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Window Shopping on Healthcare.gov and the State-Based Marketplaces: More Consumer Support Needed

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Abstract
This data brief examines the window-shopping experience that consumers encountered on each health insurance marketplace website during the first two weeks of the Affordable Care Act's second open enrollment period. The marketplaces have made some progress toward adopting the recommended "Top 5 Rules for Decision Support." Shoppers found plenty of sorting and filtering options, but insufficient information about providers and little true decision support. Although there is still a long way to go, there are grounds for optimism about further progress for the next open enrollment period.

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In-Brief

This data brief examines the window-shopping experience that consumers encountered on each health insurance marketplace website during the first two weeks of the Affordable Care Act's second open enrollment period. The marketplaces have made some progress toward adopting the recommended "Top 5 Rules for Decision Support." Shoppers found plenty of sorting and filtering options, but insufficient information about providers and little true decision support. Although there is still a long way to go, there are grounds for optimism about further progress for the next open enrollment period.

Research has shown that choice architecture can have a significant impact on the decisions that people make when choosing among available options. Coined by behavioral economists, the term "choice architecture" refers to the conscious effort to design the environment in which people make decisions, with the goal of improving those decisions. In the context of the web portals for the health insurance marketplaces, choice architecture can include the order in which the available health plans are displayed, the amount and type of information that is displayed regarding each plan, as well as the availability of sorting and/or filtering options, just to name a few. Good choice architecture does not necessarily focus on the number of options (although there is concern that too many options may overwhelm the consumer), but rather on structuring choice environments so that consumers are most likely to pick the option that is optimal for them, based on their needs and preferences.

Based on existing research on choice architecture, with assistance from LDI's Tom Baker and his co-author Eric Johnson, and with funding from the Robert Wood Johnson Foundation, the Pacific Business Group on Health (PBGH) developed in 2013 the "Top 5 Rules for Decision Support" for the ACA's health insurance marketplaces. PBGH recommended that the marketplaces: 1) provide individualized total cost estimates to allow consumers to make meaningful financial comparisons; 2) offer an individualized, smart plan presentation that displays plans in the order of their fit for the consumer selecting the plan, but allows customized sorting and filtering; 3) include short cuts that allow consumers to choose plans without detailed comparisons if they wish; 4) use an information hierarchy that highlights what matters most to consumers and allows them to access additional information in a second layer, and 5) include an integrated provider directory that allows consumers to determine which individual providers and how many different kinds of providers are in the networks of each plan. These basic recommendations guided our investigation into the features of each state's marketplace website.

Dr. Charlene Wong's recent article in the Annals of Internal Medicine, "The Experience of Young Adults on HealthCare.gov: Suggestions for Improvement," also provided insight that guided our investigation. Dr. Wong's study followed a group of educated young consumers as they went through the insurance enrollment process on HealthCare.gov last year. Study participants struggled with insurance terminology ("deductible," for example), felt overwhelmed by the amount of information, misunderstood eligibility for subsidies, and expressed a desire for more and better decision support.

WHAT WE DID:

Our team of researchers collected data by visiting the websites for each of the state-based health insurance marketplaces and Healthcare.gov during the initial 15 days of the second open enrollment (November 15-30, 2014), systematically engaging in the window shopping experience, and filling out a survey of the web portal features that were available without creating an account.

We identified over 25 aspects of choice architecture that we used to compare the web portals. At least two researchers independently surveyed each web portal; supervisors audited the results and resolved any discrepancies by visiting the web portal. The research team took and retained detailed screenshots of web pages in order to allow each answer in the survey to be verified by supervisors and available for subsequent research and analysis. Our process simulated a typical shopping experience on each marketplace. It is possible that we may

have missed certain features, but, if so, those features were not apparent to multiple observers with experience navigating the web portals and, thus, would be unlikely to be readily apparent to an ordinary consumer.

In order to standardize data collection, researchers provided the same demographic information when window shopping on each state's website, wherever possible: 30 years old, female, $25,000 annual income (alternately, $10,000 was used when answering questions related to Medicaid), and one person per household. These basic demographics ensured that our "shoppers" would be eligible for tax credits and cost sharing subsidies (gross income between 138% and 250% of the Federal Poverty Level (FPL)), and that pregnancy status could be factored into potential Medicaid eligibility, where applicable.

FINDINGS

Total cost estimates: None of the web portals offer consumers a personalized total cost estimate that shows consumers the sum of their premiums (net of subsidies) and estimated out-of-pocket expenses. The California and Idaho marketplaces point in the right direction, however, by presenting estimated total costs based on low, medium and high use of medical services.

Smart presentation of plans: None of the web portals are able to present plans following PBGH's "smart organization" recommendation, but California and Minnesota point in the right direction. California provides an initial sort organized by estimated overall cost, and Minnesota provides an initial sort organized according to consumer preference.

Although Healthcare.gov and most of the state marketplaces have robust sorting and filtering capacities along most of the dimensions that we looked for, it is doubtful that these capacities, alone, promote good decisions. In most cases the portals first present plans according to premium, from least to most expensive, and then offer users the ability to sort and filter along other dimensions, without suggesting, or providing a tool that the consumer can use to determine, an "all things considered," personalized best fit. The research shows that consumers need more help than this.

Shortcuts: None of the marketplace web portals implement the PBGH recommendation that consumers be given "the choice between the long road (e.g., more preference questions and plan details) and the short cut (e.g., fewer preference questions and plan details)."

Information hierarchy: All of the web portals employ some version of an information hierarchy that highlights summary information in the initial presentation and allows consumers to see additional information in a second layer.

Provider directory: Only six of the state-based marketplace web portals contain an integrated provider look-up, and only three of those – Kentucky, Massachusetts, and Washington – include a look-up for participating hospitals. Healthcare.gov does not contain an integrated provider directory for the states that we reviewed.

Additional findings: In addition to examining whether the web portals implemented the PBGH decision support recommendations in the window shopping experience, we analyzed whether the web portals 1) informed consumers of Medicaid eligibility, 2) "nudge" those consumers who are eligible for the very valuable cost sharing subsidies toward the silver plans that are eligible for these subsidies, 3) provide quality ratings, 4) contain a prescription drug formulary look-up tool analogous to the recommended provider look-up tool, and 5) contain easy to find definitions of terms as recommended by Dr. Wong.

All of the marketplaces except New York inform window shopping consumers of Medicaid eligibility (we understand that the New York real shopping experience does so). Five of the state portals provide the recommended cost sharing eligibility nudge. Five of the states provide plan quality ratings. Only one of the web portals – Colorado – contains an integrated formulary look-up tool, and that tool is hard to find on the Colorado web portal. Finally, most of the web portals contain easy to find definitions of health insurance terms, but Healthcare.gov and five of the state portals do not employ the preferred pop-up definitions that appear whenever the cursor points to a health insurance term.

Table 1 presents the web portal survey results regarding total cost estimates, provider directory, and the aspects of decision support not included in the PBGH recommendations.

Table 2 presents the web portal survey results regarding smart presentation of plans.

Comparison between window shopping in the first and second open enrollment: We also compared the results of the second open enrollment window shopping survey with a partial survey conducted during the first open enrollment. These comparisons are available in an online appendix. There were relatively few differences in choice architecture between the first and second open enrollment window shopping experience. This is unsurprising given the short time between the first and second open enrollments. Differences include more robust sorting and filtering capacities in the second open enrollment on Healthcare.gov and some states, the availability of the overall cost estimates on the California and Idaho portals, greater use of the cost sharing nudge, provider look-up tools, and quality ratings in the second open enrollment web portals. Most of these differences are encouraging steps in the right direction.

DISCUSSION

The web portals for the health insurance marketplaces are making progress toward following choice architecture recommendations but there is still a long way to go.

The portals generally provide robust sorting and filtering options, but they do not provide robust decision support. Except for the limited information provided on the California and Idaho portals, consumers cannot compare their total estimated costs under the available plans. Nor is it possible for consumers to see the plans ranked in terms of best fit for them, though Minnesota's MNsure portal has taken some steps in that direction.

With that said, it is important to emphasize that the PBGH total cost and smart presentation recommendations were very difficult for the public web portals to implement in time for the fall 2014 open enrollment period, as the necessary data analytics and technology solutions are only just now being developed. Medicare.gov has total cost calculators available for Part D prescription drug plans, but not for Medicare Advantage plans, which are more analogous to the health plans available on the marketplaces. Based on recent developments in decision support technology, we expect to see substantial progress toward adopting these recommendations in the next open enrollment period.

The web portals also have a long way to go in order to provide adequate integrated provider directories. Most sites are limited to linking to individual plan directories and searches. Provider look-up tools have proven to be a difficult challenge across the health care marketplace. With the increasing emphasis on narrow network plans, there is a pressing need for tools that will allow consumers to find out which providers are in which networks and, even more importantly, to value those networks.

While only one of the web portals has a drug and formulary look-up tool, those tools present much less of a technical challenge, suggesting that the absence of those tools represents a judgment about priorities. The robust drug look-up and formulary cost tools available on Medicare.gov for Medicare Part D prescription drug plans suggests that Healthcare.gov and the state marketplace portals will be able to make rapid progress on developing those tools once they become a priority.

Finally, the adoption of the cost-sharing subsidy nudge by five of the states suggests that the marketplaces may be willing and able to employ low cost and easy to implement choice architecture recommendations. The challenge going forward is to encourage Healthcare.gov and the remaining web portals to adopt this recommendation and to identify more such recommendations.

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About The Leonard Davis Institute of Health Economics

The Leonard Davis Institute of Health Economics (LDI) is the University of Pennsylvania's center for research, policy analysis, and education on the medical, economic, and social issues that influence how health care is organized, financed, managed, and delivered. LDI, founded in 1967, is one of the first university programs to successfully cultivate collaborative multidisciplinary scholarship. It is a cooperative venture among Penn's health professions, business, and communications schools (Medicine, Wharton, Nursing, Dental Medicine, Law School, and Annenberg School for Communication) and the Children's Hospital of Philadelphia, with linkages to other Penn schools, including Arts & Sciences, Education, Social Policy and Practice, and Veterinary Medicine.

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Table 1. Decision Support

	Total Cost Estimates		Provider Directory	Other Decision Support					
STATE	Individualized Total Cost Estimate	Standardized Total Cost Estimate	Integrated Provider Look-Up	Premium Subsidy Calculator	Integrated Drug Look-Up	Quality Ratings	Definitions	Alerted to Medicaid Eligibility	CSR Subsidy Nudge
HealthCare.Gov				✓			✓ Glossary	✓	
California		✓		✓		✓	✓ Pop-Ups	✓	✓
Colorado			✓	✓	✓	✓	✓ Pop-Ups	✓	
Connecticut				✓		✓	✓ Pop-Ups	✓	✓
District of Columbia								✓	
Hawaii			✓	✓			✓ Glossary	✓	
Idaho		✓		✓			✓ Pop-Ups	✓	
Kentucky	*		✓	✓				✓	
Maryland			✓	✓		✓	✓ Pop-Ups	✓	✓
Massachusetts			✓	✓			✓ Pop-Ups	✓	
Minnesota				✓			✓ Glossary	✓	
New York				✓		✓	✓ Pop-Ups		
Rhode Island				✓			✓ Pop-Ups	✓	
Vermont			-				✓ Glossary	✓	✓
Washington			✓	✓			✓ Pop-Ups	✓	✓

* *Kentucky's portal has an out-of-pocket cost estimator that requires the user to report average costs and frequency of office visits and drugs.*

Table 2. Smart Presentation of Plans

	Initial Sort	Are Premiums Displayed Post-Subsidy?	Total Cost Estimate		Post-Subsidy Premiums		Max Out of Pocket Cost		Deductible		Metal Level		Insurance Company		Quality Rating		Plan Type		Provider		Plan Compare Feature	Other Sort/Filter Options
STATE			Sort	Filter	Sort	Filter	Sort	Filter	Sort	Filter	Sort	Filter	Sort	Filter	Sort	Filter	Sort	Filter	Sort	Filter		
HealthCare.Gov	Premium Post-Subsidy: Cheapest to most expensive	✓			✓	✓	✓	✓	✓			✓		✓				✓			✓	Filter by "Medical Management Programs"
California	Out of Pocket cost lowest to highest, based on medical use	✓	✓		✓							✓			✓						✓	
Colorado	Premium Pre-Subsidy: Cheapest to most expensive				**	**		✓	✓	✓		✓		✓						✓*	✓	
Connecticut	Premium Pre-Subsidy: Cheapest to most expensive				**	**			✓	✓	✓	✓	✓	✓	✓	✓					✓	Under filtering, can choose how much of tax credit to apply to monthly premium
District of Columbia	Not Available (Sample only, by metal level)																					
Hawaii	Premium Pre-Subsidy: Cheapest to most expensive				**	**						✓	✓	✓				✓			✓	
Idaho	Premium Post-Subsidy: Cheapest to most expensive	✓	✓		✓		✓		✓	✓		✓		✓			✓				✓	Filter by HSA-qualified
Kentucky	No discernible order				**	**		✓	✓	✓		✓		✓	✓	✓				✓	✓	
Maryland	Premium Post-Subsidy: Cheapest to most expensive	✓			✓	✓			✓	✓	✓	✓	✓	✓	✓	✓					✓	Under filtering, can choose how much of tax credit to apply to monthly premium
Massachusetts	Premium Pre-Subsidy: Cheapest to most expensive				**	**		✓	✓	✓		✓		✓						✓	✓	
Minnesota	"My Preference Match"				**				✓	✓	✓	✓									✓	Filter by wellness program, HSA-qualified
New York	Premium Post-Subsidy: Cheapest to most expensive	✓										✓		✓		✓					✓	Sort by "Coverage Type" (med/dental)
Rhode Island	Premium Post-Subsidy: Cheapest to most expensive	✓			✓	✓		✓	✓	✓	✓	✓		✓						✓*	✓	
Vermont	Not Available (Sample only, by metal level)																					
Washington	Premium Post-Subsidy: Cheapest to most expensive	✓			✓	✓	✓	✓	✓	✓		✓		✓				✓		✓	✓	Filter by HSA-qualified, "Health Plan Wizard" function

** While these states allow users to filter by provider, the providers that can be filtered do not include hospitals.*
*** These states display pre-subsidy premiums only and thus only allow users to sort and/or filter by pre-subsidy premiums.*