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Contact Information

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Personal Information: DOB 11/07/1986, US Citizen

Academic Positions:

Seidman Fellow, Harvard Medical School, 2019-
Research Scholar, Stanford Institute for Economic Policy Research, 2017-2019
Post-Doctoral Fellow, UC-Berkeley Haas School, 2016-2017

Additional Academic Affiliations:

Faculty Affiliate, Wash. U. Envolve Center, 2018-
Visiting Scholar, UC-Berkeley, 2017-
Visiting Scholar, The Dartmouth Institute, 2014-2017

Education:

Ph.D., M.S, Applied Economics, University of Pennsylvania-Wharton School, Sept 2011-Dec 2015
Thesis Title: Essays in Health Economics and Public Finance
Dissertation Advisors: Mark Duggan (chair), Jon Gruber, Bob Town

A.B., Economics and Mathematics, Dartmouth College, 2005-2009
Magna Cum Laude, Phi Beta Kappa, High Honors in Economics

References

Professor Michael Chernew
Harvard Medical School
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Professor Mark Duggan
Department of Economics, Stanford U.
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Professor Jonathan Kolstad
Haas School of Business, UC-Berkeley
jkolstad@berkeley.edu

Professor Tim Layton
Harvard Medical School
layton@hcp.med.harvard.edu

Teaching and Research Fields:

Health Economics, Public Economics, Strategy

Teaching Experience:

Fall 2013	Managerial Economics (undergrad), UPenn-Wharton, T.A. for Gilles Duranton
Fall 2012	Global Business (undergrad), UPenn-Wharton, T.A. for Rob Jensen
Spring 2012	Wharton on Policy (MBA module), UPenn-Wharton, T.A. for Mark Duggan

Honors, Scholarships, and Fellowships:

2020	Co-Investigator, NIA P01 supplement for research on Medicare-Medicaid duals
2020	Co-Investigator, NIA P01, 'Improving Medicare in an Era of Change'
2020	RDRC Pilot Grant for Research on Medicaid Long Term Care ($85k, co-PI)

2019	Finalist for 2019 NIHCM Prize (recognizing the most impactful health care research of preceding year)
2017	NIA P01 Supplement for Research on Medicare Part D (Co-investigator, $170k)
2017	NIA Pilot Grant for Research on Medicaid Managed Care ($50k, co-PI with Tim Layton)
2013-2015	Pre-Doctoral Research Fellowship, NBER
2014	Leonard Davis Institute Pilot Grant
2013	Penn Trio Pilot Grant
2013	Russell Ackoff Fellowship
2012	Amy Morse Prize (top 2nd year PhD student in Applied Economics)
2011-2015	Wharton Doctoral Fellowship

Professional Activities:

Referee Service: Quarterly Journal of Economics, Journal of Political Economy, Journal of Public Economics, AEJ: Economic Policy, RAND Journal of Economics

Publications:

Private Versus Public Provision of Social Insurance: Evidence from Medicaid
(with Tim Layton, Nicole Maestas, and Daniel Prinz)
Forthcoming, AEJ: Economic Policy

The Consequences of Health Care Privatization: Evidence from Medicare Advantage Exits
(with Mark Duggan and Jon Gruber)
AEJ: Economic Policy, 2018
Finalist for 2019 NIHCM Research Award

Who Benefits When the Government Pays More? Pass-Through in the Medicare Advantage Program
(with Mark Duggan and Amanda Starc)
Journal of Public Economics, 2016

Working Papers:

The Behavioral Foundations of Default Effects: Theory and Evidence from Medicare Part D
(with Zarek Brot-Goldberg, Tim Layton, and Adelina Yanyue Wang)
Revise and Resubmit, American Economic Review

We show that default rules in the low-income portion of Medicare Part D have large and persistent effects on enrollment and drug utilization. We develop a framework for optimal default policy and show that a key unknown parameter is the elasticity of active choice propensity with respect to the value of the default assignment. Using randomly-assigned defaults, we estimate an attention elasticity close to zero, even when beneficiaries face substantial losses in drug consumption. Variation in active choice rates appears to be largely random. Beneficiaries are likely to benefit from paternalistic or ”smart” defaults rather than be hurt by them.

Rationing Medicine Through Paperwork: Authorization Restrictions in Medicare Part D
(with Zarek Brot-Goldberg, Samantha Burn, and Tim Layton)
Job Market Paper

While the costs of U.S. health insurance administration have provoked worry among policymakers, we know little about the benefits of such administration. We study prior authorization restrictions, a major source of administrative costs, among Low-Income Subsidy beneficiaries of Medicare Part D. Prior

authorization restrictions reduce insurer drug spending costs but also impose paperwork burdens on physicians. Using auto-assignment to randomly-chosen plans as a source of variation, we find that prior authorization reduces use of focal drugs by 23%. Measures of aggregate paperwork burdens may reflect choices along an efficient frontier, trading off paperwork costs against program utilization costs, rather than being pure waste.

The Value of Improving Insurance Quality: Evidence from Long-Run Medicaid Attrition
(with Ajin Lee)
Submitted

The US government increasingly provides public health insurance coverage through private firms. We examine associated welfare implications for beneficiaries, using a novel 'revealed preference' framework based on beneficiaries' program attrition rates. Focusing on the Medicaid program in New York State, we exploit quasi-random variation in beneficiary initial assignment to public versus private Medicaid, based on birth weight. We find that infants assigned to private Medicaid at birth are less likely to subsequently leave Medicaid. We show that reduced attrition reflects beneficiary responses to improved program quality, rather than alternative mechanisms such as private Medicaid plans reducing reenrollment barriers.

Efficiency Gains Under Incomplete Contracting: Evidence from Medicaid

While government contracting is pervasive, there is limited understanding of the magnitude of resulting efficiency gains, and particularly the degree to which incomplete contracting inhibits their pass-through to either governments or constituents. I examine these questions by looking to Medicaid contracting in New York, where the state pays private insurers to coordinate beneficiary care and reimburse providers, in lieu of doing so directly. These contracts exhibit incompleteness, as private insurers end up responsible for some but not all medical services, with the rest remaining under public provision. For causally identifying the effects of incomplete contracting, I leverage a change in contract completeness over the sample period, through the integration of previously excluded drug services. While I find evidence of efficiency gains, I find that incomplete contracting reduces their pass-through to governments, by leading private plans shift costs to medical services that remain under public provision. Eventual integration of these services into existing private contracts yields a 16% reduction in overall fiscal costs.

Cost Sharing Among Those Who Can't Pay: Evidence from Medicare Disenrollments (new draft coming soon!)
(with Zarek Brot-Goldberg and Pauline Mourot)

Cost-sharing for medical services could lower spending through reductions in moral hazard and consequent decreases in low-value care. Simultaneously, cost-sharing could introduce behavioral hazard through potential reductions to high-value care, which could lead to offsetting increases in avoidable care. The net effect of cost-sharing, through these two opposing mechanisms, is ultimately an empirical question and could furthermore be population dependent. We examine this question in the context of a high-cost and financially needy group: dual-eligibles simultaneously enrolled in Medicaid and Medicare, who account for 35% of overall program spending. We leverage an exogenous court ruling that resulted in a substantial cost-sharing increase from approximately 0% to 15% for 25,000 dual-eligibles, through subsequent loss of Medicaid coverage, and isolate the effects of cost-sharing here from other accompanying changes. We find that this cost-sharing bump increases overall spending by 6%, through increases in preventable inpatient services, which more than offset concurrent outpatient reductions. We also find that the spending increases come from the sickest subset of the population, with spending actually falling among all other groups.

Selected Research in Progress:

How do Medicaid and Medicare Compare? Evidence from Dual-Eligible Enrollees
(with Tim Layton, Nicole Maestas, Daniel Prinz, and Mark Shepard)

The US employs two distinct pathways to provide public health insurance coverage-the Medicaid and Medicare programs-which collectively cover over 100 million Americans. Given differences between Medicaid and Medicare in program design and costliness, there has been ongoing policy debate on how much of the population should be covered through one program versus the other, as well as whether the design of one program should more closely mimic the other. Unfortunately, little is known about how these programs actually compare on important outcomes, such as government spending and beneficiary well-being. We investigate these questions by leveraging involuntary age-based transitions into Medicare at 65, among those previously in Medicaid. We find that the government spends 30% more to cover a given beneficiary under Medicare relative to Medicaid, with most of this difference coming from higher payment rates to providers rather than through increased healthcare utilization. Higher spending on Medicare does not appear to translate into improved beneficiary health. Rather, most of the higher spending appears to accrue to providers, as opposed to beneficiaries.

Grading State Medicaid Programs: Investigating Cross-State Program Differences
(with Tim Layton, Nicole Maestas, Daniel Prinz, and Mark Shepard)

Individual state Medicaid programs vary substantially in their design and operation, given the substantial flexibility each state is granted in program administration. In theory, this classic federalist arrangement should allow individual Medicaid programs to function as laboratories of democracy, although in practice it has been challenging to tease out the effects of state program design from other confounders. Attempting to do so here, we leverage a number of empirical strategies, including beneficiary moves across states and beneficiaries living immediately adjacent to a state border. We find that cross-state variation in Medicaid program design leads to significant differences in key outcomes, including government cost of providing coverage. These differences are particularly pronounced when it comes long-term and post-acute care. We examine whether higher program spending translates into improved health outcomes and beneficiary well-being.

How Are Medicare Part D Plans Different? Evidence from Randomly Assigned Enrollees
(with Tim Layton, Daniel Prinz, and Anna Zink)

While substantial focus has been paid to the financial characteristics of prescription drug plans, far less attention has been given to the impact of non-financial features, including formulary composition, utilization restrictions, and pharmacy network composition. To examine the causal impact of non-financial plan features and furthermore decompose them from financial ones, we leverage the randomized assignment of five million low-income subsidy beneficiaries across a subset of Part D plans, with these specific plans being financially uniform and instead differing solely in non-financial dimensions. We take advantage of novel data individually identifying everyone getting randomly assigned to a Part D plan, due to lack of active choice, for the entire US for the 2007-2015 period. We find that beneficiaries randomly assigned to lower-spending plans have lower prescription drug spending, and that this come largely through intensive-margin substitution to lower cost drugs, rather than extensive-margin reductions in number of prescriptions. We find no evidence of short-run medical spending offsets or health effects.

Non-Academic Employment:

Various Digital Health Firms, *Advisor, Consultant:* 2014–
Picwell, *Founding Team Member, Advisor*: 2014–2015
Edgeworth Economics, *Consultant*: 2009–2011

Personal:

Languages: English (native), Russian (native), French (proficient)
Interests: Classical Piano, Traveling, Hiking, Biking, Skiing, Sailing