

VIEWPOINT

Replacing the Affordable Care Act Lessons From Behavioral Economics

Jonathan S. Skinner, PhD

The Dartmouth Institute for Health Policy and Clinical Practice, DHMC, Hanover, New Hampshire.

Kevin G. Volpp, MD, PhD

Philadelphia VA Medical Center and Perelman School of Medicine and Wharton School, University of Pennsylvania, Philadelphia.

Republican efforts to replace the Affordable Care Act (ACA) are not over, despite the failure of the American Health Care Act (AHCA) legislation. The major challenge facing the AHCA was the loss of insurance coverage for an estimated 24 million people.¹ Any subsequent reform, especially those less costly than the ACA, will have the same challenge of keeping currently insured individuals and households from discontinuing their insurance. In this Viewpoint, we draw on behavioral economics to propose 4 general principles for health insurance reform to help ensure that the currently insured will not lose their coverage.

Incentives for Healthy Individuals

In insurance markets, healthy people subsidize people with acute and chronic disease and other health conditions. Insurance is still valuable for healthy people, because they need not be concerned about the risk of no insurance coverage in the event of unexpected injuries or acute health events. However, there is often a tendency to minimize those future risks and use the money now for more pressing concerns rather than signing up

Coupled with other approaches to reduce costs, behavioral reform could provide some needed optimism for 2017: Lower health insurance premiums for the first time in recent memory.

for expensive insurance. Once enough healthy people no longer elect to enroll in and purchase health insurance, a major challenge occurs, with rising premiums and the eventual collapse of insurance markets.

Incentives to encourage healthy individuals to sign up for health insurance can be described as either carrots or sticks. The ACA has both carrots (refundable tax credits) and a stick—the mandate—to ensure that healthy persons purchase insurance. Granted, the stick was not always effective; initially the amount was too small, and the penalty is too far in the future. But it was widely credited with increasing enrollment by overcoming “present bias,” the idea that potential future medical costs are discounted too much when compared with having to write a check for insurance premiums today. By contrast, current proposals rely almost entirely on carrots—tax credits for enrollees.

Behavioral Economics Principles

The first principle from behavioral economics research is that carrots do not work nearly as well as sticks; \$2 in subsidies induces approximately the same behavioral-

response as \$1 in penalties.² Furthermore, subsidies drain money from the federal treasury, whereas sticks bring in more revenue.

A second behavioral economics principle involves instant gratification; paying significant premiums means that something is received in return. Bare-bones or catastrophic plans, along with health savings accounts, do not do well from the perspective of instant gratification. Aside from the relatively few families who benefit from receiving catastrophic care, the vast majority of people do not experience any “immediate gratification” from paying those premiums, because they never reach the catastrophic cap. Even current enrollees in bronze high-deductible plans wonder why, after paying substantial premiums, they still are responsible for burdensome deductibles and co-pays.

People’s tendency to focus on immediate gratification also has important implications for the continuous coverage requirement in the AHCA. This requirement is a stick but is unlikely to work. Under this provision, if an individual who did not purchase insurance coverage now or who lets current insurance coverage lapse, would have been subject to a 30% penalty to sign up again. It is unlikely that young invincibles, young healthy people who see themselves as invulnerable who have been ignoring health insurance up until now, will suddenly become concerned about their ability to buy insurance many years down the road. Furthermore, the 30% stick would have discouraged uninsured people from buying insurance—precisely the opposite effect of the mandate.

The third principle is to use inertia to maintain enrollments. The simplest evidence-based approach would be to create automatic, annual renewal of health insurance for those currently covered by ACA plans, with the out-of-pocket premiums close to what they paid last year. People could opt out of the system but then would lose both the subsidy and their existing health insurance coverage. The bias toward holding on to a plan, combined with inertia and the sense of loss from giving up those federal subsidies, could work toward keeping people enrolled.²

The biggest challenge is a factor that even inertia cannot solve—that any proposal leading to higher out-of-pocket premium payments, especially among low-income and older people nearing retirement, can potentially lead to substantial disenrollment. Even for this seemingly intractable problem, behavioral economics can still provide some guidance.

Health insurance is an 80-20 proposition; 20% of enrollees account for 80% of costs. If the least healthy

Corresponding Author: Kevin G. Volpp, MD, PhD, LDI Center for Health Incentives and Behavioral Outcomes, University of Pennsylvania Perelman School of Medicine and the Wharton School, 423 Guardian Dr, 1120 Blockley Hall, Philadelphia, PA 19104-6021 (volpp70@exchange.upenn.edu).

patients can be moved off of the exchanges, this will allow for a substantial decline in premiums on the exchange for the 80% healthier people who remain. With inertia and automatic reenrollment, millions of individuals would likely be motivated to stay with their plans, despite shrinking subsidies. Congressional reformers understand this and have recommended moving high-cost patients into separate high-risk pools, but early experience with these pools has demonstrated their limitations that without a dedicated revenue source, they are perpetually underfunded.

So what can be done? The fourth principle relies on the salience of taxation—creating new taxes to pay for health insurance subsidies is far more painful politically and economically than simply shifting high-cost enrollees into an existing insurance plan that already enjoys wide political support.³ Most individuals with Social Security Disability Insurance (SSDI) already receive coverage under the Medicare program. The chronically ill individuals currently enrolled through the health insurance exchanges could be shifted into Medicare. There is already a mechanism for people older than 65 years who do not have Social Security to sign up for Medicare; the current price of enrolling is \$413 per month for Part A (hospital) cov-

erage, and \$134 for Part B coverage (for incomes under \$84 000). Combined with the currently proposed tax credits, out-of-pocket premiums could actually decline for many older people.

While placing additional pressures on the Medicare Trust Fund, this idea would yield a further cost-saving bonus for enrollees and the federal government: Because inpatient private insurance reimbursements are 75% higher than Medicare reimbursements,⁴ the overall health care spending would immediately decline. Most importantly, insurance premiums for everyone else also would decline immediately as the most expensive chronically ill patients are moved off private plans and into Medicare.

Conclusions

The behavioral economics approach cannot solve all of the problems facing US health care. But behavioral principles can inform approaches to help ensure that insurance markets do not unravel, which is the first and most important challenge of any “repeal and replace” efforts. Coupled with other approaches to reduce costs, behavioral reform could provide some needed optimism for 2017: Lower health insurance premiums for the first time in recent memory.

ARTICLE INFORMATION

Correction: This article was corrected online April 17, 2017, to correct the corresponding author’s departmental affiliations and address.

Published Online: April 3, 2017.
doi:10.1001/jama.2017.4084

Conflict of Interest Disclosures: Both authors have completed and submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest. Dr Volpp reported receiving research funding from CVS, Humana, Hawaii Medical Services Association,

Weight Watchers, and Vitality (Discovery-South Africa). He is a partner in the behavioral economics consulting firm VAL Health. No other disclosures were reported.

REFERENCES

1. Kahneman D, Tversky A. Prospect theory: an analysis of decision under risk. *Econometrica*. 1979; 47(2):263-292.
2. Madrian BCM, Shea DF. The power of suggestion: inertia in 401(k) participation and savings behavior. *Q J Econ*. 2001;66(4):1149-1187.

3. Chetty R, Looney A, Kroft K. Saliency and taxation: theory and evidence. *Am Econ Rev*. 2009; 99(4):1145-1177.

4. Selden TM, Karaca Z, Keenan P, White C, Kronick R. The growing difference between public and private payment rates for inpatient hospital care. *Health Aff (Millwood)*. 2015;34(12):2147-2150.