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«THE VALUE OF CHOICE IN MANDATORY HEALTH INSURANCE»

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The Value of Choice in Mandatory Health Insurance*

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Abstract

Giving consumers choice can improve welfare in principle. In this study, we explore choice optimality in a health insurance market that allows for variations in coverage but is standardized otherwise, theoretically implying optimal conditions for observing welfare improvements from choice. However, we find that as much as 49 percent of the adult population opts into non-welfare maximizing plans. In a laboratory experimental setting, we estimate treatment effects of increasing transparency through information provision and restricting choice on choice optimality. We find that decision quality cannot be improved meaningfully by our interventions and that non-optimal choice is economically relevant as it accounts for approximately 9.4 percent of total annual health costs. We suggest several policy changes in light of our findings.

JEL codes: D81, D83, G22, I13.

Keywords: health insurance, policy, value of choice

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1 Introduction

Consumers struggle with choosing health insurance plans from a menu of options. The utilitarian value of giving agents choice among a set of alternative options can easily be argued in theory; for example, based on market efficiency and preference heterogeneity arguments. However, the prevalence of empirically observed choices that deviate from utility-maximizing behavior in health insurance markets¹ questions the validity of such arguments, even in settings without clearly dominated options.

In this study, we exploit real and experimental health insurance choices as well as experimental preference measures to make inferences about the financial consequences of choice among a set of alternative deductible levels and presentation format. Our empirical context is the Swiss mandatory health insurance market, which is a particularly interesting setting for our research question for several reasons. First, this market is highly regulated with regard to covered services and pricing, while allowing for variation in coverage. In fact, the level of deductible is the sole meaningful choice consumers have to make. Thus, in theory this implies an optimal setting for observing welfare improvements from choice. Second, at the aggregate level, we observe coverage choices in the absence of selection effects as insurance is compulsory. Third, the choice menu is relatively small and systematic but includes non-optimal “middle” deductible options by design that are frequently chosen. The notion of non-optimal options refers to such deductible options, which can only be rationalized by very few (and extreme) combinations of risk type and risk preferences. In particular, we show that optimal choices should be driven first-order by risk type and result in the two corner solutions with either the high (for low-risk types) or the low (for high-risk types) deductible.

We first show the non-optimal nature of four of the system’s six deductible choices under expected utility theory and then, in a laboratory experiment, exogenously vary both the number of deductible options to choose from and the presentation format with varying levels of information using current market rates. This setup enables to ensure external validity of our experimental decision as well as causal inference on limiting choice and increasing information. In particular, relative to the benchmark setting of the extant system, we evaluate decisions under conditions with a reduced number of choices (i.e., only the two optimal options) as well as with an increased level of information available. The latter is motivated by the recent work of Samek and Sydnor (2020), who present participants with

¹See, for example, Bhargava, Loewenstein, and Sydnor (2017), Handel (2013), Ericson (2014), Handel (2013), Hortaçsu, Madanizadeh, and Puller (2017), Ericson and Sydnor (2018), Bulut (2017), Schmitz and Ziebarth (2017), Ericson and Starc (2012), Fang, Keane, and Silverman (2008), Frank and Lamiraud (2009), Kairies-Schwarz et al. (2014), Kling et al. (2012), Vardell (2017).

so-called “consequence graphs” that map individual total incurred health costs (i.e., costs caused by accessing medical services) to individual health spending (i.e., costs borne by the insured) for a set of contracts in a graphical representation. In addition to the financial consequences of the total incurred health costs, we also provide information on conditional probabilities and focus on non-optimal, but not clearly dominated options, from which we know that they are chosen by consumers.

In our study, we exploit both the most recent real-world and the experimental health insurance deductible choices. A particularly beneficial feature of the Swiss basic health insurance market is its transparency, which allows us to determine the exact premium that participants pay for their basic health insurance coverage. Combined with data on income, wealth, beliefs, and preferences, we provide a comprehensive picture of welfare in the current system. This data also allows for a test of external validity of our laboratory health insurance deductible choices, which we subsequently use to make inferences about the financial consequences of several policy changes.

While we find that information provision and restricting choice improves the likelihood that users will select one of the normatively sensible deductible plans, individuals still fail to choose optimally, overspending about 9.4 percent of total annual health costs. In particular, we could not identify any meaningful differences in decision quality across treatments, thereby providing information aids and restricting choice, questioning the value of choice in this setting. Future policy should acknowledge the individual behavior that fails to maximize with regard to a rational benchmark model, thus generating welfare-reducing choices. In this context, we discuss the role of a unique, age-dependent deductible level and changes in the deductible discount scheme of the current system combined with a reduction to only one “middle option” (instead of four).

Our work contributes to several streams of the recent literature. First, we add to the literature documenting non-optimal choice in health insurance markets. A number of studies show that a lack of understanding caused by the number of options and plan characteristics induces welfare losses. In a representative US survey with private health insurance customers, Loewenstein et al. (2013) provide evidence that consumers do not understand traditional health insurance characteristics including deductible, coinsurance, and maximum out-of-pocket cost. Similarly, Abaluck and Gruber (2011) use a US longitudinal sample of prescription drug records among the elderly, thus documenting significant welfare losses due to the dismissal of important plan characteristics. Furthermore, Handel and Kolstad (2015) show that information frictions and hassle cost are important predictors of health plan choices and risk preference. Based on the survey and market data for the Swiss health

insurance market, Frank and Lamiraud (2009) show that large choice sets reduce switching probabilities and lead to large price differences in homogeneous products. In a hypothetical choice experiment, Bhargava, Loewenstein, and Sydnor (2017) find that the popularity of dominated plans is driven by participants' lack of understanding. Schram and Sonnemans (2011) and Besedeš et al. (2012) analyze the role of choice complexity in order to understand welfare loss. While Schram and Sonnemans (2011) document that an increase in the number of choice alternatives decreases the quality of choices, Besedeš et al. (2012) show that increasing the number of options increases effort to eliminate the worst options among seniors.

The second stream of literature to which our study relates investigates the role of “decision aids” for improving decision making. In a large meta-analysis on the role of decision aids for choices about medical treatments, Stacey et al. (2017) find improved knowledge and more accurate risk perceptions among patients when decision aids are used. In a recent contribution, Samek and Sydnor (2020) document the strong effects of presenting subjects with a visual representation of the financial consequences of health cost (conditional plan choice), on the health insurance choice optimality within a laboratory setting. Somewhat in line with Samek and Sydnor (2020), we apply an adapted consequence graph visualization to improve choice quality. However, in addition to their artifactual laboratory design, our choice situation is closer to the actual choices to be made in the Swiss basic health insurance markets and can be compared against those choices, thus hopefully inducing a high level of external validity. Furthermore, we extend consequence graphs with probability information that convey conditional probabilities of falling within certain cost ranges and elicit beliefs and risk and uncertainty preferences.

The remainder of this paper proceeds as follows. In Section 2, we provide an overview of the Swiss health insurance system including an assessment of optimal plan choice under the extant scheme. Section 3 includes an account of the experimental design and the experimental population. Furthermore, we derive our central hypotheses here. In Section 4, we discuss our experimental data and conclude in Section 5.

2 Optimal versus actual plan choice

Since the Health Insurance Act (KVG) came into effect in 1996, every citizen residing in Switzerland is insured under the compulsory basic health insurance with standardized covered services. Basic health insurance plans vary across two main dimensions: insurance company and deductible level. For the latter, the law defines six deductible levels for adults

aged 19 or older: CHF 300, CHF 500, CHF 1,000, CHF 1,500, CHF 2,000, CHF 2,500.² A coinsurance rate of 10 percent applies to all costs exceeding the respective deductible. The maximum out-of-pocket is capped at CHF 700. Premiums for the different deductible plans differ slightly between providers; however, the general incentive structure is the same. In particular, the KVG regulates the maximum discount for an increase in the deductible relative to the premium for the base deductible plan (i.e., CHF 300), which cannot be larger than 70 percent of the difference to the base deductible.³ In 2019, market rates show that the average discount providers grant is 69 percent. All services and aspects of covered services are identical between providers. Figure 1 shows the mapping of total incurred health cost to health spending for the average plan menu in 2019 in the canton of St. Gallen.

Figure 1: Mapping of total health cost incurred to cost borne by the insured

Making assumptions about the initial level of wealth, the propensity to take risks, and the probability distribution over total annual incurred health costs, Figure 2 shows the optimal deductible contracts. In our exemplary illustration, we applied two wealth levels: CHF 200,000 (Panel B) representing the median population wealth and CHF 10,000 (Panel A) as the threshold level of wealth for the lower 10 percent of the population. Furthermore, we assumed canonical constant relative risk aversion (CRRA) EUT. For the underlying risk profiles (i.e., distribution of health costs conditional on age and gender), we relied on

²For children 18 and under, there are the following seven deductible levels: CHF 0, CHF 100, CHF 200, CHF 300, CHF 400, CHF 500, CHF 600.

³For example, the maximum discount that could be granted to go from the CHF 300 deductible plan to the CHF 500 deductible plan is $0.7(\text{CHF } 500 - \text{CHF } 300) = \text{CHF } 140$.

Figure 2: Optimal deductible plan choice under EUT for males (Panel A and B) and females (Panel C and D)

Note: The figures present the first-ranking deductible options conditional on age and risk aversion under CRRA EUT. Panel A assumes initial wealth of CHF 10,000, while Panel B assumes CHF 200,000 in initial wealth. The underlying risk profiles (i.e., distribution of health costs conditional on age and gender) have been kindly provided by the Swiss Federal Office of Public Health.

population statistics that have been provided by the Swiss Federal Office of Public Health.⁴ The simulation results make apparent that none of the middle deductible contracts (i.e., CHF 500, CHF 1,000, CHF 1,500, CHF 2,000) is optimal in a meaningful preference range. Only for extremely risk-averse individuals do some of the middle deductible plans become dominant. Furthermore, risk aversion only plays a role for individuals relatively low in wealth.

Taken together, the baseline rational expectation hypothesis would be that only the two boundary deductible contracts with CHF 300 and CHF 2,500 are chosen and that, among

⁴We ran the same exercise using constant absolute risk aversion (CARA) EUT as well as a rank-dependent utility model with the Prelec (1998) weighting functional for decision weights, generally suggesting the same conclusions.

these two contracts, individuals choose (conditional on wealth) their expected health costs, and risk aversion (if sufficiently low in wealth). In addition, Figure 2 shows that the dominant driving factor for choosing the optimal deductible contract is individuals' expected health costs, represented here as age. More specifically, for individuals who anticipate expected health costs to be below CHF 2,000, the optimal contract would be the highest deductible contract, i.e., CHF 2,500. For individuals who anticipate expected health cost higher than CHF 2,000, the optimal contract would be the CHF 300 deductible plan. Overall, the CHF 2,500 deductible plan is the dominant choice, while the expected annual health cost is below the threshold level of CHF 2,000, and the CHF 300 deductible plan dominates other plans while expected health costs are greater than the threshold level of CHF 2,000.

Figure 3: Actual deductible choices in 2015

Note: The figure presents the share of the Swiss adult population purchasing the respective deductible options based on data from the Swiss Federal Office of Public Health (FOPH).

The empirically observed deductible choices of adult individuals in Switzerland presented in Figure 3, however, look vastly different. About 36 percent of the population choose non-optimal “middle” deductible plans, and 13 out of the 44 percent choosing the CHF 300 deductible plan have health costs below CHF 2,000, rendering their choice non-optimal with high probability. In total, a first glance on the selection into the six deductible plans reveals that as much as 49 percent of the adult population choose non-welfare maximizing plans, thereby triggering a significant redistribution of welfare. We’re interested in testing the

implications of obvious policy changes, such as eliminating non-optimal “middle” plans and increasing transparency on deductible plan choice, in an experimental setup.

3 Design

3.1 Experimental design

In our behavioral experiment, we aim at identifying the treatment effects of restricting choice in the deductible menu plan as well as providing information aids. Prior to the experimental task, we gather sociodemographic data and elicit a measure of risk preference.

In the health insurance experiment, subjects choose a deductible level among a set of deductible options for a basic health insurance plan. Participants are randomly assigned to one of six conditions as presented in Table 1. The experimental health insurance choices are hypothetical, as the introduction of scaled-down laboratory monetary stakes in this realistic decision situation that participants face once a year in real-life can only generate confusion (see Camerer and Hogarth (1999) for a review on the effects of incentives in different settings). The control condition C represents the choice situation as it currently is implemented in the market, in which individuals are presented with the general contract characteristics (i.e., deductibles, coinsurance, maximum out-of-pocket) and the six deductible levels with their respective premiums. The treatment conditions then have two aspects of variation from the control. In the restriction condition $T_{Restrict}$, we restrict the options for two normatively meaningful boundary deductible levels (i.e., CHF 300 and CHF 2,500), while under the information conditions T_{Cons} , T_{ConsP} , T_{ConsC} , and T_{ConsSP} , we keep the menu as it is, but provide participants with further information in the form of either “consequence graphs”, that chart the individual total incurred health costs to individual health spending for a set of contracts in a graphical representation (see Figure 1) or consequence graphs plus information on conditional probabilities. Subsequent to the health insurance decision, we elicit beliefs and confidence in beliefs about total annual health costs within one year in the future.

Table 1: Treatment conditions

Treatment	Format	Plans
C	standard text	6
T_{Cons}	consequence graphs	6
T_{ConsP}	consequence graphs + conditional probabilities	6
T_{ConsC}	consequence graphs + cap on health costs	6
T_{ConsSP}	consequence graphs + simplified conditional probabilities	6
$T_{Restrict}$	standard text	2

3.2 Hypotheses

In the following section, we outline the two principal areas of manipulation we're interested in and their expected effects on deductible choices. We also outline our empirical testing strategy.

Information conditions—The information conditions T_{Cons} , T_{ConsP} , T_{ConsC} , and T_{ConsSP} aim at increasing transparency and saliency of choice-relevant information. We expect higher choice frequency of the boundary deductible options (i.e., CHF 300 and CHF 2,500) under treatment T_{Cons} relative to the control treatment C , because the non-optimal nature of the middle deductible options becomes more salient (H1).

However, with limited and potentially uncertain information about the likelihood of certain levels of total annual health costs, it is not clear whether participants would necessarily go for the (potentially) optimal high deductible plan among the two generally sensible plans. We consider the highest deductible plan (i.e., CHF 2,500 deductible) to be the potentially optimal deductible plan, since our experimental subjects are drawn from a student population for which the assumption of expected health costs below the relevant threshold level (i.e., approximately CHF 2,000) to render the CHF 300 deductible plan optimal is likely to hold. Indeed, when estimating utility from the different deductible plan choices based on participants' beliefs about annual health costs and some realistic assumptions on participants' risk aversion in a simple EUT framework, our analysis shows that the CHF 2,500 deductible plan is indeed the optimal plan for all participants. We expect that the additional provision of conditional probabilities for total annual health cost in treatment T_{ConsP} will lead to a higher choice frequency of the (potentially) optimal high deductible contract among the two boundary deductible options (i.e., CHF 300 and CHF 2,500) relative to treatment T_{Cons} and the control treatment C (H2).

In line with the presentation in Figure 1, we present financial consequences of different deductible plans conditional on health costs up to a limit around CHF 10,000, at which point the total costs borne by the insured no longer increase for all deductible plans in treatment T_{Cons} . The presentation of this large range of incurred health costs potentially biases the likelihood perceptions of incurred health costs upward, merely by the visual salience of such costs, implicating a visual dominance of the CHF 300 over the CHF 2,500 deductible plan. In treatment T_{ConsC} , we thus cap annual incurred health costs at CHF 4,000 and expect that this will lead to a higher choice frequency of the (potentially) optimal high deductible contract among the two boundary deductible options relative to treatment T_{Cons} (H3).

In T_{ConsSP} , we aim at making salient the threshold of incurred health costs at which optimality of the deductible plan shifts from CHF 2,500 to CHF 300 (i.e., CHF 2,000) and the cumulative probabilities for the share of states of the world in which either of the two plans is optimal. For our particular subject population, the probability of incurred health costs falling below this threshold is 80 percent, while the probability of incurred health costs being higher than this threshold is 20 percent. We expect that this design variation will cause a higher choice frequency of the high deductible contract (i.e., CHF 2,500) among the two boundary deductible options (i.e., CHF 300 and CHF 2,500) relative to treatment T_{Cons} , T_{ConsP} , and the control treatment C (H4).

Restriction condition—Limiting the number of deductible options to those that are normatively meaningful (i.e., CHF 300 and CHF 2,500) is an obvious potential policy intervention to increase transparency and decrease confusion. There is, however, mixed evidence on the effects of reducing the number of choice options. Also, in our setup, the implications are not straightforward. For example, an individual who would choose one of the normatively non-optimal middle deductible options is confronted with choosing from the two boundary deductible options only. Her choice under the restricted choice setting could thus be the optimal first-ranking option or the potentially lowest-ranking option out of the set of generally optimal choices (i.e., CHF 300 and CHF 2,500). However, as the complexity of the choice situation becomes lower, we hypothesize that the (potentially) optimal high deductible plan will be chosen more frequently under $T_{Restrict}$ compared to the control treatment C (H5).

Since we're contrasting two different interventions – information provision and restriction of choice – we also test the relative (potential) advantage of one over the other. At this point, however, it is difficult to define an explicit hypothesis regarding the differences between T_{Cons} , T_{ConsP} , T_{ConsC} , and T_{ConsSP} on the one hand side and $T_{Restrict}$ on the other.

3.3 Procedures and sample characteristics

We ran two laboratory experiments in March 2019 and June 2020 in the Behavioral Lab at the University of St. Gallen, Switzerland. The first part of the experiment is conducted in the Behavioral Lab, while the second part of the experiment is conducted in an online setting. Both parts rely on the same subject pool of the Behavioral Lab. Experimental conditions are randomized at the individual level within each session. We recruited 540 participants through the subject pool of the experimental laboratory, and participants were required to have a good command of the English language and to be between 18 and 65 years of age.

The structure of an experimental session is as follows. First, a pre-experimental survey is conducted to gather participants' socio-demographic characteristics. Each participant then is assigned to one of the six experimental conditions, while the order is conditional on random assignment. Detailed explanations are provided before the experimental decision. We explain the approximate duration, number of tasks, and payout mechanism to all participants in advance. After the experimental health insurance decision, we elicit beliefs and confidence in beliefs about the total annual health costs being realized one year in the future and administer a post-questionnaire to assess participants' personality and numeracy as well as their most recent real-world basic health insurance choice. A full account of the experimental protocols can be found in the Online Appendix.

Table 2 presents the descriptive statistics of our sample population as well as the equality of means t-tests of treatments versus the control condition. The results show that individual characteristics are balanced throughout the treatments (i.e., versus the control treatment C) and that only two variables exhibit significant differences. Treatments T_{ConsC} and T_{ConsSP} show lower income, and treatments T_{Cons} , T_{ConsP} , T_{ConsSP} , and $T_{Restrict}$ exhibit slightly higher levels of subjective health. However, overall, the sample is balanced across treatment groups.

4 Experimental results

4.1 Main results

Figure 4 presents a breakdown of the deductible plan choices conditional on treatment assignment. The choice pattern under the control condition C appears comparable to the real-world choice pattern of the comparable age group (see Figure A1 of the Appendix). 16

Table 2: Descriptive statistics

	C	T _{Cons}	T _{ConsP}	T _{ConsC}	T _{ConsSP}	T _{Restrict}
Age	22.865	22.656	22.556	22.544	22.824	22.622
(in years)	(0.351)	(0.349)	(0.349)	(0.349)	(0.348)	(0.349)
Gender	0.618	0.567	0.522	0.478	0.505	0.644
(1 = male, 0 = female)	(0.053)	(0.052)	(0.052)	(0.052)	(0.052)	(0.052)
Income	3.584	3.4	3.222	2.367***	2.374***	3.3
(1 = CHF < 500 to 5 = CHF > 3,500)	(0.151)	(0.15)	(0.15)	(0.15)	(0.15)	(0.15)
Subjective health	2.079	2.167**	2.189**	2.144	2.231*	2.233**
(1 = excellent to 5 = poor)	(0.084)	(0.084)	(0.084)	(0.084)	(0.083)	(0.084)
Expected annual health cost	3.73	3.767	3.389	3.356	3.429	3.467
(1 = 0 to 8 = CHF 20'001 to 50'000)	(0.145)	(0.144)	(0.144)	(0.144)	(0.143)	(0.144)
Risk aversion	5.921	5.578	5.6	5.744	5.473	5.933
(1 = high to 10 = low)	(0.201)	(0.199)	(0.199)	(0.199)	(0.198)	(0.199)
Observations	89	90	90	90	91	90

Notes: Mean coefficients reported with standard errors in parantheses. The following significance levels relate to equality of means t-tests of respective treatments versus the control treatment *C*:

*** Significant at the 1 percent level.

** Significant at the 5 percent level.

* Significant at the 10 percent level.

percent of the experimental subjects select the CHF 300 deductible plan, 30 percent select the CHF 2,500 deductible plan, and the middle deductible plans account for 54 percent.

With regard to changes in the choice patterns caused by the variation in information (i.e., T_{Cons} , T_{ConsP} , T_{ConsC} , T_{ConsSP}), we observe only modest effects, with T_{Cons} displaying some reallocation from the middle deductible plans to the normatively meaningful plans. $T_{Restrict}$ logically only entails the CHF 300 (46 percent) and CHF 2,500 (54 percent) deductible plan choices.

A more detailed discussion of the results is structured along the hypotheses defined in Section 3.2. As a point of departure for our main analysis, we show the average choice probability for the two normatively meaningful options (i.e., CHF 300 and CHF 2,500) across treatments in Figure 5A as well as the average choice probability for the optimal deductible plan in Figure 5B. We identify the optimal deductible contract based on the distribution of health cost provided by the Federal Statistic Office conditional on an individual's age and gender. For all participants from our subject population, the optimal deductible plan is CHF 2,500 (see Figure 2). Appendix Table A1 provides the linear probability and logit estimates of average treatment effects and mirrors the visible differences in the figures.

Hypothesis 1— When providing information aids to participants, our expectation was that the information would induce choices more in line with the normative optimum. We expected

Figure 4: Choice patterns

Note: The figure presents the choice frequency of different deductible choices by treatment.

improved effects relative to the control treatment C from the provision of consequence graphs in treatment T_{Cons} (H1). Figure 5A shows supporting evidence for H1, as the probability to choose one of the normatively meaningful deductible plans moves from 46.07 percent to 60 percent, which is statistically significant (p -value = 0.0416). A clear visualization of the relationship between incurred health costs and costs borne by the insured for each deductible plan thus seems to improve choices, as has been found also in Samek and Sydnor (2020).

Hypothesis 2—From the further addition of probability information in treatment T_{ConsP} , we expected participants to exhibit a higher probability of selecting the highest deductible plan relative to treatment T_{Cons} and the control treatment C . This initial belief is based on the idea that participants might perceive a high level of uncertainty toward their expected annual health costs, thus biasing their expected cost assessments in the direction of higher costs. Providing participants with an age-specific distribution of average health costs could lead them to choose the highest deductible plan with higher probability. In the context of our expectations, the results are rather surprising. Our experimental data presented in Figure 5B show that the choice frequency of the highest deductible plan is not statistically different from the control treatment C (p -value = 1), or even seemingly, but it is not significantly, lower than that of treatment T_{Cons} . This leads us to reject hypothesis H2, suggesting that the way we provide probability information here does not improve decisions (relative to C)

Figure 5: Main results

Note: The figures present the choice probabilities for either the CHF 300 or CHF 2,500 deductible plans (Panel A) or the potential optimal deductible plan predicted conditional on health cost risk, CHF 2,500 only (Panel B).

and potentially reduces decision-making quality (relative to T_{Cons}). A possible interpretation of these results points towards the detrimental effect of information complexity that cancels out the positive impact of consequence graphs observed under treatment T_{Cons} .

Hypothesis 3—Restricting the visual presentation of the consequence graphs x-axis (i.e., annual incurred health cost) under condition T_{ConsC} was expected to generate a higher share of high deductible plan choices relative to condition T_{Cons} (H3). The consequence graph (see Figure 1) provided in condition T_{Cons} extends to incurred health costs as extreme as CHF 10,000, while the consequence graph provided in condition T_{ConsC} caps the x-axis at CHF 4,000. The hypothesis is driven by the underlying idea that participants form more pessimistic beliefs about their incurred health costs because of the salience of high incurred health cost in the graphical presentation. Our results do not provide evidence supporting the hypothesis that the probability to choose one of the normatively meaningful deductible plans is higher relative to treatment C . The probability of opting into the high deductible plan is 33.33 percent, which is not statistically different from the treatment C group (p -value = 0.9983).

Hypothesis 4—In line with hypothesis H2, we presume that participants exhibit a high level of uncertainty about their annual incurred health cost, and therefore would benefit

from probability information. At the same time, we are concerned that subjects might be overloaded with information in T_{ConsP} . We therefore provide probability information in a reduced form in T_{ConsSP} , in which we only show the cumulative probabilities for areas of incurred health cost where the CHF 300 and the CHF 2,500 deductible plans are optimal, expecting the share of high deductible plan choices to increase relative to treatment T_{ConsP} and the control treatment C (H4). Our results do not provide evidence for a higher choice frequency of the high deductible plan relative to T_{ConsP} (p -value = 0.9926) and the control condition C (p -value = 0.9991), leading us to reject hypothesis H4 .

Hypothesis 5— Restricting the choice set to the two boundary options (i.e., CHF 300 and CHF 2,500) appears to be a sensible policy given the non-optimal nature of the middle options for most individuals. Aside from moving the choice probability mass from the middle options to the boundary options, we expect the deductible choices of participants to be more in line with a higher share of optimal high deductible plan choices (H5). Our experimental data supports hypothesis H5. We find that the probability to choose the CHF 2,500 deductible plan increases from 30.34 percent to 54.44 percent (p -value = 0.0099). In addition, the difference between T_{Cons} and $T_{Restrict}$ with 15.56 percentage points is also large and significant (p -value = 0.0047).

4.2 Financial consequences

The results so far illustrate how different frames affect choice patterns. At this level, our findings seem to indicate that consequence graphs and choice restrictions outperform the status quo and the other interventions included in this study with regard to improving decision making. However, this view is too narrow to suggest anything about the value of these effects at the aggregate, as this study only focuses on observed shifts in the demand patterns for the normatively meaningful deductible plans (i.e., CHF 300 and CHF 2,500) and because financial losses from poor choice increase with decreasing deductible levels among our low risk experimental population.⁵ To say something about the aggregate benefits of the interventions, we should consider the whole range of deductible choices. Consider, for example, the observed increase of optimal choices under the $T_{Restrict}$ condition. While this increase per se seems optimal, it is unclear whether this reduces or even increases financial losses in the aggregate because the share of participants opting for the lowest deductible plan with the highest financial losses increases at the same time. We thus estimate the average expected losses conditional on treatment assignment in this section to shed light on this

⁵This relationship is reversed for high risk types.

Figure 6: Choice expected loss relative to optimal attainable expected value

Note: The figure presents mean values of the expected cost from the deductible choice made relative to the expected cost-efficient deductible choice (i.e., CHF 2,500) by treatment.

question.

Figure 6 presents the expected financial losses (in CHF per annum) from poor choice conditional on treatment assignment. In particular, we present the average difference between the total costs borne by the insured between the optimal deductible plan (i.e., CHF 2,500) and the actual plan selected.⁶ If everyone selected their individually optimal deductible plan, this value would be zero.

The first result is that annual financial losses resulting from poor choice are economically meaningful. Under the status quo scenario (i.e., *C*), individuals face average annual financial losses of CHF 535. This accounts for approximately 9.4 percent of the total annual health costs borne by the insured (i.e., total annual health cost).⁷

The treatment effects on annual financial losses are all relatively small and insignificant (at the maximum reducing annual financial losses by CHF 77 or 14.5 percent). Our results suggest that the current design of the Swiss mandatory health insurance evokes financial

⁶The expected financial loss estimates are based on population-wide estimates for the loss distribution.

⁷The estimation of the total annual health costs borne by the insured obviously depends on the selected deductible level and range between CHF 5,837 to CHF 5,410. For the estimation of the benchmark average total annual health costs borne by the insured we're assuming an equal distribution across deductible plans.

losses through non-optimal choices, which cannot be easily improved on by increased information provision or even by restricting choice to the two normatively sensible deductible plans (i.e., CHF 300 and CHF 2,500).

5 Conclusion

In a standard single period rational choice framework, giving consumers choice among a set of alternative options can only increase welfare. However, a broad collection of literature empirically documents choice patterns not in line with the standard normative theory, thereby questioning the welfare effects of choice. Potential causes of seemingly sub-optimal choices include limited understanding of the financial consequences, imperfect information, and non-standard preferences and beliefs.

In this study, we're interested in the welfare effects of giving consumers choice and providing decision aids in the context of insurance choices while controlling for many of the relevant factors identified yet. The empirical setting we rely on is the mandatory Swiss basic health insurance market, which is characterized by fully standardized covered services across insurance companies, full transparency of pricing, and only one central level of heterogeneity, which is the deductible. Among the six deductible levels, only two are optimal for sensible combinations of risk type and risk preferences, so these deductible plans should be chosen predominantly. However, actual uptake data shows that non-optimal plans are chosen frequently, implying large negative effects on welfare.

We investigate the incentive structure of the current Swiss basic health insurance scheme theoretically and exogenously vary both the set of deductibles to choose from and the presentation format with varying levels of information content in a laboratory experiment. We provide evidence of two obvious possible policy changes – increasing transparency and reducing the number deductible levels to choose from. While we find that information provision and choice restriction improves the likelihood to select one of the normatively sensible deductible plans, individuals still fail to choose optimally and suffer economically meaningful financial losses.

In terms of implications, our results suggest that choice menus that entail non-optimal options such as the ones implemented in the Swiss mandatory health insurance scheme evoke welfare-reducing choices that cannot be easily addressed by improved information provision or even restricted choice to normatively sensible plans. Future policy should acknowledge individual behavior that fails to maximize with regard to a rational benchmark model, thus

generating welfare-reducing choices. In practical terms and with regard to the Swiss example, one option could be to set default deductible levels conditional on expected health costs, for example, by age (i.e., CHF 2,500 below approximately 65 years and CHF 300 above), while all middle options would be canceled.⁸ This setup, however, needs to include an opt-out option for younger individuals with significantly increased expected health costs, which could be easily operationalized, for example, by an additional underwriting question on subjective health status and/or expected health costs. Alternatively, more deductible levels could remain in the system; however, in this case, the scheme for discounts from increasing deductible risk needs to be adapted to reflect risk. Currently, increases in deductible levels are granted the same premium discount independent of whether an individual moves from CHF 500 to CHF 1,000 or from CHF 2,000 to CHF 2,500. The probability for costs in the higher range is obviously lower than the probability for costs in the lower range, thus requiring lower premium reductions from a present value perspective. To reduce complexity further but conserve meaningful choice that reflects heterogeneity in risk type and risk preferences it would be suitable to consider reducing the the set of “middle” options to only one that is being priced according to the previous discussion. In that sense the documented tendency to choose middle options can be exploited to assure at least second-best outcomes.

⁸The exact threshold age could be moved by adapting the relative premium discount from the increase in deductible risk, which is currently capped at 70 percent of the deductible difference by the regulator.

6 Appendix

Figure A1: Deductible choice patterns of young adults as of 2017

Note: The figure presents the share of the Swiss adult population aged between 25 and 30 purchasing the respective deductible plans based on data from the Swiss Federal Office of Public Health (FOPH).

Table A1: Average treatment effects

	OLS Norm.	Logit Norm.	OLS Opt.	Logit Opt.
Intercept	0.461*** (0.048)		0.303*** (0.05)	
T _{Cons}	0.139** (0.068)	0.139* (0.074)	0.086 (0.071)	0.086 (0.071)
T _{ConsP}	0.006 (0.068)	0.006 (0.075)	-0.014 (0.071)	-0.014 (0.068)
T _{ConsC}	0.017 (0.068)	0.017 (0.075)	0.03 (0.071)	0.03 (0.07)
T _{ConsSP}	0.078 (0.068)	0.078 (0.074)	0.026 (0.071)	0.026 (0.069)
T _{Restrict}	0.539*** (0.068)	0.539*** (0.053)	0.241*** (0.071)	0.241*** (0.072)
Observations	540	540	540	540
R-squared	0.148		0.032	

Notes: The table shows OLS and logit estimates of the treatment effects on choosing one of the normatively meaningful deductible plans (i.e., CHF 300 and CHF 2,500) in columns 2 and 3 and the (potentially) optimal deductible plan (i.e., CHF 2,500) in columns 4 and 5.

*** Significant at the 1 percent level.

** Significant at the 5 percent level.

* Significant at the 10 percent level.

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ONLINE APPENDIX: PROTOCOLS

General information

§1. Welcome and thank you for participating in our experiment today! You will soon enter the lab. First, let me give you some pieces of information: The session today will take about **25 minutes**. **If you're not feeling good or for any other reason, you can stop the experiment at any time.**

§2. When you have settled in at your seat in the lab, you can soon start the experiment. If you have questions during the experiment, please raise your hand and we will come over to assist you. It is important to us that we get feedback from you, whether we explain everything clearly. Do you have any questions? [Wait some moments.]

§3. The experiment is structured as follows:

- (1) Personal questionnaire.
- (2) Health Insurance Experiment.

§4. In the experiment today, you can earn CHF 6 (on average CHF 15 hourly) for participating the experiment today.

§5. Now, please draw a paper slip out of this box that will tell you your seat in the lab. Please keep this slip of paper until the payment at the end of the session. Also, please turn off your phone and do not talk to other participants during the experiment. You can now enter the lab.

§6. After you went through the experiment, please you raise their hand and wait until one of the assistants brings you from the lab to the payoff-table and else staying in the lab. And one assistant hand out your earnings and you sign the receipt.

Introduction to health insurance experiment

[Implementation instructions: this experiment has six treatment conditions (STEP 1) in a randomized between subject design (i.e., each subject only takes one of the six conditions). The decision in STEP 1 is followed by an elicitation of health cost beliefs (STEP 2) and a measure of confidence in such beliefs (STEP 3) that every subject answers.]

STEP 1: Treatment C

Introduction

In this part of the experiment, we want to understand, how you would choose your health insurance plan. Basic health insurance in general is compulsory for anyone residing in Switzerland. Even though you might be exempted from buying basic health insurance in Switzerland because you have coverage in a different country, assume for now that you would have to make this decision here.

How basic health insurance works

Coverage is precisely defined in the Health Insurance Act (KVG) and is the same irrespective of the health insurer. The total amount that you have to pay for medical services per year depends on (1) the insurance premium and (2) the out-of-pocket expenses:

- (1) Insurance premium: given your age, canton of residence, and health insurer, the annual premium only depends on the so-called deductible (or “franchise”). Up to the amount of the selected deductible, policyholders have to pay the cost of medical services out of their pocket. The health insurer only pays for medical services cost that exceed the amount of the selected deductible in a given year. There are six deductibles to choose from: 300 Fr., 500 Fr., 1,000 Fr., 1,500 Fr., 2,000 Fr., 2,500 Fr.
- (2) Out-of-pocket expenses: if costs for medication, medical treatment by a doctor or hospital treatment occur, the policyholder must contribute to these costs in addition to the health insurance premium. This out-of-pocket payment includes the deductible and a coinsurance. Up to the amount of the selected deductible, policyholders have to pay the cost of medical services out of their pocket. After that, they must pay 10% of the costs exceeding this deductible themselves (coinsurance) up to a maximum of 700 Fr. per year.

Decision

In the following you find the six deductible options and their respective annual premiums. Please choose one of the options as if you would have to actually make this decision for real. Enter the letter (i.e., one out of the letters A, B, C, D, E, F) that marks your preferred option in the computer interface when you're ready.

- A. Deductible of 300 Fr. for an annual premium of 5,250 Fr (or CHF 438 per month).
- B. Deductible of 500 Fr. for an annual premium of 5,120 Fr (or CHF 427 per month).
- C. Deductible of 1,000 Fr. for an annual premium of 4,795 Fr (or CHF 400 per month).
- D. Deductible of 1,500 Fr. for an annual premium of 4,470 Fr (or CHF 373 per month).
- E. Deductible of 2,000 Fr. for an annual premium of 4,145 Fr (or CHF 345 per month).
- F. Deductible of 2,500 Fr. for an annual premium of 3,820 Fr (or CHF 318 per month).

STEP 1: Treatment T_{Cons}

Introduction

In this part of the experiment, we want to understand, how you would choose your health insurance plan. Basic health insurance in general is compulsory for anyone residing in Switzerland. Even though you might be exempted from buying basic health insurance in Switzerland because you have coverage in a different country, assume for now that you would have to make this decision here.

How basic health insurance works

Coverage is precisely defined in the Health Insurance Act (KVG) and is the same irrespective of the health insurer. The total amount that you have to pay for medical services per year depends on (1) the insurance premium and (2) the out-of-pocket expenses:

- (1) Insurance premium: given your age, canton of residence, and health insurer, the annual premium only depends on the so-called deductible (or “franchise”). Up to the amount of the selected deductible, policyholders have to pay the cost of medical services out of their pocket. The health insurer only pays for medical services cost that exceed the amount of the selected deductible in a given year. There are six deductibles to choose from: 300 Fr., 500 Fr., 1,000 Fr., 1,500 Fr., 2,000 Fr., 2,500 Fr.
- (2) Out-of-pocket expenses: if costs for medication, medical treatment by a doctor or hospital treatment occur, the policyholder must contribute to these costs in addition to the health insurance premium. This out-of-pocket payment includes the deductible and a coinsurance. Up to the amount of the selected deductible, policyholders have to pay the cost of medical services out of their pocket. After that, they must pay 10% of the costs exceeding this deductible themselves (coinsurance) up to a maximum of 700 Fr. per year.

Now, please read the figure below carefully. It shows, how total annual costs for medical services (e.g., medication, medical treatment by a doctor or hospital treatment) translate to what you have to pay in total per year (premium and out-of-pocket) dependent on the deductible you choose.

Decision

In the following you find the six deductible options and their respective annual premiums. Please choose one of the options as if you would have to actually make this decision for real. Enter the letter (i.e., one out of the letters A, B, C, D, E, F) that marks your preferred option in the computer interface when you're ready.

- A. Deductible of 300 Fr. for an annual premium of 5,250 Fr (or CHF 438 per month).
- B. Deductible of 500 Fr. for an annual premium of 5,120 Fr (or CHF 427 per month).
- C. Deductible of 1,000 Fr. for an annual premium of 4,795 Fr (or CHF 400 per month).
- D. Deductible of 1,500 Fr. for an annual premium of 4,470 Fr (or CHF 373 per month).
- E. Deductible of 2,000 Fr. for an annual premium of 4,145 Fr (or CHF 345 per month).
- F. Deductible of 2,500 Fr. for an annual premium of 3,820 Fr (or CHF 318 per month).

STEP 1: Treatment T_{ConsP}

Introduction

In this part of the experiment, we want to understand, how you would choose your health insurance plan. Basic health insurance in general is compulsory for anyone residing in Switzerland. Even though you might be exempted from buying basic health insurance in Switzerland because you have coverage in a different country, assume for now that you would have to make this decision here.

How basic health insurance works

Coverage is precisely defined in the Health Insurance Act (KVG) and is the same irrespective of the health insurer. The total amount that you have to pay for medical services per year depends on (1) the insurance premium and (2) the out-of-pocket expenses:

- (1) Insurance premium: given your age, canton of residence, and health insurer, the annual premium only depends on the so-called deductible (or “franchise”). Up to the amount of the selected deductible, policyholders have to pay the cost of medical services out of their pocket. The health insurer only pays for medical services cost that exceed the amount of the selected deductible in a given year. There are six deductibles to choose from: 300 Fr., 500 Fr., 1,000 Fr., 1,500 Fr., 2,000 Fr., 2,500 Fr.
- (2) Out-of-pocket expenses: if costs for medication, medical treatment by a doctor or hospital treatment occur, the policyholder must contribute to these costs in addition to the health insurance premium. This out-of-pocket payment includes the deductible and a coinsurance. Up to the amount of the selected deductible, policyholders have to pay the cost of medical services out of their pocket. After that, they must pay 10% of the costs exceeding this deductible themselves (coinsurance) up to a maximum of 700 Fr. per year.

Now, please read the figure below carefully. In the upper part, it shows, how total annual costs for medical services (e.g., medication, medical treatment by a doctor or hospital treatment) translate to what you have to pay in total per year (premium and out-of-pocket) dependent on the deductible you choose. In the lower part, it shows the chance of having costs in the marked ranges (between the arrowheads) for a person that is between 21 and 30 years of age.

Decision

In the following you find the six deductible options and their respective annual premiums. Please choose one of the options as if you would have to actually make this decision for real. Enter the letter (i.e., one out of the letters A, B, C, D, E, F) that marks your preferred option in the computer interface when you're ready.

- A. Deductible of 300 Fr. for an annual premium of 5,250 Fr (or CHF 438 per month).
- B. Deductible of 500 Fr. for an annual premium of 5,120 Fr (or CHF 427 per month).
- C. Deductible of 1,000 Fr. for an annual premium of 4,795 Fr (or CHF 400 per month).
- D. Deductible of 1,500 Fr. for an annual premium of 4,470 Fr (or CHF 373 per month).
- E. Deductible of 2,000 Fr. for an annual premium of 4,145 Fr (or CHF 345 per month).
- F. Deductible of 2,500 Fr. for an annual premium of 3,820 Fr (or CHF 318 per month).

STEP 1: Treatment $T_{Restrict}$

Introduction

In this part of the experiment, we want to understand, how you would choose your health insurance plan. Basic health insurance in general is compulsory for anyone residing in Switzerland. Even though you might be exempted from buying basic health insurance in Switzerland because you have coverage in a different country, assume for now that you would have to make this decision here.

How basic health insurance works

Coverage is precisely defined in the Health Insurance Act (KVG) and is the same irrespective of the health insurer. The total amount that you have to pay for medical services per year depends on (1) the insurance premium and (2) the out-of-pocket expenses:

- (1) Insurance premium: given your age, canton of residence, and health insurer, the annual premium only depends on the so-called deductible (or “franchise”). Up to the amount of the selected deductible, policyholders have to pay the cost of medical services out of their pocket. The health insurer only pays for medical services cost that exceed the amount of the selected deductible in a given year. There are two deductibles to choose from in our setup here: 300 Fr., 2,500 Fr.
- (2) Out-of-pocket expenses: if costs for medication, medical treatment by a doctor or hospital treatment occur, the policyholder must contribute to these costs in addition to the health insurance premium. This out-of-pocket payment includes the deductible and a coinsurance. Up to the amount of the selected deductible, policyholders have to pay the cost of medical services out of their pocket. After that, they must pay 10% of the costs exceeding this deductible themselves (coinsurance) up to a maximum of 700 Fr. per year.

Decision

In the following you find the two deductible options and their respective annual premiums. Please choose one of the options as if you would have to actually make this decision for real. Enter the letter (i.e., one out of the letters A, B) that marks your preferred option in the computer interface when you're ready.

- A. Deductible of 300 Fr. for an annual premium of 5,250 Fr (or CHF 438 per month).
- B. Deductible of 2,500 Fr. for an annual premium of 3,820 Fr (or CHF 318 per month).

STEP 1: Treatment T_{ConsC}

Introduction

In this part of the experiment, we want to understand, how you would choose your health insurance plan. Basic health insurance in general is compulsory for anyone residing in Switzerland. Even though you might be exempted from buying basic health insurance in Switzerland because you have coverage in a different country, assume for now that you would have to make this decision here.

How basic health insurance works

Coverage is precisely defined in the Health Insurance Act (KVG) and is the same irrespective of the health insurer. The total amount that you have to pay for medical services per year depends on (1) the insurance premium and (2) the out-of-pocket expenses:

- (1) Insurance premium: given your age, canton of residence, and health insurer, the annual premium only depends on the so-called deductible (or “franchise”). Up to the amount of the selected deductible, policyholders have to pay the cost of medical services out of their pocket. The health insurer only pays for medical services cost that exceed the amount of the selected deductible in a given year. There are six deductibles to choose from: 300 Fr., 500 Fr., 1,000 Fr., 1,500 Fr., 2,000 Fr., 2,500 Fr.
- (2) Out-of-pocket expenses: if costs for medication, medical treatment by a doctor or hospital treatment occur, the policyholder must contribute to these costs in addition to the health insurance premium. This out-of-pocket payment includes the deductible and a coinsurance. Up to the amount of the selected deductible, policyholders have to pay the cost of medical services out of their pocket. After that, they must pay 10% of the costs exceeding this deductible themselves (coinsurance) up to a maximum of 700 Fr. per year.

Now, please read the figure below carefully. It shows, how total annual costs for medical services (e.g., medication, medical treatment by a doctor or hospital treatment) translate to what you have to pay in total per year (premium and out-of-pocket) dependent on the deductible you choose.

Decision

In the following you find the six deductible options and their respective annual premiums. Please choose one of the options as if you would have to actually make this decision for real. Enter the letter (i.e., one out of the letters A, B, C, D, E, F) that marks your preferred option in the computer interface when you're ready.

- A. Deductible of 300 Fr. for an annual premium of 5,250 Fr (or CHF 438 per month).
- B. Deductible of 500 Fr. for an annual premium of 5,120 Fr (or CHF 427 per month).
- C. Deductible of 1,000 Fr. for an annual premium of 4,795 Fr (or CHF 400 per month).
- D. Deductible of 1,500 Fr. for an annual premium of 4,470 Fr (or CHF 373 per month).
- E. Deductible of 2,000 Fr. for an annual premium of 4,145 Fr (or CHF 345 per month).
- F. Deductible of 2,500 Fr. for an annual premium of 3,820 Fr (or CHF 318 per month).

STEP 1: Treatment T_{ConsSP}

Introduction

In this part of the experiment, we want to understand, how you would choose your health insurance plan. Basic health insurance in general is compulsory for anyone residing in Switzerland. Even though you might be exempted from buying basic health insurance in Switzerland because you have coverage in a different country, assume for now that you would have to make this decision here.

How basic health insurance works

Coverage is precisely defined in the Health Insurance Act (KVG) and is the same irrespective of the health insurer. The total amount that you have to pay for medical services per year depends on (1) the insurance premium and (2) the out-of-pocket expenses:

- (1) Insurance premium: given your age, canton of residence, and health insurer, the annual premium only depends on the so-called deductible (or “franchise”). Up to the amount of the selected deductible, policyholders have to pay the cost of medical services out of their pocket. The health insurer only pays for medical services cost that exceed the amount of the selected deductible in a given year. There are six deductibles to choose from: 300 Fr., 500 Fr., 1,000 Fr., 1,500 Fr., 2,000 Fr., 2,500 Fr.
- (2) Out-of-pocket expenses: if costs for medication, medical treatment by a doctor or hospital treatment occur, the policyholder must contribute to these costs in addition to the health insurance premium. This out-of-pocket payment includes the deductible and a coinsurance. Up to the amount of the selected deductible, policyholders have to pay the cost of medical services out of their pocket. After that, they must pay 10% of the costs exceeding this deductible themselves (coinsurance) up to a maximum of 700 Fr. per year.

Now, please read the figure below carefully. In the upper part, it shows, how total annual costs for medical services (e.g., medication, medical treatment by a doctor or hospital treatment) translate to what you have to pay in total per year (premium and out-of-pocket) dependent on the deductible you choose. In the lower part, it shows the chance of having costs in the marked ranges (between the arrowheads) for a person that is between 21 and 30 years of age.

Decision

In the following you find the six deductible options and their respective annual premiums. Please choose one of the options as if you would have to actually make this decision for real. Enter the letter (i.e., one out of the letters A, B, C, D, E, F) that marks your preferred option in the computer interface when you're ready.

- A. Deductible of 300 Fr. for an annual premium of 5,250 Fr (or CHF 438 per month).
- B. Deductible of 500 Fr. for an annual premium of 5,120 Fr (or CHF 427 per month).
- C. Deductible of 1,000 Fr. for an annual premium of 4,795 Fr (or CHF 400 per month).
- D. Deductible of 1,500 Fr. for an annual premium of 4,470 Fr (or CHF 373 per month).
- E. Deductible of 2,000 Fr. for an annual premium of 4,145 Fr (or CHF 345 per month).
- F. Deductible of 2,500 Fr. for an annual premium of 3,820 Fr (or CHF 318 per month).

STEP 2: Beliefs

In which of the following ranges do you think your total annual cost of medical services will most likely be?

Exactly 0 Fr.

Between 1 Fr. and 500 Fr.

Between 501 Fr. and 1,000 Fr.

Between 1,001 Fr. and 2,000 Fr.

Between 2,001 Fr. and 5,000 Fr.

Between 5,001 Fr. and 10,000 Fr.

Between 10,001 Fr. and 20,000 Fr.

Between 20,001 Fr. and 50,000 Fr.

More than 50,000 Fr.

STEP 3: Confidence in beliefs

How confident are you that your actual total annual cost of medical services will be within the range stated in the previous question on a scale from 1 to 5, where 1 means not confident at all and 5 means very confident?

Questionnaire

questionID	question
age	What is your age?
gender	What is your gender?
disposableIncome	How much money do you have at your disposal per month? 1 - Less than CHF 500 2 - CHF 500 to 1'499 3 - CHF 1'500 to 2'499 4 - CHF 2'499 to 3'499 5 - CHF 3'500 or more
subjhealth	Would you say your health is ___? 1 - Excellent. 2 - Very good. 3 - Good. 4 - Fair. 5 - Poor.
dohmenrisk	How do you see yourself: are you generally a person who is fully prepared to take risks or do you try to avoid taking risks? Please tick a box on the scale, where the value 0 mean: 'not at all willing to take risks' and the value 10 means: 'very willing to take risks'.
healthinsdeductible	Which of the following deductible levels have you chosen under the mandatory health insurance plan? (Note: the deductible is the amount per year you have to pay out of pocket (e.g., for doctor visits, hospitalization))
insurancepremiumstotal	Please provide an estimate of your total annual spending for insurance premiums (in CHF).