**Managing Behavioral Hazard: Value-Based Insurance Design and Inertia**

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**Motivation**

Value-based insurance design (VBID) reduces cost-sharing for high-value services to improve adherence and health outcomes, particularly for patients managing chronic conditions. Despite its theoretical appeal, empirical evidence on whether VBID achieves genuine behavioral change versus merely shifting costs remains limited, especially for chronically ill populations where medication adherence has the highest clinical stakes.

**Setting and Design**

In 2019, the California Public Employees' Retirement System (CalPERS) redesigned its one of its PPO plans, PERS Select, reducing primary care copayments from $20 to $10 for enrollees with a designated personal physician while simultaneously increasing specialist copayments from $20 to $35 and doubling the individual deductible from $500 to $1,000 and introducing deductible reduction incentives. The reform created sharp cross-sectional variation in net cost-sharing incentives across service types, providing a natural experiment for evaluating VBID in a large, administratively rich setting.

**Data and Empirical Strategy**

We use administrative claims data from 2015–2022. Our primary identification strategy is a difference-in-differences design comparing PERS Select enrollees before and after the 2019 redesign, using another PPO plan as a control group with an identical pre-period benefit structure that was unchanged in 2019. To decompose the benefit design channel from the premium income effect — California state employees received a premium reduction to $0 under all 40 bargaining units — we employ a triple-differences specification exploiting cross-sectional variation in employer-type premium pass-through. We adopt a plan-year intent-to-treat sampling frame to capture compositional responses to the redesign. To assess heterogeneous effects by chronic disease burden, we stratify by baseline (2018) Charlson Comorbidity Index category.

**Results**

The redesign increased primary care visit probability by 4.4 percentage points and visit counts by 0.49 visits per year. Out-of-pocket spending rose by $99, consistent with the deductible increase. The triple-differences specification reveals that the pooled prescription drug spending reduction of $251 ($p<0.10$) masks substantial heterogeneity by chronic disease burden: among members with mild-to-moderate chronic conditions (Charlson score 1–2), prescription drug spending fell by $1,035 ($p<0.10$), compared to $128

(insignificant) among healthy members (Charlson score 0). This fourfold differential suggests the Rx response reflects reduced adherence to maintenance medications among chronically ill patients rather than discretionary drug use reduction among healthy enrollees.

**Welfare Implications**

Partial equilibrium welfare calculations incorporating downstream hospitalization risk from medication non-adherence yield positive net welfare estimates across all scenarios, with gains from increased primary care utilization outweighing estimated adherence costs. However, the concentration of Rx reductions among Charlson 1–2 members — for whom medication adherence has the highest clinical stakes — raises concerns about the long-run health consequences of deductible-induced cost-sharing increases alongside copay reductions for primary care.

**Contribution**

This paper makes three contributions. First, we provide clean identification of the benefit design channel by separating it from the premium income effect via triple-differences. Second, our intent-to-treat sampling frame avoids endogenous sample selection from plan switching, addressing a limitation of prior work on this redesign. Third, we provide the first evidence that VBID-induced Rx reductions are concentrated among chronically ill members, with implications for the design of cost-sharing schedules targeting high-value primary care.