Comments on Liebman and Zeckhauser:
Simple Humans, Complex Insurance, Subtle Subsidies

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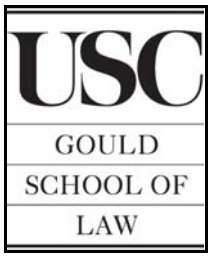

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I. Introduction and Summary

It is almost an embarrassment for me to comment on work by Richard Zeckhauser and Jeffrey Liebman. The entire field of behavioral economics and public policy, in which I have been dabbling for a few years (McCaffery & Slemrod 2006, McCaffery & Baron 2006) may profitably be said to be a footnote to Zeckhauser. Liebman, Zeckhauser's younger colleague at the Kennedy School of Government, has been a major contributor to an impressive array of public policy domains himself, including such pressingly important matters as the earned income tax credit, social security, and housing policy. Together and apart, Zeckhauser and Liebman set the standard to which scholars like me can only aspire. Their chapter in this volume characteristically contributes timely insights into the current debate over health insurance and the tax system.

But if writing this commentary is indeed an embarrassment, it is, for me, also an embarrassment of riches, on two counts. First, because I get to make my way through and point out some of the joys of Zeckhauser and Liebman's important chapter. Second, because, finding that it scarcely needs any critical help, constructive or otherwise, from me, I can then venture forth unbound, and offer some of my own thoughts on what behavioral economics and psychology can add to the questions at the core of this volume, the nexus---if any there should be---between taxes and health insurance policy in the 21st century.

To begin with some background, in their wonderfully and characteristically interesting paper, "Schmeduling" (2005), Liebman and Zeckhauser showed, *inter alia*, that it is really hard to figure out how much it costs to run a dishwasher.

In their chapter in this volume, Liebman and Zeckhauser show that it is really really hard to figure out how to buy health insurance.

Now this should not surprise any of us. Life today is complex in many dimensions. Ordinary people have little time or inclination to ascertain with precision their optimal choices in a wide range of contexts. This is why impersonal mechanisms such as markets, which serve as arbitrage and information-gathering mechanisms to aid our limited cognitive facilities, are so critically important to ideal, or even adequate, functioning in modern times. But no market mechanism to tell you how much it costs to run a dishwasher, or which among a dizzying menu of health insurance choices to make. The question as always in a pressing public policy context is, What can be done about it?

In fact, the case against complexity in health insurance choices is over-determined, by:

- Bounded rationality (Simon 1955), notwithstanding the "independence axiom" of rational choice theory, which holds, in essence, that more can never be less---that adding even an irrelevant option to a choice set cannot decrease welfare;
- Behavioral economics, as in Liebman and Zeckhauser's chapter; and
- Common sense and experience.

On the last front, compare for example the recent experiences with the Medicare prescription drug plans, or the sub-prime lending crisis, or fill in an example of your choice of human error leading to public policy crisis. It is abundantly clear that people when confronted with too many too complex options make poor choices, judged by their own later lights.

Yet policy-makers persist in promulgating complex plans and throwing over to the people a dizzying array of decisions to make, with lots of room for individual choice to go around. Skepticism about such an approach can easily lead to an attack on the whole idea of this volume, addressing health care needs through the *income tax* system. Tax is perhaps the only instrument of public policy more inane and difficult to understand than health insurance. We are a long way from running a dishwasher, here. Indeed, most of the chapters in this volume, in one way or another, cast doubt on the arbitrary admixture of tax and health care. Does anyone really think tat flexible spending accounts (FSAs) will make the task of choosing health insurance *easier*?

Liebman and Zeckhauser do an excellent job at setting up the decisions faced by any individual looking to provide for her own or her household's health care. The authors helpfully break matters down into two stages in time, pointing to the *insurance* and the *care* decisions. (As a small point, given "preexisting condition" rules, the insurance decision will often, perhaps typically, affect a longer term than one year, as Liebman and Zeckhauser tend to assume, but, given that even a one year time frame is sufficient to overwhelm our cognitive capacities, the longer horizon, *a fortiori*, certainly does.) The authors note the various aspects of these decisions that challenge cognitive capacities: uncertainty and risk,

the long time horizon, and the inherent complexity of tasks and calculations chief among them. This is all, characteristically, good and smart stuff.

II. A Few Questions and Possible Answers

In the face of the great learning that Liebman and Zeckhauser bring to bear on the health insurance questions, two major questions stand out for me to press. One, what does behavioral economics add to what I take to be the over-determined case against simply dumping complex choices in every citizen's lap? Two, and related, is there even "a" behavioral economics to predicate in the first question, as Liebman and Zeckhauser seem at times, in their writing at least, to assume?

In Liebman and Zeckhauser's chapter, behavioral economics emerges, as it often does, as a catalog, a list of heuristics and biases, most if not quite all of them familiar to consumers of the discipline. Examples include:

- Status quo bias/loss aversion/endowment effect
- Myopia and time-inconsistent preferences
- Self-serving biases
- Sub-additivity and other probabilistic errors
- "Bad-outcome myopia" (the idea that we are especially ostrich-like when it comes to decisions involving potential bad outcomes, like death or disease).

The problem is that this or similar lists can often seem like just that: lists in search of a theme. As Colin Camerer (1990), a leading practitioner of behavioral economics, put it some

two decades ago, with reference to a then leading candidate for a general field theory, "Prospect theory is a skeleton of empirical observations around which a theory is draped." There is an ad hoc feel to the enterprise, a nagging suspicion among a lay audience at least that one bias can be set off against another, in an endless loop of underdeterminacy. Real problems require real solutions, however, and real politicians will sooner or later venture forth and give some, whether they are informed by the wisdom of behavioral economics or not.

Is there then a better way to *present* the findings of the field---I would not dare presume to tell Liebman and Zeckhauser that there is any better way to *develop* the ideas in the first place---while we all wait, as if for Godot, for a widely accepted general field theory to arrive (perhaps in the emergent area of neuron-economics)? I believe that there are two ways out of the illusion of ad hocery. One is to choose *a* bias, and present axiomatic model, in the manner of Gruber and Koszegi (2001) or Bernheim and Rangel (2005), on particular topics such as cigarette smoking or savings behavior. A second, and my suggestion here, is to group and summarize the biases into coherent policy recommendations. Otherwise, the catalog approach itself generates cognitive confusion, and a sense that the biases are ad hoc, and perhaps cancel each other out

To begin fashioning some specific policy-centered advice here, a useful distinction can be drawn between the individual heuristics and biases---or suboptimal decision-making procedures and protocols---and the institutional settings in which choices are made (Barberis and Thaler 2003). In the case of publicly provided, subsidized, or mandated health insurance, where a significant residuum of individual choice is all but certain to be left in any event, the

case for simplifying, simplifying, simplifying is very strong. Behavioral economics in general teaches us that individuals will make complex decisions in isolation, focusing on salient clues, not integrating the whole, and being easily misled. These general tendencies have been grouped together by different scholars under the generally helpful labels of "choice bracketing" (Read, Loewenstein and Rabin, 1999; Rabin and Weizsacker 2007), "isolation effects" (McCaffery and Baron 2006); and "focusing" effects (Idson et al. 2004; Legrenzi, Girotto and Johnson-Laird 1993). There are subtle differences among these ideas, and even between different articulations of each of them, but they all come down to much the same place: people will make poor decisions, on their own lights, but in generally predictable ways, by focusing on the most salient and immediate decision to be made. This is certain enough by now to be used in making general policy recommendations.

Here, Liebman and Zeckhauser point out that "competition will not, in general, prevent the exploitation of unaware consumers by optimizing firms" (citing Gabaix and Laibson 2006). This is a key point, which returns to a theme anticipated above. It is not just, or only, the catalog of heuristics and biases, but also the absence of any plausible arbitrage mechanism that complicates the analysis of effective public health care and insurance policies, as I pick up again below. The combination of complex choices and no pervasive institutional mechanisms for making them leads to a strong suggestion to *standardize* features of health insurance options–especially the *financial* aspects–to allow competition based on more relevant *health-related* factors, such as location, facilities, and reputation for care. We ought, that is, to give people limited menus, with the variables being real ones that matter: less really can be more, independence axiom be damned.

Perhaps Liebman and Zeckhauser's most important contribution in their chapter is to shift focus to the chooser, and not just the choice setting---or, better put, to the choice setter. The authors see as a virtue in employer-provided care---and many blessings on them for even attempting to see a virtue in the status quo---that employers have a good incentive to give employees limited but generally beneficial choices, as witnessed for example in our experience with 401(k) plans (putting aside the perverse incentive to invest in own-company stock, a problem of Enron-era notoriety). Compare the argument, in law and economics, for strict liability over a negligence standard in say products liability: this turns on the idea that manufacturers are the best cost avoiders, and so should bear the residual risk of non-negligent harm, and are *also* the best loss spreaders (insurers). There is an analogous case here for *someone* else– a managed care group, employers, the government---bearing the residual risks. We can add, as Liebman and Zeckhauser suggest, that someone other than individuals is likely to be the best decision-maker, or, better put, decision-framer. There is nothing in behavioral economics, per se, that suggests that employers are better than bureaucrats on this score, although common sense and experience might suggest that they are, and there may be yet other third parties who could helpfully provide this service. But the insight that someone, somehow, should winnow through the decisional landscape is a very smart one, indeed. Note finally that the argument in torts for strict liability overcomes "paternalistic" objection to compulsory insurance bundled into the cost of good: strict liability *is* mandatory universal insurance. This suggests, as an aside, that "paternalism" worries are contextual, a matter of the perceived social defaults.

One question for behavioralists like Liebman and Zeckhauser to consider is how much changes with a more systematic government commitment to subsidizing health care---

perhaps, and perhaps ideally, through some *non*-tax mechanism that promises to deliver resources more evenly throughout the income distribution, and what difference this makes. Note, for example, that, in other insurance markets (e.g. auto, homeowners), individuals – irrationally! – so oppose high deductibles that this contractual option does not even exist. (Cutler and Zeckhauser 2000). This suggests that we see high deductible *health* insurance because of liquidity constraints – the price of putting all costs ex ante, into the premia is too high, such that the insurer must be able to recoup some costs ex post, via the high deductible – but that this swims against deep-seated cognitive tendencies We can assume that the high premia that markets would have to charge for low-deductible policies would themselves lead to an inertial resistance to signing up for health insurance in the first place, such that there is indeed a cognitive tradeoff involved in giving the people what they want and what they can afford. We can ask, however, whether moving to a system of mandates and/or universal care opens up possibilities.

In sum and in short, we can move beyond behavioral economics as a seemingly endless list of mistakes we all make from time to time, and start making some specific, helpful recommendations in specific, important public policy areas. Indeed, I believe that Liebman and Zeckhauser do precisely this, but disciplinary norms have prevented them from making their points more clear. So I am here to play the happy role of commenter without portfolio, and make two strong recommendations about publicly provided or regulated health care. One, we should pay attention to the choices facing individuals under any new health care system, sensitive to their inability to make optimal decisions from amidst overly large and complex choice sets. And, two, we should pay attention to the institutional setting in which such choices are made, especially to who should be setting the terms of the choice.

III. A Modest Proposal

Can we go beyond the two general propositions, important as they are? I believe, however tentatively---I am now venturing into personal embarrassment land, truth by told---that we can.

It seems clear from both common sense and the evidence that Liebman and Zeckhauser produce that *under*consumption of at least preventative health care is more likely and common than overconsumption. Behavioral economics certainly generally supports this insight: inertia, myopia, self-serving optimism, and related traits and tendencies are very common. Indeed, it would be interesting to see if there are any systematic patterns of *over*consumption. I suspect that if there were such, they would be concentrated among a distinct subset of the populace. This brings up the too often forgotten point, as Liebman and Zechauser to their credit acknowledge, that people are not all the same. But it is not just, or even most importantly, along cognitive-error dimensions that we vary from each other. Wealth level is likely to be more important than any other demographic variable when it comes to health-care matters. (Gruber and Koszegi, 2004.)

An admittedly crude mapping of the poor to risk preference (poor people are more likely to smoke, less likely to save, and more likely to play the lottery), and the rich to risk version, with the middle being risk neutral, combined with the insights set forth above, leads to a plan to create "levels" of insurance. Within each level, the government or some third party could set basic terms of price and coverage, allowing competition among other dimensions.

The levels would look, as Liebman and Zeckhauser and their sources suggest, to high and low probabilities and costs: P, p, C, and c.

Government policy, with or (probably better) without the tax code to assist it, could provide Basic Care through mandated and/or universal coverage looking at Pc, high frequency/low cost events. Here, especially for poor, who seem risk-preferring, we might have no deductibles or copays and even pay bonuses for certain treatments.

A second level of care, which we can call Basic +, might extend to high probability but costly events, and to low probability/low cost ones as well (the least important category): PC and pc. Here, in the vast middle ranges, people might approach risk neutrality, and so we could use modest deductibles and co-pays as needed to keep ex ante costs down and calibrate patient decisions.

Finally, we could add an upper level, called Basic ++, to bring into the fold low probability/high cost events, pC, leading to full insurance. Such coverage would be for wealthiest/most risk averse/most likely over-consumers, and so could well feature high deductibles and copays.

This is, as I have said, crude and simple stuff, but it is the kind of public policy thinking that is informed by market and individual psychological realities and, in that regard at least, is better than much of what we have in fact observed. See the Medicare prescription drug plan, or the sub-prime crisis, yet again.

IV. Last Thoughts

My suggestions to Liebman and Zeckhauser and their fellow behavioral economists are then to be bolder and more systematic in recommending cognitively-sensitive reform. The field has come far since its early dates, and has much to offer, but it owes the public sphere clear and forceful policy proposals. These recommendations ought to be folded into the big structure options for reform being discussed in the public sphere today, such as calls for universal care, single-payer plans, and mandates Minimal findings are that options should be limited and standardized, allowing for competition over few but important (real, non-financial) features. Mandates (with opt outs if need be) are likely better than universal access to opt in. Highly cost-effective treatments should be free at point of care, even paid for, especially for lower income citizens. Care should be taken that sensible decision framers are chosen, who can mediate the landscape of policy choices for individuals thoughtfully, as employers seem generally better able to do than government bureaucrats. And the reformers' Hippocratic Oath should be: "To do no more complexity"

My suggestions to the rest of my readers are to run the dishwasher, and read as much as you can of Liebman and Zeckhauser's work, wherever and whenever it appears.

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