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# Commentary

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## Consumer Choice Among Health Insurance Options

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by David Mechanic

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With competition increasing among health care plans, employees of large firms typically are faced with more opportunities for choice and more complex options than in the past. These may include traditional forms of Blue Cross/Blue Shield and commercial insurance coverage, prepaid group practice plans, independent practice associations (IPAS), and preferred providers. These plans may be offered in the context of broader choices as well, such as in cafeteria plans. Within health plans of similar kind, there also may be large variations in coverage, cost sharing, major medical provisions, and required premiums. It is not uncommon for employees to be faced with five or ten choices, and in many instances, such as in the Federal Employees' Health Benefits Program (FEHBP), the range of choices can stagger even an expert.

The premise underlying the medical marketplace is that consumers make rational choices among alternatives. Those studying choice either explicitly or implicitly depict the decision process as a rational calculation of costs and benefits of varying alternatives in which options most consistent with perceptions of risk vulnerability, personal tastes, and preferences are considered relative to costs.<sup>1</sup> Choice, however, is highly stable with little shifting in open enrollment situations, although much more would be expected given expressed preferences. These facts suggest important barriers to the expression of rationality. In most choice situations, only a few percent shift from one plan to other during any open enrollment period. In May 1982, the FEHBP mandated changes reducing benefits by 12 to 16 percent, and premiums increased by 30 percent, establishing unusually strong incentives for rational consumers to shift plans.<sup>2</sup> While the magnitude of shifting tripled to a rate of 21 percent, there was much inertia.

Typically, those who wish to emphasize the rationality of choice

attribute inertia to “information costs,” but such explaining by naming simply begs the question. Consumer health behavior is rational within a severely restricted range. The deficiency lies in the paucity of clear, easily understood information on any dimensions other than costs and coverage. With this issue in mind, I explore in this Commentary what we know at present about consumer choice.

In recent years, the choice literature has grown, and I draw on a variety of studies and reviews.<sup>3</sup> I argue that a truly competitive marketplace will require that consumers receive information on a broader range of dimensions than now available, in forms that are easily understood and that facilitate comparison.

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### Choice Situations

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For many individuals, the choice of a health care plan is not salient.<sup>4</sup> Choice situations are more immediate to persons new to a geographic area, those who become especially dissatisfied, and those who anticipate new large needs. Shifting choices also may occur when there are substantial economic inducements to do so, as in the modifications of the FEHBP previously noted, but in general most employees seem resistant to change and unaffected by new opportunities during open enrollment periods.

Most people understand that such choices may be important for them, but their decision making also appears very limited. Thus, we have been making some modest exploratory efforts to discuss with persons how they have gone about making decisions. This interviewing is qualitative and not particularly systematic, but the exercise is a preliminary step to assess whether inquiries of this sort might help us improve the quality of choice situations.

The dominant model of choice assumes careful examination and weighing of alternatives, but as the number of choices grows, this becomes an increasingly complex and difficult task. Beyond the typical inertia, individuals who are motivated to make an informed choice are inclined to simplify it to its bare essentials. In Herbert Simon’s terms, typical health insurance consumers “satisfice;” given the difficulty of locating reliable information relevant to their preferences, they have no good way of seeking an optimal solution for themselves and their families.<sup>5</sup> I suggest that they do this by using some relatively simple preference criteria that direct choice. Some of these preference criteria appear to be more important than others, but there are sufficient differences among consumers in tastes, personal circumstances, and life stage to make it impossible to establish any rigid hierarchy of priorities.

**Rating preferences.** Most people have a few highly valued “preference

rules" that dictate how they approach a decision situation and distinguish among its elements. Simply giving respondents a list and asking them to rate the importance of various facets of their medical care is unlikely to elicit their preferences accurately.<sup>6</sup> Respondents will indicate that many of the items you ask them about are important, but these identical criteria may not be particularly salient to them as they make their choices. Preferences are conditioned by one's location in the life cycle and family context, by the psychological costs of uncertainty and time required to acquire new information, and by the limits in understanding how varying plans function.

In existing choice studies, variables yielding inconsistent results are typically broad structural and socioeconomic indicators that are, at best, crude proxies for preferences and motivation that more directly affect the choice situation. We should not be surprised that sex, education, workforce status, age, income, marital status, family size, and similar measures present an ambiguous picture.<sup>7</sup> In contrast, such variables are likely to set important conditions for the expression of preferences. For example, in our study of disenrollment from a health maintenance organization (HMO), lower-income persons were no less dissatisfied with care than those more affluent, but high income enabled a shift in choice more easily among those with low satisfaction.<sup>8</sup>

**Weighing the issues.** While consumers understand that health plan choices are important, typically the issues at stake are not highly salient or immediate at the point of decision making, not unlike the circumstances in general surveys where patients typically rate physician satisfaction high. Moreover, people do not have a clear idea of how to seek detailed information of most immediate relevance to them, and thus motivation appears weak. There is a tendency to remain with whatever plan one has if one anticipates little unmet need for future care or if one's experiences have not been unsatisfactory. Young, single people, for example, typically anticipate little need for care and are relatively indifferent to distinctions among plans other than those related to cost. Low anticipated need also helps explain the fact that young people are disproportionately uninsured.

The salience of need among those who have special health concerns results in more specific appraisals. Such persons are more inclined to make efforts to match their anticipated needs against the specific benefits plans provide. Persons with serious medical problems, for example, face a complex choice that requires consideration of not only degree of coverage and related cost issues but also questions of freedom of choice and quality. Such persons or those who face health issues they define as highly personal seem especially averse to uncertainty and demonstrate

strong resistance to leaving physicians with whom they have established a satisfactory personal relationship. Similar inclinations occur among women who have developed a good relationship with an obstetrician.<sup>9</sup>

As one talks with consumers in choice situations, one gains the impression that less effort is devoted to exploring health care options as compared with, say, the purchase of an automobile. One also has the sense that consumers see such insurance choices as more distant from their daily lives and that most lack a strategy for making the necessary comparisons, except in relatively simple ways. Unlike the selection of a car, good sources of comparative information that go beyond the typical marketing brochures are not readily available. In some sense, the consumer selects among alternative “trusting relationships” when choosing a health plan, but few have any notion of how one gains information on how trustworthy a plan will be.

The selection of health plans and providers is, in part, an iterative process in which individuals better learn to make informed choices responsive to their needs. The instability in initial choices, however, suggests considerable failure to understand important differences among plans in access, cost, and freedom to select providers or to be reimbursed for services outside the plan. This is particularly true as populations select plans with which they have had little prior experience. That one-quarter of older HMO members covered by Medicare disenrolled during the first year suggests a failure in structuring informed initial enrollment choices. Such failures can be costly both to the consumer and to the plan.<sup>10</sup>

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### **Important Preferences**

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**Physician/patient relationship.** Some preferences seem much more central to people’s decisions than others. The primary preferences are related to the character of established doctor/patient relationships, cost, and special needs. The single largest and most consistent result in the literature is the power of a strong doctor/patient relationship in predicting consumer retention in a plan that covers that doctor’s services. This relationship is based on both the perceived quality of interaction and its stability and continuity. Individuals having such satisfactory relationships are unlikely to change health care plans unless the options allow them to retain preferred health care providers with additional advantages. This gives a strong marketing advantage to IPAs whose physician list in any geographic area may be reasonably extensive.

**Cost of plans.** A second important preference is cost. Most consumers are cost sensitive and are attracted, other factors comparable, to plans with the lowest premiums and out-of-pocket costs.<sup>11</sup> Existing research

does not allow assessment of the relative influence of premium versus cost-sharing expenditures. Intuitively, it seems reasonable that enrollees would prefer the lowest premiums, believing they have control over the frequency of use of services and related out-of-pocket costs. But, alternatively, many people prefer not to have to worry about out-of-pocket costs at the time they seek care. This accounts for consumers' strong attraction to "front-end" insurance despite its relatively high price. In contrast, when consumers choose among plans, the premium cost is most salient and is known, and low premiums are especially attractive to persons who are not strongly fearful of assuming some risk. Long and his colleagues, in studying disenrollment in various plans in Minneapolis, demonstrate the importance of premiums in directing employees' decisions.<sup>12</sup>

The perception of significant savings varies in direct relationship to household income, and thus cost factors will disproportionately affect those with low and modest family incomes. Consumers with higher family incomes will be more willing to incur additional costs in retaining valued established relationships. One study estimated that significant cost savings are necessary to induce patients to leave an established relationship to join an alternative health plan—\$120 to \$240 in current dollars.<sup>13</sup> Consumers with serious problems who feel dependent on their doctors may be unwilling to consider a shift even if their choice involves economic hardship.

**Perceived need.** The third major preference area relates to perceived individual or family need. Individuals anticipating special needs will be more sensitive to the details of the benefit package than others will be. Special needs will operate differently in the case of persons with serious or long-standing chronic disease and those who require many routine services often associated with copayment such as prenatal and pregnancy care and well-baby and child care. In instances of need for routine care, preference tends toward the most comprehensive outpatient coverage. But in situations of special need, preference will be for opportunities to receive covered services from a trusted provider if one already exists.

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## Decision Rules

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In approaching choice situations, persons immediately make efforts to narrow the number of operative choices to a psychologically manageable set. Typically, individuals consider very few alternatives and focus the comparison only on a subset of the many relevant dimensions. People are more likely to select familiar options, although a small segment of the population with no critical anticipated health needs—commonly the young, healthy, and relatively well educated—may be attracted to inno-

vative programs because of their own proclivity to change and innovation. Familiarity may be assessed by prior experience with a particular type of health plan arrangement; knowing other satisfied enrollees of the plan; being aware of the popularity of a particular plan in one's own immediate geographic area, particularly among acquaintances; and, in less common instances, having developed a view of the program through attendance at open houses or other forms of direct contact. Most commonly, where the respondent has limited information and no direct experience, the opinions of relatives, friends, and coworkers are influential in directing choice. These informal advisers are particularly credible because they tend to share many characteristics with decisionmakers, and their motives are not in any way suspect. Long and his colleagues found that the proportion of fellow employees in one's plan had a substantial effect on continuing enrollment, controlling for economic and other factors.<sup>14</sup>

Individuals will seek to shift health care plans when they feel dissatisfied with the responsiveness of present care arrangements. The most central dimensions of satisfaction include *access* and *physicians' interest and responsiveness*. The ability to make a timely appointment is probably the strongest proxy for access; other considerations such as location or operational features are typically less salient. Consumers are intensely concerned with the physician's personal interest in them, which can be measured in varying ways; evidence of a continuing relationship with a single doctor is a rough proxy. More specific indicators include the perceived quality of communication, not feeling rushed, and the like.

In choosing a family policy, the preference criteria will concern the member of the family whose needs and dissatisfactions are perceived to be the most critical. Cultural values and family context may affect definitions of priorities and the relative importance of needs, introducing some unpredictability, but in most instances the preferences described earlier will persist. It becomes especially important to understand the needs and concerns of the family member defined as most central to the choice.

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### Contingent Preference Criteria

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By contingent preference criteria, I refer to those considerations that are typically not central to decision making but may shift preferences at the margins. In any individual instance, these criteria may be primary, but they are most commonly of secondary significance. Contingent preferences include convenience and physical proximity to care, attractiveness of centralized services, avoidance of paperwork and forms, limited wait-

ing time in the office to get care, perceived responsiveness of nonprofessional personnel, attractiveness of the premises of the care provider, availability of prevention and educational programs, and the like. If asked, many respondents rate these dimensions as highly important, but for most they seem to occupy only secondary significance.

All respondents attribute great importance to technical competence and quality, but except for rare instances these are interpreted through the dimensions already described and do not involve independent assessments. Proxies for competence and quality include the recommendations of relatives and friends, the quality of doctor/patient communication, the perceived thoroughness and sensitivity of the physician's workup, the satisfactory demeanor of physicians, and the modernity of facilities.

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### **Problems In Linking Preference Rules To Choice**

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One might assume that ascertaining a respondent's preferences and decision rules would allow reasonably adequate predictions of choices since these can be linked readily to the objective characteristics of the available health care options. Prediction, however, often is not satisfactory because many consumers are not knowledgeable about the plans they choose and often attribute incorrectly to their choices the preferences they have. These incorrect choices are largest during the initial enrollment in a new type of health insurance plan and decrease over time in light of newly acquired information. Shifts in choice occur earliest in the choice career and decrease over time, leaving a more stable residue of continuing members in various health care plans. This sorting process goes on in all choice behavior but is particularly apparent during entry into new options with which individuals have had little experience.

Most studies of choice are cross-sectional, making it difficult to assess whether individuals incorrectly attribute their preferences to plans they choose because of lack of information, or whether people make global choices that are relatively simple and then associate their preferences with their selection in a form of wishful thinking or desire for consistency. Patterns of response seem similar to those described by studies of voting behavior in which persons select candidates in a relatively global way (for example, by their party identification or personal presentation) but then often incorrectly attribute their personal political views to the candidate. In selecting a candidate, few individuals carefully research the candidate's record. Most voters are guided by prior loyalties, general impressions, or one or two key issues. The difficulty of assessing a candidate's stance on the range of relevant issues, weighing them in importance, and arriving at some optimal assessment is beyond the motivation or capacity of most of

us, and we seek simple markers such as party identification to help guide us through the choice.

Discovery of an incorrect choice among health plans depends on experience, and dissatisfaction may not become apparent until the person needs sustained care. For some, this may be too late. Because individuals interact fairly frequently with health care services, those who select plans with difficult access, tough gatekeepers, and insensitive physicians may discover the limits of their option relatively quickly, and this explains the surge of shifting in initial enrollment periods. But many others will learn the limitations only when they need to make more than perfunctory use of the system. This helps explain a continuing erosion of voluntary membership in plans at a relatively low but fixed rate following the initial period of unstable choice. The choice system is dynamic and iterative. Not only are individual needs changing and critical incidents unpredictable, but the systems of care are adaptive to the changing context of medical practice and competition among plans.

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## Conclusion

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For the past twenty-five years, health services researchers have tried to predict how consumers choose among health options, but with only modest success. The evidence suggests that assumptions of rationality accurately reflect how most people approach these decisions, but the real constraints on rational choice are so large that many simply opt out. The information typically informing choice is restricted, the plans vary on so many dimensions that comparisons are difficult to make, and the marketing literature confuses ideal statements with real operational performance. Consumers, for example, are commonly told by HMOs that they keep people healthy by early intervention encouraged by elimination of fee barriers. They are not told much about the variety of nonfee rationing approaches through which HMOs reduce utilization. Some large programs like the FEHBP provide useful summary comparison charts that help consumers compare premiums, services covered, and cost sharing. A private, nonprofit organization, the Center for the Study of Services, also issues a guide to special features of specific plans and findings from customer service surveys.<sup>15</sup> These efforts begin to suggest the type of information base essential for thoughtful choices. In the typical situation, the consumer simply gets a collection of slick brochures from each of the plans that provide little detail on how these programs actually function and how they differ.

In this context it is easy to understand why individuals focus on what they can directly experience: whether their present relationship with

their doctor is satisfactory; whether they can reach the doctor when needed; how much the medical care plan costs; and whether particularly important medical needs are covered. If there are no obvious problems, people are reluctant to try something different when the choices are so difficult and uncertain. For most, such decisions are probably the correct ones given the difficulty in obtaining information on relative performance of plans and quality of care. People may know what they prefer, but they are not particularly good at matching their preferences against the characteristics of the health care plans among which they choose. It seems that the fault is more in the character of information in the marketplace than in the criteria people use.

Consider how an informed buyer purchases a car. First, the average buyer has had experience with cars and probably has driven in a variety of vehicles. Buyers, once they narrow their choices, can test-drive alternatives. They can easily obtain considerable performance data if they wish on a broad range of indicators ranging from acceleration time to frequency of repair experiences from *Consumer Reports* or an array of other such magazines. They can easily compare prices among dealers for the same car. Individuals may have brand and dealer loyalties that are more emotional than objective, but they also have the information and capacity to make informed choices about tradeoffs. Buying a car and choosing a health plan are not the same. But it is clear that the patient consumer could benefit substantially from more intensive information of the kind that car buyers can readily obtain.

**Sources of information.** Unlike data on car performance and repair frequency, the kinds of information health consumers want is more intangible and difficult to gain in an objective way. Moreover, people's tastes in physicians' personality and style of practice are not easily measured. Also, within any large health plan there is much heterogeneity in professional staff and practice settings. Yet, I believe we exaggerate the difficulty of providing helpful information. Individual consumers are limited in the data they can reasonably garner by themselves, but consumer and employee organizations and representatives can do a great deal to assist employees to make choices better fitted to their preferences.

The types of comparison information on benefits, premiums, and average out-of-pocket expenditures in various plans—such as the information available within the FEHBP—serves as a base on which to build. Simple descriptions that convey how such programs as HMOs operate in practice can be helpful particularly when supplemented by specific information on ease or difficulty in getting routine and emergency appointments, average waiting time for an appointment, indications of patients' satisfactions and dissatisfactions with the plan, and the

like. Such information can be obtained through routine, short sample surveys carried out for this purpose. In the case of large employee groups, obtaining such information would be relatively inexpensive and practical given the numbers of employees involved. Objections comparable to those now heard in the health field were common when universities first began collecting course and teacher ratings for faculty evaluation and student use. Such information is now routinely collected in many institutions and is helpful to students and administrators. The collection of such data does not require the same rigor as scientific surveys.

Depending on the commitment of the consumer organization, information of varying sophistication might be collected. When employee reports suggest serious problems of access, objective validating information could be obtained. Such information would not only serve as a guide to consumers but also signal competing health plans to improve their practices. Measuring quality and effectiveness of care in varying plans is, of course, a far more difficult challenge, and not one likely to be productively pursued within the types of contexts I have described here. But even simple, well-presented, and easy-to-understand comparisons of levels of coverage, premiums, likely out-of-pocket costs, degree of coverage in such areas as mental illness, and related issues contribute to rationality. When such information is supplemented with indications of ease or difficulty of access, waiting times for appointments, and other indicators of responsiveness, the quality of choice is further enhanced. Gaining such information is easily within our technical capacities and not expensive.

It is plausible that even more can be done, particularly as health care plans compete. Drawing on the car purchase analogy again, it is not far-fetched to suggest that health programs might offer potential patients opportunities to visit care settings, to meet the primary care physicians who will look after their needs, and to gain some experiential sense of what their care will be like. Indeed, some HMOs offer visits and tours to potential enrollees, and we found that enrollees who actually visited the setting before enrolling were less likely to disenroll later. These patients were no more satisfied than others, but we suspect that their experiences were more consistent with expectations as a result of increased familiarity with the plan. Opportunities to visit with primary care physicians before enrollment obviously raise resource issues, but I suspect that only a small segment of the population would actually seek to do so.

In short, consumers understand clearly that there are tradeoffs among choices, and have no difficulty articulating their preferences. What they most lack, and what most accounts for their inertia, is the difficulty of linking their preferences to the various characteristics of the choices they

must make. When good comparative cost information is provided, consumers show they can identify good buys.<sup>16</sup> When improved performance data become available, consumers will be able to better fit their additional preferences to real differences among alternative plans. Consumers can behave rationally if only we allow them to do so.

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## NOTES

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