

POLICY BRIEF 2015-08

Getting the Most from Marketplaces: Smart Policies on Health Insurance Choice

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Getting the Most from Marketplaces: Smart Policies on Health Insurance Choice

The most significant recent reforms to the U.S. health-care system—the Patient Protection and Affordable Care Act (ACA) of 2010 and the Medicare Prescription Drug, Improvement, and Modernization Act of 2003—rely heavily on private provision of health insurance. A key feature of these reforms is that consumers choose among privately provided insurance plans, often with some form of subsidy. The reforms are predicated on the view that active and well-informed consumers choosing a health insurance plan from a large menu of options each year support vigorous competition among insurers.

However, a range of recent evidence suggests that it is difficult for those purchasing insurance to make fully informed and effective choices from among the many plans offered by insurers. Consumers must consider an array of complex calculations, including what out-of-pocket costs they will face when receiving care, what medical services and prescription drugs the plans cover, and which hospitals the plans allow them to use. In addition, consumers must make a short-term forecast about the amount and type of health-care services they are likely to need, which then determines their estimated costs, given their plan's deductibles and coinsurance payments. Numerous studies find large implied costs resulting from consumers miscalculating their health and financial risks and choosing a plan that is misaligned with their needs. And once they have selected an insurance plan, many consumers do not search for potentially better plans as they become available, even if their chosen plan becomes more expensive. As a result, consumers stand to lose because of higher health-care costs, and federal and state governments are forced to pay the larger subsidies that accompany more-expensive health plans. For example, considering Medicare Part D alone, research shows that the federal government spends an extra \$5 billion a year in the low-income subsidy market, where it bears virtually the full burden of poor consumer choice. Indeed, selecting an insurance plan remains a complex—and expensive—endeavor.

In a new Hamilton Project discussion paper, Ben Handel and Jonathan Kolstad of the University of California, Berkeley, propose a series of reforms to facilitate more-informed and more-effective choices by consumers who are using publicly operated health insurance exchanges. The authors focus on these exchanges because they are an increasingly common means of purchasing private insurance, there is substantial evidence that consumers and the government would benefit, and publicly operated exchanges are already required under

the ACA to implement a decision support tool. Operationally, the authors' reforms would promote a more-targeted consumer search tool than is currently used when consumers are choosing among plans offered through Medicare or the health insurance exchanges. Handel and Kolstad also propose a more proactive set of smart default policies designed to apply behavioral nudges to assist consumers in choosing the best plans for themselves. Private employers may also benefit from implementing the changes promoted by Handel and Kolstad, and they would not need new legislation or regulation to do so.

The Challenge

Many consumers spend more money than they need to on health insurance for a mix of services that may not be best suited for them, needlessly inflating costs for themselves and adding to government expenditures. The challenge posed by the current system, according to Handel and Kolstad, is the misalignment between consumers' selected insurance plans and the insurance plans that best suit consumers' individual preferences and needs. Given the cost of insurance plans and consumers' health-care needs, sensitivity to risk, and preferences for particular physicians and hospitals, picking the right plan can be difficult. As a result, consumers pay more for insurance than needed, and when consumers obtain these plans through the ACA exchanges or Medicare with the help of a subsidy, their excess payments translate into higher federal and state government outlays.

The authors argue that there are two main reasons for the misalignment between the best plan for a consumer and the plan she may choose. For one, consumers may lack the high-quality information necessary to select the plan that would be best for their needs. For example, in many scholarly studies, the authors and other scholars observe that consumers lack information on a range of important primary insurance features, including (1) the plan's financial characteristics (e.g., deductibles, coinsurance, and out-of-pocket maximums), (2) provider networks, and (3) their own financial medical expenditure risks. As a result, consumers overpay for more-generous insurance coverage than is needed to pay for their expected health costs. Handel and Kolstad also suggest that consumers may have trouble making sense of the information they receive. Looking across a range of studies, there is evidence of consumers choosing plans that could never deliver greater financial value than other available options. As a result, consumers overpay for health insurance—in one estimate by an average of 42 percent of their annual premiums. Other studies point to consumers inaccurately comparing the financial characteristics of their plan options, costing themselves hundreds or thousands of additional dollars.

Second, Handel and Kolstad point to the problem of consumer inertia in changing plans. Many consumers exhibit inertia by passing on the opportunity to switch plans when a better-aligned plan is available, perhaps owing to high switching costs. The effects of inertia often worsen over time: not only do consumers continue to pay for more insurance coverage each year than they need, but consumers' health profiles and insurance needs also change in a way that often leads to even greater misalignment over time between consumers and their health plans. The authors point to a large body of literature showing how inertia is costly for consumers, above and beyond the costs stemming from consumers' selection of coverage.

A New Approach

Handel and Kolstad offer two solutions to address these challenges: providing personalized recommendations through a decision support tool to help consumers choose plans, and implementing smart defaults to counteract the effects of consumer inertia in the insurance market. They call for the Centers for Medicare & Medicaid Services (CMS) and operators of the state health insurance exchanges to

1. Adopt and promote a narrower and more-targeted consumer search tool based on algorithms that assess consumers' projected needs and how they might experience each plan, and
2. Create an opt-out system of health insurance plan selection, where the insurance exchange regulator switches a consumer from a poorly matched to a well-matched plan during the open enrollment period but only if the regulator is highly confident that the consumer would be made better off and if the consumer can easily switch back to the previous plan.

Notably, their proposal is an extension of the ACA requirement that some form of consumer search tool be provided by any ACA exchange. They propose that CMS and the state exchanges use the authority in the ACA to develop decision support tools that are more precise and that take into account individual-specific characteristics, potential future health-care costs, risk protection, and hospital and physician networks.

To implement personalized recommendations and smart default policies, the necessary data infrastructure must be in place. Such an infrastructure would encompass information about plans' benefit design and coverage of health-care networks, consumers' health needs, their preferences for providers, and so forth. Handel and Kolstad note that the optimal data infrastructure for their policies is an all-payer claims database, which incorporates medical claims at the individual level from all insurers participating in a given exchange. An infrastructure incorporating these data can be used to either recommend plans or implement smart defaults in a highly targeted way for each individual at the time of plan choice.

Because many exchanges are years away from being able to implement such a system, the authors propose that a basic database with more-limited fields be used in the short term. Such a database would include individual-specific information (such as basic demographic data collected by exchanges or provided by users, as well as limited administrative information providing rough indicators of individual health conditions), up-to-date information on hospital network inclusion and benefits, and standardized descriptions of benefits and coverage. A combination of these data would allow exchanges to implement personalized recommendations and smart default policies to varying degrees.

Personalized Recommendations and Decision Support

Handel and Kolstad identify four key elements to facilitating effective personalized recommendations and decision support:

1. Individualized Plan Cost Calculator

First, any personalized decision support should allow an individual to understand how much she can reliably expect to spend in each plan offered to her. This information should be provided as a total, plan- and individual-specific, expected out-of-pocket cost. Cost calculators should incorporate the potential costs of hospital and physician services as well as those of medications under each plan.

Critically, these proposed cost calculators would be both forward looking and personalized. That is, unlike many existing cost calculators that use average enrollee characteristics, the proposed calculators take into account a range of future health-care outcomes for a specific individual. The cost calculators rely on algorithms to assess consumers' preferences and how they might use the services of each plan. These algorithms use predictive models in a similar way as the product recommendation features of non-health-care online marketplaces such as Amazon or Netflix. Specifically, a predictive cost calculator would take information that an individual would supply (e.g., age, gender, zip code, and current medications) and predict how much that individual can expect to spend in each plan. Data from potentially millions of other individuals' actual medical experiences, as well as from plan benefits and other sources, would inform this prediction. In addition to predicting the average experience for an individual, it also allows for an assessment of "good" and "bad" scenarios, again based on individuals' personal characteristics and health status.

2. An Assessment of Individualized Risk Protection

An important goal of the decision support tool is to help individuals understand how each plan provides coverage in different potential health scenarios. As in the cost calculator case, a tool with sufficient data would help individuals understand the protection that a plan provides without them having to do a lot of computation on their own. For example,

suppose a Medicare enrollee is choosing between two Medicare Part D benefit options to cover her drug spending. Suppose that the current medications she is taking have precisely the same expected out-of-pocket cost (i.e., the premium plus the deductibles, coinsurance, and copayments for those drugs). Suppose further that one of the plans is much more restrictive and does not cover many frequently prescribed drugs. A risk-averse consumer—and appropriate decision support for that consumer—would prefer the more generous plan because the downside risk is larger in the plan with less coverage for the same price today. Although this particular weighing of the risks and benefits is common for people buying insurance, existing decision support tools rarely incorporate these considerations.

3. Information about Hospital and Physician Networks

The authors propose a comprehensive tool that will allow individuals to evaluate the breadth and quality of available networks of hospitals and physicians under each plan. One version of this tool would provide individuals with the ability to sort or screen out plans by which doctors and/or hospitals are covered. An alternative version of this tool would allow consumers to understand the costs and benefits of all plans, including those without coverage for some or all of their hospital and physician preferences. Either option has its share of trade-offs: although the first version is simpler to implement, requiring only network information for each plan, it could leave individuals without the ability to easily balance costs with network generosity, a major advantage of the second version.

4. Information about Individual Preferences

Taking the ability to evaluate networks of hospitals and doctors to the next level, the authors propose extending the decision support tool on individual parameters. Unlike under the previous element, where consumers have to sort and screen out plans using the available criteria (e.g., covered hospitals, physicians, or costs), the authors propose integrating data about individuals' preferences and expected utilization to deliver customized recommendations. This would simplify the demands placed on consumers, eliminating the need for them to analyze different network combinations and trade-off costs between networks.

The primary goal of personalized decision support should be to enhance consumer well-being by moving consumers toward choices that best reflect their underlying preferences over health-care access, insurance product quality, and financial risk protection. A decision support tool that provides personalized recommendations along the lines of the four elements described here would make significant progress toward achieving this goal.

Roadmap

- The Centers for Medicare & Medicaid Services (CMS) and the operators of state insurance exchanges will adopt and promote a narrow and personally targeted consumer search tool based on algorithms that assess consumers' projected needs using a combination of administrative and consumer-provided information. The decision support tool will have four components:
 1. Individually customized plan cost calculator;
 2. Individually customized assessment of risk;
 3. Hospital and physician network information; and
 4. Information about individual preferences.
- CMS and the state exchange regulators will implement a smart default model in which the regulator switches a consumer from a poorly matched to a well-matched plan during the open enrollment period.
 - Regulators will develop and use statistical models of health risk based on administrative individual-level data to predict the probabilities of different levels of total medical spending among individuals the next year. Regulators will combine their models with a model of insurance plan payments (for each plan in the market) to assess the expected financial benefit from the new default.
 - Consumers will be switched only if there is a demonstrated financial gain, minimal extra risk exposure, and continuity between providers covered in the current and proposed plans.
 - Consumers will maintain the ability to opt out of their smart default plan, returning to their current plan or selecting a new plan from the menu of available options.

Learn More about This Proposal

This policy brief is based on The Hamilton Project discussion paper, “Getting the Most from Marketplaces: Smart Policies on Health Insurance Choice,” which was authored by

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Smart Defaults

Noting that inertia can have a large negative impact on the value consumers derive from using insurance exchanges, Handel and Kolstad next propose defaulting consumers into the best low-cost, high-quality plan available. Using the same tools that enable personalized search, exchange operators and regulators will automatically enroll consumers in the plan that is best predicted to fit their individual needs. All enrollees would still have the ability to opt out of the default and instead choose from any of the available plans.

According to Handel and Kolstad, the design of their smart default model will rely on three components:

1. Increase in Expected Plan Value

Consumers’ expected financial benefit from the new default option, relative to their current plan, should be greater than some given amount, which will depend on the confidence the exchange regulator has in its assessment of insurance plans and differences among consumers.

2. Minimal Extra Risk Exposure

The exchange regulator will determine the maximum allowable financial loss from switching consumers’ default options from their current plan to the new default. This threshold will be based on a model incorporating consumers’ income, family status, and risk aversion.

3. Provider Continuity

Consumers’ new default options would contain all medical providers from which consumers have regularly received care over the past two years. Regular visits would be defined by the exchange regulator and could be health-condition specific. If key regular providers are not in-network for a candidate default option, consumers will not be defaulted into that option.

Specific regulators can fine-tune their smart default policy to be more or less aggressive depending on how they weight the potential gains in value relative to the losses that might occur through misassignment. A more-aggressive policy would:

(1) reduce the amount that triggers a switch from consumers’ current plan to the low-cost alternative; (2) increase the size of the maximum worst-case outcome for consumers who are switched to new plans; and (3) reduce the permissible range of available in-network providers (while allowing the consumer to keep those providers currently used). The regulator could thus implement this policy in a manner that only defaults, for example, the 1 percent of the sample who are leaving substantial value on the table into a new plan, or, in contrast, the 50 percent of consumers who seem to be leaving some value on the table.

Consumers would be notified if they had been switched to a new plan. They would then have a set period of time to change back to their prior plan or enroll in a completely different plan (by doing none of these things, they would remain in the new plan). The length of time consumers have to act on their default would fall to the discretion of individual exchange regulators, though one guide could be existing open-enrollment periods.

In cases where the federal government is subsidizing enrollee cost sharing or premiums, Handel and Kolstad argue that there is both an opportunity and a clear rationale to take decision support a step farther with smart defaults. In many cases those individuals who receive government subsidies when enrolling in insurance do not feel the impact of their cost errors because cost sharing is partially or fully covered by the subsidies. Therefore, much of the burden falls on federal government budgets. As noted, one study predicts that the federal government could save \$5 billion a year in Medicare Part D alone from implementing a simple smart defaults policy.

Handel and Kolstad emphasize that a smart default policy will be the most effective policy in encouraging consumers to enroll in high-value insurance options given the current market structure, and should always deliver more value than implementing a decision support tool without smart defaults. Nevertheless, the availability of data will vary from exchange to exchange, making the first proposal of personalized recommendations and decision support valuable on its own, especially in the near term.

Conclusion

There is considerable evidence that consumers could save money on health insurance. Handel and Kolstad offer two proposals to help consumers achieve lower health insurance costs: personalized recommendations and decision support to address the lack of useful information available to consumers, and smart defaults to address the tendency of consumers to retain their current coverage even as better plans become available. These changes will improve consumer welfare by matching them with the high-quality, low-cost plan that best fits their needs. The public budget impact of insurance subsidies will also be substantially reduced.

Questions and Concerns

1. What are the data privacy implications of this proposal to individuals and insurers?

Medical privacy law (e.g., the Health Insurance Portability and Accountability Act of 1996 [HIPAA]) may restrict the way that individual-level data can be shared with regulators. There are many examples of high-quality recent research conducted using appropriately anonymized, individual-level data that are compliant with HIPAA. Using this as a guide, sufficient anonymization can be achieved to support the two proposals outlined here.

In addition, insurers may be unwilling to share their data, and may not be compelled to do so, especially if their claims data contain proprietary information. However, more-sensitive types of information can typically be removed without reducing the detail of the data that is necessary for supporting consumer choice. This is an issue that will be at the center of the upcoming Supreme Court decision *Gobeille v. Liberty Mutual Insurance Co.* (2015) that may limit the ability of all-payer claims database operators to subpoena data from private insurers.

2. What are the technical barriers that would impede implementation of the proposed reforms?

In the short run, many insurers and state governments may lack the technological expertise or data infrastructure themselves to build a centralized system. Relying on private vendors who are able to develop these tools and harness existing data is a plausible and likely efficient solution, particularly in the short term.

Furthermore, if it takes a long time to transfer data from an insurer to the centralized data repository, data might not be sufficiently current, leading to worse recommendations or choice predictions. While there is value in rapidly updating data, the need to choose a health plan is reasonably infrequent. Infrequent choice, combined with widely available retrospective data to support decision making and smart default tools, means this issue is unlikely to become a major barrier.

3. Can smart default policies backfire?

Policymakers in any health insurance market should assess whether smart defaults will be too effective in getting consumers to switch insurance plans. For example, if the regulator's smart default option is not sufficiently nuanced, it may end up steering many consumers toward one or two insurance options. This clustering could reduce competition in the market by favoring one insurer over others. Additionally, insurers could try to use the smart default model to their advantage by improving plans on certain dimensions and reducing coverage on dimensions not sufficiently valued by the smart default algorithm to attract more consumers. Thus, while smart defaults have the potential to increase competition by effectively creating more price- and value-sensitive consumers, they also have the potential to harm competition by heavily favoring certain options and expanding their market share.

To this end, regulators can implement a policy that limits the percentage of consumers in the market that can be defaulted into a given insurance option (with a mechanism for determining the consumers with the most to gain from that default option). This limit would be effective in situations where regulatory capture or models that favor specific insurance plans are issues.

Highlights

There is substantial evidence of consumers miscalculating their health and financial risks when choosing health insurance, which often results in extra costs that can run into the hundreds of dollars. Evidence also documents consumers remaining in their selected health insurance plans, even as better and more cost-effective options become available. In addition, since federal and state governments often subsidize private health insurance, public outlays are much higher than they need to be. Ben Handel and Jonathan Kolstad of the University of California, Berkeley, offer two proposals to help consumers select the health insurance plan that is cost-effective and best aligns with their needs. They focus on those individuals enrolled in the federal and state-run insurance exchanges, including the ACA exchanges, Medicare Part D, and Medicare Advantage.

The Proposals

Introduce a Decision Support Tool with Personalized Recommendations. This tool would incorporate an individualized cost calculator, an assessment of risk, hospital and physician network information, and individual preferences.

Institute Smart Defaults. The exchange regulator would switch consumers from their current plan to a new plan if the new plan offered more value, minimal new risk exposure, and continuity of covered providers. Consumers would maintain the ability to switch out of the smart default plan to retain their current coverage or to select a different plan.

Benefits

These proposals would benefit the consumer, helping her to save up to hundreds of dollars each year. Federal and state governments could also save billions of dollars from the reduction in subsidies that results from better matches between consumers and their insurance plans.



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