education (n=120)	
Some high school but did not graduate	9%
High school graduate or GED	23%
Some college	38%
Two-year college degree	13%
Four-year college graduate or higher	17%
Income (n=120)	
Less than $10,000	13%
$10,000 to less than $20,000	22%
$20,000 to less than $35,000	38%
$35,000 to less than $60,000	26%
$60,000 or more	2%
Geographic Location	
Urban/suburban	79%
Rural	21%
Employment	
Employed	71%
Unemployed	29%

The CHAT Process

SHD developed the "Just Coverage" version of CHAT for a previous project and modified it somewhat for the 2007 sessions with the uninsured. On individual laptops, participants considered various coverage options depicted on a pie chart. There were 15 categories (pie chart wedges), with up to three tiers of benefits in each. Participants had 50 markers to spend, representing a premium of approximately $230 per person per month, and there were 80 marker spaces to choose from. Higher tiers brought better benefits but cost more. The number of markers required for each category/tier was based on approximate costs calculated by Milliman, Inc., a national health care consulting firm.

Participants were told to assume that health care coverage would be mandated for individuals without employer-based coverage, and that the plan they were going to design was the one to be available to adults without insurance, including themselves.

CHAT was conducted in four rounds: 1) participants created an individual plan for themselves only; 2) groups of three worked together to create a plan for all uninsured adults in the state; 3) the whole group, led by a facilitator, created one uniform plan for the state; and 4) individuals worked alone to create their final version of a statewide plan for all the uninsured. After the first two rounds, a health event lottery exposed participants to medical scenarios that showed how the plans they created would affect those with this coverage. The round 3 discussions were tape recorded, transcribed, and analyzed. Participants completed pre- and post-CHAT surveys for demographic data, preferences, and reactions. All data were collected anonymously.

Findings

SHD collected the data from all four rounds of CHAT decisions. The findings below are based on the composite results of the last round of CHAT, when participants were most knowledgeable about the process, and each independently designed the coverage plan for all uninsured adult Californians. Table 2 shows a complete description of the categories and tiers and the percent of participants that picked each tier during the last round. The

findings below also incorporate select responses to survey questions and demographic analysis.

Cost sharing. Participants were worried that high cost sharing would be a barrier to accessing medical care. In CHAT, cost sharing was represented by ranges of copayments and share of premium. Although a strong majority of participants settled on the mid-range amounts ($50 per month for the individual's share of premium and $15 copayment for doctor visit: see Table 2 for complete descriptions), women indicated greater concern about costs than did men.

While only 12 percent of participants chose the lowest copayment level ($5 office visit), women outnumbered men three to one in choosing this level. Additionally, 62 percent of women thought that insurance was more important for routine expenses than for large unexpected medical bills. Only 38 percent of men agreed.[3]

While participants thought it was appropriate that everyone pay something, the Premium category generated more debate than Copayments because participants knew this was a continuous financial commitment, regardless of how often they used health care services. For some people, $80 per month was easy; others said, "I would be terrified of how I was going to make ends meet, if I had that kind of expense." (The significance of cost sharing was also evident on the pre-CHAT survey. Among important characteristics of health care services, 73 percent of participants included paying as little as possible for doctor visits, drugs, etc. in their top three, making it the highest ranked response of the six listed.)

Provider choice. Whereas choice of doctor is usually seen as one of the highest health care priorities, it turned out to be less important for the CHAT participants. Two-thirds of participants chose the lowest provider category, which meant medical care from a small group of local doctors, restricted use of specialists, and no choice of hospital. Said one participant, "I'd be happy to see anybody that has a shingle that says MD on it." This was consistent with a pre-CHAT question where only 27 percent indicated that having many doctors to choose from was among the most important aspects of health care services.

Whereas choice was less important, participants cared more about quality of medical care. Sixty-eight percent indicated that getting the same quality of medical care as those with insurance was an important consideration.

Health care needs and coverage breadth. Comprehensiveness of coverage (i.e., covering as many categories of health care needs as possible) was a consistent theme in all the sessions. "If I've only x dollars to spend, I'm going to make sure it goes all the way around the circle" (i.e., pie chart). This sentiment reflected a strong value that when considering the interests of many people, the fairest approach is to cover all the bases. Yet this commitment to comprehensiveness required its own trade-offs and setting of priorities, and participants compromised by foregoing higher tiers for many of the categories.

Participants' rationale for exclusions:

- *If interventions are not likely to be effective.* This was the reasoning for not covering higher tiers of catastrophic care, end-of-life care, and prevention. Most participants believed that the higher tiers described coverage that did not offer a likely chance of being beneficial to a large enough group of people or that it did not justify the additional cost.
- *If problems are the result of irresponsible behavior.* This dominated their perspective in rejecting a higher tier in mental and behavioral health. Most felt that behavioral health problems

(smoking and substance abuse) or less severe mental health problems were the responsibility of the individual and not the responsibility of society.

- *If interventions are less likely to be used.* Extraordinary, though life-saving, interventions, such as heart transplants, are rarely considered essential for basic coverage: Few people need them, they may not work anyway, and more money should be devoted to prevention than to these types of last-ditch efforts.

Conversely, there were certain characteristics that participants felt were important to be included.

- *Needs that affect many people.* This was particularly relevant for dental and vision care. Participants were in such agreement that dental care was integral to good health and was used and needed by everyone that it warranted almost no debate. The value of "benefiting many people" was a consistent theme in all sessions.
- *Needs that seem tangible and relevant to basic functioning.* For example, 70 percent of participants chose the higher tier for maternity, covering complications of pregnancy. They believed that complications were so common that it was irresponsible to put the health of the mother and baby in jeopardy. Almost half also chose a higher tier of complex chronic care to provide more extensive coverage (e.g., joint replacements) for those with serious chronic illnesses. They saw this as a more obvious benefit than higher coverage for maintenance at the earlier stages of chronic illness.

Implications for Policy Leaders

This project captures the views of Californians who may be particularly affected by an individual insurance mandate and the rewards and responsibilities that this entails. The trade-offs and priorities outlined below provide a starting point from which to develop a responsible and acceptable coverage plan.

Tailor cost sharing. While one way to manage premiums is to institute high deductibles, the project findings suggest that this one-size-fits-all approach is counterproductive for lower-income individuals. Since women are particularly concerned about high cost sharing (and are known to make most of the family decisions about health care), other strategies may be more effective in assuring access to needed care and discouraging inappropriate use. Possible approaches include the following:

- Vary copayments and premiums according to income level.
- Reduce copayments for those with chronic diseases whose out-of-pocket expenses would otherwise be unmanageable.
- Increase cost sharing for more expensive interventions if less costly alternatives are available.
- Use financial incentives (positive or negative) to encourage healthy behaviors and medical compliance. This approach also fits well in the personal responsibility ethic that participants espoused.

Designate providers selectively. To achieve the savings inherent in tier 1 providers, there must be provider networks staffed by professionals committed to high-quality care in an environment that supports careful use of resources. Primary care providers—including nurse practitioners—are the mainstay of service delivery, and referrals to specialists are carefully managed. This model has all the earmarks of capitated health care systems—public or private—with strong utilization management. There

are existing examples of this in California, such as some of the Medi-Cal managed care plans.

Cover the care that matters most. A common approach now is to eliminate whole categories of coverage, such as rehabilitative services, dental care, or mental and behavioral health. Instead, consider including coverage for most health care needs but incorporate limits. Specify that standards of evidence-based medicine are required and not optional and apply cost-effectiveness criteria, especially in the use of very expensive but marginally effective interventions.

Consider eliminating coverage of needs that do not have an impact on individuals' ability to function well as members of society. Among all coverage categories, more participants (40%) were willing to forgo the quality-of-life category, which described such medical problems as infertility and impotence. A thoughtful process could identify other such conditions whose treatment cost might be the responsibility of individuals.

Findings strongly suggest that dental care (and probably vision care) should be a part of any health plan, regardless of how basic it is. Although dental and vision are usually the first to be dropped from leaner plans, participants were unequivocal in their need and desire for these services. The coverage does not have to be rich (e.g., a maximum annual dollar limit on the benefit could be imposed), but should include—as it would for preventive medical care—free or low-cost screenings and preventive treatment. Even if there is an individual mandate, people need to believe that they are getting value for their portion of the premium, and, for most people, having dental coverage is a priority.

Conclusion

The policy debate about expanding health coverage and ensuring affordability should incorporate the priorities and values of uninsured Californians. Findings that reflect informed trade-offs, such as those offered here, can contribute to those important discussions.

Limitations of the Project

The small size of the project—121 participants—makes it difficult to extrapolate the findings to other uninsured in California. Participants were also required to be English-speaking and literate (as well as computer literate), characteristics that exclude many of the uninsured in this state.

The significance of the CHAT process depends on how the markers are assigned to each category and tier. By designing categories/tiers around health care needs (rather than health care services), actuarial estimates of the value of each category and tier are less precise. Even small errors in cost assignment might have affected participants' choices.

This project also outlined some trade-offs, but not all possible ways to reduce the cost of health care. Other cost drivers (such as the market-driven prices of drugs and devices, administrative costs, profit margins, and unnecessary duplication of services) represent formidable obstacles to an efficient system. If strategies to address these cost-drivers were implemented and effective, there is no doubt that consumers would prefer them to restrictions on coverage.

Table 2. Coverage Categories/Tiers and Uninsured Individuals' Decisions
Below are descriptions of the categories and tiers, and the percentage of the 121 uninsured individuals that selected each tier in Round 4. The higher the tier chosen, the richer the benefit and the higher the cost. The coverage level chosen by the majority of individuals is in bold italics (percentages greater or less than 100% are due to rounding).

Health Care Needs	Percent Selected	Descriptions of Coverage
Catastrophic Care		**Treatment of sudden, serious injury or illness. Examples: liver failure from food poisoning; being badly hurt in a car crash; deadly cancer.**
	4%	No coverage
	74%	***TIER 1: Treatments are given to try to save your life. Insurance pays for all medical care that is known to be useful.***
	21%	TIER 2: If the useful treatments do not work, also covers treatments that have little chance of helping you but are the only hope left.
Complex Chronic		**For treating chronic illness or conditions, such as diabetes, heart disease, arthritis, and obesity, when they have become serious long-term problems.**
	1%	No coverage
	55%	***TIER 1: Your doctor uses the least costly ways to manage your illness. Such treatments work well for most people. But sometimes they may not work as well as more costly ones.***
	40%	TIER 2: In addition to Tier 1, also covers the more costly treatments. Examples: new knee if arthritis keeps you from walking, insulin pump for diabetics, and stomach surgery for severe obesity.
	4%	TIER 3: If you are at the end stage of your disease, this also covers very expensive treatments (such as heart transplant) that might help you live longer.
Dental/Vision		**For preventing and treating dental problems; testing and correcting for problems with eyesight.**
	6%	No coverage
	24%	TIER 1: Dental care only. Cleanings and X-rays yearly without copayment. Basic dental services are 80% covered, such as emergencies, cavities, oral surgery. Pays 50% of crowns and bridges. Maximum coverage is $1,000 per year.
	70%	***TIER 2: In addition to dental care in Tier 1, covers vision care, which includes vision testing once a year, if needed. Covers $75 toward glasses every 2 years, but not contact lenses.***
End-of-life Care		**This is care when medical treatment cannot cure you, and you are expected to die within the next few months.**
	17%	No coverage
	70%	***TIER 1: Covers hospice care in the home or hospital. This provides good pain control, treats other discomfort, and gives emotional and spiritual support to you and your family. It does not pay for high-tech care that delays dying.***
	13%	TIER 2: Covers hospice care. If you want them, this also covers treatments that delay death for a few days, weeks, or months. Examples: hospital intensive care, CPR, and breathing machines.
Episodic Care		**Treatment for common problems such as sprained ankle, ear infection, strep throat, and poison oak. Also includes emergency cases like appendicitis.**
	1%	No coverage
	74%	***TIER 1: You go to your regular primary care provider for treatment. All emergencies and urgent care are dealt with quickly. If it is not urgent, you may have to wait a week or longer before seeing your doctor or nurse.***
	26%	TIER 2: Besides Tier 1, if you do not want to wait, you may also go to any drop in "store-front" clinic in your area to get care right away, including evenings and weekends. You have the same copayment as if you were seeing your own doctor or nurse.

Table 2. Coverage Categories/Tiers and Uninsured Individuals' Decisions (cont.)

Health Care Needs	Percent Selected	Descriptions of Coverage
Maintenance		**For regular check-ups and treatment for early chronic conditions when they are not yet serious. Examples: asthma, high blood pressure, and diabetes. This will help keep these problems from getting worse.**
	4%	No coverage
	79%	***TIER 1: Your doctor must follow expert guidelines for tests, treatment, and drugs that work well and are the least costly way to control your illness. Though most people do fine with these, they may not work well for all people.***
	17%	TIER 2: If Tier 1 treatment does not work well, also covers more expensive tests, treatments and drugs that also follow expert guidelines.
	1%	TIER 3: Your doctor can order any test, treatment and drugs that he or she thinks will help you, without having to follow expert guidelines for effectiveness.
Maternity		**For medical care of women during pregnancy and childbirth.**
	6%	No coverage
	24%	TIER 1: Covers routine pre-natal care and normal childbirth. This includes monthly doctor visits, pre-natal medications, testing, delivery of the baby, and short hospital stay. DOES NOT cover any additional costs if there are unexpected problems.
	70%	***TIER 2: In addition to Tier 1, covers costs if there are unexpected problems during pregnancy or childbirth. Examples: if pregnancy is not going well and patient has to stay in hospital or if a C-section is needed.***
Mental & Behavioral Health		**For detecting and treating mental illness. Also covers treatment for unhealthy habits, such as smoking and substance addiction.**
	12%	No coverage
	55%	***TIER 1: Pays for treatment of severe mental illness. Examples: bipolar disease, severe depression, and eating disorders. Covers hospital stay, clinic therapy, and medicine. Does not cover smoking, alcohol, or other addiction problems.***
	26%	TIER 2: In addition to Tier 1, covers short-term counseling and medicine for less severe mental health problems, such as mild depression or anxiety. Also covers counseling and medicine for smoking, alcohol, and drug addiction problems.
	7%	TIER 3: Coverage is better than in Tier 2. Now includes long-term counseling for less severe mental health problems. Also covers treatment in the hospital for alcohol and drug addiction, if no other treatment has helped.
Prevention		**To help prevent many diseases and find medical problems as early as possible. There are no copayments for these services.**
	9%	No coverage
	66%	***TIER 1: Covers wellness exams, screening tests, and vaccines, but only when they meet national standards for getting good results. Examples: flu shots, PAP tests at a certain age, colon exams at age 50, and cholesterol screening.***
	25%	TIER 2: In addition to Tier 1, also covers screening that does not meet national standards for getting good results. Examples: mammograms for women under 40 and testing all newborns for very rare diseases.
Quality of Life		**Covers problems in function, appearance or comfort that are not seriously disabling but affect people's quality of life. Examples: injuries that keep you from playing sports, infertility, impotence, and hair loss.**
	40%	No coverage
	60%	***TIER 1: Covers all drugs, medical, and surgical treatment to try to correct these problems.***

Table 2. Coverage Categories/Tiers and Uninsured Individuals' Decisions (cont.)

Health Care Needs	Percent Selected	Descriptions of Coverage
Restorative		**For repairing the ability to do basic daily activities (walking, talking, dressing, bathing, working). This is often needed after broken bones, surgery on joints, strokes, or amputations.**
	16%	No coverage
	44%	***TIER 1: Covers all necessary rehab services, such as physical therapy, to improve important functions. Covers artificial limbs but not patient equipment used at home.***
	40%	TIER 2: In addition to Tier 1, covers basic equipment needed for daily activities, such as crutches and regular wheelchairs. Also covers half the cost of more costly equipment like electric wheelchairs.
Features of the Delivery System		**Descriptions of Coverage (The following four categories were not optional. Participants had to select a tier in each category.)**
Copayments		**These are the amounts that you pay when you use health care services. Copayments are NOT required for the services in the prevention category.**
	31%	TIER 1: There are copayments for most services, such as $30 for doctor visits. You pay $15 for generic drugs and $30 for brand-name drugs. You pay $150 when you go to the ER and $500 for a hospital stay.
	58%	***TIER 2: Copayments are lower than Tier 1. Doctor visits are $15. Generic drugs are $10 and brand-name drugs are $25. You pay $100 when you go to the ER and $250 for a hospital stay.***
	12%	TIER 3: Copayments are lower than Tier 2. Doctor visits are $5. Generic drugs are $5 and brand-name drugs are $10. You pay $25 when you go to the ER and $100 for a hospital stay.
Premium		**Most of your monthly health insurance payments (premium) will be paid by government and businesses. This category sets the amount that YOU pay as part of the monthly $230 premium.**
	26%	TIER 1: You pay $80 per month toward the cost of the health insurance premium.
	64%	***TIER 2: You pay $50 per month toward the cost of the health insurance premium.***
	11%	TIER 3: You pay $30 per month toward the cost of the health insurance premium.
Providers		**These are the professionals that provide your regular medical care, such as exams to keep you healthy, short-term and chronic illness care, and hospital care.**
	66%	***TIER 1: You get your regular medical care from a small group of doctors in your community. Referrals to specialists are not easy to get. If you need hospital care, you can't choose which hospital you go to.***
	33%	TIER 2: You join an HMO to get more choice of doctors. Though you need a referral to see a specialist, this is easier than in Tier 1.
	1%	TIER 3: You have a wide choice of doctors and hospitals. You do not need a referral from your primary doctor to see a specialist.
Care Management		**These are programs to help people stay as healthy as possible. This includes a health review form and care management classes for those with chronic illness. There is no cost to you to participate.**
	84%	***TIER 1: As a new patient, you must complete a health review form. If you have a chronic condition, such as diabetes or obesity, you must attend care management classes if your doctor tells you.***
	16%	TIER 2: You do not have to complete a health review form. If you have a chronic condition, you are not required to attend care management classes.

Endnote

1. The original Just Coverage project included 800 northern Californians, most of them insured. For project results, see www.sachealthdecisions.org/docs/jc_report.pdf or M. Ginsburg, S. Goold, and M. Danis, "(De)constructing 'Basic' Benefits: Citizens Define The Limits of Coverage," *Health Affairs* 25, no. 6 (2006): 1648-1688;10.377/hlthaff.25.6.1648.
2. For information on CHAT visit http://healthmedia.umich.edu/chat/.
3. The difference between men and women was statistically significant based on the Chi-square Test of Independence and standardized residuals (p-value of 0.05 or less).

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