

Health Care Workshop, Project No. P131207:
Structuring the Choice Architecture of Insurance Exchanges
Created Under the Affordable Care Act

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Disclaimer: I am a student at Columbia University. This comment to the Federal Trade Commission reflects my own personal opinions, not Columbia University or the Trustees of Columbia University.

Abstract: Insurance exchanges will have a choice architecture that can be structured to maximize the number of buyers who select optimal insurance plans. Increasing the proportion of buyers who choose optimal insurance plans will increase their health and wealth, while also saving money on subsidies. Cost calculators and smart default options are two choice architecture interventions that have been shown by randomized trial to dramatically improve buyers' chances of making optimal insurance choices. These two interventions should be implemented on the federal insurance exchange, which most states will use. A mandate to extend these interventions to state-run exchanges would not be feasible in the current political climate, and many state-run exchanges use similar tools already. These state-run exchanges also run policy experiments, and could produce more innovative policy ideas. The federal exchange should implement the above interventions, while watching closely for other policy alternatives that arise at the state level.

Issue Statement

State and federal insurance exchanges present their policies to potential buyers, and an exchange's system of presenting its policies – its choice architecture – has an effect on buyers' choices. Many buyers do not make optimal insurance choices on existing insurance exchanges.

Background

The choice architecture of insurance exchanges created under the Affordable Care Act (ACA) will affect millions of Americans. States have considerable freedom to manage their exchanges as they choose:¹ some states leverage choice architecture interventions to influence the decisions of insurance buyers, while others act as a “clearinghouse,” where insurance plans are presented without an attempt to influence the buyer.² The variety in their choice architecture systems is paralleled by the variety in their governance: 14 states run their own exchanges, seven states run exchanges through a partnership with the federal government, and 29 states have defaulted to the federal insurance exchange.³ Each of these exchanges has a unique choice architecture, as choice architecture is unavoidable: as long as buyers are presented with options, the structure of that presentation will affect their decisions. The specific choice architectures used on state and federal exchanges could have major downstream consequences.

The choice architecture of an insurance exchange matters because it shapes buyers' decisions. Choice architecture studies show that decisions are affected by how information is presented: voters, for example, have a tendency to select candidates listed at the top of the ballot.^{4,5} With respect to health insurance, potential buyers prefer “gold” plans to “silver” or “bronze” plans, even when the label given to a plan is changed and the plan itself stays the same.⁴ Moreover, choice architecture is unavoidable, because as long as buyers are presented with options, the structure of that presentation will affect their decisions. If an insurance buyer's choice is influenced by factors other than the insurance policies themselves, the presence of such factors in state and federal insurance exchanges will have widespread effects. Nearly seven million Americans have already bought health insurance through insurance exchanges,⁶ and the Congressional Budget Office (CBO) expects that number to increase to 25 million by 2017.⁷ The choice architecture of insurance exchanges will shape the choices of millions of Americans.

Optimal insurance choices are those that minimize the total cost to the buyer, and are beneficial to buyers for both financial and health reasons. Studies on Medicare Part D insurance exchanges show that suboptimal insurance choices increase buyers' costs by an average of 30.1%.^{8,9,10} Another study found that 30% of subjects using the Massachusetts exchange with incomes low enough to qualify for subsidies did not to take them, showing that suboptimal choices can make the poorest yet poorer.¹¹

¹ Nadash P, Day R. Consumer choice in health insurance exchanges: can we make it work? *Journal of health politics, policy and law*. 2014;39(1):209-35.

² Krinn K, Karaca-Mandic P, Blewett LA. State-based Marketplaces using 'clearinghouse' plan management models are associated with lower premiums. *Health affairs (Project Hope)*. 2015;34(1):161-9.

³ KFF. State Decisions on Health Insurance Marketplaces and the Medicaid Expansion. In: KFF, editor. *State Health Facts*: Kaiser Family Foundation; 2015.

⁴ Brockington D. A low information theory of ballot position effect. *Political Behavior*. 2003;25(1):1-27 % @ 0190-9320.

⁵ Ubel PA, Comerford DA, Johnson E. Healthcare.gov 3.0--behavioral economics and insurance exchanges. *N Engl J Med*. 2015;372(8):695-8.

⁶ Levitt L. Why health insurance literacy matters. *Jama*. 2015;313(6):555-6.

⁷ CBO. Insurance Coverage Provisions of the Affordable Care Act—CBO's January 2015 Baseline 2015 [updated January 2015]. Available from: <https://www.cbo.gov/sites/default/files/cbofiles/attachments/43900-2015-01-ACAables.pdf>.

⁸ Abaluck J, Gruber J. Heterogeneity in choice inconsistencies among the elderly: Evidence from prescription drug plan choice. *The American Economic Review*. 2011;101(3):377-81.

⁹ Heiss F, Leive A, McFadden D, Winter J. Plan selection in Medicare Part D: Evidence from administrative data. *Journal of health economics*. 2013;32(6):1325-44.

¹⁰ Abaluck JT, Gruber J. Choice inconsistencies among the elderly: evidence from plan choice in the Medicare Part D program. *National Bureau of Economic Research*; 2009.

¹¹ Sinaiko AD, Ross-Degnan D, Soumerai SB, Lieu T, Galbraith A. The experience of Massachusetts shows that consumers will need help in navigating insurance exchanges. *Health affairs (Project Hope)*. 2013;32(1):78-86.

Moreover, more costly insurance plans mean more government spending on subsidies: one estimate calculated that suboptimal choices could cost the government an additional \$9.12 billion per year, which is nearly 10% of the CBO's projected total cost of those subsidies.^{12,13} These higher costs have health consequences: randomized trials have demonstrated that high-cost insurance translates into decreased healthcare use, which yields a twofold increased risk of mortality for high-risk patients.¹⁴ Thus, optimal insurance choices are critical to buyers' health and wealth.

Suboptimal insurance choices could threaten the financial stability of the insurance exchange program. Existing evidence consistently shows that buyers significantly overweight some costs, such as premiums, in their insurance choices,^{15,16} causing them to purchase plans with higher total costs.^{17,18} Insurance exchanges are not a captive markets, so suboptimal plans outside of insurance exchanges can attract buyers by having low premiums. This is potentially destabilizing for insurance exchanges because the ACA requires them to be self-financing, so they have to attract enough insurance buyers to cover their operation costs.^{19,20} A vicious cycle of adverse selection, the so-called "death spiral," would amplify this problem: if suboptimal insurance choices lead buyers away from exchanges, exchanges may have to raise user fees to cover their costs,^{21,22} which will only push more buyers away, increasing total costs yet further.²³

It is not surprising that suboptimal insurance choices are common given the complexity of insurance, and buyers' ignorance of relevant topics. Fifty-five percent of American adults show only basic or below basic levels of numeracy.^{24,25} Financial literacy rates may be even lower.^{26,27} This lack of financial knowledge and quantitative skill is compounded by ignorance of insurance itself: Estimates indicate that 77% of insurance exchange users will have only a high school degree or less,²⁸ and 97% will be buying insurance for the first time.²⁹ Only 64% of uninsured adults know that insurance premiums have to be paid monthly, only 57% know what a provider network is, and only about half can correctly describe a deductible.^{30,31} Even highly-trained, financially literate adults find

¹² CBO. Insurance Coverage Provisions of the Affordable Care Act—CBO's January 2015 Baseline 2015 [updated January 2015]. Available from: <https://www.cbo.gov/sites/default/files/cbofiles/attachments/43900-2015-01-ACAtables.pdf>.

¹³ Johnson EJ, Hassin R, Baker T, Bajger AT, Treuer G. Can consumers make affordable care affordable? The value of choice architecture. *PloS one*. 2013;8(12):e81521.

¹⁴ Manning WG, Newhouse JP, Duan N, Keeler EB, Leibowitz A. Health insurance and the demand for medical care: evidence from a randomized experiment. *The American economic review*. 1987;251-77 % @ 0002-8282.

¹⁵ Johnson EJ, Hassin R, Baker T, Bajger AT, Treuer G. Can consumers make affordable care affordable? The value of choice architecture. *PloS one*. 2013;8(12):e81521.

¹⁶ Ubel PA, Comerford DA, Johnson E. Healthcare.gov 3.0--behavioral economics and insurance exchanges. *N Engl J Med*. 2015;372(8):695-8.

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¹⁸ Abaluck JT, Gruber J. Choice inconsistencies among the elderly: evidence from plan choice in the Medicare Part D program. *National Bureau of Economic Research*; 2009.

¹⁹ Nadash P, Day R. Consumer choice in health insurance exchanges: can we make it work? *Journal of health politics, policy and law*. 2014;39(1):209-35.

²⁰ Day R, Nadash P. New state insurance exchanges should follow the example of Massachusetts by simplifying choices among health plans. *Health affairs (Project Hope)*. 2012;31(5):982-9.

²¹ Nadash P, Day R. Consumer choice in health insurance exchanges: can we make it work? *Journal of health politics, policy and law*. 2014;39(1):209-35.

²² Day R, Nadash P. New state insurance exchanges should follow the example of Massachusetts by simplifying choices among health plans. *Health affairs (Project Hope)*. 2012;31(5):982-9.

²³ Cutler DM, Reber S. Paying for health insurance: the tradeoff between competition and adverse selection. *National Bureau of Economic Research*; 1996.

²⁴ Kutner M, Greenberg E, Jin Y, Boyle B, Hsu Y-c, Dunleavy E. Literacy in Everyday Life: Results from the 2003 National Assessment of Adult Literacy. NCES 2007-490. National Center for Education Statistics. 2007.

²⁵ Day R, Nadash P. New state insurance exchanges should follow the example of Massachusetts by simplifying choices among health plans. *Health affairs (Project Hope)*. 2012;31(5):982-9.

²⁶ Day R, Nadash P. New state insurance exchanges should follow the example of Massachusetts by simplifying choices among health plans. *Health affairs (Project Hope)*. 2012;31(5):982-9.

²⁷ Lusardi A. Financial literacy: an essential tool for informed consumer choice? : National Bureau of Economic Research; 2008.

²⁸ KFF. A Profile of Health Insurance Exchange Enrollees. In: Foundation TKF, editor. Focus on Health Reform: Kaiser Family Foundation; 2011.

²⁹ Johnson EJ, Shu SB, Dellaert BGC, Fox C, Goldstein DG, Häubl G, et al. Beyond nudges: Tools of a choice architecture. *Marketing Letters*. 2012;23(2):487-504 % @ 0923-645.

³⁰ Levitt L. Why health insurance literacy matters. *Jama*. 2015;313(6):555-6.

³¹ Barcellos SH, Wuppermann AC, Carman KG, Bauhoff S, McFadden DL, Kapteyn A, et al. Preparedness of Americans for the Affordable Care Act. *Proceedings of the National Academy of Sciences of the United States of America*. 2014;111(15):5497-502.

insurance purchasing difficult: when Ivy League business school students enrolled in a Consumer Finance course are asked to pick the most cost-effective insurance plan, only 73% are able to do so, though nearly half of them used Excel modeling to inform their decisions.³² In the same study, average buyers pick the most cost-effective plan at rates no better than chance. Given the complexity of the decision and the lack of relevant knowledge, it is clear why consumers choose insurance policies so poorly.

Existing evidence suggests that choice architecture interventions can improve buyers' insurance choices. A large, randomized trial assigned study participants to receive different interventions to assist them in their insurance choices, or not to receive any intervention. They found two interventions that yielded significant improvements in consumer choice: cost calculation aids and smart default options.³³ When combined, these tools lead consumers to make optimal choices almost four times as often as they otherwise would have, approaching the same level of success as business school students with the expertise and financial software to make informed decisions. Choice architecture interventions may maximize the number of insurance buyers who select optimal insurance policies.

Choice architecture interventions have been built into some existing insurance exchanges, showing that such interventions are feasible. Medicare Part D and the Massachusetts Commonwealth Connector, for example, use cost-calculators and smart default options in their choice architectures.^{34,35} The Medicare Part D's CMS plan finder and the Massachusetts Commonwealth Connector allow users to enter relevant financial and health information, and then display lists of plans that are deemed most cost-effective based on their health needs. Consumers maintain the choice to follow or ignore the suggested options, but are nevertheless nudged toward optimal insurance choices. These existing policies demonstrate the feasibility of choice architecture interventions, and provide a model for interventions on other exchanges.

Despite evidence that choice architecture interventions can increase the rate of optimal insurance choices, some evidence from existing insurance exchanges dampen enthusiasm for such interventions. Many people ignore the suggestions of choice architecture interventions: despite the CMS Cost Calculator's suggestions, nearly three quarters of Medicare Part D enrollees choose suboptimal insurance plans.^{36,37,38} Furthermore, the aforementioned fact that 30% of Massachusetts study participants elected not to use the subsidies they qualified for, despite the system's smart default options and cost calculation aids, suggests that choice architecture interventions alone cannot eliminate suboptimal insurance choices.³⁹ When randomized to receive smart default options as an intervention, 21% of study participants will actively choose to change to a less cost-effective insurance plan.⁴⁰

³² Johnson EJ, Hassin R, Baker T, Bajger AT, Treuer G. Can consumers make affordable care affordable? The value of choice architecture. *PloS one*. 2013;8(12):e81521.

³³ Johnson EJ, Hassin R, Baker T, Bajger AT, Treuer G. Can consumers make affordable care affordable? The value of choice architecture. *PloS one*. 2013;8(12):e81521.

³⁴ Day R, Nadash P. New state insurance exchanges should follow the example of Massachusetts by simplifying choices among health plans. *Health affairs (Project Hope)*. 2012;31(5):982-9.

³⁵ Heiss F, Leive A, McFadden D, Winter J. Plan selection in Medicare Part D: Evidence from administrative data. *Journal of health economics*. 2013;32(6):1325-44.

³⁶ Abaluck J, Gruber J. Heterogeneity in choice inconsistencies among the elderly: Evidence from prescription drug plan choice. *The American Economic Review*. 2011;101(3):377-81.

³⁷ Heiss F, Leive A, McFadden D, Winter J. Plan selection in Medicare Part D: Evidence from administrative data. *Journal of health economics*. 2013;32(6):1325-44.

³⁸ Abaluck JT, Gruber J. Choice inconsistencies among the elderly: evidence from plan choice in the Medicare Part D program. *National Bureau of Economic Research*; 2009.

³⁹ Sinaiko AD, Ross-Degnan D, Soumerai SB, Lieu T, Galbraith A. The experience of Massachusetts shows that consumers will need help in navigating insurance exchanges. *Health affairs (Project Hope)*. 2013;32(1):78-86.

⁴⁰ Johnson EJ, Hassin R, Baker T, Bajger AT, Treuer G. Can consumers make affordable care affordable? The value of choice architecture. *PloS one*. 2013;8(12):e81521.

While optimizing insurance choices is critical to the ACA's success, and interventions exist to promote it, these interventions are not without limitations.

Goal

The goal of choice architecture systems on insurance exchanges should be to maximize the proportion of buyers who buy insurance plans that minimize their total costs, including the cost of out-of-pocket payments and the insurance policies themselves.

Policy Alternatives

- Provide no specific federal guidance regarding the choice architecture of insurance exchanges
- Implement cost calculators and smart default options as choice architecture interventions on the federal insurance exchange only
- Implement cost calculators and smart default options as choice architecture interventions on the federal exchange, as well as the federal-state partnership exchanges and state-run exchanges

Recommendations

- Implement cost calculators and smart default options as choice architecture interventions on the federal insurance exchange only

Rationale

Choice architecture interventions are beneficial, even if the results are less than perfect. The nearly four-fold increase in optimal insurance choices created by interventions would be beneficial in budgetary and health terms, increasing the efficiency of insurance exchanges.^{41,42} The financial and health burdens from suboptimal choices inequitably fall on the poor, and the proposed interventions could redress that inequity. Moreover, choice architecture is inevitable: as long as buyers are presented with options, the structure of that presentation will affect their decisions. If it is inevitable, then it is preferable to use it to reduce costs, increase health, and ameliorate inequity. The imperfect results of the proposed choice architecture interventions do not negate their net positive impact, therefore those interventions should be implemented.

Intervening on only the federal level is more feasible in the current political climate than mandating changes on both the federal and state exchanges. Lawmakers originally anticipated that most states would create their own insurance exchanges, but few states have done so,^{43,44} as political opposition to creating state exchanges is considerable.^{45,46} Historically, healthcare is a highly partisan policy arena,⁴⁷ making it no surprise that party politics are a significant factor here: nearly two-thirds of states with Democratic governors created insurance exchanges, compared to less than a quarter of states with Republican governors.⁴⁸ Furthermore, even in Republican-controlled states that *have* established their own exchanges, further federal mandates may not be welcome: when federal guidance established training and certification processes for personnel on both federal and state exchanges,⁴⁹ the Executive Director of Nevada's exchange demanded that large portions of the law be deleted, and the

⁴¹ Johnson EJ, Hassin R, Baker T, Bajger AT, Treuer G. Can consumers make affordable care affordable? The value of choice architecture. *PloS one*. 2013;8(12):e81521.

⁴² Manning WG, Newhouse JP, Duan N, Keeler EB, Leibowitz A. Health insurance and the demand for medical care: evidence from a randomized experiment. *The American economic review*. 1987;251-77 % @ 0002-8282.

⁴³ Jones DK, Bradley KWW, Oberlander J. Pascal's wager: health insurance exchanges and the Republican dilemma. *Journal of health politics, policy and law*. 2012.

⁴⁴ KFF. State Decisions on Health Insurance Marketplaces and the Medicaid Expansion. In: KFF, editor. *State Health Facts*: Kaiser Family Foundation; 2015.

⁴⁵ Jones DK, Greer SL. State politics and the creation of health insurance exchanges. *American journal of public health*. 2013;103(8):e8-e10.

⁴⁶ Rosen S. State-Based Versus Federally-Facilitated Health Insurance Exchanges of the Affordable Care Act: A Qualitative Analysis of State Decision-Making. Princeton University Senior Theses. Princeton, NJ: Woodrow Wilson School; 2013. p. 129.

⁴⁷ Kingdon, John W. *Agendas, Alternatives, And Public Policies – Updated Second Edition*. p.134. New York : Longman, 2011. Print.

⁴⁸ Jones DK, Greer SL. State politics and the creation of health insurance exchanges. *American journal of public health*. 2013;103(8):e8-e10.

⁴⁹ CMS-9955-P Exchange Functions: Standards for Navigators and Non-Navigator Assistance Personnel, Federal Register, Vol. 78, No. 66, Friday, April 5, 2013, Rules and Regulations, pp. 20581-20597.

bulk of its requirements be dropped.⁵⁰ In an antagonistic political climate, additional mandates for state-run exchanges will be poorly received, and may even discourage further cooperation or the creation of more state-run exchanges.

Political concerns aside, mandating choice architecture interventions on state exchanges would not produce a significant benefit, as most states do not have their own exchanges. Even among states that do, many use choice architecture interventions on their exchanges to optimize buyers' choices, e.g. Massachusetts, so no federal mandate is needed to elicit the desired result for their exchange.⁵¹ By contrast, an intervention on the federal exchange would have a broad impact, as most states will be using it. Implementing changes to the federal exchange only, rather than both state and federal exchanges, will only slightly diminish the effect of the proposed intervention while making it considerably more politically palatable.

Without mandates on the choice architecture of state exchanges, states will have the freedom to innovate, possibly developing programs that can later be implemented elsewhere. States vary considerably with respect to their approaches to common policy issues, depending on the peculiarities of their politics.⁵² By allowing such variations, policy alternatives can be tested, allowing for policy innovations to develop that can later be considered for widespread adoption if applicable. Vermont, for instance, considered establishing a statewide single-payer system.^{53,54} While the effort was abandoned due to its costs, it was a significant learning opportunity for policymakers, and such policy experiments should be encouraged.⁵⁵

Insurance exchanges will have a choice architecture that can be structured to maximize the number of buyers who select optimal insurance plans. Increasing the proportion of buyers who choose optimal insurance plans will increase their health and wealth, while also saving money on subsidies. Cost calculators and smart default options are two choice architecture interventions that have been shown by randomized trial to dramatically improve buyers' chances of making optimal insurance choices. These two interventions should be implemented on the federal insurance exchange, which most states will use. A mandate to extend these interventions to state-run exchanges would not be feasible in the current political climate, and many state-run exchanges use similar tools already. These state-run exchanges also run policy experiments, and could produce more innovative policy ideas. The federal exchange should implement the above interventions, while watching closely for other policy alternatives that arise at the state level.

⁵⁰ Hager JM. Comments regarding Standards for Navigators and Non-Navigators Assistance Personnel, May 6, 2013 In: Exchange SSHI, editor. Carson City, NV: Silver State Insurance Exchange; 2013.

⁵¹ Day R, Nadash P. New state insurance exchanges should follow the example of Massachusetts by simplifying choices among health plans. *Health affairs (Project Hope)*. 2012;31(5):982-9.

⁵² Barrilleaux C, Brace P. Notes from the laboratories of democracy: state government enactments of market-and state-based health insurance reforms in the 1990s. *Journal of health politics, policy and law*. 2007;32(4):655-83 % @ 0361-6878.

⁵³ Hsiao WC. State-Based Single-Payer Health Care—A Solution for the United States? *New England Journal of Medicine*. 2011;364(13):1188-90 % @ 0028-4793.

⁵⁴ Hsiao WC, Knight AG, Kappel S, Done N. What other states can learn from Vermont's bold experiment: embracing a single-payer health care financing system. *Health Affairs*. 2011;30(7):1232-41 % @ 0278-2715.

⁵⁵ Fox AM, Blanchet NJ. The Little State That Couldn't Could? The Politics of "Single-Payer" Health Coverage in Vermont. *Journal of health politics, policy and law*. 2015;2888381 % @ 0361-6878.