

HEALTH INSURANCE COMPLEXITY LEADS TO CONSUMER WASTEFUL SPENDING



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Health Disparities Institute
POLICY BRIEF

ABOUT THE HEALTH DISPARITIES INSTITUTE

UConn established the Health Disparities Institute in 2011 as part of the Bioscience Connecticut initiative to enhance research and the delivery of care to minority and underserved populations in the state. Bioscience Connecticut is a package of state investments in UConn Health and other health care entities in the region, introduced by Governor Dannel P. Malloy, to bolster the state's health care and biomedical research capacities while creating thousands of jobs.

MISSION

To reduce disparities by turning ideas shown to work into policies and actions.

VISION

Everyone in Connecticut has an opportunity to enjoy good health and wellbeing.

Context

This report describes how health insurance complexity often leads consumers to select “the wrong” plan when lower cost alternatives with identical benefits are available.¹ Based on evidence to date we make recommendations that would make insurance plans simpler, easier for consumers to use, more affordable and ultimately more effective to promote good health and wellbeing for Connecticut’s most vulnerable residents. Recommendations are based on consumer surveys, focus groups, behavioral economics research, simulation experiments and systematic real-world observations.^{2,3} Much of the evidence was presented at a series of Health Insurance Simplification seminars hosted by the Health Disparities Institute between 2017 and 2018 and funded by the Connecticut Health Foundation. The focus of this brief is on commercial insurance such as plans purchased through an employer or through the Affordable Care Act (ACA) exchanges.

Health insurance complexity has been proven to be a major barrier to rational, informed and purposeful plan selection.^{4,5} While even savvy consumers have difficulty choosing and using a “just right” health plan the barriers are greatest for racial/ethnic minorities, people with less than a high-school education and those not fluent in English. From the societal point of view irrational consumer purchasing behaviors cannot lead to an efficient “consumer driven healthcare” as a market solution to health care unaffordability and quality woes.

Unravelling Health Insurance Complexity: A Case Study

Since consumers’ insurance preferences and goals are not observable, it may be hard to distinguish a “mistake” in selecting a plan from a personal preference. To understand what happens in real life, a large employer allowed wide discretion to its 23,894 employees to design their own health insurance. Employees had a chance to balance their health care needs with their household budgets, financial risk tolerance and other personal preferences. Employees could build their own plan combining one of each of the four common features of high deductible health insurance.

- four different deductibles
- two copays
- two co-insurances
- three out-of-pocket limits

Employees had up to 48 possible plan combinations; all had identical coverage and provider networks. The only difference was in cost sharing (out-of-pocket costs) and monthly premiums. Premiums were set such that employees would be guaranteed to spend more out-of-pocket than necessary if they chose any plan with deductibles under \$1,000, the highest deductible available. To illustrate how easy it would be to choose the wrong plan, consider the choices in Figure 1.

Figure 1: Which healthcare option would you choose?

Assume the plans have identical coverage and provider network, and covers all costs after the deductible has been met

Option	Annual Deductible	Monthly Premium
A	\$1,000	\$72
B	\$750	\$110
C	\$500	\$118
D	\$250	\$163

Source: (modified) Bhargava S, Loewenstein G, Sydnor J. Choose to Lose: Health Plan Choices from a Menu with Dominated Option. *Q J Econ.* 2017;132(3):1319-1372. <https://academic.oup.com/qje/article-pdf/132/3/1319/18773600/qjx011.pdf>.

The best answer to the question in Figure 1 is “A.” All other plans with identical coverage and provider networks will result in more out-of-pocket (OOP) spending for no additional benefits (see explanation in Figure 2 below). One problem is that the menu in this figure presents only the monthly premium, not the annual premium, making it more difficult to figure out which plans will save the consumer the most money after meeting the deductible. The result of the employer experiment was that over half of all employees made poor decisions in designing their own plan.

Figure 2, illustrates the same case, but the menu of choices shows both, the monthly and the annual premium. This makes it easier to see that plan “A” is the more economical choice.

Figure 2: Which healthcare option would you choose?

Assume the plans have identical coverage and provider network, and covers all costs after the deductible has been met

Option	Annual Deductible	Monthly Premium	Annual Premium
A	\$1,000	\$72	Multiply by 12 → \$864
B	\$750	\$110	Multiply by 12 → \$1,320
C	\$500	\$118	Multiply by 12 → \$1,416
D	\$250	\$163	Multiply by 12 → \$1,956

Source: (modified) Bhargava S, Loewenstein G, Sydnor J. Choose to Lose: Health Plan Choices from a Menu with Dominated Option. *Q J Econ.* 2017;132(3):1319-1372. <https://academic.oup.com/qje/article-pdf/132/3/1319/18773600/qjx011.pdf>.

In this example, if an employee preferred his/her insurance to “kick in” sooner by lowering the annual deductible from \$1,000 to \$750 — a \$250 annual savings — the employee would have to spend \$456 in excess annual premium, a net loss of \$206/year (\$456 minus \$250) for no additional benefit whatsoever. Other studies of employee plan selection have shown the same tendency of widespread “errors” (failure to select the most cost-effective plan from a confusing menu of choices).

Offering a wide variety of plan choices seems to make

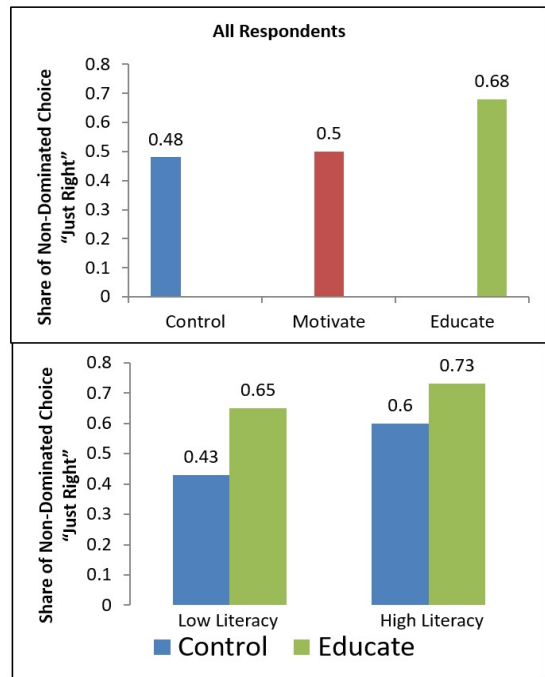
good sense given the variety of consumers’ healthcare needs, household budgets, risk tolerance and other personal preferences. However, analysis of the employer experiment and multiple other studies have shown that consumers cannot benefit from lots of choices because the decision is too complex.

The result is that people’s preferences do not lead them to logically select a "just right" plan. In fact, the employer experiment revealed some counter-intuitive outcomes: lower income employees (<\$40,000/year) were more likely to choose “the wrong” plan as were women (usually higher utilizers than men) and older employees.

Six reasons why choosing the “just right” plan is so hard

1. **Information overload:** The mental burden of sorting through too many complex choices compels people to disengage early from the decision process and take “cognitive shortcuts” based on an easily grasped factor such as the monthly premium.
2. **Financial risk aversion:** People may prefer a low deductible plan because they hate having to make repeated out-of-pocket payments for a longer period to reach the higher deductible. With low deductibles the insurance “kick-in” sooner and helps consumers avert the negative feelings associated with large or repeated out-of-pocket outlays. It has been shown that certain payment arrangements are more psychologically painful (e.g.: cash out-of-pocket) than others (automatic paycheck deductions). Consumers try to mitigate the psychologic pain of out-of-pocket spending by choosing low deductibles even if economically disadvantageous.
3. **Family budget constraints:** Choosing a plan based on monthly premiums is understandable if the family operates on a tight monthly budget. Being unaware that the annual out-of-pocket cost of insurance can be lower with an alternative plan is a missed opportunity to adjust household monthly budgets to realize the most savings. Failure to consider the annual cost of insurance is somewhat analogous to unknowingly borrowing money with interest.
4. **Low health insurance literacy (HIL).** People with low HIL have the added disadvantage of lacking convenient access to competent “insurance coaches” or navigators to help them through the maze. It has been proven that health insurance education and a motivational messages (e.g.: “you may be able to get the same benefit for less money”) can greatly enhance the likelihood of wiser choices (Figure 3). Subsidies such as Premium Cost Sharing and Premium Tax Credit

Figure 3: Impact of Health Insurance Education on Choice



Source: Loewenstein G, Health Insurance Simplification Seminar. December, 13, 2017. *This deductible amount is the best plan choice in this particular case

offered through the Affordable Care Act that favor one “metal” tier partially overcomes the negative effect of low health insurance literacy by driving consumers to purchase subsidized plans.

5. **Misleading insurance plan naming.** An experiment was sparked by concerns that metal naming conveys the wrong impression that Gold is always more valuable or better than Silver and Silver always better than Bronze as is the case with Olympic medals. When consumers were asked to choose from three metal tiers Bronze, Silver, and Platinum or from three “medical need” tiers based on anticipated medical utilization named “low care”, “medium care” and “high care” or from three neutral tiers named “A”, “B” and “C”. An additional choice included three generic named plans accompanied by a recommendation. All choices had identical coverage and network. The goal was to determine which naming system resulted in a better or “just right” selection. The “just right” plan was defined as the one with the lowest annual out-of-pocket cost compared to any other plan. In contrast, naming products based on the person or family medical need proved to be more helpful. The impact of testing is shown in Table 1.

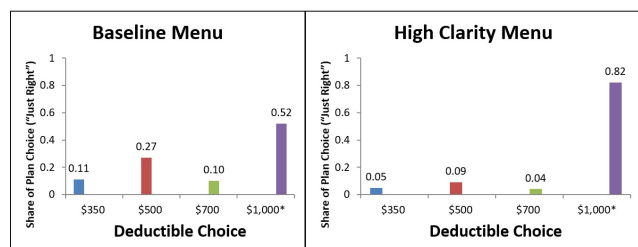
Table 1: How Naming Convention Impacts Insurance Coverage selection

Naming Convention	Over-Insured	Just Right	Under-Insured
Metal	43%	24%	33%
Medical Need	19%	53%	28%
Neutral Name	37%	40%	23%
Recommended	34%	47%	19%

Selection based on medical need yielded the highest proportion of “just right” choices. It is estimated that consumers “guided” by metal naming overspend an average of \$888/year.

- 6. Insufficient clarity of plan features and trade-offs among competing choices.** Improved methods of displaying insurance choices can greatly reduce errors, simplify consumer choice and facilitate the selection of a “just right” plan. Evidence shows that many consumers prefer graphical displays to tables because graphs make the choices more obvious. An example of these improved ways of presenting insurance choices are the so-called “consequence graphs” and “high clarity menus”. These have been shown to dramatically reduce consumer selection errors (Figure 4).

Figure 4: Plan Choice by Clarity of Plan Menu



Source: Loewenstein G, Health Insurance Simplification Seminar, December, 13, 2017.
 *This deductible amount is the best plan choice in this particular case

- 7. Decision Inertia:** After making an initial poor choice, many people tend to keep the same plan upon re-enrollment in subsequent years because the default (no change) is less time consuming and less mentally and emotionally burdensome. In the current system, the consequences of an initial poor choice often carry over to subsequent years which worsens the inefficiency of the insurance system.

Summary of Barriers and Recommendations

Caveat — Consumers are routinely advised to choose a plan that includes their provider(s) in the network and their drugs in the formulary. These considerations are extremely important and may override financial factors.

Barrier 1: Low health insurance literacy (HIL)

Recommendations:

- Policy changes requiring a significant boost in HIL education by carriers and the state educational system.
- Support grass-roots health insurance literacy consumer education, especially among racial ethnic minorities, non-English native speakers and those with less than a high-school education.
- Shore up health insurance literacy training for teachers, Community Health Workers, Certified Application Counsellors (CACs), clinic and

hospital front desk personnel.

- Make insurance documents easier for consumer to understand by lowering their reading level.

Barrier 2: Insufficient clarity in menu of insurance plans offerings.

Recommendations:

- Require carriers to display **annual and monthly premiums** alongside annual deductibles and out-of-pocket maximums.
- Simplify health insurance choice menus by adopting “consequence graphs” or similar displays.
- Encourage wider use of motivational messages to search for the “just right” plan, especially upon re-enrollment.

Barrier 3: Lack of decision support tools or health insurance coaching

Recommendations:

- Offer consumers access to decision support tool as part of the enrollment and re-enrollment process. The tool must estimate anticipated personal and family medical need and match it with a narrower range of plan choices.
- Test (with appropriate consent and consumer protections) the performance of artificial intelligence as an aid to selecting an optimal plan from a menu of choices.

Barrier 4: Misleading plan naming

Recommendations:

- Investigate legal and regulatory requirements for re-naming misleading tier names such as Bronze, Silver, Gold, while preserving the benefits of each tier and government subsidies.
- Consider all possible unintended adverse consequences of metal tier re-naming

Barrier 5: Eliminate predictably poor health plan choices from the menu of plans

Recommendations:

- Investigate the frequency, if any, of predictably disadvantageous plan choices (“dominated plans”) through AHCT and estimate their economic consequences for consumers.
- Investigate the use of predictably disadvantageous plans by member race, ethnicity, educational level and language preference.

Barrier 6: Confusing deductibles and co-insurance.

Recommendations:

- Simplify plan designs by phasing out co-insurance (first) and then re-structure or eliminate deductibles from plan offerings.
- Consider introducing the Basic Health Plan alternative as New York and Minnesota have already done*.

References

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Read the full report on our website:

<http://h.uconn.edu/hdi>

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