MIT Economics

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DOCTORAL STUDIES

Massachusetts Institute of Technology (MIT)
PhD, Economics, Expected completion June 2022
DISSERTATION: "Essays in Health Economics"

DISSERTATION COMMITTEE AND REFERENCES

Professor Amy Finkelstein
MIT Department of Economics
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Professor James Poterba
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Professor Jonathan Gruber
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PRIOR EDUCATION

University of California, Davis — 2014
B.A. in Economics with a minor in Biological Sciences, Highest Honors

CITIZENSHIP United States **GENDER:** Female

FIELDS

Primary Fields: Public and Health

Secondary Fields: Labor

TEACHING EXPERIENCE

14.41: Public Finance and Public Policy (undergraduate) — 2019
Teaching Assistant to Professor Jonathan Gruber

14.472: Public Economics II (graduate) — 2019
Teaching Assistant to Professor Amy Finkelstein

RELEVANT POSITIONS	Research Assistant to Professor Amy Finkelstein	2017-19
	Stanford Law School Research Fellow: Research Assistant to Professor Daniel Kessler	2014-16
FELLOWSHIPS, HONORS, AND AWARDS	NBER Pre-Doctoral Fellowship in Aging and Health	18-20, 21-22
	National Science Foundation Graduate Research Fellowship	2016-2021
	UCD Economics Distinguished Undergraduate Student	2014
	Phi Beta Kappa	2013
	UCD Regent's Scholarship	2010-2014
	National Merit Scholarship	2010
PROFESSIONAL ACTIVITIES	MIT Labor Lunch co-organizer	2018-19
	NBER Health and Aging Trainee Seminar organizer	2019-20

PUBLICATIONS

"Medicare Advantage Plans Pay Hospitals Less Than Traditional Medicare Pays," (with M. Kate Bundorf, Laurence Baker, and Daniel Kessler) *Health Affairs* 35.8 (2016): 1444-1451

"Hospital Ownership of Physicians: Hospital Versus Physician Perspectives," (with M. Kate Bundorf, Laurence Baker, and Daniel Kessler) *Medical Care Research and Review* 75.1 (2018): 88-99.

"Why Don't Commercial Health Plans Use Prospective Payment?" (with M. Kate Bundorf, Laurence Baker, and Daniel Kessler) *American Journal of Health Economics* 5.4 (2019): 465-480.

RESEARCH PAPERS

"Volume Responses to Changes in Medicare Reimbursement" (Job Market Paper)

Medicare sets reimbursement rates defining provider payments and cost-sharing for the healthcare of the United States elderly and disabled, but the impact of these rates on care volume, and hence spending and access is not well understood. Theoretically the impact of reimbursement on volume could be either negative or positive depending on whether provider substitution effects, provider income effects, or demand effects dominate. And the empirical literature has found mixed results in a variety of settings. I study this using relatively modern and exogenous variation from an Affordable Care Act provision that increased reimbursement for professional care in four states in 2011. I estimate two difference-in-difference analyses focusing on office-based care, which received the largest price increases. First, I compare affected states and a matched set of control areas, and second, within affected states, I compare more and less affected providers. These two analyses with very different identifying assumptions both yield a positive estimate for the effect of reimbursement on volume. The positive response is driven by increases in the number of providers and services rather than increases in service intensity. The positive relationship suggests that Medicare should be concerned about access when it decreases reimbursement rates.

"Telemedicine Persistence in Medicare: Utilization Patterns before COVID"
Telemedicine increased dramatically during the COVID-19 pandemic introducing the modality to many patients and providers. To understand how exposure to telemedicine affects subsequent utilization, I examine persistence with telemedicine in pre-COVID Medicare. I analyze patient and provider telemedicine visits in Medicare from 2006 to 2016, a sample where telemedicine was predominantly used in rural areas and for mental health conditions. I measure patient persistence by the share of care provided via telemedicine over time and compare this to in-person persistence with a unique provider. Similarly, I evaluate provider persistence by the share continuing to provide telemedicine. Patients were somewhat persistent: for mental health visits in particular, the share via telemedicine fell from over 60% at the first visit to 40% the next quarter and subsequently to 20% three years later, while in a matched comparison group, the share of in-person visits to the same provider fell by roughly half as much from 64% to 44% over three years. The selected subset of patients whose initial providers continued to provide any telemedicine, a group more likely to retain access, were quite persistent. Providers were somewhat more persistent than the average patient though results varied by specialty. If telemedicine were a valuable experience good then exposure should lead to increased or persistent utilization in the absence of other constraints. My results suggest this is not the case and that supply constraints were a limiting factor. The policy implication is that COVID's impacts on future telemedicine may stem from changes in the supply side regulations and reimbursement rather than from exposing potential patients to the modality, so maintaining those changes is likely necessary to maintain higher telemedicine levels.

RESEARCH IN PROGRESS

"Urgent Care Clinics, Ownership, and Health Care Efficiency" (with Annetta Zhou)
Over the past few decades retail and urgent care clinics have increased in number dramatically. These clinics increase access to care and previous research shows that they can cause people to substitute out of emergency rooms, but it is unknown how they impact total spending because they reduce the hassle cost of care and exacerbate ex post moral hazard for people with health insurance. There is heterogeneity in both the locations and health system membership of these clinics—independent clinics compete with the emergency rooms, while clinics in the same health system as the nearby emergency rooms have other primary goals. In this project we use events studies around clinic openings in Massachusetts to investigate the impacts of the clinics as well as how such impact varies with these differences in market structure. Using the All-Payer Claims Database in years 2012 to 2016 we observe 89 urgent care clinics and 26 retail clinics opening. We interact clinic ownership with the event study to investigate differential impacts on emergency room substitution, substitution from providers offices, changes in aggregate care, and referrals to other system providers.