

NUDGING HEALTH

Health Law and Behavioral Economics

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To Peggy Hoffman, Doug Hutchinson, and the late Dan Meltzer.
Cherished teachers whose lessons echo in my mind to this day.
IGC

To Adrian and Theodore Lynch, my favorite people to nudge—
and sometimes shove.
HFL

To Jamie Cox Robertson, whose nudges are always welcome
(and good for my health).
CTR

In Memoriam: Professor Jeremy Blumenthal, JD, PhD,
Syracuse University College of Law

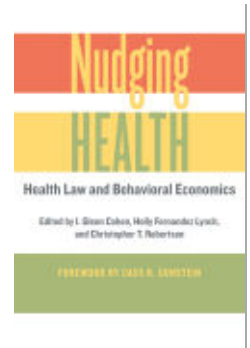
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Forced to Choose, Again

The Effects of Defaults on Individuals in Terminated Health Plans

Anna D. Sinaiko and Richard J. Zeckhauser

The Affordable Care Act (ACA), the most significant U.S. health policy measure since Medicare was enacted in 1965, aims to improve outcomes in the market for health insurance and to reduce dramatically the percentage of uninsured people in the United States. At its center is the extension of private health insurance through new health insurance marketplaces, where regulated health plans are sold through a web-based portal and are subsidized based on enrollee income. Plans offered in the non-group market (both within and outside the marketplaces) must cover a defined essential benefit package and must be classified into one of four cost-sharing tiers (platinum, gold, silver, or bronze) that are defined by actuarial value, where the least generous plans (those offered in the bronze tier) are required to provide coverage for, on average, 60% of an individual's health costs.

In 2014, 3.8 million more Americans had health insurance than in the previous year, and more than 7 million individuals enrolled in health insurance plans through ACA marketplaces. However, 2.6 million people—18.6% of all individuals enrolled in a non-group health plan in 2013—received a notice canceling their plan for 2014 because it failed to meet the coverage requirements of the ACA (Clemans-Cope and Anderson 2014). Insurance coverage in the non-group market has always encountered frequent disruptions (Sommers 2014). However, the driver behind these cancellations is new: the requirements of federal legislation, specifically the ACA. Moreover, this tally does not count another group facing plan terminations driven in part by the ACA: individuals whose employers stopped offering coverage. Their numbers are not known.

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Media attention pushed these cancellations to the forefront of the policy debate, raising the possibility that the ACA hurt large numbers of individuals. Stories of terminated individuals were prominent in the news in the fall of 2013. The story that profiled Jeff Learned of California was typical. On bemoaning his need to find a new plan for his teenage daughter, who has a health condition that has required multiple surgeries, he complained: “I don’t feel like I need to change, but I have to” (Appleby and Gorman 2013). Another representative news piece involved Valentina Holroyd, a 58-year-old from San Ramon, California, who, following the termination of her plan from Kaiser Permanente, faced either a 29% premium increase plus additional costs to enroll in a plan offering equivalent coverage, or an increase in deductible from \$1,000 to \$5,000 for a plan offering an equivalent monthly rate to her terminated plan (Luhby 2013). Such media coverage implied that taking people out of a health plan that they had selected for themselves and forcing them to choose a different one was inherently a bad thing. But was it?

Whether or not plan terminations are, in economic terms, welfare reducing is an empirical question that depends on individual outcomes following the terminations. To examine this, we label as “terminated choosers” the individuals who selected a health plan in a prior period that is no longer offered. Hence, they are forced to choose again. Whether terminated choosers are worse off following a termination depends first on whether they stay insured or become uninsured, and second, if they stay insured, whether they end up in a plan that is inferior to their previous plan. Although the answers to these questions are important, no literature currently exists on the impact of the choice environment and defaults on terminated choosers.

Health insurance in the United States is increasingly offered in exchange settings, where plans will regularly enter and exit the market—whether for economic reasons or because of regulatory impositions—and where the number of clients in terminated health plans is likely to continue to grow. Private insurance exchanges, where employers can give their employees vouchers and let them shop among exchange plans for health and/or dental benefits, are gaining popularity among firms as a way to increase choice while controlling employer costs. The Medicare program includes two exchange settings, one for private health plans (Medicare Advantage) and one for prescription drug plans (called Part D). Finally, several states are introducing exchanges into their Medicaid programs, whether by offering choices of Medicaid-managed care plans (Florida) or by enrolling newly eligible Medicaid individuals into plans offered in the ACA marketplace (Arkansas). In any exchange setting, some plans will be terminated, forcing significant numbers of individuals to select new health plans.

In this chapter, we argue that whether a plan’s cancellation harms terminated choosers depends not only on the remaining alternatives in their choice sets, but also on the choice architecture and on whether the terminated choosers make active or passive decisions. More specifically, terminated choosers who fail to make an active choice may be subject to defaults, which have been shown to powerfully influence

choices. If the default is contrary to an individual's original preferences, the nudge it represents may diminish the terminated chooser's welfare.

We first discuss how terminated choosers differ from other consumers in health insurance markets, and then analyze how default options affect consumers generally and terminated choosers specifically, for whom the interplay among preferences, search frictions, and defaults is unique. The experience of terminated choosers in the Medicare Advantage program serves as our case study. We conclude with a discussion of policy alternatives for choice architecture and defaults that could be implemented in health insurance markets to improve outcomes for future terminated choosers.

What Is Different about Terminated Choosers?

Terminated choosers differ in a few important ways from those who are selecting a plan from a set of options for the first time, individuals we label "original choosers." First, other factors being equal, having one's plan terminated is experienced as much worse than having chosen originally from a set of alternatives that did not include that plan. The principle describing this phenomenon is loss aversion: a preference for avoiding losses because the disutility associated with surrendering an object is greater than the utility associated with acquiring it (Tversky and Kahneman 1991). The disparity between losses and gains can be demonstrated by a thought experiment: imagine a college student who had narrowly decided to take course "L." Course "L" was then withdrawn, but courses "M," "N," and "O" were offered. For the student conjecturing about the benefits of the withdrawn course, none of the new offerings is viewed as an equal replacement; in part, the gap is due to loss aversion. Likewise, in a health insurance market, the loss of a chosen plan is likely to outweigh the benefits of a few added plans.

Terminated choosers also differ from original choosers because they had the opportunity to make an active choice among alternatives in a prior period, which provides information about their preferences. In a health insurance market, individuals who select a plan reveal their preferences regarding the management of their care, their access to physicians, and their tolerance for risk, all of which are relevant to the preferred new plan for a future period.

Preferences for health insurance are known to be "sticky," which has implications for terminated choosers. Status quo bias describes the disproportionate adherence of earlier entrants to their previous choices, in contrast to the distribution of selections made by new entrants in a market (Samuelson and Zeckhauser 1988). Such persistence may reflect a rational reliance on an informal assessment of search and transition costs combined with uncertainty about alternative options, or it may reflect a sensible conclusion that options change slowly and that people's preferences remain fairly consistent. However, status quo bias may also be driven by loss aversion, by the tendency of individuals to avoid the regret occasioned by learning that their initial choices were

poor, or because individuals weight errors of commission (switching plans when they should not) far more than errors of omission (failing to switch when they should).

For terminated choosers, status quo bias reinforces the preference to remain in their terminated plans. Thus far, in the health insurance literature, status quo bias has been studied as a force for inertia, where the choices of individuals already engaged in a market are compared to those of new entrants. We have no evidence of how status quo bias affects terminated choosers—individuals who are forced to make choices because their current selections are no longer available. In these situations, individuals cannot resurrect the status quo; they cannot reproduce their original health plan choices. Not only will elements of the new choices be different (locations, physicians, etc.), but there is an additional psychological effect as terminated choosers move away from a prior reference point. When a terminated chooser faces a range of new plan choices, some similar to the original choice, some not, it is likely that the forces of status quo bias will push in the direction of choosing similar substitutes.

The Power of Defaults and Terminated Choosers

In decision-making, the default option is the selection individuals will be assigned if they fail to choose an option on their own. Defaults have been found to influence outcomes in a range of consequential decisions, including retirement savings and organ donations. Madrian and Shea's (2001) study of participation in an employer's 401(k) program found that participation increased by 50% when the default was changed so that new employees were enrolled unless they elected to opt out. Johnson and Goldstein (2003) found that rates of organ donation are significantly higher in countries where the default is a consent to donate organs, rather than the opposite.

If rational prescriptions were followed, positioning an alternative as a default would not affect its likelihood of being chosen.¹ Thus, evidence that defaults are powerful adds to the growing evidence that consumers often depart from rational prescriptions when making decisions. Defaults influence decisions, in part, because they are perceived as being endorsed by authorities (such as financial planners, personnel officers, and policymakers) who "know what is best for us" (Frank 2007; Goldstein et al. 2008). Defaults also get status quo recognition; an alternative choice risks a significant and regrettable error of commission (Samuelson and Zeckhauser 1988).

The "nudge" concept was developed to counter decision-making errors. It guides policymakers on ways to structure choice architecture and, in particular, on setting defaults to lead to the most effective choices by consumers (Thaler and Sunstein 2008). A default policy may be chosen to maximize individual welfare, or to take a broader societal view and consider as well benefits and costs to external parties, including government. A default may assure that some option is chosen, or the default outcome may be no involvement, as with many employer-based insurance programs, such as those for long-term care.

Goldstein et al. (2008) present a taxonomy of default options including mass defaults, which are the same for all consumers of a product, and personalized defaults, which are tailored to individuals. Smart defaults attempt to optimize for the community on average (if a mass default) or for the individual (if personalized).

Mass defaults are used most prominently for individuals making first-time choices. Thereafter, persistent personalized defaults are common: individuals not choosing are assigned the same choice they made in the prior period, on the theory that what they wanted previously is what they would want now. Employee benefits, often involving multiple products, represent a situation where persistent defaults are widespread.

In considering the right default for terminated choosers, a persistent default is not possible. However, the appropriate default for a terminated chooser may differ from the optimal default for original choosers. Unless the terminated chooser is being terminated from a prior default plan, the terminated chooser has shown a preference among the choices available, and this active choice provides *prima facie* evidence that the prior default was not her preferred choice. Moreover, that choice provides information that could help determine a personalized default.

The percentage of a population that elected a choice other than the default is also relevant. If 95% of people had accepted the prior default, this would suggest that the default choice served the population well since some who would have chosen actively obviously preferred it. It would also indicate that a particular terminated chooser who was part of the 5% who opted out of the default was an outlier. In these cases, using the same highly popular default as a mass default for terminated choosers might be reasonable. The small percentage of contrary outliers could still actively choose an alternative other than the default, as they had done previously.

However, when a sizable percentage of clients previously opted away from the initial default, utilizing information from prior choices might be worth the effort. The Medicare and Medicare Advantage market illustrates a situation where a large and growing portion of consumers opt away from the original default. From 2003 to 2008, the number of first-time Medicare enrollees who chose a Medicare Advantage plan grew from 11% to 21%.

This pattern indicates that traditional Medicare, the default for first-time choosers, was increasingly selected against, to the point where one in five beneficiaries selected an alternative. As a result, making the additional effort to personalize defaults for terminated choosers within this population might be desirable; that is, the terminated choosers would be better off in expectation if they were assigned a default option determined by considering their past choices rather than an undifferentiated mass default to traditional Medicare. There is a potential welfare loss when traditional Medicare is made the default because some terminated choosers are likely to end up in the default option either because they responded to the “authoritative” pressure of the nudge, or because they failed to make an active choice, perhaps because they were not paying attention or perhaps because of cognitive decline associated with aging. The default to traditional Medicare does avoid the danger of individuals’ mistak-

enly being left without health insurance, a danger that arises in other health insurance markets, but so too would a more personalized default. We now analyze the Medicare Advantage case study in greater detail.

Case Study: A Mass Default Gone Wrong—Terminated Choosers in Medicare Advantage

The Medicare Advantage program gives Medicare beneficiaries the option to choose a private health plan instead of fee-for-service traditional Medicare. Medicare Advantage plans must provide benefits that are at least actuarially equivalent to traditional Medicare. The vast majority of Medicare Advantage plans have been managed-care plans, primarily HMOs (health maintenance organizations), which use primary-care gatekeeping, utilization management, and selective provider networks to reduce healthcare spending. In exchange for these restrictions, Medicare Advantage beneficiaries typically avoid either traditional Medicare's substantial cost sharing or its premiums for supplementary coverage. Medicare Advantage plans fully cover their enrollees' medical care. Medicare Advantage beneficiaries also usually enjoy coverage for some additional services, such as vision and hearing. Medicare Advantage plans receive in return a risk-adjusted, monthly, per-enrollee payment from the Medicare program.

Since 2003, increasing numbers of Medicare beneficiaries have found the Medicare Advantage program to be preferable to traditional Medicare. From 2003 to 2008, Medicare Advantage program enrollment more than doubled, increasing from approximately 4.5 million beneficiaries in 2003 to 9.9 million in 2008. This growth is a result of three forces: large numbers of new Medicare beneficiaries, an increasing preference for Medicare Advantage among new beneficiaries, and more switchers from traditional Medicare to Medicare Advantage relative to individuals making the opposite switch (table 23.1). The increasing popularity of Medicare Advantage was likely due to two factors. First, in 2003, Congress passed the Medicare Modernization and Improvement Act, which increased payment rates paid to Medicare Advantage plans. That, coupled with regulatory provisions, led to plans being established with richer benefit packages than traditional Medicare, in the form of reduced out-of-pocket costs and extra benefits (Medicare Payment Advisory Committee 2007, 2009). Second, the variety of Medicare Advantage plan options expanded substantially. Medicare Advantage began to include preferred provider organization (PPO) plans, managed-care plans with less restricted physician networks, and private fee-for-service (PFFS) plans that, from 2003 to 2008, were similar to traditional Medicare. They offered fee-for-service coverage, but without any provider restrictions. Apart from their specific reasons for selecting Medicare Advantage plans, all of these plans' beneficiaries revealed that they preferred an Medicare Advantage plan to traditional Medicare.

Generally, insurers contract with Medicare to offer a specific type of plan (HMO, PPO, or PFFS) in a county, but they frequently offer multiple plans with different names

Table 23.1. Medicare Beneficiary Transitions in and out of Medicare Advantage, 2003–8

| | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 |
|----------------------------------|------------|------------|------------|------------|------------|------------|
| Age 65 | | | | | | |
| Percent into MA | 1,630,443 | 1,695,993 | 1,683,276 | 1,735,996 | 1,830,302 | 2,041,461 |
| Percent into TM | 11.0% | 11.2% | 12.9% | 16.0% | 19.0% | 21.1% |
| | 89.0% | 88.9% | 87.2% | 84.0% | 81.0% | 78.9% |
| In MA in prior year and age 66+ | | | | | | |
| Percent transition from MA to TM | 4,330,876 | 4,211,538 | 4,330,177 | 4,772,588 | 5,575,978 | 6,402,756 |
| N transitioning from MA to TM | 10.6% | 7.7% | 6.7% | 7.8% | 7.2% | 7.2% |
| | 459,073 | 325,552 | 288,390 | 371,785 | 403,701 | 463,560 |
| In TM in prior year and age 66+ | | | | | | |
| Percent transition from TM to MA | 22,875,785 | 23,365,548 | 23,681,460 | 23,610,252 | 23,241,231 | 22,931,475 |
| N transitioning from TM to MA | 0.8% | 1.2% | 2.3% | 3.9% | 3.9% | 4.0% |
| | 178,431 | 271,040 | 532,833 | 918,439 | 906,408 | 908,086 |

Source: Author's calculations from Medicare enrollment files (100% sample).

Notes: MA, Medicare Advantage; TM, traditional Medicare. Sample includes those whose original reason for entitlement was reaching age 65. Beneficiaries eligible for Medicaid (dual-eligibles) were excluded.

and variable benefits under each contract. As with any marketplace for health insurance, each year some insurers choose not to renew their contract. From 2008 forward, exits from the Medicare Advantage program became more common, primarily because of legislation that changed the amounts that plans were paid and the ways plans were regulated.² Some counties experienced more exits than others, though beneficiaries in all counties continued to have access to at least one Medicare Advantage plan of each plan type from 2007 to 2010 (Medicare Payment Advisory Committee 2011).

An insurer must notify beneficiaries when a plan terminates and must explain that they can change to traditional Medicare or choose another Medicare Advantage plan from a provided list of plans available in the service area. Beneficiaries have approximately four months to choose a new plan. In all cases the beneficiaries remain insured by Medicare, as those who do not actively choose for themselves are automatically enrolled in traditional Medicare. This is an example of a mass default.

Medicare's current policy to massively default to its own program is in many ways a conservative choice. Having terminated choosers default into traditional Medicare mimics the default facing original choosers. Traditional Medicare offers the widest physician network, and is thus the most liberal in terms of physician access. In addition, unlike an implicit default, under which terminated choosers who failed to select a new option for coverage would lose their health insurance coverage, this default seeks to avoid harm by keeping beneficiaries enrolled in health insurance.

However, having traditional Medicare as the default option for terminated choosers fails to consider that the terminated choosers originally chose to enroll in Medicare Advantage rather than in traditional Medicare. Valuable information is thus ignored. In addition, a higher proportion of Medicare Advantage as opposed to traditional Medicare clients enroll in Medicare Part D; Part D offers prescription drug coverage at heavily subsidized rates, and thus reflects an appropriate choice for most individuals. However, following an Medicare Advantage plan termination, the current default into traditional Medicare does not include prescription drug coverage. Neither does it cover several additional benefits that are included in the majority of Medicare Advantage plans. Thus, the mass default plan is both actuarially less favorable and less generous than the plan terminated choosers chose previously. Terminated choosers who enter traditional Medicare can elect to enroll in a prescription drug plan, but this requires active choice on their part and does not occur should the terminated chooser passively accept the default.

What is the impact of having traditional Medicare as the default for terminated choosers of Medicare Advantage? We find a moderate impact on the transitions of beneficiaries from terminated plans in Medicare Advantage to traditional Medicare. An analysis of the choices made by nearly 233,000 terminated choosers who were enrolled in an Medicare Advantage plan that included Part D prescription drug coverage from 2006 to 2010 finds that large percentages of terminated choosers, including 95% of beneficiaries terminated from an HMO in 2006 and 83% of beneficiaries terminated from an HMO or PFFS plan in 2009, actively chose to select a new Medicare Advantage

plan (Sinaiko and Zeckhauser 2014). These active choices by terminated choosers likely stemmed from the same preferences that had led to their choices to enroll in Medicare Advantage during earlier periods. The persistent preferences of these individuals were perhaps magnified by status quo bias, the proclivity of individuals to stick to their original plan or a close substitute. This bias has been shown to exist, for some combination of rational and irrational reasons, among Medicare beneficiaries (Sinaiko, Afendulis, and Frank 2013; Afendulis, Sinaiko, and Frank 2014).

However, we also observe that some beneficiaries were likely affected by the nudge, which is exercised through the default policy. Even with such high rates of terminated choosers returning to Medicare Advantage, terminated choosers were more likely to be enrolled in traditional Medicare in the year following their plan terminations than were non-terminated choosers. Moreover, 21% of terminated choosers who enrolled in traditional Medicare dropped Part D coverage, whereas only 2% of those actively choosing to stay in Medicare Advantage dropped it. This is likely due to passive acceptance of the default (and some general susceptibility to nudges) because enrollment in Part D requires active selection of a Part D plan within a finite period of time, whereas terminated choosers who passively accepted the default and were assigned to traditional Medicare would end up without Part D coverage.

As we mentioned briefly above, all of the beneficiaries in this study were terminated from a plan that included prescription drug coverage. If judged from the standpoint of the individual beneficiaries, the current nudge into traditional Medicare without actuarially favorable Part D prescription drug coverage almost certainly represents a welfare loss from their prior position of being enrolled in an Medicare Advantage plan with drug coverage. Improving the default provisions for terminated choosers in the Medicare Advantage program would, therefore, have the potential to improve significantly the welfare of the affected individuals.

Can We Design a Better Nudge for the Medicare Program?

The current mass default of terminated choosers into traditional Medicare mimics the default option for original choosers and is thus administratively simple. It also preserves beneficiary access to familiar physicians because, while traditional Medicare covers services provided by any physician who accepts Medicare, Medicare Advantage plans use networks that exclude some physicians. Finally, by allowing beneficiaries a period of time in which they can choose a new plan for themselves (an opt out), the current policy avoids the significant error of putting beneficiaries into traditional Medicare when they strongly prefer an alternative and are sufficiently alert to make an alternative choice.

A default away from a terminated chooser's original choice could serve as a beneficial wakeup call if the persistent enrollment of Medicare beneficiaries in the same health plans over time was overwhelmingly due to status quo bias (and not their preferences). Given that health insurance plans and individuals' conditions change regu-

larly, the terminated chooser's original plan might no longer be optimal. If so, a default away from his original plan could force a reevaluation of his enrollment decision. However, our work elsewhere (see Sinaiko and Zeckhauser 2014) finds that rates of reenrollment in Medicare Advantage plans by terminated choosers are high (as described above). Moreover, they are greater than rates of reenrollment into Medicare Advantage by beneficiaries who voluntarily switch out of their Medicare Advantage plans (that is, voluntary switchers are more likely to transition to traditional Medicare) and greater than rates of take-up of Medicare Advantage by newly eligible Medicare beneficiaries. This evidence suggests that when forced to reevaluate, terminated choosers still choose an Medicare Advantage plan. Status quo bias, even if it is powerful, is at worst minimally harmful.

Using traditional Medicare as a mass default also minimizes government financial outlays; insuring a beneficiary in traditional Medicare costs the government less than in an Medicare Advantage plan. However, this disparity has been shrinking from 2008 to 2014, and further narrowing is expected (Henry J. Kaiser Family Foundation 2014). Nonetheless, Medicare Advantage is unpopular in some political circles, and policy-makers who prefer Medicare to be an overwhelmingly public program would find the default into traditional Medicare politically favorable.

Despite these policy and political advantages, the current policy of default into traditional Medicare is far from optimal. It ignores available information about beneficiaries' preferences among plans. More specifically, a second Medicare Advantage plan is likely to be more similar to a terminated chooser's original choice than is traditional Medicare in several consequential ways (for example, covered benefits and cost-sharing requirements) and, therefore, better suited to the beneficiary. The failure of the current default to include or even attend to the highly subsidized Part D pharmaceutical coverage, whether due to a desire to mimic the original default (which also excludes Part D coverage), to respond to some political interests, or to hold down government expenditures, has a strong negative consequence. That policy fails to best serve the well-being of individual Medicare recipients. Moreover, given that consumers have been found to be susceptible to nudges, particularly in arenas, such as health insurance, that are characterized by complex information, the welfare-attending need for an alternative default is clear.

What would the optimal policy for terminated choosers in Medicare Advantage look like? It would include an explicit default into some form of insurance that would yield maximum expected benefits for the inevitable individuals who will fail to choose a new plan for themselves. A choice architecture that employs a personalized smart default that takes account of individual starting positions, preferences, and expected needs (Smith, Goldstein, and Johnson 2009) can be used to allow terminated choosers the opportunity to select a new Medicare Advantage plan or enroll in traditional Medicare. The nudge for beneficiaries who fail to make an active choice for themselves should be back to Medicare Advantage with a plan that includes Part D prescription drug coverage.

As insurers end plans that they find unfavorable to them and as regulations force plans out of existence, terminated choosers will represent a significant component in other government-sponsored health insurance markets, as well as in their purely private counterparts. The experiences and outcomes for terminated choosers in these other markets should be analyzed to inform the design of optimal choice architecture for Medicare. Indeed, smart defaults are already being used in some public health insurance programs, such as the California Demonstration Project to Integrate Care for Dual Eligible Beneficiaries (the Cal MediConnect program). There, eligible individuals are being passively enrolled in health plans using an “intelligent assignment” process that analyzes the individuals’ recently used providers and matches those providers to the physician networks of participating plans (California Department of Health Care Services 2014). This smart default includes the opportunity for individuals to opt out and actively select their own plans. In cases where they fail to do so, the default places them in plans that prioritize continuity of care. Research should examine outcomes for consumers in these programs.

Implementing a smart default in Medicare would take some work. It would be a complicated system to organize, and careful attention would need to be paid to educating beneficiaries on the process and on their options so as to maximize their well-being. Administrative complications would arise because physician networks differ across Medicare Advantage plans, and because different individuals would be defaulted into different plans. However, smart defaults are feasible and, in this case, would be preferable to the current system. A smart default system could analyze the degree of overlap in physician networks across Medicare Advantage plans in an area. An even more sophisticated algorithm could consider the physicians the individual has previously used. Possible policy alternatives could default a terminated chooser into the plan most similar to the just-terminated plan, or into the plan where the physician network had the greatest degree of overlap with the prior plan. Traditional Medicare would be employed as a backup only if there were no reasonable fit.

Upgrading the default provisions for terminated choosers in the Medicare Advantage program has the potential to improve significantly the welfare of the affected individuals. The addition of a smart default modification to Medicare’s architecture for terminated choosers would be an effective step toward the expressed goal of beneficial healthcare for all Americans. As such, it would also serve as a template for defaults in other insurance programs.

Notes

1. This assumes no (or minimal) search and transaction costs associated with learning about and selecting alternatives.
2. The Patient Protection and Affordable Care Act (ACA) of 2010 reduced payments to Medicare Advantage plans relative to traditional Medicare. This legislative measure led to

less availability of HMO and PPO plans (Afendulis, Landrum, and Chernew 2012). The payment reductions, along with provisions in the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 that imposed a network requirement on PFFS plans, likely resulted in fewer PFFS plans being offered.

References

- Afendulis, Christopher C., Mary Beth Landrum, and Michael E. Chernew 2012. "The Impact of the Affordable Care Act on Medicare Advantage Plan Availability and Enrollment." *Health Services Research* 47(6): 2339–52.
- Afendulis, Christopher, Anna Sinaiko, and Richard Frank. 2014. "Dominated Choices and Medicare Advantage Enrollment." National Bureau of Economic Research Working Paper No. 20181.
- Appleby, Julie, and Anna Gorman. 2013. "Thousands of Consumers Get Insurance Cancellation Notices Due to Health Law Changes." *Kaiser Health News*. October 21. <http://www.kaiserhealthnews.org/stories/2013/october/21/cancellation-notices-health-insurance.aspx>.
- California Department of Health Care Services. 2014. Duals Demonstration Memorandum of Understanding (MOU). www.dhcs.ca.gov/Pages/demoMOU.aspx.
- Clemans-Cope, Lisa, and Nathaniel Anderson. 2014. "How Many Nongroup Plans Were Canceled? Estimates from December 2013." *Health Affairs Blog*. <http://healthaffairs.org/blog/2014/03/03/how-many-nongroup-policies-were-canceled-estimates-from-december-2013>.
- Frank, Richard G. 2007. "Behavioral Economics and Health Economics." In *Behavioral Economics and Its Applications*, edited by Peter Diamond and Hannu Vartiainen. Princeton University Press. Princeton, NJ.
- Goldstein, Daniel G., Eric J. Johnson, Andreas Herrmann, and Mark Heitmann. 2008. "Nudge Your Customers toward Better Choices." *Harvard Business Review*:99–105.
- Henry J. Kaiser Family Foundation. 2014. "The Role of Medicare Advantage." *Journal of the American Medical Association* 312(10):990.
- Johnson, Eric J., and Daniel Goldstein. 2003. "Do Defaults Save Lives?" *Science* 302:1338–39.
- Luhby, Tami. "Obamacare Pricier for Some Individual Buyers." 2013. *CNN Money*. October 29. <http://money.cnn.com/2013/10/29/news/economy/obamacare-insurance/>.
- Madrian, Brigitte C., and Dennis F. Shea. 2001. "The Power of Suggestion: Inertia in 401(k) Participation and Savings Behavior." *Quarterly Journal of Economics* 116(4):1149–87.
- Medicare Payment Advisory Commission. 2009. *Report to the Congress: Improving Incentives in the Medicare Program*. Medicare Payment Advisory Commission. Washington, DC.
- . 2007. *Report to Congress: Medicare Payment Policy*. Medicare Payment Advisory Commission. Washington, DC.
- . 2011. *Report to Congress: Medicare Payment Policy*. Medicare Payment Advisory Commission. Washington, DC.
- Samuelson, William, and Richard Zeckhauser. 1988. "Status Quo Bias in Decision Making." *Journal of Risk and Uncertainty* 1:7–59.
- Sinaiko, Anna D., Christopher C. Afendulis, and Richard G. Frank. 2013. "Enrollment in Medicare Advantage Plans in Miami-Dade County: Evidence of Status Quo Bias?" *Inquiry* 50(3):202–15.

- Sinaiko, Anna D., and Richard Zeckhauser. 2014. "Selection Effects versus Default Power: The Choices of Terminated Medicare Advantage Clients." Unpublished Working Paper, Harvard University.
- Smith, N. Craig, Daniel G. Goldstein, and Eric J. Johnson. 2009. "Smart Defaults: From Hidden Persuaders to Adaptive Helpers." *INSEAD Business School Research Paper No. 2009/03/ISIC*. http://papers.ssrn.com.ezp-prod1.hul.harvard.edu/sol3/papers.cfm?abstract_id=1116650.
- Sommers, Benjamin D. 2014. "Insurance Cancellations in Context: Stability of Coverage in the Nongroup Market Prior to Health Reform." *Health Affairs* 33(5):887–94.
- Thaler, Richard H., and Cass R. Sunstein. 2008. *Nudge: Improving Decisions about Health, Wealth, and Happiness*. Yale University Press. New Haven, CT.
- Tversky, Amos, and Daniel Kahneman. 1991. "Loss Aversion in Riskless Choice: A Reference-Dependent Model." *Quarterly Journal of Economics* 106(4):1039–61.