

Behavioral Economics and the Affordable Care Act:  
What States Should Know As They Design Health Insurance Exchanges

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## **THE NORTH CAROLINA JUSTICE CENTER: HEALTH ACCESS COALITION**

The Health Access Coalition works to expand access to quality, affordable health care for everyone in North Carolina, including people who are low-income, are elderly, or have disabilities.

The goals of the Health Access Coalition are to:

- Expand access to health services for low- and moderate-income families.
- Secure health-care policies that prioritize the needs and well-being of North Carolina consumers, especially with respect to the implementation of federal health reform.
- Empower health-care consumers with information about their rights, available services, and how they can become effective health-care advocates.
- Provide assistance to individuals trying to access public health programs.
- Promote the consumer perspective on state and federal health care policy in the press and at public forums.

The Health Access Coalition lead the effort to educate state lawmakers about reform and ensure that new state laws governing reform put the needs of consumers first. As part of that effort, they created one of the largest health advocacy coalitions ever assembled in the state, Citizens for Responsible Health Care, in order to inform and mobilize those with a stake in the health reform process.<sup>i</sup>

## TOP FIVE TAKEAWAYS FOR NORTH CAROLINA

### 1. Enrollment will be key

North Carolina has opted to let the federal government set up their health insurance exchange (HIX). This means that the key responsibility retained by the state will be in enrolling residents. This is critical as one of the key assumptions behind a functioning market is full participation (hence the individual mandate).

### 2. North Carolina could set up a more effective HIX than the federal government

The federal government is overwhelmed and struggling to set up exchanges around the country. The state could be a more appropriate and responsive steward of this function.

### 3. Choice matters

Limits on the number of choices a person must make can lead them to a better decision (and one they feel better about). If, however, the limits are so prohibitive that they lead to a monopoly, they would be a hindrance to efficiency.

### 4. Setting robust minimum standards is important

Research on the Massachusetts HIX reveals that a majority of their enrollees choose the lowest level of coverage. As such, setting minimum standards is critical, as it is likely that a majority of enrollees will default to this option.

### 5. Issues of literacy and numeracy will affect consumers' decisions

Consumers often do not understand the definitions of terms used in health plans. Reworking these definitions and then testing them for comprehensibility is a simple step that can make a great difference in how people choose their insurance.

## **INTRODUCTION**

One of the signature pieces of legislation passed under the Obama administration, the Patient Protection and Affordable Care Act (hereafter referred to as “ACA”) is a vast expansion of the healthcare system in the United States. Part of the law requires that states set up a health insurance exchanges. These exchanges are a key element of expanding coverage to those currently uninsured--particularly people who will be purchasing insurance on their own--and will be responsible for implementing several key aspects of the ACA.

First, insurers will be prohibited from refusing insurance to someone. Guaranteed issue of insurance will help lower costs by expanding the pool of insured and spreading around the risk. The ACA also puts into place restrictions on the practice or rescission, or denying coverage because of pre-existing conditions. The ACA places limits on the price variation of plans so that they vary on four categories and by no more than a cumulative factor of 10. Plans will be offered in four “metallic” tiers ranging from bronze to platinum based on coverage offered and premiums.

These recommendations are divided into two sections. The first two are relevant because the state has opted out of designing its own health insurance exchange. The next three are relevant to the design of an exchange and will be important if the state decides, after several years of federal control, that it wants to reassert its authority over its exchange. The first two deal with the responsibilities and rights of the state—both retained and foregone. The next three pertain to behavioral economics and the user interface of the exchange, a small but critical piece of the puzzle.

## **WHAT IS AN INSURANCE EXCHANGE AND WHY DOES BEHAVIORAL ECONOMICS MATTER?**

The ACA will bring many changes starting January 1, 2014 to people who don't currently get their health coverage through their job. Part of the law requires that states set up health insurance exchanges. These exchanges are a key element of expanding coverage to those currently uninsured--particularly people who will be purchasing insurance on their own since they work in a small business that doesn't offer coverage or are self-employed.

A health insurance exchange is a governing body that sets standards for what health insurance plans are offered in a state. It is not itself an insurance company and does not offer any insurance plans, rather it ensures that the insurance market in a state is fair, transparent, competitive, and provides adequate benefits. It also provides an online marketplace where people can log on and purchase insurance.

It's important that North Carolina's health exchange works well - it must be an easy, efficient and informative place for people to buy coverage. This isn't a given. Imagine, if you can, the challenge that a person who has never bought insurance before would face when making this decision. They log on to a website and are presented with dozens of plans, prices, and options. Do you think they know what a deductible is? Or a co-pay? How good do you imagine their budgeting skills are? Throw on top of that the likelihood that they have limited literacy and numeracy skills and the assumption they will make the best choice for themselves and their family becomes even more of a stretch.

The way in which information is presented to people can significantly affect their decisions--that's no secret (particularly if you've ever worked in marketing). When presented with the complicated information comprising a health insurance plan, people can struggle to process all that information. At times, they can be overwhelmed by the decision and choose a sub-optimal insurance plan.

The ACA allows significant latitude in exchange design and research from the field of behavioral economics should play a role. Challenging the traditional economic assumption that humans are perfect utility-maximizing machines, behavioral economics melds psychology and neo-classical economics to understand how people make decisions. By understanding the places where people often struggle to make choices, policymakers can develop strategies to mitigate those problems.

While North Carolina has decided to allow Washington to create the exchange, the state will still be responsible for enrollment in the exchange. Creating a thoughtful choice architecture--a structure in which consumers can make an optimal decision--for the user interface of the insurance exchange can help North Carolinians buy the best and most affordable health care plan for themselves and their families.

#### **ENROLLMENT IS THE KEY RESPONSIBILITY RETAINED BY THE STATE**

One of the key takeaways regarding enrollment is that advertising and strong political support are critical to successful enrollment. This was the message carried by Jon Kingsdale, who ran the Massachusetts Connector as executive director between 2006 and 2010, in a recent conference

call. “Even in states that are doing exchanges, we see some tepid political leadership,” he said, “The business community is not necessarily supportive the way it was in Massachusetts.”<sup>ii</sup>

As North Carolina has rejected the Medicaid expansion and setting up a HIX, it is a safe assumption that political leadership on this will be tepid at best. One strategy the Health Access Coalition might pursue is relaying the effective strategies that other Republican state legislatures and governors have employed to North Carolina’s legislators. These strategies may be better received as they provide political cover because fellow conservatives generated them.

A general framework for enrollment is to first think about how people are going to apply and then how to improve each of those processes. The main ways people are expected to apply are through an online application, paper application, telephone, and in-person. The bulk of these are expected to be via online application (growing over time) and paper (diminishing over time). Fewer people are expected to apply in person or via telephone (if the state even permits this).<sup>iii</sup>

Some strategies that the state can employ to improve processes for these groups are listed below:

- Online
  - Monitor when consumers use the application and provide live assistance during peak times.
  - Develop smartphone apps that will reach populations with limited Internet access—specifically African-Americans and Latinos.<sup>iv</sup>
- In-person

- Create a system by which navigators and assistors on the ground serve as a feedback loop to policymakers on how consumers are reacting.
- Gather data on consumer experience and use that to inform changes to the system.
- Via Telephone
  - Allow for telephonic signatures to streamline the application process.

Working with its partners, the Health Access Coalition can fill the critical role of advocating for and informing consumers about the benefits of participating in the health insurance exchange.

There are several relevant statutes in the Affordable Care Act that the Health Access Coalition can cite in support of its work. They are:

- §1002 - Creates grants for offices of health insurance consumer assistance or health insurance ombudsman. These grant-funded offices must educate consumers about their rights and responsibilities regarding group health plans and health insurance coverage.
- §1311 - Requires the Exchange to consult with educated health care consumers, small business representatives, state Medicaid offices and advocates for hard to reach populations relevant to carrying out the required activities of the Exchange.
- §1312 - Establishes consumers' right to choose an insurance plan in or outside of the Exchange.
- §1501 - Requires individuals to maintain minimum essential coverage or face a tax penalty, unless they qualify for a financial or religious exemption.
- §1511 - Establishes employer responsibilities, including automatic enrollment for employers with over 200 employees; notification to employees of their coverage options



and eligibility status for tax credit and voucher programs; and penalty payments for certain large employers that do not offer health insurance.

#### **NORTH CAROLINA COULD SET UP A MORE EFFECTIVE HIX THAN THE FEDERAL GOVERNMENT**

North Carolina gave up a significant amount of autonomy when it opted to allow the federal government to set up its exchange. With that decision, it limited its involvement to enrolling participants in the HIX. While this is a critical component of the process, it has left the state at the mercy of a federal agency that is straining to implement this part of the ACA with limited resources.

The federal government recently announced that it would only include one option in SHOP, the HIX for small businesses. Several of the states which have opted to create their own exchanges will have more robust exchanges with enough options to create competition and lower costs.

At some point over the next few years, North Carolina may decide to resume responsibility for its HIX. Those that support states' rights may eventually realize that in letting the federal government set up its exchange, the state has waived its right to determine what insurance will be offered to its citizens and how that process will work. If the state reclaims that responsibility, there are several things legislators and policymakers should bear in mind as it designs the user interface for its exchange.

## **CHOICE OVERLOAD: TOO MUCH OF A GOOD THING**

While the one option offered in SHOP is almost certainly not enough, it raises the question of what the appropriate amount of options is. The Atlantic recently published “A Million First Dates,” an article on online dating which included the story of Jacob, a recently single man in his early thirties. After years of struggling to find the right woman, Jacob finds himself in an unusual position--he’s simultaneously dating several women he’s attracted to and finds interesting. His newfound options make it more difficult to settle down. A new world of opportunities is open to him and he takes full advantage of it--with one downside. “Maybe I have the confidence now to go after the person I really want,” he says. “But I’m worried that I’m making it so I can’t fall in love.”<sup>v</sup>

Jacob is not alone in this struggle. In fact, although we are conditioned to believe that freedom of choice means more choices leads to better decisions, most people freeze up in the face of too many options. A study by Sheena Iyengar tested this hypothesis by offering people different types of jam. She found that, though more jam options enticed more shoppers to browse, fewer people actually purchased when more jams were available.<sup>vi</sup>

This tasty test illustrates the point that more choice is not necessarily better. In fact, it often leads to what behavioral economists call ‘choice overload’, a barrage of options that leaves the consumer unable to make a good decision.

Iyengar hypothesizes that two factors can further exacerbate choice overload. The first is the importance of the decision. That is, if making the ‘wrong’ choice will have a significantly negative impact. Secondly, if substantial time and effort are required to make an informed decision, the choice becomes more difficult. Clearly, both of these factors are present when choosing health insurance.

Retirement was the subject of another Iyengar study that looked at 800,000 employees and their choice of and satisfaction with a 401(k). The study found that as options increased, participation decreased. Controlling for a range of factors, participation dropped by approximately 1.5 percent to 2 percent for every ten funds added.<sup>vii</sup>

This offers a reasonable comparison to insurance because it involves a series of choices, the details of which many people will struggle to comprehend. Each retirement plan contains various permutations of mutual funds, stocks, insurance companies, and other investment opportunities. Add to this the decision of how much to regularly contribute to the plan and the decision becomes even more complicated. In short, choice overload will be a real issue for people purchasing through a health insurance exchange--not necessarily due to non-participation (because coverage is mandated) but because people are not likely to understand or consider all their options.

Research has also shown that if the attributes of the products consumers are choosing between are “non-alignable”, the decision becomes even more difficult.<sup>viii</sup> In essence, non-alignable

attributes are of a nature that they cannot be compared relative to another product. That is, they are “take it or leave it” features.

One way in which the insurance exchange can mitigate this problem is by standardizing the features by which insurance plans are compared. Thus, consumers would be able to make the marginal decisions based on relative costs and benefits.

### **THE ECONOMIC ARGUMENT FOR LIMITED CHOICES**

The idea of the free market is a powerful and guiding force in the US economy. In theory a perfectly free market is one without restrictions or government interventions in the form of regulations, taxes, subsidies and other mechanisms generally thought to distort the market (i.e. make some goods cheaper or more expensive than they would otherwise be).

There are, however, several things that must be in place for a free market to exist and function fairly. Among them are:

- Perfect competition--the market cannot be controlled by a monopoly or cartel. There is a low cost to enter a market and transaction costs are low.
- Perfect information--consumers need to have complete understanding of what it is that they are buying.
- No externalities--there can't be some additional cost or benefit that is not included in the transaction. Pollution is the most common example--without regulation, it would not be included in the price of producing a good.

- Public goods--some things, such as national defense, are common to everyone in the community and you would not want to move it into the private market.
- Perfectly rational consumers--people understand the decision and process information in a way that maximizes the benefit to themselves.

When one of these is off-kilter, the government will sometimes intervene in an attempt to correct the market and make it more efficient. This might come in the form of a tax or subsidy or in a new regulation. This is why we don't consider the US economy to be a perfectly free market, but rather a 'regulated free market'.

Several of the above conditions do not hold in our health insurance market. When it comes to behavioral economics, the focus is primarily on people as rational actors. Do people always make the best choices? Do they put aside biases and emotions when making a decision? Do people have complete understanding of all the repercussions of their actions? A quick review of our own behavior and the actions we observe on a daily basis reveals that the answer is clearly 'no'.

In many cases, we rely on experts to make decisions for us. For example, I don't go to the hospital and tell the doctor what treatment I need. I defer to her expertise and training to guide me to a good decision. We often rely on our friends and family for guidance when making everyday decisions ('Is this a good car?' "Should I buy these tools?"). Whoever it is, we defer to the experts in our lives every day.

This brings up the question: does offering a limited number of choices hinder the free market? The right answer, as is often the case with difficult topics, is maybe. Behavioral research has demonstrated that some limits on the number of choices a person must make can lead them to a better decision (and one they feel better about). At the same time, if the limits were so prohibitive that they essentially led to a monopoly, then they would be a hindrance to efficiency. The key is finding the sweet spot of enough choice without overwhelming the consumer. This is why health insurance exchanges under the new health care law must be responsible curators of insurance plans in their states.

A health insurance marketplace with literally thousands of different plans - essentially what we have now - offers little but confusion. For example, most small business owners want to spend their time growing their businesses and serving customers, not sorting through thousands of complex health plans. A health marketplace that offers a reasonable number of plans from high-deductible catastrophic coverage to more comprehensive health insurance is easier to sort through and make a choice that is in line with what an individual or business really needs.

#### **THE MASSACHUSETTS CONNECTOR: WHY MINIMUM STANDARDS MATTER**

One way to set up a really good exchange is to take a look at how people actually behave currently in a similar situation. With that in mind, let's take a look at some of the research that has been conducted on the Massachusetts Connector, the health insurance exchange in Massachusetts, and one of the models that many states are considering replicating.

Research on the Massachusetts Connector (it was created by the 2006 health care reform act in Massachusetts that served as the basis for the ACA) demonstrates that a majority of enrollees (60%) chose the lowest level of coverage to satisfy the mandate.<sup>ix</sup> This may be in part due to the fact that, while Massachusetts has been very successful in enrolling low-income residents, it has had a lower take-up rate for the non-group and small group markets.<sup>x</sup> These markets are likely to produce fewer subsidized plans and perhaps higher enrollment in more expensive plans.

Additionally, researchers at the University of Pennsylvania found that price sensitivity varied significantly by age.<sup>xi</sup> In fact, they note that the youngest person in their model (age 27) is twice as sensitive as the oldest (age 64). They conclude that, because the ACA allows that premiums can vary by age by a factor of three, insurance companies may charge higher premiums to older consumers because they are less sensitive to price, look for more generous coverage, or some combination of the two.

This has significant implications for how states determine the minimum acceptable amount of coverage. The reality is that most people who enroll simply default to the cheapest plan. This means that in choosing their minimum benefits, the government needs to keep in mind that that is likely what a majority of people using their exchange will end up with.

Bearing this in mind, the federal government has set a floor by issuing minimum standards that all health plans must meet. These are called “Essential Health Benefits.” For example, in states opting to create their own exchanges, they have the option to defaulting to the largest small-group plan, which is offered by Blue Cross Blue Shield, as its benchmark for Essential Health

Benefits.<sup>xii</sup> After selecting this benchmark, the state must still supplement to make sure the plan meets the federal standards and then can adjust the benefits.<sup>xiii</sup> Throughout this process, the state must be mindful that what it sets as the minimum is likely to have a huge effect on its citizens' coverage.

The ACA establishes benefit tiers and the requirement for essential health benefits. Relevant sections include:

§1302 - Charges the Secretary of HHS with defining essential health benefits that include inpatient and outpatient care, emergency care, rehabilitation services, mental health treatment, preventive and maternity care, laboratory services, pediatric care and prescription drugs. The Secretary must take into account certain special populations, including women, children, persons with disabilities, and others when defining benefits. Also defines levels of coverage: bronze, silver, gold and platinum, based on the actuarial value of the essential benefits and limits on cost-sharing and deductibles. The Secretary must ensure that the scope of essential benefits is equal to a typical employer plan.

§1311 - States may require additional benefits for plans that offer coverage through the Exchange, but they must assume the cost of those benefits.

### **POOR NUMERACY AND LITERACY**

Perhaps most importantly, the people who will be using the health insurance exchange are likely those who are currently uninsured or underinsured. This may indicate that they have poor numeracy and literacy skills in addition to the complications arising from bounded rationality.



Another concern is presented by the ACA itself, which requires that plans be ranked platinum, gold, silver, or bronze based on the amount of coverage they offer. These designations have other connotations, though, and cause people to choose the more precious metals even when it may be more coverage than they require. This effect is particularly strong amongst people with poor numeracy.

At a more basic level, consumers often do not understand the definitions of terms used in health plans. Reworking these definitions and then testing them for comprehensibility is a simple step that can make a great difference in how people choose their insurance.

Related to the issue of numeracy, the way in which costs are presented can be confusing and counter-productive. For example, when costs are presented at a monthly or weekly rate people often will purchase a more expensive plan than they would if the very same costs were presented as an annual figure. This is because at the weekly rate, the difference between plans is relatively low, whereas the annual cost magnifies that difference. In order to make sure people are well aware of the costs, it is prudent to provide both annual costs as well as monthly or weekly costs for household budgeting purposes.

Additionally, people tend to put too much emphasis on having a low deductible. Risk aversion tends to push people towards plans with higher premiums, as they attempt to smooth consumption and avoid the spike in payment that a relatively larger deductible would cause. In the end, however, this can lead to higher payments overall. One way in which a health insurance

exchange could address this is to provide a cost estimate based on the care or usage a person expects. Essentially, the exchange could calculate ranges of expected utility for each level of costs and benefits that the plans offer. These are the types of calculations that neoclassical economics expects consumers to adhere to, but they rarely happen in practice.

### **ANCHORING**

An example of bounded rationality, anchoring is the tendency for people to overemphasize or rely too heavily upon the first piece of information that they receive.<sup>xiv</sup> This can be particularly troublesome in presenting health insurance plans because the way in which the information is displayed can skew consumers' choices. For example, were the plans ranked by price, the buyer may be subconsciously nudged towards purchasing insurance that is more expensive. Likewise, if a person is presented first with a plan that offers low benefits, they might anchor their decision about the amount of coverage they need to that low figure and under-insure.

One approach to combat this is to get consumers to reveal their preferences before being presented with a set of plans. Similar to booking a flight, buyers could specify their preferences across a range of characteristics that are most often used by consumers in choosing health plans. Then, they are able to make marginal decisions that should be closer to their true preferences.

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