Choice Architecture: A Tool for Ratcheting Up Benefit and Wellness Results

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According to most economics textbooks, human beings are superrational creatures who know what is in their own best interest and always act accordingly. When making a decision to buy something, the rational consumer will evaluate all the possible alternatives before making a purchase, having already conducted research on the state of the market. He or she would not buy something on the spur of the moment or the recommendation of a friend. Nor would a rational consumer be unduly influenced by advertising or a brand name in making purchasing decisions. This explanation of human behavior is known as the *rational agent model*. Sound realistic?

While the rational agent model is useful for some economic analysis, such as when we examine the economy as a whole, it clearly does not correspond to how human beings behave in the real world.

So why do people sometimes make decisions that are not strictly in their own best interest? Nowhere is irrational behavior more evident than in the way employees often make decisions regarding their health benefit and wellness programs. It is not unusual for employees to pick health benefit options that are less valuable, actuarially speaking, than other choices, but they perceive the most expensive plan, or the brand they recognize the most, to be the best. Many employees leave money on the table when offered incentives to complete a simple online health risk assessment (HRA) or biometric screening, even though the results could inform them of areas in need of health improvement.

Behavioral economics is a relatively recent field of study that examines how nonrational factors like emotion or altruism influence economic choices. It applies the lessons of disciplines like psychology and sociology to explain decisions about consumption, investment and other facets of economic life. *Choice architecture* is the positioning of choices in such a way as to influence the decision in the direction that the "choice architect" believes to be in the best interest of the decision maker. Whether or not they know it, benefit and human resource professionals are choice architects. Choice architecture, popularized in the book *Nudge* by Richard Thaler and Cass Sunstein, provides practical examples of how to change the world for the better by leveraging behavioral economic principles.

I had the privilege of taking behavioral economics classes taught by Thaler at the University of Chicago Booth School of Business. Thaler told a story about how he convinced the university to change the way employees enrolled in their 403(b) retirement plan from an opt-in approach to an opt-out approach. This new opt-out method enrolled all eligible employees as participants in the plan automatically, at a certain percentage of their pay, placing them in standard investment options. Employees who did not wish to participate, or who preferred other investment options, could simply opt out or make changes. The participation in the plan went up dramatically once the new opt-out default was established. Since that time, almost every major retirement vendor encourages employers to take this approach, which leverages the principles of choice architecture.

Central to behavioral economics is the notion of *bounded rationality*—the idea that people are rational only to a point, because human cognitive capacity is limited. The term was first coined by the American Herbert Simon, who in 1978 was the first behavioral economist to receive a Nobel Prize.

However, it was two Israeli-born psychologists, Daniel Kahneman and Amos Tversky, who brought mainstream recognition to behavioral economics. During the 1970s and '80s, they built on Simon's idea of bounded rationality by identifying a range of common behavioral biases, based on real-world experimental evidence. In 2002, Kahneman was awarded the Nobel Prize for his

work with Tversky on how people make decisions when faced with uncertainty.

One of their best-known findings is called the *endowment effect*—the tendency for people to place more value on expected losses than expected gains, otherwise known as *loss-aversion*. Although this sounds like common sense, it presents a real problem for traditional economics, which assumes that people place the same value on a dollar regardless of context.

A good example of the endowment effect is how two different clients introduced a financial lever for employees to complete an HRA during open enrollment for their 2014 health benefit plan. (See table.) Both clients were large hospital/health systems with more than 10,000 employees. Both clients decided on a financial lever in the amount of $30 per month to be provided to each employee who completed the HRA. Both clients built the cost of the $30 into the premium structure that was cost-neutral to the plan.

Client A used a "carrot" (incentive) approach by providing a $30 discount, or premium credit, to employees who completed the HRA. Client B used a "stick" (penalty) approach by charging a surcharge of $30 per month for employees who failed to complete the HRA. Economically, the levers were the same. In other words, employees who chose not to complete the HRA would pay $30 per month more for the health benefits than employees who completed the HRA, whether they worked for Client A or Client B. However, Client B enjoyed 95% participation while Client A achieved 80%. While both results were stellar, Client B leveraged the endowment effect to achieve higher participation. The fear of loss (the surcharge or stick) was a greater motivator than the hope of gain (the credit or carrot).

Since the 1970s, many kinds of behavioral biases have been confirmed through experiment. These show that people not only have bounded rationality, they also suffer from *bounded willpower*—the failure to do something even when they know it is in their best interest.

A very common behavioral trait associated with bounded willpower is *status quo bias*. This is the tendency to stick with the current state of affairs, even though there are clearly better ways of doing things. Although most people would recognize this as procrastination, standard economics assumes that people will always do something if it is in their best interest to do so. A common example of status quo bias is the failure to enroll in the new account-based health plan, with a health reimbursement or health savings account, because it is new and complicated, even if the value is higher, considering contributions and out-of-pocket expenses, than the old traditional plan.

Of course, these kinds of behavioral quirks are part of everyday life and would be familiar to most of us. However, economists in the past assumed that irrational behavior occurs randomly and that its effects are not noticeable at the level of the economy as a whole. The achievement of behavioral economics has been in showing that irrational tendencies are systematic and predictable and are just as likely to occur among well-educated people as any others.

There are now dozens of recognized deviations from strictly rational behavior. For example, *framing bias* is the tendency to draw conclusions according to the way something appears, rather than the reality of the situation. In the federal and private health insurance marketplaces, plan choices are labeled Bronze, Silver, Gold and Platinum—labels that depict the relative actuarial value of each plan. While people may not understand actuarial value, they do know that platinum is more valuable than bronze. Some large employers that plan to continue offering employer-sponsored health benefits are considering using the same labels and easy-to-understand descriptions to help frame choices and demonstrate to employees that their plans are competitive.

Simple changes, such as framing, can make a big difference and go a long way to counteract the biases and *heuristics* (rules of thumb) that strongly influence behavior. The following biases unconsciously influence how employees make benefit and health decisions:

TABLE

Comparison of Carrots vs. Sticks

Hospital/Health System	Financial Lever	Activity	Participation Percentage
Client A	$30/month credit	Complete online HRA	80%
Client B	$30/month surcharge	Complete online HRA	95%

- *Availability bias* is the tendency to rely on easily available information to make decisions, rather than seeking out information that is more relevant but harder to acquire.
- *Confirmation bias* is the tendency to rely on evidence that accords with our preexisting beliefs, even when other evidence suggests otherwise.
- *Choice overload* occurs when there are so many options available that we end up making no decision at all.

An example of the *low-probability/high-reward bias* is the use of a sweepstakes drawing to increase participation in wellness programs. People purchase lottery tickets despite knowing the cost exceeds the probability-adjusted return. One client implemented an early-bird drawing for its wellness program whereby employees who completed their HRA in the first two weeks of open enrollment earned an entry into a prize drawing for an iPad. One winner for each location (12 total) was drawn out of a hat and announced to the entire workforce at the end of the second week. The participation in the first two weeks was dramatically higher than the last two months combined, and the early momentum helped propel them to an overall participation rate of 80%.

These insights might be of only academic interest if it weren't for the serious impact that irrational decision making has in the real world. When seen through a behavioral prism, the current health care crisis is the culmination of many poor choices made by individuals over a long period of time. The result in many cases is poor health of individuals and the associated high cost.

Because it is based on real-world evidence rather than textbook theories, behavioral economics is growing in influence among academics and policy makers. Benefit and wellness professionals are now considering choice architecture as one of the most practical tools in their toolbox to influence the decisions that employees make that will lead to healthier lives.

Massaging the Data: What Health Benefits Plan Usage Tells Us About "Want" Versus "Need"

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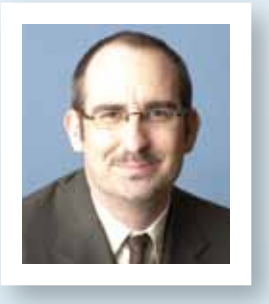
This article is based on the author's presentation at the 2015 Symposium.



David Willows

A comprehensive yearlong study of health benefits usage by Green Shield Canada (GSC) revealed some startling facts for both health benefits advisors and employers. The study examined claims data that included prescription drugs, eyewear, foot care and an array of health service providers. It turns out that the way benefit programs are being used and the dollars spent on those programs do not appear to align with the predominant health challenges facing Canadian employees.

Health Care Service or Lifestyle Choice?

The study showed a rapid increase in spending on paramedical services—specifically, massage, chiropractic and physiotherapy. GSC found that the highest expenditure of any service was for massage—starting with young children and continuing through the age bands. What's more, massage, chiropractic and physiotherapy are often combined, especially by the highest cost claimants. Of course, there are situations in which this traveling in threes is medically warranted. But the rate of consumption of this combination of benefits suggests that cross referrals, often at the same clinic, are happening more and more. It doesn't seem like a great leap to ask whether we're creating future generations accustomed to the services of paramedical practitioners as preventive measures rather than as a response to injury.