The CHAT Project: Choosing Healthplans All Together

Summary: A program of research to develop mechanisms for public deliberation to promote just rationing of health care services.

Section: Ethics and Health Policy – Unit on Prioritization

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Collaborators:

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Background: Health care is notoriously costly and constantly threatens to exceed available financial resources. Hence, insurers, both public and private, are nearly always faced with decisions about how to allocate limited funds. Prominent ethicists who study the ethics of rationing, including Daniels, Fleck and Emanuel have argued that the application of ethical principles fail to consistently resolve disagreements about how to distribute limited resources fairly. On these grounds, there has been a call for finding fair procedures for allowing stakeholders to make allocation decisions. Along with the lack of useful procedures, is a remarkable lack of public involvement in these decisions, particularly when we consider how profoundly and directly these decisions affect the public. The lack of public or consumer involvement in setting priorities in health policy has been identified as a serious impediment to setting priorities in our health care systems with any solid moral basis.

The obstacles to public involvement are several-fold: When feeling well, most individuals do not perceive the salience of the issues to them. They may be confused or frustrated by the complexity of information. At the community or organizational level, mechanisms for participation are lacking.

The intent of this research is to overcome these obstacles by designing tools and promoting opportunities to involve the public in prioritizing insured health care services.

Objectives:

1. To develop methods for giving a voice to the public in priority setting
2. To create opportunities to utilize these methods for public input in health insurance decisions
3. To determine predictors of health insurance preferences

Methodology: In its initial phases, this research has relied on three methods: game design, electronic health media design, and survey methods. As the project matures, it relies, in addition, on methods of community engagement. The project has been fortunate to involve consultation and collaboration with nationally renowned experts in game design and electronic health media development.

Game methodology is especially useful for our purposes. This stems from the capacity of games to draw participants' attention to the problem of expectations that exceed resources and allow them to address the problem by participating in a collective dynamic interaction that is not possible through routine survey techniques. A game allows concepts to be presented in an efficient and appealing way offering structured information in a logical progression. Gaming techniques evoke discussion of concepts with the use of simple language and yield a high retention rate of the concepts. Through abstraction of the problem to its most salient elements, games which are also known as simulation exercises allow participants with varying perspectives to achieve a shared overview of the problem and thus an understanding of policies related to the problem. The technique is useful for overcoming cultural barriers and facilitating communication. The tangible materials used in the game capture the essence of the problem and induce participation and discussion. Games are constructed to include a series of predictable steps that serve to focus participants on the appropriate level of abstraction. Details of a technical nature are less the focus than is the overview, which allows participants to understand the 'big picture.'

Results:

<u>Tool development</u>

1. The development of tools for individual involvement in health plan design under a fee-for-service model:

This reserch was prompted by the observation in earlier surveys conducted by the PI that when patients are given a choice, they express a preference for extremely costly treatments in order to achieve life prolongation for as short a time as a month. It became clear that inclusion and engagement of patients in decisions about the use of resources for their care would require the development of strategies that make them more cognizant of the trade-offs that are necessary in the face of limited resources. Thus, the first phase of this project was to engage lay participation in health care trade-offs. It yielded the design of a tool to engage individual patients in health insurance design under a

fee for service model. The exercise involved giving game participants rectangular puzzle pieces that represented medical services such as pharmacy benefits, hospital care, and long-term care and asking participants to select the services they would prefer by fitting them into a puzzle board representing the total available premium. The size of the puzzle pieces was determined by the actuarial cost of covering each service and the total area of the pieces exceeded the board thus necessitating rationing by participants. Assessment of this exercise by over 100 elderly patients was that the exercise was easy to understand and use, as well as enjoyable and informative.

2. Development of an exercise for group decision-making regarding managed care:

Following the development of the initial exercise, Marion Danis began collaboration with Dr. Susan Goold at the University of Michigan to create an exercise that offered several advances over the initial puzzle exercise. Since health insurance involves pooling resources to share risk, the new exercise was intended to involve groups in deliberation about rationing decisions. Because individuals are likely to be healthier when purchasing insurance than when they use their health insurance, the exercise incorporated illness scenarios to simulate health problems and inform players about the consequences of their choices. Because the financing of health insurance had progressed from fee-for-service model to a managed care model, the exercise offered choices not only among service categories, but also among levels of management restrictions. For example, the options among pharmacy benefits included choices of generic versus brand name medications, a more and less restricted formulary, and higher and lower co-payments.

The exercise, entitled 'CHAT: Choosing Healthplans All Together,' was jointly funded by the Clinical Center at the NIH as well as the Robert Wood Johnson Foundation through a Generalist Faculty Scholars Award to Dr Goold. The exercise was designed with the collaboration of Richard Duke, Ph.D. who is a renowned designer of group decision exercises. The exercise allows participants to design their health insurance coverage by using a limited number of pegs to fill holes on a circular board that contains a selection of health services at various levels of expense (see figure 1). This selection process is repeated as a series of rationing-decisions, first alone, then in triads, and then in whole groups. This sequence teaches participants to deliberate together. Between repeated decisions, to be sure that participants appreciate the consequences of their choices, participants spin a roulette wheel which assigns them cards containing illness scenarios. Testing of the CHAT exercise with 50 groups has revealed that it is easy to understand and use, enjoyable and informative. Furthermore, the vast majority (86%) of participants were willing to abide by their groups' choices of insured services.

In keeping with the goal of achieving as much public engagement as possible, the exercise is designed to be useful to participants with as little as a sixth grade reading level and is meant to respect diversity by allowing the expression of diverse preferences in the selection of insurance benefits.

3. Development of CHAT player software and CHAT planner software:

In order to make the CHAT exercise as useful as possible to communities facing difficult health care coverage decisions, we have recently developed an electronic version of the CHAT exercise. It offers several innovations: a planner program so that communities can modify the size of the premium, the services to be offered for selection, and the illness scenarios; and a database so the results of participants' choices can be automatically collected and analyzed for easy use. As with the prior version, the computerized version of the exercise is designed for use by participants with a sixth grade education, and is also designed for use by individuals with little or no experience with computers in order to make participation as broadly accessible as possible. Testing of the exercise with ten groups recently showed that participants with no computer experience and individuals who use the computer as infrequently as once a month, found the exercise understandable and enjoyable.

The University of Michigan has copyrighted the CHAT exercise and the NIH has joint ownership of it.

<u>Promoting opportunities for public participation in priority setting through use of the CHAT exercise</u>

Projects involving several populations have been conducted:

1. The uninsured:

While 86 percent of the U.S. population has health insurance, the remainder, comprising approximately 40 million people, does not. Of the numerous hurdles preventing the development of universal health insurance, one of the more intractable issues is the definition of an affordable and equitable benefit package. We have used the CHAT exercise to survey groups of low-income, uninsured individuals regarding the benefit package they would prefer under resource constraints faced in an average employer-sponsored managed care plan. All twenty two participating groups (N=234 individuals) chose packages that included hospitalization, pharmacy, dental services, specialty care, and 21 groups chose primary care and mental health services. In general, they were willing to accept management restrictions for the sake of a broader package of services.

Aside from surveying the uninsured themselves, we have utilized the CHAT exercise to determine to what extent insured individuals would be willing to utilize some of their insurance to extend coverage to the uninsured. In CHAT exercises conducted with groups of employees in Minnesota, we have examined the willingness of individual participants and groups to utilize four percent of their benefit package to insure all children in Minnesota or eight percent of their benefit package to insure all uninsured children and adults. Fifty four percent of individual participants were initially willing to insure either children alone or both children and adults. When working together in groups there was unanimous selection of coverage for the uninsured (either children only, 24%; or children and adults, 76%). Through audiotaping and qualitative analysis of the content of

group discussions, we examined the arguments made for and against extension of coverage to the uninsured. The predominant reasons participants gave each other for extension of coverage were: enlightened self-interest, a concern for the vulnerable, belief in health care as a right, and a belief that universal coverage would be more efficient. This work won the Mark S. Ehrenreich Prize in Healthcare Ethics from the Pacific Center for Health Policy and Ethics.

2. Medicare enrollees:

While the Medicare program offers the only universally available insurance for an entire segment of the population, the fiscal solvency of the program is a matter of concern. A variety of cost containment efforts including the institution of reimbursement based on diagnosis-related groups (DRGs), utilization review, prospective payment, and managed care, have been used. While Medicare costs currently are rising more slowly, the demographic shift toward a more elderly population and the availability of an ever-expanding number of therapeutic interventions constantly threaten the program's fiscal solvency. These financial issues are not merely a concern for policy makers. Individual Medicare enrollees, most of whom live on modest fixed incomes, currently spend an average of 19 percent of their incomes on out-of-pocket medical expenses. Aside from concerns about the cost of the program, the need for reform in order to revise the benefit package is broadly recognized. Several benefits, particularly pharmacy coverage, are currently excluded from the traditional Medicare program.

We have therefore used both the first puzzle game and the CHAT exercise to ascertain how Medicare enrollees themselves would set priorities for the program. As shown here, using the CHAT exercise, most Medicare groups were willing to forgo complementary medicine, transplants and experimental therapy in order to add pharmacy, dental and long-term care benefits. Many also showed a willingness to extend Medicare coverage to the uninsured.

	Benefit Selections in Medicare CHAT Games									
Coverage Type	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Complementary Medicine				B						
Dental Care	B	B	B	B	B	B	B	B	B	B
Home Health	M	B	B	H	M	B	B	M	B	B
Hospitalization	M	M	M	M	M	M	M	M	M	M
Transplants and Experimental Therapy										
Long-Term Care		B	B			B	B	B	B	B
Mental Health	B	B		B	B	B	B	B	B	B
Other Services	B	B	B	B	B	B	B		B	B
Pharmacy	B	B	B	M	M	B	B	B	B	B
Primary Care	H	B	B	B	B	M	B	B	B	B
Specialty Care	M	B	M	B	M	B	B	B	B	B
Tests	B	B	M	B	B	B	B	B	B	B
Coverage of the Uninsured	B	B			B		B	B	B	B
Vision Care	B	B	B	B	B	B	B	B	B	B

*Coverage levels chosen: B=Basic (highly managed), M=Medium, and H=High (less restricted).

3. Commercially sponsored employees

While the shift from an indemnity model to a managed care model of health care financing offered a reprieve from inflationary increases in health care costs for several years in the 1990s, costs have begun to rise steeply again. Employers have been very interested in strategies for limiting costs. Over the last several years, prompted by the governor of Minnesota, the Allina Foundation and the Chamber of Commerce in Minneapolis have sponsored community wide projects using the CHAT exercise to foster discussion among employees about the design of their health benefits package.This effort has been the first community wide and community initiated use of the CHAT exercise. A total of eighty games involving approximately 1,000 participants were conducted in 2000 and 2001.

Future Directions:

Future efforts will continue methodological development and promote use of the CHAT exercise among various populations.

1. Methodological development
   - Teaching CHAT:

In presenting CHAT at national conferences, we have found substantial interest in the exercise as a tool to teach students training in the health professions about the need for rationing and the availability of strategies for fair deliberation in the rationing process. We are modifying the exercise for use in the classroom.

   - Web CHAT

In using the CHAT exercise, we have realized that while it offers a unique tool for group deliberation, the intense small group process allows the participation of a limited number of participants. In order for the CHAT exercise to usefully provide public input in policy-making, we are planning to develop a web-based version. Data will thus be collectable from large numbers of systematically sampled individuals to assure the representativeness of the results. We are currently in the design phase of the Web version.

   - CHAT modifications

In an effort to make the CHAT exercise as useful as possible in reducing inequities in health care access, we plan to incorporate strategies for more progressive allocation of the financial burden of health care costs into the exercise.

We are also planning to modify CHAT so it can be used for more focused coverage decisions. Thus, we are designing a version of CHAT that will permit public participation in the design of pharmacy benefit packages.

2. Use of tools by various populations
   - Public and private employers in California

This 24-month project, under the leadership of Sacramento Healthcare Decisions (SHD), which began in September 2002, will involve consumers in the process of designing health plan benefits consistent with available resources. The project

will conduct dozens of CHAT exercises with public and private sector employees, including state employees. Project partners will include the Sacramento Metro Chamber of Commerce, individual businesses, consumer and employee advocacy groups and representatives of local and state policymakers. The Sacramento CHAT Project is designed to engage local consumers in the challenges and realities priority setting; provide purchasers – employers and government – with specific, quantitative data on consumers' priorities from which to consider future coverage decisions; and contribute to a growing body of research on consumer values related to allocating finite resources.

- Oregon Medicaid program

  We are currently discussing with the leadership of the Oregon Health Assessment Project the possibility of using the CHAT exercise as part of an effort to revise the Oregon Medicaid program.
- Priority setting in developing countries

  We hope to translate and adapt the CHAT exercise in Sri Lanka and Thailand in efforts to promote public input into health care priority setting in developing countries.

Dissemination of the CHAT exercise
Several efforts are focused on informing potential users and making CHAT widely available. We have been invited by the editors of the bioethics series of MIT Press to submit a book proposal about public deliberative rationing and the CHAT exercise. The CHAT CD will be included with the book. In addition, we have signed a licensing agreement allowing Cirdan Health Systems to offer their services to communities and organizations that seek assistance in tailoring the exercise and using it.

Publications

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