

# Prioritizing Health Care Spending

Engaging Employees in Health Care Benefit Design



**Authors:**

Janet McNichol, SPHR, CAE

Len M. Nichols, PhD

Shruti Aiyar, MS

Lisabeth Buelt, MPH

Michael Ciarametaro, MBA

Robert W. Dubois, MD, PhD

**Author Affiliations:**

Janet McNichol, SPHR, CAE, is the president of Inside Workplace Wellness, a human resources consulting company, and the human resources director for the American-Speech-Language-Hearing Association (ASHA); however, this analysis does not seek to represent the views of the ASHA organization. Len M. Nichols, PhD, is the director of the Center for Health Policy Research and Ethics and a professor of health policy at George Mason University. Shruti Aiyar, MS, is a graduate research assistant for the Center for Health Policy Research and Ethics at George Mason University.

Lisabeth Buelt, MPH, research associate, Michael Ciarametaro, MBA, vice president, research, and Robert W. Dubois, MD, PhD, chief science officer, are all employees of the National Pharmaceutical Council (NPC). NPC, a health care policy research organization based in Washington, DC, provided funding for this written case study.

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## Introduction

In 2017, the United States spent 18 percent of its gross domestic product on health care, and recent projections from the Centers for Medicare and Medicaid Services predict that this number will increase to almost 20 percent by 2026.<sup>1</sup> These projections reflect a persistent trend. For decades, spending on health care has grown faster than both the economy and employee wage increases, leading to health care costs that consume a growing share of employees' paychecks.<sup>2</sup>

Over half of insured Americans get their insurance through their employers.<sup>3</sup> However, as health care costs have continued to increase, employers have responded by shifting a growing portion of those costs to their employees through deductibles, copayments, and coinsurance.<sup>4</sup> Between 2006 and 2016, total out-of-pocket expenses for people with employer-provided coverage rose 54 percent, while wages rose only 29 percent in the same period.<sup>5</sup> A survey of employers found that annual premiums for employer-sponsored family health coverage rose to an average of nearly \$20,000 for a family plan in 2018.<sup>6</sup>

The financial constraints associated with health care coverage require stakeholders, including patients, health plans, providers, and employers, to make significant tradeoffs – for example, choosing to accept increased spending and its associated consequences; or to narrow coverage to higher-value services as a way to reduce spending growth. Within the employer-sponsored insurance market, these tradeoffs are tough, value-laden decisions: Individual needs can often be very different from population health needs. Typically, these tradeoffs are made by human resources professionals in consultation with their benefits advisors. However, these decisions often lack input from another group of key stakeholders: employees.

Employees have a vested interest in how their employer-sponsored health plan is constructed. The price of insurance for any one person depends on the health services covered, the negotiated rates of

these services, and utilization by everyone in the shared risk pool. An employer may pay the most substantial portion of the cost, but every employee in the plan shares in the cost by paying a monthly premium as well as deductibles, copayments, and coinsurance. Further, the health insurance coverage an organization provides reflects the organization's culture and values, yet employees are rarely activated and included in decisions about employer-sponsored health benefit design.

This raises a few crucial questions: When educated about their insurance benefit options, are employees able to make tradeoffs related to the coverage of various benefit categories? How would the plan design change if employees decided what tradeoffs to make? Would they be more accepting of limits if they made the decisions themselves?

This case study explores a framework for engaging employees in the design of an employer-sponsored health benefit. Using a deliberative process, this exercise facilitated thoughtful discussion among the participants and identified the tradeoffs employees were willing to make between their individual preferences and what was best for the group. Results are being used to inform the design of a new health benefit offered by the employer but can also inform frameworks for health policy discussions more broadly.

This case study has two key findings. First, if employees are involved in the deliberation process, limits on coverage may be more likely to be considered ethical and accepted as legitimate and fair. Second, this case study provides a framework for how employees can be meaningfully engaged in conversations about necessary health care tradeoffs, which may also help to facilitate discussion about how much should be spent on health care and how those dollars could be allocated.

The objective of this exercise was to design a low cost, low cost-share plan using an engaging deliberative group process to ultimately create a benefit that reflects the preferences and values of ASHA employees.

## Methods

The Health Care Benefits Builder case study was facilitated by the Human Resources Director of the American-Speech-Language-Hearing Association (ASHA). Recently, the majority of ASHA's staff has chosen to move out of the network-only health plan into a traditional PPO or a high-deductible health plan. The objective of this exercise was to design a low cost, low cost-share plan using an engaging deliberative group process to ultimately create a benefit that reflects the preferences and values of ASHA employees.

ASHA is the national professional, scientific, and credentialing association for 198,000 members and affiliates who are audiologists; speech-language pathologists; speech, language, and hearing scientists; audiology and speech-language pathology support personnel; and students. The Association's headquarters is located in Rockville, Maryland, just outside of Washington, DC. The Association self-insures its employee health plan. ASHA employed 291 people in the second half of 2017 when this exercise took place.

### The Deliberative Process

The design of the deliberative process instrument used in this case study was informed by previous research on community deliberation about health care. Countries with universal coverage like the United Kingdom, Canada, and Australia have years of experience debating what should be included in their national health plans. They have developed approaches to support decision-makers in setting priorities and allocating resources, which have had varying degrees of success and varying degrees of applicability to the U.S. health system. These approaches can be applied within an organization to decide what to cover, what not to cover, and how much to pay.

In addition to informing funding decisions, deliberative processes bring people with diverse perspectives together and help participants develop an understanding

of an issue that is informed by the views of the other participants. In a 2012 study, deliberative methods were shown to have a more significant impact than education materials on knowledge and attitudes.<sup>7</sup> Building on that finding, this case study explores whether a deliberative process could be used to improve employees' understanding of their employer-sponsored health benefits.

The deliberative process instrument designed for this exercise was informed by existing literature and methodological approaches for community deliberation, including Choosing Health Plans All Together (CHAT), Program Budgeting and Marginal Analysis (PBMA), and ChoiceDialogue, as well as *The Facilitator's Guide to Participatory Decision Making*. Additional information about how these approaches informed the design of this exercise can be found in Appendix 1.

## The Instrument

When designing a health plan as a group, it is critical that participants develop an understanding of each other's perspectives. This can generally be achieved when participants engage in constructive dialogue and listen to and empathize with one another. Board games encourage conversation, turn-taking, and fair play – social conditions that are an essential part of the deliberative process. To capitalize on these social conditions, a board game was developed and incorporated into this exercise. It served as the primary data collection instrument and captured both the individual participants' preferences for coverage as well as what was agreed by the group.

The instrument was designed using ASHA's claims data from the 2016 plan year. The data included medical expenses paid through the group's third-party administrator, prescription drugs paid through the pharmacy benefit manager, dental expenses paid through the dental carrier, and vision expenses paid through a separate vision program. The expenditures were first grouped according to the ten Essential Health Benefits included in the Affordable Care Act. Ultimately, these groupings were revised to include 12 categories of benefits that align with the choices made

in the implementation of a health plan. Expenses were categorized across each of the 12 benefit categories, providing a total spent for each category as well as a percentage of the overall expenses each category represents. It was also necessary to estimate the value of services that are not currently covered by ASHA (and therefore could not be calculated based on previous claims data). Although an actuary did not do the computations, they were reviewed by benefits consultants and researchers and deemed to be realistic.

Each category of benefits was further divided into levels and labeled *Good*, *Better*, and *Best*. The distinctions between these levels were focused on elements in plan design that are available to an employer and can realistically be implemented in the design of a health plan. These opportunities vary based on employer size. For example, a center of excellence program is cost-saving for a large employer with enough volume for the covered services, while the same program for a small employer increases expenses but may achieve other desired outcomes.

Some of the categories included fewer than three levels because meaningful distinctions in levels could not be made. For example, as shown in Figure 1, four benefit categories included the *Good* and *Better* levels (preventive services, diagnostic testing, vision, and dental), but did not offer a *Best* level of coverage. In addition, the Emergency Services category offered only a *Good* benefit level.

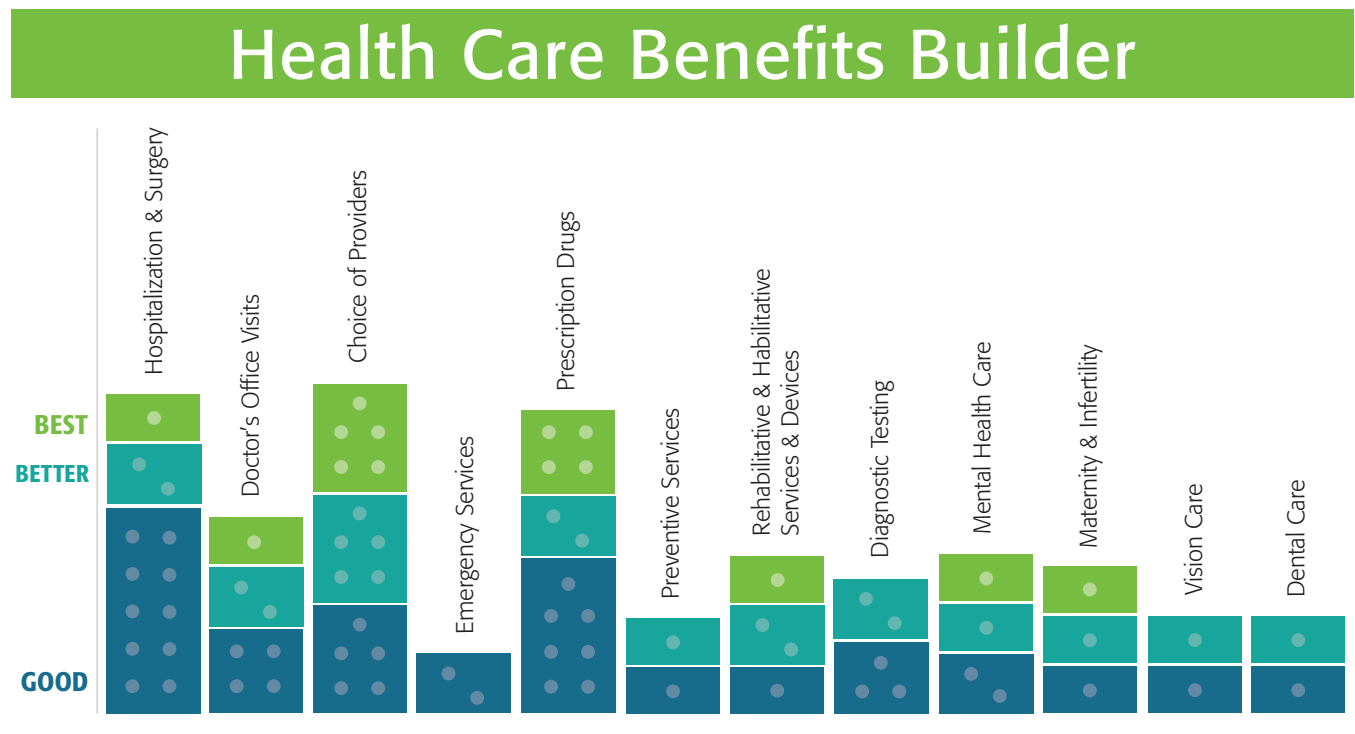
Descriptions were developed for each of the 12 categories as well as for each level within the categories to allow participants to contrast the options. The categories and levels were described in an easy-to-use chart and included information about access, quality, and cost. Definitions for categories of benefits can be found in Appendix 2.

It was anticipated that having participants in a group decision-making process work with actual dollars would be confusing and might lead to a discussion of the priceless nature of people's health and well-being, so costs were translated into marker values or "chips." Each chip represents approximately 2 percent of the Association's costs. The numbers were rounded for simplicity.

To illustrate the tradeoffs involved, the game board used in the Health Benefits Builder exercises is included below (Figure 1). Note that to acquire the *Good* level of Hospitalization and Surgery, a participant would have to spend 10 chips. The *Best* level costs three more than the *Good* level (and one more than *Better*) or 13 in total. Conversely, the *Best* level of Rehabilitative & Habilitative Services and Devices costs only four chips in total, just one more chip than *Better*.

The entire board game offers a benefits package that costs 72 chips. However, to force participants to prioritize services and make tradeoffs about their coverage, each participant was only given 55 chips, or about 76 percent of the chips they would need to purchase the highest level of coverage for each benefit category.

**Figure 1. Health Care Benefits Builder Game Board**



*A series of vertical bars were used to represent each category of benefits. The categories were presented in a random order. The approach lent itself to conveying the hierarchy of benefit levels—Good, Better, Best—within each category by using a stacked bar chart approach. Participants used markers to indicate what they decided to include in their benefits plan.*

## Health Care Benefits Builder Sessions

All 291 ASHA staff members were invited to participate in a Health Care Benefit Builder session. Twelve sessions were held between June and December 2017; in total, 171 ASHA employees participated in one of these sessions. Many participated with the team they work most closely with day-to-day. Facilitated sessions lasted 2 to 2.5 hours with 10 to 24 participants.

After some initial introductory remarks, participants viewed a short video about tradeoffs and the need for negotiation.<sup>8</sup> Participants were then given written instructions for the exercise, a game board, and 55 chips, and were asked to build an ideal health plan that reflected their individual needs and coverage preferences. They were instructed to consider only their own needs during this part of the exercise. Participants were told that each chip represented 2 percent of ASHA's health care expenses in 2016. This was



designed to help participants understand the magnitude of what things cost. The relative value of the categories and levels of benefits was made clear to participants by the number of chips required for each. For example, individuals learned that hospitalization and prescription drugs are among the biggest expenses in ASHA's health plan because they required the most chips to purchase.

Once their individual plans were complete, each participant drew a Life Event card. To ensure that a wide variety of perspectives were considered, Life Event cards articulated a variety of scenarios that would cause people to seek health care services. In addition, they included scenarios where the value of a service may differ significantly between the individual and the population, for example weight-loss surgery, mental health care, transgender surgery, specialty medications, or obtaining high-cost care that is of low value. The scenarios were written in a non-judgmental manner and intended to elicit empathy. They were also meant to instigate a discussion of the value of services and to educate participants about how care is paid for by health insurance. Participants read their cards aloud and shared observations about how well the plan they designed worked in the scenario they were assigned. This helped to transition participants from thinking about their own needs to thinking about the needs of others.

After this discussion, participants gathered around the game board to design a health plan for the organization as a group. They were instructed to develop the plan as if it were the only one being offered to the staff. Participants were encouraged to complete the exercise without voting because voting tends to disadvantage those in the minority. Instead, they were encouraged to continue listening and asking one another questions until they developed a shared framework of understanding. Once agreement was reached and the group-designed benefit was complete, participants were given the option of "purchasing" additional chips. Each extra chip required that every member of the staff give up \$300 in a future salary increase to pay for it.

At the conclusion of the exercise, participants were asked to complete a debrief survey indicating their satisfaction in both their individually-designed and group-designed health plans. The survey also inquired

whether participants believed that coverage was inadequate for any service category, whether they would be willing to pay more for additional coverage, and if so, how much more they would be willing to pay.

## Analysis

The goal of this exercise was to determine the extent to which participants were willing to make tradeoffs. This was done by comparing individually-designed plans to their group-designed plan (Table 2). Health insurance benefit tradeoffs are made at two levels: Individuals sacrifice some of their specific preferences for group harmony, and groups make different collective choices than other groups, even within the same employee population. The results of this deliberative exercise allowed us to draw inferences about both types of tradeoffs made by ASHA employees.

To characterize the individual tradeoffs, we created a distance measure. Values were assigned as follows:

|  |    |
|--|----|
| Individual made same choice as group for given element ..... | 0  |
| Group choice was higher level than individual choice .....   | +1 |
| Group choice was lower level than individual choice .....    | -1 |

Distance values were not zero for at least some people in every element except emergency room services, which only had one level.

Descriptive statistics for the participating ASHA employee population are included in Table 1. We tallied individual preferences and group choices, which are shown in Figure 2. Having conducted multivariate regression tests to correlate selected demographic characteristics with distance, we determined distance and direction between individual and group choices (Table 2). T- and chi-square tests for groups that ultimately chose more of one benefit revealed the tradeoffs they made and the benefits they were likely to choose less of (Table 3).



In subsequent sessions, both the individual plans and the group plans were saved, and finally the debrief form was introduced and used in the last seven sessions.

## Limitations

This analysis has two main limitations. First, it is important to note that the facilitation of this exercise evolved over the 12 sessions. In the initial sessions, only the results of the group exercise were saved. In subsequent sessions, both the individual plans and the group plans were saved, and finally the debrief form was introduced and used in the last seven sessions. This evolution explains the differences in the numbers of participants with data of different kinds; however, methodological adjustments were made to ensure that this phased approach did not change or confound the overall results.

Second, ASHA offers relatively rich benefits, which affects both how each level of benefit is defined and how many chips are required to purchase each level of coverage (e.g., *Good, Better, Best*). This can limit the extrapolation of the results from this analysis to other employers who offer less comprehensive benefit options.

## Results

ASHA employees are older, more female, more full-time, and less married than the labor force of the United States as a whole. These facts should be taken into account before generalizing about the specific tradeoff choices they made.

N for group choices = 171. All participants engaged in a group decision process after determining their individual preferences. Individual preferences were collected from 106 individuals. Not all benefit categories included three levels of choice (*Good, Better, Best*). ER allowed only *Good*. Preventive, Diagnostic, Vision and Dental allowed only *Good* and *Better*.

Figure 2 highlights the differences between health plans designed by individuals and those designed by the 12 groups. Overall, mental health, maternity, vision, preventive, and rehabilitative/habilitative care saw the largest movements as groups listened to co-members and coalesced around decisions.

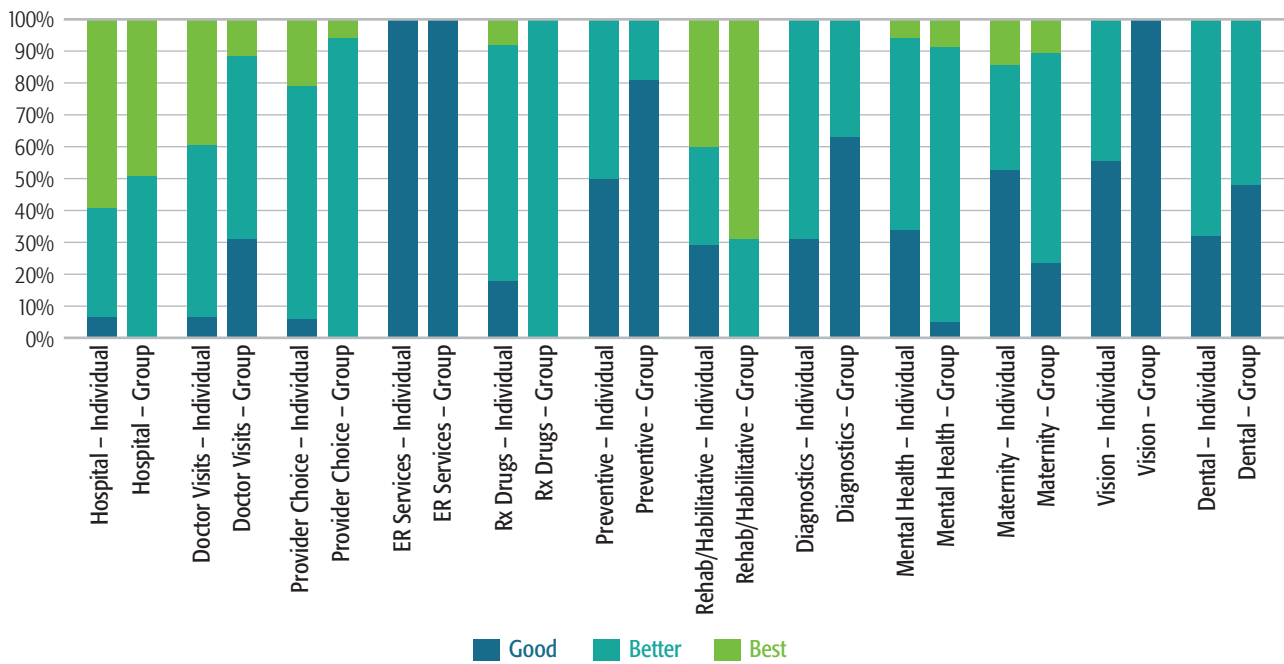
**Table 1. Descriptive Statistics on the ASHA Participating Employees**

| Variable      | Mean (percent) | Standard Deviation |
|---------------|----------------|--------------------|
| Young (25-45) | 49.1           | .5                 |
| Older (46-64) | 41.5           | .49                |
| Elderly (65+) | 9.4            | .29                |
| Black         | 22.2           | .42                |
| White         | 66.7           | .47                |
| Other Race    | 11.1           | .315               |
| Female        | 71.9           | .62                |
| Married       | 64.9           | .48                |
| Salaried      | 74.3           | .43                |
| Full Time     | 94.2           | .78                |
| VA            | 12.9           | .34                |
| MD            | 79.5           | .4                 |
| DC            | 7.6            | .23                |

Figure 2 also illustrates that the variation in group choices is much larger in some benefit categories than others. Every group settled on the *Good* level for vision services, and on *Better* for drug coverage. Group choices for mental

health by contrast were almost normally distributed across all three levels, whereas for maternity services 24 percent chose *Good*, 65 percent chose *Better*, and 11 percent chose *Best*.

**Figure 2. Preferences of Individuals and Choices Ultimately Made by Groups**



**Table 2. Selected Sociodemographic Characteristics That Were Statistically Associated With “Distance” Between Personal and Group Choices**

| Benefit Categories              | Selected Sociodemographic Characteristics |       |        |            |
|---------------------------------|---|-------|--------|------------|
|                                 | Young                                     | Older | Female | Virginians |
| Hospital and Surgery            | --  | --    | --     | --         |
| Doctor Visits                   | --  | --    | --     | --         |
| Provider Choice                 | Less                                      | Less  | --     | More       |
| ER Services                     | --  | --    | --     | --         |
| Prescription Drugs              | More                                      | More  | Less   | --         |
| Preventive Care                 | More                                      | More  | --     | --         |
| Rehabilitative and Habilitative | --  | --    | --     | --         |
| Diagnostics                     | Less                                      | Less  | --     | --         |
| Mental Health                   | More                                      | More  | --     | --         |
| Maternity                       | More                                      | --    | --     | --         |
| Vision                          | Less                                      | Less  | --     | --         |
| Dental                          | Less                                      | Less  | --     | --         |

*Other control variables tested included race, marital status, salaried or hourly worker, and Maryland residence. The omitted category for age was Elderly, so the Young and Older effects should be interpreted as relative to people in the Elderly category. Associations that were not statistically significant are identified with “--”.*

## Statistical Results

Using separate simple multivariate regressions for each benefit category, we found that age was the most important sociodemographic variable associated with distance (Table 2). Of the three age categories present in the ASHA workforce – Young (25-45), Older (46-64), and Elderly (65+) – older workers wanted more mental health, preventive care, and drug coverage than their group typically chose, and wanted less provider choice, diagnostics, vision, and dental coverage. Young workers also wanted more mental health, preventive care, and drug coverage, but less intensely (with smaller distances) than the Older workers. Both the Older and Young subgroups wanted more than the Elderly of these services.

To equal degrees both Older and Young workers wanted less provider choice, vision, diagnostic and dental services. Predictably, Young workers wanted more maternity coverage than older or Elderly. The only other

demographic categories that correlated with distances were females, who preferred less drug coverage than their group chose; and Virginia residents, who wanted more provider choice.

Table 3 depicts explicit group benefit tradeoffs that were observed (e.g. how the preferences of the 12 groups differed from one another). For example, groups that chose less coverage for dental care (*Good*) chose a higher level of provider choice, on average, than those who chose more dental care (*Better*). Conversely, groups that chose lower dental levels also chose lower vision levels. Vision and dental care then can be interpreted as complements: More (or less) of one is associated with more (or less) of another.

Both high and low maternity levels were associated with higher average levels of diagnostics (and medium maternity with lower diagnostics). The ER Services category provided only one benefit level (*Good*), and therefore no variation in the group-designed health

**Table 3. Benefit Tradeoffs Observed**

When participants chose less of the benefits in the rows, they chose more or less of the benefits in the columns as indicated.

|                      | Dental | Diagnostics | Hospital & Surgery | Provider Choice | Rehab & Hab | Vision | Doctor Visits | Maternity | Mental Health |
|----------------------|--------|-------------|--------------------|-----------------|-------------|--------|---------------|-----------|---------------|
| Dental               |        |             |                    | +               | +           | -      | +             |           | -             |
| Diagnostics          |        |             | +                  | +               | +           | -      | +             | +         |               |
| Hospital and Surgery |        | +           |                    | +               | +           | -      |               |           | -             |
| Provider Choice      | +      | +           | +                  |                 | -           |        | +             | +         | +             |
| Rehab & Habilitative | +      | +           | +                  | -               |             | +      |               | -         |               |
| Vision               | -      | -           | -                  |                 | +           |        | -             | +         | -             |
| Doctor Visits        | +      | +           |                    | +               | -           | -      |               | +         |               |
| Maternity            | +      | +           | +                  | +               | -           | -      | +             |           | -             |
| Mental Health        | -      | -           | -                  | +               | +           |        | -             | -         |               |
| More - Less = Score  | 2      | 3           | 2                  | 5               | 2           | (4)    | 2             | 2         | (3)           |

\*Blanks indicate no variation.

plans was possible for this category. In addition, there was no variation in the Prescription Drug category (as demonstrated in Figure 2). Since there was no variation in levels chosen by groups for emergency or drug coverage, these elements were omitted from this table and the t- and chi-square testing.

As illustrated in Table 3, when examining differences in means between specific choices at the group level, we found that the benefit most often traded for was provider choice, and those most often traded away were vision and mental health. Doctor visits, dental, and hospital/surgery also had net positive traded-for scores. However, we found notable heterogeneity of preferences across groups. For example, as popular as more provider choice proved to be, some groups were willing to trade it for more mental health coverage.

## Debrief Survey Results

Willingness to pay for more benefits varied substantially. Almost half of the employees who took the debrief survey

(35/72) reported that they were willing to trade wages or pay more out of pocket to get additional coverage in one or more benefit category. The benefits that employees listed as more desirable spanned the gamut of all benefits available.

Overall, the average amount more they were willing to pay was \$38 a month. However, regression results revealed that the probability of any willingness to pay, or the actual dollar amount itself, was not systematically related to any demographic or distance variable. This means we cannot make inferences about what groups of people are more willing to trade salary for a richer benefits package, as they are roughly equally likely to do so. This could be unique to the ASHA employee group, as their benefits package is relatively rich and their employees are mostly professional.

Satisfaction was high after each group’s dynamic process: 83 percent of respondents were satisfied or very satisfied with the group plan elements ultimately chosen and the average level of satisfaction with the individually-designed plan was 92 percent.

## Discussion

Overall, this analysis found that group welfare was important to most participants. Ultimately, many groups were willing to give up some conveniences. However, this was a difficult choice and was often decided only after considerable discussion.

This case study set out to determine whether and how employees make health insurance tradeoffs using a structured deliberative process. The changes from individual to group plan designs demonstrate that employees can make tradeoffs. Across the 12 facilitated workshops, participants were likely to sacrifice their own preferences for richer dental and diagnostic benefits so the broader group could have access to more comprehensive mental health and maternity services. This also suggests how the intensity of preferences of some members of a group for maternity and mental health services may persuade individuals in the group to acquiesce in the reallocation of scarce resources in ways not completely aligned with their individual self-interest.

Overall, this analysis found that group welfare was important to most participants. Ultimately, many groups were willing to give up some conveniences, such as being able to see a specialist without getting a referral and being able to get a diagnostic test without special approval, so they could include more benefits. However, this was a difficult choice and was often decided only after considerable discussion.

This case study also found that some participants were also willing to pay more for additional services. However, as described to participants in the group exercise, purchasing an additional chip required that every member of the staff give up \$300 in a future salary increase. So while a subset of participants showed a willingness to pay for more services, the amount (\$19.08/month) was below what was required to purchase additional services (\$25/month to add up to \$300/year for a single chip).

In addition to the insights gleaned from the quantitative analysis of individually-designed and group-designed benefit plans, several observations were made from listening to participants during the facilitated discussions.

First, participants generally advocated for access to the best quality services for low-frequency, high-cost events, particularly if they had been through or cared for a family member with a serious illness. They also debated the effectiveness of some services like bariatric surgery, but generally assumed whatever their doctor prescribed or recommended was the most effective course of treatment. Many participants also reported that they expect that their physicians have considered effectiveness and cost when they recommend a particular treatment.

Second, participants in each session engaged in a dialogue about the need for ASHA's health benefit to reflect the values, culture, and diversity of the organization's staff (e.g. what groups of employees feel cared for or marginalized based on specific coverage decisions). For example, participants were inclined to include services performed by speech-language-pathologists and audiologists as well as devices like hearing aids, reporting that they could not effectively advocate for others to cover these services if ASHA does not.

Third, the facilitation appeared to have a team-building effect. When participants were designing the benefit plan as a group, tensions were typically higher, and it was easy for people to misinterpret one another's suggestions. However, when participants ultimately developed a shared understanding, the pace of the discussion accelerated and ideas converged. Participants reported continuing the discussions in their staffing teams for weeks following their participation. As participants talked about their experience in the session with colleagues, people who had not participated expressed a desire to do so.

One participant said, "I thought this was a terrific experience. I think all staff should participate. To be able to have the difficult conversation our team had – and still like each other afterward – was amazing."

Overall, participants reported an increased understanding and a greater appreciation for their health insurance benefits after participating. The same participant commented, "The exercise gave me a better understanding of insurance with the costs associated."

A second participant noted, "I am really grateful for [the experience] in helping us understand health insurance and how ASHA negotiates its contracts. The connection between our personally designed plan and our randomly chosen health profiles was powerful!"

This understanding was reinforced as participants interacted and supported one another after participating in a shared decision-making process. The ease by which participants understood the elements of a health plan when presented in the format used suggests it would be worthwhile to redesign benefit communications using the same approach.

## Policy Implications

By using a deliberative process, employees demonstrated that they were willing to make tradeoffs to prioritize the needs of the group over their own preferences. Despite differences between the individually-designed plans and those that were ultimately designed by the group, satisfaction with the group-designed plan remained high. Eighty-three percent of respondents were satisfied or very satisfied with the group plan, which compares very favorably to the 71 percent average level of satisfaction with private health plans, according to J.D. Power's annual survey.<sup>9</sup> However, it's important to note that ASHA offers three very rich benefit options, which can confound a comparison with other employers that, on average, offer less comprehensive benefit options.

The small 9-percentage-point difference in satisfaction between the individually-designed plan and the group-designed plan suggests a high level of buy-in to the process, despite significant movement from individuals' ideal preferences. This reflects not only a deeper appreciation of one's colleagues' different situations and needs but also learning about life events that may be more likely than one thinks in the abstract, without going through a learning experience like this facilitated discussion. This illustrates that engaging employees in a discussion of health care trade-offs could create a sense of shared ownership and increase buy-in and satisfaction.

Within a broader policy context, employee appreciation and acceptance of tradeoffs are essential to managing overall health care spend. If employees are engaged in the deliberation process, necessary limits on coverage may be more likely to be considered ethical and accepted as legitimate and fair. This type of consultative and deliberative process, appropriately modified for different circumstances and beneficiary groups, could be useful for discussions of limits on public program benefits and tradeoffs as well. This approach seems worth exploring as discussions of how to restore balance to the federal budget intensify over the next few years.

## Conclusion

As rising health care spending increases the opportunity cost of coverage and care, important tradeoffs are increasingly unavoidable. Employers, as significant providers of health insurance, are responsible for making key decisions related to their employees' access to health care services and products. As employers design their health care benefit plans, they must consider important tradeoffs pertaining to coverage and spend (e.g., Should they offer higher wages in place of a more generous health benefit?). Engaging employees in the discussion of these tradeoffs could result in employees considering the limits on coverage ethical, legitimate, and fair.

This case study found that employees were willing to make tradeoffs for the good of the group. Some employees expressed greater willingness to pay for specific services. Despite employees making tradeoffs from their personally preferred position, satisfaction in the ultimate group-designed plan remained high. This suggests a high level of buy-in to the group process and a willingness to accept changes in plan design and coverage. This case study illustrates a framework for employers to engage their employees in a substantive dialogue about the need for health care tradeoffs.



# Appendix 1:






## Community Deliberation Resources

The following approaches to community deliberation were studied and drawn on to design the approach used in the Employer Benefits Builder Case Study:

- Choosing Health Plans All Together (CHAT) is a simulation exercise for designing a benefits package. Dr. Susan Gould at the University of Michigan and Dr. Marion Danis at the National Institutes of Health developed CHAT in 1998.<sup>10</sup> They described categories of benefits and divided them into levels of available services. Originally designed for coverage decisions relevant to the public health system, it continues to be used to support community dialogues in the state of California. The general structure of CHAT informed the instrument ASHA used. A CHAT exercise as part of an online course from the University of Michigan<sup>11</sup> provided inspiration for this project.
- Americans have much more limited experience with organized deliberation but have debated health care coverage at the state level – Oregon provides a good example – and more recently at the national level when the Affordable Care Act (ACA) established Essential Health Benefits, ten categories of care that were believed to be consistent with the typical employer plan.<sup>12</sup> Though this list of benefits was not developed with deliberative input from citizens, it provides the starting point for categorizing the benefits within a health plan used by ASHA.
- Program Budgeting and Marginal Analysis (PBMA)<sup>13</sup> is a priority-setting approach that has been used in Canada and other countries. It involves exploring changes at the margin – a step up or down in coverage – that will achieve the greatest benefit if funded and do the least harm if not funded. PBMA has a seven-step approach as described in Mitton et al. (2014): (1) determine the aim and scope of the priority setting exercise; (2) compile a program budget; (3) form an advisory panel; (4) determine the relevant decision-making criteria; (5) identify options for (a) service growth (b) resource release from gains in operational efficiency (c) resource release from scaling or ceasing some services; (6) evaluate investments and divestments; (7) validate results and reallocate resources. These seven steps outline the process that was followed from inception through implementation at ASHA.
- ChoiceDialogue<sup>14</sup> is a research technique based on the work of Daniel Yankelovich and Steven Rosell. The ChoiceDialogue approach leads people from highly unstable top-of-mind opinions to a thoughtful and more stable judgment that is informed by expert opinion and dialogue with other participants. Low health literacy can make viewpoints volatile. In health care, only 4 percent of Americans can correctly define *deductible*, *coinsurance*, *co-pay*, and *out-of-pocket maximum*.<sup>15</sup> The ChoiceDialogue process is a structured deliberative approach that requires participants to learn about the issues, consider options, and make tradeoffs. This approach results in decisions that are more stable, more valid, and more readily supported by others, and informs how a facilitator can lead participants to re-examine assumptions, beliefs, values, and preferences.
- *Facilitator's Guide to Participatory Decision-Making*, by Sam Kaner,<sup>16</sup> outlines specific steps a facilitator can take to build sustainable agreements. It was particularly helpful in describing what type of support participants would need at different points in the process of reaching an agreement.

# Appendix 2: Health Care Benefits Builder Benefit Category Levels

## Health Care Benefits Builder

| Benefit Category   | Good – Level 1  | Better – Level 2   | Best Level 3  |
|--|---|--|---|
|  <b>Hospitalization &amp; Surgery</b><br>Care you receive as a hospital patient including room and board. Also includes surgeries performed in outpatient facilities and care received in a skilled nursing facility. | <b>Access:</b> Any in-network facility. Care in a skilled nursing facility is limited to 45 days per calendar year.<br><b>Quality:</b> LOW-value care is NOT covered e.g., if the doctor suggests a certain treatment, if research shows that the likelihood of benefit is very small, you pay the full cost.<br><b>Cost:</b> You pay \$100. <p style="text-align: right;"><b>10</b></p>  | <b>Access:</b> Any in-network facility. Care in a skilled nursing facility is limited to 100 days per year.<br><b>Quality:</b> Less emphasis is placed on the value of treatment. What we have now.<br><b>Cost:</b> Same as level 1. <p style="text-align: right;"><b>2</b></p>  | <b>Access:</b> Same as level 2, but includes the cost of a private hospital room.<br><b>Quality:</b> Level 2 services plus travel and housing related expenses for care provided at centers of excellence for certain procedures like transplants, joint replacement, and spine surgery.<br><b>Cost:</b> You pay \$500. <p style="text-align: right;"><b>1</b></p>  |
|  <b>Doctor's Office Visits</b><br>Primary or specialty care you receive in a doctor's office or clinic. It includes pediatric care.   | <b>Access:</b> You designate a primary care provider. Visits to a specialist require a referral from a primary care physician.<br><b>Cost:</b> You pay \$15 for visits to a primary care physician and \$30 when you see a specialist. <p style="text-align: right;"><b>4</b></p>   | <b>Access:</b> You can see any specialist in the network whenever you like. (A referral is not required.)<br><b>Cost:</b> Same as level 1. <p style="text-align: right;"><b>2</b></p>  | <b>Access:</b> Includes level 2 services plus home care when necessary and care by alternative medicine providers like acupuncturists.<br><b>Cost:</b> Same as level 1 except you pay \$15 for visits to alternative medicine providers. <p style="text-align: right;"><b>1</b></p>   |
|  <b>Choice of Providers</b>   | <b>Access:</b> All services are provided by a narrow network of doctors, therapists and hospitals. All medical care must be provided by them; patient pays the entire cost if using a provider outside this network. This network excludes some respected providers like Johns Hopkins. <p style="text-align: right;"><b>5</b></p>  | <b>Access:</b> All services are provided by a broad network of doctors, therapists and hospitals. All medical care must be provided by them; patient pays the entire cost if using a provider outside this network. <p style="text-align: right;"><b>5</b></p>   | <b>Access:</b> In addition to level 2, you may see health care professionals outside the network.<br><b>Cost:</b> Visits to out-of-network providers are subject to a \$500 deductible and 20% co-insurance. <p style="text-align: right;"><b>5</b></p>   |
|  <b>Emergency Services</b><br>A visit to the emergency room. Includes transport by ambulance. Also, urgent care services.   | <b>Access:</b> Any hospital for care you receive for conditions that could lead to serious disability or death. Includes in-network urgent care and clinics.<br><b>Cost:</b> You pay \$200 for an emergency room visit, \$100 for an urgent care center and \$15 for a clinic like CVS Minute Clinics. <p style="text-align: right;"><b>2</b></p>   |  |   |
|  <b>Prescription Drugs</b>  | <b>Access:</b> Includes medicines on an approved list (formulary). Only generic versions of drugs are covered where generics are available. Expensive drugs need special approval and will only be covered when a doctor has tried less expensive alternatives first. Lifestyle drugs and over-the-counter drugs are not covered.<br><b>Cost:</b> \$10 co-pay for generic drugs. \$20 co-pay for brand name drugs. You pay 20% of the cost of specialty medications. <p style="text-align: right;"><b>7</b></p> | <b>Access:</b> Your plan only pays for medicines on its approved list (formulary). Expensive drugs will need special approval. Lifestyle drugs and over-the-counter drugs are not covered.<br><b>Cost:</b> \$10 co-pay for generic drugs. \$20 co-pay for brand name drugs. \$60 for specialty drugs. <p style="text-align: right;"><b>2</b></p> | <b>Access:</b> Your plan pays for medicines on its approved list (formulary) as well as many drugs that are not on the formulary list. It covers lifestyle drugs like Viagra and prescription strengths of medications available over-the-counter like Nexium.<br><b>Cost:</b> \$10 co-pay for generic drugs. \$20 co-pay for brand name drugs on the formulary. \$40 copay for drugs not on the formulary. \$60 co-pay for specialty drugs. <p style="text-align: right;"><b>4</b></p> |

| Benefit Category  | Good – Level 1   | Better – Level 2   | Best – Level 3  |
|---|--|--|---|
|  <p><b>Preventive Services</b></p>   | <p><b>Access:</b> Annual physical and National Institutes of Health recommended screenings based on age and gender. Immunizations. Contraception.</p> <p><b>Cost:</b> Zero in-network.</p> <p style="text-align: right;"><b>1</b></p>                                  | <p><b>Access:</b> Level 1 services plus physician supervised weight loss programs and nutritional counseling, bariatric surgery for morbidly obese patients. Includes elective abortions.</p> <p><b>Cost:</b> Subject to regular primary, specialty and hospital co-pays.</p> <p style="text-align: right;"><b>1</b></p> |   |
|  <p><b>Rehabilitative &amp; Habilitative Services &amp; Devices</b></p> <p>Rehabilitative services—help recovering skills, like speech therapy after a stroke—and habilitative services—help developing skills, like speech therapy for children, as well as durable medical equipment like prosthetics.</p> | <p><b>Access:</b> Rehabilitative services and durable medical equipment only. 30 visit limit. Excludes habilitative services, hearing aids and orthotics.</p> <p><b>Cost:</b> \$15 co-pay per visit.</p> <p style="text-align: right;"><b>1</b></p>                    | <p><b>Access:</b> Rehabilitative services, habilitative services and durable medical equipment. 30 visit limit per specialty. Excludes hearing aids and orthotics.</p> <p><b>Cost:</b> Same as level 1.</p> <p style="text-align: right;"><b>2</b></p>   | <p><b>Access:</b> Rehabilitative services, habilitative services and durable medical equipment. Unlimited visits. Includes up to \$6,000 per year for hearing aids and up to \$500 a year for orthotics.</p> <p><b>Cost:</b> Same as level 1.</p> <p style="text-align: right;"><b>1</b></p>          |
|  <p><b>Diagnostic Testing</b></p> <p>Laboratory, radiology and other testing to help a doctor diagnose an injury, illness or condition, or to monitor the effectiveness of a treatment.</p>  | <p><b>Access:</b> Your doctor needs to get expensive tests (like MRIs) approved in advance.</p> <p><b>Quality:</b> LOW-value care (like getting an MRI scan for a simple headache.) is NOT covered.</p> <p style="text-align: right;"><b>3</b></p>                     | <p><b>Access:</b> Your doctor can order any test deemed necessary.</p> <p><b>Quality:</b> Covers treatment where the benefit is minimal. What we have now.</p> <p style="text-align: right;"><b>2</b></p>  |   |
|  <p><b>Mental Health Care</b></p> <p>Inpatient and outpatient care provided to evaluate, diagnose and treat a mental health condition or substance abuse disorder. Includes behavioral health treatment, counseling, and psychotherapy.</p>  | <p><b>Access:</b> Your plan pays for up to 20 visits per year to a therapist or counselor.</p> <p><b>Cost:</b> \$15 co-pay per visit. Hospitalization as described.</p> <p style="text-align: right;"><b>2</b></p>   | <p><b>Access:</b> Unlimited visits per year to a therapist or counselor.</p> <p><b>Cost:</b> Same as Level 1.</p> <p style="text-align: right;"><b>1</b></p>   | <p><b>Access:</b> Includes everything in level 2 plus gender confirmation procedures and surgery.</p> <p style="text-align: right;"><b>1</b></p>  |
|  <p><b>Maternity &amp; Infertility</b></p>   | <p><b>Access:</b> Includes maternity care. Infertility treatments are not covered.</p> <p><b>Cost:</b> Zero for office visits. Hospitalization as described.</p> <p style="text-align: right;"><b>1</b></p>  | <p><b>Access:</b> Level 1 plus infertility treatments are included with an underlying medical diagnosis for all couples. Lifetime maximum benefit of \$100,000.</p> <p><b>Cost:</b> Same as level 1.</p> <p style="text-align: right;"><b>1</b></p>  | <p><b>Access:</b> Level 2 plus infertility treatments are included with a broad definition that provides services for same sex couples without a diagnosis of infertility. Lifetime maximum benefit of \$100,000.</p> <p><b>Cost:</b> Same as level 1.</p> <p style="text-align: right;"><b>1</b></p> |
|  <p><b>Vision Care</b></p> <p>Routine services to correct your vision with glasses or contact lenses.</p>  | <p><b>Access:</b> Annual eye exam, prescription glasses or contact lenses. (What we have now.)</p> <p><b>Cost:</b> \$15 per exam. Prescription glasses have a \$25 co-pay. \$130 annual allowance for contact lenses.</p> <p style="text-align: right;"><b>1</b></p>   | <p><b>Access:</b> In addition to level 1, refractive surgical procedures like lasik are covered for people who are nearsighted. Lifetime maximum benefit of \$10,000.</p> <p><b>Cost:</b> Same as level 1.</p> <p style="text-align: right;"><b>1</b></p>  |   |
|  <p><b>Dental Care</b></p>   | <p><b>Access:</b> Regular cleanings and x-rays (if appropriate) every 6 months. Includes fillings and extractions. Covers root canals and crowns. Excludes implants.</p> <p><b>Cost:</b> Co-pay for each visit is \$15.</p> <p style="text-align: right;"><b>1</b></p> | <p><b>Access:</b> Level 1 plus implants and a \$2,500 lifetime orthodontia benefit. (What we have now.)</p> <p><b>Cost:</b> Same as level 1.</p> <p style="text-align: right;"><b>1</b></p>  |   |

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1717 PENNSYLVANIA AVENUE, NW | SUITE 800 | WASHINGTON, DC 20006  
202-827-2100 | [INFO@NPCNOW.ORG](mailto:INFO@NPCNOW.ORG)  
[WWW.NPCNOW.ORG](http://WWW.NPCNOW.ORG)

