

What Do Consumers Do When They Select Health Insurance Plans?

Chenyuan Liu ¹ Lan Zou ²

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¹Tsinghua University

²University of St Gallen

Motivation

- ▶ Consumers make poorly informed decisions $\Rightarrow$ incur significant financial losses.
- ▶ Inertia is common and expensive.
 - ▶ Defaults are pervasive in household markets.
 - ▶ Consumer engagement is limited.
- ▶ Approaches:
 - ▶ Standard approach: financial incentives (e.g., subsidies)
 - ▶ Alternative approach: decision aids (nudges)
- ▶ Why do consumers make poor decisions, and why do they stick with default plans?

Overview of the paper

- ▶ Study “triggers” that nudge choices away from defaults
 - ▶ Starting point: ~51% make non-cost-minimizing choices
 - ▶ Three possible triggers:
 - (1) Inattention in active choice (full-attention benchmark / rational inattention → attenuation)
 - (2) Learning about market prices
 - (3) Health-belief updates (private information / internal attention)
- ▶ **Identification**: new vs. existing enrollees
 - ▶ Matching: compare and track matched new and existing enrollees over five years
- ▶ **Economic implications for policy**
 - ▶ Key idea: nudges are valuable only if they improve choice quality. How well does this work in health insurance?

Outline

- ▶ Setting & enrollee variation
- ▶ Results I: Stylized facts (new vs. existing)
- ▶ Results II: Three factors behind poor decisions: full attention, learning, health beliefs
- ▶ Financial outcome from switching
- ▶ Policy implications

Setting: Swiss mandated health insurance market

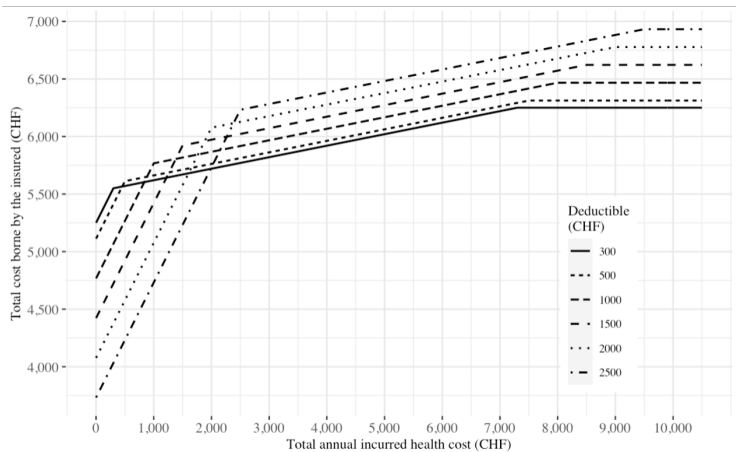
- ▶ **Setting:** Swiss mandated health insurance market
 - ▶ Relevant choice: high versus low insurance coverage plans
- ▶ **Plan choices:** Standardized and simple
 - ▶ Standardized cost sharing and covered services.
- ▶ **Clean optimal deductible plan**
 - ▶ The optimal deductible is a simple function of health expenditure.

Optimal deductible plan

Choice menu

Deductible	Co-insurance rate	Cap co-insurance	Premium (CHF)
CHF 300	10%	CHF 700	4,960
CHF 500	10%	CHF 700	$4,960 - (500 - 300) \times 70\% = 4,829$
CHF 1,000	10%	CHF 700	$4,960 - (1,000 - 300) \times 70\% = 4,479$
CHF 1,500	10%	CHF 700	$4,960 - (1,500 - 300) \times 70\% = 4,129$
CHF 2,000	10%	CHF 700	$4,960 - (2,000 - 300) \times 70\% = 3,779$
CHF 2,500	10%	CHF 700	$4,960 - (2,500 - 300) \times 70\% = 3,429$

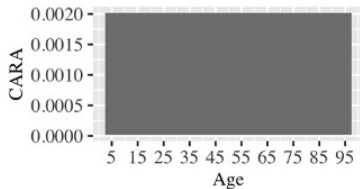
Optimal deductible plan



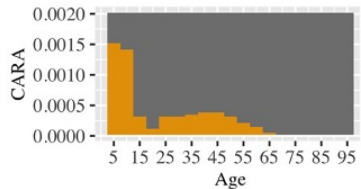
- ▶ Medical spending $\leq$ CHF 2,000, cost-efficient plan = CHF 2,500;
- ▶ Medical spending $\geq$ CHF 2,000, cost-efficient plan = CHF 300;
- ▶ We consider myopic and perfect foresight throughout our analysis.

Optimal deductible plan

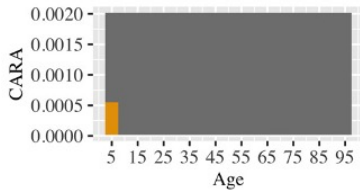
(a)



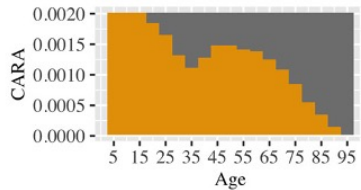
(b)



(c)



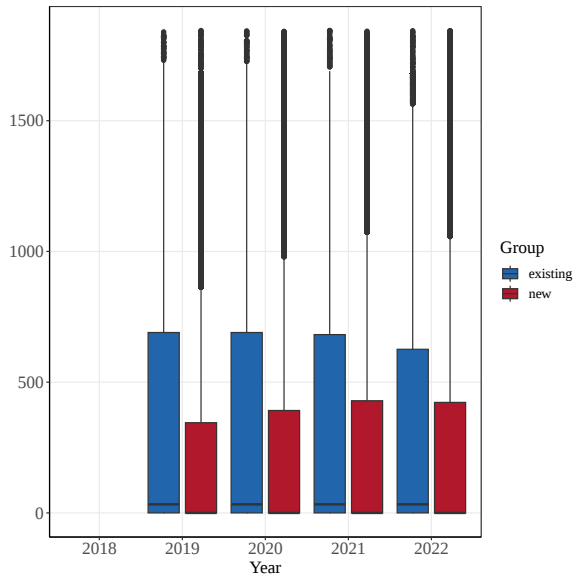
(d)



Stylized fact: active choice vs. default

- ▶ New enrollees (active): **70% optimal**, **11% dominated**.
- ▶ With defaults (existing): **51%** optimal vs **66%** for new.
- ▶ Annual switching rate: **5%** overall; inertia is persistent.

Foregone savings

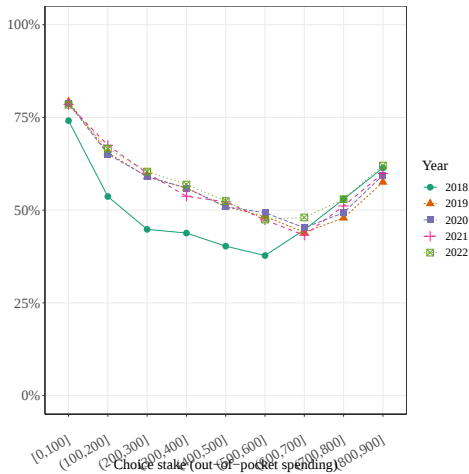


Result I: Full attention

- ▶ How well they make poor decision?
 - majority (70%) choose the optimal plan based on their expected health expenditure.
 - Average foregone savings: 260 CHF/year $\cong$ 295 USD/year

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 - Average foregone savings: 260 CHF/year $\cong$ 295 USD/year
- ▶ Why make poor decision? Rational inattention
- ▶ Learning over time? Very little
 - No significant improvement in choice quality over five years.
 - Rates of optimal choices remain constant, dominated choices persist, and foregone savings do not decrease.

Result II: Learning over time

1. New enrollees: active decisions + learning (system & health change)
 2. Existing enrollees: default to previous plans + learning (health change)
- Preview: we test whether learning improves choice quality and realized savings

Result II: Learning over time

Table: Switching and savings from switching(after match), 2019-2022:

	2019	2020	2021	2022
New enrollee				
Switched deductible from the prior year (%)	5.44	6.87	6.15	5.41
Ex post approach with perfectly inelastic demand for healthcare				
Mean savings from switching	251	177	119	137
Median savings from switching	462	420	357	416.1
Percent that saved > 0 from switching (%)	65.8	65.3	63.8	65.2
Exist enrollee				
Switched deductible from the prior year (%)	6.14	5.71	5.19	4.99
Ex post approach with perfectly inelastic demand for healthcare				
Mean savings from switching	448	329	270	260
Median savings from switching	463	446	372	381
Percent that saved > 0 from switching (%)	76.0	72.8	70.9	70.8

Result II: Learning over time

Table: Switching and savings from switching for aged 65, 2019-2022:

	2019	2020	2021	2022
New enrollee				
Switched deductible from the prior year (%)	5.10	4.05	3.90	3.77
Ex post approach with perfectly inelastic demand for healthcare				
Mean savings from switching	389	124	78	161
Median savings from switching	462	217	217	345.9
Percent that saved > 0 from switching (%)	73.0	65.0	68.8	75.8
Exist enrollee				
Switched deductible from the prior year (%)	2.80	3.53	3.19	3.18
Ex post approach with perfectly inelastic demand for healthcare				
Mean savings from switching	309	117	197	118
Median savings from switching	372	178	252	147
Percent that saved > 0 from switching (%)	78.7	70.5	72.8	66.0

Result II: Learning over time

Summary

- ▶ New enrollees: active decisions + learning (system & health change)
 - ▶ Existing enrollees: default to previous plans + learning (health change)
-
1. New enrollees have larger switching rate, but they save less from switching.
 2. Big amount: per-person savings reaching CHF 117 in 5 years, which goes up to CHF 3.7 million in 5 years.

Incentives to switch

- ▶ Why do people change plans? Two views:
 - ▶ **Friction models:** switching *responds* to the **incentive to switch**.
 - ▶ **Mental-gap model:** switching does not respond to monetary incentives.
- ▶ **Definition (incentive):** potential annual savings from moving off the default

$$v_{it} = (\text{Premium} + \mathbb{E}[\text{OOP}])_{\text{default}} - (\text{Premium} + \mathbb{E}[\text{OOP}])_{\text{lowest-cost}}$$

Interpretation: $v_{it} > 0$ means the person can save v_{it} CHF by switching.

Incentives to switch

Table: Regression Results

	Switching Rate (1)	Switching Rate (2)
(Intercept)	0.037*** (0.001)	
incentive to switch (000)	0.053*** (0.002)	0.082*** (0.003)
Num.Obs.	90066	180132
R2	0.013	0.299
R2 Adj.	0.013	0.066
R2 Within		0.013
R2 Within Adj.		0.013
Enrollee FE	N	Y

Incentives to switch

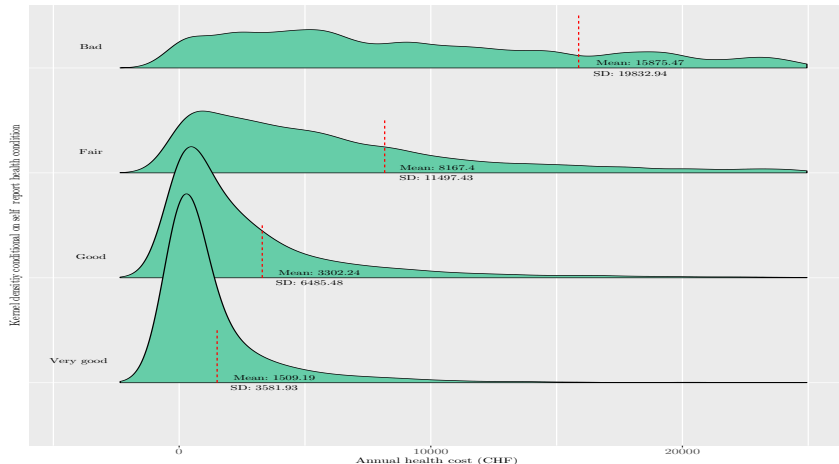
Summary

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- ▶ The relationship is non-monotonic.
 - ▶ a 1000 CHF increase in the incentive to switch results in an increased switching rate of 5% to 8%.

Result III: Health beliefs

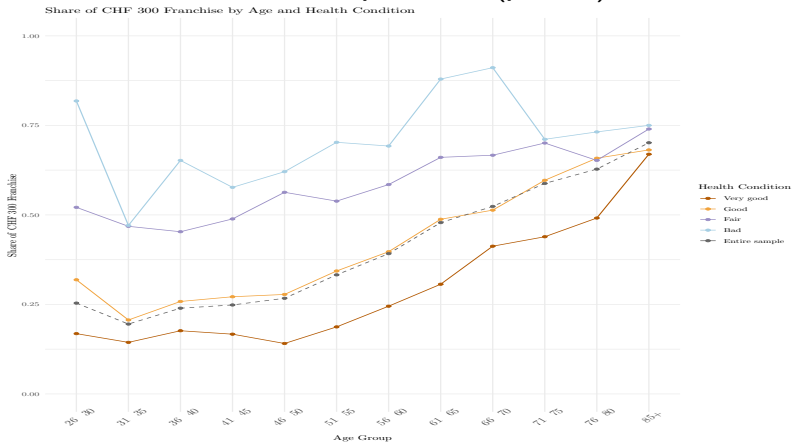
Result III: Health beliefs (descriptives)



- Self-reported health aligns with realized medical spending.

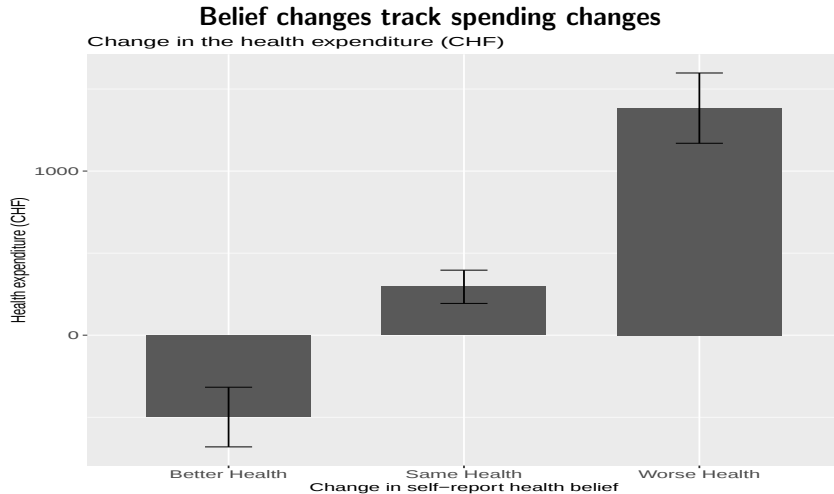
Result III: Health beliefs

Beliefs reflect private risk (pri. info)



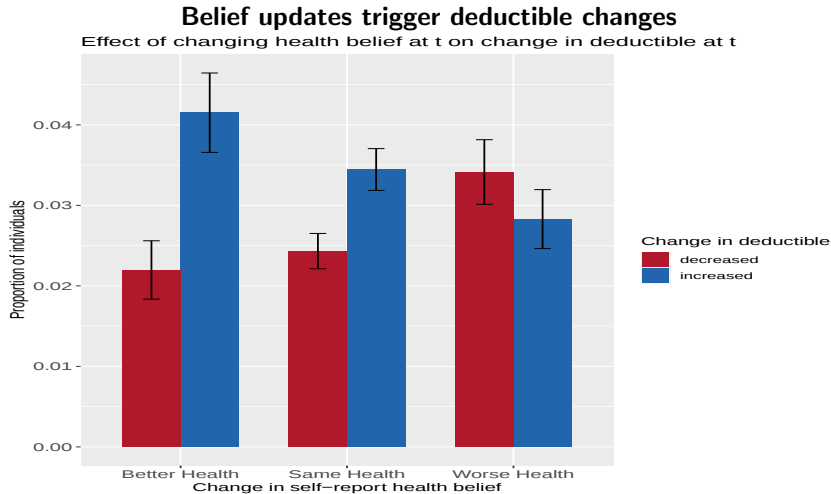
- ▶ Age gradients are steeper among healthier individuals.
- ▶ Private information meaningfully shapes coverage choices.

Result III: Health beliefs



- Self-reported health is a reliable proxy for health updates.

Result III: Health beliefs



- Belief updates raise switching rates—modestly, not dramatically.

Conclusion

- ▶ **Large impact of inertia on health insurance choices (+20 p.p.)**
 - ▶ Under a full-attention benchmark, $\approx 70\%$ choose the optimal plan vs. $\approx 51\%$ with defaults (inertia).
 - ▶ Policy implication: Roughly 30% of poor choices are attributable to limited understanding or rational inattention.
- ▶ **Factors**: learning, frictions, belief updates (internal attention)
 - ▶ General point: These mechanisms improve decisions only modestly and do not fully correct mistakes.
- ▶ **Policy implications**: Use targeted, efficient interventions rather than simply trying to raise attention.

Thank you!

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