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# Health Insurance Exchanges — Making the Markets Work

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Americans purchase health insurance in various ways. Some buy individual policies. For them, medical underwriting is common, and preexisting conditions can preclude, limit, or dramatically increase the cost of coverage. Many buy insurance through small employers, which typically offer little or no choice of plan. Their premiums tend to be higher than those of consumers purchasing through large employers, which can bargain effectively on prices. Large employers usually offer a modest selection of high-quality plans at competitive prices. Medicare recipients can join traditional Medicare and then choose drug coverage from any of dozens of stand-alone prescription-drug plans (PDPs) or join Medicare-Advantage and choose among numerous private health plans.

Given that plan choices are difficult to make and that large purchasers can whittle down prices, a reformed health care system is likely to employ health insurance exchanges to stand between consumers and insurers. The Massachusetts Health Insurance Connector, in operation since 2007, runs the best-known such organization.

Exchanges focus on the purchase of insurance for individuals, households, and groups of small employers — all of which will be more likely to obtain coverage if it is made more affordable or more available, and certainly if it is made mandatory. Exchanges mimic some functions that are performed by large employers as purchasers, including assembling, organizing, and disseminating information about competing health plans; enacting policies that promote risk pooling; specifying benefit packages; negotiating premiums; limiting the number and types of plans that may be marketed; and structuring the enrollment and plan-selection process. They thus seek to extend to all consumers the benefits of having a large employer purchase one's insurance.

The rationale for an exchange is that consumers are rarely well equipped to deal with markets offering large numbers of complex, expensive, hard-to-evaluate products — products that, as in the case of health insurance policies, may nonetheless be critical to their well-being. Consumers facing complex, high-stakes choices are prone to predictable errors.[1] They are likely to lack the skill and time to make choices based on a careful assessment of the relative costs and quality of competing health plans, tending instead to choose on the basis of anecdotal information, such as their friends' experiences. An effective intermediary could substantially improve their choices — and thereby promote competition and thus enhance quality and efficiency.

The exchange concept has stirred great excitement and has broad support. But there is disagreement on how exchanges should function, beginning with the question of how much help consumers need in order to make markets work efficiently.

One prominent approach would have exchanges adopt a traffic-cop role similar to that played by the Centers for Medicare and Medicaid Services in running the MedicareAdvantage program and the Part D prescription-drug benefit. In those programs, any supplier who meets some qualification standard is admitted. The number of sellers is not limited. Plans retain considerable control over the specifics of their offerings (formulary design, cost-sharing provisions) and over their premiums. Consumers are given information and some tools (Web-based comparison programs and plan summaries) to assist them in evaluating choices. Still, consumers are confronted with a multitude of plans, each with numerous provisions. Faced with too many options that vary in subtle but possibly important ways, consumers usually just stick with their current choice or follow the lead of a friend or relative.

Consider the example of a senior citizen in a Boston suburb who is seeking a Medicare PDP. The graph shows the price variation within a single county. The consumer can choose among 47 PDPs, 23 of which have a quality rating of at least 3.5 stars out of 5 and are classified as either identical or actuarially equivalent to the Part D standard plan. Thus, on average, the coverage offered by these plans is similar. The most expensive of the 23 plans charges a premium that is 2.4 times that of the least expensive plan. Presumably, people who choose the more expensive



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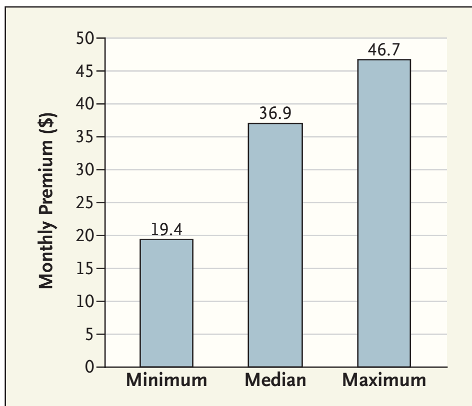


**Minimum, Median, and Maximum Monthly Premiums for Medicare Prescription-Drug Plans in Middlesex County, Massachusetts.**

plans are unaware of much less costly alternatives offering a similar product. Price competition is not working.

Though their fundamentals are the same, the 23 plans can vary with respect to the drugs on their formulary, cost-sharing rates for specific drugs, rules governing utilization (e.g., prior-authorization rules), mail-order opportunities, quality of customer service, and the location of contract pharmacies. Such differences hardly explain the large price differentials, but they do complicate consumers' choices.

Now consider what large employers do. They prescreen qualified health plans and narrow the range of choices on the basis of premium negotiations, benefit design, quality, member support services, and other features. Employees are typically given a choice of three to six health plans that vary in price and other important dimensions; they are provided with information on these differences and are often offered assistance in making selections. To our knowledge, there are virtually no complaints about employers' negotiation of premiums, prescreening, and limiting of the choices available.

Should exchanges play a similarly active role in structuring and managing the health insurance market, so as to guide people to appropriate plans, enhance competition, and thereby improve quality and reduce price? A few decades ago, the conventional wisdom in economics was that individuals could make effective choices in markets, even when the options were numerous and complex. Extensive research in behavioral economics calls this belief into question. In many circumstances, particularly when uncertainties and high stakes are involved, consumers have trouble making good decisions. The purchase of health insurance presents just such challenges. Hence the potential benefits of exchanges.

The design of exchanges should attend to the lessons of behavioral economics. First, beware of choice overload. As people face an increasingly large number of similar health plan choices, their tendency to switch plans to reduce their premiums is unlikely to increase and may actually decline — a consumer may be more likely to switch from 1 plan among 6 than from 1 plan among 23. A recent analysis of the Swiss health insurance experience revealed the phenomenon of "inertia due to numbers."[2] Depending on the canton in which they lived, Swiss consumers faced the choice of 30 to 75 health plans, all meeting mandated coverage standards. Information on plans, including premium amounts, was made widely available. Under these circumstances, one might expect frequent switching and robust price competition. Instead, people who were offered more alternatives were less likely to switch plans. The result was greater price variation in markets offering more choices. The implication is that when choice sets become very large, people "leave more money on the table" — possibly because the abundance of alternatives overwhelms them or prevents them from getting enough information on an alternative plan to induce them to switch.

"Inertia due to numbers" reinforces "status quo bias,"[3] which derives from people's tendency to stick with previous choices, even when market circumstances such as price and quality have changed or when the first "choice" was imposed on them. This bias afflicts private health insurance markets in the United States: people of the same health status and demographic profile make different choices, depending on whether they have a plan from the past.[4] The bias blunts consumer responsiveness to price and quality differences in health insurance. Insurers, having captive customers and only modest prospects of "stealing" from others, compete only weakly.

Consumers facing complex, uncertain, and consequential choices may also rely on simple rules of thumb. An analysis of Medicare recipients choosing among PDPs suggests that they used such rules to their detriment[5] — for example, by overweighting premium outlays and slighting the total expected out-of-pocket costs. As a result, many chose a plan that was expected to be more costly and offered no advantages in terms of features or quality.

These experiences suggest that exchanges should be structured to foster effective consumer choices, and thereby efficient outcomes, by providing consumer-friendly information about the coverage, cost, and quality of different plans. Ironically, one way to en-



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hance the prospect of informed choices is to limit the number of options. Plans then compete on price, quality, or both in order to be included. Requiring plans to offer identical features would promote competition and facilitate decisions but limit choice. The trade-off between these objectives should be carefully weighed by officials legislating, designing, and operating exchanges.

Most people's understanding of health plans is based on anecdotal information from friends and relatives. Vast amounts of information are lost. Exchanges should enable consumers to share their experiences with plans (as TripAdvisor.com does for hotels), perhaps using Internet-based methods to aggregate assessments. Consumers could then learn on a wholesale basis and focus effectively on cost, quality, and coverage. Choices would be improved. Competition would be enhanced. And as a result, prices would be lower, and quality higher.

Dr. Frank reports holding equity in WellPoint. No other potential conflict of interest relevant to this article was reported.

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