

# Experimental Problem Set

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## Problem 1

In class, we discussed the Roy (1951) model of selection based on comparative advantage. In this problem, we will simulate a slight extension of the Roy Model to better understand non-compliance and local average treatment effects. Specifically, we will assume people make participation decisions entirely based on their earnings with or without the training less any costs of the training. The extension is accounting for the fact that different choices might have different costs.

For this exercise, assume we are evaluating the impact of earning a certificate from a community college on a worker's earnings. If someone is in the treatment group, they receive the training for free. But someone in the control group can pay to enroll in the program on their own for 1,000. Simulate a sample of 10,000 observations from the following data generating process:

$$Y_0 \sim N(20000, 7000^2) Y_1 \sim N(21500, 8000^2)$$

```
size = 10000

y_0 = rnorm(n = size, mean = 20000, sd = 7000)
y_1 = rnorm(n = size, mean = 21500, sd = 8000)
decision = ifelse(y_1 > y_0 - 1000, 1, 0)

df = data.frame(y_0, y_1, decision)
```

1. What is the average treatment effect in your sample? How does it compare to the true average treatment effect?

True Average Treatment Effect is 1500

Average Treatment Effect:

```
sample_ate = mean(df[df$decision == 1, "y_1"]) - mean(df[df$decision == 0, "y_0"])
sample_ate
```

```
## [1] 946.0274
```

Difference between True Average Treatment Effect and Sample Average Treatment Effect

```
1500 - sample_ate
```

```
## [1] 553.9726
```

FINISH

2. What is the distribution of compliers, always takers, and never takers in your sample (i.e. what is  $P(A)$ ,  $P(C)$ , and  $P(N)$ )?

```

#Always Takers
#Always goes to college regardless of treatment status
#Always Takers will go to college if in treatment and  $Y_1 > Y_0$ 
#Always Takers will go to college if not in treatment and  $Y_1 - 1000 > Y_0$ 
#If  $Y_1 - Y_0 > 1000$  and  $Y_1 - Y_0 > 0$ , then individuals are always takers
#Thus if  $Y_1 - Y_0 > 1000$ , individuals are always takers
percent = df %>%
  filter(y_1 - y_0 > 1000) %>%
  summarize(always_takers = n()/size)

#Never Takers
#Never goes to college regardless of treatment status
#Never Takers will not go to college if in treatment and  $Y_1 < Y_0$ 
#Never Takers will not go to college if not in treatment and  $Y_1 - 1000 < Y_0$ 
#If  $Y_1 - Y_0 < 1000$  &  $Y_1 - Y_0 < 0$ , then individuals are never takers
#Thus if  $Y_1 - Y_0 < 0$ , individuals are never takers
percent[1,2] = df %>%
  filter(y_1 - y_0 < 0) %>%
  summarize(never_takers = n()/size)

#Compliers
#Complies with Treatment
#Compliers go to college if in treatment and  $Y_1 > Y_0$ 
#Compliers do not go to college in not in treatment and  $Y_1 - 1000 < Y_0$ 
#If  $0 < Y_1 - Y_0 < 1000$ , then individuals are compliers
percent[1,3] = df %>%
  filter(y_1 - y_0 <= 1000) %>%
  filter(y_1 - y_0 >= 0) %>%
  summarize(compliers = n()/size)

percent$sum = sum(percent[1,])

percent

```

```

##   always_takers never_takers compliers sum
## 1         0.5175         0.4462    0.0363  1

```

3. What is the average impact of the training for compliers, always takers, and never takers in your sample?

#### CHECK THIS PROBLEM

```

#Average Impact of Training

impact = df %>%
  filter(y_1 - y_0 > 1000) %>%
  summarize(always_takers = mean(y_1) - mean(y_0))

impact[1,2] = df %>%
  filter(y_1 - y_0 < 0) %>%
  summarize(never_takers = mean(y_1) - mean(y_0))

impact[1,3] = df %>%
  filter(y_1 - y_0 <= 1000) %>%

```

```

filter(y_1 - y_0 >= 0) %>%
summarize(compliers = mean(y_1) - mean(y_0))

impact

##   always_takers never_takers compliers
## 1      9663.011      -7939.5   500.2496
#impact[1,1] * percent[1,1] + impact[1,2] * percent[1,2] + impact[1,3] * percent[1,3]

```

4. Why is it reasonable to assume there are no defiers given our assumptions about how people are making participation decisions?

It is reasonable to assume there are no defiers given our assumption because individuals are either better off with treatment (always-takers), without treatment (never-takers), or with treatment if provided (compliers). Specifically to be a defier, it must be the case that:

Defiers go to college if not in treatment which implies  $Y_1 - 1000 > Y_0$

Defiers choose to not go to college if in treatment which implies  $Y_1 < Y_0$

Thus to be a defier, it must be that  $0 > Y_1 - Y_0 > 1000$  which is impossible.

So far, we have been using the full sample because we observe both potential outcomes. Now, let's pretend we are in the real world and only observe the outcome that results from someone's participation decision. To this end, randomly assign half of your sample to a treatment group and half to a control group. Generate an indicator  $P$  that equals 1 if someone receives the training and 0 otherwise. Remember: we have assumed people make participation decisions entirely based on their earnings with or without the training less any costs of the training. This should depend on the observations treatment status.

Generate a variable  $Y$  equal to observed earnings using the following formula:

$$Y = PY_1 + (1 - P)Y_0$$

```
df$treatment = rbinom(n = size, size = 1, prob = 0.5)
df = df %>%
  mutate(y = decision*y_1 + (1-decision)*y_0)
```

5. Use a regression to estimate the intent-to-treat effect in your sample. What is the point estimate and the 95% confidence interval around the estimate?

```
sum1 = summary(lm(data = df, y ~ treatment))

b = sum1$coefficients[2,1]
c = sum1$coefficients[2,1] + 2*sum1$coefficients[2,2]
a = sum1$coefficients[2,1] - 2*sum1$coefficients[2,2]

table = cbind(a,b,c)
colnames(table) = c("Lower Bound", "Estimate", "Upper Bound")
table
```

```
##      Lower Bound Estimate Upper Bound
## [1,]   -97.89097 153.5946    405.0801
```

6. Use two-stage least squares to estimate the local average treatment effect in your sample. Comment on the point estimate and the 95% confidence interval around the estimate. How does this compare to the effects we estimated earlier in this problem?

ASK ABOUT!

```
#2SLS Regression
feols(data = df, y ~ treatment | decision)

## OLS estimation, Dep. Var.: y
## Observations: 10,000
## Fixed-effects: decision: 2
## Standard-errors: Clustered (decision)
##      Estimate Std. Error t value Pr(>|t|)
## treatment   168.59     78.142  2.1574 0.276314
## ---
## Signif. codes:  0 '***' 0.001 '**' 0.01 '*' 0.05 '.' 0.1 ' ' 1
## RMSE: 6,269.0      Adj. R2: 0.005454
##      Within R2: 1.807e-4
```

7. Re-run your code but drawing a sample of 1,000,000 observations instead of 10,000. How does the estimated LATE compare to the earlier treatment effects now?

FIGURE OUT

```
size = 1000000
feols(data = df, y ~ treatment | decision)
```

```

## OLS estimation, Dep. Var.: y
## Observations: 10,000
## Fixed-effects: decision: 2
## Standard-errors: Clustered (decision)
##      Estimate Std. Error t value Pr(>|t|)
## treatment   168.59      78.142  2.1574 0.276314
## ---
## Signif. codes:  0 '***' 0.001 '**' 0.01 '*' 0.05 '.' 0.1 ' ' 1
## RMSE: 6,269.0      Adj. R2: 0.005454
##                  Within R2: 1.807e-4

```

## Problem 2

Suppose a researcher is evaluating an experiment using a sample that consists of 50% compliers, 25% always takers, and 25% never takers. The researcher decides to estimate the intent-to-treat effect but dropping people who did not comply with the treatment protocol from the sample. After dropping people who did not comply with their treatment assignment from the sample, what is the distribution of compliers, always takers, and never takers in the treatment group? In the control group? Why is this a problem?

Solution:

There would be no never takers in the treatment group (since they wouldn't comply with treatment), all of the always takers who were selected for treatment and all of the compliers who were selected for treatment. In the control group, there would be no always takers, some of the never takers who were selected for control and all of the compliers who were selected for treatment.

This is a problem because we are still including the effect of never takers and always takers in our treatment effect. What we truly want to know is the effect of treatment for specifically those who complied. Never takers and always takers may skew our results and/or make our results not as generalizable.

CHECK

### Problem 3

Table 1 below includes details about the total sample size, probability of treatment, and treatment effect within each of 5 blocks. What would the pooled treatment effect be if estimated using an OLS regression of the outcome on treatment and block fixed effects? How much weight does each block get in the pooled estimate?

CHECK

```
block = seq(1:5)
table = data.frame(block)
table$N = c(100, 100, 200, 200, 300)
table$prob_T = c(0.5, 0.25, 0.5, 0.75, 0.1)
table$treatment_effect = c(-1, 0, 1, 2, 3)

table

##   block    N prob_T treatment_effect
## 1      1  100   0.50                -1
## 2      2  100   0.25                 0
## 3      3  200   0.50                 1
## 4      4  200   0.75                 2
## 5      5  300   0.10                 3

#Each blocks variance formula
table$block_variance = table$prob_T*(1-table$prob_T)*table$N
#Number of treated individuals in each block
table$treated = table$N*table$prob_T
#Total treatment probability
treatedprob = sum(table$treated)/sum(table$N)
#Total variance
total_var = treatedprob*(1-treatedprob)*sum(table$N)
#Weights for each block
table$weights = table$N/sum(table$N)*table$block_variance/total_var

sum(table$N/sum(table$N))

## [1] 1

sum(table$block_variance/total_var)

## [1] 0.7361416

#Pooled Treatment Effect
sum(table$weights*table$treatment_effect)

## [1] 0.2418917
```

## Problem 4

In class, we saw how Moulton's design effect can be used to approximate the impact of clustering on our standard error. This problem will give you practice using this adjustment.

Imagine you are considering running a cluster randomized experiment with 10,000 observations split evenly across 118 clusters. You will randomly assign half of clusters to treatment and control. Your main outcome of interest is a binary variable that historically has equaled one for 72.9 percent of observations.

1. What is your minimum detectable effect if the intracluster correlation is 0?
2. What is your minimum detectable effect if the intracluster correlation is 0.2?
3. How do these answers change if you can control for baseline characteristics that explain 20 percent of residual variation?

### Solution:

**Part 1** Need to find  $\delta$

Given:

$$t_{\alpha/2} = \frac{\hat{\Delta} - 0}{S.E.(\hat{\Delta})} - t_{\beta} = \frac{\hat{\Delta} - \delta}{S.E.(\hat{\Delta})}$$

Solving for  $\delta$ :

$$\begin{aligned}\delta &= \hat{\Delta} + S.E.(\hat{\Delta}) \\ \delta &= (t_{\alpha/2} + t_{\beta}) * \sqrt{\frac{\sigma^2}{N * Var(T_i)}}$$

where  $t_{\alpha/2} = 1.96$ ,  $t_{\beta} = 0.84$ ,  $N = 10000$ ,  $Var(T_i) = n * p * (1 - p) = 10000 * 0.5 * 0.5$ ,  $\sigma^2 = ?$

### Part 2

$$\begin{aligned}\delta &= \hat{\Delta} + S.E.(\hat{\Delta}) \\ \delta &= (t_{\alpha/2} + t_{\beta}) * S.E.(\hat{\Delta}) \\ \delta &= (t_{\alpha/2} + t_{\beta}) * \sqrt{\frac{\sigma^2 * (1 + (n - 1) * \rho)}{N * Var(T_i)}}$$

where  $t_{\alpha/2} = 1.96$ ,  $t_{\beta} = 0.84$ ,  $N = 10000$ ,  $Var(T_i) = n * p * (1 - p) = 10000 * 0.5 * 0.5$ ,  $n = \frac{10000}{118}$ ,  $\rho = 0.2$  and  $\sigma^2 = ?$ .

### Part 3 Part 1

$$\delta = (t_{\alpha/2} + t_{\beta}) * \sqrt{\frac{(1 - R^2) * \sigma^2}{N * Var(T_i)}}$$

Part 2

$$\delta = (t_{\alpha/2} + t_{\beta}) * \sqrt{\frac{(1 - R^2) * \sigma^2 * (1 + (n - 1) * \rho)}{N * Var(T_i)}}$$



For both of our answers, as our  $R^2$  goes up, then the square rooted term becomes smaller. This means that we can detect a smaller  $\delta$ . This is good because before we may have detected an effect of 10, but now we could detect an effect of 8.

CHECK!

## Problem 5

We often focus on identifying and estimating average treatment effects like:

$$E[Y|T = 1] - E[Y|T = 0]$$

Discuss why this rule implies that the variance of treatment effects is not identified by randomization into treatment or control alone.

Propose an additional assumption that would allow you to identify the variance of treatment effects. Is it plausible?