RESEARCH SPOTLIGHT

Revisiting the 'Paradox of Choice'

BY HELEN FESSENDEN

The "paradox of choice" is the idea that decisionmaking becomes more difficult as one's options multiply, leaving the status quo as the default preference. It has produced a rich literature that spans markets from retirement plans to laundry detergent. Medicare's prescription-drug benefit, known as Part D, might seem to be a particularly good example: It offers a wide array of private drug plans with complex information on coverage and pricing. Some health care analysts have argued that its consumers, who are retirees, may be unable to keep up with detailed changes in plan offerings. Indeed, many experts initially brought up this concern to make the point that drug companies wouldn't have an incentive to compete on price unless beneficiaries were making cost-based switching decisions.

A new article in the *American Economic Review*, however, finds that "choice overload" has not flummoxed Part D enrollees. Authors Jonathan Ketcham of Arizona State University, Claudio Lucarelli of the Universidad de los Andes in Chile, and Christopher Powers of the Centers for Medicare and Medicaid Services (CMS) analyze CMS data on millions of Part D consumers to see whether expanding choice mattered. They look at the program's first five years, 2006 through 2010, and conclude that more choice actually increased enrollees' likelihood of switching — as long as the additional options were not significantly more expensive than their current plan. Furthermore, as time went on, consumers who stayed in one plan became more sensitive to cost if it became substantially pricier and therefore became more likely to shop for alternatives. And when enrollees did change, they tended to reap savings and reduce their out-of-pocket expenses closer to the level covered by the cheapest ("minimum-cost") plan.

"Paying Attention or Paying Too Much in Medicare Part D." Jonathan D. Ketcham, Claudio Lucarelli, and Christopher A. Powers. *American Economic Review*, January 2015, vol. 105, no. 1, pp. 204-233.

The researchers devise their sample by taking the entirety of the Part D population who were not eligible for the low-income subsidy (where plan enrollment is automatic) and randomly selecting one-fifth of that group. They then calculate average out-of-pocket costs, how those costs compared to the cheapest available plan, the number of plans offered each year, and how those plans stacked up to each other by cost category. They also run two regressions for each finding to account for drug price elasticity: Under one scenario, drug prices were completely inelastic (i.e., changes in cost did not affect demand at all), and in the other, elasticity was moderate (-0.54, considered the benchmark for Medicare enrollees); in Part D, it turns out, the level of elasticity did not fundamentally affect switching or the trend toward cost containment over the years. The authors also controlled for several health factors, such as dementia.

They discover that switching rates held steady at about 11 percent a year. But experience also mattered: The cohort that began in 2006 and stayed on Plan D through 2010 exhibited higher switching rates over time than those of newer enrollees. Most of those who changed plans, often more than 80 percent, saved money. By 2010, almost 28 percent of all enrollees had swapped plans at some point, resulting in total savings of almost $1.07 billion under the elastic scenario.

Did the number of plans affect switching decisions? The authors contend it did — as long as the additional offerings stayed within $500 of the minimum-cost option. Every time a new plan was made available during open enrollment, provided it stayed within $100 of the minimum-cost plan, the chance of a consumer switching rose by 0.6 percentage point; adding expensive plans ($500 or more) did not affect switching at all because enrollees tended to ignore options they considered beyond their budget. And if enrollees faced an extra $100 in out-of-pocket costs by sticking with the status quo plan, the chance of their switching rose by 2.9 percentage points to 4.0 percentage points. Enrollees tended to become less responsive to cost, however, if certain factors applied, notably aging or the onset of dementia.

The authors suggest that CMS took effective steps to reduce the risk of "asymmetric learning," in which enrollees know less than the drug companies do and cannot make informed decisions. For example, CMS offers a "plan finder" to compare plans' coverage and ensure that drug companies can't sow confusion by offering plans that are too similar.

This research could fill in part of the bigger puzzle over Part D: It's a rare example of a subsidized government benefit that is much cheaper than expected. According to the Congressional Budget Office (CBO), government spending on Part D is only about half of initial projections. A July 2014 CBO report noted a broader deceleration of national drug spending, from 13 percent annual growth before 2003 to 2 percent by 2007-2010, when many brand drugs lost their patent protection and generics boomed. The CBO report did not analyze switching behavior, but it found that the share of generic prescriptions in Part D rose in those latter years from 63 percent to 73 percent. Other possible factors may help explain Part D's surprising economy, but it's notable that, starting in 2006, enrollees exercised choice based on cost while having more cost-saving generic drugs available. This new research suggests that plan choices were a boon rather than a burden. **EF**