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

FTC Microeconomics Conference
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Efficient Health Care Utilization

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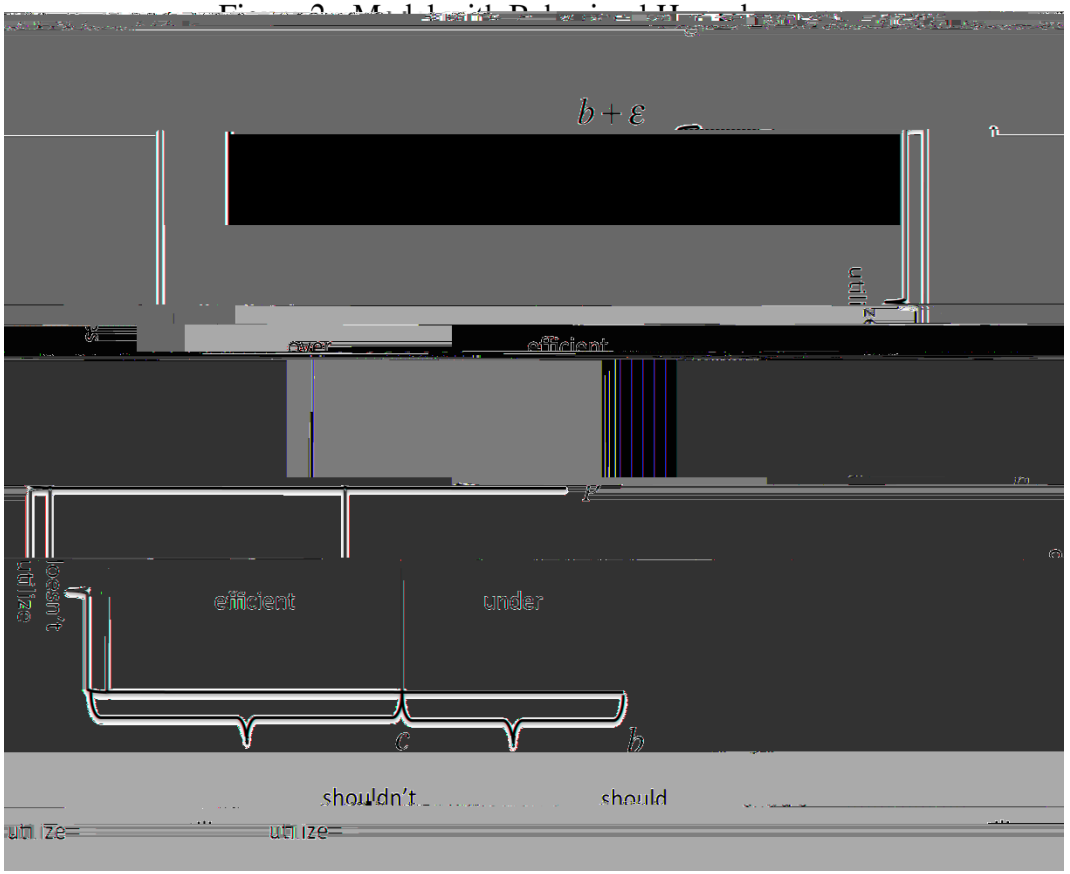
Different structures for empirically assessing efficient health care utilization

Moral Hazard Only

Baseline in Economics

Moral Hazard + Behavioral Hazard

Moral Hazard + Behavioral Hazard + Externalities



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

Efficient Health Care Utilization

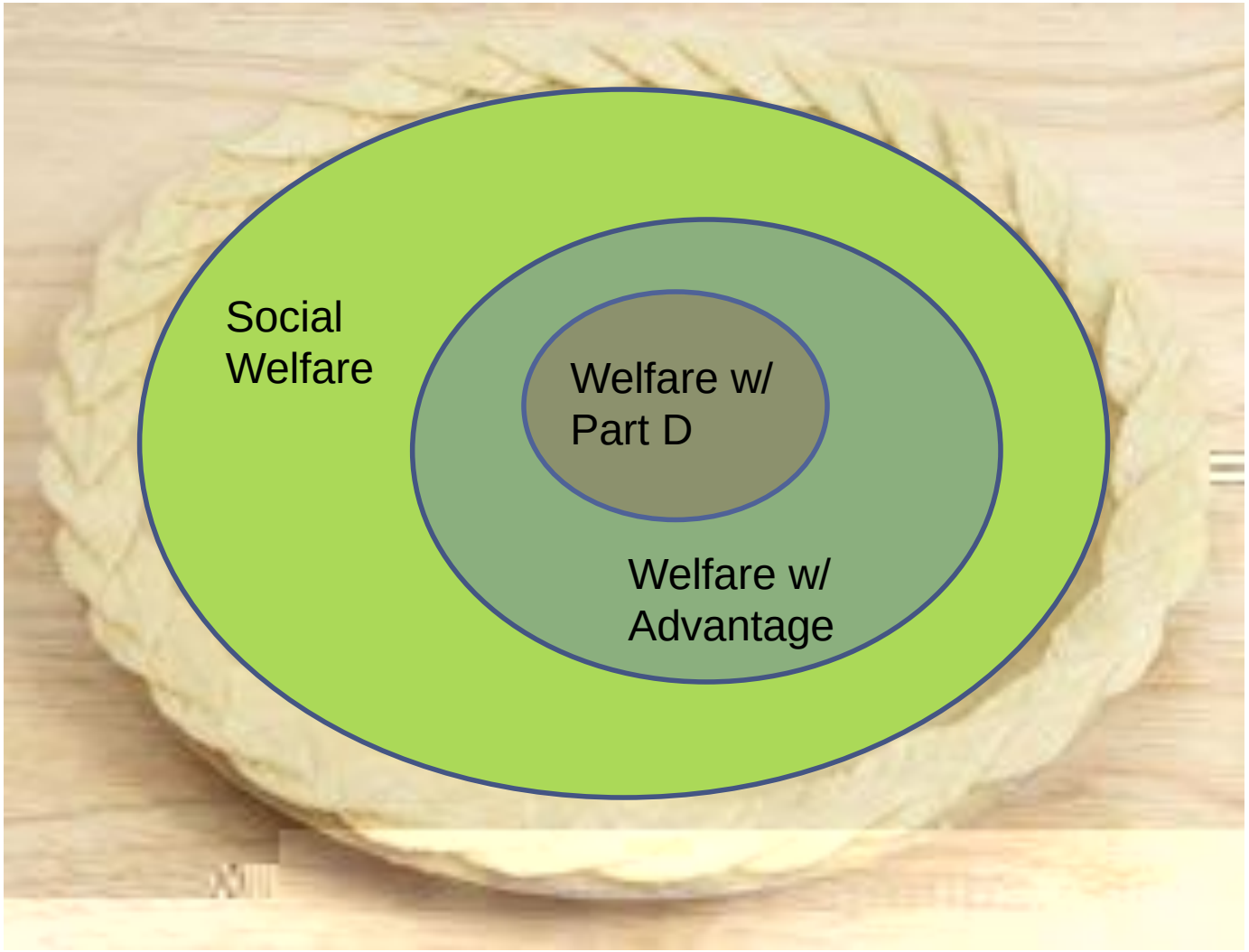
This Paper

Key Premise
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

Surplus from Health Care



Surplus from Health Care

Key Results

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

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

> Einav et al. (2015), Brot-Goldberg et al. (2015), Dalton et al. (2015), Abaluck et al. (2015)

Comment 1: Welfare

Prior work shows very specific cases of offsets [e.g. Chandra et al.

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

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

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