



Discussion of “Adverse Selection and (un)Natural Monopoly in Insurance Markets,” Discussant: Andrew Ching, JHU



# Main ideas of the paper

- » Motivated by ACA concentrated markets, the authors ask why?
- » Adverse selection may incentivize insurers to lower their prices to compete for patients with lower risks (healthier), in order to reduce their AC.
- » But the aggressive pricing would lead to lower profits.
- » Hence, fewer insurers will find it profitable to enter/stay in the market.
- » It is possible that only one insurer finds it profitable to stay in the market.
- » But when only one insurer survives, it become an monopoly. Because there is no need to compete, it is free to charge monopoly price, i.e., it will end up setting prices much higher than when there are two firms.
- » The authors argue that imposing a “price floor” could help increasing competition and improving consumer welfare.

# Comments



- »» There could be alternative way to compete: An equilibrium where one firm targets sicker patients, and the other firm targets healthier patients.
- »» Imagine hospitals differentiate themselves in high and low quality.
- »» Suppose sicker patients put more utility weight on the quality of care.
- »» To target sicker (healthier) patients, an insurer can contract with high (low) quality hospitals, and set their plan at a higher (lower) price.
- »» Are there any institutional features of the US health insurance market which could prevent this from happening?
- »» Fact: Only one-fifth of markets with 1-2 participating insurers, and other markets have more participating insurers. It's not really the case that we see many monopoly markets.

# Empirical Part



- » Data from Commonwealth Care in Massachusetts.
- » Data tracks healthcare utilization and spending for each person.
- » **Plans are differentiated in their networks of hospitals and doctors, and premiums.**
- » Premium could vary only on specific factors (e.g., income and region), but not on age or health status.
- » About half of the market pays \$0 premium, this substantially reduces firms' incentive to use price to compete.



# Empirical Part (cont'd)

- » The main goal of the empirical exercise is to estimate the demand side (utility function) parameters, and the cost parameters of serving different types of patients.
- » The counterfactual exercise is then conducted to illustrate the equilibrium outcomes in the presence of adverse selection, under various policies of price floor, risk adjustment subsidy, etc.
- » **Key assumption:** the potential entrants' network of hospitals and doctors is exogenously given (use what's being observed in the data).
- » What if we relax this assumption and let potential entrants to choose their network? Theoretically, one can add one more stage to the game (before they decide whether to enter).
  - We might see the sorting equilibrium.
  - Challenge: This is a high-dimensional optimization problem.
  - But one maybe able to put some structure to the problem to simplify it, e.g., allowing firms to choose a few pre-set network configurations.



# Other detailed comments (model predictions)

- » One prediction is that monopoly will set price high.
  - Is there any empirical evidence to support this?
  - Does the prediction ignore the potential threat of new entrants?
  - I understand that the paper argues that it won't be profitable for a potential entrant to enter and hence no need for the monopoly to price low.
  - But do we need to assume the incumbent has some absolute advantages?
    - Otherwise, a potential entrant could kick the incumbent out (50-50 odd?).
    - But even with a small chance to win, if the monopoly profits is high, it may still induce entry (as it drives up the expected profits).
  - What if a potential entrant is very efficient (low cost), but it is uncertain about the demand and how profitable this market is?

# Other comments (cont'd)



- »» Use the below-poverty group (pays \$0 premium) as the control group to help control for unobserved plan characteristics over time.
  - But the below-poverty group preference could be systematically different from the rest.
  
- »» More empirical support for adverse selection theory: Could it be the case that markets with more insurers have less patient heterogeneity in their health status (costs and price sensitivity)? That's a measure of adverse selection incentive.
  
- »» Or, empirical support for sorting equilibrium: One can check the degree of differentiation in insurer's network of hospitals/doctors across markets.
  
- »» Why not use ACA data to calibrate the model?

# Conclusion



- » This is a very interesting paper with new insights about the interaction between adverse selection, price competition **and firms entry**.
- » It provides a new explanation about the lack of competition in ACA markets.
- » I have learnt a lot. I would encourage you to read it!