14.472 Public Finance II
Topic II_d: Adverse Selection: Welfare analysis without revealed preference

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Both EFC (QJE 2010) and EFS (EMA 2010) rely on observing demand and using revealed preference.

Two additional topics to consider in welfare analysis of insurance markets:

- [Up next] What if we want to abandon revealed preference / “go behavioral”?
- What if market doesn’t exist / has completely unraveled. How do we recover preferences / estimate demand?
Why might demand not reveal value / willingness to pay for insurance?

- Economic constraints: Liquidity constraints (NO!)
- Timing of measurement of demand - after information revealed / risk resolved
- Behavioral constraints: misperception, inattention, inertia, cognitive limitations

Two nice conceptual papers emphasize these points:

- Hendren (2017 mimeo): timing of measuring demand
- Spinnewijn (2017) model of misperception of risk (applies more generally to behavioral frictions)
Revealed preference

- Does demand reveal value in the presence of liquidity constraints?
- What are liquidity constraints?
  - inability to borrow against future income at market rate of interest
- Insurance products often have a temporal dimension (Casaburi and Willis 2016)
  - pay premiums up front; therefore transfers income across time as well as states
- This means that in terms of PDV lifetime budget might want to purchase insurance at existing price but do not want to purchase insurance out of current income
  - Cost of borrowing is higher than market interest rate
- Liquidity constraints not relevant for normative analysis
  - If WTP for health insurance is low because individuals have a high value of current cash due to liquidity constraints, this means they prefer other consumption to health insurance
Hendren (2017) Measuring ex ante welfare

- Key idea: observed demand does not capture value of insurance prior to when demand is measured
- By time demand is measured may have already learned something about your type (that generates adverse selection) which destroys some of the insurance value
- EFC (2010) may systematically under-state welfare cost of adverse selection!
- Consider extreme example: if demand is measured at the point where individuals know their costs, demand equals cost and private market would unravel
  - If use observed demand and cost curves to measure welfare loss, would find no loss - willingness to pay does not exceed costs for anyone
  - But what about individuals’ willingness to pay prior to learning their costs?
Individuals have $30 and face a uniformly distributed risk of losing between $0 and $10. How much would they be willing to pay \((D_{ex-ante})\)?

\[
u(30 - D_{ex-ante}) = \int_{0}^{10} u(30 - x) \, dx
\]

Assuming coefficient of relative risk aversion of 3, \(D_{ex-ante} \approx 5.50\), so indifferent between $24.50 with certainty or a uniformly distributed consumption between $20 and $30.

Expected cost to insurer of insuring everyone is $5, so insurance delivers a surplus of \(W_{ex-ante} = 0.50\).
But if demand is observed after individuals have learned their loss $m$ with certainty

- Then WTP will equal cost: $D(s) = m(s)$
- Given uniform distribution of risk this generates a linear demand curve falling from $\$10$ at $s = 0$ to $\$0$ at $s = 1$ (where $s \in [0, 1]$ denotes fraction insured)
- Demand always equals marginal cost (not willing to pay above MC because no uncertainty)
- Insurance would completely unravel because average cost of insuring fraction $s$ in market always exceeds demand

Using observed demand would not measure any welfare loss (0 DWL bc $D=MC$)

- But recall from ex-ante perspective, welfare loss from not having insurance was $\$.50$
Figure 1: Example Demand and Cost Curves

A. Before Information Revealed

B. After Information Revealed

Now, suppose demand is observed after some information about the loss has been revealed to the individuals. To simplify the example, assume individuals have learned their loss with certainty. In this case, their observed demand will simply equal the costs they would impose on the insurance company. Figure 1, Panel B, illustrates this case. The demand curve is given by $D_{\text{Observed}}(s) = 30 - 10s$, so that the person with the highest willingness to pay ($s = 0$) has $D_{\text{Observed}}(0) = 30$ and the person with the lowest willingness to pay ($s = 1$) has $D_{\text{Observed}} = 20$. The marginal cost imposed by each person on the insurance company equals the demand curve, $MC(s) = 30 - 10s$.

If an insurer were to attempt to sell insurance in this environment, the market would completely unravel ($s_{CE} = 0$). This is because the average cost of insuring a fraction $s$ of the market, $AC(s)$, lies everywhere above the demand curve. For example, if the insurance company set prices of $5, the set of people who would purchase insurance would have an average cost of $7.50, as reflected in the average cost curve, $AC(s)$. If prices rose to $7.50, the average cost of those who would purchase insurance would then be $8.75, again above $7.50. And so on. In this case, the unique competitive equilibrium results in no one obtaining any insurance, $s_{CE} = 0$.

What is the welfare cost of this complete market unraveling? From a deadweight loss perspective, each individual’s observed willingness to pay equals the cost they impose on the insurance company: $D_{\text{Observed}}(s) = MC(s)$, so that there is no deadweight loss, $DWL = 0$. But from an ex-ante perspective, the welfare loss of having no insurance market is $W_{Ex-Ante} = 0.50$. In this sense, welfare conclusions about the cost of adverse selection and the value of government intervention depend on the perspective the researcher wishes to take about when to measure demand and welfare. From the perspective of deadweight loss at the time demand is measured, there is no welfare loss. But from behind the veil of ignorance, the absence of a market delivers a welfare loss from adverse selection of $0.50.
How do we measure ex ante welfare?

- Need to know
  - Extent of ex ante heterogeneity - i.e. distribution of risk types before information is revealed ("behind the veil of ignorance")
  - How risk averse are individuals (curvature of utility function)

- Key insight: slope of the *observed* demand and cost curves reveal extent of ex ante heterogeneity
  - If ex ante everyone were same, demand and cost curves would be flat
  - Ex-post cross-sectional heterogeneity (slope of demand and cost curves) is ex ante risk heterogeneity

- Where do we get risk aversion?
  - Calibrate (i.e. assume) it from other estimates - very standard (but problematic)
  - Or back it out from difference between observed demand and cost curve (requires assumptions like e.g. no moral hazard)
Aside: Reclassification risk

- Ex-ante perspective related to issue of reclassification risk ("premium risk")
- In dynamic (multi-period) context, individuals benefit not only from period-by-period "event" insurance but also from insurance against becoming a bad risk and being reclassified into a higher risk group with a higher premium
- Problem is one of symmetric information:
  - How to "insure" information that is known at time of contracting (but from an earlier perspective one faced ex-ante risk)
  - e.g. risk of being (or becoming) a bad driver
- Will discuss as an extra topic if we have time
  - For those interested, two great references are Hendal and Lizzeri (QJE 2003) and Handel, Hendel and Whinston (EMA 2015)
Imagine there is some “non-welfarist constraint” that affects insurance demand but not insurance value.

Example. Discrepancy between perceived and actual risks.

Key: Creates a wedge between actual value of insurance and value of insurance revealed by individual demand.

In this setting, revealed preference approach likely systematically understates the welfare cost of adverse selection.
Key selection effect

- If there is discrepancy between perceived and actual risks, on average those who select insurance will tend to over-estimate value of insurance and those who don't buy will under-estimate it
  - Note: can get this even if beliefs are accurate *on average* as long as there is some distribution of gap between perceived and actual risk
- As a result, demand curve overstates surplus for insured and understates potential surplus for uninsured
- If we treat demand curve as value curve (i.e. use revealed preference) get unambiguous sign to bias
  - Under-estimate welfare cost of selection; under-estimate welfare gain from mandate
- EFC (2010) may systematically under-state welfare cost of adverse selection!
Perceived vs “true” value

- Individuals differ on a vector of characteristics $\zeta$
- $v(\zeta)$: true value of insurance (relevant for welfare)
- $\hat{v}(\zeta)$: perceived value of insurance (Determines demand)
- noise term $\epsilon$ drives wedge between true and perceived value

$$\hat{v}(\zeta) = v(\zeta) + \epsilon(\zeta) \text{ with } E_{\zeta}(\epsilon) = 0$$

e.g. Noise term is positive if over-estimate risk, negative if under-estimate risk

Key insight: even if noise cancels out across entire population (so true and perceived value are equal on average), since demand for insurance depends only on perceived value, true and perceived value may differ substantially conditional on insurance decision
Demand curve vs. value curve

- Demand: Buy if perceived value exceeds price: \( \hat{v}(\zeta) \geq p \)

\[
D(p) = 1 - F_{\hat{v}}(p)
\]

- Demand curve reveals WTP of marginal buyers at different prices. Price reveals perceived value for marginal buyer at that price:

\[
p = E_{\zeta}(\hat{v} | \hat{v} = p)
\]

- For welfare, what is relevant is expected true value of marginal buyers

\[
MV(p) \equiv E_{\zeta}(v | \hat{v} = p)
\]
The demand for insurance depends only on the perceived value, the true and perceived value may differ substantially conditional on the insurance decision. An individual with characteristics \( x \) will buy an insurance contract if her perceived value exceeds the price, \( v > p \). The demand for insurance at price \( p \) equals \( D(p) = F(v | \hat{v} = p) \). As is well known, the demand curve reflects the willingness to pay of marginal buyers at different prices. That is, the price reveals the perceived value for the marginal buyers at that price, \( p = E(v | \hat{v} = p) \). However, to evaluate welfare, the expected true value for the marginal buyers is relevant, which I denote by \( \text{MV}(p) \).

The central question is thus to what extent the true value co-varies with the perceived value. A central statistic capturing this co-movement is the ratio of the covariance between the true and perceived value to the variance of the perceived value, \( \frac{\text{cov}(v, \hat{v})}{\text{var}(\hat{v})} \).

Graphically, one can construct the value curve, depicting the expected true value for the marginal buyers for any level of insurance coverage \( q \), and compare this to the demand curve, depicting the perceived value \( D_1(q) \) for that level of insurance coverage, as shown in Figure 1. The mistake made by a naive policy maker, who incorrectly assumes that the demand curve reveals the true value of insurance, depends on the wedge between the two curves. I analyze the systematic nature of this difference along the demand curve.

2.2 Infra-marginal Policies: Robust Bias

I start by comparing the true and perceived insurance value for the infra-marginal individual. For the insured, the expected true value of insurance, \( E(v | \hat{v} = p) \), determines...
Implications for inferring insurance value

- (Proposition 1): If true value $v$ and noise term $\varepsilon$ are independent, demand curve overestimates insurance value for insured and underestimates the insurance value for the uninsured.

- Simple selection effect: those who buy are selected for positive $\varepsilon$ (and those who do not for negative $\varepsilon$):

$$E_\zeta(\varepsilon | \hat{v} \geq p) \geq 0 \geq E_\zeta(\varepsilon | \hat{v} < p) \text{ for any } p$$

- What if noise is not independent of true value?
  - (Proposition 2) If true and perceived value are normally distributed, sign of bias remains same as long as the correlation between noise term and true value is not “too negative”.

- Naive policy maker (using demand curve) will overestimate insurance value for insured and underestimate insurance value for uninsured when true value changes less than one for one with perceived value.
Implications for cost of adverse selection

- Assume Adversely selected equilibrium generates too little insurance, measured wrt the marginal value (MV) curve
- Welfare cost of under-insurance depends on difference between MV curve and MC curve for those not insured in equilibrium (demand below AC) but efficient to insure (MV above MC)
- If instead use demand curve to estimate welfare cost of adverse selection estimate welfare cost of adverse selection as difference between demand and MC for those not insured in equilibrium (demand below AC) but efficient to insure (demand above MC)
- Two causes of under-estimating welfare loss from under-insurance (from using Demand curve instead of MV curve):
  - Misidentify set whom it is efficient to insure
  - Misidentify the welfare loss for those inefficiently uninsured
3.2 Cost of Adverse Selection

The average and marginal cost of providing a contract at price $p$ equal respectively,

$$AC(p) = E(j^v p)$$
$$MC(p) = E(j^v/p)$$

If the willingness to buy insurance is lower for lower risk types, the market will be adversely selected in the sense that the insured are more risky than the uninsured. Figure 2 illustrates this by plotting the marginal and cost curve together with the demand curve. The marginal cost is decreasing with the share of insured individuals, since the risk of the marginal individual buying insurance is decreasing with the price. The average cost function is thus decreasing as well, but at a slower rate, and lies above the marginal cost function, as shown in the left panel of Figure 2. In advantageously selected markets, individuals with higher risk are less likely to buy insurance and the average cost function will be below rather than above the increasing marginal cost function. In general, the less an individual's risk affects his or her insurance choice, the less the marginal cost will depend on the price. This attenuates the average and marginal cost curve and reduces the wedge between the two.

In a competitive equilibrium, following Einav et al. (2010a), the competitive price $p^c$ equals the average cost of providing insurance given that competitive price, $AC(p^c) = p^c$. Graphically, this is the price for which the demand and average cost curve intersect. However, it is efficient for an individual to buy insurance as long as her valuation exceeds the cost of insurance. Hence, at the constrained efficient price $p^*$, the marginal

Figure 2: Adverse Selection: the naively estimated cost $\Gamma^n$ vs. the actual cost $\Gamma$. 
Nice, and likely important insight

What are the sources of “noise” (ε)

- Uses example of perceived vs actual risk
- Other behavioral constraints: inattention, cognitive inability, inertia

Welfare can become trickier. Why is \( \nu(p) \) relevant for welfare instead of \( \hat{\nu}(p) \)? Welfare from whose perspective?
Key challenge: how implement empirically?

In addition to the demand and cost curves needed for EFC (2010), need one additional statistic:

- share of the variation in insurance demand - left unexplained by heterogeneity in risks – that is driven by non-welfarist constraints rather than by heterogeneous preferences

Need additional data to disaggregate revealed value of insurance into true value and constraints

Two components

- Testing: How do we identify these “behavioral” constraints empirically? Will now discuss. There has been progress but scope for more.
- Quantifying: How do we estimate the value curve - i.e. what the demand curve would be in absence of all behavioral frictions?
  - A key - and ongoing – challenge
Behavioral models of insurance demand

1 Evidence of failures of rational model
   1 Consistency of choices across contexts (Barseghyan et al AER 2011)
   2 Consistency of choices within contexts (Abaluck and Gruber AER 2011)
   3 "Comparison frictions" - Kling et al (QJE 2012)

2 The challenge (and the frontier) I: Testing - Using the data to identify the behavioral model
   1 Survey evidence to identify information frictions (Handel and Kolstad 2014 AER)
   2 Dominated Choices / Switching costs (Handel AER 2013; Bhargava et al. 2017 QJE)
   3 Probability weighting (Barseghyan et al AER 2013)

3 The challenge (and the frontier) II: Estimating the "value curve" - i.e. demand curve in absence of any (!) behavioral frictions
   1 Handel, Kolstad and Spinnewijn (forthcoming, ReStat)
Key theme

- Key role of modeling assumptions to identify departures from neoclassical model (or to estimate the rational model in non-behavioral work)

  - Fundamental identification problem: observe risk realization not underlying risk, so can rationalize all choices with flexible enough distributions of risk type and risk preferences
    - Is the individual making a mistake when he looks healthy and is buying very comprehensive insurance.
    - Or is he very risk averse?
    - Or has private information he’s higher risk than we (the econometrician) think?

  - Difficult enough to jointly identify risk type and risk preferences and now introducing another degree of freedom (mistakes!)
    - So almost always going to come down to assumptions (rational expectations, particular mistakes model etc)
Key theme (con’t)

- The current frontier: trying to find ways to get the data to identify departures from neoclassical model with as few assumptions as possible
- One very nice model for empirical papers:
  - Start with descriptive/“model free” results
  - Add more assumptions as needed (so consumer can decide what is the data and what is the model)
Stability of risk preferences across contexts

- Neoclassical model of decisions under uncertainty: context-invariant risk preferences
  - Individuals have a single, concave utility function over wealth.
  - One risk aversion parameter for the individual that guides choices in different contexts
  - Relatedly, we often calibrate models one one context (e.g. savings, labor supply) with estimates of risk aversion from another (Jeopardy, insurance demand)

- Other extreme: literature in psychology and behavioral economics arguing little, if any, commonality in how same individual makes choices in different contexts

- Until recently, little evidence from real world / market decisions (vs. hypotheticals, experiments etc)
Two related papers

- Barseghyan, Prince and Teitelbaum (AER 2011)
  - Commercial insurance company
  - Policyholders choices regarding auto collision, auto comprehensive, and home

- Einav, Finkelstein, Cullen and Pascu (AER 2012)
  - Alcoa employees’ choices of different benefits (health, dental, drug, stdi, ltdi, 401(k) asset allocations)
Looking at consistency of risk preferences across contexts

Setting: choice of deductible in auto (comprehensive and collision) and homeowner
Use data on insurance claims and deductible choices to estimate risk aversion in a given context.

- Key again is choice is over a well-defined *financial* risk (vs. e.g. HMO vs PPO choice).

Because choices are discrete, will get, conditional on model and estimate of risk type, an interval for the possible risk aversion (more on this in a moment).

Will estimate the individual’s interval of risk aversion separately in each of the 3 markets. If the three intervals do not intersect, then choices cannot be reconciled with a single coefficient of risk aversion.

Main finding: reject hypothesis of stable risk preferences: only about one quarter of sample have intersecting intervals.
How do they estimate risk aversion “interval” for each context?

- Core idea is Cohen and Einav (2007 AER) "Estimating risk preferences from deductible choice"
- This basic intuition is used in several papers (EFS 2010, Barseghyan et al 2011, 2013, Handel 2013 etc)
Cohen and Einav (AER 2007)

- Setting: deductible choice in Israeli automobile insurance
  - Regular (~$350) vs. low (~$200) deductible
- Observe insurance choices and claims
- Three key assumptions allow them to use data on (ex post) realized claims to estimate distribution of (ex ante) claims rates
  - Claims are generated by a Poisson process at the individual level
  - Individuals have perfect information about the Poisson claim rate
  - No moral hazard
- Then use choice of deductible to estimate distribution of risk aversion and its correlation with claim rate
- Key point: estimate heterogeneity in risk preferences from deductible choices, accounting for adverse selection (unobserved heterogeneity in claim risk)
Equation (7) defines an indifference set in the space of risk and risk aversion, which we will refer to by \((r^*(\lambda_i), \lambda_i)\) and \((\lambda_i, r^*(\lambda_i))\) interchangeably. Both \(r^*(\lambda_i)\) and \(\lambda_i^*(r)\) have a closed-form representation, a property that will be computationally attractive for estimation. Both terms are individual specific, as they depend on the deductible menu, which varies across individuals. For the rest of the paper, we regard each individual as associated with a two-dimensional type \((r_i, \lambda_i)\). An individual with a risk parameter \(\lambda_i\), who is offered a menu \(\{(p_{ih}, d_{ih}), (p_{il}, d_{il})\}\), will choose the low-deductible contract if and only if his coefficient of absolute risk aversion satisfies \(r_i^{-\lambda_i} (\lambda_i)\). Figure 2 presents a graphical illustration.

**B. The Benchmark Econometric Model**

**The Econometric Model.**—The econometric model we estimate is fully described by the five equations presented in this section. Our objective is to estimate the joint distribution of \((\lambda_i, r_i)\) — the claim rate and coefficient of absolute risk aversion — in the population of policyholders, conditional on observables \(x_i\). The

20 For example, estimating the CARA version of the model (Section IIID), for which \(r^*(\lambda_i)\) does not have a closed-form representation, takes almost ten times longer.
Intuition (con’t)

- Conditional on your risk type (claim risk $\lambda$) your choice of deductible depends on your risk aversion.
- Distribution of risk types can be backed out from claim data alone given three key assumptions:
  - Claims are generated by a Poisson process at the individual level (or any distributional assumption).
  - Individuals have perfect information about the Poisson claim rate (or any specific informational assumption).
  - No moral hazard.
- Therefore can use deductible choice as an additional layer of information to identify unobserved heterogeneity in risk aversion (and correlation with risk type).
Intuition (con’t)

- Distribution of risk types can be backed out from claim data alone given three key assumptions
- Therefore can use deductible choice as an additional layer of information to identify unobserved heterogeneity in risk aversion (and correlation with risk type)
  - Have (quasi-random) variation in menus (different deductibles and premiums) which create different indifference sets (as in Figure 2) that cross
  - Use parametric assumptions for parts of distribution where indifference sets don’t cross and in tails (EFS 2010 uses parametric assumptions because don’t have good variation in choice set)
- Findings: Large heterogeneity in risk aversion (larger than heterogeneity in unobserved risk)
Estimate Cohen and Einav model separately for the three different settings (auto collision, auto comprehensive and homeowner)

Key assumptions
- Households maximize expected utility
- Claims are generated by Poisson process at household level (or some distributional assumption)
- Households know their coverage specific claim rates and use them in calculating EU (or some assumption about information set)
- No moral hazard

Given menu of options and choices and an estimate of claim rate, each deductible choice by the household implies risk aversion lies between two indifference points
- E.g. if chooses a $500 deductible from a menu of $100, $500 and $1000, then indifference points between $500 and $1,000 provides a lower bound on risk aversion and indifference points between $100 and $500 provide an upper bound
- Recall Cohen and Einav Figure
For each household, use choices in 3 contexts to identify three different intervals of risk aversion (NB: intervals bc choices are discrete).

If 3 intervals for an household fail to intersect, that household’s choices cannot be rationalized by the same coefficient of risk aversion.

Note: don’t need to take a stand on “reasonableness” of level of risk aversion – comparison is within individual across contexts.
Findings

- Reject hypothesis of stable risk preferences
- Find 23% of sample have all three risk aversion intervals overlapping
  - If choices were random, would get 14%

- Implications for using "estimates from literature to calibrate risk aversion"

Their test is a *joint test* of the null of domain-general risk preferences *and* their model

Rejection of the null could mean either the model or domain-general preferences or both are wrong

This is a key theme that will see in many of these “choice inconsistency” papers

- Key challenge / goal in this literature is (should be): to design tests that are require as few modeling assumptions as possible (hard!)
- Of course this is also a challenge for the “neoclassical” papers that assume away inconsistencies / rationalize with enough heterogeneity in risk aversion and risk type (Cohen and Einav 2007; EFS 2010).
A key modeling assumption: backing out distribution of claim type from claim realizations.

Recall key assumptions: no moral hazard; claims generated by Poisson process; households know their claim rate.

Baseline model: household risk type = predicted risk type from the Poisson estimation of claim

\[
\ln \lambda_{ij} = x_{ij}' \beta_j + \varepsilon_{ij}
\]

where \( \lambda_{ij} \) is claim rate for household \( i \) for coverage \( j \)

- Allow for unobserved heterogeneity in risk type (\( \varepsilon_{ij} \)) but baseline model ignores it (assumes your risk type is your predicted risk type).
- Robustness check where note that if they allow for unobserved heterogeneity “expected” success rate (i.e. amount of intersection of intervals if preferences are fully domain general) would fall to 50%.
  - so 100% overlap under null of full domain generality may not be right benchmark to compare their estimate of 23% to.
But the issue is deeper / not solved by robustness checks
I can rationalize any choices as consistent with a common risk aversion if I “free up” risk type enough.

“Robustness” analysis is by definition limited
Not that that approach is necessarily very satisfying either...
Choice inconsistencies in Part D: Abaluck and Gruber (AER 2011)

- Medicare Part D introduced 2006
  - Adds prescription drug coverage for elderly to Medicare
  - Key novel feature: Private insurers offer a range of products with varying prices and cost-sharing, and consumers pick (vs uniform benefits in Part A and B)

- Typical elder faces choice of over 40 plans.
  - Plans vary in cost-sharing features like deductible, coverage in "donut hole", cost sharing for branded vs generic drugs etc

- Neoclassical economics: more choice is better
  - Competition / productive efficiency
  - Preference heterogeneity / allocative efficiency
  - [What about adverse selection?!!]

- But what if individuals “make mistakes”?
- They study choices elderly make in first year of program (2006)
The figure shows the standard benefit design in 2008. "Pre-Kink coverage" refers to coverage prior to the Initial Coverage Limit (ICL) which is where there is a kink in the budget set and the gap, or donut hole, begins. As described in the text, the actual level at which the catastrophic coverage kicks in is defined in terms of out-of-pocket spending (of $4,050), which we convert to the total expenditure amount provided in the figure. Once catastrophic coverage kicks in, the actual standard coverage specifies a set of co-pays (dollar amounts) for particular types of drugs, while in the figure we use instead a 7% co-insurance rate, which is the empirical average of these co-pays in our data.
Use data on individual Part D choices and subsequent claims to test 3 predictions of the neoclassical model:

- **Prediction 1**: Individuals should value a $ of premiums the same as a $ of expected out of pocket costs

- **Prediction 2**: Conditional on premium and distribution of out of pocket costs, individuals should not care about other financial characteristics of the plan like the deductible or donut hole coverage
  - These should matter only by affecting distribution of out of pocket costs

- **Prediction 3**: All else equal, individuals should prefer plans that have a lower variance of out of pocket costs
Are these robust predictions of the neoclassical model?

- Prediction 1: Individuals should value a $ of premiums the same as a $ of expected out of pocket costs
  - What if there is state-dependent utility?
  - or state dependent prices (e.g. family lends money to cover oop costs but not premiums)?
  - What if there are liquidity constraints? Then timing / lumpiness of expected out of pocket payment stream matters (Ericson and Sydnor, 2018)

- Prediction 2: Conditional on premium and distribution of (annual) out of pocket costs, individuals should not care about other financial characteristics of the plan like the deductible or donut hole coverage
  - What if there are liquidity constraints?

- Prediction 3: All else equal, individuals should prefer plans that have a lower variance of out of pocket costs
Empirical approach

- Very similar in spirit (if not in details) to Cohen and Einav 2007, Barseghyan et al 2011 etc
- Observe data on insurance options, choices and claims
- Make key assumptions regarding: information set of consumer about risk type, distribution of risk type, no moral hazard
- If don’t make distribution of risk type and risk aversion sufficiently (infinitely?!?) flexible, can’t rationalize all choices with standard model
- NB: b/c unlike Barseghyan et al. looking at inconsistency within a single context, also have to take a stand on level of risk aversion
Model of plan choice

- Conditional logit model of plan choice

\[ u_{ij} = \pi_j \beta_0 + \mu_{ij}^* \beta_1 + \sigma_{ij}^2 \beta_2 + x_j \lambda + q_{b(j)} \delta + \varepsilon_{ij} \]

where \( \pi_j \) is premium of option \( j \)
\( \mu_{ij}^* \) is mean oop costs for individual \( i \) in plan \( j \) (estimated)
\( \sigma_{ij}^2 \) is variance of oop costs for individual \( i \) in plan \( j \) (estimated)
\( q_{b(j)} \) are vector of non financial characteristics of plan (vary across brand)
\( x_j \) : other plan financial features (deductible, whether covers donut hole etc)
Model of plan choice

\[ u_{ij} = \pi_j \beta_0 + \mu_{ij}^* \beta_1 + \sigma_{ij}^2 \beta_2 + x_j \lambda + q_{b(j)} \delta + \epsilon_{ij} \]

- Estimate model using construction of choice sets, observed choices and claims
- Test three predictions:
  - \( \beta_0 = \beta_1 \) (value premium and expected out of pocket costs the same)
  - \( \lambda = 0 \) (conditional on mean and variance of oop costs, don’t care about other plan characteristics)
  - \( \beta_2 < 0 \) (dislike variance; individuals are risk averse)
Constructing risk type

\[ u_{ij} = \pi_j \beta_0 + \mu_{ij}^* \beta_1 + \sigma_{ij}^2 \beta_2 + x_j \lambda + q_{b(j)} \delta + \epsilon_{ij} \]

- Observe single realized (ex post) claims but not ex ante risk type from which they are drawn
- Need to estimate \( \mu_{ij}^* \) and \( \sigma_{ij}^2 \)
- Common theme - see prior papers!
Assume no moral hazard

Construct cells of “identical” individuals, “identical” in terms of decile of drug expenditures, days supply of branded drugs and days supply of generic drugs from year prior to the choice year studied (=2005, before introduction of Part D)

1,000 cells (interaction of deciles of three measures)

Sample realized (2006) claims from 200 people within the cell. Use these to construct $\mu_{ij}$ and $\sigma_{ij}^2$

i.e. this is the individual’s information set about his risk type when selecting a plan
Findings: reject all three “neoclassical” predictions

\[ u_{ij} = \pi_j \beta_0 + \mu_{ij}^* \beta_1 + \sigma_{ij}^2 \beta_2 + x_j \lambda + q_{b(j)} \delta + \epsilon_{ij} \]

- \( \beta_0 > \beta_1 \) people place more weight on premiums than expected out of pocket expenses
- \( \lambda \neq 0 \). Conditional on (modeled) distribution of out of pocket costs, other financial features of plan affect choices
  - dislike deductibles, value donut coverage etc
- Cannot reject \( \beta_2 = 0 \). Cannot reject that (supposedly risk averse) individuals don’t care about variance
Comment: implications of mistakes?

- Cannot reject $\beta_2 = 0$. Cannot reject that (supposedly risk averse) individuals don’t care about variance.
- Why then do we care about mistakes? Aren’t they just a transfer?
Once again joint test of “choice consistency” and model

\[ u_{ij} = \pi_j \beta_0 + \mu_{ij}^* \beta_1 + \sigma_{ij}^2 \beta_2 + x_j \lambda + q_{b(j)} \delta + \epsilon_{ij} \]

- Some key assumptions include
  - Modeling of risk type \( \mu_{ij}^* \) and \( \sigma_{ij}^2 \)
  - Homogeneous risk aversion across individuals
  - Quadratic utility (only care about mean and variance)

- Can (and they do) probe robustness on many dimensions

- But fundamentally robustness tests of limited
  - Can rationalize the data if we want to (is it credible though?! How to formally assess?)
Once again joint test of “choice consistency” and model

- Fundamental identification problem: observe risk realization not underlying risk
  - can rationalize all choices with flexible enough distributions of risk type and risk preferences
  - Is the guy making mistake when he looks healthy based on “cell” and buying really expensive plan? Or is he very risk averse? Or has private information he’s higher risk than we think?
  - Difficult enough to jointly identify risk type and risk preferences and now introducing another degree of freedom (mistakes!)
Comment: Naming the error term

\[ u_{ij} = \pi_j \beta_0 + \mu_{ij} \beta_1 + \sigma^2_{ij} \beta_2 + x_j \lambda + q_{b(j)} \delta + \varepsilon_{ij} \]

- Note that if model is correctly specified, nothing but distribution of out of pocket costs should affect choices.
- That’s the key insight behind the test of whether plan features like deductible etc affect choices (they should not)
- By similar token, the logit error term \( \varepsilon_{ij} \) represents “mistakes” – nothing else should matter
- So in their normative welfare analysis in paper, choices other than what is predicted (w/o error term) is a “mistake”
  - Contrast with “standard” neoclassical approach which interprets the error term as unmodeled preference heterogeneity
  - Neither particularly palatable.

- Has welfare economics come down to what we choose to call the error term?
Again the setting is Part D and the question relates to the novel feature of choice in Social Insurance

[Recall: question of choice in social insurance subtle even w/o violations of rationality due to adverse selection]

Run a randomized field experiment in which they send people personalized cost information

- Based on the prior year’s drug utilization, what would their out of pocket costs be under each plan
- How much they would save by switching to the lowest cost plan

Comparison group given only a website where this information is available

Key: information was already available: free and widely advertised
Sample is patients at University of Wisconsin Hospital System who met screening criteria and agreed to participate.

Key finding: treatment had impact on switching.

28% of treatment group switched plans (compared to only 17% of control group).

- Even control switching is twice national average. (Sample has higher rates of drug utilization and reported plan dissatisfaction than average)

Cost savings: plan switching caused average decline in predicted annual costs of about $100 (about 5%).
Comparison frictions: Positive interpretation

- Giving people the same information that is available on a website affects behavior.
- Evidence of what authors term “comparison frictions” - wedge between availability of comparative information and consumers’ use of it.
  - Analogy to search frictions – challenge of buyers and sellers in locating each other.
- Typically we assume if make information available for free and at low transaction cost there are no “comparison frictions”. Appears not to be the case.
Comparison frictions: Normative interpretation

- Implications for welfare? For policy?
- Treatments switched when information became more salient?
- Were they making mistakes before? Was switching optimal? Or did we prime them to do something that may not be optimal?
- Information is all about costs *assuming next year’s drug utilization profile is same as last year’s*
  - i.e. how much you save by switching to “lowest cost” plan given your prior utilization
- But is the assumption of stable utilization reasonable?
  - Isn’t the purpose of insurance to reduce the variance, not the mean?
  - Do we think it’s optimal to choose the lowest cost plan? (If I buy comprehensive insurance and have no claims was it a mistake?)
- But then, in presence of comparison frictions, how do we design optimal informational intervention?
  - Don’t know what plan is optimal without knowing what person’s risk preferences are and his private information about risk type....
Observed demand may systematically understate welfare cost of selection

- Hendren (2017)
- Spinnewijn (2017)

Testing the rational model (and finding it lacking)

- Choice inconsistencies across and within contexts
- Fundamentally joint tests of model + the null of rationality

[Up next]: The challenge (and the frontier) I: Using data (vs. assumptions) to identify "behavioral" departures

- Survey evidence on "information frictions" (Handel and Kolstad 2014)
- Dominated choices / switching costs (Handel AER 2013)
- Probability weighting (Barseghyan et al AER 2013)

[Then] The challenge (and the frontier) II: What does value curve look like?
Handel and Kolstad (2014)

Standard set up where observe employee (health) insurance options, choices and subsequent claims

So in principle can estimate a model of risk preferences and risk type la Cohen and Einav (2007)

Novel feature: survey employees about what they know about the plans

Focus on choice between a high deductible health plan (HDHP) and a much lower cost sharing plan (PPO) with identical non-financial features

Very few (~11%) choose HDHP and they argue that this is due to "information frictions" / lack of understanding about HDHP
Table 3: People in HDHP know more about the cost-sharing under HDHP than people in PPO

<table>
<thead>
<tr>
<th>Question</th>
<th>Correct (%)</th>
<th>Incorrect (%)</th>
<th>Not Sure (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) What is the deductible under the HDHP?</td>
<td>27.08%</td>
<td>22.40%</td>
<td>50.53%</td>
</tr>
<tr>
<td>HDHP-Existing</td>
<td>52.68</td>
<td>11.23</td>
<td>36.10</td>
</tr>
<tr>
<td>HDHP-New</td>
<td>50.79</td>
<td>13.49</td>
<td>35.73</td>
</tr>
<tr>
<td>PPO</td>
<td>21.53</td>
<td>24.66</td>
<td>53.82</td>
</tr>
<tr>
<td>(2) What is the coinsurance rate under the HDHP?</td>
<td>18.56</td>
<td>25.64</td>
<td>55.80</td>
</tr>
<tr>
<td>HDHP-Existing</td>
<td>33.85</td>
<td>21.24</td>
<td>44.91</td>
</tr>
<tr>
<td>HDHP-New</td>
<td>29.07</td>
<td>21.37</td>
<td>49.56</td>
</tr>
<tr>
<td>PPO</td>
<td>15.66</td>
<td>26.61</td>
<td>57.73</td>
</tr>
<tr>
<td>(3) What is the out-of-pocket maximum under the HDHP?</td>
<td>18.47</td>
<td>21.98</td>
<td>59.55</td>
</tr>
<tr>
<td>HDHP-Existing</td>
<td>28.32</td>
<td>22.11</td>
<td>49.57</td>
</tr>
<tr>
<td>HDHP-New</td>
<td>31.87</td>
<td>18.91</td>
<td>49.21</td>
</tr>
<tr>
<td>PPO</td>
<td>15.85</td>
<td>22.31</td>
<td>61.84</td>
</tr>
</tbody>
</table>
Table 4: People in HDHP more likely to know that plans are identical on non-financial features

<table>
<thead>
<tr>
<th>Question</th>
<th>Same</th>
<th>HDHP bigger</th>
<th>PPO bigger</th>
<th>Not sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>(7) How do the provider networks of the two plans compare?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HDHP-Existing</td>
<td>41.28</td>
<td>6.74</td>
<td>2.76</td>
<td>49.22</td>
</tr>
<tr>
<td>HDHP-New</td>
<td>49.39</td>
<td>3.33</td>
<td>4.20</td>
<td>43.08</td>
</tr>
<tr>
<td>PPO</td>
<td>32.09</td>
<td>6.26</td>
<td>14.48</td>
<td>47.16</td>
</tr>
</tbody>
</table>

Table 4: Responses to Plan Non-Financial Characteristics, Hassle Cost and Medical Expenditure Survey Questions. Exact wording of questions and answers in Appendix A.18

Finkelstein ()
PF Slides
Fall 2019 60 / 97
(Very) nice to try to get data to speak to departures from neoclassical model rather than inferring them from modeling choices.

But it is not clear can interpret the survey evidence as "information frictions"

- Financial results in Table 3 seem explainable by experience learning (existing HDHP) and salience (new HDHP)
- Results in Table 3 and 4 seem explainable by people in HDHP are smarter / have it together (note HDHP = new / less traditional choice) and/or better at answering surveys

They re-estimate the standard Cohen and Einav (2007) type model of plan choice, adding in as an individual covariate (plan shifter) how informed their survey answers are.

- Again, same interpretation issues as reduced form
Switching costs - Handel (2013)

- Standard economic theory: choice is good
  - Competition / productive efficiency
  - Preference heterogeneity / allocative efficiency

- Thus far, have considered two separate factors that can mitigate against value of choice
  - Adverse selection (potential welfare improving role for mandates)
  - “Mistakes” / choice inconsistencies

- Handel (2013) now combines them
  - Investigates consumer inertia in health insurance markets where adverse selection is a potential concern
Employee menu of health insurance options, choices, and claims over several years in a large firm

Very similar set up to Alcoa data

Key features: Changes in menu

- Firm significantly altered menu of plans, forced employees out of old plans (no longer offered) and required them to make an active choice from new menu (no stated default)
- In subsequent years, options remain same but premiums changed a lot and if no active choice, defaulted into prior year’s choice

Key identifying feature for inertia: when employees join firm relative to when menu or price changes occur
Overview of Approach

- Descriptive evidence of inertia
  - e.g. Comparison of choices made by different cohorts of new employees (very different choice environment; otherwise appear quite similar)

- Model (a la Cohen and Einav) to recover distribution of risk type, risk preferences and switching costs. Can be used to
  - Quantify the extent of switching costs
  - Model plan choice and welfare under counterfactual policies (such as forced active choice / no inertia by construction)

- NB: Very nice pairing
  - Descriptive evidence on key feature of model (relatively model free)
  - Additional modeling assumptions allow him to ask questions (counterfactual choice; welfare) that you can’t get from the reduced form
Overview of findings

- Substantial inertia from descriptive evidence
  - As plan prices and choice environment change over time, incoming cohorts of new employees make active choices that reflect updated setting while prior cohorts make very different choices that reflect past setup (cohorts look otherwise similar)
  - Some options become *dominated* and yet most consumers stay with them (NB: strict dominance doesn’t require modeling assumptions about e.g. risk type or preferences)

- Counterfactual results from model: inertia ameliorates adverse selection and improves welfare
  - Reduces adverse selection pressure (i.e. healthiest dropping out)
  - Application of theory of the second best
Key idea: new employees forced to make active choices (vs prior cohorts)

Compare how choices vary for new employees vs old (confirming that demographics don’t vary across cohorts)

Notation:
- $t_0 =$ year of menu change (everyone has to make an active choice)
- $t_1 =$ menus don’t change (so can be passive) but large price changes

Examines: how do $t_1$ choices vary for those who enter at $t_1$ (active choices) vs. those already in at $t_0$ (potentially passive)
Table 2

New Enrollee Analysis

<table>
<thead>
<tr>
<th></th>
<th>New Enrollee $t_{-1}$</th>
<th>New Enrollee $t_0$</th>
<th>New Enrollee $t_1$</th>
</tr>
</thead>
<tbody>
<tr>
<td>$N, t_0$</td>
<td>1056</td>
<td>1377</td>
<td>-</td>
</tr>
<tr>
<td>$N, t_1$</td>
<td>784</td>
<td>1267</td>
<td>1305</td>
</tr>
<tr>
<td>$t_0$ Choices</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$PPO_{250}$</td>
<td>259 (25%)</td>
<td>287 (21%)</td>
<td>-</td>
</tr>
<tr>
<td>$PPO_{500}$</td>
<td>205 (19%)</td>
<td>306 (23%)</td>
<td>-</td>
</tr>
<tr>
<td>$PPO_{1200}$</td>
<td>155 (15%)</td>
<td>236 (17%)</td>
<td>-</td>
</tr>
<tr>
<td>$HMO_1$</td>
<td>238 (23%)</td>
<td>278 (20%)</td>
<td>-</td>
</tr>
<tr>
<td>$HMO_2$</td>
<td>199 (18%)</td>
<td>270 (19%)</td>
<td>-</td>
</tr>
<tr>
<td>$t_1$ Choices</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>$PPO_{250}$</td>
<td>182 (23%)</td>
<td>253 (20%)</td>
<td>142 (11%)</td>
</tr>
<tr>
<td>$PPO_{500}$</td>
<td>201 (26%)</td>
<td>324 (26%)</td>
<td>562 (43%)</td>
</tr>
<tr>
<td>$PPO_{1200}$</td>
<td>95 (12%)</td>
<td>194 (15%)</td>
<td>188 (14%)</td>
</tr>
<tr>
<td>$HMO_1$</td>
<td>171 (22%)</td>
<td>257 (20%)</td>
<td>262 (20%)</td>
</tr>
<tr>
<td>$HMO_2$</td>
<td>135 (17%)</td>
<td>239 (19%)</td>
<td>151 (12%)</td>
</tr>
<tr>
<td>Demographics</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean Age</td>
<td>33</td>
<td>33</td>
<td>32</td>
</tr>
<tr>
<td>Median Age</td>
<td>31</td>
<td>31</td>
<td>31</td>
</tr>
<tr>
<td>Female %</td>
<td>56%</td>
<td>54%</td>
<td>53%</td>
</tr>
<tr>
<td>Manager %</td>
<td>20%</td>
<td>18%</td>
<td>19%</td>
</tr>
<tr>
<td>FSA Enroll %</td>
<td>15%</td>
<td>12%</td>
<td>14%</td>
</tr>
<tr>
<td>Dental Enroll %</td>
<td>88%</td>
<td>86%</td>
<td>86%</td>
</tr>
<tr>
<td>Median (Mean) Expense $t_1$</td>
<td>844 (4758)</td>
<td>899 (5723)</td>
<td>-</td>
</tr>
</tbody>
</table>
Look at what happens when one option becomes dominated due to a price change over time.

In $t_1$ firm increased the premium for the (more comprehensive) $250 deductible plan ($PPO_{250}$) and decreased the premium for the (less comprehensive) $500 deductible plan ($PPO_{500}$).

For some combinations of family size and income (which determine employee premium contributions) $PPO_{250}$ became strictly dominated by $PPO_{500}$.

Strict dominance: for any level and type of total medical expenditures, $PPO_{500}$ leads to lower employee expenditures (premium plus out-of-pocket) than $PPO_{250}$.

Attraction of strict dominance: don’t have to model individual’s risk type.
Strict dominance: illustration

Figure 1: This figure describes the relationship between total medical expenses (plan plus employee) and employee out-of-pocket expenses in years $t_0$ and $t_1$ for PPO 250 and PPO 500. This mapping depends on employee premium, deductible, coinsurance, and out of pocket maximum. This chart applies to low income families (premiums vary by number of dependents covered and income tier, so there are similar charts for all 20 combinations of these two variables). Premiums are treated as pre-tax expenditures while medical expenses are treated as post-tax. The bottom panel presents the analogous chart for time $t_1$ when premiums changed significantly. This can be seen by the change in the vertical intercepts. At time $t_0$ healthier employees were better off in PPO 500 and sicker employees were better off in PPO 250. For this combination of income and dependents covered, at time $t_1$ all employees should choose PPO 500 regardless of their total claim levels, i.e. PPO 250 is dominated by PPO 500. Despite this, many employees who chose PPO 250 in $t_0$ continue to do so at $t_1$, indicative of high inertia.
Many people remain in dominated choices
Of those whose choice becomes dominated in $t_1$, only 11% switch. Even by $t_2$ only 25% total have switched out of dominated option.
Interesting question: How common is it for firms to offer dominated choices? Which firms tend to? And why?
More on dominated choices

- Bhargava et al. (QJE 2017) present evidence from a large firm that majority of employees (and particularly lower income ones) choosing dominated plans
- Non-trivial consequence: estimate dominated choice results in excess spending equal to about 25% of chosen plan premium
- Conduct choice experiments that suggest
  - simplifying and shortening menu doesn’t have much effect
  - clarifying economic consequences of plan choice does reduce dominated choices substantially
- Conclude: reflects fundamental lack of understanding of health insurance
- "Our findings challenge the standard practice of inferring risk preferences from insurance choices, and raise doubts about the welfare benefits of reforms that give consumers more choice"
More on dominated plans

- Why do firms offer dominated plans (Liu and Sydnor NBER WP 2018)
  - Provide descriptive evidence that dominated plan offerings are common
  - High deductible plan often dominates lower deductible plan
  - They propose it’s due to selection: high deductible attracts better risks and lower costs are then passed onto enrollees

- Are dominated plans actually dominated (Ericson and Sydnor NBER WP 2018)?
  - In presence of liquidity constraints, individuals may rationally prefer "dominated" plan
  - Compare low vs high deductible plan where premiums + oop for low plan exceed high for any realization of health care spending
  - But liquidity constrained individual may prefer a series of small payments to one large lumpy expenditure
Handel (2013): Moving past the descriptive

- Descriptive evidence of inertia is compelling.
- Model useful if want to quantify in a meaningful way and/or perform counterfactuals: how would choices (and welfare) change if we reduce inertia?
Choice model

Model: essentially Cohen and Einav (2007) + inertia

- Three dimensions of heterogeneity: risk type, risk preference, inertia
- Same sort of modeling choices with respect to risk type and risk preferences that we have discussed

- Inertia modeled as an incremental (monetary) cost $\eta$ that is paid to switch plans (structural interpretation is that of a switching cost). Has direct negative impact on utility
Choice model

\[ U_{kjt} = \int_{0}^{\infty} f_{kjt}(\text{OOP}) u_k(\text{W}_k, \text{OOP}, P_{kjt}, 1_{kj,t-1}) \, d\text{OOP} \]

- \( k \) is family unit, \( j \) is plan choice, and \( t \) is one of three years (\( t_0 \) to \( t_2 \))
  - \( t_0 \) everyone forced to make new, "active" choice
  - \( t_1 \) large relative price changes
- 3 plan choices: \( PPO_{250}, PPO_{500}, PPO_{1200} \)
  - differ only in financial aspects (premiums and cost sharing)
  - \( PPO_{1200} \) includes HSA (save tax-free for later medical expenses)
- \( U \) is v-NM expected utility
- \( \text{OOP} \) is realization of medical expenses from \( F_{kjt}(\cdot) \)
- \( \text{W}_k \) denotes family-specific wealth
- \( P_{kjt} \) is family \( \times \) time specific premium contribution for plan \( j \) (note varies across families bc premiums depend on how many dependence are covered and employee income)
- \( 1_{kj,t-1} \) is an indicator for whether family was enrolled in plan \( j \) in previous time period
Choice model

- CARA assumption
  - for a given ex-post consumption level $x$:
    \[
    u_k(x) = -\frac{1}{\gamma_k(X^A_k)} e^{-\gamma(X^A_k)x}
    \]
  - $\gamma_k$ is a family-specific risk preference parameter (known to family; unobserved to econometrician)
    - $\gamma_k$ is a random coefficient, assumed to be normally distributed (truncated just above zero) with a mean that is linearly related to observable characteristics $X^A_k$ (employee age and income)
      - $\gamma_k(X^A_k) \sim N(\mu_{\gamma}(X^A_k), \sigma^2_{\gamma})$
      - $\mu_{\gamma}(X^A_k) = \mu + \beta(X^A_k)$
  - Note: CARA assumption means don’t need to observe wealth because level of absolute risk aversion $\frac{-u''}{u'} = \gamma$ which is constant with respect to level of $x$
Choice model

- family’s consumption $x$, conditional on a draw $OOP$ from $F_{kjt}(\cdot)$ is given by:

$$x = W_k - P_{kjt} - OOP + \eta(X^B_{kt}, Y_k)1_{kj,t-1} + \delta_k(Y_k)1_{1200} + \alpha H_{k,t-1}1_{250}$$

- Inertia ($\eta$) modeled as an implied monetary cost / reduction in consumption (structural interpretation similar to a tangible switching cost)
  - depends on linked choice ($1_{kj,t-1}$) and on demographic variables ($X^B_{kt}$ and $Y_k$)
  - $\eta(X^B_{kt}, Y_k) = \eta_0 + \eta_1 X^B_{kt} + \eta_2 Y_k$
  - $X^B_{kt}$ contains potentially time varying variables that may affect inertia (e.g. income, health status, change in predicted medical expenditures etc)
  - $Y_k$ is family status (single vs dependents)
Choice model: inside the sausage factory

- family’s consumption $x$, conditional on a draw $OOP$ from $F_{kjt}(\cdot)$ is given by:

$$x = W_k - P_{kjt} - OOP + \eta(X_{kt}^B, Y_k)1_{kj,t-1} + \delta_k(Y_k)1_{1200} + \alpha H_{k,t-1}1_{250}$$

- $\delta_k$ is an unobserved family-specific intercept for $PP0_{1200}$
  - expect non-zero $\delta_k$ because HSA in $PP0_{1200}$ is horizontally differentiated
  - so makes sense (and i’m guessing also helps fit the data better)

- $H_{k,t-1}$ is a binary variable for family above 90th pctile of cost distribution last year
  - $\alpha$ measures an intrinsic preference of a high cost family for $PPO_{250}$
  - "Intended to proxy for empirical fact that almost all families with very high expenses choose $PPO_{250}$ whether or not it is the best plan for them".
family's consumption $x$, conditional on a draw $OOP$ from $F_{kt} (\cdot)$ is given by:

$$x = W_k - P_{kt} - OOP + \eta (X_k, Y_k) \mathbf{1}_{kj,t-1} + \delta_k (Y_k) \mathbf{1}_{1200} + \alpha H_{k,t-1} \mathbf{1}_{250}$$

$\epsilon_{kjt}$ is a family-plan-time specific idiosyncratic preference shock

- assume probit error term, distributed $i.i.d$ for each $j$ with zero mean and variable $\sigma_{e_j} (Y_k)$

Standard thing to do (makes it a lot easier to rationalize the data) but kind of strange when choices differ purely on financial characteristics (conditional on the modeled $PPO_{1200}$ differentiation)

- Particularly unappealing if heterogeneity in preferences (or joint distribution of unobserved heterogeneities) is a focus
- Einav et al. (2013 AER, selection on moral hazard) are focused on joint distribution of unobserved preferences, risk type and moral hazard type

- Do not include this additional error term / "preference shock"
- And incur much pain and suffering as a result
Cost model (for distribution of OOP)

- Model individual’s (ex-ante - i.e. at time of insurance choice) expected future spending at time of plan choice using past diagnostic, demographic and cost information
  - generate ex-ante distribution faced by individual by grouping individuals into bins based on mean predicted future spending and estimate spending distribution for upcoming year based on ex-post observed cost realizations
  - similar to Abaluck and Gruber (2011)

- Impose two restrictions:
  - No moral hazard (total expenditures do not vary with \( j \))
  - No private information about health conditional on model above
    - Question to class: so how can he estimate / study adverse selection?
Identification (loosely)

- Risk type modeled directly from (rich) information not only on claims but on “risk score” (past spending and diagnoses) which is used to group individuals into cells for whom spending distribution is computed (v. similar to Abaluck and Gruber).
  - No additional unobserved heterogeneity (or moral hazard).
- Risk aversion identified by choice between $PPO_{500}$ and $PPO_{250}$
  - Identified by active choices at $t_0$
- Inertia identified by choice movement (or lack thereof) over time as plan values change due to changes in price or health status
- Of course requires (some) parametric assumptions
  - Described specific choices above
  - Explores robustness
Central (pervasive) challenge in many applications: separating path-dependence from serial correlation / persistence of types
e.g. argument over whether welfare "creates dependency" / reduces labor market potential. How separate path-dependence from persistence of types (does welfare erode human capital or do people with low human capital end up on welfare?)

Here, fundamental challenge is to separately identify "inertia" from persistent, unobserved preference heterogeneity
inertia = state-dependence. if you randomly assigned someone to a plan they would be more likely to still be in it the subsequent year.

Key to their approach: Changes in prices and health status over time identify inertia separately from risk preference levels and risk preference heterogeneity
Findings

- Large (and heterogeneous) inertia
  - Average employee to forgo ~ $2,000 annually (sd is $446)
  - Relative to average family spending of ~$4,500

- Counterfactual policies that “reduce inertia” (from $\eta_k$ to $Z\eta_k$) where $Z$ is some fraction
  - As $Z$ goes to 0, eliminate inertia
  - Considers welfare as the certainty equivalent that equates expected utility under a health plan choice with a certain monetary payment such that individual indifferent between losing that amount for sure and obtaining the risky payoff from enrolling in the plan
How to think about $\eta$

- Do you count reduction in $\eta$ as “direct” welfare benefit. Depends on underlying source of inertia (e.g. real tangible switching cost vs. some abstract psychic force causing delay?)
- Tries allowing for various fractions of $\eta$ reduction to “count” in welfare

Two main counterfactuals as reduce inertia

- Partial equilibrium / naive: Changes in plans and welfare, holding premiums fixed
- Allow supply side response: prices adjust as people move across policies (need model of supply side)
Model findings (con’t)

- Counterfactual: Reducing inertia by three-quarters (not counting $\eta$ directly in welfare)
- Partial equilibrium
  - 44% increase in fraction enrolling in $PPO_{500}$ at $t_1$ (recall big decrease in relative premium)
  - Increase in welfare of about 5% of premiums
- Allowing supply side response of premiums:
  - Still improves plan choices conditional on prices (recall too few were choosing $PPO_{500}$ at $t_1$) but now exacerbates adverse selection leadings to a reduction in welfare.
Why does reducing inertia reduce welfare once account for supply side response of premiums?

Reduced inertia / choice frictions causes more people to re-optimize

- leads to more enrollment in $PPO_{500}$ when relative price decreases
- On the margin it is the healthier ones who choose this lower coverage plan ($PPO_{500}$)
- So this drives up the price in $PPO_{250}$ as it becomes more adversely selected
- Over time, counterfactuals suggest $PPO_{250}$ could experience a death spiral (a la Cutler and Reber 1998)
Two reasons now in insurance markets that greater choice may not improve welfare

- Selection
- “Behavioral” issues / “bad choices”

But what is “inertia”? 

- Matters crucially for welfare analysis (as paper realizes)
- Modeled as a real switching cost (but baseline welfare analysis assumes it’s not directly affecting utility)
- Are search costs “behavioral”? 

Comments
Handel (2013) finds that inertia ameliorates adverse selection in this setting once one accounts for supply side premium response.

But there is no general theorem. (e.g. "Anything that gums up choices ameliorates adverse selection").

- although paper is often (mis-) interpreted this way

Polyakova (2016) finds for Medicare Part D switching costs help sustain an adversely selected equilibrium.

Depends crucially on “where you start”

- In Handel setting, inertial consumers respond little to the relative premium decrease for the low coverage ($PPO_{500}$) plan.
- Recall adverse selection creates problem of too little insurance / above MC pricing in higher coverage plans.
- If the price change had been relative premium decrease for high coverage ($PPO_{250}$) plan, inertia would have exacerbated adverse selection.
Table 3: Evidence of switching costs: choice patterns in 2006-2009 tracked for cohorts entering in different years

<table>
<thead>
<tr>
<th></th>
<th>65 y.o. in 2006</th>
<th>65 y.o. in 2007</th>
<th>65 y.o. in 2008</th>
<th>65 y.o. in 2009</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Enrollment shares</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contracts of type 1</td>
<td>22 %</td>
<td>22 %</td>
<td>19 %</td>
<td>17 %</td>
</tr>
<tr>
<td>Contracts of type 2</td>
<td>73 %</td>
<td>73 %</td>
<td>77 %</td>
<td>79 %</td>
</tr>
<tr>
<td>Contracts of type 3</td>
<td>4 %</td>
<td>5 %</td>
<td>5 %</td>
<td>4 %</td>
</tr>
<tr>
<td><strong>N</strong></td>
<td>37,500</td>
<td>37,500</td>
<td>37,500</td>
<td>37,500</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>in year 2006</th>
<th>in year 2007</th>
<th>in year 2008</th>
<th>in year 2009</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>B. Incremental premium</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contracts of type 2</td>
<td>$138</td>
<td>$125</td>
<td>$54</td>
<td>$37</td>
</tr>
<tr>
<td>Contracts of type 3</td>
<td>$375</td>
<td>$360</td>
<td>$410</td>
<td>$469</td>
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</table>
Table 4: Evidence of switching costs: price sensitivity estimates for individuals with and without incumbent plans

<table>
<thead>
<tr>
<th>Age of beneficiaries</th>
<th>65</th>
<th>66</th>
<th>67</th>
<th>68</th>
<th>69</th>
<th>70</th>
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<tbody>
<tr>
<td>Price coefficient</td>
<td></td>
<td></td>
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<tr>
<td>[p-value]</td>
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<tr>
<td>Baseline</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>2006</td>
<td>-0.003</td>
<td>0.0001</td>
<td>0.0002</td>
<td>0.0006</td>
<td>-0.0001</td>
<td>0.0006</td>
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<tr>
<td></td>
<td>[0.000]</td>
<td>[0.809]</td>
<td>[0.683]</td>
<td>[0.386]</td>
<td>[0.876]</td>
<td>[0.321]</td>
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<tr>
<td>Interaction</td>
<td></td>
<td></td>
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<tr>
<td>2007</td>
<td>-0.003</td>
<td>0.0018</td>
<td>0.0012</td>
<td>0.0011</td>
<td>0.0013</td>
<td>0.0010</td>
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<td>[0.035]</td>
<td>[0.031]</td>
<td>[0.002]</td>
<td>[0.040]</td>
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<tr>
<td>Interaction</td>
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<tr>
<td>2008</td>
<td>-0.003</td>
<td>0.0022</td>
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<td>0.0021</td>
<td>0.0019</td>
<td>0.0020</td>
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<td>[0.000]</td>
<td>[0.000]</td>
<td>[0.001]</td>
<td>[0.001]</td>
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<tr>
<td>Interaction</td>
<td></td>
<td></td>
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<td></td>
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<td></td>
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<tr>
<td>2009</td>
<td>-0.010</td>
<td>0.0072</td>
<td>0.0085</td>
<td>0.0090</td>
<td>0.0085</td>
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<td>[0.000]</td>
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<td>[0.000]</td>
</tr>
</tbody>
</table>

The price coefficients are estimated using the following random utility specification:

\[ u_{ij} = -\alpha_{65}p_{ij} + \alpha_{66}p_{ij} 1\{Age = 66\} + \alpha_{67}p_{ij} 1\{Age = 67\} + \alpha_{68}p_{ij} 1\{Age = 68\} + \alpha_{69}p_{ij} 1\{Age = 69\} + \alpha_{70}p_{ij} 1\{Age = 70\} + brand_j + \epsilon_{ij} \]
Other interesting aspects of inertia / switching costs

- How does it affect firm pricing?
- Ho, Hogan and Morton (2017 RAND) "Impact of consumer inattention on insurer pricing"
  - Theoretically unclear whether equilibrium prices higher or lower with strategic (dynamic) pricing behavior
    - Competing goals: invest (lower prices) vs harvest (raise prices)
  - Descriptive evidence that firm pricing reflects strategic response to inertia (e.g. increasing over time)
  - Explore implications for counterfactual pricing and welfare with non-strategic (static) pricing
Final example of using relatively “model-free” tests to identifying departures from “standard” models

Bargesghyan et al. (AER 2013) “The Nature of Risk Preferences: Evidence from Insurance Choices"
  
  Same data and setting as other paper
  Key feature exploited: choice sets include more than two deductible options
  Use this to explore potential distortions in perceived claim probabilities
Departures from “standard” risk aversion

- 3 deductible options: $1000, $500, $250
  - Consider a model of standard risk aversion against a model of “distorted” claim probabilities
  - Assume any claim is > highest deductible option

- WTP to reduce deductible is increasing in both risk aversion and perceived claim probabilities

- For any given (possibly distorted) perceived claim probability
  - A risk neutral individual would pay exactly twice as much to reduce deductible from $1000 to $500 than from $500 to $250
  - A risk averse individual will be willing to pay more than twice as much to reduce deductible from $1000 to $500 b/c of curvature of utility (larger losses hurt utility more)
Departures from “standard” risk aversion (con’t)

- For any given (possibly distorted) perceived claim probability
  - A risk neutral individual would pay exactly twice as much to reduce deductible from $1000 to $500 than from $500 to $250
  - A risk averse individual will be willing to pay more than twice as much to reduce deductible from $1000 to $500 b/c of curvature of utility (larger losses hurt utility more)

- Key insight: given an estimated WTP to reduce deductible from $1000 to $500, if willing to pay more to reduce deductible from $500 to $250 there must be a probability distortion
  - More generally, with an estimate of risk aversion comes an implied WTP for the $500 to $250 reduction and departures from that can be interpreted as probability distortions
  - Can get estimates of risk aversion off of any pair of choices (a la Cohen and Einav)
Thus far we have talked about more or less data driven ways to identify behavioral frictions in health insurance markets.

More work certainly needed!

Key open question: When behavioral frictions exist, when and why are they quantitatively important for welfare? for policy?

Can imagine that depending on correlation between behavioral friction, costs, and willingness to pay, could get any type of rotation of demand curve relative to value curve.

Similar point in intellectual history in the adverse selection literature. Now need to move beyond testing.
Estimating the value curve: a few initial thoughts

- I am not sure how to do this!
- Handel, Kolstad and Spinnewijn (forthcoming)
  - Take frictions estimates from H&K "Health Insurance for Humans" + modeling assumptions to try to estimate Spinnewijn’s value curve (vs demand curve)
- Presumably a key object is how the "value" curve varies with price
  - i.e. in addition to cost and demand curve, also want to know how "behavioral stuff" (e.g. choice of dominated plan) varies with price
  - If behavioral factors are flat with respect price then less consequential for welfare analysis using demand vs value curve?
- Do you have to take a stand on the behavioral model?
Recap: key challenges (and opportunities!)

- Detecting departures from neoclassical model: data vs. modeling assumptions
- Welfare analysis: what do we call the error term?
  - Preference heterogeneity vs. mistakes?
  - How do we get away from ad hoc decisions / make it more data driven?
- Thus far we have seen work exploiting:
  - Changes in menus for different cohorts ("inertia")
  - Dominated choices
  - Consistency of choices across deductible options
  - Ripe for additional work!
- Key challenge: how do we identify the value curve (i.e. the demand curve in the absence of any behavioral frictions)?