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Comment

Amy Finkelstein

This is an excellent installment in a fruitful and fascinating line of ongoing work by this research team on the Medicare Part D program. This research program is motivated by two important and complementary goals. The first is evaluating the impact of the introduction of Medicare Part D. This was arguably the largest single expansion in social insurance in the United States since 1965. It is therefore an extremely important program to understand in its own right. The second goal, however, goes beyond this important policy evaluation to use the introduction of Medicare Part D as a tool for gaining insight more generally in consumer responsiveness to the economic incentives in social insurance programs. I am going to confine my comments to the second goal, but of course the importance of the application makes the analysis and results all the more interesting.

The current chapter examines the determinants of individual enrollment decisions and plan choices. It examines in particular the role of past drug use, self-rated health, and measures of the individual's time horizon (discount rate), risk attitudes, and decision-making competence. The main findings are twofold. First, prior drug use is a strong (positive) predictor of both whether the individual enrolls and the comprehensiveness of the plan chosen. Second, the other factors examined do not seem to have much explanatory power.

These results are fascinating for several reasons. The first finding—regarding the positive correlation between prior drug use and plan enrollment and comprehensiveness—provides clear evidence of a role for private information about risk type in influencing insurance decisions. Because adverse selection offers a canonical economic rationale for the existence of social

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insurance programs such as Medicare Part D, it is important and interesting to document its existence in this setting.

Moreover, although it might not be apparent from reading the chapter and seeing the seeming effortlessness by which the authors document adverse selection, doing so is in general quite challenging empirically. The widely-used "bivariate probit" test for asymmetric information pioneered by Chiappori and Salanié (2000) is the current industry standard. It rejects the null of symmetric information if there is a positive correlation between insurance coverage and ex post risk occurrence (among individuals who face the same option of contracts). A typical application would be to examine whether those with drug coverage (or those with more comprehensive drug coverage) use more drugs than those without drug coverage (or those with less comprehensive drug coverage). However, a long-recognized limitation of such analysis is that it is a joint test for the presence of either adverse selection or moral hazard. A finding that those with more drug coverage use more drugs may reflect either adverse selection (individuals who ex ante knew that they were higher risk for drug use selected more drug insurance) or moral hazard (ex post those who have more coverage have an incentive to consume more drugs). Since these are two very different forms of asymmetric information and since they have potentially very different public policy implications—the government may have a comparative advantage in ameliorating the welfare costs of adverse selection but does not generally have any comparative advantage in addressing the inefficiencies caused by moral hazard—distinguishing between them is of critical interest and importance.

The authors manage to do this by exploiting the panel nature of their data—and the fact that, prior to 2006, no one in their sample had drug coverage. As a result, their measure of "past drug use" (in 2005) is a pure measure of ex ante expected risk type, not contaminated by contract effects arising from differential insurance coverage (i.e., moral hazard). Their examination of whether drug use in 2005 among the then-uninsured predicts enrollment and plan choice when Medicare Part D opens in 2006 is thus a direct test for adverse selection. It is relatively rare to be able to exploit panel data to distinguish selection from moral hazard; for another example and more discussion of the uses of panel data for this purpose see Abbring and Chiappori (2003) and Abbring et al. (2003).

Their second main finding—that other than prior drug use (i.e., expected risk type) the other measured factors such as individual discount rates, risk attitudes, and decision-making competence do not appear to be important in explaining drug insurance choices—is also of note. In stands in contrast to several recent empirical papers in other insurance markets that have found that preference heterogeneity or heterogeneity in cognitive ability is as or more important than heterogeneity in privately known risk type in explaining insurance choices; these papers include applications to the U.S. long-term care insurance market (Finkelstein and McGarry 2006), the Israeli automobile insurance market (Cohen and Einav 2007), and—closest to the

application in this chapter—the U.S. Medigap market for private insurance to supplement Medicare (Fang, Keane, and Silverman 2008). This evidence of heterogeneity in dimensions other than risk type (which influences insurance choices) is important because it suggests that the standard bivariate probit test of asymmetric information may fail to detect asymmetric information in the presence of multiple forms of heterogeneity (Finkelstein and McGarry 2006). It also suggests that the welfare consequences of imposing mandatory coverage in adversely selected markets may be more ambiguous than theories of unidimensional private information suggest (Einav, Finkelstein, and Schrimpf 2007).

The results in the current chapter that find no evidence for other forms of heterogeneity in determining insurance coverage are intriguing. One plausible explanation is that in this market the unidimensional models are a reasonable approximation. Another possibility is that other individual characteristics—such as risk aversion—do in fact affect insurance demand but are very hard to measure. The authors' work leaves open the interesting and important question of which explanation is correct; since these have different implications for—among other things—the value of mandatory insurance coverage, more work on this question would be greatly valuable.

In particular, given the authors' finding of adverse selection in this market, a natural question concerns the value of offering choice in Medicare Part D. A distinguishing feature of the design of Medicare Part D—relative to traditional Medicare Parts A and B—is that it allows the beneficiaries choice in the nature of their insurance benefit. This opens up scope for adverse selection (as the authors demonstrate indeed appears to be the case) and the resulting allocative inefficiency that adverse selection produces.

Their documentation of adverse selection raises the question of whether a mandatory (uniform) drug coverage plan would be socially optimal. This is conceptually ambiguous. When individuals differ in their preferences as well as their risk type, mandatory uniform coverage involves a trade-off: it can redress the allocative inefficiency induced by adverse selection, but at the cost of potentially imposing allocative inefficiency by requiring individuals whose first-best (symmetric information) insurance allocation may differ to all have the same coverage. Which source of inefficiency is larger—and therefore whether or not the gains from allowing choice in insurance exceed the costs—is an empirical question (see Einav, Finkelstein, and Cullen [2008] for an empirical approach to examining this question). In the context of Medicare Part D, it is also a very important policy question and one that I hope future work in this area will address.

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