Can Limiting Choice Increase Social Welfare? The Elderly and Health Insurance

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Herbert Simon's work on bounded rationality has had little impact on health policy discourse, despite numerous supportive findings. This is particularly surprising in regard to the elderly, a group marked by a decline in higher cognitive functions. Elders' cognitive capacity to make decisions will be challenged even further with the introduction of the new Medicare prescription drug benefit program, mainly because of the many options available. At the same time, a growing body of evidence points to the perils of having too many choices. By combining research from decision science, economics, and psychology, we highlight the potential problems with the expanding health insurance choices facing the elderly and conclude with some policy suggestions to alleviate the problem.

Key Words: Bounded rationality, choice, decision making, elderly, health insurance.

IN A TELEVISED INTERVIEW, ARTHUR RUBINSTEIN, ONE of the twentieth century's most renowned pianists and then eighty years old, was asked how he was able to sustain such a high level of piano playing. He answered that he played fewer pieces of music and practiced more often, and to compensate for the loss of mechanical speed, he used a sort of impression management technique: he played more slowly than usual those segments preceding rapid ones, thereby giving the impression that they were faster than they actually were (reported in Baltes, Staudinger, and Lindenberger 1999). Few people are as musically gifted or even as intuitively insightful as Arthur Rubinstein

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was. But even musical geniuses are not immune to the effects of old age. Rubinstein's honest statement reveals more than just the difficulties associated with a decline in finger dexterity. It nicely illustrates the problem of having to master too much information (i.e., having to play a wide range of musical compositions), the cognitive and physical decline that many elders experience, and the challenge to elders of old and familiar tasks, let alone new ones. Finally, Rubinstein's statement hints that we still expect elders to perform at, or close to, their top form.

How important are these issues, and do they carry any ramifications for the new Medicare prescription drug benefit? One of the problems, to which Rubinstein alluded, is that elders may be facing too many options and too much information and thus need to devise "impression management" techniques in order to compensate for cognitive or physical loss. To investigate this problem, which affects millions of elders throughout the United States, our study brings together Herbert Simon's work on bounded rationality and research on the elderly's cognitive ability with more recent studies suggesting that more information and choice could adversely affect decision makers. We provide examples from the many temporary prescription drug discount cards (more than forty choices available to the elderly in 2004 and 2005) and the even greater number of choices with the full introduction of the Medicare drug benefit in 2006.

Although we focus on elders here, we do not mean to suggest that other age groups would not encounter similar problems in equally complex environments. But elders not only will be making more health-related decisions as a result of the recent changes in Medicare policies, they also will have to make them in one of the most challenging and complex environments ever designed by policymakers. As Peters and colleagues observed, "In an information-rich and risky environment, this task [of making the right financial decision] can be difficult even for those who are knowledgeable and capable. For those with decrements in information-processing capabilities, exercising good judgment and making wise financial decisions may be beyond their capacities" (2000, 145). The second part of our article describes the complex choice environment that most elderly will face.

The first section of our article cites the problems and difficulties that elderly people might have in making decisions. We first discuss Simon's work on bounded rationality, pertaining to humans' limited information-processing capacities (e.g., memory) and the need to better

understand the relationship between their environmental structures and mental architecture. Then we discuss the research showing that elders experience cognitive decline, at least in higher executive functioning, and difficulties trying to choose a health insurance policy. We conclude the first section with an overview of the recent research on the perils of providing consumers with too many choices and options. In the second section we survey the Medicare, Medigap, and the prescription drug choices that the typical elderly person must make, particularly what will make these programs less successful than initially projected. We note how the many options available to the elderly could hamper their decisions. The last section of the article offers policy suggestions that could help remedy these problems.

The Problems Facing the Elderly

Bounded Rationality and Elderly People's Decision Making

Herbert Simon (1955, 1956) introduced the notion of bounded rationality to describe people's restricted information-processing capacities, inexpert computational abilities, incomplete knowledge of the world, and limited time for making decisions. Inspired by findings demonstrating the chasm between rational choice benchmarks and people's actual performance (for recent reviews, see Conlisk 1996; Kahneman 2003; Rabin 1998), Simon wanted to devise a theory that would more accurately capture and explain the human decision-making process. He also believed that "a great deal can be learned about rational decision making . . . by taking account of the fact that the environment to which it must adapt possess properties that permit further simplification of its choice mechanism" (1956, 129). In other words, people's environmental structure—that is, whether it is information rich or information poor—can affect their decision-making process.

Although Simon's work has been highly influential in several disciplines, it has had little impact on health policy (but see de Roo 1990; Smith and Bayazitoglu 1993). At the same time, Simon and others have largely neglected to broaden their research methodology to encompass elderly people's decision-making processes. This lacuna is surprising, given that the U.S. health care system is one of the most complicated in the world, and so making the right decision is difficult for even the

most able minds. American consumers must choose, among other things, providers, insurance plans, and treatments in a fragmented delivery system. In addition, they often must make these choices without certainty, as they must forecast their health and preferences far into the future. This complex decision-making environment makes choices of health care hard for all.

This issue is even more vexing for the elderly, who often experience cognitive limitations and who also have the most interactions with the medical care system. Elders tend to be sicker, have more complex health conditions, and must make more decisions about their health and health care. They also must choose among a plethora of health care plans and prescription drug options, a good example of dynamic decision making under uncertainty. Even the architects of the new Medicare prescription drug plan have had difficulty figuring out its intricacies. Indeed, the copies of the program's *Medicare & You Handbook* that they mailed to beneficiaries contained erroneous information (Mathematica Policy Research 2005b). At the same time, it has been well established that under such circumstances, the ways that people make decisions conflict with traditional ways of making efficient decisions, like maximizing expected utility (Frank 2004). Because the elderly are likely to be somewhat less well equipped to process certain types of information, making decisions is even harder for them than for the average adult.

Even though much of the research on decision making has focused on young adults (college students), two related areas of research—elderly people's cognitive abilities and decision-making styles—are pertinent to our discussion. Researchers (MacPherson, Phillips, and Sala 2002) have repeatedly shown an age effect (young versus old adults) on tasks involving executive function and working memory and a negative relationship between old age and dual tasking (Korteling 1991). Even on pragmatic tasks such as remembering and learning daily menus, bus schedules, and maps, old-age groups tend to score lower on tests of working memory, declarative learning, and information-processing speed (Kirasic et al. 1996). Studies examining adults' decision making (Beisecker 1988; Ende et al. 1989) indicate that elders tend to be less engaged and involved in making medical decisions, have more difficulties recalling medical information (Brown and Park 2002) and treatment recommendations (Meyer, Russo, and Talbot 1995), and generally score lower on comprehension tests (Morrell, Park, and Poon 1989). Others (Phillips and Sternthal 1977) have argued that elders are more likely to be persuaded and deceived, are less likely to notice unfair business practices (Zaltman,

Srivastava, and Deshpande 1978), are less likely to use information aids (Bearden and Mason 1979), are less likely to remember product-related information (Stephens 1982; Zeithaml 1982), and are less consistent in their product ratings and assimilate fewer product facets into their general product judgment (Capon, Kuhn, and Gurucharri 1981). Finally, in one of the field's early studies, Johnson (1993) showed that older (versus younger) adults examined less information before selecting an apartment for rent, and in another study (1990) she demonstrated that older adults spend more time reviewing information but used less information and reevaluated information more frequently when making simulated car-purchasing decisions. In a related study, Chen and Sun (2003) compared older and younger adults on a yard-sale task, designed to simulate the dowry problem (see Ferguson 1989). They found that older adults did show a marked reduction in memory capacity and amount of information utilized. Elderly were far more likely to use a "satisficing heuristic," as Simon suggested.

According to this research, older people appear to process information and make decisions differently than younger people do. Although it is not clear what drives this behavior, elders may be trying to adapt to their environments and circumstances. In other words, do cognitive limitations in combination with a very complex world lead to the use of shortcuts or other heuristic techniques? An increase in the number of alternatives (three, six, and nine) being considered in this research has been shown also to increase the number of participants (21 percent, 31 percent, and 77 percent, respectively) who rely on elimination strategies (Timmermans 1993), leading to a reduction in the amount of information used. Elders might fit nicely into this conclusion: they tend to process less information and to use heuristic-based strategies and are more likely to feel overloaded with information. Finally, the decline in elders' cognitive/executive functions and their decision-making strategies fit Simon's notion of bounded rationality. Therefore, by constructing information environments that contain many options and choices, are we only making the problem worse for the elderly?

Problems for Elders Deciding on Health Insurance

Elders face several hurdles when making health insurance choices. First, many do not have the educational skills to perform the tasks needed to choose health insurance. Only about 17 percent of Americans aged

sixty-five and older are college graduates, and nearly 30 percent did not graduate from high school (U.S. Bureau of the Census 2005). Basic literacy and vocabulary, of course, are necessary, as well as an ability to read graphs and juxtapose information from more than one health plan.

Second, many elders seem to understand only the simplest metrics and thus discredit the importance of more complex ones. In a study of working-age persons, Hibbard and Jewett (1997) explained health care–quality report cards to focus groups and then tested their understanding. Not surprisingly, the participants understood satisfaction rates better than any other quality measure. As a result, they tended to say that satisfaction rates provided the most important information about *all* aspects of a plan’s performance even when other metrics were specifically designed to be more sensitive indicators. That is, Hibbard and Jewett found that consumers considered satisfaction ratings to be more important indicators of “monitoring and follow-up of conditions” than the indicators designed for that purpose, such as rates of eye examinations for diabetics and asthma hospitalization rates.

If consumers do not understand information, they are more likely to dismiss it as unimportant. . . . Including only preferred indicators would mean that only the most comprehensible information would appear in report cards . . . [but] it would be counterproductive to ignore comprehension difficulties and use consumer salience as a sole guide to determining report-card content. A truly informed choice must be based on an understanding of quality differences as well as an understanding of the nature of the choices. (1997, 226)

Third—and more specific to health insurance choices—most elders do not know enough about managed care to make fully informed choices. In a survey of Medicare beneficiaries living in areas of the country with high enrollments in managed care programs, conducted in late 1997 (a period of high Medicare HMO enrollments), Hibbard and colleagues (1998) found that “30 percent of all respondents knew almost nothing about HMOs” (185) and that only 16 percent of those deemed knowledgeable based on a screening test, or “only about 11 percent of respondents,” “had adequate knowledge (scores of 76 percent or higher) to choose between traditional Medicare and an HMO” (186). Among the 70 percent of beneficiaries who did have enough knowledge to take a multiple-choice quiz, more than one-third scored no better or worse than if they had randomly guessed at the answers.

Sometimes, providing more information has unintended and, arguably, deleterious consequences. In one controlled experiment with working-age people, those participants who were given additional explanations of how to interpret plan-quality charts actually performed less well than did those not given this information; that is, they were less likely to understand the comparison charts and were more likely to describe the benefits incorrectly (Hibbard et al. 2000).

In this regard, some studies have found that the more information the elderly have, the less likely they are to use it. In another controlled experiment, this time with Medicare beneficiaries, three experimental groups were compared with a control group that received no additional information. One group received a copy of the complete *Medicare & You*; another received this publication plus a Consumer Assessment of Health Plans (CAHPS) report giving quality scores on area Medicare HMOs; and a third group received only a very abbreviated version of *Medicare & You*. Curiously, those who received more information ended up being less likely to use it, and less likely to switch health plans, than did those not receiving any of the publications (the control group). The authors posited that one reason for this outcome might be that all the publications noted in boldface: "You don't have to change health plans this year if you are happy with the plan you have," a statement that apparently persuaded most people not to bother even reading the information (McCormack et al. 2001).

Earlier, we stated that when choosing health plans, older people are less likely to be able to process information as efficiently as younger people do. Three studies in the area of health insurance confirm that this is the case. In one, Short and colleagues (2002) asked privately insured, Medicaid, and Medicare respondents how much difficulty they had in choosing their health plan (often out of several HMOs or PPOs). The Medicare beneficiaries reported that they had a great deal more difficulty than the others reported. Compared with those with private insurance, about 5 percent of whom on average said it was "very hard," 24 percent of Medicare beneficiaries said that it was "very hard." Conversely, about 40 percent of those with private insurance deemed the plan selection process to be "very easy," compared with just 15 percent of those on Medicare.

Finucane and colleagues (2002) assessed the decision-making capability of elders compared with that of younger adults. A total of 253 elders and 239 younger people in Oregon were given questionnaires containing

tasks to assess their ability to compare health plan information. In performing each of five tasks using tables or graphs, elders performed far worse than did their younger counterparts, with error rates averaging 25 percent for elders and 14 percent for the others. Even though elders may have more spare time and a more vested interest in choosing the right health care plan, we do not know of any study comparing younger and older adults' decision-making competence that demonstrates superior performance for the elderly population.

Finally, in another article, Hibbard and colleagues (2001) used the same sample of Oregon elders and younger people. Each group was judged on its interpretation of comparative health plan information presented in text, tables, and charts. Thirty-five tasks were assessed. The authors "found striking differences between the Medicare and younger sample in ability to use information accurately. Medicare beneficiaries made almost three times as many errors as younger respondents did (25 percent versus 9 percent)" (Hibbard et al. 2001, 200).

When Less Is More

Economists and psychologists have long advocated that more choices are better than fewer choices. Indeed, there is ample evidence to support the claim that having choices is necessary and beneficial. From an economic standpoint, a lack of choices makes it difficult, if not impossible, to satisfy a diversity of consumers. Moreover, a lack of choices is associated psychologically with reduced motivation and a decreased sense of well-being.

Therefore, a balance is needed between giving consumers no choices and giving them too many choices, as both can have deleterious effects, though for different reasons. Because a variety of choices has, until now, generally been considered advantageous for consumers, we will concentrate on having too many choices.

We should point out, however, that our argument is not robust enough (nor is it intended to be) to cover all facets of life. In some areas, having more choices would certainly seem to be superior. For example, we would not suggest cutting back on the number of restaurants in our city. Besides reducing variety and convenience, fewer restaurants could result in higher prices and make parking and waiting time at the remaining establishments even worse. In contrast, many of us have been to restaurants whose long menus lead only to confusion and, after the meal,

make us wonder whether we should have ordered that other dish we were considering. In this regard, the late Tibor Scitovsky once declared that when faced with unfamiliar choices, sometimes someone else may choose better than we can ourselves.

The economist's traditional picture of the economy resembles nothing so much as a Chinese restaurant with its long menu. Customers choose from what is on the menu and are assumed always to have chosen what most pleases them. That assumption is unrealistic, not only of the economy, but of Chinese restaurants. Most of us are unfamiliar with nine-tenths of the entrees listed; we seem invariably to order either the wrong dishes or the same old ones. Only on occasions when an expert does the ordering do we realize how badly we do on our own and what good things we miss. (1976, 149–50)

Thus, whether more (or fewer) choices are preferable is an important empirical question to which researchers have only recently started to pay attention. At the same time, Hibbard and colleagues' (2001) findings do challenge the advisability of using the market approach for health insurance for the elderly. Even though their work focused on just one domain, recent findings have extended this assumption to other areas.

Barry Schwartz (2004) illustrated the gap between having more choices and making satisfactory decisions in a broad range of cases (from health insurance to beauty treatments) to suggest a ubiquitous and troubling phenomenon. In contrast to economic thinking, Schwartz claimed that "aspiration to self-determination, presumably through processes resembling those of rational choice, is a mistake, both as an empirical description of how people act and as a normative ideal" (Schwartz 2000, 80).

In an earlier study, Beattie and colleagues (1994) demonstrated that when consumers are faced with difficult decisions such as medical ones, they actually prefer to relinquish their freedom to choose and to transfer the decision to their care provider. Iyengar and Lepper (2000) showed that more choices, compared with fewer choices, can lead consumers to feel less satisfaction and more regret and thus to avoid making any decisions at all.

In a series of ingenious experiments, shoppers at an upscale grocery store in California encountered a tasting booth offering a set of either six or twenty-four varieties of jams, with the opportunity to taste as many jams as they wished. Customers also were offered a \$1 discount coupon

for buying any one of the jams. Iyengar and Lepper's (2000) results show that even though more customers (60 percent) were attracted to the larger sample (twenty-four jams), only 3 percent of them bought any. In contrast, whereas only 40 percent of the customers stopped at the six-jam booth display, 30 percent ended up buying one of the jams.

In a second study, the same authors had two groups of college students choose among an assortment of Godiva chocolates. One group had thirty different flavors from which to choose, and the other group had only six flavors. At the end of the experiment, the participants reported how satisfied they were with their choice and whether they would like to be compensated for their participation by receiving money or Godiva chocolates. Those participants who had the choice of six flavors reported far more satisfaction with their choice, in addition to being more likely to ask for chocolates, rather than money, as compensation. In a third study, university students were offered the chance to write an extra-credit essay, choosing from a group of either six or thirty topics. They then were compared on both their likelihood of writing an essay and its quality. Similarly, those students who were offered only six topics were far more likely to write the extra-credit assignment, as well as to write a better one.

These findings accord with earlier research showing that one of the primary sources of decision conflict arises when people are faced with competing alternatives and feel incapable of trading one option for another and in which no option stands out (Shafir, Simonson, and Tversky 1993; Tversky and Shafir 1992). In the words of Iyengar and Jiang, "rather than risking the potential regret associated with choosing the less than optimal choice, decision makers instead respond to their preference uncertainty by either delaying or opting out of choosing entirely" (2005, 4).

To the best of our knowledge, Iyengar and her colleagues did not test the participants' satisfaction and reaction to having no choice, for example, one kind of chocolate or a single test topic. Had they done that, we believe, the participants probably also would have expressed similar dissatisfaction, although not necessarily for the same reasons. Iyengar and her collaborators may simply have taken this fact for granted, assuming that there was no need even to test this hypothesis. But clearly, someone who detests dark chocolate would at least like to have a choice between dark and milk chocolate. In other words, having no choice can be a bad option too.

Schwartz and colleagues offer another explanation for Iyengar and Lepper's findings. In the spirit of Simon's work, they maintain that increasing the number of choices "creates a seemingly intractable information problem" (2002, 1179). It is hard enough to evaluate six options, let alone thirty options. Thus, rather than maximizing or trying to find an optimal solution, as economics models assume, people "may disengage, choosing almost arbitrarily to complete the process" (Schwartz et al. 2002, 1179). Their claim is, in fact, stronger, suggesting that trying to optimize can even adversely affect a person's psychological well-being. To support this idea, they presented data from several experiments showing a significant positive relationship between the attempt to maximize and a sense of regret, thwarted perfectionism, and even depression; maximizers also reported significantly less happiness, satisfaction with life, optimism, and self-esteem. Finally, the maximizers were, not surprisingly, less satisfied with their choices.

More recently, Iyengar and Jiang (2005) showed that a larger number of investment options had a deterrent effect on consumers' likelihood to invest. For example, they found that for every increase of ten options, the probability of participating in a 401(k) retirement savings plan fell by 2 percent. More surprisingly, an increase in the number of investment options induced risk-averse behavior. There is nothing wrong, of course, in being risk averse. But Iyengar and Jiang's research demonstrates that risk aversion can be expensive, as when selecting portfolios that offer the lowest yield. Similarly to the argument by Schwartz and colleagues, Iyengar and Jiang maintain that "the presence of increasingly more choices may render many choosers helpless. [Consumers'] ability to choose is disabled, decision quality diminishes, and both financial and subjective well-being may be sacrificed" (2005, 37).

In a related work evaluating investors' preference for more choices and more freedom to choose, Benartzi and Thaler (2002) reported a number of results similar to those in the study by Iyengar and Lepper (2000). In both cases, individuals first wanted the larger number of choices and then switched to the smaller number of choices offered later. For example, 36 percent of the individuals in one plan initially rejected portfolios generated automatically by a computer program and spent valuable resources constructing their own portfolio. Later, however, these same persons found their own portfolios less desirable than the ones generated by the computer program. Echoing the ideas developed by Simon and extended in our article, we maintain that although selecting a

candy is relatively easy, even trained economists have difficulty choosing the right portfolio (Benartzi and Thaler 2002). Indeed, Iyengar and Lepper acknowledge that far more than demonstrating the discouraging effect of more choices in trivial cases, their research shows that

choice overload may be further exacerbated in contexts (such as decisions about major stock purchases or alternative medical treatments) in which (a) the costs associated with making the “wrong” choice, or even beliefs that there are “wrong” choices, are much more prominent, and/or (b) substantial time and effort would be required for choosers to make truly informed comparisons among alternatives. (Iyengar and Lepper 2000, 1004)

This research resonates with an article in the *Los Angeles Times* (Gosselin 2005, 1) revealing that a number of Nobel laureates in economics have been making bad retirement investment choices. For example, Harry M. Markowitz, the father of “modern portfolio theory,” failed to diversify his personal investment portfolio, in complete negation of his own theory, and Daniel Kahneman said that he thinks very little about his retirement plans, “because [he] knows that thinking could make [him] poorer or more miserable or both.”

Nobel laureates in economics are not the only group showing less savvy than economic theory and some policymakers suggest. A study by Benartzi and Thaler (2001) found that when considering retirement saving plans, people are more sensitive to the *number* of options offered, rather than the *kinds* of options. That is, people tend to allocate their contributions evenly across the options offered, regardless of the plan, suggesting that they use a “1/n” rule of thumb. In one case, University of California (UC) employees were faced with two different asset allocation options: the first option contained four core stock funds and one core bond fund, and the second option contained the reverse: one stock fund and four bond funds. Benartzi and Thaler found that “when [UC employees] chose from a set of mostly bond funds [they] selected asset allocation heavy in bonds, but when they chose from a mostly stock mix . . . they chose to invest mostly in stocks” (2001, 81).

If UC employees exhibit naive diversification tendencies and some Nobel laureates in economics do not always follow their own advice, we can only guess how elders will feel and fare when confronted with the new Medicare prescription drug benefit, a program that requires even more complicated choices than that of a retirement plan. Given

the dominance of the “more is better” approach, researchers have only recently started to question the merit of reducing the number of choices facing consumers, and most of the few existing studies focus on college students. Accordingly, we have no direct evidence regarding the effect of more choices on the satisfaction of older people.

Finally, when faced with difficult decisions, older people may refer the decision to someone else, like their doctor, a family member, or a friend. This could be a wise move, especially for those who have cognitive impairments or are overwhelmed by the available options. Indeed, people of all ages often turn to external sources to help them make difficult decisions. At the time of this writing, it is too early to know how often seniors will rely on external choices or help when they choose a plan in the new Medicare prescription drug benefit. In a national poll taken in October 2005, one month before the opening of enrollment in the new Medicare drug plans, only 20 percent of seniors reported that they were “very” likely to use friends or family members for help in deciding whether to enroll (Kaiser Family Foundation 2005b).

In the following sections, we apply these issues of bounded rationality, cognitive limitations of the elderly, and the possibility that too many choices may reduce welfare to an area of great policy interest: the health insurance choices now available to the elderly in the United States. The implementation of the new Medicare prescription drug benefit in 2006 has greatly increased the number of choices that elders must make. We discuss evidence based on past experiences, present the current choices, and conclude with policy suggestions.

Elders’ Choices Regarding Health Insurance

Medicare was never designed to pay all of its members’ health care costs. Indeed, in 2002, it paid just 45 percent of all the elderly population’s medical and long-term costs (Kaiser Family Foundation 2005a). The principal uncovered expenses were long-term care, prescription drugs (which changed in 2006 with the institution of a voluntary, somewhat limited drug benefit), and various patient cost-sharing responsibilities for hospital, physician, and nursing-home services. Since the inception of Medicare, largely because of these gaps in coverage, there has been a private insurance market known as “Medigap,” as well as other ways

in which program beneficiaries can supplement their benefits. In 2001, 34 percent of Medicare beneficiaries aged sixty-five and over received supplemental coverage from a current or former employer; 23 percent had a Medigap policy; 18 percent were in a Medicare HMO; 12 percent had Medicaid coverage; 2 percent had other public coverage; and 11 percent had no supplemental Medicare coverage (Laschober 2004). Most analysts believe that those who are eligible for supplemental coverage from Medicaid or a former employer should retain those sources. But because more and more employers are reducing retirees' benefits and raising their share of expenses (McCormack et al. 2002), over time this option is likely to become both less available and less attractive when it is available. Cuts in government funding may do the same for Medicaid.

Current Choices

Medigap Insurance. Although Medigap coverage is not the most common form of Medicare supplementation, it has received the most attention. Because of serious problems in the quality of the products available as well as abuses by agents and companies selling the coverage, it has become a highly regulated product. In the late 1970s, the federal government became involved after congressional testimony (U.S. House of Representatives 1978) and a Federal Trade Commission report (Denova and Shearer 1978) indicated that the market was functioning poorly. The alleged problems included agents pressuring elderly persons to buy policies, policies providing few benefits, overlapping (duplicate) coverage, and consumers not knowing what they were buying. As a result, Congress passed the so-called Baucus Amendments in 1980, which established a voluntary certification program for Medigap policies. To receive certification, the policies had to, among other things, provide certain minimum benefits.

The Baucus Amendments, however, did little to fix the market. We believe that the reason is that they did not limit the vast number of choices available. In particular, establishing *minimum* benefits did not standardize the product very much, and as a result, consumers found it almost impossible to compare benefits across different companies because different companies included many extra benefits, configured in multiple ways, that exceeded the minimum benefit requirements. Even after the legislation was fully implemented, most of the problems in the market persisted, including poor consumer understanding of the product,

marketing abuses, duplicate coverage, and low “loss ratios” (the percentage of premiums returned to policyholders in the form of medical benefits) (Fox, Rice, and Alecxih 1995). To illustrate, a study of nine leading Medigap insurers that offered prescription drug coverage found that they all did so in a different manner (Rice and Thomas 1992). Annual deductibles were \$50, \$100, \$200, and \$250; coinsurance rates were 20 percent, 25 percent, and 50 percent; and maximum payments per year were \$300, \$500, and unlimited amounts. This variation pertains to just one benefit; the policies varied on many other dimensions as well.

In 1990, Congress acted on the continuing problems in the Medigap market by applying, for the first time, mandatory regulations to policy sales. The main feature was product standardization. When the legislation was implemented in 1992, only those policies with particular benefit configurations could be sold. There were ten such policies, entitled A, B, . . . J. (New policy types K and L became available in 2006.) This meant that consumers could make “apples with apples” comparisons of different companies’ products.

Two studies, one conducted soon after the regulations were implemented (McCormack et al. 1996; Rice, Graham, and Fox 1997) and another several years later (Fox, Snyder, and Rice 2003), found that the legislation was successful in many but not all respects. The main successes were a dramatic reduction in consumer complaints and a concomitant increase in consumer understanding and satisfaction, clearly a result of making policy benefits more transparent through standardization. But the rate of increase in premiums (perhaps not surprising given the growth in health care costs generally) or the increase in policy loss ratios, which have been steady at around 80 percent, has not stopped. One explanation is that product standardization made it much easier for people to understand *what* they were buying, but the many available products still made choosing *which* policy to buy difficult. In California, for example, despite the smaller number of companies selling Medigap policies after standardization, there still were about fifty competitors in 1995, and the number of companies in the market has been relatively stable in most states since then.

Medicare HMOs. In most parts of the United States, Medicare beneficiaries have a choice of Medicare HMOs as an alternative to traditional fee-for-service coverage. The enrollment rates, however, are low, currently hovering around 11 percent. Even at their highest point, only

about 18 percent of the elderly chose to join, which has disappointed many policy analysts, who point to the HMOs' broader benefits and relatively low cost-sharing requirements. There are many reasons that Medicare HMO enrollment dropped and, so far, has not picked up again, but enumerating all of them goes beyond the scope of this article. But one reason that has not been widely discussed in the literature was recently raised by Frank: too many choices for beneficiaries to handle:

Research in behavioral economics shows that as the number of choices among complicated products expand[s], consumers appear to consider a decreasing number of the available options or they attempt to avoid choices altogether by putting off decisions or reverting to a default option. . . . For example, the U.S. Medicare program offers a rich laboratory for such investigations. There is a great heterogeneity in the number of managed care plan options available to Medicare beneficiaries across the U.S., yet in all markets there is a common default plan, the traditional fee for service Medicare plan. Policy makers and researchers have been repeatedly surprised by the low rates of enrollment in Medicare managed care plans given the richer assortment of insurance coverage they frequently offer (e.g., prescription drugs at no additional premium cost). . . . [A]re Medicare beneficiaries that face larger numbers of choices more likely to choose traditional Medicare over managed care plans? This would be important information for a Congress that has shown such strong interest in encouraging enrollment in managed care arrangements for Medicare beneficiaries. (2004, 30)

The benefits of Medigap policies varied greatly before standardization, and this is still the case with Medicare HMOs, which have not been standardized. One study of the plans available in Los Angeles and Chicago found wide variation. For example, "the maximum supply allowed per fill for drugs dispensed through a retail pharmacy among the six HMOs studied is thirty, thirty-one, ninety, or 100 days," with the other two HMOs not stating the limit in their materials (Fox et al. 1999, 45).

If an elder makes the "wrong" choice with regard to supplemental health insurance, the financial consequences can be serious. To illustrate, in 2001 an eighty-year-old, frail woman in Dade County, Florida, could buy any of the ten standardized Medigap plans (offered by dozens of companies) or could join any of five Medicare HMOs. A study by Snyder, Rice, and Kitchman (2003) calculated how much each HMO and each Medigap plan type would pay for the kind of care such a woman would typically get. Focusing on just the HMOs, all of which appeared

to be the same because they did not charge a premium, the authors calculated the expenses not covered for a particular set of services, which therefore would have to be paid out of pocket. They ranged from a low of \$1,342 per year to a high of \$4,954 per year, amounts that would have been invisible to the Medicare beneficiary deciding which, if any, of the plans to choose because the differences were based entirely on which services the different HMOs would cover. The authors described the confusing situation confronting beneficiaries:

In the area of Medicare supplementation, there are no obvious “right” choices for Medicare beneficiaries. Spending is often lower in [HMOs], but this is not always the case. Forgoing supplemental coverage could save money—but only if a beneficiary remains healthy. Scope of coverage provided by supplemental insurance is often a more important determinant of total out-of-pocket costs than are premiums, but often difficult for consumers to assess and compare. Even those with chronic illnesses and predictable service and equipment needs would be challenged to project cost under alternative supplemental insurance options, due to formularies and coverage limits that are often difficult to decipher prior to enrollment. (Snyder, Rice, and Kitchman 2003, vi)

Prescription Drug Discount Cards. Although the Medicare Modernization Act (MMA) was signed into law in December 2003, the prescription drug benefits did not take effect until January 2006. In the meantime, beginning in May 2004, Congress allowed for the temporary sale of prescription drug discount cards to Medicare beneficiaries. There is some debate on how valuable these cards were (for which companies could charge up to \$35 annually), but two studies concluded that they could save money (Cubanski, Frank, and Epstein 2004; Health Policy Alternatives 2004).

The choice of discount cards available to Medicare beneficiaries was extensive. In mid-2005, thirty-nine companies sold a discount card nationally, and thirty-three others served one or more states. Depending on the state in which a beneficiary lived, he or she could choose between thirty-nine and forty-three discount cards (Health Policy Alternatives 2004).

Information to determine which card provided the best service (largest discounts, most convenient pharmacy) could be obtained either from the Medicare website or a toll-free telephone number. An interesting study by the U.S. General Accounting Office (2004) found that only 61 percent

of typical calls (i.e., not just about drug discount cards) to the toll-free number were answered correctly by the customer service representatives.

The greatest source of information for the drug cards was the website www.medicare.gov, but few beneficiaries used it. Indeed, a survey of program beneficiaries conducted in October 2005 revealed that 76 percent of the elderly had never used the Internet and that of the 23 percent who had used it, only 6 percent had visited the website (Kaiser Family Foundation 2005a). A survey conducted in December 2004 found that just 8 percent of elderly people say that the Internet is their preferred way of obtaining information about the Medicare drug benefit (Kaiser Family Foundation 2005c). One of our colleagues, who is an expert on Medicare, reported that she helped a parent, who was taking four prescription drugs, use the website to find the best card. She reported that it took forty-two “clicks” or word entries to get an answer, which illustrates the website’s complexity, requiring information be input about such things as each medication used and its dosage, current drug spending, and pharmacy preferences.

Given the large number of plans available and the difficulty of obtaining information about which one to choose, it is not surprising that enrollment in the drug card program was much lower than originally predicted, with only 6.2 million of the 36 million elderly in the United States signing up. One disappointing finding pertains to low-income beneficiaries not on Medicaid, who were eligible to receive the card for free and could receive up to \$600 in free prescriptions in each of the program’s two years. But relatively few people signed up for the card, and the majority who did were automatically signed up by state programs. It is estimated that of the 7 million low-income beneficiaries eligible, only 1.7 million (24 percent) had obtained a card as of February 2005 (U.S. Department of Health and Human Services 2005). This is hardly surprising, given that another survey of the elderly found that only 24 percent of low-income beneficiaries even knew that the drug law included a provision for a drug discount card (Kaiser Family Foundation/Harvard School of Public Health 2004).

New Choices

Beginning in 2006, Medicare beneficiaries were no longer able to buy the discount cards, but they faced other choices instead. Two are particularly important: buying voluntary part D prescription drug coverage and

enrolling in new “regional” preferred provider organizations (PPOs). The Medicare drug benefit is somewhat notorious for having a large “doughnut hole.” In 2006, those choosing a stand-alone prescription drug plan (PDP) would face a \$2,850 gap in coverage after paying an initial \$250 deductible and receiving 75 percent coverage on the next \$2,000 in annual drug spending. Only after spending \$5,100 annually would they obtain 95 percent “catastrophic” coverage.

The demand for coverage is difficult to predict. On the one hand, the several choices of both managed care and PDP coverage might be expected to encourage more enrollment. On the other hand, the proliferation of companies may complicate the choice of a particular plan and, as the evidence indicates, thus reduce demand.

Medicare beneficiaries will face what Berenson (2004, W4-576) called “bewildering complexity” under the new drug benefit. We developed Figure 1 to illustrate the range of choices. At the top of the figure, Medicare beneficiaries are divided into two groups based on income. Those with incomes below 150 percent of the federal poverty level (FPL) who meet certain restrictions, such as very few assets, may qualify for subsidized prescription drug coverage as well as subsidized nondrug coverage through Medicaid or the Qualified Medicare Beneficiary Program (QMB) or the Specified Low-Income Medicare Beneficiary Program (SLMB). Those who are eligible and enroll will receive discounted medical services and will choose a Medicare drug plan and seller for subsidized drug coverage. Those people who do not qualify for subsidized drug coverage, as well as everyone whose income exceeds 150 percent of the FPL, have the following choices: If they are offered drug coverage by a former employer and choose to accept it, they will not buy Medicare drug coverage. If they are not offered an employer’s drug coverage or choose not to buy it, then they face the following:

1. They must choose either traditional Medicare or one of several Medicare Advantage plans. The two main choices are HMOs and PPOs, and beneficiaries may buy drug coverage from these companies. Other, less common choices are private fee-for-service plans, medical savings accounts, or local specialized plans for special-needs beneficiaries (Berenson 2004).
2. If they choose an HMO or PPO, they also must choose basic drug coverage, extended coverage, or no coverage. In reality, the range of drug coverage is much larger because it is not standardized

FIGURE 1. Health Insurance Decisions Facing the Elderly

but needs only to be actuarially equivalent to or greater than the benefits specified in the regulations. For simplicity, Figure 1 lists only basic versus extended coverage. Then, buyers must choose a company from which to buy their drug coverage.

- 3. Those people choosing traditional Medicare must make two more choices:
 - If they currently have Medigap plans H, I, or J or the high-deductible plan J, they must decide whether to renew it.

- If they do not, they must decide whether to buy one of Medigap plans A through G, Medicare Select, high-deductible plan F, or new plans K and L.
- If they do not renew their supplemental drug coverage (first bullet point), they must decide whether to buy a stand-alone PDP and, if so, whether to choose basic or extended drug coverage.

At the time of this writing, PDPs and Medicare Advantage plans have had to notify the Centers for Medicare and Medicaid Services (CMS) as to whether they will offer drug benefits to beneficiaries. Many have chosen to do so. Our county of residence (Los Angeles County) has thirty-eight Medicare Advantage plan choices from eighteen companies: thirty-three HMOs and five PPOs. In addition, forty-seven stand-alone PDPs are offered by eighteen companies, making a total of eighty-five choices of plans. Rural states have fewer, but still numerous, choices. Arkansas, for example, has seventy-five counties, but only eight will have Medicare HMOs in 2006, with most offering only a handful of HMOs from a single company. The beneficiaries of most of the state's counties have three PPO choices from a single company, but fifteen companies offer forty PDPs (<http://www.medicare.gov/medicarerereform/map.asp>).

When asked about the number of drug plans to choose from (in October 2005, the month before open enrollment commenced), only 5 percent of seniors from a nationally representative sample estimated that they would have more than twenty choices. When told that they would have at least forty to choose from, only 22 percent said that this would be helpful in finding the best plan, with 73 percent saying that it would instead make it "confusing and difficult" (Kaiser Family Foundation 2005b).

This discussion and Figure 1 concentrate on the *number* of choices facing the elderly. What we may not have made clear is the complexity of the choices. Although space does not allow for a full discussion here, consider just two of the many choices: whether to join a Medicare Advantage plan, and how to choose a stand-alone prescription drug plan.

Deciding whether or not to choose an HMO has always been difficult for Medicare beneficiaries. On the one hand, for those without supplemental coverage from an employer, HMOs tend to be cheaper than Medigap plans and often offer more benefits. But determining whether a particular plan does offer more benefits is extremely difficult because

the benefits are not standardized. Moreover, unless one has had experience with a particular chronic disease, it is difficult to determine in advance whether one's preferred provider (especially specialists) will be a member of the HMO network.

The availability of Medicare PPOs offering drug benefits further complicates matters. One must weigh the freedom of choice inherent in PPOs against their generally higher premiums. Even more difficult is the fact that PPOs—in contrast to HMOs—often pay their providers in ways that do not discourage the provision of services. How does an elderly person weigh these trade-offs, particularly when the method of compensation is not clarified? The configuration of benefits of drug plans offered in Medicare Advantage plans are likely to differ from those in the stand-alone plan, making the decision even tougher. Although a savvy beneficiary will compare drug formularies beforehand, only a small fraction of beneficiaries are likely to do so.

Suppose that an elder chooses to buy a stand-alone drug plan (a potentially difficult choice, since coverage is voluntary and late enrollment is penalized). How would he or she select the particular insurer from which to buy the benefit? Premiums are an obvious metric, but the particular drugs on the formulary, the location of pharmacies, differences in the configuration of benefits, and the anticipated level of service (or, conversely, the amount of claims hassle) should be considered as well. The person may also be influenced by aggressive advertising, perhaps far more so than by the available objective information.

The Centers for Medicare and Medicaid Services (CMS), which administers the new benefit as well as the Medicare Advantage programs, is giving beneficiaries some tools to help them choose. Examples available from the CMS website (the CMS also can be accessed by speaking to a CMS representative at a toll-free telephone number) include the following:

- Through a website entitled “The Landscape of Local Plans” (<http://www.medicare.gov/medicarereform/map.asp>), beneficiaries can get a list of all Medicare Advantage plans available in a particular county and the PDPs in a particular state. For the Medicare Advantage plans, the website provides information about such things as which companies offer which types of plans, premiums, the size of the drug deductible, copayments, and how many of the top 100 drugs are on

the company's formulary. Nearly identical information is available for all PDPs sold in the state.

- Through a website entitled "Medicare Prescription Drug Plan Finder" (<http://www.medicare.gov/MPDPF>), beneficiaries can personalize a search for a specific Medicare Advantage or PDP. To illustrate how it works for PDPs, a beneficiary can enter his or her Medicare number or search by zip code and then indicate what, if any, type of supplemental insurance coverage he or she currently carries (e.g., Medigap, employer, Medicaid), as well as the maximum deductibles and/or premiums. (Although not available at the time of this writing, the website eventually will allow people to input their current medications.) The website then will list those plans meeting these criteria and allow the beneficiary to enroll online.
- Through a website entitled "Formulary Finder" (<http://plancompare.medicare.gov/formularyfinder/selectstate.asp>), beneficiaries can find which health plans available in their state have all of their prescription drugs on the plan's formulary.
- Through a website entitled "Medicare Prescription Drug Plan Cost Estimator" (<http://www.medicare.gov/medicarereform/minitool.asp>), beneficiaries can find how much the drugs they normally use would cost if they enrolled and what plan in their area would provide the lowest cost (Mathematica Policy Research 2005b).

Medicare beneficiaries often seek help in making these decisions, and these websites obviously are available to family and friends who wish to help them. Furthermore, over time, program beneficiaries are likely to acquire more proficiency in using the Internet as their primary source of information. Average education levels, and hence their reading and mathematical ability, should also rise gradually, which could alter some of these findings and ideas. In sum, how well beneficiaries will fare in this unusually choice-rich environment is an open—and, ultimately, empirical—question. Accordingly, we next offer some suggestions to make the process easier.

This article has provided both theoretical and empirical reasons to question the advisability of so many choices, but we have also presented the possibility that seniors, in consultation with family and friends, may be able to successfully grapple with the environment—perhaps more so in the future than currently. Certainly, there is a potential problem, so

in the final section, we offer a number of ways to ameliorate the issues that arise from excessive choice.

Policy Suggestions

In a hearing of the U.S. Senate Committee on Finance (2004, 2) on the temporary Medicare drug discount cards, Senator Max Baucus stated that the vast number of choices offered to the elderly is “daunting, confusing, and downright unattractive to many beneficiaries.” He further noted,

In my view, the main problem—and the root cause of many other problems—is that there are simply too many drug card options. Some argue that choice is good. Choice is liberating, empowering. I hear this again and again. I don’t oppose choice. I believe in choice. But I believe in meaningful choice—not choice for the sake of ideology. This drug card program has elevated the ideology of choice over the best interests of Medicare beneficiaries. (1)

Baucus was particularly critical of the Medicare administrators who encouraged more and more firms to offer discount cards, “even after they had more than two dozen already signed up” (2).

We noted earlier that in some urban areas, Medicare beneficiaries have as many as eighty-five choices of Medicare managed care and drug plans, because nearly any company wishing to sell benefits is permitted to do so. In addition, Figure 1 shows that these choices of health insurance represent only a few of those facing the elderly. Contrast this to the situation of working-age persons whose employers typically act as brokers for their employees, thereby reducing their health insurance choices to just a handful.

The Center for Studying Health System Change has given us data tabulations from the 2005 Kaiser Family Foundation—Health Research and Educational Trust Employer Survey. Among employees offered health insurance by their employers, 37 percent have a single plan choice, 20 percent have two choices, 13 percent have three, 6 percent have four, 4 percent have five, and just 20 percent have more than five. Even when confining the choice to large employers, only 28 percent have five or more choices—this is a sharp contrast to seniors, for whom those in most parts of the country have more than forty choices and, in urban areas, often twice that many.

It is hardly surprising, then, that a study by the Kaiser Family Foundation (2005a), conducted in the month before open enrollment, found that only 35 percent of elderly say they understand the drug benefit “very well” or “somewhat well”; 58 percent do not think they have sufficient information; 37 percent have an unfavorable opinion of it (in comparison, only 31 percent have a favorable opinion); and only a minority (39 percent) believe the law will be helpful to them. Senator Baucus understood the problem of having too many choices. However, to the best of our knowledge, few remedies have been offered. We still need ways to help elders sift through the numerous options without becoming unduly confused or, worse, avoiding a decision altogether. While we cannot offer a solution to all the problems facing the elderly in the health insurance market, we can suggest a number of ways to relieve some of the concerns discussed in this article.

Free-market economists and policymakers will likely disagree with our suggestions. After all, free choice is one of the hallmarks of a free-market economy. Any attempt to tamper with it—as we are suggesting here—is bound to be criticized. So how can we justify limiting choice? We have argued that consumer decision makers are not as savvy as economic theory declares them to be. Using Herbert Simon’s work plus other similar and supporting findings, Sunstein and Thaler (2003; see also Thaler and Sunstein 2003) raise the interesting possibility of “libertarian paternalism.” What does this mean and how does it relate to our study?

The idea of libertarian paternalism might seem to be an oxymoron, but it is both possible and desirable for private and public institutions to influence behavior while also respecting freedom of choice. Often people’s preferences are unclear and ill-formed, and their choices will inevitably be influenced by default rules, framing effects, and starting points. In these circumstances, a form of paternalism cannot be avoided. Equipped with an understanding of behavioral findings of bounded rationality and bounded self-control, libertarian paternalists should attempt to steer people’s choices in welfare-promoting directions without eliminating freedom of choice. It is also possible to show how a libertarian paternalist might select among the possible options and to assess how much choice to offer. (Sunstein and Thaler 2003, 1159)

We conclude with three ways to simplify choice, to be used separately or together. We describe them only briefly here; numerous details would need to be worked out before they could be implemented.

Reduce the Number of Decisions

As Figure 1 illustrates, the elderly face a daunting task in choosing what type of supplemental coverage to have—over and above the choice of which insurer(s) to choose. To simplify the discussion (the reality facing the elderly is more complicated), suppose that a Medicare beneficiary who is eligible for Medicaid supplementation enrolls in it and that all employers offering retiree coverage include prescription drugs, with all those eligible for it enrolling. As noted earlier, all other beneficiaries must choose between traditional Medicare and an array of Medicare Advantage plans; if they choose a Medicare Advantage plan, what (if any) drug coverage in which to enroll; if they choose traditional Medicare and have Medigap drug coverage plans H through J, whether to reenroll; if they do not, whether to enroll in Medigap and, if so, which of the many plan options (e.g., plans A through G, K, L, Medicare Select, high-deductible plan F); and, regardless of whether they buy Medigap, whether to buy a stand-alone drug policy and, if so, the degree of drug coverage.

We recognize that current policy is going in the opposite direction, with the addition of the new regional Medicare PPOs. Some of the current options, however, do seem to be underused. In March 2005, only about 0.2 percent of beneficiaries were enrolled in one of the Medicare Advantage choices, private fee-for-service. Only slightly more (0.3 percent) were enrolled in a Medicare PPO demonstration project whose anticipated enrollment was expected to be much higher (Mathematica Policy Research 2005a). Thus, fewer choices of Medicare Advantage plans could be helpful, although only marginally, since most beneficiaries are unaware of some of these available options.

Another way to simplify choice is to reduce the number of standardized Medigap plans available. Currently, there are as many as twelve standard Medicare plans (A through J, plus two high-deductible plans F and J). Moreover, two more options are being added in 2006, plans K and L. Plan K is like the others except that it generally fills 50 percent rather than 100 percent of cost-sharing “gaps” in coverage. Plan L fills 75 percent. Some plans (H through J and high-deductible J) will not be available to new subscribers after January 2006, but current policyholders can renew them. We wonder whether making these renewal choices available is a good idea, given that these plans tend to be extremely expensive and are in some ways inferior to the new drug benefits in the Medicare Modernization Act (MMA): (1) they are not subsidized by the federal

government; (2) they have a higher deductible; (3) they have higher coinsurance rates after the deductible; and (4) they have a limit to how much they will pay out each year. But they do not have a doughnut hole. Moreover, it should be possible to consolidate plans A through G, the nondrug plans. Two of these seven plans (D and G) constitute only 2 percent to 3 percent of Medigap sales each, and their particular benefits are of questionable value (Fox, Snyder, and Rice 2003). The addition of plans K and L is in keeping with recent efforts to make consumers pay more of their cost of care, but we suspect that these will be unpopular, since elders have tended to avoid plan A, which has the highest cost-sharing requirements.

Drawing on the lessons from the Medigap market, policymakers may also wish to revisit the issue of standardizing Medicare HMO (and other managed care) options. As we noted earlier, HMO benefits are not standardized, and one study found that each of the competing HMOs in an area had its own set of benefits, even in something so seemingly basic as the number of pills per prescription refill (Fox et al. 1999). When this is compounded by the dozens of other benefit combinations, comparison shopping is challenging at best. Another study also showed that a wrong decision could cost elders thousands of dollars annually (Snyder, Rice, and Kitchman 2003). Just as the Medigap market has, by most measures, improved a great deal by limiting choice through the standardization of benefits, so too could the Medicare HMO market.

Reduce the Number of Competing Firms

Having the CMS encourage more and more firms to compete for prescription drug discount cards was counterproductive, as beneficiaries balked when faced with so many competing choices. But the drug cards, which were temporary, were only emblematic of the long-term problem: too many firms competing at several of the decision points.

In the Medigap market, often as many as fifty competing firms (e.g., see the choices available in Missouri at <http://insurance.mo.gov/cgi-bin/medigap.cgi>) and, as noted earlier, often dozens of choices of Medicare managed care plans are available in urban areas. Insurers in most states offer a total of forty or more choices of stand-alone PDPs.

Having so many choices means *making* a choice is much harder (as with sampling jams and chocolates). An obvious way to make it easier would be for government to act as a real broker, actively soliciting competitive bids

and reducing the number of companies that ultimately can offer a product to consumers. This is what many employers do for their employees, which keeps the number of choices to a manageable level. Hibbard and colleagues (2001) have recommended this from their research on the problems facing the elderly in making health insurance choices.

We recognize the difficulties involved. Firms will argue that the government should not exclude them from competing and that consumers should ultimately decide which competitors should succeed in the market. How, they might ask, can government ensure that it is representing the consumer when it includes some firms and excludes others? Furthermore, the persons responsible for reducing the list of competing firms may feel pressure from industry, and beneficiaries could be subject to influence peddling or even bribery. Thus, carrying out this step will impose both research and political challenges.

One source of optimism comes from the military. Historically and even now, a politically thorny issue is choosing which military bases in the United States to shrink or close down, for localities rely on them as sources of economic strength. Because such decisions are essentially zero-sum games—those communities that keep military bases are winners, and those that do not are losers—Congress established a system designed to remove (as much as possible) political considerations from such decisions. The Defense Base Closure and Realignment Act of 1999 (and amended several times since then) operates as follows: An independent, bipartisan commission is appointed to recommend to the secretary of defense and Congress which military bases should be shrunk or closed. Congress then has forty-five days to either accept or reject the recommendations as a whole (<http://www.fws.gov/laws/lawsdigest/baseclo.html>). This law has resulted in the closure of hundreds of military facilities and the reduction in size of hundreds of others, with savings estimated to be more than \$20 billion through 2001 and \$6 billion annually thereafter (<http://www.globalsecurity.org/military/facility/brac.htm>).

Thus, one way to diminish the amount of political influence in making decisions—should the federal government decide to cut the number of insurers that are made available to Medicare beneficiaries—would be to establish an independent commission charged with this task (Fox, Rice, and Alecxih 1995). Congress would also list the criteria that the commission would consider when making its recommendations to the secretary of health and human services and to Congress. By requiring a wholesale “up or down” vote, it would be difficult for individual congressional

representatives to favor one company over another. In effect, such a system would do for the elderly what employers already do for their employees: provide a tractable number of good, alternative insurance choices from which consumers can choose.

Provide Effective Decision Support Systems

Altering current policies might not always be feasible even if the new alternatives were deemed to be superior. But regardless of what type of choice environment elders will eventually face, some additional recommendations can help them choose. That is, whether the elderly will encounter many options, a few options, or even one option, it is clear that the information disseminated by both the government and private entities should be easy to understand and use by the largest possible number of people. Such information should be designed to help elders understand, among other things, the merits of alternative choices at the various decision points, what information they need to make such choices, and their rights (e.g., their ability to change a carrier once a year), as well as to help them sift through the multiple sellers at each decision point.

Using the new Medicare prescription drug benefit as an example, it is not completely clear why so many elders are confused about the drug program—did they receive the wrong information, not enough information, too much information, or just inappropriate information? A number of steps, however, can be used to improve the comprehension and usage of information. As discussed earlier, only a minority of elders are college graduates, and nearly 30 percent did not even graduate from high school (U.S. Bureau of the Census 2005). While reading ability is necessary for understanding written information, it is not sufficient to ensure comprehension. In addition, elders must be able to understand, remember, and use this information to make their decisions (e.g., Campbell et al. 2004). The challenge is, according to Hibbard and Peters, “not merely to communicate accurate information to consumers, but to understand how to present and target that information so that it is actually used in decision making” (2003, 414). Vaiana and McGlynn, similarly, argued that we should make “cognitive demands [that are] consistent with the basic processes by which people make decisions” (2002, 4).

In a study of report cards, Hibbard and colleagues (2000) showed that providing consumers with a “risk-message” (i.e., the impact of

a loss) compared with a “gain-message” significantly helped the participants respond correctly to questions about comparison charts (this does not mean, however, that all information should be framed as risk-messages). That is, the way that information is framed can either help or hinder elders’ ability to understand it. Other studies indicate the importance of graphics and charts (Baker et al. 2004; Hibbard and Peters 2003) to boost participants’ understanding, while others contend that special attention should be given to context and other features in order to create a user-friendly document (Vaiana and McGlynn 2002).

If the following suggestions (see Aldridge 2004) are implemented, they will at least help elders understand the written material and, one hopes, motivate them to use it to make their decisions:

- Written material should be at the appropriate reading level.
- Type fonts should be large.
- Lists should be bulleted so they are easy to read.
- Critical information should be placed prominently and repeated more than once.
- Graphics and pictures should be used to augment the text and help explain difficult concepts.
- The pages should contain a lot of white space.
- The cognitive load should be reduced as much as possible.
- Information should be geared to help consumers understand relevant information and decisions (e.g., those saving money).
- The authors should keep in mind the diverse audience, including those who need special help.

To compare these recommendations with the information currently provided to elders, we ordered information from the Medicare hotline and received a pamphlet entitled *The Facts about Medicare Prescription Drug Plans*, only to find that the material was written at too high a level, had very few bullet points, was presented uniformly regardless of its importance, had no graphics or pictures, was densely saturated with words, and did not indicate the potentially large amount of money that could be saved by joining this voluntary program.

Another smaller, but nevertheless important, step to improve consumer understanding is to standardize the information that different companies provide to consumers. This was done for the Medigap market in the 1980s, where, as part of the Baucus Amendments, insurers were required to provide standardized outlines of benefits. (This has since

been replaced by the much more stringent standardization of policy benefits.) Information could be required to be presented in a particular format to allow simple comparisons across different companies' marketing brochures, requiring certain key words and language.

Previous research has demonstrated that many consumers lack a basic understanding of managed care issues and even their own health plan, often leading to confusion, frustration, and lower satisfaction (Cunningham, Denk, and Sinclair 2001). Providing elders with easy-to-understand and standardized information is an important incremental reform, albeit not nearly so important as limiting the number of choices of insurance plan.

Concluding Remarks

In a May 22, 2005, article in the *New York Times*, Robert Pear wrote, "For two years, health policy experts have been warning that Medicare beneficiaries may be confused by complexities of the new prescription drug benefit. Now it turns out that Medicare officials were also confused, not just about the drug benefit but also about other options" (26). After examining the 2006 Medicare handbook, it was found "that many statements in [the first draft of] the document were inaccurate, misleading or incomprehensible, even to people who have worked on the program for decades." When the architects of the new prescription drug benefit program are getting it wrong, can we seriously believe that elders will be able to get it right? Based on the research presented here, we will not be surprised if confusion will be high, satisfaction low, and enrollment below expectations. In fact, the month before open enrollment began, only 28 percent of those seniors who did not currently have drug coverage said that they planned to enroll, with 23 percent saying they would not enroll and 49 percent being uncertain (Kaiser Family Foundation 2005a)—and this with a benefit subsidized at a 75 percent level.

The choices facing the elderly can be simplified in many ways, but not until the many choices we have given them are recognized as a potential disservice.

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