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Enhancing employee capacity to prioritize health insurance benefits

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Abstract

Objective To demonstrate that employees can gain understanding of the financial constraints involved in designing health insurance benefits.

Background While employees who receive their health insurance through the workplace have much at stake as the cost of health insurance rises, they are not necessarily prepared to constructively participate in prioritizing their health insurance benefits in order to limit cost.

Design Structured group exercises.

Setting and participants Employees of 41 public and private organizations in Northern California.

Intervention Administration of the CHAT (Choosing Healthplans All Together) exercise in which participants engage in deliberation to design health insurance benefits under financial constraints.

Main outcome measures Change in priorities and attitudes about the need to exercise insurance cost constraints.

Results Participants ($N = 744$) became significantly more cognizant of the need to limit insurance benefits for the sake of affordability and capable of prioritizing benefit options. Those agreeing that it is reasonable to limit health insurance coverage given the cost increased from 47% to 72%.

Conclusion It is both possible and valuable to involve employees in priority setting regarding health insurance benefits through the use of structured decision tools.

Introduction

High cost has steadily eroded the availability of employer sponsored health insurance in the United States.[1–3] Health insurance premiums rose 73% between 2000 and 2005 and the percentage of individuals with job-related insurance dropped from 69% to 60% in this 5-year interval.[4]

In addition to loss of insurance, the rising cost of insurance has led to cost shifting from

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employers to employees.[5] In 2001 alone, one-third of working adults with employer sponsored insurance faced higher deductibles or co-payments or had their benefits reduced.[6] While out-of-pocket costs remained steady in the last 2 years, there are a growing number of high deductible plans and other cost reduction strategies.[4] These changes have generated significant tension between employers and employees regarding the share of cost borne by each.

Concern about the cost of insurance has prompted efforts to limit benefit coverage. Restrictions in choice of providers, covered services and formulary options are prominent examples. In such constrained circumstances, with so much at stake, employees deserve a voice in the process. Their inclusion in coverage decisions might also diffuse tensions over the structure of health benefits. We therefore report a project that was designed to demonstrate that employees can be engaged in setting priorities for employer-sponsored health insurance benefits.

Methods

Study design and setting

Structured small group exercises were conducted in a community setting in Sacramento, California from September 2002 to July 2003 by Sacramento Healthcare Decisions, a non-profit, non-partisan organization that educates and involves the public in health-care policy and practice issues.

Intervention

Groups used the CHAT exercise, a computerized, interactive, decision tool designed to facilitate deliberation about the design of health insurance benefits by groups of individuals.[7,8] The exercise uses a pie chart in which health insurance benefits such as primary care, hospitalization and pharmacy are represented (see Appendix A for description of benefit options). Participants can choose benefits at three levels: Basic, Medium and High. These levels offer differing degrees of choice, cost sharing, convenience and expanded services. Each benefit category is selected by using a specific number of markers determined by its actuarial cost in 2002. The benefit categories used in this project were defined by an Advisory Committee to be consistent with California trends and calculated by Milliman USA. The exercise gives participants 50 markers to use in choosing benefits. In this project, the markers were assigned the value of the average per-member-per-month premium for employees in Northern California in 2002 so that participants would be making choices within the constraints of the prevailing average expenditure for employees. The entire offering of benefit options comprised 99 markers.

A CHAT session involves 9–12 participants, each using a computer while sitting around a large table. A facilitator guides participants in designing health-care benefits packages in four rounds: during Round 1 participants work individually as though they are choosing for themselves and their families; in Round 2 they work in groups of three – in this project as though on behalf of all employees in their company; in Round 3 they deliberate about their choices as an entire group – in this project as though on behalf of all insured employees in California and in Round 4, again individually for themselves and their families.

After Rounds 1 and 2, participants are randomly assigned Health Events, depicting illnesses along with the service and cost consequences of benefit choices. Participants read Health Events aloud and discuss them.

During Round 3, rather than using individual computers, the facilitator displays the CHAT board on a screen at the front of the room and leads a group discussion to design a uniform benefits package. Participants take turns nominating categories and benefit levels. Participants discuss category selection to reach consensus. Groups vote if they cannot come to agreement.

Participants

Participants in the Capitol CHAT Project included employees or associates from 41 public and private sector employers in the greater

Sacramento region (see Appendix B for list of employers). Each employer sponsored from one to five CHAT sessions for a total of 72 CHAT sessions.

Data collection

Participants' health benefit choices were recorded anonymously on individual computers. In addition, participants responded to anonymous pre-exercise and post-exercise questionnaires to gather socio-demographic information and pre-exercise and post-exercise attitudes.

Statistical analysis

Socio-demographic characteristics for all 744 participants were analysed using summary statistics. To examine the possibility that participant characteristics would be associated with initial benefit choices, we used cross-tabulation tables, the chi-squared test of independence, and standardized residuals.[9] We hypothesized that individuals with a higher income (> \$60 000) would choose higher benefit levels than low-income individuals that women would be more likely than men to select mental health coverage, and that older individuals (> 50 years) would choose long-term care more than younger individuals.

To analyse changes between Round 1 and Round 4, coverage choices were recoded from 'basic', 'medium' and 'high' to 'chosen' or 'not chosen'. Change in a coverage choice in Round 1 compared with Round 4 was conducted using the McNemar test of change. We also examined the change in the overall number of benefit categories chosen, to see if participants favoured breadth over depth at the conclusion of the exercise. The mean change in number of coverage choices in Round 1 vs. Round 4 was analysed using a paired *t*-test.

To test the desirability of various benefit options, several early sessions allowed participants to use extra markers. The 46 participants who were given extra markers were included in the analysis of pre-exercise vs. post-exercise responses to questions ($n = 744$), but were excluded in the analysis of Round 1 vs. Round 4 coverage choices ($n = 698$).

We examined changes in participants' agreement with the statement 'It is reasonable to limit what is covered by health insurance given the cost' comparing before vs. after CHAT responses using the McNemar's test.[10]

To discern the influence that group deliberation had on individual participant choices, participant decision-making patterns were classified into four categories that reflect the extent to which they made choices that matched their group choices (Table 1). For this analysis we compare the frequency with which participants changed their choices in a manner that was congruent (category 3) or incongruent (category 4) with the group choice, using the Test of Independent Proportions.[9] Analyses were conducted using SPSS 11.5.

Human subjects protection

The project was approved by the Office of Human Subjects Research at the National Institutes of Health and by the IRBs at the University of Michigan and Catholic Healthcare West.

Results

Participant characteristics

Participants included 744 individuals, the majority of whom were female. Participants were approximately representative of adults in the greater Sacramento region's ethnic composition but had higher than average education and income levels (Table 2).

Initial benefit choices

At the outset, over 90% ($n = 628$) of participants selected five benefits predominantly including Primary care, Pharmacy, Hospital care, Specialty care and Scan/X-rays (Table 3). When picking these benefits, a minority opted for the medium or high levels of these benefits.

Table 1 Categories of congruency between individual and group choices

Category	Individual decision in Round 1	Group decision	Individual decision in Round 4
1	Chose the same benefit in Round 1 and Round 4 and choice was consistent with group's choice made in Round 3		
	No	No	No
	Yes	Yes	Yes
2	Chose the same benefit in Round 1 and Round 4 and choice was opposite of the group's choice made in Round 3		
	No	Yes	No
	Yes	No	Yes
3	Changed benefit choice from Round 1 to Round 4 to the group choice made in Round 3		
	Yes	No	No
	No	Yes	Yes
4	Changed benefit choice from Round 1 to Round 4, contrary to group choice in Round 3		
	Yes	Yes	No
	No	No	Yes

Examination of the association between participant characteristics and their choices of benefits and benefit levels revealed that lower income participants pick the medium and high level of the pharmacy benefit 33 (32%) vs. 35 (16%) and less likely to pick the specialty benefit at all 85 (87%) vs. 206 (96%). Men and women did not differ significantly in the choice of mental health services 98 (36%) vs. 172 (41%), respectively, $P = 0.208$; younger (<30) and older (50+) participants did not differ in the choice of long-term care 14 (14%) vs. 38 (18%), respectively, $P = 0.325$.

Changing benefit choices

Individual participants' views and choices changed considerably over the course of the CHAT session (Table 3). Participants selected more benefit categories in Round 4 than Round 1 (10.00 ± 1.44 vs. 9.31 ± 1.55, $t_{691} = -10.81$, $P < 0.001$). While some benefit categories such as Primary Care and Hospital Care were extremely stable across all rounds, others showed considerable variation. For instance, more participants increasingly chose Rehabilitation (46% vs. 68%), Mental Health (39% vs. 61%) and Last Chance (38% vs. 60%) as they progressed from Round 1 to Round 4. Participants spent far fewer of their markers on medium and high benefit levels in Round 4. For example, 166 (22%) of participants chose medium or high hospital care in Round 1 while only 63 (8.5%) chose those coverage levels in Round 4. The initial difference in selection of pharmacy benefit levels between low- and high-income participants in Round 1 disappeared in Round 4.

Group selections and group influence

When groups deliberated about benefit packages for all insured employees in their state, the major categories of coverage – Primary care, Hospital Care, Specialty and Pharmacy as well as Scans and X-rays – were selected by all 68 groups (Table 4).

Group deliberations appeared to influence individual choices. For all categories except Uninsured and Infertility, individuals were more

Table 2 CHAT participant demographic characteristics (N = 744)

Characteristic	N (%)
Gender (% female)	461 (62.0)
Age (years)	
18–29	101 (13.6)
30–39	184 (24.8)
40–49	236 (31.8)
50–59	182 (24.5)
60+	40 (5.4)
Race or ethnic group	
White	534 (71.8)
Hispanic or Latino	78 (10.5)
African American	62 (8.3)
Asian	56 (7.5)
Other	29 (3.9)
Education	
Less than high school	4 (0.5)
High school graduate or GED	61 (8.2)
Some college or 2-year degree	252 (33.9)
Four-year college degree	259 (34.8)
Post-graduate degree	164 (22.0)
Household income	
Less than $35 000	116 (15.7)
$35 000–$59 999	182 (24.7)
$60 000–$90 000	170 (23.1)
More then $90 000	269 (36.5)
Health status	
Excellent	201 (27.1)
Very good	383 (51.7)
Good	136 (18.4)
Fair or poor	20 (2.7)

likely to change their choices to be congruent with the group's choices than to change them to be different (see Table 5). Eighty-two percentage of individuals changed at least one category to be congruent with the group's choice, whereas only 48% of participants changed at least one category to be different from the group's choice.

Acceptance of limited coverage

Initially, 352 (47%) of participants agreed strongly or somewhat that it is reasonable to limit what is covered by health insurance, whereas at the conclusion, 531 (72%) agreed with that statement ($\chi^2 = 136.21$, $P < 0.001$; Table 4). While men were more likely than women and higher income individuals were more likely than lower income individuals to initially agree, the degree of change in opinion was consistent among participants of all characteristics yielding a 53% increase in acceptance of coverage limits overall.

Acceptance of a group plan

Despite the fact that 129 (47%) of participants felt that their current health benefits were more generous than the CHAT benefits, following the deliberative process, 646 (87.5%) of CHAT participants indicated they were willing to abide by their group's decision. While enthusiastic about group decision-making, many indicated that they would want to purchase additional coverage if a benefits package were too limiting.

Discussion

The Capitol Region CHAT project demonstrates that employees can deliberate effectively about the design of health insurance benefits using a structured group exercise. The process expanded participants' capacity to recognize the need for coverage limits, gave them insights into the consequences of benefit choices and increased their acceptance of tight benefit management for the sake of a broader number of benefits. It helped them appreciate that a variety of possible solutions to the problem exist and facilitated their ability to work co-operatively to find an acceptable benefit package for a statewide employee population.

This study has several limitations. First, it might have been instructive to give participants clear choices among more comprehensive benefits and lower cost-sharing with more restricted provider networks vs. higher cost-sharing but less restricted provider networks. However, in order to keep the exercise from being too unwieldy some 'lumping' of the choice options was necessary. We have been able to explore participants' views about these trade-offs in qualitative analysis that is available in an on-line report of this study (http://www.sachealthdecisions.org/docs/chat_report.pdf). A second limitation is that we did not offer participants the option of increased take home pay in lieu of spending all the markers

Table 3 Individual benefit choices at the beginning and end of CHAT*

	Round 1 (benefit level chosen, $N = 698$, %)				Round 4 (benefit level chosen, $N = 698$, %)			
Category	Total†	Basic‡	Medium	High	Total	Basic	Medium	High
Primary care	98	45	47	6	99	62	36	1
Pharmacy	98	75	18	5	99	84	14	1
Hospital	99	76	19	4	99	91	8	0
Specialty	92	80	11	1	99	92	7	0
X-rays	91	80	11	§	97¶	94	3	
Tests	89	78	11		95¶	92	3	
Dental	87	77	10		87	85	2	
Rehabilitation	46	39	7		68¶	62	6	
Vision	73	73			65¶	65		
Mental health	39	34	5		61¶	47	14	
Last chance	38	38	0		60¶	55	5	
Complementary	25	25			25	25		
Quality of life	19	19			14¶	14		
Long-term care	15	15	0	0	13	12	1	0
Uninsured	10	10	0		10	9	1	
Infertility	8	6	2		6	5	1	

*Participants' choices when creating a plan for themselves and their immediate family for a 5-year period.
†Percentage of participants who chose each benefit.
‡Percentage of those participants choosing a benefit who selected each level in that benefit category.
§Blank space indicates that a benefit levels was not oered.
¶Coverage areas statistically compared were those for which participants varied selection, McNemar's test, $P < 0.001$.

Table 4 Group coverage choices

	Benefit levels chosen by groups ($N = 68$ groups, %)			
Category	Total*	Basic†	Medium	High
Primary care	100	78	22	0
Pharmacy	100	96	4	0
Hospital care	100	99	1	0
Specialty care	100	100	0	0
Scans and X-rays	100	100	0	
Tests	99	97	1	
Mental health	94	54	40	
Dental care	91	91	0	
Rehabilitation services	88	85	3	
Last chance	71	66	4	
Vision	69	16		
Complementary	19	19		
Long-term care	12	12	0	0
Uninsured	10	10	0	
Quality of life	3	3		
Infertility	1	1	0	

*Percentage of groups that chose each benefit category in order of descending frequency.
†Percentage of those groups choosing a benefit who selected each level in that benefit category.

on health insurance benefits. We should note, however, that the CHAT exercise is designed to offer this option for those who are interested in examining this trade-off.

A third limitation is that the exercises reported here represent a decision simulation and the trade-offs may not replicate those being considered by a particular company or those available from health plans. Furthermore, what individuals prioritize in a simulation exercise may not be the same as they would choose in reality. We do note, however, that one of the participating employers used the collected information to change its benefit plan and a second went on to conduct additional, customized CHAT exercises to seek employee input for possible benefit changes. Further systematic studies with the CHAT exercise will be necessary to examine how it contributes to health benefits negotiation or change in health benefits design. The results for participating employers in this project reflected the perspectives of as few as 10 employees. To ensure adequate representation and reliable information, an employer would

Table 5 Congruency of individual and group choices

	Pattern 4 (changed choice in the opposite direction of the group decision)		Pattern 3 (changed choice in same direction as the group decision)			
Coverage area	*n*	Proportion	*n*	Proportion	*z*	*P*-value
Primary care†	1	0.00	10	0.01	−2.82	< 0.0048
Pharmacy†	2	0.00	10	0.01	−2.24	< 0.0250
Hospital care†	1	0.00	7	0.01	−2.28	< 0.0227
Specialty care	6	0.00	50	0.07	−6.90	< 0.0001
Scans and X-rays	11	0.02	46	0.07	−4.75	< 0.0001
Tests	16	0.02	66	0.10	−5.77	< 0.0001
Mental health	40	0.06	202	0.29	−12.04	< 0.0001
Dental care	98	0.14	56	0.08	3.60	< 0.0003
Rehabilitation services	69	0.10	229	0.33	−10.87	< 0.0001
Last chance†	0	0.00	212	0.30	−17.46	< 0.0001
Vision	86	0.12	120	0.17	−2.59	< 0.0096
Complementary	55	0.08	112	0.16	−4.70	< 0.0001
Long-term care†	0	0.00	84	0.12	−9.76	< 0.0001
Uninsured	32	0.05	45	0.06	−1.48	< 0.1399
Quality of life	50	0.07	94	0.14	−3.89	< 0.0001
Infertility	13	0.02	24	0.03	−1.75	< 0.0801

†$n = 0$ for a category or $n < 15$ in both categories combined.

need to engage a larger number of employees were this exercise to be used in practice. Despite these caveats, the outcome of this project suggests that an informative and engaging process can transform the capacity of employees who may not be familiar with the health-care delivery system to participate in prioritizing health-care coverage.

The priorities expressed by participants in this exercise, if replicable, have implications for the design of insurance benefits. Participants were more willing in the end to accept more tightly managed benefits, such as a lower level of pharmacy benefit, to gain broader benefit packages. They also shifted to more catastrophic coverage. For example, Last Chance benefit (organ transplant and experimental interventions) was chosen by 38% of participants in Round 1 and by 60% in Round 4, while Vision care was chosen by 73% initially and 65% finally. This suggests that at the beginning of CHAT, concern about a catastrophic health event was a lower priority than having coverage for services that they knew they would use. This shift in coverage appears to involve a transfer of priority from familiar services to services that they realize during the exercise might be necessary in circumstances they are not yet familiar with and a greater understanding of the value of sharing risk for the most financially threatening events.[11] These findings can be useful as employers and employees negotiate health benefits. This is not to say that out-of-pocket payments for smaller and more frequent medical interventions, which would be necessitated by some of these final choices, are inconsequential. Certainly for individuals with low incomes and chronic illness, out-of-pocket payments can be particularly burdensome – a problem that can nonetheless be addressed by designing these payments to minimize such a disparate burden.[12]

All employers who sponsor health insurance are concerned about its cost, and indeed the increasing cost of and decreasing access to health insurance is of vital concern to most US citizens. A recent Kaiser Family Foundation study reported that costs for employer sponsored health in the US had reached $8500

annually and cost for covered families had reached $3000.[13] This is an 87% rise since 2000. The findings in this study that employee participation in a decision exercise to prioritize insurance benefits increased insight into the need to limit costs and greater capacity to make necessary trade-offs, is thus of broad potential use. A process that yields these results could bring employees, key stakeholders, into the decision-making process – making them more attuned to the issues, more prepared to be effective partners in finding solutions, and generally more empowered in this arena.

While employers of all sizes face tough coverage decisions, employees in small firms are particularly susceptible to the consequences of rising health insurance costs – they are the most likely to face loss of insurance or increased share of premiums, raised co-payments and deductibles, switched products and carriers and reduced benefits as costs rise.[14] While engaging in the exercise may not be realistic for small employers in isolation, projects such as the one reported here may be useful for small employers when done in collaboration. Large public employers such as state and municipal governments and large private employers may find it very worthwhile given the highly contentious issues they face regarding the continuously rising cost of health insurance and the need to make tough coverage decisions.

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Appendix A

CHAT benefit categories and benefit levels

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

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

Dental care
Pays for the care of your teeth.
(3) BASIC: Cleanings and X-rays every 6 months at no cost to you. Limited network of dentists who use basic materials. After $50, basic dental services are 80% covered such as emergencies, cavities, oral surgery. Pays 50% of crowns, bridges. Maximum coverage is $1000 years.

(3 + 4) MEDIUM: Same dental services as Basic level, but many dentists to choose from who use more elaborate materials. Your plan pays for 80% of all dental care (50% for dentures) up to maximum of $2000 years. Braces are covered at 50% for each family member up to $1000 each.

Hospital care
Pays for inpatient hospital bills except for mental illness.
(12) BASIC: You have no choice about which hospital you go to. You pay nothing for your hospital stay. Your doctor needs to discharge you as soon as possible.

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

(12 + 3 + 1) HIGH: You can go to any hospital you choose but you may have to pay up to 10% of the cost ($2000 maximum). Your doctor can keep you in the hospital as long as he or she wants.

Infertility
Pays for tests and procedures for a woman having trouble getting pregnant.
(1) BASIC: All types of infertility testing and medical treatments are covered, including surgical procedures to correct problems that prevent pregnancy.
(1 + 1) MEDIUM: In addition to testing and procedures, this includes up to $30 000 for

procedures that may help you (or spouse) get pregnant, such as *in vitro* fertilization (IVF).

Last chance
Pays for special treatments in very serious or life-threatening situations when the usual remedies do not work.
(1) BASIC: Your plan covers all the cost of organ transplants.
(1 + 1) MEDIUM: In addition to organ transplants, it also pays for you to take part in research on new treatments that are being tested. This would be an option if you are not getting better with current treatments.

Long-term care
If you become badly disabled or injured, it pays for extended care in a nursing facility or at home. You must be healthy at the time you apply for this benefit.

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

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

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

Mental health
Pays for outpatient and inpatient treatment for mental illnesses; may include alcohol or drug treatment programmes.
(1) BASIC: Provides coverage for nine mental health problems, such as schizophrenia, manic-depressive disorder and anorexia. Unlimited therapists visits; you pay $20 a visit. Also covers inpatient care for these nine problems. Choice of therapists and hospitals is limited.

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

Pharmacy
Pays for the medicines that your doctor prescribes.
(5) BASIC: Your plan only pays for medicines on its accepted list ('formulary'). A pharmacist must give you the generic, instead of brand-name, if available. You pay $10 for generic, $20 for brand-name.

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

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

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

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

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

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

Quality of life

Pays for tests, procedures and medications that may enhance quality of life, even though they may not be 'medically necessary'.

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

Rehabilitation services

Pays for outpatient physical, speech and occupational therapy, nutritional counselling and equipment such as wheelchairs, hearing aids, artificial limbs and special devises for your home.

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

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

Scans and X-rays

Pays for X-rays and high-tech scans (such as CAT scans and MRIs) that help identify certain medical problems.

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

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

Specialty care

Pays for visits with a specialist, including treatments and procedures for complex illness or injuries that your primary doctor does not handle. This includes doctors who do surgery, treat cancer, heart problems, etc.

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

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

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

Tests

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

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

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

Uninsured

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

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

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

Vision

Pays for eye examinations, glasses and contact lenses.

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

Appendix B: Participating businesses and organizations

Private sector (total meetings = 43)	Public sector (total meetings = 29)
California Chamber of Commerce	California Senate Fellows Program
California Foundation for Independent Living Centers	California Legislative Staff
EDS (3)	CalPERS
'Focus group' (2)	Department of Managed Health Care (2)
Golden State Donor Services	DHS, Medi-Cal Operations Division (2)
Health Rights Hotline	El Dorado County Health Plan Advisory Committee
Hubbert Systems Consulting	Elk Grove School District (4)
Kaiser Institute for Health Policy	Executive Fellowship Program
KVIE	Placer County Health Department
Leadership Sacramento (2) (Sacramento Metro Chamber of Commerce)	Sacramento County
Legal Services of Northern California	Department of Public Works (2)
Loaves and Fishes	Department of General Services (2)
MAAP (Mexican-American Alcoholism Program)	Department of Health and Human Services (3)
Ogilvy Public Relations	Department of Human Assistance
PRIDE Industries (2)	Department of Workers Compensation
PriMed Consulting (5)	IHSS (In Home Supportive Services) Staff
PWA Insurance Services	IHSS Providers
Raley's	San Juan School District, Administrators Association
Sutter Community Benefits Committee	Yolo County Employees (2)
Sutter Regional Programs	
Sacramento Bee (4)	
Safety Center, Inc.	
Teichert Corporation (5)	
VSP (4)	
Western Contract	