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Personal Information: DOB 11/07/1986 (St. Petersburg, Russia), US Citizen

Academic Positions:
Faculty Associate & 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, 2011-2015
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 Mark Duggan
Department of Economics, Stanford U.
650-723-3982, mgduggan@stanford.edu

Professor Jonathan Gruber
Department of Economics, MIT
617-253-8892, gruberj@mit.edu

Professor Jonathan Kolstad
Haas School of Business, UC-Berkeley
650-269-7018, jkolstad@berkeley.edu

Professor Robert Town
Department of Economics, UT-Austin
512-475-8542, robert.town@austin.utexas.edu

Teaching and Research Fields:
Health Economics, Public Economics

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:

2019	Finalist for 2019 NIHCM Prize (recognizing the most impactful health care research of preceding year)
2017	Arnold Foundation Grant for Medicaid Managed Care Research ($1M, PI: Layton)
2017	P01 Supplement for Research on Medicare Part D ($100k, PI: Joe Newhouse)

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 (2x), AEJ: Economic Policy (2x), RAND Journal of Economics

Publications:

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:

Private Versus Public Provision of Social Insurance: Evidence from Medicaid (with Tim Layton, Nicole Maestas, and Daniel Prinz)
Released as NBER Working Paper #26042

Public health insurance benefits in the U.S. are increasingly provided by private firms, despite mixed evidence on welfare effects. We investigate the impact of privatization in Medicaid by exploiting the staggered introduction of county-level mandates in Texas that required disabled beneficiaries to switch from public to private plans. Compared to the public program, which used blunt rationing to control costs, we find privatization led to improvements in healthcare—including increased consumption of high-value drug treatments and fewer avoidable hospitalizations—but also higher Medicaid spending. We conclude that private provision can be beneficial when constraints in the public setting limit efficiency.

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 Medicaid Disenrollments

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. I 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. I 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. I find that this cost-sharing bump surprisingly increases overall spending by 6%, through increases in preventable inpatient services, which more than offset concurrent outpatient reductions. I also find that the spending increases come from the sickest subset of the population, with spending actually falling among everyone else. These results highlight potential benefits from expanding accessibility of supplemental Medicare insurance among the Medicare disabled, particularly through Medicaid and Medigap, given existing coverage limitations.

Selected Research in Progress:

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

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. This is an important gap in the literature, given the substantial non-financial differences that exist across drug plans, and given broader questions that these could tie into. 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, but provide suggestive evidence of increased consumer satisfaction under relatively higher spending plans. In addition to contributing to the literature on insurance and benefit design, our study also contributes to understanding of moral hazard and selection, by identifying how (non-financial) tools could reduce spending and at the same time influence beneficiary willingness to remain in plans.

Understanding Active Choice in Subsidized Medicare Part D (with Zarek Brot-Goldberg, Tim Layton, and Adelina Wang)

Prior literature has documented behavioral frictions such as inattention and inertia that cause consumers to make sub-optimal health plan choices, or to neglect to make choices altogether and instead be 'defaulted' into an option by the regulator. Unfortunately, much of this literature has been hindered by an inability to observe 'defaulting' behavior directly in the data, limiting the researcher's ability to understand consumer intentions. Further, many behavioral frictions (such as inertia, switching costs,

etc.) have been difficult to separate, given that these frictions often result in similar observable consequences. In this paper, we look at these questions in the context of low-income beneficiaries in Medicare Part D, as this institutional setting uniquely allows us to overcome many long-standing empirical challenges. First, we make use of novel data directly tracking active choice status for this population; beneficiaries failing to actively choose a plan get randomly assigned to one. In this setting, we can also effectively track potential ex-ante determinants of active choice, through individually-linked data from Medicaid that predates beneficiaries' enrollment in Medicare. An additional innovation is the separate identification of inertia and switching costs, enabled by an institutional setting where the default choice is sometimes a different plan, with the non-default option being continued enrollment in the existing plan. We find that the highest-risk beneficiaries make active choices at only slightly higher rates than the lowest-risk beneficiaries, suggesting that lack of active choice is not fully 'rational'.

Medicaid Programs as Laboratories of Democracy (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 collectively function as laboratories of democracy. Yet in practice, it has been difficult to realize gains from this cross-state experimentation or more specifically draw valid policy inferences, given that states will also differ along other unrelated characteristics. In this paper, we try to fulfill the promise of this institutional setting, by introducing a novel approach for teasing out the effects of state-specific program differences from other state-specific factors. To do so, we focus on Medicaid-only enrollees aging into Medicare at 65, as convergence to a nationally uniform form of coverage allows us to isolate state-specific Medicaid program effects from all others. In addition, we make use of unique nationwide Medicaid and Medicare claims data as well as unique SSA individual mortality indicators, which are all longitudinally linked. We find that cross-state Medicaid program differences translate directly into spending and outcome differences, and identify the program design elements most driving this.

Non-Academic Employment:

Various Digital Health Firms, *Advisor, Consultant* 2016–
Nuna Health, *Health Economics and Product Dev*: 2015–2016
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