The (Ir)rational Consumer and the Case for High Deductible Health Plans

By Mark Mack
High-deductible health plans (HDHPs) have become a prominent feature in the landscape of American health care. In 2003, only 1 million people were covered by HDHPs; by 2014, that number had grown to nearly 17 million. Sixty percent of large private employers now offer HDHPs.¹

Part of the reason these plans have become so popular is that they clearly reduce the employer’s cost of providing health benefits to the workforce. Employers can realize hard-dollar savings quickly compared to programs like wellness initiatives. A recent survey showed that HDHPs have provided lower annual premium costs for employers — about $1,000 (18 percent) lower for individual employees and $1,500 (12 percent) lower for families, compared to traditional plans.² Further, evidence suggests that HDHPs reduce costs for employees, with HDHP participants reducing their health-care spending by 5 to 14 percent after the switch.³

The problem is that these savings are not necessarily obvious to employees as they scrutinize their health benefits options. By definition, HDHPs have a high deductible (usually between $6,000 and $10,000 for an individual, and $15,000 and $20,000 for a family⁴), which puts the onus on the plan participant to make cost-conscious decisions about using health care. This approach runs counter to (more familiar) traditional plans, which have relatively low (or no) deductibles and co-pays, obscuring the true cost of medical services from the plan participant. Employees tend to stick with the status quo unless they see a clear and compelling reason to switch.

But plan sponsors need to be sure they’re looking at the big picture. In theory, a higher deductible will lead the participant to forego unnecessary care and to choose more efficient providers when care is needed, but studies have not shown that these reductions are rational and well-researched choices. One study showed that HDHP participants indiscriminately reduced their use of all care,⁵ and another indicated that HDHP participants with chronic conditions moderately reduced their adherence to prescription drug regimens, especially for asymptomatic conditions such as hypertension and high cholesterol.⁶ Studies have also failed to prove conclusively that patients with HDHP plans switch to lower cost providers; one study (which examined only prescription drugs) showed only a small shift toward generic and mail-order alternatives.⁷

These findings are even more of a concern because most studies of HDHPs were conducted years ago, when the total number of participants was relatively small and, research has found, made up of employees who tend to be more knowledgeable and conscientious about their health than the average patient.⁸ These individuals were therefore more likely to make better-than-average choices. As employers expand the number of participants in HDHPs, enrollees are likely to include those who are not knowledgeable and conscientious early adopters. Moreover, research has shown that over time, HDHP participation does not increase participants’ knowledge and conscientiousness about their health care.⁹ This means that as the number of less knowledgeable and less conscientious HDHP participants increases, the rationality and wisdom behind the decisions participants make might, in fact, decrease — unless we rethink some of the assumptions behind HDHPs.

A FLY IN THE OINTMENT

HDHPs are rooted in the classic economic idea of the “rational consumer,” which assumes that all consumers: 1) behave rationally; 2) know their preferences; and 3) have all the relevant facts about the products or services they are planning to purchase. In recent years, however, these foundational assumptions of classic economic theory have faced serious challenges from the rising field of behavioral economics.¹⁰

Behavioral economics introduces aspects of behavioral psychology into the analysis of economic decision making, producing an array of experimental evidence showing that people often make different decisions than classic economic theory would predict. For example, imagine that you are paired up with another person, who is given $10. That person
is then told they have the option of splitting the $10 with you in whatever way they see fit. However, you have the option of vetoing the entire deal if you don’t like the split that the other person has decided on. If you exercise your veto, then neither of you gets anything. Now, imagine that the other person decides to take $8 and give you $2. What do you do?

Classic economic theory suggests that taking any split offered is the rational thing to do because $2 is more than you had before, and more than you would get if you exercise your veto. In experimental settings, however, participants routinely reject offers of $2 or less and sometimes even reject offers that are less than half. These results hold when the amount of money in play is increased to equal three month’s salary. Irrational decision making is prevalent in many real world situations as well, including health-care choices.

Questioning the assumption of the rational consumer does not invalidate classic economic theory and HDHPs. Rather, it presents an opportunity to apply findings from behavioral economics to HDHPs to create more effective health-care plans. Let’s consider a few common challenges HDHPs encounter and how they might be approached using behavioral economics.

**PROMOTING HDHP ENROLLMENT**

Classic economic theory predicts that consumers will choose an optimal amount of medical services based on their needs and the costs, but behavioral economics tells us that consumers are loss averse. People derive more dissatisfaction from loss than the satisfaction they take from gains — by twice as much, according to behavioral economists. For example, a person’s happiness in finding $10 is less than the regret they would experience if they lost $5.

Mitigating Perceptions of Loss. Traditional plans heavily subsidize non-catastrophic services, so employees who switch from a traditional plan to an HDHP pay more out of their own pockets. Behavioral economics suggests that to make HDHPs seem more enticing, the employer must mitigate the perception of loss.

Fortunately, the U.S. tax code provides an easy way to accomplish this: a health savings account (HSA). Employees and employers can contribute pre-tax funds to HSAs to cover health-related expenses. An employer can moderate the perception of loss by not only providing a HSA, but also using some of the savings gained from switching to an HDHP to make contributions to the account.

Seeding an HSA with funds does much to reduce the employee’s perception of potential loss, especially since (unlike flexible spending accounts) money in an HSA does not expire at the end of the year. An HSA is also “owned” by the employee, so it will “travel” with the employee to a new employer.

Make HDHP the Default. Make use of our propensity to stick with the status quo by automatically enrolling all new employees in an HDHP (if this is legally permissible). Employees can still choose other options that may be available, but an employer-selected default option often leads to better outcomes than leaving the choice open. In this case, employers may want to “screen” employees to make sure HDHP is a good fit.

The concept of default options can even be expanded into programs that support HDHPs. For example, if an online comparative shopping tool would normally require participants to register, the employer might register participants on their behalf.

GFOA’s Strategic Health-Care Plan Designs best practice provides important information that local governments should keep in mind when making decisions about implementing a new health-care plan or making changes to an existing plan.

The document is available at http://gfoa.org.
MAXIMIZING BENEFITS

Even after an employee enrolls in an HDHP, behavioral economics suggests that the enrollee might adjust his or her usage. As employees switch to paying out of pocket, they tend to minimize their perceived losses by seeking out fewer preventative services — which can have a negative effect on long-term health.

Provide Support. Plans can be designed to subsidize high-value services that employees might otherwise underuse, like preventive services. Employers can also supplement an HDHP with software and apps designed to help people comply with treatment regimens. For example, predictive analytics can be used to forecast which employees are at risk for misusing medications, based on available claims, clinical, and intervention data — RxAnte has a library of resources. In addition, apps can remind people to take medications on schedule.

Establish an Onsite Clinic. Classic economic theory tells us that the main reason employees fail to use the most efficient provider of medical services is that they don’t have access to relevant cost information — and indeed, pricing medical services can be difficult or impossible. We are seeing some initial movement in the medical and insurance industry to make medical costs more transparent, but there’s a long way to go. And the decision-making process needs to be as straightforward and easy as possible because, according to behavioral economists, most decisions are based on intuition, gut feeling, and rules of thumb. It is far less common for people to put in the work needed for a rational analysis. The implication is that making information available for rational analysis by the plan participants won’t be enough.

A solution to this issue is the onsite clinic. An onsite clinic provides a number of key medical services in a facility the government operates at, or very near, the workplace. Office hours and scheduling are convenient. With such a clinic, the most cost-effective option is literally across the street. (For more information, see “Considering an Onsite Clinic,” by Vickie Chan, in the December 2015 issue of Government Finance Review.)

Prescription Drug Support. Technology can help employees find cost-effective prescription drugs. For example, despite a surprising amount of variation in the retail price of prescription drugs (even in the same neighborhood), most consumers will, by default, go to their preferred pharmacies. To fight this tendency, employers can promote technologies that aggregate pricing information, helping employees perform price comparisons using a web browser or an app. GoodRx.com, a useful tool for this purpose, found one commonly used drug priced at $154 at one pharmacy, and at $14.38 at another pharmacy nearby.

A similar tool, healthcarebluebook.com, provides “fair price” information about common medical procedures like x-rays, and ratemds.com catalogs information about individual physicians. These kinds of technologies are in their infancy, and comparison shopping for medical services is not nearly as straightforward as shopping for prescription drugs, but employers should watch for further developments and consider how these tools might be used.

The problem with HDHPs is that any health-care savings they might realize are not necessarily obvious to employees as they scrutinize their health benefits options.
CONCLUSIONS

Behavioral economics suggests that employers can improve the way HDHPs are administered. This may take the form of expanding the list of free preventative care, automatic registration, medication reminder services, or offering easy-to-use comparative medical shopping tools. Providing the initial investment in an HSA appears to offer the most immediate benefit, particularly when the seeded amount is high enough to get the employee’s attention. The objective of these strategies is to provide plan participants with a financial stake in making good health-care choices while overcoming the inherent limited rationality that consumers exercise in making health choices.

Notes

10. For more information about the difference between these two schools of thought, see: Richard Thaler, Misbehaving: The Making of Behavioral Economics (W. W. Norton & Company, 2015).
11. The experiment, called “The Ultimatum Game,” was originally designed by German economists and has been replicated in various settings by numerous researchers.
17. This is referred to as “system 1” and “system 2” styles of decision making, first described by Nobel Prize-winning behavioral economist Daniel Kahneman.

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The research for this article was sponsored by a grant GFOA received from Colonial Life to study best practices for employee health benefit cost-management strategies for public employers. GFOA used the grant to interview thought leaders and investigate secondary sources. The findings and publication were reviewed and approved by an independent panel of GFOA members with experience in managing employee benefits.