

Internalizing Behavioral Externalities: Benefit Integration, Health Insurance, and Welfare

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Amanda Starc (Wharton)
Robert Town (Wharton)

Discussant: Ben Handel (Berkeley)

Efficient Health Care Utilization

- Different structures for empirically assessing efficient health care utilization

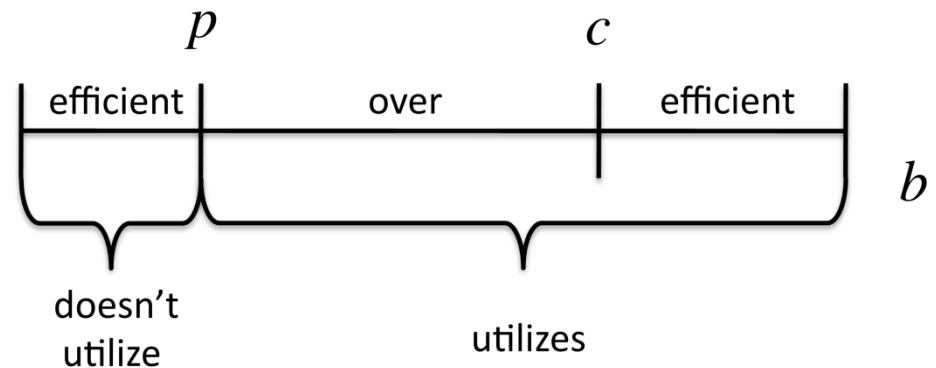
Moral Hazard Only

- **Baseline in Economics**

Moral Hazard +
Behavioral Hazard

Moral Hazard +
Behavioral Hazard +
Externalities

Figure 1: Model with Only Moral Hazard



* Baicker et al. (2015), *QJE*

Efficient Health Care Utilization

- Different structures for empirically assessing efficient health care utilization

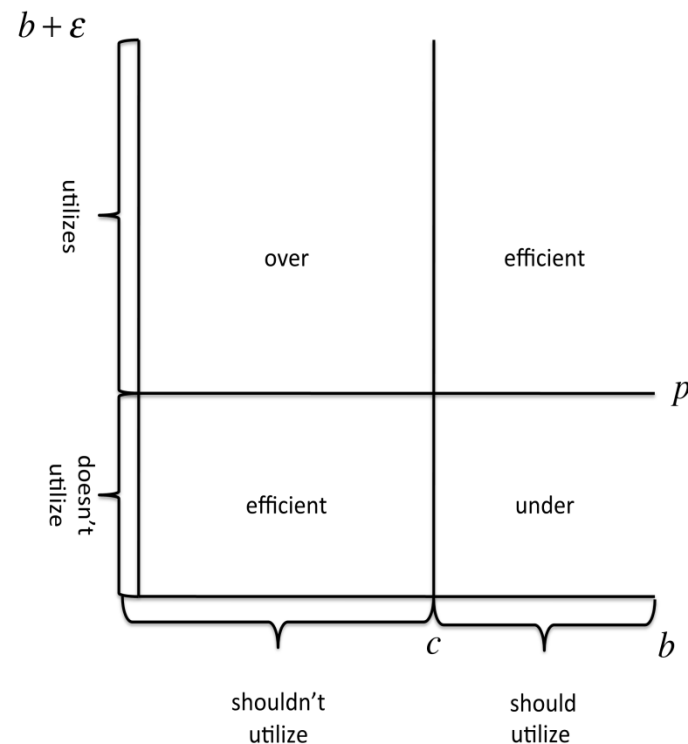
Moral Hazard Only

- Baseline in Economics

Moral Hazard + Behavioral Hazard

Moral Hazard + Behavioral Hazard + Externalities

Figure 2: Model with Behavioral Hazard



* Baicker et al. (2015), *QJE*

Efficient Health Care Utilization

- Different structures for empirically assessing efficient health care utilization

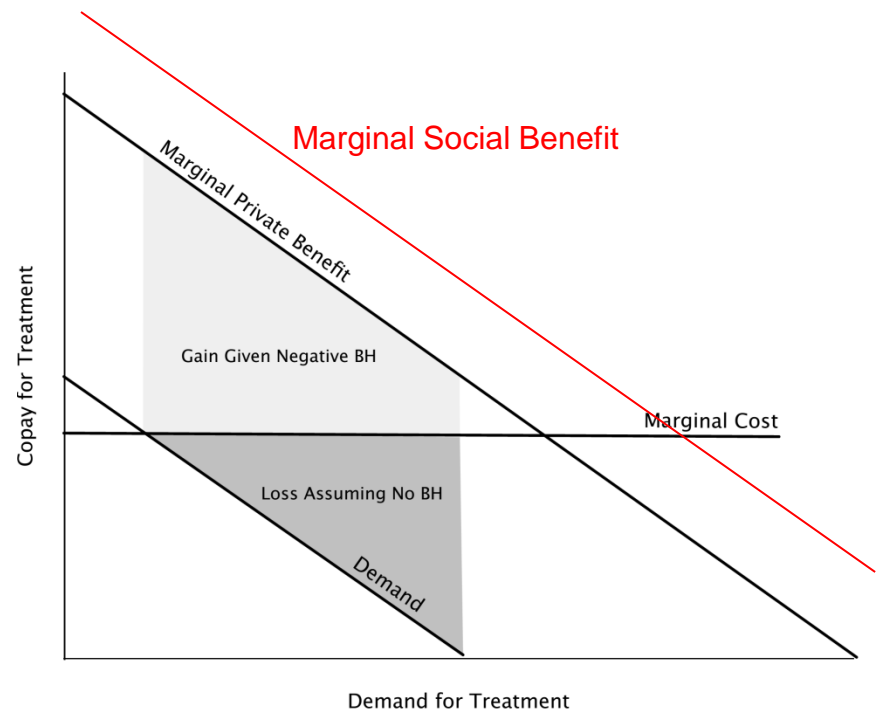
Moral Hazard Only

- Baseline in Economics

Moral Hazard + Behavioral Hazard

Moral Hazard + Behavioral Hazard + Externalities

- Productivity
- GE System Constraints
- Government Budgets



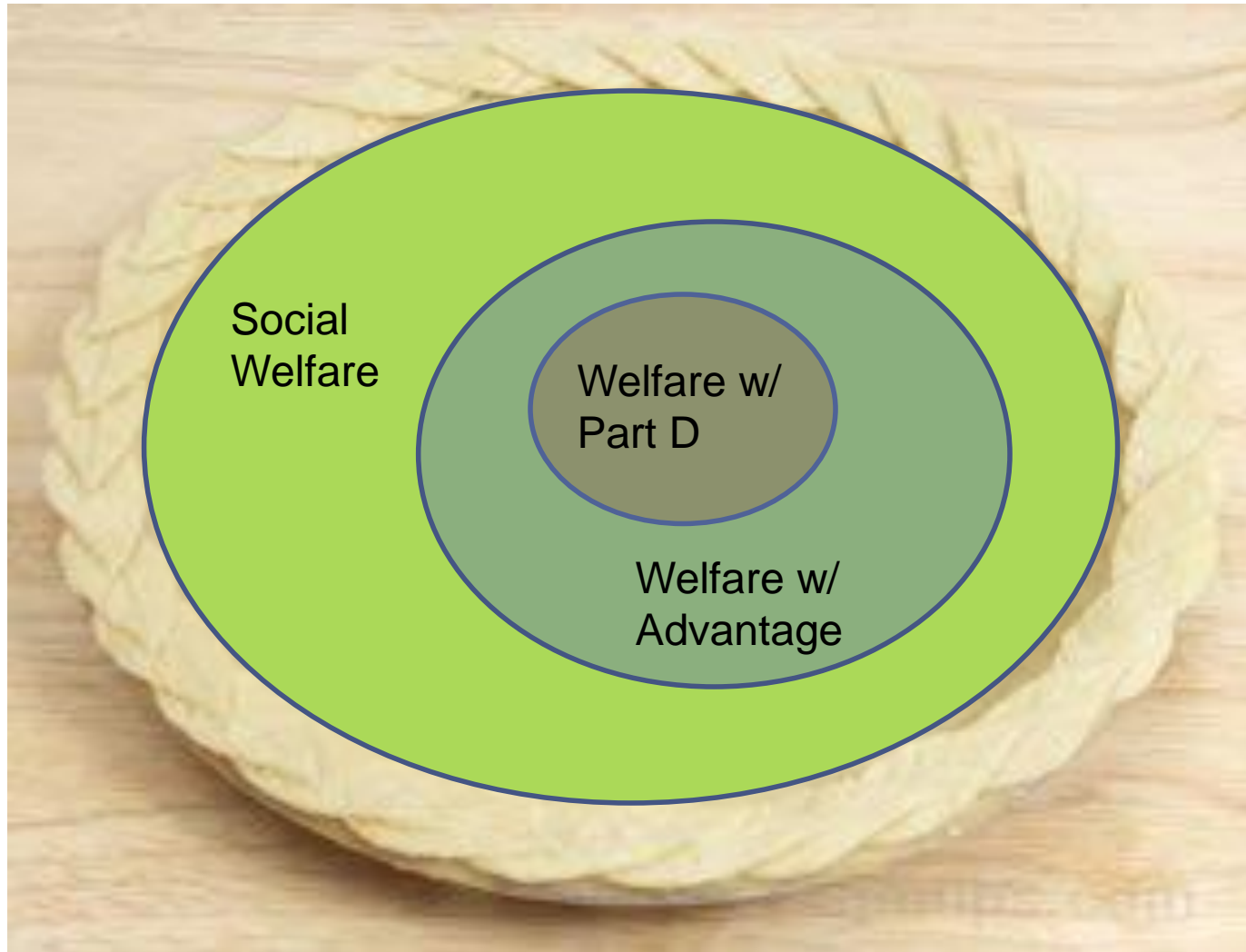
(a) Negative Behavioral Hazard

* Baicker et al. (2015), QJE

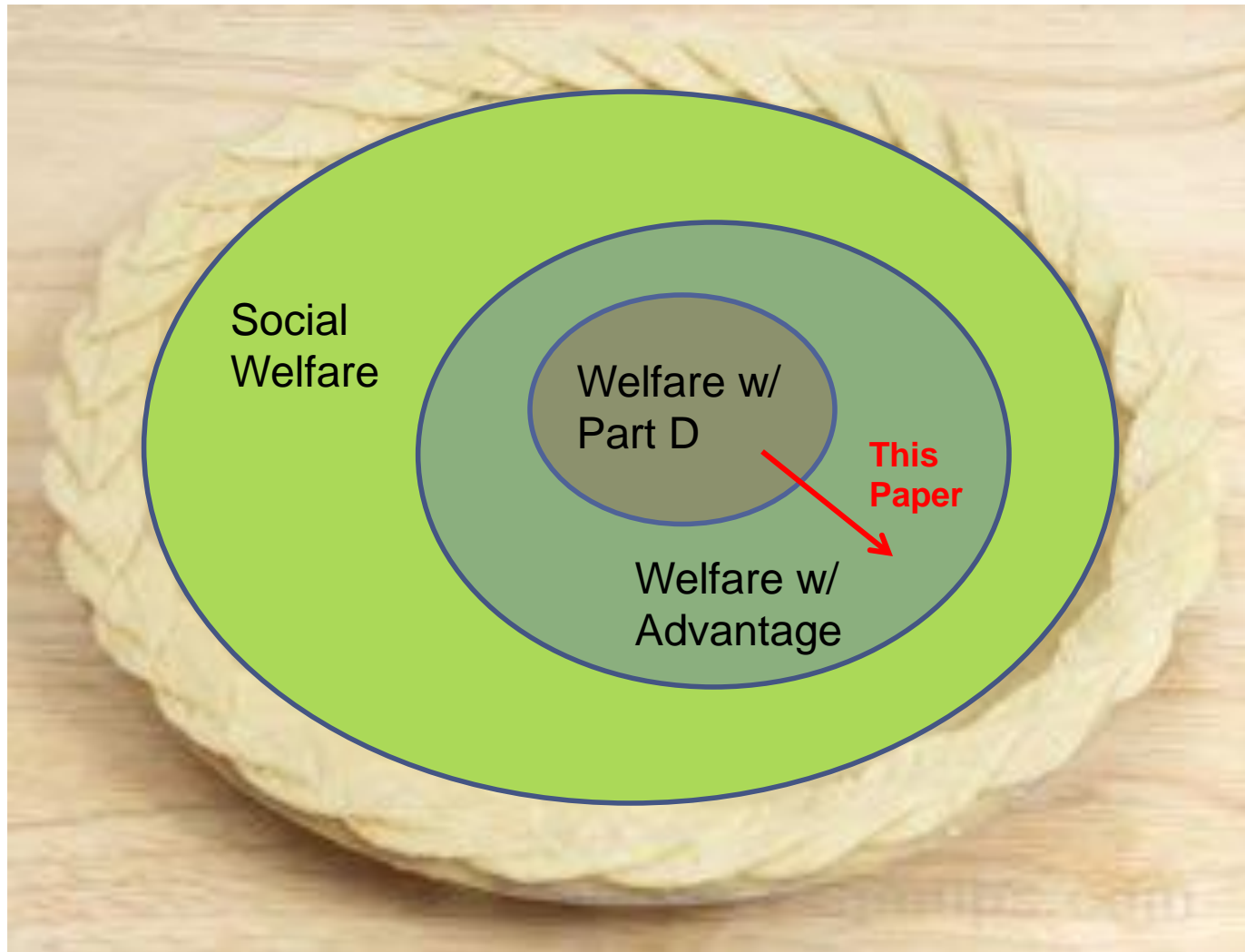
This Paper

- **Key Premise:** Consumers don't care much about coverage generosity when choosing plans, mostly about premiums
- **Key Premise:** Evidence in literature that consumers respond to cost-sharing once enrolled, and do so in naïve manner
 - Response to non-linear contracts, foregoing valuable care
- **Medicare Part D**
 - Competition more intense on premiums than generosity
 - Design generosity primarily to minimize drug costs
 - This works because consumers are not sensitive up front to changes in generosity
- **Medicare Advantage**
 - Competition more intense on premiums than generosity
 - Design generosity primarily to all medical minimize costs

Surplus from Health Care



Surplus from Health Care



Key Results

- This paper brings a novel IO research design to study “offsets,” or downstream costs not internalized w/ current consumption
- RD Design around Advantage pricing and market share as function of reimbursement policy, combined with detailed data on drug utilization, pricing, and insurance plan pricing
 - First stage: 16-17% more likely in urban to be in MA-PD
 - Causal Impact: MA-PD increases total drug spending by \$122 per enrollee, despite \$265 reduction in cons. OOP
- Evidence linking to internalized offsets:
 - Analysis by consumer retention
 - Analysis of hyperlipidima
 - Analysis of “Category I” Drugs: Most convincing, 40% of expenditure here, all increased spending here in MA

Key Results

- Next part of paper brings in structural oligopoly model with main purpose to estimate unobserved total medical costs
- Model is clever / sophisticated, and uses premiums from Medicare Advantage full plan to back out marginal costs of changes in premiums and/or generosity
- Premiums can be used to back out costs with assumptions on oligopoly conduct, demand estimates, and data.
 - IV strategy follows rural-urban policy change identification
- Welfare + Counterfactuals: (i) forced internalization of offsets (13% more drug spending) (ii) budget-neutral cost sharing subsidy (negative consumer welfare impact)

Comment 1: Welfare

- Paper currently assumes that we can learn about welfare using revealed preference from consumers choices
- But, a key premise underlying behavioral hazard and information frictions is that consumers are not ultimately picking the best plans or health care from an *ex post allocative view*
- In fact, many papers in the utilization literature with very granular data don't conduct welfare analysis for this reason
 - Einav et al. (2015), Brot-Goldberg et al. (2015), Dalton et al. (2015), Abaluck et al. (2015)

Comment 1: Welfare

- Papers that do this well often rely on informed consumers as benchmark for welfare
 - Bronnenberg et al (2015), Handel and Kolstad (2015)
- Different options to move paper forward include:
 - Sticking to positive analysis, which analysis is already very instructive / useful for
 - Construct welfare results for hypothetical \$/substituted drug spending values
- Bottom line: it's hard to use revealed preference of all consumers for welfare while also making point that they are making poor choices in both choice and utilization domains

Comment 2: What are “Offsets”?

- Prior work shows very specific cases of offsets [e.g. Chandra et al. (2010)], here we don't know why / how offsets occur, or if they are actually offsets in the sense typically considered
- Consumers may not be making optimal choices, MA plans have a lot going on outside of the drug choice context
 - Consumers choosing MA also choosing general coverage
- It could be that MA plans are choosing lower quality doctors / providers for reasons related to optimization in the general market, and that this *causes* substitution to drugs for reasons not explicitly welfare enhancing in and of themselves
 - Competition between MA and regular Medicare, selection, plan profits are objective function, not social welfare
 - Role for granular MA medical data, in select mkts (test model)
 - Results on offset drugs help

Additional Comments

- Unobserved heterogeneity in choice and utilization
- No inertia
- Risk-adjustment and Duggan et al. paper in MA
- Complexity in plan design: it is outside the scope of this work, but interesting to think about how to design complex value-based incentives in insurance contracts if it is already difficult for consumers to parse simpler current structure
 - Related to cost-sharing subsidies: how specific can levers used be?

Great Paper

- This paper brings a really innovative idea to the table in the way it uses IO methods to think carefully about the externalities that Part D standalone plans don't internalize
- Convincing evidence that MA-PD is spending more on drugs, especially drugs for high offset value
- Nice way to back out medical costs when MA medical data can be quite hard to get systematically, good integration with counterfactuals / policy questions
- Brings new evidence on extremely important policy issue: regardless of fine details, it is clear that Part D likely internalizes narrower aspect of social surplus than MA-PD