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Comment

Amy Finkelstein

This is a fascinating and extremely timely chapter analyzing the elderly's enrollment choices in the new Medicare Part D prescription drug program. The new Medicare prescription drug benefit, which began in 2006, arguably represents 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. In addition, the authors' findings have interesting implications more broadly for how to think about the optimal design of social insurance programs.

The chapter focuses on individuals' decisions during the initial enrollment period (November 15, 2005 to May 15, 2006). It investigates the determinants of both whether an individual enrolls during this period, and the timing of enrollment conditional on enrollment. The chapter provides both positive and normative analysis of the elderly's choices. I discuss each in turn, and their implications for the optimal design of social insurance, particularly for offering choice within a social insurance program.

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Descriptive Analysis

The chapter begins by presenting new data from a survey that the authors designed and conducted. The survey contains information on whether individuals enroll during the initial enrollment period, and if so whether they enrolled early or late within this initial enrollment period. Individuals who enroll after the end of the initial enrollment period and did not have coverage from another source face a late enrollment penalty. This late penalty is designed to reduce adverse selection by encouraging individuals to enroll at the beginning of the program rather than waiting until they develop health problems. The survey also contains information on the individuals' prior year drug costs, their self-reported health status, and various socioeconomic characteristics.

Early enrollment is rational for individuals with high expected drug costs. Consistent with this incentive structure, the authors find that expected drug costs are strongly predictive (in the expected direction) of early enrollment. Late enrollment within the initial enrollment period is rational for individuals with intermediate drug costs or a high present value of the penalty; the incentives for late enrollment (conditional on not enrolling early) therefore depend not only on expected drug costs but also on other characteristics of the individuals, such as their preferences (for example, risk aversion) and their understanding of the penalty system. Again consistent with this incentive structure, the authors find that socioeconomic variables (which may well proxy for preferences or understanding of the penalty system), are the main drivers of the late enrollment decision; expected drug costs are only weakly predictive of late enrollment.

These twin results provide extremely nice examples of the difference between single dimensional and multidimensional selection problems. Standard adverse selection models of insurance markets (such as Rothschild and Stiglitz [1976] consider single dimensional selection; they assume that individuals differ only in their private information about their risk type (here, their expected drug costs). In such models, those who have private information that they are higher risk (higher expected drug costs) will self-select into the insurance market.

The authors' results indicate that the early enrollment decision appears to follow these standard models and reflect a single dimensional selection problem: those who expect to be higher risk are more likely to enroll early. By contrast, the late enrollment decision appears to be driven by factors other than expected risk type, such as preferences and cognition. This is consistent with a growing body of empirical work suggesting that, in many insurance markets, the selection problem may be multidimensional. As a result, differences in nonrisk characteristics of the individual can be as or more important than their private information about their risk type in predicting insurance decisions. Several recent empirical papers have found substantial

evidence of unobserved (by the insurance company) preference heterogeneity that is an important determinant of insurance decisions. Examples include automobile insurance (Cohen and Einav 2007), long-term care insurance (Finkelstein and McGarry 2006), reverse mortgages (Davidoff and Welke 2005), Medigap (Fang, Keane, and Silverman 2006), and annuities (Einav, Finkelstein, and Schrimpf 2007). Interestingly, many of these insurance markets are for the elderly. Indeed, in the case of Medigap, which provides private health insurance to supplement some of the (other) gaps in Medicare, Fang, Keane, and Silverman (2006) find that cognitive ability is an important determinant of insurance coverage. Likewise, the authors here conjecture that some of their socioeconomic variables may proxy for cognitive understanding of the penalty for late enrollment.

When selection into an insurance market is based on multiple dimensions of private information—that is, preferences as well as risk type—a market may suffer from adverse selection even if expected risk type is not positively correlated with the coverage decision (Finkelstein and McGarry 2006). Detecting adverse selection empirically thus becomes more difficult once the possibility of multiple dimensions of private information (and hence of selection) is recognized (Chiappori et al. 2006; Finkelstein and Poterba 2006).

The presence of multiple dimensions of private information also raises interesting questions regarding optimal design of social insurance. Mandatory social insurance is the canonical solution to the problem of adverse selection in insurance markets (e.g., Akerlof 1970). Yet, as emphasized by Feldstein (2005) (among others), mandates are not necessarily welfare improving when individuals differ in their preferences. When individuals differ in both their preferences and their (privately known) risk types, mandates may involve a trade-off between the allocative inefficiency produced by adverse selection and the allocative inefficiency produced by imposing a uniform, "one size fits all" program on individuals whose optimal insurance coverage varies. Whether and which mandates can increase welfare thus becomes an empirical question. Analyzing the welfare consequences of different mandates in turn requires estimation of the joint distribution of individuals' (privately known) preferences and (privately known) risk type (Einav, Finkelstein, and Schrimpf 2007).

Normative Analysis

The second part of the chapter is a normative analysis of whether individuals' enrollment decisions are "rational." Specifically, the authors investigate whether individuals' behavior matches the predictions of an optimal dynamic stochastic programming problem that they develop and estimate. They find that, on the margin, individuals seem to understand the (simple) fact that an increase in expected drug costs increases the benefits from enrollment. However, they also find that the level of enrollment is lower than the

optimal level that they estimate, and that individuals are less aware of the (complicated) consequences of the penalty of late enrollment.

As the authors point out, any discrepancy between the actual choice and the predicted choice may reflect a failure of rational expectations, a failure of optimization, and/or a failure of the model they have specified. To the extent that the discrepancies the authors find reflect either a failure of rational expectations or a failure of individuals to optimize appropriately, these findings also have implications for the benefits of allowing choice within social insurance programs. In particular, it becomes important to distinguish between differential behavior across individuals that reflects real differences in underlying preferences as opposed to differences in behavior that reflect "mistakes." The former suggests some benefits from allowing individuals choice within social insurance, while the latter suggests that there may be some value to restricting choice. The authors' interesting findings suggest that an important direction for future work—both for Medicare Part D and for other social insurance programs more generally—is distinguishing between "true" preference heterogeneity and failures of rationality.

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