Executive Summary

The Affordable Care Act (*ACA*) has three primary, overarching objectives: increase health insurance coverage, reduce rising healthcare costs, and improve the quality of care provided (Key). A significant component of the ACA includes the establishment of health insurance marketplaces (these marketplaces are also referred to as exchanges). The marketplaces provide information to facilitate consumer choice and create a platform for selling health insurance that boosts competition in the market for health insurance. The marketplaces present potential health insurance consumers with a variety of information about specific health insurance plans, including premiums, deductibles, co-pays, and coverage information for a given plan in one single, easy-to-access location (Cox, et al.). The marketplaces also stimulate competition in the market with the intention of driving down costs as health insurance firms seek to outbid each other to win over potential new customers. By way of the ACA, consumer choice was presented as a potential method to help level the playing field when it comes to purchasing health insurance – provide consumers with a single, user-friendly platform that lets them choose a plan best for their specific set of needs and preferences. But what happens when consumer choice is hindered because of lack of consumer knowledge, a multitude of relatively confusing options and poorly presented information, or unintended influence and bias? If consumer choice cannot function properly as a key tenant of the ACA, expected achievements in reducing health care costs and increasing insurance coverage could be either stifled or halted. This analysis examines ways to address barriers that prevent fully informed consumer choice.

Problem

A variety of failures exist in the market for health insurance – all of which inhibit effective and efficient execution of consumer choice. These failures include: asymmetric information, financial illiteracy, excessive plan options, and ineffective influencing factors.

Asymmetric information exists when one participant in a transaction knows more than the other, greatly influencing consumer or provider actions (Nadash and Day). The health insurance marketplaces seek to address this by providing an easy-to-access platform for knowledge transfer. However, recent evidence suggests that exchanges may not be using all methods possible to address this issue. A Kaiser Family Foundation survey found that only 72% of respondents could define an "annual health insurance deductible" (Norton, et al.). Moreover, among the same survey, only 53% of uninsured respondents were able to define the term, clearly indicating a knowledge gap among a population targeted to use the exchanges (Norton, et al.). A similar survey conducted by Watson Wyatt Worldwide found that among employees with employer-sponsored insurance, only 33% could explain what the terms 'out-of-pocket' or 'co-insurance' mean (Nadash and Day). Another study found that many participants in the Massachusetts's exchanges do not understand basic insurance concepts (Nadash and Day). Without firm understanding of these terms, consumers are unable to make decisions that align with their needs and preferences.

Aside from understanding specific information about health insurance, many Americans are not able to calculate the financial implications of choosing a specific health insurance plan. A survey conducted by the *National Center for Education Statistics* to assess national adult literacy found

that "55% of adults exhibited 'basic' or 'below basic' levels of financial literacy" (National). Levels were assessed by asking adults to calculate how much three baseballs tickets would cost in total when considering postage and handling charges (Nadash and Day). This presents significant problems when considering the relative complexity of financial calculations required to assess a health insurance plan's cost effectiveness. This begs the question – can the average, uninsured consumer accurately calculate the financial impact that policy mechanisms such as co-pays, deductibles, cost-sharing, and co-insurance have with respect to out-of-pocket costs for a given year?

Additional evidence suggests that having too many plan choices complicates the decision making process (Iyengar and Lepper). A study of consumers seeking insurance plans through the Massachusetts Health Connector Program, a form of health insurance exchange, found that nearly 30% of all respondents thought that their choice would have been made easier with fewer plan options (Sinaiko, et al.). The survey also found that 42% of respondents thought information on plans was difficult to understand (Sinaiko, et al.). With a multitude of providers offering multiple plan options, it is easy to understand why consumers might be confused when confronted with far too many options. As evidenced above, consumers are clearly not being presented with information in the most effective way possible.

Well-intentioned design elements have led to some inherent biases that are improperly influencing consumers towards purchasing certain types of plans. To enhance comparability between specific plans, the ACA introduced a tiered system that classifies plans based on "the average percentage of health care expenses that will be paid for by the insurer" using a medal-tiered system (i.e. gold, silver, bronze) (Monahan, et al.). While relatable, this structure could be construed as misleading. In a simple convenience survey conducted by the authors of the article *Healthcare.gov 3.0 – Behavioral Economics and Insurance Exchanges*, respondents demonstrated a propensity to choose the 'gold' plans regardless of their respective content (Ubel, et al.). In this particular survey, respondents demonstrated a lack of understanding of critical concepts that should be understood when choosing a plan. For example, when given a scenario where a plan has higher premiums but lower care costs, and a plan with lower premiums but higher care costs, a majority of respondents chose the plan that was labeled 'gold', regardless of the specific health needs they had (Ubel, et al.).

This problem has not gone unnoticed or unaddressed. A variety of policy mechanisms have been put in place to curb the negative impacts of the previously mentioned systemic flaws. For example, to be included in an exchange, plans must meet minimum coverage requirements (i.e. quality improvement standards, essential health benefits, and services provided) and must fulfill their actuarial value as established by the tiered system explained above (Nadash and Day). This helps address comparability by establishing required information that makes it easier to assess differences between plans. Moreover, the ACA also requires that exchanges provide in-person assistance, helplines, and minimum information about plans to help those who need assistance navigating the exchanges (Nadash and Day). The ACA also required that the National Association of Insurance Commissioners convene a working group that develops charts to assist consumers in their choice of plans. However, questions remain on how this will be integrated into purchasing platforms (Nadash and Day). Lastly, some states have implemented policy changes that limit the number of plans or benefit designs insurers can offer, require standardized

benefit designs, and/or adopt meaningful difference standards so that there aren't a host of plan options flooding the market that are too similar – all of these seek to "help consumers by creating a more transparent and competitive shopping experience" (Monahan, et al.).

Goal

Recommendations below provide policy options that would equip consumers with the information needed to make informed, effective decisions about which health insurance plans best suit their needs. The approaches draw on evidence analyzed thus far, and primarily seek to:

- Further reduce existence of asymmetric information
- Provide alternative means of addressing financial illiteracy
- Reduce confusion caused by excessive options
- Re-assess and re-direct inherent biases produced by exchanges

Policy Alternatives

Option 1: Implement a requirement that exchanges produce default options based on a series of specific, situational questions.

This policy option would utilize the behavioral economics theory that individuals tend to inherently choose default options (Madrian and Shea). This option would formulate a 'recommended' default option for consumers that was based on a series of questions meant to survey their healthcare preferences and needs, as well as collect a variety of socioeconomics indicators (including income, family size, etc.). It recognizes the fact that some people will not be able to learn the extent of healthcare jargon, so instead it takes the expertise of health insurance industry and government specialists and utilizes it to help recommend default, but customized plan options. A consumer could then use the plan-specific information to seek a provider that offers that plan on the exchange, comparing prices side-by-side while maintaining the integrity of the recommended plan. Consumers would still have access to the array of plans, but this would serve as an initial 'nudge' in the right direction. Industry professionals would be convened to develop the framework of how survey responses translate into plan recommendations. Exchange operators (public or private) would be required to integrate this mechanism into existing exchange sites.

Technically, this option would require a large investment in web-based platform changes and human resources to develop the framework; however, if implemented correctly, it could solve many of the issues that consumers have when choosing plans. Industry professionals tend to agree on the profiles of people that should secure different types of plans, which would indicate that industry specialists will not have a significant level of opposition to this option.

Option 2: Develop and publish 'typical purchaser' profiles with scenario-based narratives.

To address asymmetric information between insurance providers and consumers, one option is to increase relatability of information provided to potential consumers using data and narratives from current consumers. This policy option would require that health insurance firms publish

data on a typical profile of consumers that frequently purchase a given policy type. With these 'typical purchaser' profiles, the marketplace could more effectively connect with potential consumers, providing a relatable reference point that helps a consumer establish and recognize purchasing and selection trends. Moreover, health insurance firms, with the support of The Center for Consumer Information and Insurance Oversight (*CCIIO*), would publish interactive, scenario-based narratives that describe actual situations in which previous consumers have made different types of decisions on health insurance plans. These scenarios could provide alternate means of understanding health insurance terminology other than simple definitions (Johnson, et al.). This approach also helps use biasing factors in a more effective manner than, for example, the medal-based tiered system.

While labor intensive, this option establishes a way to connect with a large swath of Americans who have made less than ideal decision about their health insurance given a lack of knowledge. By providing a means to which one can enhance their plan, costs savings will be eventually realized. This would not likely be controversial as it mends with the overall methodology of the ACA to provide better information that supports consumer choice.

Option 3: Introduce procurement mechanisms that limit number of options and enhance quality and competition within the marketplace.

To reduce confusion based on excessive health insurance plan options, state or federal legislators could pass an ACA policy amendment that put in place exchange-based procurement mechanisms that limit the number of providers allowed into the exchange for a specified period of time. This, in concert with the pre-existing standards dictating what types of plans are allowed in the exchange, will help refine the number of choices simply by reducing the number of providers in the market, and will help refine the quality of plans offered, as now firms will still need to be more competitive to keep their respective plans in the exchange (Merlis).

This option would require strong support from politicians and interests groups, but would help reduce various elements of confusion that deter people from choosing plans that eventually contribute to meeting goals established in the ACA. This option has been implemented in some other exchanges with relative success, but could be controversial as it limits providers from entering the market.

Recommendation

Option 1 is the most comprehensive approach that directly and indirectly addresses the established goals, but largely maintains the integrity of the current health insurance exchange, while building on the currently established exchange model. It draws on proven research about how humans, at their core, tend to make decisions. It effectively limits the existence of asymmetric information by providing a 'solution' to the consumer based on their personal needs and preferences (not based on the preferences of the provider), equipping them with an informed option. It also helps eliminate the complexity of financial analysis through assessing plan options based on simply presented income-focused questions answered in the survey portion. Lastly, it initially limits plan options by providing an initial default option to the consumer that is better than simply displaying the cheapest plan type available using a default sort feature. While this

option will require significant investments in developing a framework that translates survey responses into actionable plan recommendations, it will generate overall cost savings, as people will be more likely to choose plans associated with industry- and specialist-determined recommendations that align with the ACA. It is also unlikely to meet significant resistance among specialists, as there is a general understanding of the types of plans that are most effective given certain consumer profiles. Moreover, this option maintains much of the original, front-end structure of the ACA-established exchanges, whereas other options would require significant modifications on the back-end.

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