

Research about behavioral economics¹ can be extremely useful in designing and communicating employee benefit plans. Many organizations have already adapted behavioral economic principles to improve how their employees use their defined contribution retirement plan. (See the sidebar “Behavioral Economics and §401(k) Plans.”)

Irrational Decisions

Many health decisions that should be rational clearly are not. In fact, irrational decisions that involve health benefits and health care are prevalent throughout peoples’ lives. The following are a few examples:

- Although children receive numerous public health messages, many young adults still become tobacco and drug users and/or obese and diabetic.
- While people understand the value of preventive health care and like the fact that many health plans now offer preventive care services without deductibles, co-payments or coinsurance,² many still fail to obtain free health screenings or physical exams.
- Few consumers access the substantial amount of data that is available about hospital costs and mortality, readmission and hospital-acquired infection rates when they make decisions about hospitals and surgeons.

Behavioral Economics and §401(k) Plans

It is no secret that most employees under-save for the day when they will stop working. Almost one-third of all workers have no savings earmarked for retirement and more than 50 percent have accumulated less than \$25,000.*

In recent years, the financial services industry has begun to deploy several behavioral-economic techniques in §401(k) plans in an effort to reverse this situation. These include automatic enrollment (with which 98 percent of employees say they are satisfied**), automatic contribution-escalation features and target-date funds*** as default options. These techniques have significantly helped solve two behavior-based problems: under-saving and poor asset allocation.

* Ruth Helman, Craig Copeland, and Jack VanDerhei, “The 2011 Retirement Confidence Survey: Confidence Drops to Record Lows, Reflecting ‘the New Normal’”, *EBRI Issue Brief*, no. 355 (Employee Benefit Research Institute, March 2011).

** David C. John. “The Case for Automatic Enrollment.” *Benefits Magazine*, May 2011

*** A target-date fund is a mutual fund that automatically resets the asset mix (stocks, bonds, cash equivalents) in its portfolio according to a selected timeframe that is appropriate for a particular investor.

¹ Behavioral economics is the study of how real people actually make financial choices; it draws on insights from both psychology and economics. Source: “The Marketplace of Perceptions: Behavioral economics explains why we procrastinate, buy, borrow, and grab chocolate on the spur-of-the-moment.” Craig Lambert, *Harvard Magazine*. March-April 2006

² The Patient Protection and Affordable Care Act requires non-grandfathered health plans to begin offering certain preventive care services at no cost to participants. Plan sponsors can design the setting (e.g., limit the benefit to the preferred provider network) and frequency of the preventive benefit.

- Many people with addictions relapse into addictive behavior following lengthy periods of abstinence and sobriety.
- When some people reach age 65, they ask a friend which of the many Medicare plans to purchase instead of researching the options and making an informed decision.

In each of these examples, behavioral biases cloud rational judgment. Understanding these tendencies can help organizations redesign how they configure and communicate their health benefit plans to “nudge” people toward better decisions that produce better outcomes for participants and employers.

This article uses two illustrations to demonstrate the potential of behavioral economics in health care:

- **Open Enrollment** Every year, employees are asked to decide which health plan option to select for the next plan year.
- **Lifestyle Changes** Many employers have introduced wellness plans with financial incentives.

Behavioral Economics and Open Enrollment

Behavioral economics can play an important part in an organization’s open-enrollment process where a key goal is to steer employees toward more cost-effective health plan options. Figure 1 below illustrates a simplified, typical representation of how three health plan options are communicated by organizations during annual open enrollment periods.

Figure 1: Overview of Health Plan Options		
Option	Description and Cost	Key Provisions
Preferred Provider Organization (PPO)	This is the same plan as last year. It has a broad provider network. Your monthly cost is \$150.	Deductible: \$500 Plan Payment: <ul style="list-style-type: none"> • In-network: 80 percent • Out-of-network: 60 percent
Healthy Living Plan	This new plan requires you to complete a health risk appraisal, biometric testing and an online wellness program. The provider network is smaller; it consists of doctors and hospitals meeting high standards for quality care. Your monthly cost is \$125.	Deductible: \$400 Plan Payment: <ul style="list-style-type: none"> • In-network: 85 percent • Out-of-network: 60 percent
Consumer-Directed Health Plan (CDHP)	This new plan provides you with a \$500 Health Savings Account; you can spend it now or save it for future years. The provider network is smaller; it consists of doctors and hospitals meeting high standards for quality care. Your monthly cost is \$100.	Deductible: \$1,500 Plan Payment: <ul style="list-style-type: none"> • In-network: 85 percent • Out-of-network: 50 percent
If you do not make an election, your current plan choice will continue next year. Review the official plan documents for more details.		
Source: Sibson Consulting		

Although the organization wants its employees to migrate from the PPO (the legacy plan) to either the Healthy Living Plan or the CDHP (which have lower costs than the PPO for the employer *and* the employees), migration is dampened by three behavioral biases:

- **Loss-Aversion Bias** People tend to overvalue the prospect of losing something of value and undervalue the prospect of gaining something of value.
- **Value System Bias** People have deeply rooted value systems and selective filters. Substantial evidence to the contrary or significant influence is required before behavior changes in a way that is inconsistent with deeply held beliefs.
- **Status Quo Bias** Inertia, or the tendency not to change, is especially significant when choices are complex.

Partly because of these behavioral biases, when the employer's health plan participants look at the choices in Figure 1, they tend to focus on the potential loss of their current doctor-patient relationship. They stay with the PPO because they value the freedom of choice they think it offers and find the notion of restricted choice unpalatable. Moreover, the employees are inclined to undervalue the financial gains and ignore the prospect of improved quality of care available through the Healthy Living Plan and the CDHP.

How might an organization encourage its employees to choose one of the better plan options? The way those options are presented can make a big difference. There are, for example, two behavioral biases that the organization could leverage in its open enrollment materials to achieve better results:

- **Clue-Seeking Bias** When faced with complex decisions, people look for clues, which they hope will be relevant to rational decision making.
- **Framing Bias** How choices are presented has a substantial influence on the decisions people make.

An effective technique the organization could use to encourage employees to select one of the better health plan options is known as “choice architecture” — how the various options are framed, ordered and described. People make decisions within a larger context. They look to their experiences and the environment to establish a frame of reference. Comparing Figure 2 on the next page to Figure 1 on the second page of this article illustrates how the order of the options, the names of the plans, the selection of decision-making factors, the use of color and the default option can be used to influence choice.

Figure 2: Overview of Health Plan Options

Plan Name and Option	Your Annual Payroll Deduction	Company Deposit into Your Account	Annual Deductible	Plan Payment Percent in Network	Provider Network
Healthy Living Plan	\$1,500	\$0	\$400	85%	Doctors and hospitals in network meet “elite” quality standards. Lower coverage for others
Thrifty Consumer Plan	\$1,200	\$500	\$1,500	85%	Doctors and hospitals in network meet “elite” quality standards.
Legacy PPO	\$1,800	\$0	\$500	80%	No “elite” status designations
No Coverage	\$0	\$500	N/A	N/A	N/A

If you do not make an election, you will be automatically assigned to the **Thrifty Consumer Plan**.
The quality standards behind “Elite Provider” status and the “Healthy Living” standards are explained in your Benefits Guidebook.
 Review the official plan documents for more details.

Source: Sibson Consulting

Although Figures 1 and 2 summarize exactly the same health plan designs and costs, the design in Figure 2 leverages behavioral biases to influence how people make choices. In preliminary testing with various focus groups, many people who choose the PPO Plan in Figure 1 subsequently choose either the Healthy Living Plan or the Thrifty Consumer Plan when presented with the design used in Figure 2. The result — which is certain, given the structure of the illustrations — will be better outcomes for both the employees and the organization.

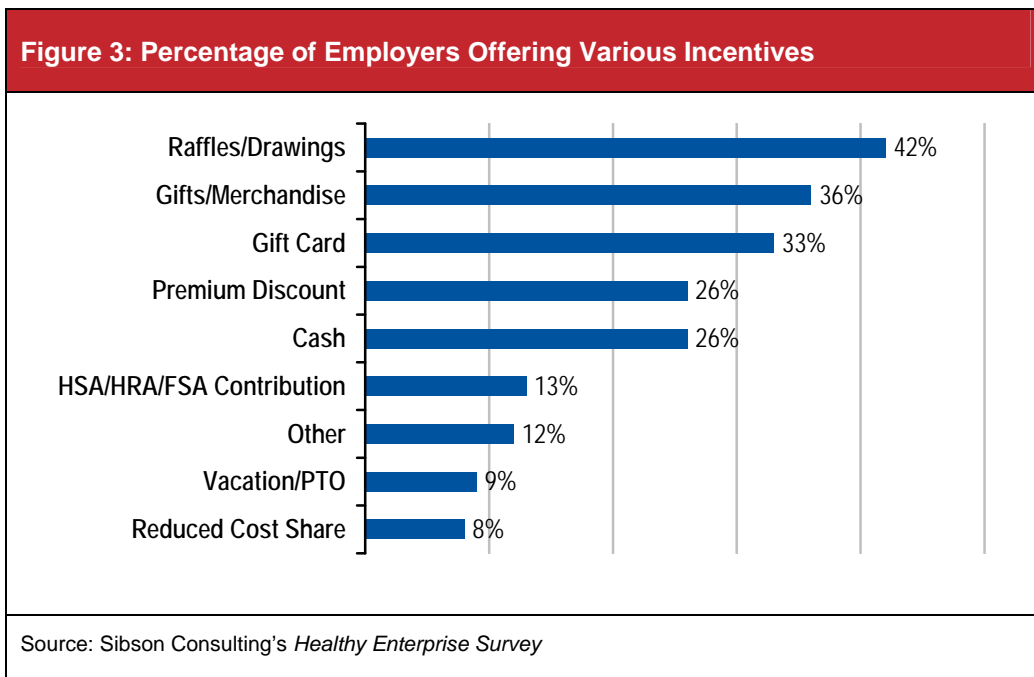
Behavioral Economics and Lifestyle Changes

Behavioral economics and motivation theory can be used as well to encourage employees to make lifestyle changes that have the potential to improve their health. One increasingly popular way to do this is by using incentives to get people to participate in the organization’s wellness programs. Studies have shown that sustained quit rates for former tobacco users are three times as high among participants receiving incentives than with the control group; when obese participants stop receiving incentive payments, many tend to regain their weight.³ Careful thought

³ Leonard Davis Institute of Health Economics. Issue Brief. *Paying People to Lose Weight and Stop Smoking*. Volume 14, Number 3, February 2009. Although it would be interesting to know what happens if the participants continued to receive the incentive payments, continuation of incentives on a long-term basis was not part of the experimental methodology.

is required when designing wellness incentives; incentives work better with some diseases than others.

In designing a wellness program, it is important to consider the incentive's structure, value and the requirements that people must meet to earn it. According to Sibson Consulting's *Healthy Enterprise Survey* (<http://www.sibson.com/publications-and-resources/surveys-studies/?id=1608>), employer-sponsored wellness programs use many types of incentives. (See Figure 3.) Sibson's research also found that as the incentive value increases, so too does participation in an organization's health risk assessment activities.



Poorly designed incentives, however, will likely fail to achieve desired outcomes:⁴

- If the incentive is too low, it will fail to motivate behavior change.
- If the incentive is too high, it may create a “choking” effect and impede performance.
- If the incentive is too distant, people will devalue the reward.
- If the qualifying period is too long, people will procrastinate. As the deadline nears, the perceived “cost” of change magnifies and people tend to give up.
- If the incentive is misguided, the reward potential “crowds out” intrinsic motivation by cheapening a task that may be interesting, fun or noble.
- If there are too many ways to earn an incentive, the complexity becomes overwhelming.

⁴ *Behavioral Economics and Psychology of Incentives*. Emir Kamenica. University of Chicago Booth School of Business. August 2011.

Putting Behavioral Economics to Work

There are many ways organizations can use behavioral economics to encourage people to take the necessary steps to improve their health. As shown in Figure 4 below, some behavioral biases can serve as bridges to better outcomes.

Figure 4: Examples of How Organizations Can Use Behavioral Biases to Help Employees Improve their Health	
Behavioral Bias	Sample Use
Jump-on-the-Bandwagon Bias People look to others for guidance and are motivated to change by unusual events championed by key influencers.	Create incentives directed at peer groups. Leverage the power of storytelling in communications. Emphasize testimonials from fellow workers who have had success in improving their health.
Lost-Opportunity-Regret Bias People regret opportunities that they ignored. Once informed about their lost opportunity, people are more likely to engage in the desired behavior than when simply presented with the same opportunity again.	Provide feedback to non-participants. Explain how they could have benefited in the past and identify future opportunities for them.
Foot-in-the-Door Bias Complying with an initially small request increases the likelihood people will comply with a subsequent larger request.	Start with incremental health improvement changes to get participants started on the right track. Subsequently, demand larger commitments to health improvement.
Low-Probability/High-Reward Bias People purchase lottery tickets despite knowing the cost exceeds the probability-adjusted return.	Consider raffles coupled with events that involve socialization.
Optimism Bias People are optimistic and overly confident about their ability to perform in the future. Although they may reject changing an unhealthy behavior today, they may promise to change it later.	Create incentives for behavior change that are directed at the individual. Establish pledges where people agree today to change their behavior in the future in exchange for current and future rewards.
Complexity Aversion Bias People avoid complex, time-consuming decisions. They tend to embrace easier decision-making scenarios.	Make undesired, unhealthy behavior difficult and fatiguing. Make the mechanics of accessing information and participating in wellness programs easy.
Source: Sibson Consulting	

Conclusion

Despite their best intentions, people do not always make rational decisions regarding their health and their health care benefits. By using principles from behavioral economics, organizations can encourage employees to make better decisions that will improve outcomes for both themselves and the organization.

Those responsible for the design and communication of health benefit plans and healthy enterprise initiatives are *de facto* choice architects. The ordering of options, highlighting of decision factors, naming of programs, structuring of incentives and selection of defaults are decisions made by management. Current decisions have consequences in terms of workforce behavioral bias, choice making and engagement. As an initial step toward applying behavioral economics, organizations should consider the following four steps:

Beyond Rational Thinking: Using Behavioral Economics
to Improve Workforce Health and Organizational Outcomes

1. Inventory existing program designs and communications to assess current behavioral biases and consequences,
2. Clarify the desired shifts in behaviors and decisions to achieve improved outcomes,
3. Identify alternative configurations for program design and for reframing that will nudge participants toward better choices about benefits, consumerism and personal health, and
4. Estimate the costs of reframing and develop an action plan for change.

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http://www.sibson.com/publications/perspectives/Volume_19_Issue_3/beyond-rational-thinking.html.

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