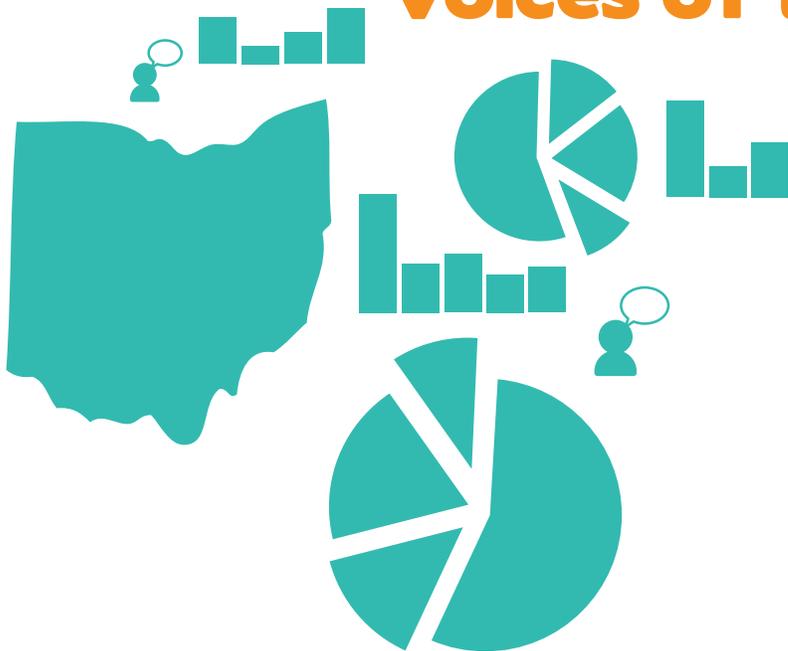




Ohio CHATs

About Healthcare

Voices of the Uninsured



Acknowledgements

The work of Ohio CHATs About Healthcare could not have been completed without the dedication, support and hard work of a number of individuals and organizations:

- The uninsured Ohioans who generously volunteered to share their time and thoughts with us around the State. Your insights, patience and humor were greatly appreciated by the CHAT Team.
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Chapter 1: Executive Summary

In 2007, Governor Strickland appointed a team of policymakers to the State Coverage Initiative (SCI) team to provide his administration recommendations on covering 1.3 million uninsured Ohioans. Policymakers on the SCI team identified the challenges presented to such an expansion effort, namely the costs associated with healthcare coverage. To this end, the SCI team requested input directly from Ohio's uninsured population. The Ohio Department of Insurance utilized a program called CHAT (Choosing Healthplans All Together) to determine what uninsured Ohioans thought a "basic" health plan must offer.

Policymakers were interested in developing a way to construct a health plan that was less expensive than an employer-sponsored plan yet one that offered sufficient protections. In order to determine these adequate protections, participants were asked through the CHAT process what was most needed and valued given a tight budget. Through individual and collective decision-making processes, CHAT participants negotiated trade-offs and developed a "basic" plan for all Ohioans, ages 18 through 64.

Most CHAT participants agreed upon the following principles or values for a “basic” health plan:

Affordability: The plan must be financially accessible to individuals at the lower to middle income levels; the young (18 and older) and those not yet eligible for Medicare; and those diagnosed with chronic health conditions.

Quality: The plan must emphasize quality care much more so than simply having more choice of providers.

Prevention: Healthcare coverage should be reasonably comprehensive (i.e., acute care and preventative care)—and provide for all levels of prevention (meaning primary, secondary and tertiary prevention).¹

Collective Good: Ohioans would be healthier and more productive if all aspects of health, including mental/behavioral and dental/vision benefits, were coordinated and taken seriously in a basic health plan.

Exclude Low-Value Interventions: The plan must include high-value and cost-efficient interventions. High-value interventions compel providers to follow established clinical guidelines for treatment and care would still be patient-centered.

This report examines the results of 18 CHAT sessions conducted throughout the state of Ohio with 177 participants. A snapshot of the plan chosen contrasting the benefits sacrificed follows.

¹On the CHAT wheel primary prevention was referred to as prevention, secondary prevention was called maintenance, and tertiary prevention was called complex chronic.

BENEFITS SELECTED AND SACRIFICED BY THE PARTICIPANTS

Healthcare Need	Benefits Selected	Benefits Sacrificed
Prevention	<ul style="list-style-type: none"> •Wellness treatment that meets national standards 	<ul style="list-style-type: none"> •Screenings that offer little chance of finding problems
Maintenance	<ul style="list-style-type: none"> •Doctor must follow expert guidelines for least costly treatment •These treatments work well for 90% of patients 	<ul style="list-style-type: none"> •Doctor can order any treatment or drug •Doctor does NOT need to follow expert guidelines
Complex Chronic	<ul style="list-style-type: none"> •Doctor uses least costly ways to manage illness 	<ul style="list-style-type: none"> •Covers costly treatments like knee replacement and heart transplant
Episodic Care	<ul style="list-style-type: none"> •Emergencies and urgent care dealt with quickly •Must wait several weeks or LONGER to see a doctor if not urgent 	<ul style="list-style-type: none"> •Can see the doctor earlier, wait is several weeks or LESS if not an emergency or urgent
Catastrophic	<ul style="list-style-type: none"> •Treatments are given to save the patient's life •Pays for all medical care known to be useful 	<ul style="list-style-type: none"> •Pays for treatments that have little chance of helping or may not work
Restorative	<ul style="list-style-type: none"> •Covers necessary rehabilitation services to improve function 	<ul style="list-style-type: none"> •Basic equipment for daily living •Covers ½ cost of costly equipment
End-of-Life	<ul style="list-style-type: none"> •Hospice care in home or hospital 	<ul style="list-style-type: none"> •High tech care that postpones death
Dental/Vision	<ul style="list-style-type: none"> •\$1,000 maximum dental benefit •Annual vision testing with biennial glasses allowance 	<ul style="list-style-type: none"> •NONE, participants selected the best benefit
Maternity	<ul style="list-style-type: none"> •Routine pre-natal care, normal childbirth and complications 	<ul style="list-style-type: none"> •NONE, participants selected the best benefit

Healthcare Need	Benefits Selected	Benefits Sacrificed
Mental/Behavioral	<ul style="list-style-type: none"> •Treatment for severe mental illness •Counseling and medication for drug and alcohol addiction 	<ul style="list-style-type: none"> •Long-term counseling for less severe mental problems •In-hospital drug and alcohol addiction treatment
Obesity	<ul style="list-style-type: none"> •Covers, medication, counseling and if necessary stomach surgery 	<ul style="list-style-type: none"> •NONE, participants selected the best benefit
Quality of Life	<ul style="list-style-type: none"> •NONE, no benefit selected 	<ul style="list-style-type: none"> •Drugs, medical and surgical treatment to correct non-disabling problems
Co-Payments	<ul style="list-style-type: none"> •Mid-range co-payments of \$20/doctor visit, \$10 generic drug and \$20 brand-name drug •\$100/ER visit and \$250/hospital visit 	<ul style="list-style-type: none"> •Lowest co-payments of \$10/doctor visit, \$5 generic drug and \$15 brand-name drug •\$25/ER visit and \$100/in-patient hospital visit
Premium	<ul style="list-style-type: none"> •Mid-range health premium of 4% of salary (\$66/mo for \$20,000/yr salary) 	<ul style="list-style-type: none"> •Lowest health premium of 2% of salary (\$33/mo for \$20,000/yr salary)
Providers	<ul style="list-style-type: none"> •Limited choice of doctors and hospitals •Referrals needed for specialists 	<ul style="list-style-type: none"> •Extensive choice of doctors and hospitals •Referrals not needed for specialists
Care Management	<ul style="list-style-type: none"> •Health review forms and care management classes are required 	<ul style="list-style-type: none"> •Patient choice to participate in health review forms and care management classes

Chapter 2: Background

A. History

Governor Ted Strickland identified healthcare reform as one of Ohio's urgent issues and established the following goals to aid Ohio's uninsured population:

1. Provide access to quality, affordable health insurance for every Ohio child and reduce the number of uninsured Ohioans.
2. Increase the number of small employers that are able to offer coverage to their workers.

To accomplish these goals, the State of Ohio applied for and was awarded a Robert Wood Johnson Foundation (RWJF) grant to join the "State Coverage Initiative" (SCI). The SCI program is designed to help states develop and implement strategies to expand access to affordable health insurance coverage and thereby reduce the number of uninsured citizens.²

Governor Strickland selected four members of his administration, four members of the Ohio General Assembly and four key stakeholders to form the SCI team that worked with RWJF, AcademyHealth and health policy experts to develop comprehensive, effective strategies to cover Ohio's uninsured residents. The SCI team received input from the Healthcare Coverage Advisory Committee, a large group of stakeholders appointed by the Governor to advise the SCI team throughout their exploration of policy options to expand coverage. The committee represented consumer advocates, providers, labor, employers, insurance companies, free clinics, community health centers, hospitals and associations. The recommendations of this year-long project were reported to Governor Strickland in "Covering Ohio's Uninsured: The SCI Team's Report to Governor Ted Strickland". To supplement the report, the SCI Team and Advisory Committee requested input directly from Ohio's uninsured population.

²Covering Ohio's Uninsured: The SCI Team's Final Report to Governor Ted Strickland, Executive Summary, 2008

B. Why CHAT?

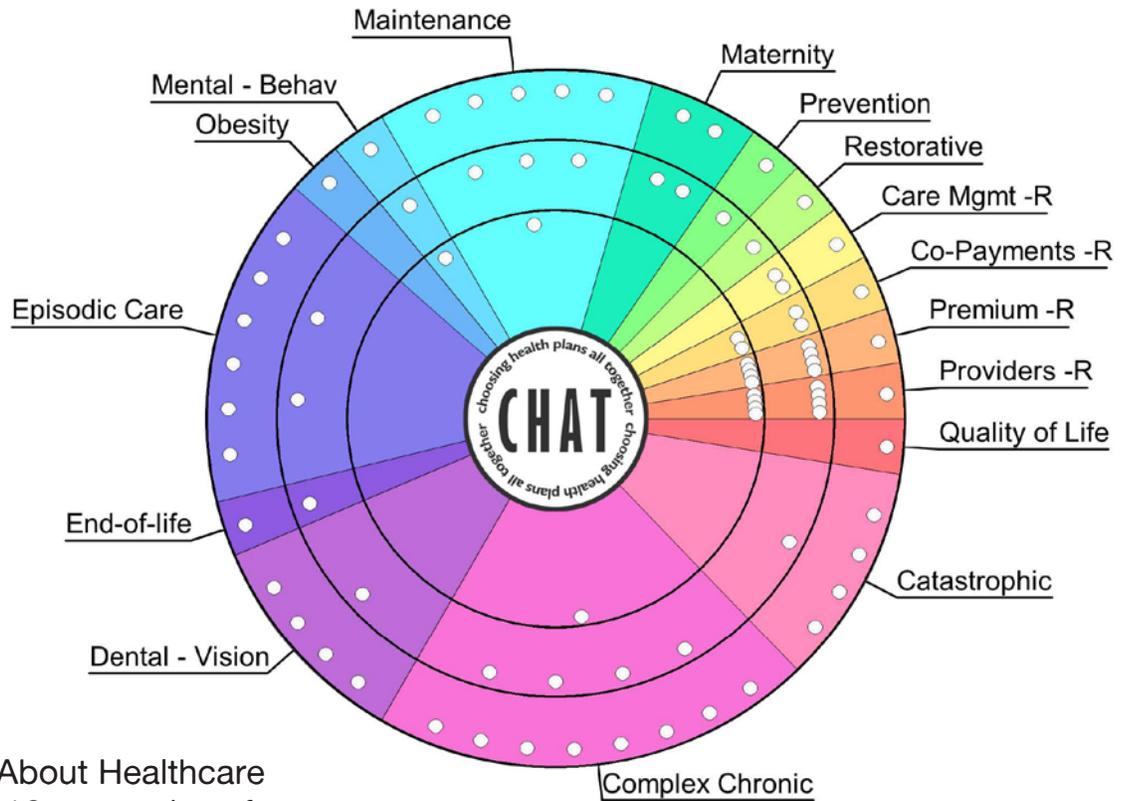
The SCI team's support staff at the Ohio Department of Insurance (ODI) were introduced to CHAT in late 2007. CHAT, also known as Choosing Healthplans All Together, is a proprietary and educational game and research tool developed by the University of Michigan and The National Institutes of Health with support from the Robert Wood Johnson Foundation. This computer-based program examines consumer healthcare choices in the context of limited resources. The software has been used in the United States and overseas.

Through a joint venture with AARP; Marjorie Ginsburg, MPH, Executive Director of the Center for Healthcare Decisions introduced CHAT to Ohio. With six years experience using CHAT, the Center for Healthcare Decisions offers consulting services to interested states. Services include game design assistance, facilitator training and technical support. Ohio secured the services of Center for Healthcare Decisions to create the project, **Ohio CHATs About Healthcare.**

The original CHAT game was tailored to reflect Ohio's current healthcare coverage environment. We decided to utilize a needs-based model over the more standard services-based model. In the needs-based model, participants choose levels of coverage for such needs as Complex Chronic, Restorative and Prevention. A complete description of the Ohio CHATs About Healthcare Categories and Tiers can be found in Appendix A. Pre- and post-CHAT questions were developed to collect participant demographics and qualitative data and can be found in Appendix D. All information is collected anonymously to encourage open dialogue and protect the identity of the participants.

C. The Game

Ohio CHATs About Healthcare seeks to answer: **What is most important to provide for Ohioans if we cannot afford healthcare coverage for everything?** In groups of 12 to 18, participants must decide whether to cover common or expensive medical needs; to restrict access to costly specialists; or to require individuals to complete a Health Review form and attend Care Management classes. CHAT allows participants to examine a variety of healthcare coverage needs and set priorities on the relative importance of those needs.



The Ohio CHATs About Healthcare wheel consists of 16 categories of needs representing different aspects of healthcare coverage. They are:

1. Catastrophic - Treatment of sudden, serious injury or illness such as car accident injuries or deadly cancer.

2. Complex Chronic Care - Treatment of serious, long-term chronic illness like a heart condition or diabetes.

3. Dental/Vision - Preventing and treating dental problems and, if selected, testing for and correcting problems with eyesight.

4. End-of-Life Care - Palliative care that cannot provide a cure for persons expected to live less than six months.

5. Episodic Care - Treatment of common problems such as ear infections and strep throat; includes emergencies like appendicitis.

6. Maintenance - Regular check-ups and treatment for early chronic conditions that are not yet serious such as high blood pressure and asthma.

7. Maternity - Medical care of women during pregnancy and childbirth.

8. Mental/Behavioral - Detection and treatment of mental illness (schizophrenia, depression, etc.) including treatment for smoking and substance addictions.

9. Obesity - Treatment for patients who are severely overweight.

10. Prevention - Tests to find medical problems as early as possible and to help prevent disease.

11. Quality of Life - Treatment for problems of function, appearance or comfort, like hair loss and infertility.

12. Restorative - Repairing the ability to do the activities of daily living (walking, dressing, etc.) needed after broken bones, surgery or stroke.

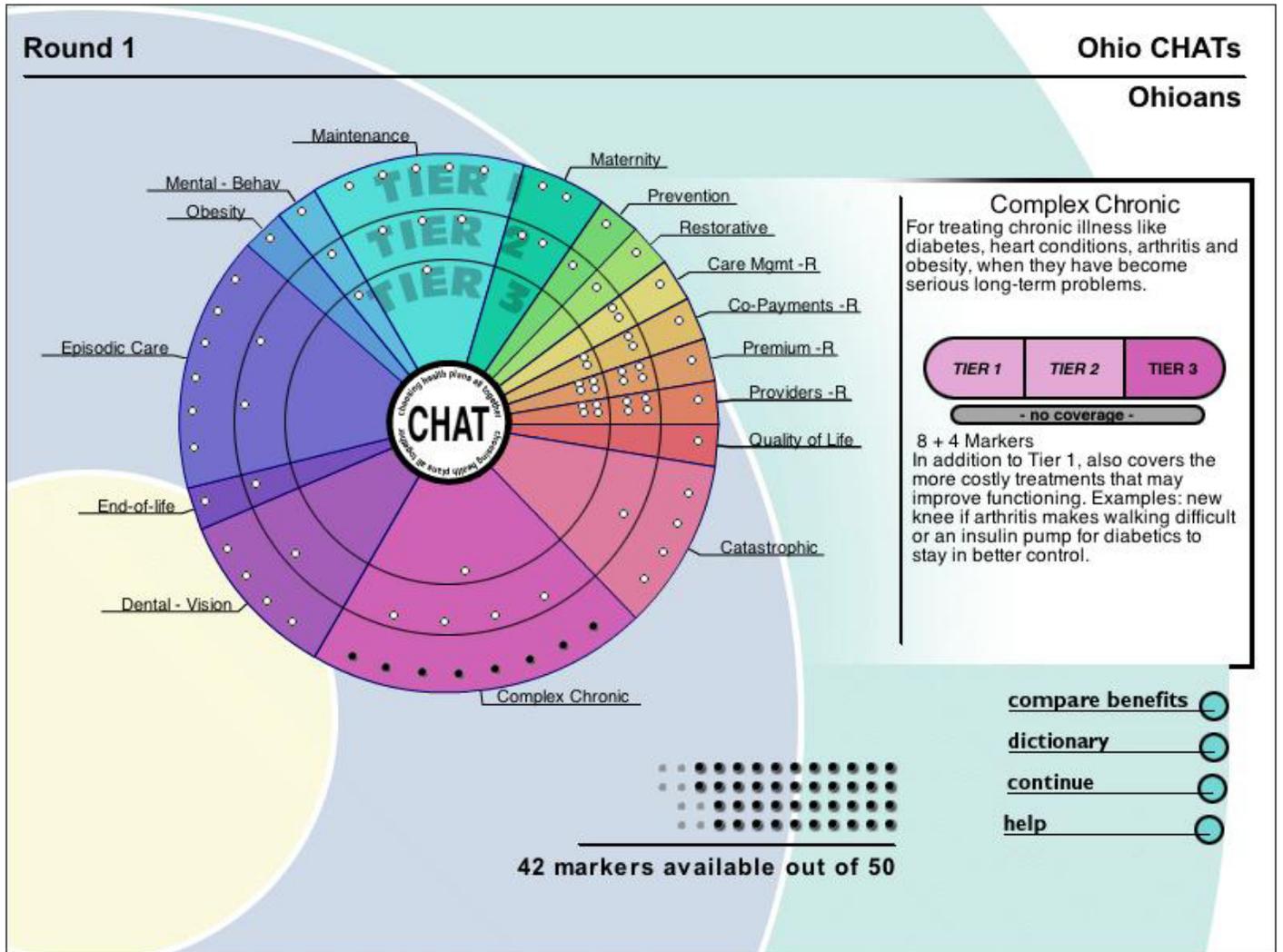
13. Care Management - A required category of programs to help people stay healthy includes a Health Review Form and Care Management classes.

14. Co-Payments - A required category of amounts individuals pay to utilize healthcare services.

15. Premium - A required category of amounts individuals must pay monthly for healthcare coverage.

16. Providers - A required category of professionals who provide all medical care including doctors, specialists, clinics, labs and hospitals.

Participants may select as many as four different levels of coverage for each category. No Coverage is an option for most along with Tier 1, Tier 2 and Tier 3 benefits. Tier 1 benefits represent basic, minimal coverage at the lowest cost. Tier 2 benefits offer better coverage than Tier 1 at a moderate price. Tier 3 benefits are the best available at the highest cost. As detailed, as the tier increases, the level of benefits and cost of coverage increases as well. Coverage in all categories is optional except for the Care Management, Co-Payments, Premium and Providers choices. Participants must select some level of coverage in each of those categories.



Each CHAT game consists of four rounds. In Round 1, participants work independently to design a plan of coverage to suit their own individual needs. Participants must consider their healthcare needs for the next three years. Potential illnesses and health events are introduced at the end of the round to demonstrate how well the plan chosen covers medical needs. Participants share these experiences with the entire group. This first round allows participants to become familiar with the game and, if necessary, the computer.

In Round 2, participants work together in small groups of 3 or 4 to create a plan for all Ohioans ages 18 through 64. The second round affords

participants the experience of working with others to build a consensus plan and to reconcile their personal healthcare needs with at least two others. Again, potential illnesses and health events are introduced, however, they are shared only in the small groups.

Round 3 brings all participants together to develop a benefit plan for all Ohioans, ages 18 through 64. Participants are given a chance to express their views on healthcare coverage needs in a roundtable discussion format. A trained facilitator leads this round, in which participants are encouraged to offer their opinion even if it means disagreeing with other participants.

In Round 4, participants return to their computers to independently design what they believe is the best plan for all Ohioans, ages 18 through 64. Participants will have the insight of the prior rounds to create a plan that is fair for all. The conversations in the prior rounds give most participants a new appreciation for others' choices and needs.

In each round, participants are given 50 markers to spend on a healthcare coverage plan. The markers represent the price of an affordable benefit package for Ohioans. However, the Ohio CHAT wheel has more options to choose from than markers to spend. Participants must decide how to get the most value from the 50 markers. Participants must also understand the coverage they design is all that is available. In these scenarios, there are no public or private programs to provide additional coverage. Participants would have to pay out of their own pocket for any benefits not included in the plans created.

A complete CHAT session lasts approximately three hours. Participants are asked to arrive at least 30 minutes early to assure an on-time start.

D. Goals and Objectives

With information collected from two states in various stages of a CHAT program as well as Center for Healthcare Decisions input, we began to lay the groundwork for a Project Plan and Session Planning Packet.

The Ohio CHAT team established specific project goals and objectives for the uninsured sessions. Project goals are:

1. To solicit input from Ohio's uninsured population about what a basic health plan should cover;
2. To educate Ohioans about healthcare coverage choices; and
3. To provide feedback to Ohio's SCI team regarding uninsured choices.

We consulted with Universal Healthcare Action Network of Ohio, (UHCAN Ohio) the Ohio Association of Free Clinics (O AFC), the Ohio Association of Community Health Centers (OACHC) and Access HealthColumbus (AHC). These organizations offered valuable insight into what to expect during the

project, how to encourage participation of the target individuals, possible funding needs and how to locate the uninsured throughout the state.

We then consulted with the Health Policy Institute of Ohio (HPIO) to determine our target audience for the project. It was understood that the project would be a “convenient” sampling; only the data of those who chose to attend a session could be collected. We wanted to ensure adequate participation of a diverse population with regard to the following:

- Age and gender;
- Race /ethnicity;
- Income and employment status; and
- Geographical area.

We utilized the HPIO 2004 Ohio Family Health Survey to determine the counties to survey. The following factors of each county were reviewed:

- Uninsured rate;
- Poverty rate;
- Unemployment rate; and
- Race/ethnicity.

We selected nine of Ohio’s largest Metropolitan areas, five Appalachian, four rural and two Suburban counties to target. We had hoped to hold at least two different sessions in each Metropolitan area and one session in each of the remaining counties. A Project Plan was written to solicit funding for stipends and refreshments. A Session Planning Packet was developed to guide coordinators through planning a successful session. The final plan and packet have been included in Appendix B and C respectively.

As an original partner, AARP agreed to expand its role and sponsor stipends for at least ten uninsured sessions. Additionally, Foundation for Healthy Communities of the Ohio Hospital Association, Ohio Business Roundtable, The Academy of Medicine of Cleveland and Northern Ohio (AMCNO), Good Samaritan Hospital, Council of Small Enterprises (COSE) and HPIO offered to fund stipends. A complete list of sponsors can be found in Chapter 6.

The Ohio Association of Free Clinics (O AFC) was the first organization to coordinate uninsured sessions. Additionally, Ohio Association of Community Health Centers (OACHC), Access HealthColumbus (AHC), Toledo Area Jobs With Justice Coalition, Kaleidoscope Youth Center and various Ohio hospitals agreed to plan uninsured sessions. A complete list of coordinators is included in Chapter 6.

We successfully secured sufficient funding to complete the project. Some of our partner organizations employed enough resources to coordinate a session and had access to a large pool of uninsured. Others, while willing to participate, lacked the staffing or interested uninsured to successfully organize a meeting. Therefore, locating participants willing to devote the time necessary to complete a session proved to be more difficult than expected. Of the 29 sessions planned, we successfully completed 18.

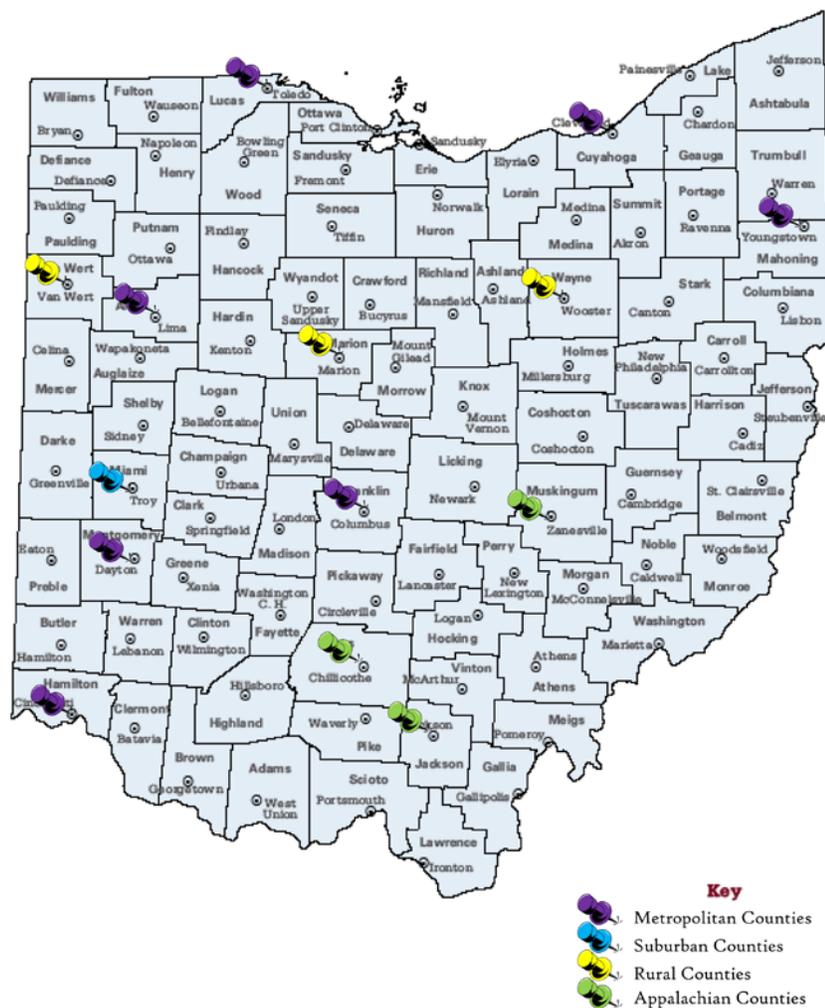
E. The Participants

We asked session coordinators to select participants who were:

- At least age 18 and under age 65;
- Able to read and understand English;
- Computer literate, have seen and used a computer before; and
- Currently uninsured and have been for at least one year.

As the sessions progressed, we found the need for computer literacy was not an important qualification. Facilitators easily trained participants to use the laptop computers. A number of participants later stated they would be interested in learning more about computers and were no longer afraid to use them. Demographic data for our CHAT participants is as follows:

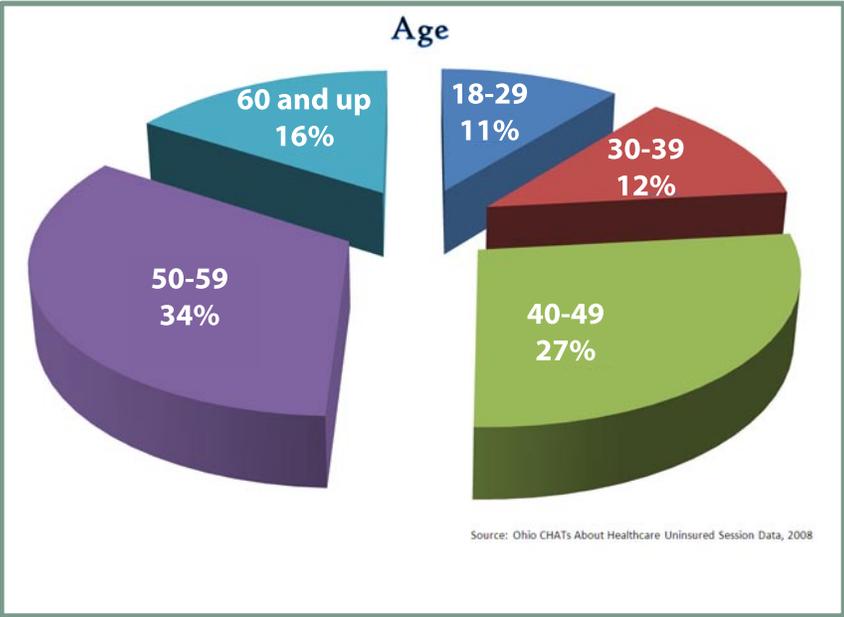
**CHAT Session Locations By Geographic Regions
March - November 2008**



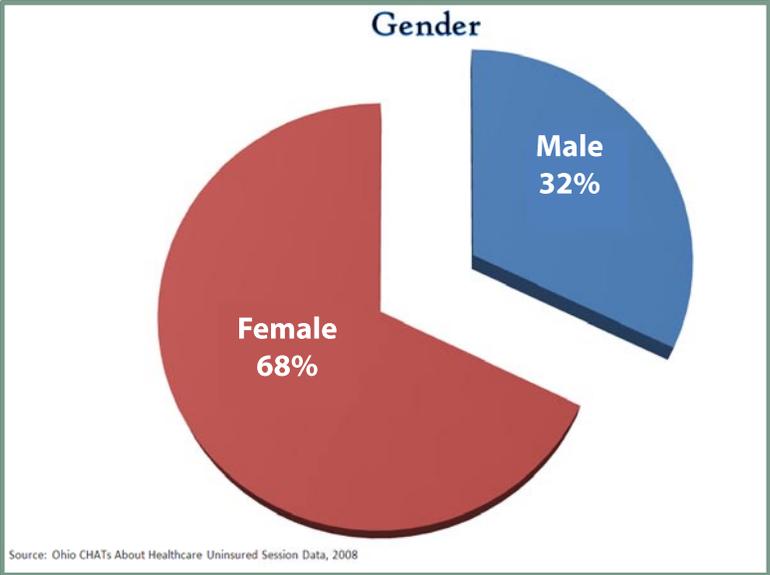
1. GEOGRAPHIC REGIONS:

The location and geographic region of the CHAT sessions is pinpointed on the map below. Additionally, sponsors and coordinators are detailed in Chapter 6.

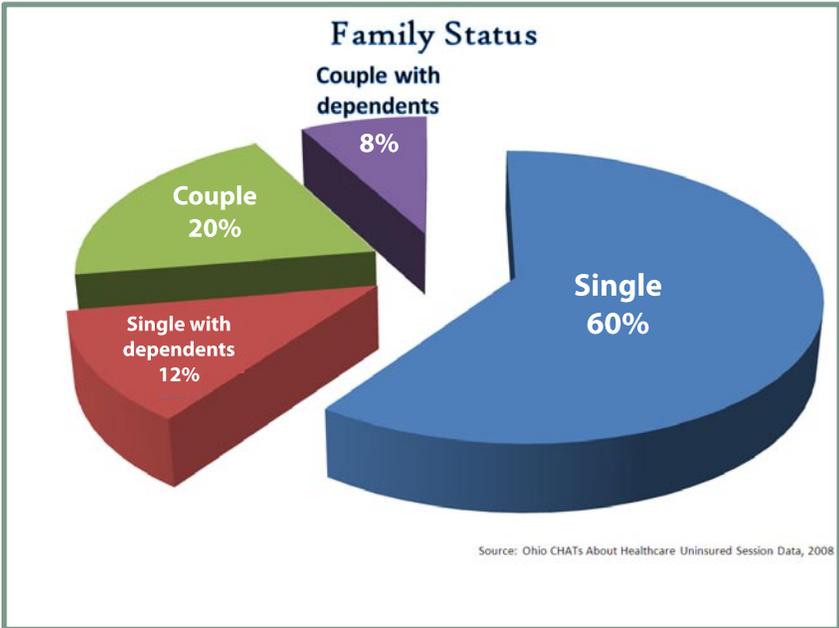
Source: Ohio CHATs About Healthcare Uninsured Session Data, 2008



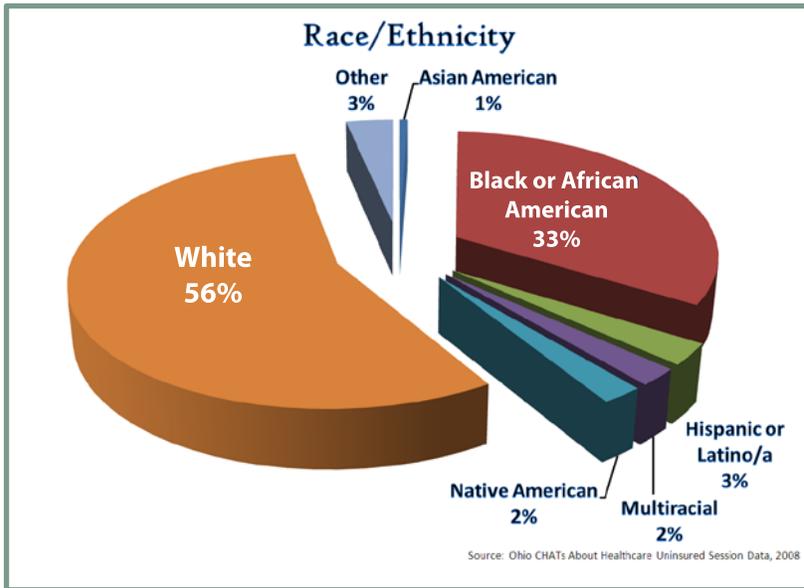
2. AGE: The average age of participants in our sessions was much higher than Ohio’s uninsured population. We attribute this difference to the voluntary nature of the project and the fact that older individuals were readily available to participate in the sessions.



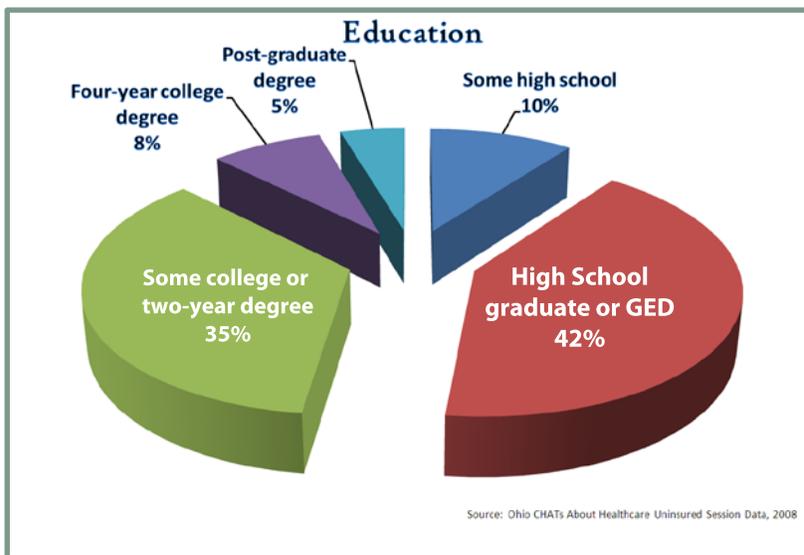
3. GENDER: 68% of our participants were women. This number was much higher than Ohio’s uninsured population of 47% female.



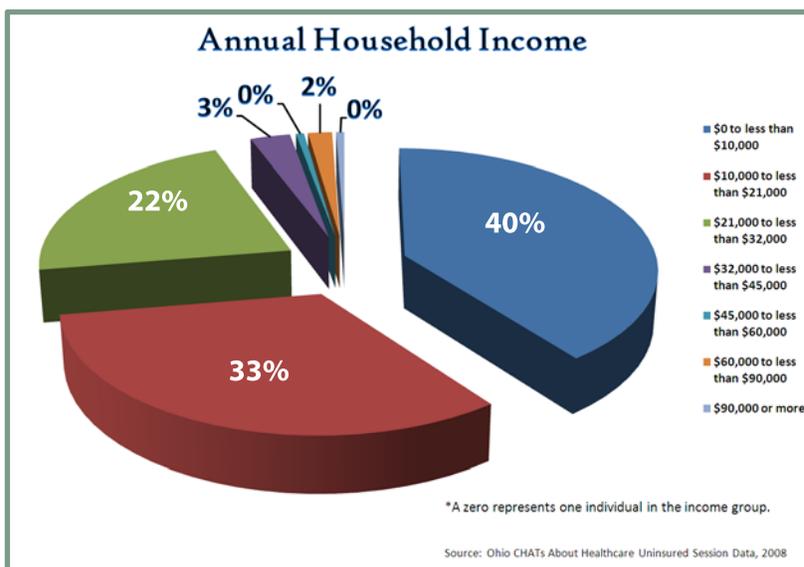
4. FAMILY STATUS: A majority of our participants were single and only 20% of participants lived in households with dependents.



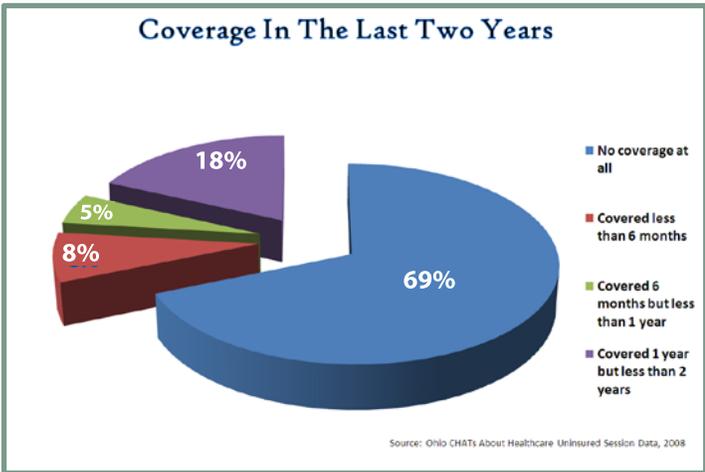
5. RACE/ETHNICITY: Racial minorities represented 44% of our participants but made up only 27% of Ohio's uninsured.



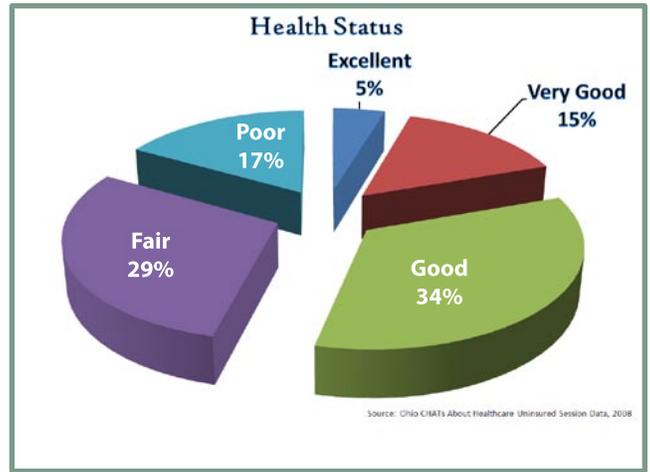
6. EDUCATION: CHAT participants were highly educated when compared with Ohio's uninsured population. Only 10% of our participants did not finish high school and 48% had post high school education.



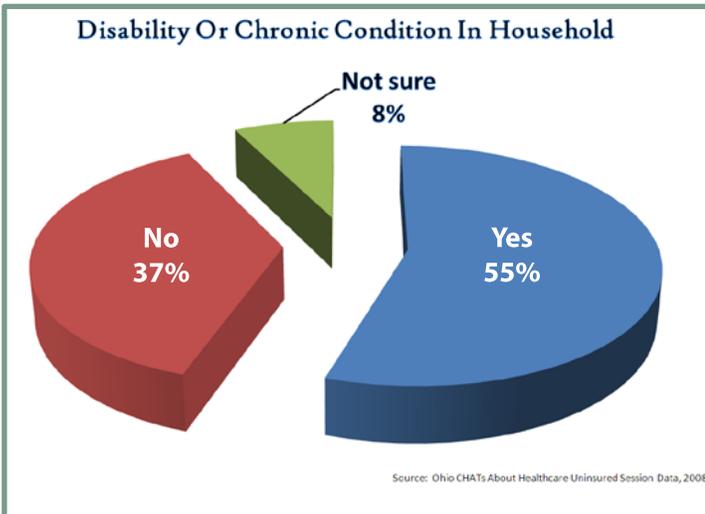
7. ANNUAL HOUSEHOLD INCOME: 73% of our participants lived in households with incomes of less than \$21,000 and only 5% of our participants reside in households with incomes of \$32,000 or more.



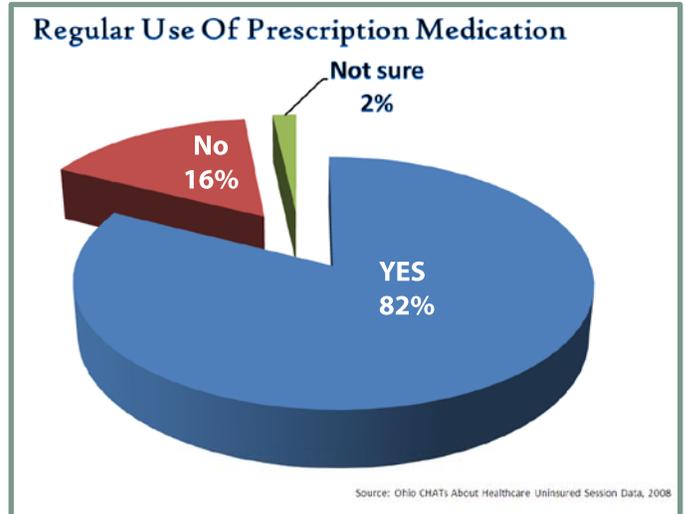
8. COVERAGE IN LAST TWO YEARS:
 The majority of our participants have had no insurance coverage in the last two years.



9. HEALTH STATUS: Most participants considered themselves in good health however 46% believed they were in no better than fair health.

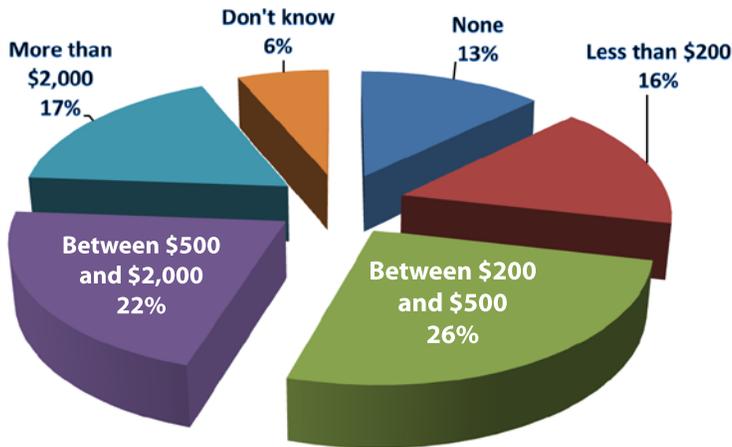


10. DISABILITY OR CHRONIC CONDITION IN HOUSEHOLD:
 55% of our participants lived with or have someone in their household with a disability or chronic health condition.



11. REGULAR USE OF PRESCRIPTION MEDS IN HOUSEHOLD: The majority of our participants or members of their households regularly used prescription medication.

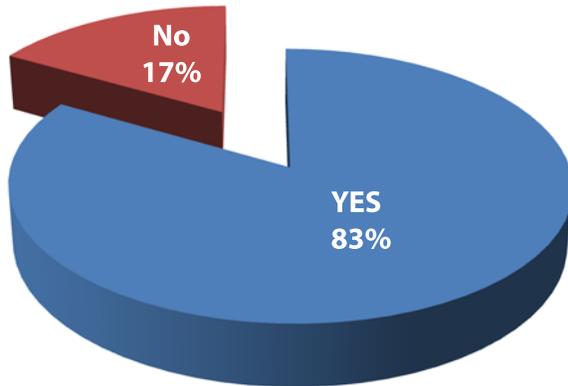
Healthcare Spending In Last 12 Months



Source: Ohio CHATs About Healthcare Uninsured Session Data, 2008

12. HEALTHCARE SPENDING IN LAST 12 MONTHS: Households of 39% of our participants had spent more than \$500 on healthcare in the last 12 months. Only 13% had no healthcare expenses in the last 12 months.

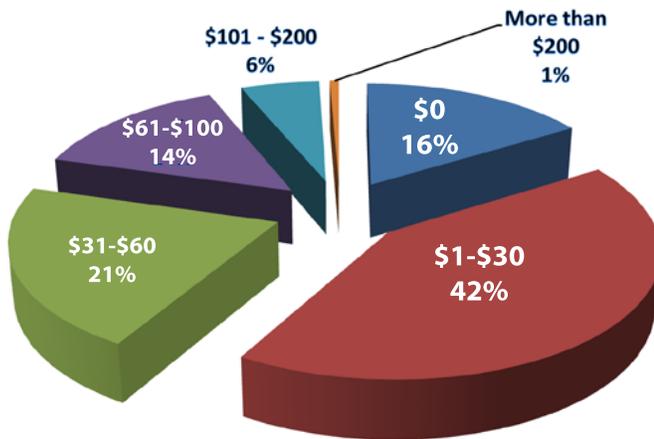
Struggled To Afford Healthcare In Past 12 Months



Source: Ohio CHATs About Healthcare Uninsured Session Data, 2008

13. STRUGGLED TO AFFORD HEALTHCARE IN LAST 12 MONTHS: Only 17% of our participants did not struggle to afford healthcare in the last 12 months.

Willing To Pay Monthly For Health Insurance



Source: Ohio CHATs About Healthcare Uninsured Session Data, 2008

14. AMOUNT WILLING TO PAY MONTHLY FOR INSURANCE: 58% of our participants were willing to pay less than \$30 per month for health insurance. Only 7% were willing to pay more than \$100 per month for health insurance.

Chapter 3: Key Values That Influenced Participant Decisions

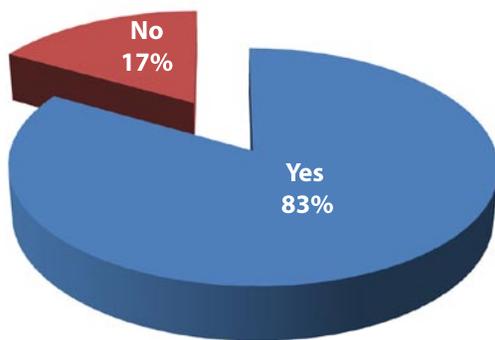
As participants discussed their choices and priorities in designing a basic plan for all Ohioans, ages 18 through 64, the following values influenced their decisions.

A. Affordability

“Getting a tank of gas can compete with your premiums,” commented one of the participants. Affordability was extremely important to all the participants. In fact, they were acutely aware that if they selected the most affordable plan they would sacrifice many other benefit categories or the richness of any given benefit. They wanted affordability upfront with low premiums, as well as on the back-end with low co-payments. Often participants were forced to compromise by selecting the lowest premium amount coupled with a mid-range co-payment. They pointed out that high premiums coupled with high co-payments simply discouraged people from seeking the care they needed.

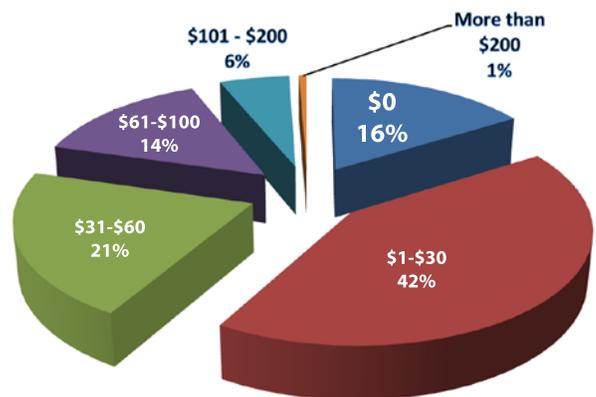
“Getting a tank of gas can compete with your premiums...”

Struggled To Afford Healthcare In Past 12 Months



Source: Ohio CHAT's About Healthcare Uninsured Session Data, 2008

Willing To Pay Monthly For Health Insurance



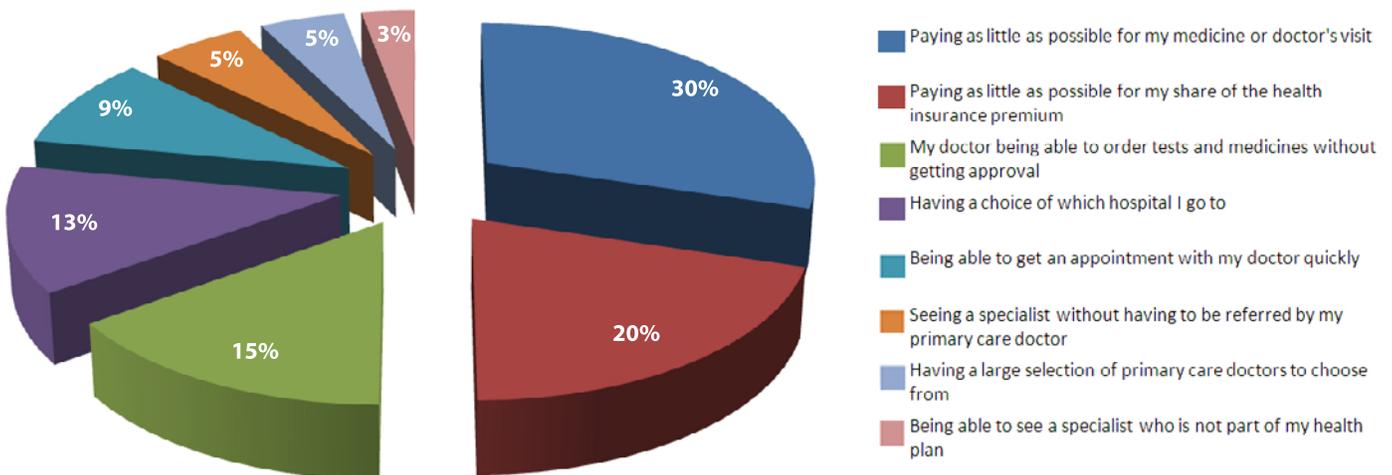
Source: Ohio CHAT's About Healthcare Uninsured Session Data, 2008

B. Quality

“More choice doesn’t always mean that I will get a compassionate doctor or a better hospital,” pointed out one participant. Many participants talked about how they would be quite happy if they had a reliable, responsive and caring primary care physician but were interested in having some choice with hospitals. Additionally, participants pointed out that some hospitals treated them poorly and others treated them with dignity and compassion. And, thus, they wanted choice concerning hospitals, primarily because they valued being treated professionally and respectfully by hospital physicians, nurses and staff members.

“More choice doesn’t always mean that I will get a compassionate doctor or a better hospital...”

Most Important Factors



Source: Ohio CHATs About Healthcare Uninsured Session Data, 2008

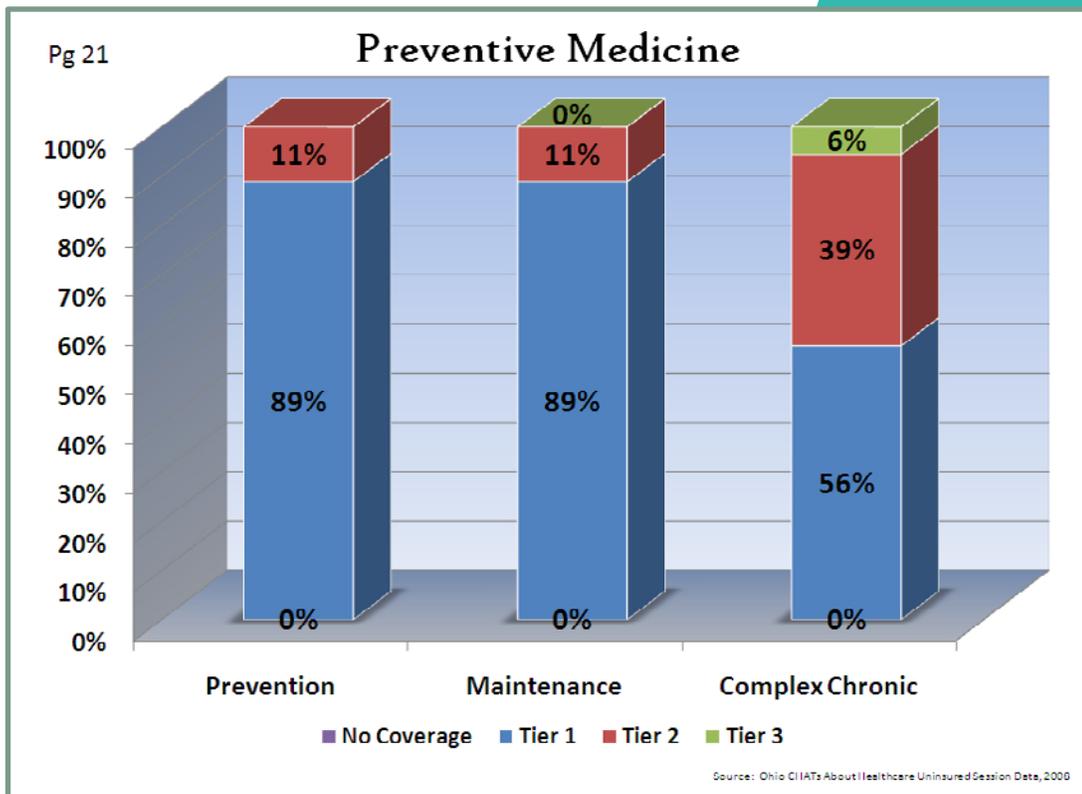
C. Prevention

“Your bones at 50 will tell you about your problems and the life you’ve lived” said one of the participants.

Participants felt strongly about all levels of prevention. At the primary level of prevention, tests are performed on individuals to discover potential medical problems. At the secondary level of prevention, or Maintenance, patients follow a protocol in order to keep early chronic or diagnosed conditions from getting worse. At the tertiary level of prevention, or Complex Chronic, the diagnosed disease is at an advanced level (and coexists with other conditions) and the individual requires long-term treatment.

The participants understood all levels are interconnected and a health plan

“Your bones at 50 will tell you about your problems and the life you’ve lived.”



should not focus on preventive medicine over Complex Chronic. Participants believed care is necessary for the sick as well as educating others to remain healthy.

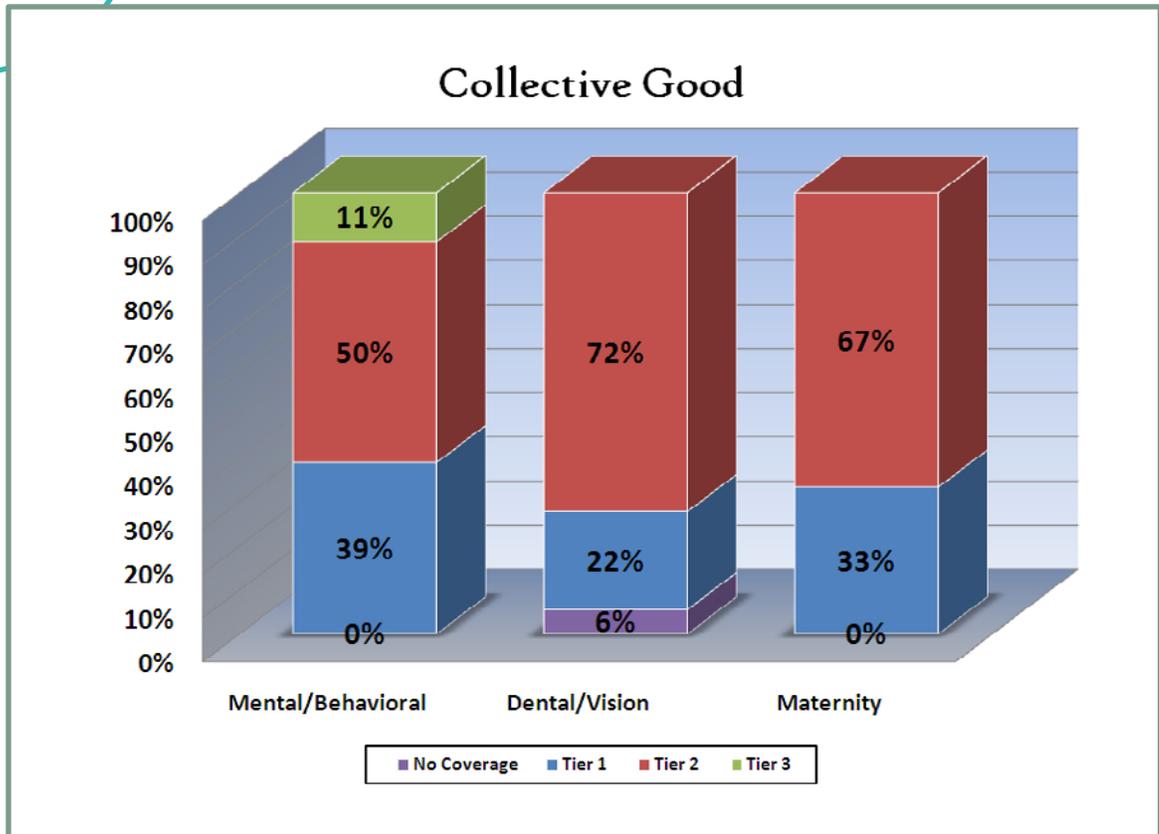
D. Collective Good

“We need to take care of the old and the young, the sick and the healthy ones” pointed out a participant.

When participants had the opportunity to discuss individual problems in a collective setting, they were generally sympathetic to concerns that they had not personally experienced. They believed Ohioans would be healthier and more productive if these issues were taken seriously in a basic health plan. For instance, participants felt that many in their communities were facing addiction problems and issues pertaining to depression. Participants associated these problems with the dire economic situations in their communities. Therefore, there was full support for a plan that went beyond only covering advanced mental illness.

Participants believed both dental and vision coverage should be included in the basic health plan. When funds were limited by other category choices, participants often settled for dental only coverage. They connected the importance of dental and vision health to the overall health of an individual.

“We need to take care of the old and the young, the sick and the healthy ones.”

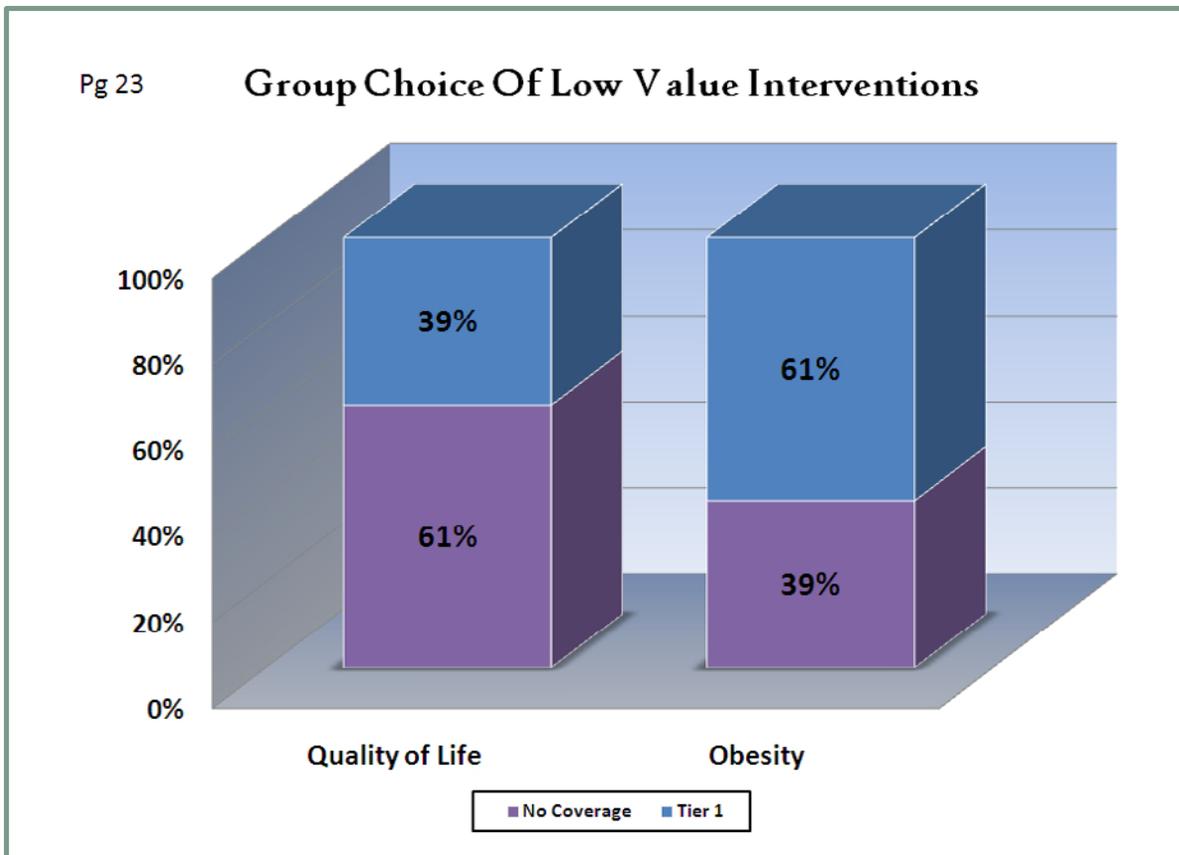


In the case of maternity, participants selected the richer tier of coverage so that unexpected complications of pregnancy would be covered. They felt that having better coverage in all of these areas would be a form of “early prevention” that could mitigate future chronic medical problems.

E. Exclude Low-Value Interventions

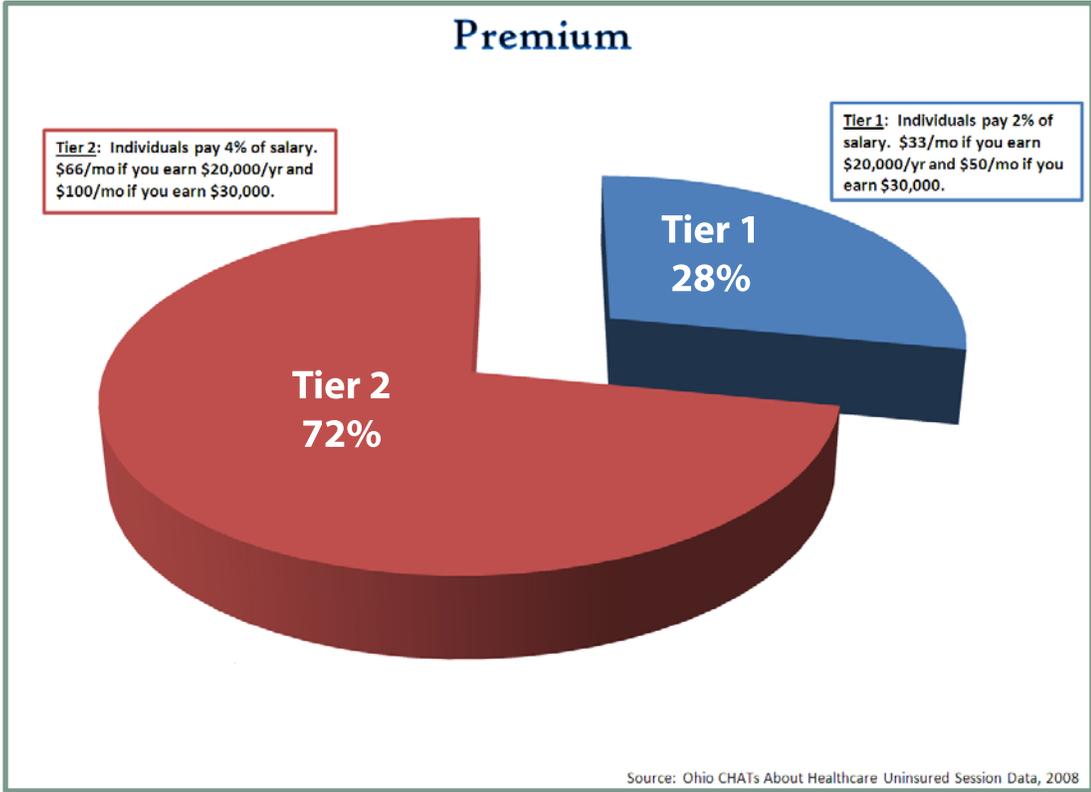
The majority of participants felt that Quality of Life and Obesity were the least valuable benefit categories. Many believed that quality of life was the most expendable category and voted for no coverage. They felt that this option was “cosmetic” and did not contain any substantive healthcare benefit or outcome. A minority disagreed and thought this “was not a vanity thing—it helps with your job and can become a mental health issue for women without hair.” The same minority felt that infertility was also an important issue.

Many acknowledged that obesity is a major problem in both the United States and Ohio. Participants felt that individuals should be able to tackle this problem on their own and other categories represented more important medical problems to address. Others thought poverty, the abundance of fast foods and the lack of affordable nutritious foods created the problem. Even though a few participants were interested in providing access to bariatric surgeries, others wondered about the safety of the procedure. Some suggested that this was simply a matter of bad genes, poor mental health, eating too much or laziness and that either obesity should be tackled under mental and behavioral health or that the individual should take “personal responsibility” for their own life.



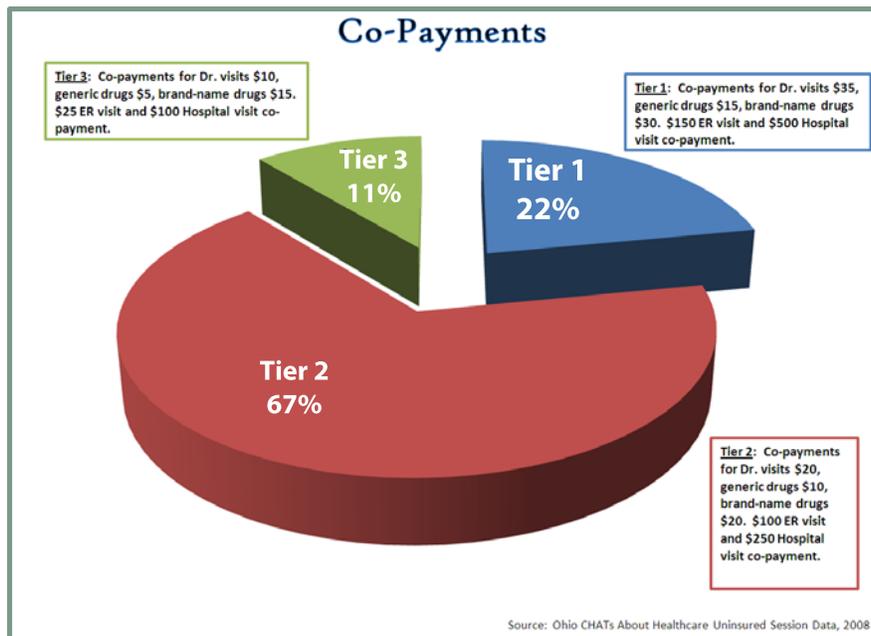
Chapter 4: Creating a Health Plan for Ohio's Uninsured

Participants felt that all of the categories on the CHAT Health Plan were very important. They struggled with how to balance individual and community health needs with limited resources. In other words, each category in the CHAT Health Plan came with a price tag that was proportionately identified by a health actuary and participants had to choose differing levels of coverage options with a set spending limit. Given that, there were certain categories that emerged as most and least important to the participants. Also, certain categories generated significantly more discussion among the participants. They include:



A. Most Important Categories

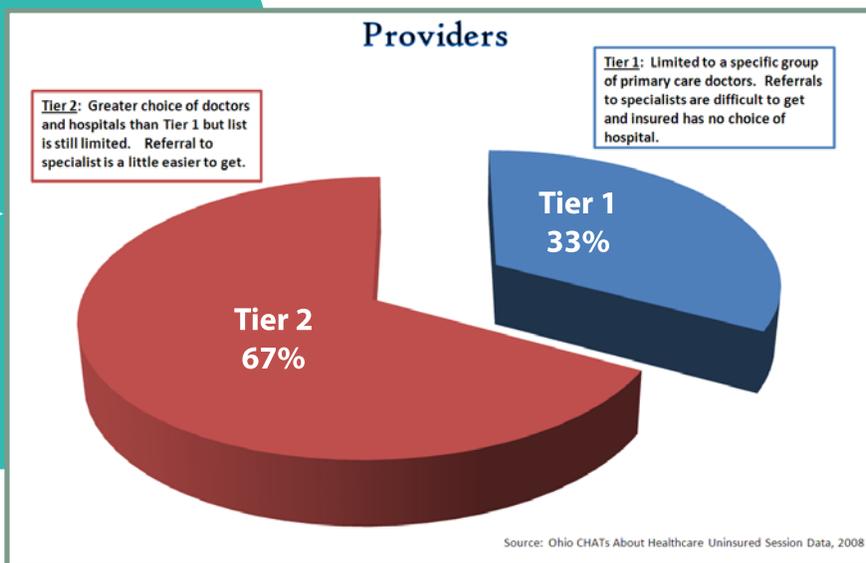
1. Premiums: Many participants felt they could not afford a monthly premium but understood the need to pay a portion of the cost up-front. A large majority pointed out repeatedly that premiums MUST be affordable so those who need the coverage can obtain it.



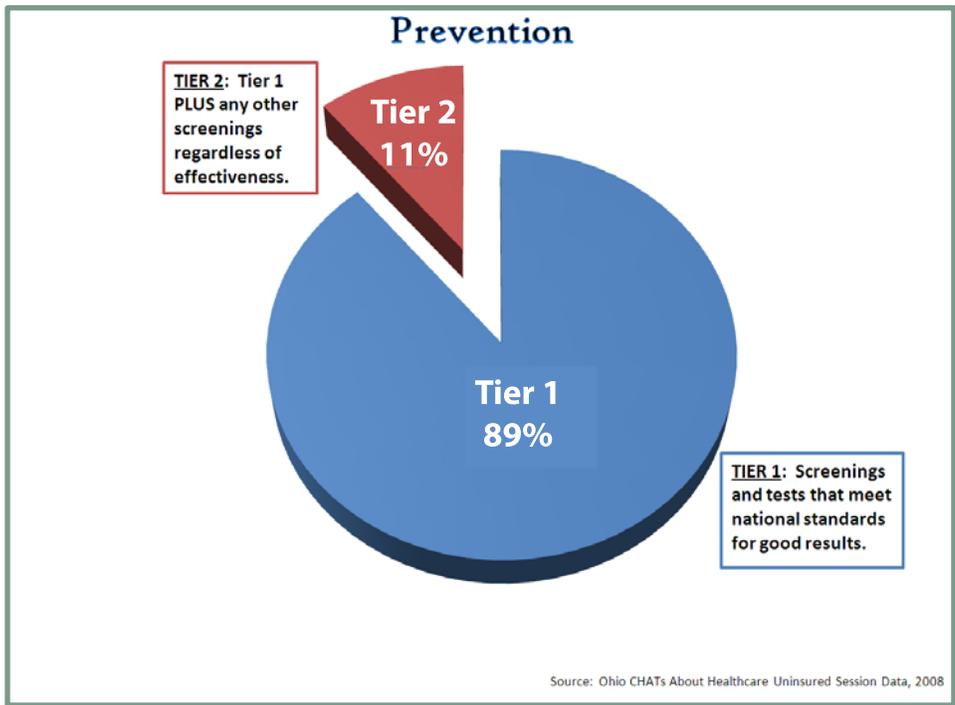
2. Co-payments: “Thank God that Giant Eagle and Kroger have generics for \$4. Something is better than nothing” remarked a participant. Participants could not decide which was more important: low premiums or low co-payments. All wanted to be sure that once the coverage was purchased, they could afford to see the doctor. A number of participants believed if they had more markers they would select the lowest co-payments available. The majority settled for the mid-range co-payment as an affordable compromise.

“Thank God that Giant Eagle and Kroger have generics for \$4. Something is better than nothing.”

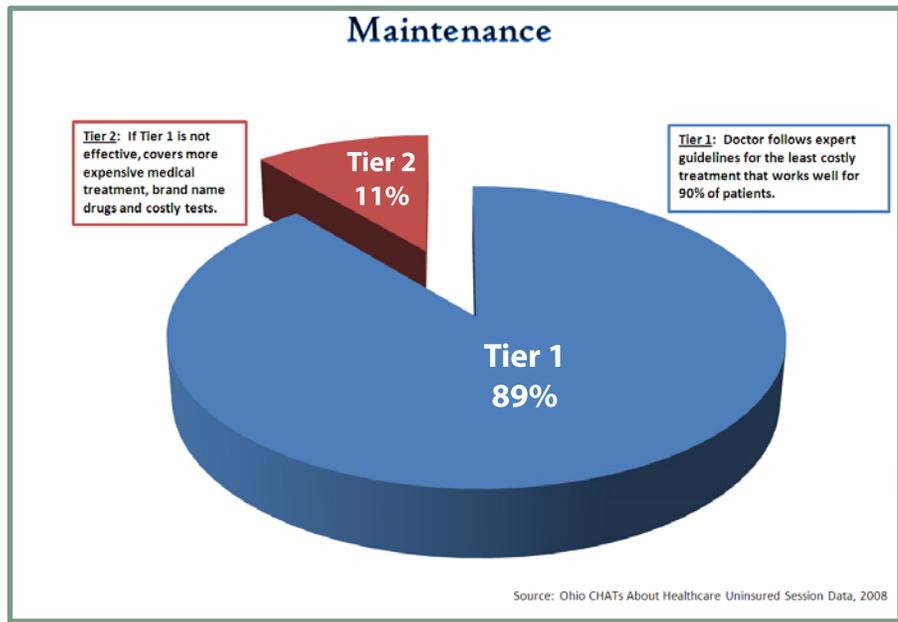
“If your doctor doesn’t care and you want to be fixed – you could be [broke more].”



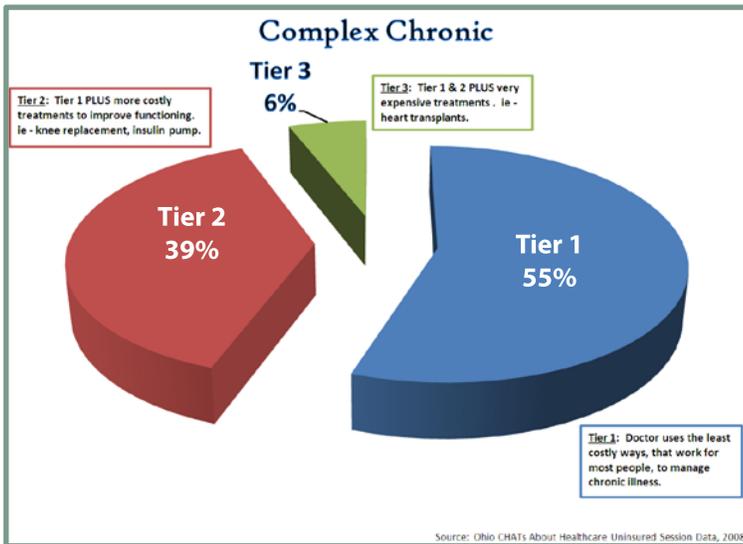
3. Providers (physicians and hospitals): “If your doctor doesn’t care and you want to be fixed – you could be [broke more]” observed a participant. Participants often pointed out that having access to a caring physician and a decent clinic or hospital can far outweigh having more choice in doctors and hospitals. In other words, participants wanted quality and good value instead of abundant low-quality choice of physicians and hospitals. And, therefore, most participants selected Tier 2 for greater choice.



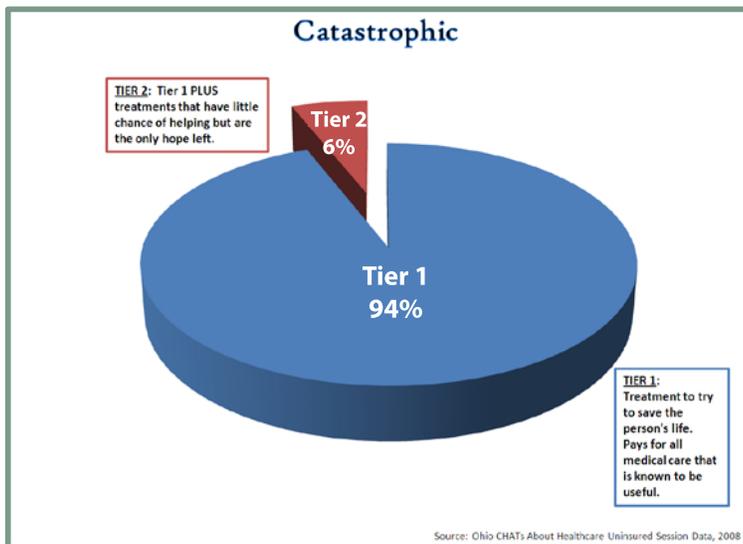
4-a. Prevention (primary level): People felt strongly about having the opportunity to access a physician who could identify any potential medical problem in its infancy.



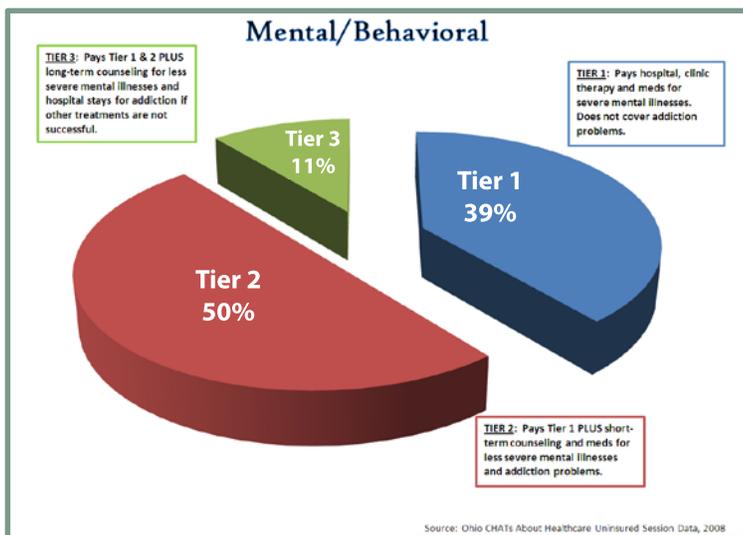
4-b. Maintenance (or prevention at the secondary level): Viewed as an important second step to promote consistent prevention. 89% of the participants selected Maintenance.



4-c. Complex Chronic (or prevention at the tertiary level): Participants wanted to be productive members of society even as they got older. Many wanted richer coverage within this category but stepped down to lower levels in order to have a more comprehensive plan for all Ohioans.



5. Catastrophic: Participants pointed out that “accidents happen and things like individual bankruptcy (sic) sneak up on you.” As a group, all participants voted for some level of catastrophic coverage. Only 6% wanted to spend the additional markers to pay for treatments that are the last hope and have little chance of working.

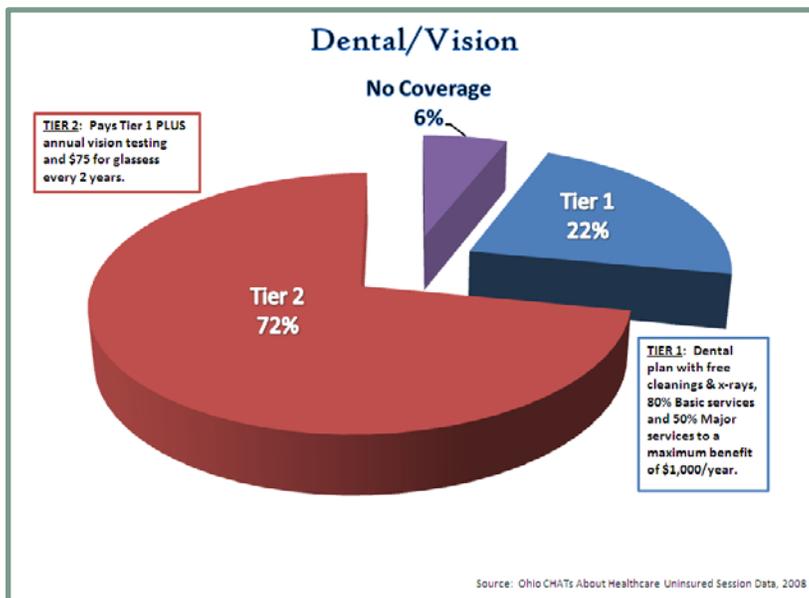
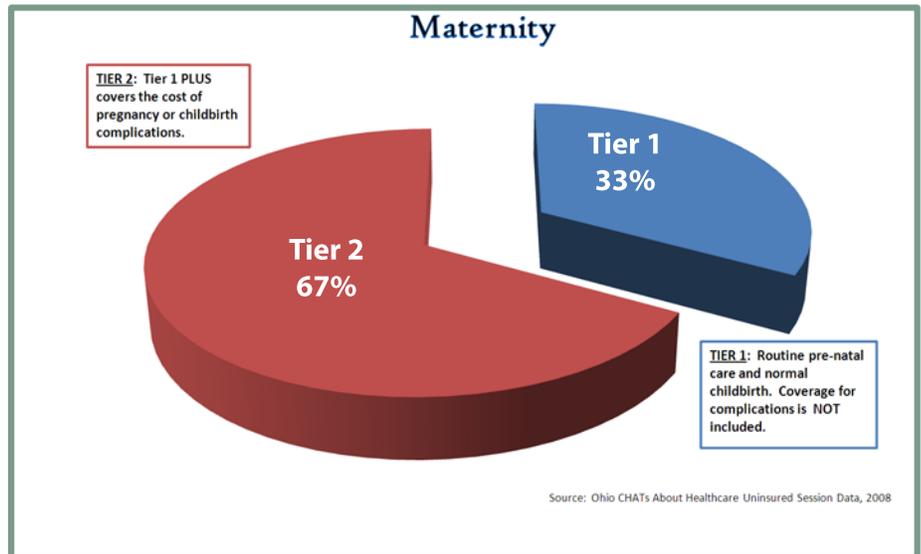


6. Mental/Behavioral Discussion about the level of mental/behavioral coverage was engaged and sometimes heated. Participants were split between those with direct exposure to these needs and those with little tolerance for these illnesses. Thoughtful dialogue and personal testimonies allowed participants to reconsider their original positions. All participants agreed to include coverage with 66% selecting Tier 2 or better benefits.

7. Maternity: Most preferred Tier 2 coverage that provides for complications of pregnancy. Participants felt that if the mother faced unexpected problems she should be covered.

Many were concerned about saddling the family with huge doctor and hospital bills. A small minority felt that maternity coverage was not important at all. Their comments against coverage included “a lot of people out there having kids who cannot afford them or take care of them...” or “just have less children,” and “...if you are going to have a baby you better pay for it. This would be like paying for the down payment for the house you buy.”

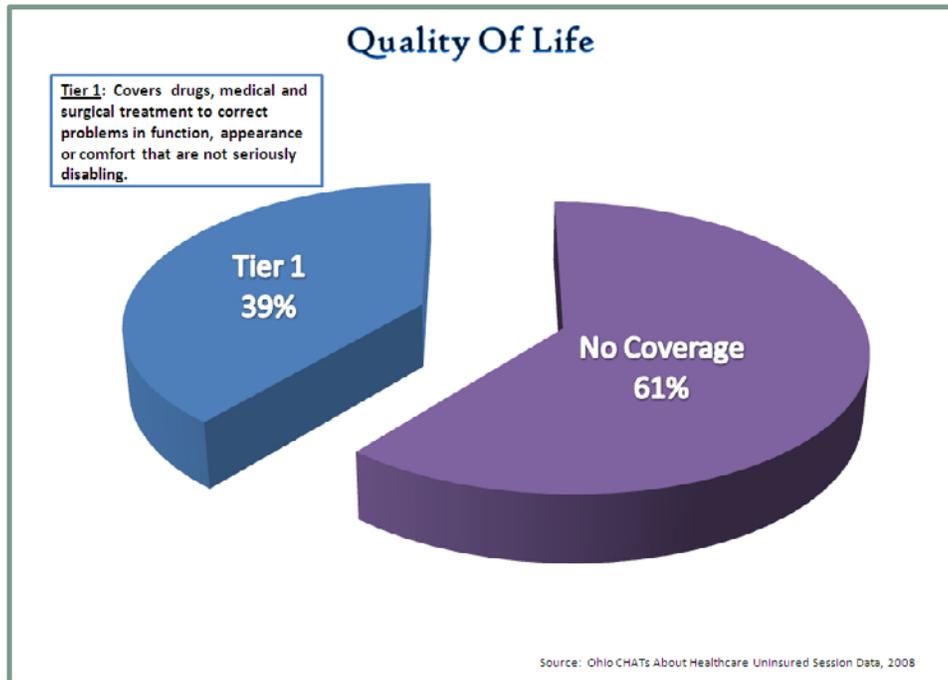
Comments supporting coverage included: “All people should have the option to have maternity coverage—just like I did. People should have access to a pediatrician.” and “People are going to have kids regardless.” In some ways this discussion mirrored the ones in the mental/behavioral and obesity categories where some participants felt that it was an individual’s responsibility to manage these problems and others saw it as a larger societal issue that required collective action.



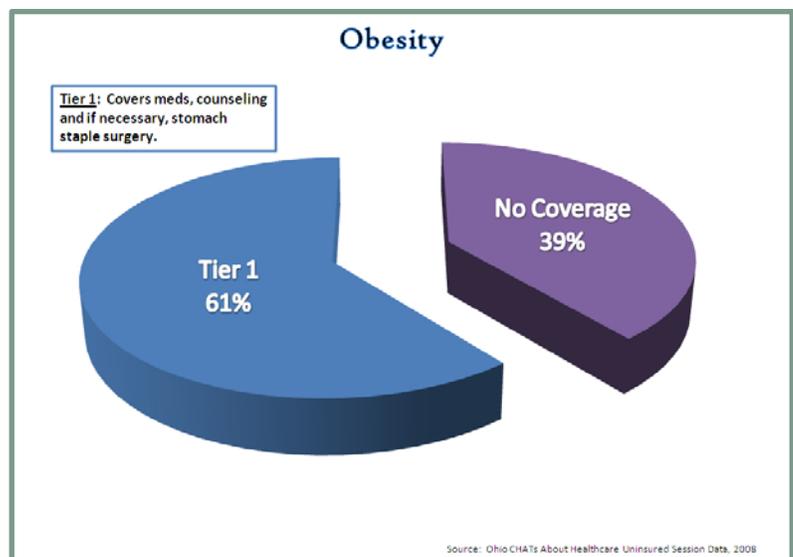
8. Dental/Vision: A large majority believed strongly in the benefit of dental and vision coverage. They felt that they are necessities rather than luxury items. Some pointed out that detecting early signs of dental or vision problems can also provide evidence of to other kinds of medical problems (such as heart disease or high blood pressure). However, participants would often protect dental (which they believed was more expensive) over vision if forced to choose. Alternatively, those who wanted vision covered would say that vision coverage is expensive and impacts how people perform at work and school. Those who felt vision wasn’t that important suggested that people go to Walmart for a pair of glasses.

B. Least Important Categories

1. Quality of Life: Most people felt that this was the most expendable category and voted for no coverage. This one “sounds cosmetic” many said. A minority disagreed and said that this “was not a vanity thing—it helps with your job and can become a mental health issue for women without hair.” Others were concerned that infertility is an important issue that would be covered. In the end, 61% agreed to spend the marker elsewhere.



2. Obesity: The obesity discussion had many parallels with the dialogue on mental/behavioral health benefits. Participants either ridiculed this as a personal failure (therefore not needing any kind of public policy) or identified with this issue as one needing societal action. The range of collective solutions, however, diverged amongst the participants. For instance, bariatric surgery, was seen by some as an unsafe quick fix and to others it was medically necessary.

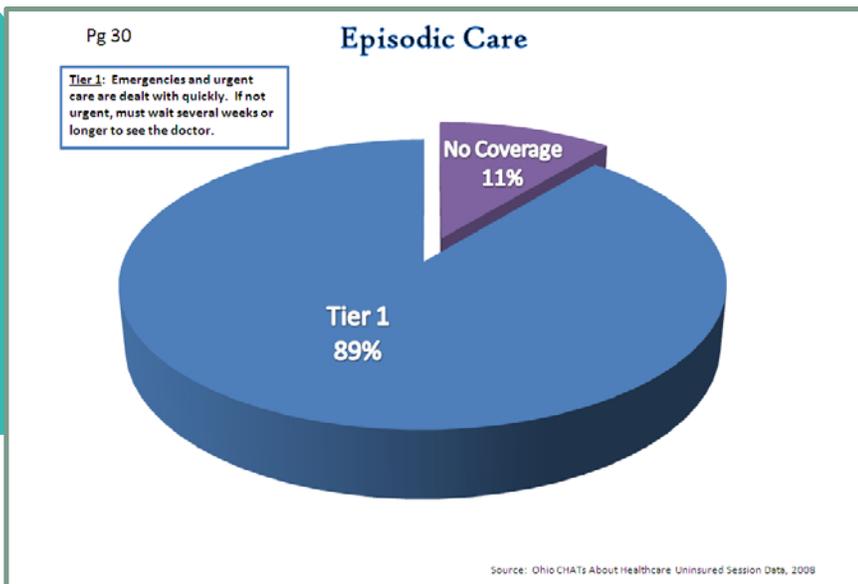
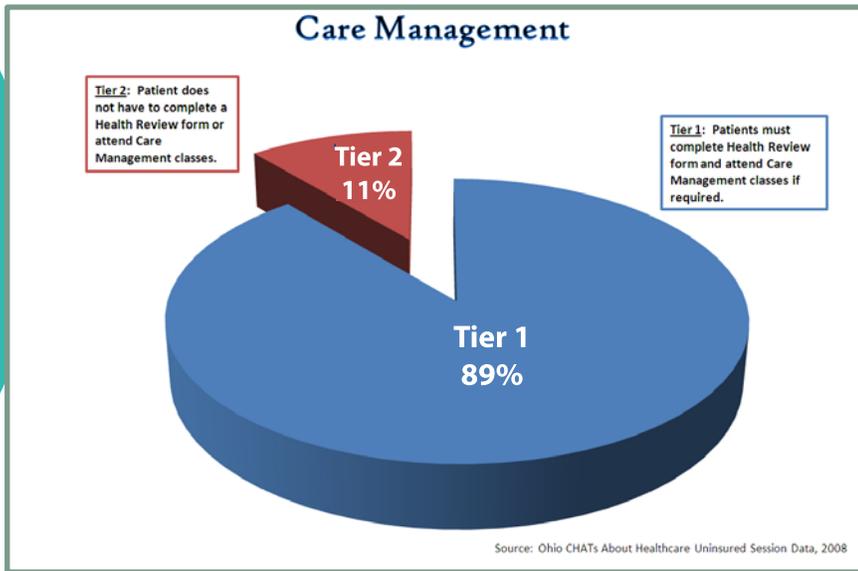


“I don’t think you can regulate people to get more educated—people won’t do it. You can’t force people to take classes. People may have a hard time finding transportation or childcare or getting to work in order to get to these classes. It’s not the ideal situation—they have to deal with other issues even if they want to take the classes. Please don’t require, just recommend that people take classes.”

C. Other Required & Elective Categories:

1. Care Management: Nearly 90% of all participants selected the mandatory health review form and, if required, care management classes. Despite its overwhelming approval, this category generated interesting discussion. Some felt that policymakers should understand that people may not be able to attend classes due to personal barriers. A participant remarked “I don’t think you can regulate people to get more educated—people won’t do it. You can’t force people to take classes. People may have a hard time finding transportation or childcare or getting to

work in order to get to these classes. It’s not the ideal situation—they have to deal with other issues even if they want to take the classes. Please don’t require, just recommend that people take classes.” For some, this was purely a matter of choice. They did not want to be told what to do and when. Others understood the importance of education as it relates to medical conditions and believed it was necessary to teach patients how to manage their conditions. Some suggested that if the patient had proper education, the problem might cease to exist.

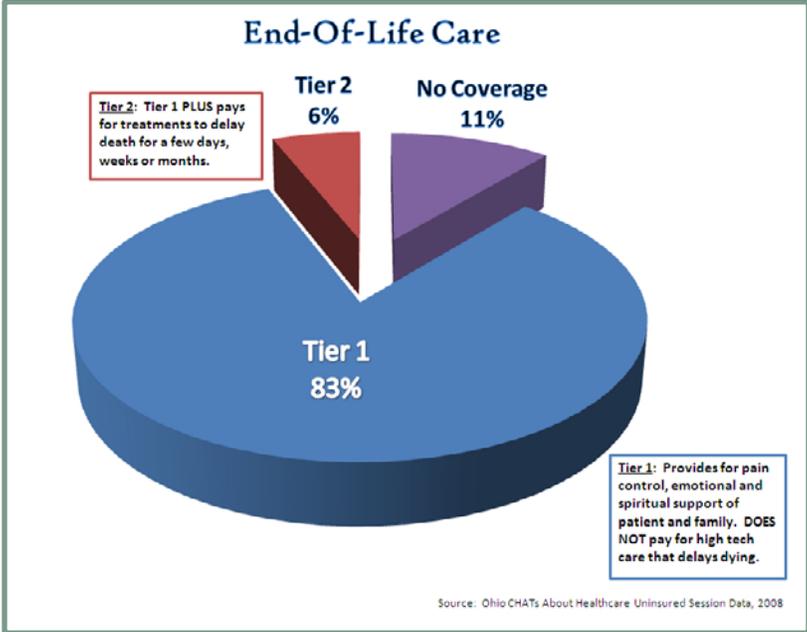
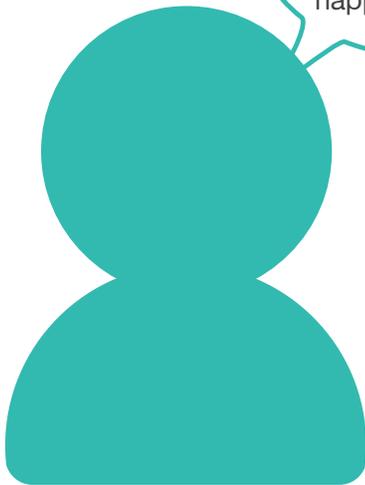


2. Episodic Care: Participants were comfortable waiting several weeks or longer to see the doctor in a non-emergency situation. None were willing to spend more markers to shorten the waiting time. Some remarked that “several weeks or longer” is what they normally wait.

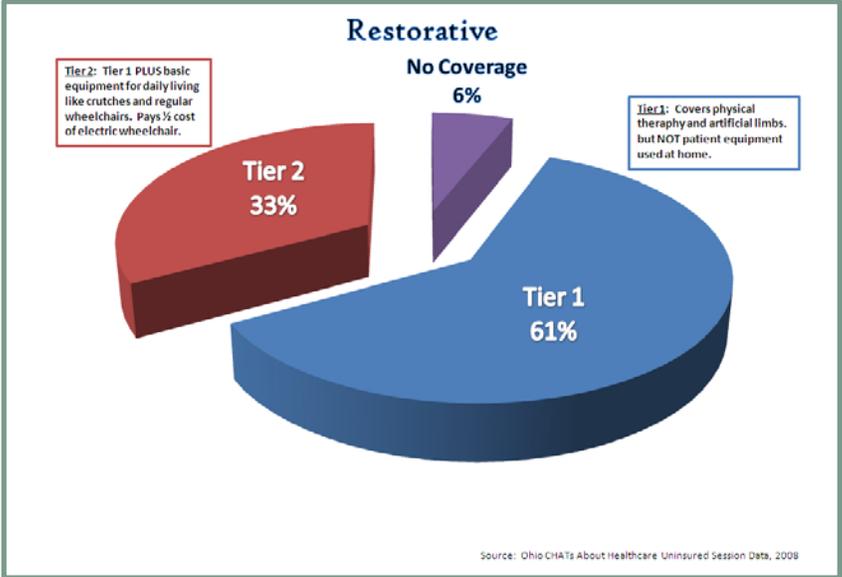
3. End of Life: A participant said: “Why delay it? When it’s your time to go (and you are comfortable) it’s your time to go. It’s going to happen anyway.”

Most participants felt the patient and family should receive adequate pain control, emotional and spiritual support. Very few were interested in covering treatments that prolong life, such as resuscitation, breathing machines or intensive care. Surprisingly, 11% believed this category should not be covered and families could provide this type of care themselves.

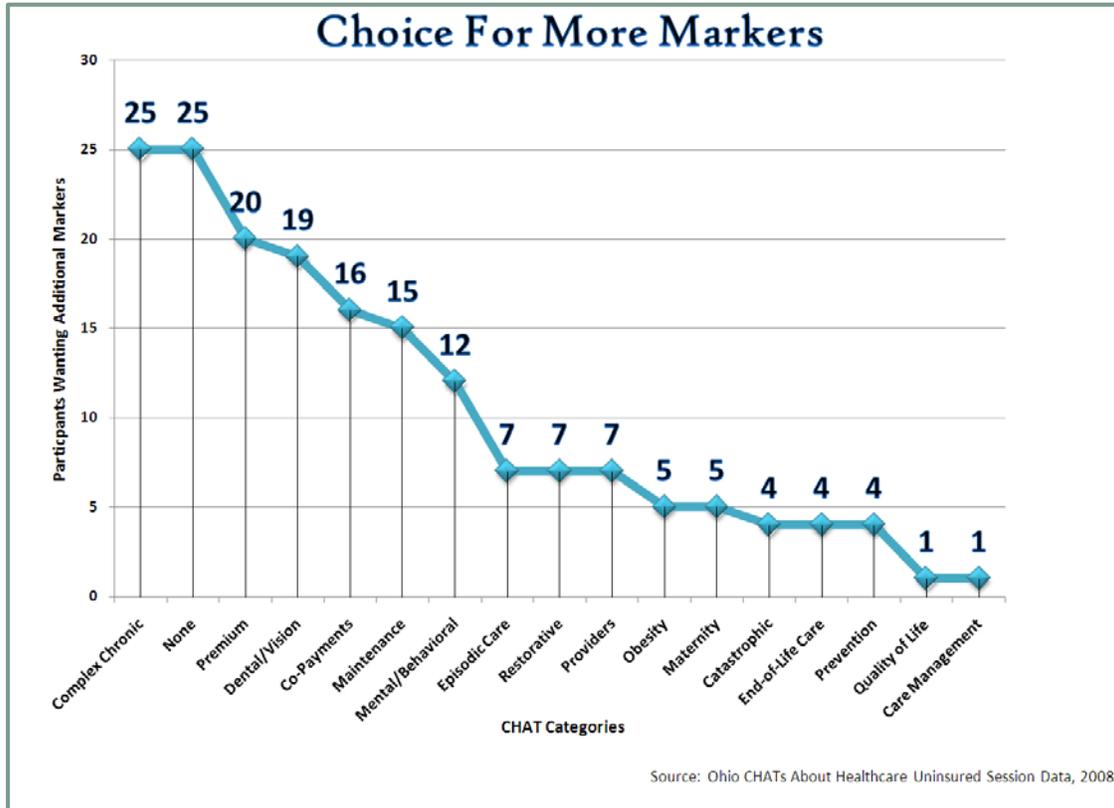
“Why delay it? When it’s your time to go (and you are comfortable) it’s your time to go. It’s going to happen anyway.”



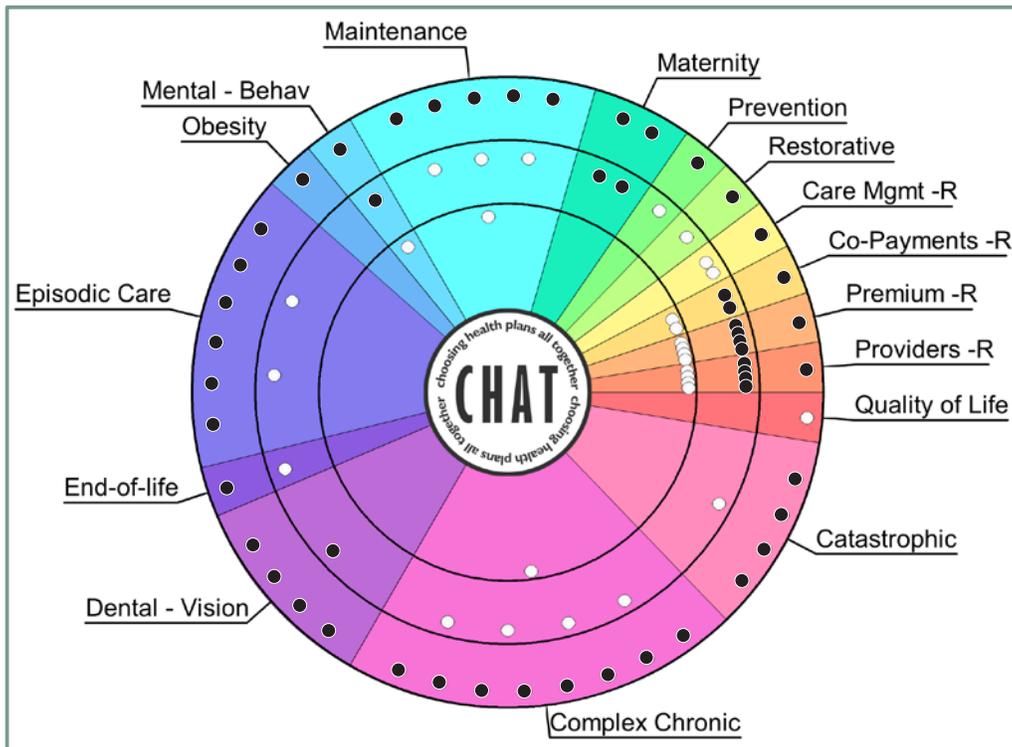
4. Restorative: Participants understood the importance of this benefit after an accident, surgery or a major illness. Many wanted Tier 2 benefits with coverage for crutches and wheelchairs. The majority selected the coverage of Tier 1 to provide a basic benefit for the lowest cost.



D. If You Had More Markers Where Would You Spend Your Money?



E. What Plan Did They Ultimately Select?



Healthcare Needs	Benefit Description
Prevention Tier 1	Covers wellness exams, screening tests and vaccines that meet national standards for good results. Examples: flu shots, PAP tests and colon exams at age 50. There are no co-payments for these services.
Maintenance Tier 1	For regular check-ups and treatment of early chronic conditions like diabetes and high blood pressure that are not yet serious. Doctors must follow expert guidelines for the least costly treatment that works well for 90% of the patients.
Complex Chronic Tier 1	Pays for chronic illness like diabetes and heart conditions once they become serious long-term problems. Doctors must use the least costly ways that work for most people to manage the illness.
Episodic Care Tier 1	Treatment of common problems such as a rash, ear infection and strep throat. Care is given by a primary care provider with all emergencies and urgent care dealt with quickly. If not urgent, the patient must wait several weeks or longer to see the doctor.
Catastrophic Tier 1	Covers sudden, serious injury or illness like car accidents or deadly cancer. All medical care known to be useful is given to try to save the patient's life. Treatments with little chance of helping are not covered.
Restorative Tier 1	For repairing the ability to perform basic activities (walking, talking, dressing, bathing, etc) needed after broken bones, strokes or amputations. Will pay for necessary rehabilitation services to improve function and artificial limbs but not patient equipment used at home.
End-of-Life Care Tier 1	Provides for pain control, emotional and spiritual support of the patient and family when medical treatment cannot provide a cure and the patient is expected to die within the next few months. Does not pay for high tech care that postpones death.
Dental/Vision Tier 2	\$1,000 annual maximum dental plan with free annual cleanings and x-rays. Plan pays 80% of basic services like cavities and oral surgery. Will pay 50% for major services such as crowns or bridges. Also covers vision testing annually and \$75 toward glasses every 2 years.
Maternity Tier 2	Pays for routine pre-natal care, normal childbirth and the costs of complications.
Mental/Behavioral Tier 2	Covers hospital stay, clinic therapy and medicine for treatment of severe mental illness. Examples: bipolar disease, major depression and schizophrenia. Also covers short-term counseling and medicine for less severe mental illness, smoking and substance addictions.
Obesity Tier 1	For patients who are severely overweight and may suffer from serious complications like diabetes or heart disease. Plan pays for medication, counseling programs and if necessary, stomach surgery.
Quality of Life	No coverage selected.
Co-payments Tier 2	Co-payments for doctor visits are \$20, generic drugs are \$10 and brand-name drugs are \$20. Patients pay \$100 when using the ER and \$250 per hospital visit.
Premium Tier 2	Each individual pays 4% of their salary toward health insurance premium. Individuals earning \$20,000/year will pay \$66/month or \$800/year. Individuals earning \$30,000/year will pay \$100/mo or \$1,200/year.
Providers Tier 2	Covers a limited choice of providers and hospitals. Patients may be referred to a specialist through the primary care doctor.
Care Management Tier 1	Patients must complete a health review form. If they have a chronic condition, they must attend Care Management classes. These programs help patients to stay as healthy as possible. There are no co-payments for these services.

Chapter 5:

Conclusion

Choosing Healthplans All Together (CHAT) sought to explore what was most valuable to uninsured Ohioans to have in their healthplan, given a finite budget. To this end, CHAT focused on healthcare needs rather than services. Additionally, the CHAT project explored these options in a way that would help negotiate the interconnected problems of lack of access to and rising costs of healthcare coverage.

CHAT participants did not accept these restrictions easily and struggled with playing the game. If current cost constraints weren't a factor the participants would have included everything (at the most generous coverage level) on the CHAT wheel. But most of all, they saw value in meeting everyone's healthcare needs in a cost-efficient and clinically effective manner that intertwined with maximizing the patient's interests. For instance, in the post-CHAT survey, individual participants identified the following as most important when considering healthcare coverage:

- **Paying as little as possible for my medications or doctor visits.**
- **Paying as little as possible for my share of health insurance premium.**
- **My doctor being able to order tests and medications without getting approval.**
- **Having a choice of which hospital I go to.**
- **Being able to get an appointment with my doctor quickly**

The sentiments expressed above were always negotiated with the limitations of costs. Participants recognized that the growing numbers of uninsured Ohioans (like themselves), coupled with budgetary constraints, would force them to set limits and make sacrifices. In the post-CHAT survey, 57% agreed that it is reasonable to limit what is covered by health insurance. One participant commented: "I realized how difficult it is to choose what's important to the majority, without forgetting the minority." Participant's values influenced a final plan where they compromised together and came up with a basic plan that maximized public good and minimized public harm.

This basic health plan emphasized reasonably comprehensive coverage with affordable patient cost-sharing. High-value and low-value interventions were carefully discussed by the participants in order to limit and include what was seen as necessary. To satisfy cost-savings, cost-efficiencies and clinical efficacies, participants placed many restrictions on medical interventions, hospital and physician use as well as the use of allied healthcare.

Most viewed their participation in CHAT positively, with 46% believing it would make a difference in the way they consider healthcare coverage and 50% felt it gave them something to think about. Only 3% of participants received no new information but found it enjoyable, and a minor 1% did not think it was a good use of their time. As it relates to plan design, 96% of participants expressed some satisfaction with the basic health plan created by their group, and if the coverage was offered, 86% would be willing to abide by the group's coverage decisions.

Finally, the participants first expressed surprise and then value in the fact that policymakers would actively count the opinions of the uninsured. To the question "What did you find most valuable about doing CHAT?" many participants responded, "having my voice be heard and it possibly make a difference" and "that uninsured people were actually being given a chance to provide feedback."



6. Sponsors



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A. Ohio CHATs About Healthcare Categories and Tiers

1. Catastrophic: Treatment of sudden, serious injury or illness. Examples: liver failure from food poisoning; being badly hurt in a car crash; deadly cancer.

Tier 1- (4) Treatments are given to try to save the person's life. Insurance pays for all medical care that is known to be useful.

Tier 2- (1) If the useful treatments do not work, also covers treatments that have little chance of helping but are the only hope left.

2. Complex Chronic: For treating chronic illness like diabetes, heart conditions and arthritis, when they have become serious long-term problems.

Tier 1- (8) The doctor uses the least costly ways to manage chronic illness. Such treatments work well for most people, but sometimes they may not work as well as more costly ones, which are not covered in this tier.

Tier 2- (4) In addition to Tier 1, also covers the more costly treatments that may improve functioning. Examples: new knee if arthritis makes walking difficult or an insulin pump for diabetics to stay in better control.

Tier 3- (1) For those at the end stage of disease, this also covers very expensive treatments (such as heart transplant) that might help patients live longer.

3. Dental & Vision: For preventing and treating dental problems; testing and correcting for problems with eyesight.

Tier 1- (4) Dental care only. Cleanings and x-rays yearly without co-payment. Basic dental services are 80% covered, such as emergencies, cavities, oral surgery. Pays 50% of crowns and bridges. Maximum coverage is \$1,000/year.

Tier 2- (1) In addition to dental care in Tier 1, covers vision care, which includes vision testing once a year, if needed. Covers \$75 towards glasses every 2 years but not contact lenses.

4. End-of-life Care: This is care when medical treatment cannot provide a cure and the person is expected to die within the next few months.

Tier 1- (1) Covers hospice care in the home or hospital. This provides good pain control, treats other discomforts, and gives emotional and spiritual support to the patient and family. It does not pay for high-tech care that delays dying.

Tier 2- (1) Covers hospice care. If the patient or family wants it, this also covers treatments that delay death for a few days, weeks or months. Examples: hospital intensive care, CPR and breathing machines.

5. Episodic Care: Treatment for common problems such as sprained ankle, ear infection, strep throat and poison oak. Also includes emergency cases like appendicitis.

Tier 1- (6) Care is given by the regular primary care provider for treatment. All emergencies and urgent care are dealt with quickly. If it is not urgent, patients may have to wait several weeks or LONGER before seeing the doctor.

Tier 2- (2) As in Tier 1, care is given by the regular primary care doctor for treatment. All emergencies and urgent care are dealt with quickly. If it is not urgent, there is a much shorter waiting time - several weeks or LESS before seeing the doctor.

6. Maintenance: For regular check-ups and treatment for early chronic conditions when they are not yet serious. Examples: asthma, high blood pressure and diabetes. This will help keep these problems from getting worse.

Tier 1- (5) The doctor must follow expert guidelines for tests, treatment and drugs that work well and are the least costly way to control chronic illness. Though most people do fine with these, about 10% of patients need more than this level of care.

Tier 2- (3) If Tier 1 treatment does not work well, also covers more expensive medical needs, such as new brand-name drugs or costly tests. Doctor must still follow expert guidelines.

Tier 3- (1) The doctor can order any tests, treatment and drugs that he or she thinks will help, without having to follow expert guidelines for effectiveness.

7. Maternity: For medical care of women during pregnancy and childbirth.

Tier 1- (2) Covers routine pre-natal care and normal childbirth. This includes monthly doctor visits, pre-natal medications, testing, delivery of the baby and short hospital stay. Does NOT cover any additional costs if there are unexpected problems.

Tier 2- (2) In addition to Tier 1, covers costs if there are unexpected problems during pregnancy or childbirth. Examples: if pregnancy is not going well and patient has to stay in hospital or if a c-section is needed.

8. Mental & Behavioral: For detecting and treating mental illness. Also covers treatment for unhealthy habits like smoking and substance addiction.

Tier 1- (1) Pays for treatment of severe mental illness. Examples: bipolar disease, major depression and schizophrenia. Covers hospital stay, clinic therapy and medicine. Does NOT cover smoking, alcohol or other addiction problems.

Tier 2- (1) In addition to Tier 1, covers short-term counseling and medicine for less severe mental health problems like mild depression or anxiety. Also covers counseling and medicine for smoking, alcohol and other addiction problems.

Tier 3- (1) Coverage is better than in Tier 2. Now includes long-term counseling for less severe mental health problems. Also covers treatment in the hospital for alcohol and drug addiction, if no other treatment has helped.

9. Obesity: Treatment for patients who are severely overweight. This condition often leads to medical problems such as diabetes and heart disease and other serious medical conditions.

Tier 1- (1) Covers medication and counseling programs. Also covers stomach surgery if the obesity is having a severe impact on an individual's ability to function or has led to serious medical problems.

10. Prevention: To help prevent many diseases and find medical problems as early as possible. **THERE ARE NO CO-PAYMENTS FOR THESE SERVICES.**

Tier 1- (1) Covers wellness exams, screening tests and vaccines, but only when they meet national standards for getting good results. Examples: flu shots, PAP tests at a certain age, colon exams at age 50 and cholesterol screening.

Tier 2- (1) In addition to Tier 1, also covers screening even when chances are very small that problems will be found. Examples: mammograms for women under 40 or annual physicals when there is no medical reason to do them.

11. Quality of Life: Covers problems in function, appearance or comfort that are not seriously disabling but affect people's quality of life. Examples: injuries that keep people from playing sports; infertility; impotence; and hair loss.

Tier 1- (1) Covers all drugs, medical and surgical treatment to try and correct these problems.

12. Restorative: For repairing the ability to do basic activities (walking, talking, dressing, bathing, working). This is often needed after broken bones, surgery on joints, strokes or amputations.

Tier 1- (1) Covers all necessary rehab services (such as physical therapy) to improve important functions. Covers artificial limbs but not patient equipment used at home.

Tier 2- (1) In addition to Tier 1, covers basic equipment needed for daily activities, like crutches and regular wheelchairs. Also covers half the cost of more costly equipment like electric wheelchairs.

THESE ARE THE "REQUIRED" CATEGORIES (participants have to pick a tier in each one; they are not optional):

13. Care Management: (REQUIRED) These are programs to help people stay as healthy as possible. This includes a health review form and care management classes for those with chronic illness. **THERE IS NO COST TO THE PATIENT.**

Tier 1- (1) All new patients **MUST** complete a health review form. If they have a chronic condition (like diabetes or asthma), they **MUST** attend care management classes if their doctor says to.

Tier 2- (2) New patients do not have to complete a health review form unless they want to. If they have a chronic condition, they may attend care management classes but are not required to do so.

14. Co-Payments: (REQUIRED) These are the amounts that individuals pay when they use healthcare services. Co-payments are **NOT** required for the services in the Prevention or Care Management categories.

Tier 1- (1) There are co-payments for most services, such as \$35 for doctor visits, \$15 for generic drugs and \$30 for brand-name drugs. Individuals pay \$150 when using the ER and \$500 for a hospital stay.

Tier 2- (2) Co-payments are lower than Tier 1. Doctor visits are \$20. Generic drugs are \$10 and brand-name drugs are \$20. Individuals pay \$100 when using the ER and \$250 for a hospital stay.

Tier 3- (2) Co-payments are lower than Tier 2. Doctor visits are \$10. Generic drugs are \$5 and brand-name drugs are \$15. Individuals pay \$25 when using the ER and \$100 for a hospital.

15. Premium: (REQUIRED) Most of the monthly health insurance payments (premium) will be paid by government and businesses. This category sets the amount that individuals pay as part of the monthly premium.

Tier 1- (1) Each person pays 6% of his or her salary. If a single person makes \$20,000 a year, the person's share is \$1,200 yearly or \$100 a month. If salary is \$30,000 a year, the person's share is \$150 a month.

Tier 2- (4) Each person pays 4% of his or her salary. If a single person makes \$20,000 a year, the person's share is \$800 yearly or \$66 a month. If salary is \$30,000 a year, the person's share is \$100 a month.

Tier 3- (4) Each person pays 2% of his or her salary. If a single person makes \$20,000 a year, the person's share is \$400 yearly or \$33 a month. If salary is \$30,000, the person's share is \$50 a month.

16. Providers: (REQUIRED) These are the professionals that provide all the regular medical care, such as exams to keep patients healthy, short-term and chronic illness care, and hospital care.

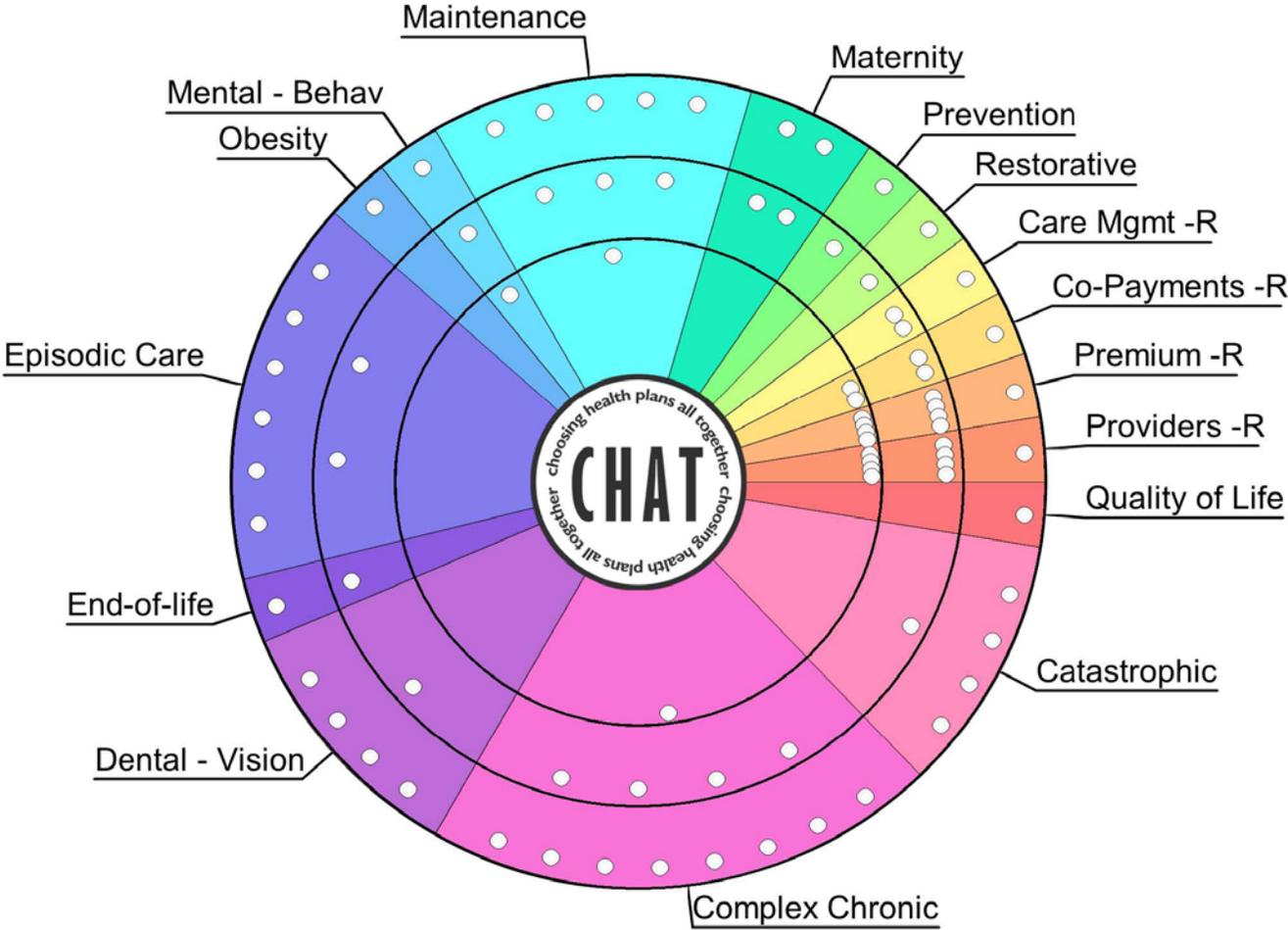
Tier 1- (1) Services are provided by a specific group of primary care doctors. Referrals to specialists are not easy to get. If hospital care is needed, the patient has no choice about which hospital to go to.

Tier 2- (4) Choice of doctors and hospitals is greater than in Tier 1, but the list is still limited. A referral to see a specialist is a little easier to get.

Tier 3- (4) There is a wide choice of doctors and hospitals. Referral from primary care is not needed to see a specialist.

B. Ohio CHATs About Healthcare Project Plan

Ohio Department of Insurance CHAT Team
August 19, 2008



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GOALS

- I. To solicit input from Ohio's insured and uninsured populations about what a basic health plan should cover

- II. To educate Ohioans about health care coverage choices

- III. To provide feedback to Ohio's SCI team regarding uninsured and stakeholder choices

TARGET AUDIENCE

- Ohio Uninsured: Individuals under age 65, who can read English, are familiar with computers and have been uninsured for at least one year.

- Ohio Stakeholders: Includes the general public, taxpayers, community leaders, government officials, small employers, providers, insurers and sales agents.

SOFTWARE/GAME

The University of Michigan and The National Institutes of Health with support from the Robert Wood Johnson Foundation have developed the proprietary and educational game and research tool known as Choosing Healthplans All Together™ (CHAT). CHAT is a computer-based program concerning consumer health care choices in a context of finite resources. The program was introduced to Ohio through a separate contract with Center for Healthcare Decisions. The Center for Healthcare Decisions will continue to support this effort. CHAT has been tailored to reflect the Ohio health care coverage environment.

In a group of 12 to 15, participants tackle the toughest question in health policy today: What is most important to provide for Ohioans if we cannot afford healthcare coverage for everything? Each session consists of four distinct rounds. In Round 1, each participant designs his/her own basic health plan. Participants combine into small groups of three or four to design a consensus basic plan in Round 2. Potential illnesses and health events are introduced at the end of each of the proceeding rounds to demonstrate how much the basic plan chosen would pay. Round 3 brings all participants together in one group to create a uniform plan with the help of a facilitator. In the final round, participants go back to design a basic health plan alone with a new appreciation for others choices and needs.

A variety of questions will be presented for data collection purposes. All data will be collected, compiled and analyzed. Reports will be developed comparing and contrasting the answers of the uninsured and the stakeholders.

PLANNING

1. We consulted with Universal Healthcare Action Network (UHCAN) of Ohio, Ohio Association of Free Clinics, Ohio Association of Community Health Centers and Access HealthColumbus to locate the uninsured throughout the state.

2. With assistance from the Health Policy Institute of Ohio and utilizing contacts defined in 1, we determined the counties to survey. We plan to survey nine metropolitan, five appalachian, four rural and two suburban counties. We will conduct two uninsured sessions in each metropolitan county and one session in each of the remaining counties.

3. In addition to the criteria detailed in the target audience section, we are requesting participation of a diverse population with regard to the following:

- a. Age and gender;
- b. Race/ethnicity;
- c. Income and employment status; and,
- d. Geographical area.

4. The Department will plan the Ohio uninsured CHAT sessions with area community organizations and the contacts in 1. ODI will work with the organization to secure the appropriate facility for the session. The organization is responsible for recruiting, reminding and assuring attendance of uninsured participants. the department will be responsible for the computers, software and facilitators.

5. It has been determined that a meaningful stipend and refreshments are required to assure participation of the uninsured. A grocery store gift card of \$30.00 is suggested. A drink and a “hearty” box lunch consisting of a sandwich, side dish, chips, dessert and fruit are recommended. Refreshments will run between \$7.00 and \$10.00 per person.

6. The department will work with stakeholders to bring the CHAT program to their membership. The department will offer at the minimum facilitation services and additional assistance as required.

TOTAL ESTIMATED COST

\$ 10,440.00 Stipend at \$30.00/uninsured, 348 total participants

\$ 3,480.00 Food at \$10.00/uninsured, 348 total participants

\$ 13,920.00 Total Estimated Cost

All funding has been secured.

PLANNED UNINSURED SESSIONS

County	Region	Available Consultant
Adams*	Appalachia	OACHC, UHCAN
 Allen*	Metropolitan	OACHC (Session held July 22, 2008)
Athens*	Appalachia	OACHC, OAFc, UHCAN
Clinton*	Rural	OAFc
 Cuyahoga**	Metropolitan	OAFc, St. Vincent Charity Hospital (Sessions held May 1 & 2, 2008)
Delaware*	Suburban	OAFc
 Franklin**	Metropolitan	AHC, KYC (Sessions held April 30 & August 28, 2008)
 Hamilton**	Metropolitan	OACHC, OHA (Sessions held July 29 & November 20, 2008)
Harrison*	Appalachia	OACHC, OHA
 Jackson*	Appalachia	OHA (Session held September 3, 2008)
Lake*	Suburban	OAFc, UHCAN
 Lucas**	Metropolitan	OAFc, TJWJ (Sessions held June 25 & July 23, 2008)
Mahoning**	Metropolitan	OHA (1st Session held September 4, 2008)
 Marion*	Rural	OACHC (Session held July 1, 2008)
 Miami*	Suburban	OAFc (Session held April 28, 2008)
Montgomery**	Metropolitan	OAFc (1st Session held July 21, 2008)
 Muskingum*	Appalachia	OACHC (Session held August 27, 2008)
 Ross*	Appalachia	OACHC (Session held August 5, 2008)
Shelby*	Rural	OAFc
Stark*	Metropolitan	OACHC, OAFc
Summit**	Metropolitan	OACHC, OAFc
 Van Wert*	Rural	OACHC, (Session held June 20, 2008)
 Wayne*	Rural	OAFc (Session held May 2, 2008)

- * = One session planned for the county
- ** = Two sessions planned for the county
-  = Sessions for county completed

Uninsured Session Sample Planning Timetable

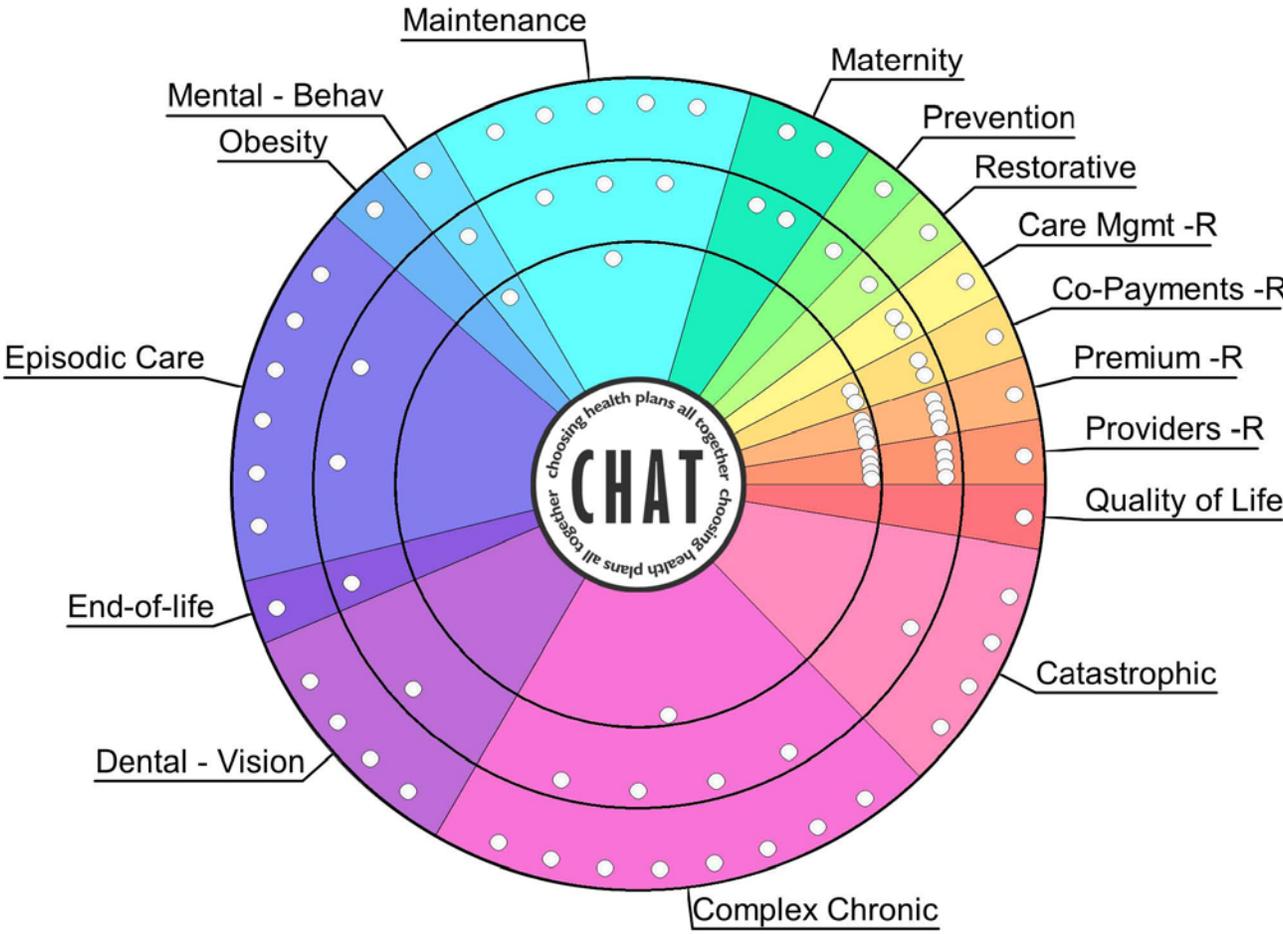
Days Prior	Duties
45	Meet with organization; determine possible dates and facility options; provide list of responsibilities and expectations.
30	Finalize date, location and flyer; schedule software installation and machine check, if necessary; invite attendees and provide directions.
15	Confirm attendee count, arrange food.
7	Send reminders to attendees, forward software to facility for installation, if necessary.
1	Check computers, if necessary; arrange room and registration table; call attendees; confirm final food count.
2 hours	Prep computers for session, obtain food.

Uninsured Session Sample Timetable

Session	Activity	Time
Evening	Food/Registration	5:30 PM - 6:00 PM
	Session	6:00 PM - 9:00PM
	Stipend	at End
AM	Food/Registration	8:30 AM - 9:00 AM
	Session	9:00 AM - 12:00 PM
	Stipend	at End
PM	Food/Registration	1:00 PM - 1:30 PM
	Session	1:30PM - 4:30 PM
	Stipend	at End

C. Ohio CHATs About Healthcare Session Planning Packet

Ohio Department of Insurance CHAT Team
August 27, 2008



Contents

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SESSION GOALS

- I. To solicit input from Ohio's uninsured population about what a basic health plan should cover
- II. To educate Ohioans about health care coverage choices
- III. To provide feedback to Ohio's SCI team regarding uninsured choices

UNINSURED PARTICIPANT QUALIFICATIONS

1. Twelve individuals, ages 18 – 64;
2. Able to read and understand English;
3. Computer literate, have seen and used a computer before; and,
4. Currently uninsured and has been for at least one year.

ADDITIONAL CONSIDERATIONS

- Individuals must be able to work independently, in a small group and in a large group of twelve.

- The session can be as long as three hours. While there are no formal breaks, participants who must leave are asked to return as quickly as possible. Individuals must be able to work comfortably for three hours without a formal break.

- In addition to the qualifications detailed on Page i, we are requesting participation of a diverse population with regard to the following:
 - a. Age and gender
 - b. Race/ethnicity
 - c. Income and employment status
 - d. Family status

- It may be difficult for individuals to participate if they are distracted. Childcare may need to be available for those with small children.

- The time uninsured can be reduced to six months if you are unable to recruit enough participants who have been uninsured for at least one year.

- Participants must complete the session to receive the stipend. Any individual leaving before the session is completed will not be paid.

METHOD

The University of Michigan and The National Institutes of Health with support from the Robert Wood Johnson Foundation have developed the proprietary and educational game and research tool known as **Choosing Healthplans All Together**™ (CHAT). CHAT is a computer-based program concerning consumer health care choices in a context of finite resources. The program was introduced to Ohio by Center for Healthcare Decisions. The Center for Healthcare Decisions brought CHAT to a number of states and will continue to support this effort in Ohio. CHAT has been tailored to reflect the Ohio health care coverage environment.

In a group of 12, participants will tackle the toughest question in health policy today: What should be the minimum coverage for Ohio's uninsured? Each session consists of four distinct rounds. In Round 1, each participant designs his/her own basic health plan. Participants combine into small groups of three or four to design a consensus basic plan in Round 2. Potential illnesses and health events are introduced at the end of each of the proceeding rounds to demonstrate how much the basic plan chosen would pay. Round 3 brings all participants together in one group to create a uniform plan with the help of a facilitator. In the final round, participants go back to design a basic health plan alone with a new appreciation for others choices and needs.

A variety of questions will be presented for data collection purposes. All data will be collected, compiled and analyzed. Reports will be developed comparing and contrasting the answers of the uninsured in different regions around the state.

PLANNING/RESPONSIBILITIES

1. Using the Uninsured Participant Qualifications and the Additional Considerations, select twelve individuals to participate in the session.
2. Over-recruiting may be necessary if you believe all individuals will not attend as scheduled. You may want to advise those considering that the session is on a first come first serve basis and when all seats are filled you can accept no more. Stipends can only be paid to those who complete the session.
3. In addition to recruiting, it is strongly recommended you remind your participants at least one week prior and again the day before the session. You may have time to recruit replacements with early notice of a no show.
4. It has been determined that a meaningful stipend and refreshments are required to assure participation of the uninsured. A grocery store gift card of \$30.00 is suggested. A drink and a “hearty” box lunch consisting of a sandwich, side dish, chips, dessert and fruit are recommended. Refreshments will run between \$7.00 and \$10.00 per person.
5. The Ohio Department of Insurance (ODI) is working with sponsors to secure funding of the stipend and refreshments. We welcome any suggestions and assistance you can provide in this matter.

SESSION SPACE CRITERIA

1. Training Room or Conference Room that can accommodate 13 computers and a projector. Configuration details are found in the attached document entitled Exhibit A - CHAT Configuration.
2. The room should be handicap accessible and close to the participants in terms of location.
3. A Registration table is needed, preferably inside the room.
4. We will need access to the space at least 1 hour prior to registration for setup.
5. We will require at least 1 hour after the session to upload data and pack equipment.

MISCELLANEOUS ITEMS TO CONSIDER

- Volunteer assistance during the session may be needed to register, direct, feed and pay the participants.
- The need to survey both the employed and unemployed must be considered when setting session times. Evening hours are available.
- Uninsured meetings can be held in concert with community leader information sessions. We encourage this option to educate government and community leadership. Please contact ODI if you are interested.

Uninsured Session Sample Planning Timetable

Days Prior	Duties
45	Meet with ODI; determine possible dates and facility options; receive Session Planning Packet
30	Finalize date, location and flyer; invite attendees and provide directions
15	Confirm attendee count, determine menu, arrange for food
7	Send reminders to attendees
1	Arrange room and registration table; call attendees; confirm final food count
2 hours	Room available for computer set up; pick up food

Uninsured Session Sample Timetable

Session	Activity	Time
Evening	Food/Registration	5:30 PM - 6:00 PM
	Session	6:00 PM - 9:00PM
	Stipend	at End
AM	Food/Registration	8:30 AM - 9:00 AM
	Session	9:00 AM - 12:00 PM
	Stipend	at End
PM	Food/Registration	1:00 PM - 1:30 PM
	Session	1:30PM - 4:30 PM
	Stipend	at End

D. Ohio CHATs About Healthcare

Pre- and post survey questions

(words in red are the software codes used to designate that question)

Pre-CHAT survey questions (these first four are permanently in the software;
all the others are created by the project sponsor)

Participant's name (ID) _____ **Player**

Year of birth: 19 _____ **DOB**

Gender: Male _____ Female _____ **Gender**

Family status: **Family status**

Single _____

Single with dependents _____

Couple _____

Couple with dependents _____

1. Race/Ethnic Group (choose all that apply): **Ethnicity**

____ Asian-American

____ Black or African-American

____ Hispanic or Latino

____ Multiracial

____ Native American

____ White

____ Other (specify: _____)

2. Highest grade or level of school completed: **Education**

____ 8th grade or less

____ Some high school

____ High school graduate or GED

____ Some college or two-year degree

____ Four-year college degree

____ Post-graduate degree

3. Household yearly income: **Income**

- \$0 to less than \$10,000
- \$10,000 to less than \$21,000
- \$21,000 to less than \$32,000
- \$32,000 to less than \$45,000
- \$45,000 to less than \$60,000
- \$60,000 to less than \$90,000
- \$90,000 or more

4. Generally, would you say your health status is: **Health Status**

- Excellent
- Very good
- Good
- Fair
- Poor

5. Do you or anyone else in your household have a disability or chronic health condition? **Disability**

- Yes
- No
- Not sure

6. Are you or anyone else in your household regularly taking prescription medicine? **Prescriptions**

- Yes
- No
- Not sure

7. During the past 12 months, how much did your household spend on medical and dental care? (Not including the cost of health insurance premium) **Health spending**

- None
- Less than \$200
- Between \$200 and \$500
- Between \$500 and \$2,000
- More than \$2,000
- Don't know

8. During the past 12 months, have you or anyone in your household struggled with healthcare because you could not afford it? **Affordability**

Yes

No

9. Do you currently have health insurance (private, Medicare or Medicaid)? If no, go directly to question 13. **Have insurance**

Yes

No

Not sure

10. Do you know the total cost of your monthly health insurance premium that is paid by your employer AND you? **Total Premium**

Yes

Do not know

11. How much of your monthly health insurance premium is paid by you or someone in your household? **Premium paid**

Do not know

\$0 (employer or government pays all)

\$1 -- \$30

\$31 -- \$60

\$61 -- \$100

\$101 -- \$200

More than \$200

I or my family pay the entire premium

12. All health plans have some coverage restrictions. Which best describes how much you know about your health plan restrictions? **Restrictions**

I know nothing

I know a little

I know a fair amount

I know a lot

13. If you currently have no insurance, describe how much coverage you have had in the last 2 years. **Time covered**

No coverage at all

Covered less than 6 months

Covered 6 months but less than 1 year

Covered 1 year but less than 2 years

14. If you currently have no insurance, how much are you willing to pay monthly for health insurance coverage for yourself? **Willing to pay**

\$0

\$1 - \$30

\$31 - \$60

\$61 - \$100

\$101 - \$200

More than \$200

Post-CHAT survey questions

1. If you had more money (markers) to spend on the last round, which ONE category would you have spent them on? **More markers**

2. To what extent were you satisfied with the health plan choices made by the whole group together? **Satisfied**

Very satisfied

Somewhat satisfied

Somewhat dissatisfied

Very dissatisfied

3. If you needed insurance coverage, would you be willing to abide by the coverage decisions that the group made today? **Accept decision**

Yes, definitely

Yes, probably

Probably not

Definitely not

Not sure

4. For me, making decisions on where to put my CHAT markers was: **Marker decisions**

Very easy

Somewhat easy

Somewhat difficult

Very difficult

5. Do you think everyone should complete a Health Review Form as a requirement of their health insurance? **Health form**

- Yes, definitely
- Yes, probably
- Probably not
- Definitely not
- Not sure

6. If patients are having health problems, do you think they should have to attend Care Management classes if their doctor thinks it is important? **Care classes**

- Yes, definitely
- Yes, probably
- Probably not
- Definitely not
- Not sure

7. Agree or Disagree: I think it is important for employees to have a role in deciding about health care coverage for their company. **Employee role**

- Agree strongly
- Agree somewhat
- Disagree somewhat
- Disagree strongly
- Not sure
- Does not apply

8. Of the factors listed below, select 3 that are most important to you in considering your health insurance coverage. **Priority list**

- Having a choice of which hospital I go to
- Paying as little as possible for my share of the health insurance premium
- Having a large selection of primary care doctors to choose from
- Seeing a specialist without having to be referred by my primary care doctor
- Being able to get an appointment with my doctor quickly
- My doctor being able to order tests and medicines without getting approval
- Paying as little as possible for my medicine or doctor visit
- Being able to see a specialist who is not part of my health plan

9. Of the factors you selected in the last question, which ONE thing is most important? **Most Important**

- Having a choice of which hospital I go to
- Paying as little as possible for my share of the health insurance premium
- Having a large selection of primary care doctors to choose from
- Seeing a specialist without having to be referred by my primary care doctor
- Being able to get an appointment with my doctor quickly
- My doctor being able to order tests and medicines without getting approval
- Paying as little as possible for my medicines or doctor's visits
- Being able to see a specialist who is not part of my health plan

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

- Agree strongly
- Agree somewhat
- Disagree somewhat
- Disagree strongly
- Not sure

11. Which statement most closely represents your view about participating in CHAT today? **View of CHAT**

- This will make a difference in the way I consider my health care coverage.
- This has given me something to think about.
- No new information but it was enjoyable.
- It was not a good use of my time.

12. Briefly, what (if anything) surprised you most in today's session? **What surprised**

13. Briefly, what (if anything) did you find most valuable about doing CHAT? **Most valuable**

Ohio CHATs About Healthcare

Voices of the Uninsured

