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

*Baicker et al. (2015), QJE*
Efficient Health Care Utilization

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Efficient Health Care Utilization

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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

Social Welfare

Welfare w/ Part D

Welfare w/ Advantage

This Paper

This Paper
Key Results

• This paper brings a novel IO research design to study “offsets,” or downstream costs not internalized with current consumption.

• RD Design around Advantage pricing and market share as a 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 consumer OOP.

• Evidence linking to internalized offsets:
  • Analysis by consumer retention
  • Analysis of hyperlipidimia
  • 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
Comment 1: Welfare

• Papers that do this well often rely on informed consumers as benchmark for welfare

• 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