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What Do We Know About Health Insurance Choice?

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Medicare for All and Beyond

CONFERENCE BRIEF SERIES

WHAT DO WE KNOW ABOUT HEALTH INSURANCE CHOICE?

Lessons for health care reform

EDITOR'S NOTE

In February 2020, Penn's Leonard Davis Institute of Health Economics (LDI) held a [conference](#), *Medicare for All and Beyond: Expanding Coverage, Containing Costs*, which included a panel discussion on the value of giving consumers a choice of health insurers.¹ At that time, "choice" was a rallying cry for proponents and opponents of various health care reform proposals. Since then, COVID-19 has shifted many people's health care priorities. While the full impact of the pandemic remains to be seen, the nation will inevitably return to important policy debates around health care reform. The role of consumer choice in health insurance will be central to those debates.

INTRODUCTION

From choosing a doctor to selecting an insurance plan, choices pervade nearly all aspects of our health care system. However, there is [little agreement](#) among policymakers and the public about what constitutes "choice," which choices are important, and how and whether patients should be asked to make various health care choices.² Although Americans claim to value having health insurance choices, research shows that when presented with options, people do not actually like to choose. Other studies suggest that people

frequently make health insurance decisions that leave them worse off, or not much better than before.

At Penn LDI's *Medicare for All and Beyond* [conference](#), a panel of researchers and policy experts discussed the current evidence around health insurance choice and implications for future health care reform efforts.¹ This brief summarizes the panel's key takeaways.

THE ROLE OF HEALTH INSURANCE CHOICE IN HEALTH CARE REFORM

“Choice” has featured prominently in the recent health care reform debate about insurance coverage. Opponents to a single-payer plan, such as Medicare for All, argue that it would [limit](#) Americans’ ability to select their coverage and care.³ However, supporters contend that while single-payer would eliminate choice of *health plan*, it may [expand](#) choice of *provider*. Since most providers would be in the same government-run plan, consumers would have a larger selection of doctors, hospitals, and other providers than under our current multi-payer system. Others advocate for a more incremental approach to insurance expansion. For instance, a “public option” such as [Medicaid buy-in](#) or [Medicare Extra for All](#), would increase health insurance choice because all individuals would become eligible to enroll in public insurance.^{5,6} Similarly, proposals to lower the [Medicare eligibility age](#) would expand health insurance choice by allowing individuals to enroll in public coverage earlier in life. Unlike a single-payer plan that would eliminate private insurance, under a public option, people would still have the choice to enroll in a private plan.⁷

The role of choice in health insurance is not new. According to Hoffman (2020), the [issue of choice](#) in health policy can be traced back decades, at least to the reproductive rights and disability rights movement.⁸ Health insurance choice first appeared on the health policy main stage during the [Nixon health reform proposal](#) of 1974, and again in the [Clinton health reform proposal](#) of 1993. The Clinton proposal, which emphasized plan competition, required that every consumer be offered a choice of at least three different plans in their region.^{9,10} Hoffman notes that the idea of “choice” quickly became [ingrained](#) in public programs administered by private insurers, such as Medicare Part D prescription coverage, Medicare Advantage,

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and Medicaid managed care.⁸ Health insurance choice was also a cornerstone of the Affordable Care Act (ACA), which created individual and small group marketplaces to [expand coverage](#) and put consumers “[back in charge](#)” of their care.^{11,12} The marketplaces, along with pre-existing condition protections, community rating and guaranteed issue requirements, and Medicaid expansion, gave millions of individuals [new options](#) for coverage.¹³

As policymakers and the public contemplate the next era of reform, it is important to re-examine the implicit assumptions surrounding health insurance choice, and the current evidence on how that choice actually plays out in practice.

CHOOSING TO NOT CHOOSE

Americans say they value choice, but evidence suggests that people do not actually like to choose. In the context of health insurance, consumers who can [switch health plans](#) rarely do, often [foregoing](#) hundreds of dollars in savings.^{14,15} This is true for employees choosing employer-sponsored health insurance, Medicare beneficiaries choosing a prescription drug plan, Medicaid enrollees choosing a managed care plan, and people choosing individual coverage on the health insurance marketplaces. How can we understand this paradox of choosing to not choose?

Some people may want to avoid the hassle associated with choosing or switching plans. Changing plans can generate substantial “[switching costs](#),” in terms of time, effort, and psychological stress.¹⁶ Similarly, people [tend to stick](#) to their current state of affairs (i.e., status quo bias) and overestimate potential losses while underestimating potential gains (i.e., loss aversion). Consumers are also less likely to make active choices when they are faced with [too many options](#) or complex information. This [choice overload](#) can interact with [status quo bias](#), leading many people to end up with the default plan when enrolling in or renewing their coverage.¹⁷⁻¹⁹

CHOOSING UNWISELY

Even if people can overcome these barriers, exercising choice does not always deliver much value. A large body of research shows that we frequently make decisions that leave us [worse off](#), or [not much better](#) than before.^{17,20} Underlying the value of choice is the economic behavioral assumption that consumers will make choices based on well-ordered preferences, and that these preferences determine our willingness to pay. Why, then, do we make suboptimal health insurance choices?

First, information about the value of different health plans may not be [readily observable](#) to consumers, making it difficult to choose the optimal plan.²¹ Second, our preferences for intangible goods (such as health care services that we have never experienced) are [not always clear](#) or well-ordered.⁸

Lastly, many people do not have the necessary financial literacy to evaluate their health care options, and lack a basic understanding of health plan characteristics. In one study, most people expressed confidence in their ability to comprehend their health insurance, but only [14 percent](#) could correctly identify the four main components of a health plan (copay, coinsurance, deductible, and out-of-pocket maximum).²² Even people with above-average financial literacy skills struggle to choose among health plans, selecting the most cost-effective plan on a simulated health insurance marketplace only [half of the time](#).²³

INFLUENCING CHOICE

Studies show that our views can be influenced. In a [recent experiment](#), James Fishkin and colleagues found that even Americans' "staunchly held" political beliefs can be changed in a matter of days. Bringing together over 500 registered voters, Fishkin found that many participants' views on health care reform changed significantly after a weekend of dialogue and deliberation. For instance, Republicans' support for ACA repeal declined from 70 to 48 percent, while Democrats' support for Medicare for All decreased from 70 percent to 46 percent.²⁴

While these high-level views of health care reform can be *changed*, evidence suggests more limited success in *improving* people's choices on health insurance marketplaces to maximize personal value. Some [consumer choices](#) can be influenced by changing choice architecture (i.e., how we frame information) or subtle nudges (i.e., behavioral prompts). The ACA tried techniques such as plan standardization, grouping plans by metal level, and decision-support tools to help marketplace enrollees make more optimal plan selections.¹⁹ However, in some instances, metal levels [confused shoppers](#) and resulted in worse plan choice.²⁵ Interventions such as [smart defaults](#) (which present preselected plan options based on an individual's health care use) can substantially improve consumers' abilities to enroll in cost-effective plans, though these defaults dampen the degree of "choice" involved.²⁵

In [one experiment](#), Colorado marketplace enrollees received one of two messages that highlighted potential savings from switching plans: a generic message that indicated the possibility of savings, or a personalized message with specific premium savings information. Though both nudges increased consumer shopping by 23 percent, few consumers actually switched plans.²⁶

As the panel discussed, much of the resistance towards a single-payer plan may stem from Americans' distrust of the government to make health insurance choices for us and design a high-quality plan that is effective for everyone.

CHOICE, AUTONOMY, AND TRUST

Some panelists suggested that our desire for health insurance choice is not actually about choice, but *autonomy*. This implies that our concerns about choice may vary by the level of trust we place in other agents or stakeholders (such as the government, our employer, or the market) to structure our health insurance options. As the panel discussed, much of the resistance towards a single-payer plan may stem from Americans' distrust of the government to make health insurance choices for us and design a high-quality plan that is effective for everyone. Transparency and oversight play a key role in whether we trust another actor to make choices on our behalf and whether we value the choices they present to us. Concerns about autonomy and trust ultimately make it difficult to limit or eliminate people's health insurance options.

CONCLUSION

Implications for Health Care Reform

Given the mixed evidence around the value of health insurance choice, what role should it play in the next era of health care reform? Here we offer a few insights for policymakers as they consider different proposals.

- **Further enhancing choice should not be the primary goal of health care reform.** When it comes to health plan choice, consumers have a lot of options, but having choices does not seem to make people better off. Moreover, offering more health plan choices does not necessarily mean that they also will be more [affordable](#).²⁷ Health care reform should focus on improving quality and affordability – the number one concern of health care consumers – rather than maximizing choice.

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- **There is often a tradeoff between choice of health plan and choice of provider.** A single-payer system where all providers are under the same plan would eliminate health plan choice, but likely increase provider choice. In a system that preserves our current multi-payer structure (such as a public option or expanded Medicare eligibility), this dynamic is flipped: we may have greater health plan choices, but more restricted provider options in any one plan. When crafting a health care reform proposal, policymakers will have to decide which type of “choice” to prioritize.
- **We should make plan selection simpler.** As we have seen with the ACA and consumer shopping studies, some [strategies](#) could help improve plan selection, including offering simplified and standardized plan options, defaults, financial calculators, and nudges.²⁸ Whether policymakers pursue sweeping health care reform, make incremental changes, or stick with the status quo, policies should be designed to help people make easier and better decisions in all health care contexts, including plan selection.
- **Having fewer, well understood choices, may help preserve autonomy.** As our panelists suggested, our desire for options may reflect our desire for autonomy. However, in a market where health insurance options are confusing and expensive, having more choices does not necessarily increase consumers’ sense of autonomy. When crafting a health care reform proposal, policymakers should consider whether offering a smaller set of choices – if well understood by consumers – could preserve consumers’ autonomy.

Health insurance choice will undoubtedly play a role in the next era of health care reform. However, it should not be considered an intrinsic good, nor as a feature of only one type of reform. Policymakers will be tasked with deciding whether reform should enhance or constrain health insurance choice, and the tradeoffs associated with each option. Where choice is constrained, decisionmakers – whether policymakers, payers, providers, or consumers – must be explicit and strive for transparency.

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THANK YOU

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