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Bio: Boris Vabson, Ph.D. is a nationally recognized health economist, with expertise at the intersection of health care, business, analytics, data, and policy. He is a member of the research faculty at Harvard Medical School, as well as a nonresident fellow at the American Enterprise Institute and the University of Southern California's Schaeffer Center.

Through his work, Dr. Vabson examines major policy questions in Medicare and Medicaid, focusing on the ongoing privatization of these programs. He also studies the impact of different health insurance design features, and how health insurance design can be leveraged to optimize cost and quality outcomes. Dr. Vabson's research is enabled by access to novel and proprietary data, obtained through close partnerships with organizations such as UnitedHealth and Inovalon. Dr. Vabson maximizes the value of these novel data through close research collaborations with other academics, as well as with a range of PhD students and research assistants.

Dr. Vabson has previously held academic appointments at Stanford University and the University of California, Berkeley. He has also served as a strategic adviser to major health tech companies. His research has been published in peer-reviewed journals including *American Economic Review, AEJ: Economic Policy*, *Journal of Public Economics*, *Journal of the American Medical Association*, and *Health Affairs*. In addition, his work has been covered by *Bloomberg News*, the *New York Times*, *Los Angeles Times*, and other major news outlets.

Dr. Vabson received an MS and PhD in applied economics from the University of Pennsylvania's Wharton School and an AB in economics and mathematics from Dartmouth College.

Personal Information: US Citizen

Academic and Policy Research Appointments:
Research Scholar & Seidman Fellow, Harvard Medical School, 2019-
Nonresident Fellow, American Enterprise Institute, 2023-
Nonresident Fellow, University of Southern California-Schaeffer Center, 2023-

Previous Appointments:
Research Scholar, Stanford Institute for Economic Policy Research, 2017-2019
Post-Doctoral Fellow, UC-Berkeley Haas School, 2016-2017

Education:
Ph.D., M.S, Applied Economics, University of Pennsylvania-Wharton School, Sept 2011-Dec 2015
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

Teaching and Research Fields:
Health Economics, Public Economics, Strategy

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 (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)
2017	NIA Pilot Grant for Research on Medicaid Managed Care (co-PI with Tim Layton)
2013-2015	Pre-Doctoral Research Fellowship, NBER
2014	Leonard Davis Institute Pilot Grant
2013	Penn Trio Pilot Grant, 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, AER: Insights

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

Publications-Econ Journals:
The Value of Improving Insurance Quality: Evidence from Long-Run Medicaid Attrition
(with Ajin Lee)
Journal of Health Economics, 2024

The Behavioral Foundations of Default Effects: Theory and Evidence from Medicare Part D
(with Zarek Brot-Goldberg, Tim Layton, and Adelina Yanyue Wang)
American Economic Review*, *2023

Private Versus Public Provision of Social Insurance: Evidence from Medicaid
(with Tim Layton, Nicole Maestas, and Daniel Prinz)
AEJ: Economic Policy, 2022

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-Econ Journals:
Rationing Medicine Through Paperwork: Authorization Restrictions in Medicare Part D
(with Zarek Brot-Goldberg, Samantha Burn, and Tim Layton)
***American Economic Review*,** Revise and Resubmit

High administrative costs in U.S. health care have provoked concern among policymakers over potential waste, but many of these costs are generated by managed care policies that trade off bureaucratic costs against reductions in moral hazard. We study this trade-off for prior authorization restriction policies in Medicare Part D, where low-income beneficiaries are randomly assigned to default plans. Beneficiaries who face restrictions on a drug reduce their use of it by 26.8%. Approximately half of marginal beneficiaries are diverted to another related drug, while the other half are diverted to no drug. These policies generated net financial savings, reducing drug spending by $96 per beneficiary-year (3.6% of drug spending), while only generating approximately $10 in paperwork costs. Revealed preference approaches suggest that the cost savings likely exceed the value of the foregone drugs to patients.

Privatizing Social Insurance: Medicare Advantage vs Traditional Medicare
(with Scott Bilder, Zarek Brot-Goldberg, Barton Jones, Iman Mohammadi, Zulkarnain Pulungan, Yalun Su, and Christie Teigland)

Accompanying White Papers: Enrollment Characteristics, Utilization, Quality, Plan Design Within MA

Privatization of social services can improve efficiency of service provision, but also introduces various frictions inherent to the contracting process. We explore this trade-off in the context of Medicare, where nearly half of beneficiaries are enrolled in the "private option," Medicare Advantage (MA). We construct a novel dataset longitudinally linking health insurance claims across employer-sponsored health insurance, public fee-for-service Medicare (FFS), and MA. We employ a difference-in-differences research design, comparing beneficiaries who enroll in MA at 65 to those who enroll in FFS, both after they enroll in the Medicare program and before, when they are enrolled in employer-sponsored health insurance. We estimate that MA reduces overall health care utilization and spend by roughly 6% in the year following enrollment and 12% over two years, relative to what the same beneficiaries' utilization would have been under FFS, and without any adverse impact on quality of care. We also find that utilization under FFS is 20% higher than it was for the same beneficiaries immediately preceding Medicare enrollment, under employer-sponsored coverage.

Medicaid vs Medicare: Evidence from Medicaid to Medicare Transitions at 65
(with Tim Layton, Nicole Maestas, Daniel Prinz, and Mark Shepard)

The US has two predominant government health insurance programs-Medicaid and Medicare-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 13% more to cover the same beneficiary under Medicare compared to Medicaid, with most of this difference coming from higher payment rates to providers rather than through increased healthcare utilization. We find significantly higher rates of outpatient care usage under Medicare, alongside lower levels of acute care usage. These results may reflect improved primary care access under Medicare, which could arise through the program's more generous physician reimbursement rates.

Estimating Variation in Productivity Across State Medicaid Programs: Evidence from Dual-Eligibles
(with Tim Layton, Nicole Maestas, Daniel Prinz, and Mark Shepard)

Many social programs involve some level of local autonomy, with local governments making some program design decisions within a set of national guidelines, and with financing being shared between local and national governments. We study the extent to which this autonomy results in heterogeneity across U.S. states in the productivity of their primary social health insurance program: Medicaid. We do this for one of the most expensive groups of Medicaid beneficiaries—those also enrolled in Medicare, i.e. "dual-eligibles". Productivity is typically defined as the ratio of outputs to inputs. For duals in Medicaid, we define inputs as the fiscal cost of the Medicaid program. We define output as providing access to healthcare goods and services, specifically access to primary care, critical surgeries, and, most importantly, long-term services and supports not covered by the Medicare program. We leverage duals who move across states to estimate state effects on fiscal costs, showing significant variation across states in these costs (a ratio of 3:1 for the highest to lowest spending states).

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. Eventual integration of these services into existing private contracts yields a 16% reduction in overall fiscal costs.

Policy and Medical Publications:

Comparing Expected Out-Of-Pocket Costs in MA and FFS Medicare, 2014-2020
Health Affairs Datawatch, 2024 forthcoming (with Ben Ippolito and Erin Trish)

How do prescription drug benefits differ between Medicare Advantage and Stand-Alone Part D Plans?
AEI Economic Perspectives, 2024 (with Ben Ippolito)

The impact of Medicare Advantage growth on Part D competition, costs, and coverage
Health Affairs Forefront, 2023 (with Ben Ippolito)

How should policymakers respond to rising cost-sharing that often goes unpaid?
Health Affairs Forefront, 2023 (with Ben Ippolito)

Comparison of Care Quality Metrics in 2-Sided Risk Medicare Advantage vs Fee-for-Service Medicare Programs
JAMA Network Open, 2022 (with Ken Cohen, Omid Ameli, et al)

Non-Academic Employment:

Various Health Tech Firms, *Advisor, Consultant, Founder:* 2014–

Personal:

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