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**“Consumer Health Plan Choice, Use of Information and  
the Promise of Behavioral Economics”**

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**Testimony by:**

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## **“Consumer Health Plan Choice, Use of Information and the Promise of Behavioral Economics”**

Hello, my name is Brian Elbel. I am an assistant professor of Medicine and Health Policy at New York University, with appointments at both the School of Medicine and the Wagner Graduate School of Public Service. I have a PhD and MPH from Yale University. I’m pleased to be appearing before the committee today. The views expressed here are my own.

I study how consumers make choices that influence their health and healthcare. This work includes a particular focus on how consumers choose health insurance plans. I have a strong emphasis in my work on behavioral economics, a field of study that combines economics and psychology to come up with realistic models of consumer behavior. And, as you likely know, this field of study can lead to a very different recommended course of action than the more traditional lens of microeconomics.

In my testimony today, I’m going to cover three general areas. First, what do we know about how consumers are generally making choices about their health plans? I’ll explore what the academic literature tells us on this, including some of my own work.

Second, I’ll focus on potential behavioral economics solutions to some of the problems described in the first section. In addition to discussing some already published studies, I will present data, from a new set of experiments that my research group recently completed, that tests out the potential influence of some of these approaches.

Third, I’ll describe what all this might mean for the Department of Labor and this committee.

First, what do we know about how consumers currently make health plan decisions and what information they use? In general, use of information is not overwhelmingly high. Through surveys and experimental work, many appear to use heuristics (or simplifying strategies) in their choice or to rely on asking their friends or family which choice to make. Health plan report cards, which attempted to present information about each plan in a standardized way, have been shown to have, if anything, a relatively small influence on health plan choice as currently conceived (Chernew and Scanlon 1998; Wedig and Tai-Seale 2002).

Others have done experimental work to better understand how consumers make health plan choices. Prominent work by Judy Hibbard at the University of Oregon has consistently found that consumers are quite influenced by how information and the plan options themselves are presented. And, even when data are presented in ways that should make choices easier cognitively (lists are ordered, options are simplified) consumers still often make choices that do not maximize quality or even choose dominated options (they could have chosen a better plan for a cheaper price, or at least the same price) (Hibbard et al. 2002).

Before describing some of my own work, I'll note one other study recently presented at the AcademyHealth Conference in Boston. Anna Sinaiko (Harvard) and Rich Hirth (University of Michigan) examined an interesting quirk in the health plan offered by the University of Michigan. Employees were actually offered as one of their health plan choices a dominated option. This means that they could have chosen a different plan that had the same quality and costs, but was less restrictive and offered slightly better benefits. Over a third of employees chose the dominated plan, and stayed with it for many years. This is fairly direct evidence that consumers are not always making choices in their best interest.

My own related work, still in progress, has focused on Medicare users, using both experiments and econometric analysis of survey data. Briefly, I've found that consumers are very easily overwhelmed cognitively. Using survey data, we found that after being presented with 5 options, consumers appear to be less likely to choose any Medicare health plan, and opt for the "default" option of Medicare Fee-for-Service. In our experimental work, we find similar results. We ask consumers to choose, in a hypothetical environment, a Medicare Health Plan, or defer the choice. And, we randomize them to varying numbers of health plan options. We find results very similar to econometric analysis; after a certain number of options, consumers are no more likely to enroll in a plan, but to defer the choice. At the same time, we also randomized consumers to choices that included dominated options; these were options that are worse in all possible dimensions. Traditional microeconomics would tell us that consumers should not choose them, and that including them should not at all change the choices that consumers actually do make among the non-dominated options. We found that while consumers adequately avoided choosing the dominated options (we made them look very bad), including these choices as options seemed to change what choices they made among the *other* options. This further adds to the evidence that the way information is presented very clearly changes the choices consumers make.

As a final note about how consumers make health-oriented choices, I'll mention further work in progress done with my colleague Sewin Chan. We examined whether a core decision making capacity, cognitive ability, influenced whether Medicare consumers chose any supplemental coverage—something almost all consumers should be doing to minimize costs. Cognitive ability had a very large influence on whether these consumers made a choice. In fact, this factor was more important than even health or income. And, the effects were not limited to those at the very lowest end of the cognitive ability spectrum, but persisted throughout the bottom third of the spectrum to some extent, and even among the "young elderly" aged 65-69. This works indicates that we need to understand whether some consumers simply might not have the core decision making capabilities to make some choices without significant assistance. We need to extend this work into the employed population, as well.

Now, I'll turn my attention to possible behavioral economic solutions to some of these potential choice problems. Very briefly, behavioral economics combines economics and psychology for what are generally considered more realistic models of humans' choices and decision making. A general premise is that consumers are quite responsive to "nudges," or subtle influences that push consumers in a particular direction but do not necessarily fully dictate a choice (Thaler and

Sunstein 2008). Applying this approach is also called libertarian paternalism or asymmetric paternalism. In general, it can range from slight, subtle nudges to the use of “default” options that consumers are enrolled in or offered, while still maintaining the option to change to any of the available options or opt out of the choice.

As you likely know, these nudges have been explored and successfully implemented in non-health realms, though program like “Save More Tomorrow” (Thaler and Bernartzi 2004). In this and similar programs, consumers are by default placed into retirement savings accounts or portions of their raises are placed into retirement accounts. A basic premise of these approaches is that consumers can always opt-out or change the choice they are “nudged” towards, but that the path of least resistance will be the choice that is likely to be in the best interest of consumers.

These approaches are much less established in health in general and health plan choice in particular. Nor do we know whether health consumers are generally accepting of these sorts of approaches. Health is different than many other realms—it is a very personal aspect of people’s lives, and one where consumers are not generally accepting of a lot of interference by “outside parties.” We very recently undertook an experiment, funded by the Robert Wood Johnson Foundation, partially designed to understand how accepting consumers might be of these sorts of behavioral economic approaches, particularly those related to a “default” option.

We performed a hypothetical choice experiment. We utilized as subjects those in the waiting room at public hospital. As such, it is important to point out that many subjects were low-income individuals who are enrolled in Medicaid. Subjects were presented with a set of health center options and asked which health center they would choose. We randomized subjects to various experimental conditions, two of which were related to behavioral economics.

The first of these is what we call our “Pandora” option. Similar to the Pandora music service, we ask consumers for basic demographic information and then ask for their relative preferences on various health center characteristics like performance on preventative care, chronic care, etc. Then, we made consumers believe that we were using an algorithm to predict the health center that is likely “best” for them. In reality, we have not yet developed this tool, but simply randomly assigned them to a plan. In a sense, this plan assignment became a potential “default” option. As a second method to change the default, individuals were told which plan was located closest to them, and in reality we randomly assigned this plan as well. After subjects were given these assignments, they still had to actively choose a plan. As such, they had an opportunity to actively choose the plan we had “nudged” them towards or move away from this nudge.

We examined whether consumers accepted these “defaults” by looking at how many consumers stayed with the plan we assigned them versus moving to a new plan. For the Pandora condition, 58% accepted our nudge and in the location condition 52% accepted our nudge (based on people choosing in line with their preferences, this would only be roughly 25%). As such, a fair number of consumers are very accepting of the nudge and are willing to

accept where it leads them. And, interestingly, consumer acceptance of the nudge doesn't seem to change much depending on whether it is based on an algorithm for preferences or simply location. This calls to mind that consumers are very much looking for these sorts of tools.

Finally, I turn to what this might mean for the Department of Labor in general and this committee in particular. I believe that the current evidence is telling us that some subset of consumers is having trouble processing information about their health choices; the manner in which this information is presented also appears to influence their choices in non-trivial ways. And, we have not yet established the best manner in which to present health plan information to consumers. The information is complex, multi-faceted, and non-intuitive to many. As such, for some consumers it may be extremely difficult to present the full set of information in a way that proves useful. As a result, behavioral economics solutions, including the use of defaults, hold great appeal. As noted earlier, one could imagine various levels of a nudge. Take as an example the tool described above, similar to the Pandora music service that we utilized in our experiment. One could imagine utilizing this tool to suggest a subset of plans for consumers to choose (if many were available), suggesting the likely "best" plan for consumers (which we did), or even automatically enrolling consumers in a likely "best" plan. While the option to reject the choice that one is nudged toward is always available, these clearly differ in their level of paternalism.

I hope these remarks have been helpful, and I'm happy to answer any questions the committee might have. I thank you for the opportunity to testify.

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