

**Volume 3, Fall 2009**

**Contents Inside**

◆ **Symposium on Teaching Health Economics**

- ◆ Teaching in Large Classrooms by Sean Nicholson
- ◆ Class Poster Exhibitions by Kosali Simon
- ◆ Using Fun and Games Teaching Health Economics by Jennifer Mellor
- ◆ Letter from ASHEcon President Michael Grossman
- ◆ Comments from Executive Director Richard Arnould
- ◆ Dear ASHEly
- ◆ Profile on ASHEcon: President Michael Grossman



**Michael Morrissey**  
Treasurer, ASHEcon  
University of  
Alabama, School of  
Public Health

**Finding Data *Andy Epstein***

For most health care services (and especially the expensive ones), physicians serve as the “team captains” of delivery. In collaboration with other clinicians, they are responsible for diagnosing patients’ illnesses and then either providing treatments themselves or referring their patients elsewhere. While economic theory about physician behavior has existed for a while (e.g., Pauly, 1980), it is only recently that good data have become available to study physician behavior empirically. Moreover, going forward, data resources covering physicians should only improve.



**Andrew Epstein**  
Yale School of Public  
Health

*(Continued on page 7)*

**Board Member Biography: Michael Morrissey**

I’m a first generation college graduate who was born in Minnesota and grew up in South Dakota. I attended a local state college with the intention of going on to law school when I was introduced to economics by a wonderful macroeconomics teacher, Ralph Brown. He in turn encouraged me to consider at least one graduate school outside the Midwest. I ended up attending the University of Washington (Seattle) because the graduate advisor, Gardner Brown, called me in the middle of the night to say “Mike, I’ve got you [TA] money.” I later found out that I was Gardner’s “gamble.”

The UW Econ Department in those days was dominated by property rights economics and economic history. I learned intuitive rather than mathematical economics with a strong dose of respect for empirical work and took fields in health, public finance, natural resources and macro. I would have had an IO filed as well but my parents came out for a visit at the time the exams were to be given. I gravitated toward health economics initially because of my wife, who worked in the UW School of Public Health. She came home one evening to say there was “free money” for doctoral students in health services.

*(Continued page 6)*

**Board Member Biography: Richard Arnould**

I received my PhD in Economics from Iowa State University, a very unusual place to receive training to become a health economist. However, like many others, I started in a different direction. Iowa State was well known for its program in applied statistics and econometrics, so I came out of that program with my emphasis in empirical industrial organization. Having become tired of research on issues in the banking industry, I decided to take a look at professional service markets with an interest in how prices are formulated. I started with the legal service industry, and moved on to real estate and accountancy. Friends said I should look at health services. I resisted this because (believe it or not) in the late 70’s I thought there already were enough people working on that industry. A PhD student at Illinois was interested in physician pricing policies and I ended up directing her dissertation. That resulted in my being more and more interested in health service markets. Little did I ever think the field would grow to its current size and status.

*(Continued on page 3)*

## Letter from ASHEcon President: Michael Grossman

**ASHEcon Independence.** The Executive Director, Officers, and Board are hard at work at making ASHEcon an independent organization. The goal of independence by 2010 was established by our charter and is being encouraged by iHEA. The official separation does not occur until the end of 2010. However, many things must be in place prior to that time to facilitate a smooth transition. Joe Newhouse, Jody Sindelar, Randy Ellis, Dick Arnould, and I have reviewed several management proposals and models. We have decided to recommend to the ASHEcon Board of Directors that the National Tax Association (NTA) manage our association and its web site. We were greatly impressed by NTA's proposal, and Jim Poterba, the current President of that association, gave it an extremely favorable recommendation.

**Activities at 2010 Allied Social Science Associations Convention.** As has been the case in the past, we will sponsor a luncheon at the ASSA Convention in Atlanta. We are in the process of recruiting a speaker for the luncheon. Members are urged to attend the sessions sponsored by

iHEA at the convention. We are organizing these sessions and hope to sponsor them officially in the future.

**Cornell Conference.** The Executive Director, Officers, Board, and the Cornell planning committee are hard at work on our third biennial conference to be held in June 2010. To keep down the cost of the conference to members, grants have been or shortly will be submitted to NIDA, NIA, AHRQ, private foundations, and pharmaceutical companies. This will also help to ensure that we have enough resources to host a high-level, quality conference. If you have any leads, please contact our Executive Director, Dick Arnould (rarnould@ad.uiuc.edu) or contact me (mgrossman@gc.cuny.edu). Kip Viscusi has agreed to give a plenary address at the conference.

**Future Conferences.** I am very pleased to announce that work is well under way to hold the 2012 conference at the Carlson School at the University of Minnesota, with Steve Parente as Chair of the Local Committee.



**Michael Grossman,**  
Professor, CUNY, The Graduate Center

### ASHEcon Newsletter-Vol. 3 Summer 2009

#### Editor's Note

With new students arriving on campus and health reform swirling in the air, this is an exciting time to be a health economist. This issue of the newsletter has lots of great ideas that you can incorporate in your teaching and pointers to good data sources on physician behavior that you can use in your research.

Best,  
Melayne Morgan McInnes  
Editor  
*University of South Carolina*

Anthony T. Lo Sasso,  
Co-Editor  
*University of Illinois at Chicago*

Kosali Simon  
Co-Editor  
*Cornell University*

#### Newsletter Board

Gloria Bazzoli, *Virginia Commonwealth University*  
W. David Bradford, *University of Georgia*  
Susan Ettner, *University of California Los Angeles*  
Timothy McBride, *St. Louis University*  
Richard Arnould, *University of Illinois Urbana-Champaign*

#### Mission Statement

The mission of the newsletter will be to develop the social capital of the health economics profession by providing a forum for community building and networking among health economics faculty, researchers, and students. This newsletter will be published thrice yearly and is not intended to engage in advocacy or to provide information already available in other newsletters.

## Profile on ASHEcon: President Michael Grossman

I am a "child" of the National Bureau of Economic Research. I have been affiliated with the Bureau since 1966 when Victor Fuchs hired me as a research assistant. Currently, I direct the NBER's Health Economics Program and am Distinguished Professor of Economics at the City University of New York Graduate Center, where I have taught since 1972. I also am a co-editor of the Review of Economics of the Household, a series co-editor of Advances in Health Economics and Health Services Research, published by JAI Press, an imprint of Emerald Group Publishing Limited, an associate editor of the Journal of Health Economics, an associate editor of the Journal of Human Capital, a member of the Institute of Medicine of the National Academy of Sciences, a past president of the Eastern Economic Association, and the current president of the American Society of Health Economists.

I received my Ph.D. in economics from Columbia University in 1970. Gary Becker and Victor Fuchs had the biggest impacts on my professional development. When Vic hired me as a research assistant in June 1966, I had just finished my all course work and exams at Columbia, I was thinking about getting married; and I did not have much money. At the end of the summer, he said that I could continue to work for him half time and have office space to work on my dissertation if I wrote in the health economics field. That is how I became interested in the field; until then I had no exposure to it. In retrospect, in 1966 an investment in health economics certainly paid me the best interest.

*(Continued on page 4)*

## Symposium on Teaching Health Economics

We asked some great teachers to share their creative approaches to teaching health economics in the class room. **Sean Nicholson** addresses the increasingly common issue of teaching health economics in a large classroom setting. **Kosali Simon** gives us a new alternative to in-class student powerpoint presentations: why not try a poster session? **Jennifer Mellor** shows how experimental economics can give us new ideas for teaching. Our own **Dear ASHEly** answers questions in our theme, and we also provide links to teaching resources available.

Stay tuned for more information about a new website that is in the making:

### ASHEcon Community Resources

## Tips on Teaching a Large Undergraduate Health Class

*Sean Nicholson*

Two years ago I inherited an undergraduate course at Cornell University, the U.S. Health Care System, which introduces students to the major players in the health care industry (insurers/payers, providers, suppliers), highlights key problems in the industry, and outlines possible policy solutions. I decided to remove the enrollment cap on the course and try to attract a large number of students, in part to encourage students to consider taking our upper-level health courses such as health economics, public health, and health policy. About 210 students enrolled in each of the first two years. I'm convinced that an introductory health course with no prerequisites can draw many students: pre-med students who want to take a break from their science courses and learn something about the business side of medicine (about 60% of my students are pre-med); students who want to be knowledgeable voters on health policy; students who realize that a working knowledge of the health care market may help them land a job.

**Here are some suggestions to consider when teaching a large undergraduate course:**

Begin the class by asking students if there are any relevant current events they would like to discuss. This is a good way to demonstrate the relevance of the course material and to figure out what the students are most interested in. Although 1-2 students usually have a suggestion, you should come with your own current event the first few times in case students are bashful. This also gives students the courage to ask questions and make comments during the lecture.

Video clips are a great way to capture the students' attention, entertain, and break up what might otherwise seem like a long lecture. My main goal is to show funny clips (e.g., Saturday Night Live, Colbert Report, The Office, and Sicko), although some are serious. I'm happy to share my clips as long as you try to contribute to the collection.

There are several good web sites for entertaining and educating. For example, I walk through a life expectancy calculator ([http://www.nmfn.com/tn/learnctr--lifeevents--longevity\\_game](http://www.nmfn.com/tn/learnctr--lifeevents--longevity_game)) when discussing the effect of medical care and health behaviors on health outcomes (e.g., show the marginal effect of smoking or drinking). Gapminder.org has great graphical displays of health measures by country by year.

Although I feel like a high school teacher, I give five unannounced quizzes (allowing them to drop the two lowest grades) throughout the semester mainly to boost attendance. A quiz consists of two True/False questions on the readings. It's amazing how 10% of the course grade is enough to inspire ultra competitive undergraduates to show up.

I post the Powerpoint slides on Blackboard a couple hours before class so that students can either print the slides out ahead of time and take notes on the slides, or take notes directly on the slides using a laptop. ■



**Sean Nicholson**  
Associate Professor, Cornell University

---

### Biography: Richard Arnould *Continued from Page 1*

I received great joy out of many of these activities, but probably the three I would put at the top are working with graduate students, going between academic research in health economics and practical consulting with government agencies and provider organizations, and instilling an interest in professions in the health care industry in students who attended my undergraduate course in Health Economics. I would be remiss if I did

not put near the top of this list playing a role in establishing ASHEcon.

I served the last seven years of my active career at the University of Illinois as Head of the Department of Economics and received the title of Professor Emeritus upon retirement. I continue to be active as a consultant, do limited teaching, and serve in the exciting capacity of Executive Director of ASHEcon. ■

## Undergraduate Poster Exhibition in Health Economics *Kosali Simon*

For several years now, I've required a paper and short presentation in my undergraduate Health Economics course. Last year, I decided to substitute a poster requirement for the presentation. Over the course of two class periods, students displayed, presented and discussed their work. It was a very rewarding and enjoyable aspect of teaching the class for me. If you are looking for an alternative medium to work into your course, I highly recommend a class poster exhibition!

**How does it work?** As part of a semester long project, groups of about 3 students each pick a question in health economics to tackle outside of class. Some groups conduct their own empirical analysis while others turn in solely secondary literature reviews. Three weeks from the end of the semester, students are asked to turn in a draft of a poster in which they will explain to the rest of the class the issue they have pursued and what they have learned about it. I provide the students with some examples of award winning posters in electronic and print form (thanks to my colleagues who have given me copies of theirs!). Turns out that one can use Powerpoint (and probably many other programs, but this is the only one I know) to create some pretty snazzy poster displays as one 'slide' with lots of content, that then gets printed in mega size on a poster printer (most libraries probably have one). Since this was my first time trying this out, I offered to do the printing for them out of classroom funds. I provide two rounds of feedback on drafts, and when they reach a final version, I print and bring them to the last 2 classes of the semester. The room in which our class met had walls that accepted thumb tacks. I had 16 groups in one class, so I split them into two sets of 8 posters each. On one day, 8 groups 'presented' their posters, while the other students were their audience. On the second day, the roles were switched. I invited some colleagues to come and judge the posters on the basis of creativity as well as content. The students also evaluated each others work, and cash prizes were given to the best posters of each day. With my students' permission, I will leave these prize winning posters on the ASHEcon community resources website, along with the evaluation sheets, instruction sheets etc that I used for this project.



### Integrating Peer Reviewing in the classroom

Peer reviewing is an integral part of any researcher's life, yet it wasn't until recently that I thought of incorporating it into my Health Economics classes. I did it in the context of the semester long project again. When the students turn in their first draft, I ask them to turn in two copies—one with their name on it for me to comment on and grade, and another copy without their names. I assign a tracking number to this second copy and turn it over to another student. Keeping track of whose draft went to whom, I ask the reviewers to provide me with a written critique of the draft which includes ideas for improving and expanding the scope of the paper, additional resources that may be helpful etc. This is meant to be an exercise in anonymous peer assistance and evaluation--thus I also grade the reviews that are written (this also serves to make sure the advice I give and the advice from the peer don't send the student in too many directions). I return the peer review anonymously, along with my graded copy of their proposal. ■

### Profile: Michael Grossman *Continued from Page 2*

When I entered Columbia, I was going to specialize in public finance. Then I met Gary Becker and decided to specialize in whatever interested him. He suggested the topic of my dissertation. Originally it was supposed to be a study of the effects of education on health, but along the way he encouraged (some might say demanded) me to broaden it into a theoretical and empirical analysis of the demand for health.

My research has focused on economic models of the determinants of health, the economics of substance use and abuse, and the determinants of interest rates on tax-exempt hospital bonds. My recently completed studies deal with the effects of excise taxes on cigarette smoking by pregnant women, the relationship between substance use and risky sexual behavior by teenagers, the economics of obesity, and the effects of managed care on hospital prices for bypass surgery and for angioplasty. My current research deals with the

effects of the introduction of national health insurance and compulsory school reform in Taiwan on child health outcomes in that country. Clearly, health care reform is the issue that is attracting the most amount of attention from health economists at the present time. But I have conducted little past research on that topic, and my new projects focus on different issues: the effects of food prices and food advertising on body composition of children, moral hazard in less invasive surgical technology for coronary artery disease, and the impacts of insurance, outcomes, and severity on pricing of major cancer surgery.

I like to say that one of my hobbies is supervising Ph.D. dissertations --98 and counting. Seriously, that is the accomplishment that gives me the most satisfaction. I am very proud of the successful research and teaching careers of my former students. Currently, 17 of my former students are members of the National Bureau of Economic Research Health Economics Program that I direct, and they account for 20 percent of the 85 members of the program. ■

Classroom games are a great way to introduce economic concepts to students. Abstract concepts can be made more tangible, passive students can become more active in the class, and everyone in the room shares an experience that can be discussed in a group setting. Having used various classroom games in my microeconomic principles course to demonstrate concepts like price determination and the free rider problem, a few years back I became interested in finding a game I could use in my undergraduate health economics course. A colleague suggested I take a look at a game by Charles Holt and Roger Sherman on the lemons market. The game has students play the roles of buyers and sellers and trade a hypothetical product of varying quality to demonstrate how asymmetric information can lead high quality goods to disappear from the market. With some tweaking, I developed a game that worked for an insurance market. The lesson at the heart of the game is well-known to health economists: when buyers of insurance have varying risk levels and sellers of insurance cannot set premiums that reflect the individual buyer's risk, low risks will forego insurance. The game can also be used to illustrate the effects of state regulations on insurers and consumers; a more complicated decision-making part of the game can be used to illustrate what happens in markets where buyers and sellers have a choice of insurance plans that vary in their generosity. Here I describe how the game illustrates these points and my experiences with the game in the last few years. Interested readers can find the detailed instructions and record sheets in my article published in the *Southern Economics Journal's* "Targeting Teaching" column of October 2005.

### The Basic Setup

The simplest use of the game is to show how "bad risks drive out good risks," and this can be done in a 50-minute class. In the SEJ article, I refer to this as Part 1 of the game; in some semesters I have had only enough time to run this portion and it works well on its own. The design of the game shares traits common to market games. Basically, students are assigned to teams of buyers and sellers of insurance policies; buyers are provided with information on the value they get from purchasing a good, and sellers are told the cost of providing the good. Both groups are told that they earn money through exchange; for buyers earnings are the value minus the price paid; and for sellers, earnings equal the price received minus the cost. The twist in this game is that buyers in the market can vary. Some are high risk, and others are low, but I call these groups type 1 and type 2 respectively so that later students can talk about the sources behind buyer variation. The cost and the value of insurance depend on the buyer type, and thus buyer type factors into sellers' and buyers' earnings calculations.

At the start of the game, sellers can set prices differentially for the two types of buyers. Over several rounds of play, competition between sellers emerges, and they undercut each other's prices until their earnings are close to zero and insurance premiums are close to the cost. Once that happens, I introduce a change. As described in the SEJ article, I announce that the state legislature has just implemented a community rating regulation. I usually see sellers set prices equal to the average cost of type 1 and 2 buyers, assuming half the buyers are of each type. In that case, the policy is favorably priced for high risks and unfavorably priced for low risks, and when only high risks buy the policy, the insurer has negative earnings. It's pretty amusing to most students when a buyer who has purchased such a policy gets to reveal their type as high risk. The frustrated reaction of the seller in

question often promotes laughter in the room. All sellers soon realize that offer prices must equal high risk's costs. Thus, the game helps students see quite clearly how bad risks drive out good risks, and moreover, students can quantify the welfare losses associated with adverse selection, something that is usually fairly abstract to them. All can see that low risk buyers "suffer" because earnings they once experienced from buying insurance are no longer had when asymmetric information is present.

### The Extended Game

If you have more time, a second part of the game illustrates the adverse selection "death spiral," in which more generous insurance plans are no longer purchased in the marketplace when sellers are unable to set premiums at fair prices by buyer type. This is called Part 2 of the game in the SEJ article, and I have run parts 1 and 2 in one 75-minute class and held the discussion in the following class period. This portion of the game starts by having sellers announce four offer prices for insurance: premiums for a moderate plan for low risks and high risks, and premiums for a generous plan for low risks and high risks. Like the simpler version, sellers are given cost information and buyers are told the value of insurance; here, cost and value vary both by buyer type and by type of plan. In designing this part of the game, I used the same cost and value information provided in David Cutler and Richard Zeckhauser's 1997 chapter on the efficiency losses of adverse selection. After a few rounds, the game very nicely illustrates the efficient sorting of buyers to plans discussed by Cutler and Zeckhauser: high risk buyers will buy the generous plans and low risk buyers will buy the moderate plans. Prices typically converge to the cost of the plans.

The asymmetric information treatment is done with an announcement that two state regulations are imposed: community rating and limits on premium increases from the previous round. These changes essentially create really affordable moderate plans, and given the design of the game, it is better for high risks to purchase these moderate plans at low risk prices than to purchase generous plans at high risk prices. No one purchases the generous plan, and its "death" is instantaneous. I usually assign the Cutler and Zeckhauser chapter for reading, and discuss with my class how death spirals can twist in a more gradual way, as their case study data from Harvard illustrate.

### Experiences with the Game

A working paper version of the game has been available on my Department's website for the past few years, and according to EconPapers statistics, it has been downloaded more than 500 times, making it one of the more popular downloads in my Department.

My own experience suggests that students both enjoy the game and learn from it. I have used the game every spring in my Health Economics course for the last eight years. My class usually has 20 to 25 students so I break students into 4 buyer groups and 3 seller groups with 3 to 4 students in each group. You can make adjustments for larger or smaller classes and employ additional students as assistants in running the game (for example, they can collect, distribute, or record information). To increase student motivation, I sometimes offer a small prize (for example, a box of Girl Scout cookies) to the seller group with the

*(Continued on page 9)*

## Dear ASHEly,

*It's the first week of class and I cannot contain my excitement at seeing such promising students and the unfolding adventure of learning before us! We have a whole semester to share and I'm looking for advice on what I can possibly cut from the attached syllabus. I can't bear to leave anything out but there don't seem to be enough days to cover all the cool, neat things I love about health economics!!! Please help!*

*Crazy4Teaching*

### Dear Crazy4Teaching:

First of all, RELAX. You need to pace yourself. I mean, "unfolding adventure of learning"?? What are you on? If you get this hysterical at the start of every semester you'll burn-out in a few weeks. Don't get me wrong, I'm sympathetic to where you're coming from. Teaching can be one of the most rewarding aspects of what we academics do. But you need to remember that maybe one-in-a-thousand assistant professors will get promoted solely on the basis of good teaching. Moreover, few of us are capable of consistently generating high course evaluations and high quality scholarly output. (For those of you can do both, you know better than to be reading this.) You junior folks need to be selfish about your time and focus the marginal moments of time on the things that are *externally* rewarded. Oh, yeah, what to leave off your syllabus... Cut the international stuff. You can't really do it right in a lecture or two anyway.

### Dear ASHEly,

*It's week 11 and there is no end in sight. The classroom LCD projector keeps overheating and a virus has seized up my desktop computer. I have an abundance of unanswered e-mails and ungraded problem sets. The students abruptly break off an animated discussion featuring heavy use of the words "jerk" and "loser" when I walk into the classroom. I fear I've lost them. Help me please!!*

*Alone&Afraid*

### Dear Alone&Afraid:

First of all, RELAX. You need to pace yourself. If you get this hysterical at the end of every semester you'll burn-out in a few years. Don't get me wrong, I'm sympathetic to where you're coming from. Teaching can be one of the most frustrating aspects of what we academics do. Even the best of us have had one clinker semester/quarter, and sometimes many more. Trust me, it happens and it's not the end of the world. The important thing is not to let it dampen your research productivity (it's ok if it dampens your committee and service work). You need to remember that good research trumps bad teaching nearly every time. Try to focus on the positives: the term will be over soon; you'll probably never see these students again; maybe next time you teach you'll have fewer students!

## Biography Michael Morrissey

*(Continued from page 1)*

Steve Shortell admitted me into the "doctoral opportunities program," an interdisciplinary program from doctoral students from all over campus. I was the first health economist to be minted by the program. Frankly, I stayed because, after taking my first health services class, I could say to my econ office mate: "This field is so bad that even I can be good." The field has come a long way!

In 1979 I accepted a position with the American Hospital Association, preferring it to an offer from the much larger and better known AMA health policy research group. In retrospect, I hated that job. Strangely enough all sorts of other duties got in the way of doing research. Chicago was a crossroads for health economics, however. Jody Sindelar and I established a monthly health economics research brown bag seminar. It was a great group including David Dranove, Bill Lynk, and Bill Marder among others. The job also gave me an opportunity to work with great colleagues: Gail Jensen, Jeff Alexander and Frank Sloan.

We moved to the University of Alabama at Birmingham in 1985 largely due to the non-research elements of the AHA job and the Chicago winters. I took this offer because, as my wife says, "there were no shadows here." There was an opportunity to establish a new health econ research enterprise where none existed. Over the years we were able to assemble an excellent group of colleagues, many remain, and others like Aaron Stinnett, Bob Ohsfeldt, David Grabowski, and Vivian Ho have moved on.

My research interests have always been eclectic: hospital economics, organization and finance; employer-sponsored health insurance; regulation in health care; medical malpractice; motor vehicle fatalities; and most recently osteoporosis and fractures. The great thing about this career is that you can do something different every two years.

My involvement with ASHE has many antecedents: the Chicago health economics group, the founding of the Health Economics Interest Group at APHA, working with Tom Getzen in the formation of iHEA (and serving as its treasurer and secretary/treasurer) and the formation of the Southeastern Health Economics Study Group with David Bradford and our southern colleagues. ASHE is long overdue and I am delighted to be working with Dick Arnould and the Board. ■

## Finding Data to Study Physician Behavior by Andy Epstein *(Continued from page 1)*

In this column, I describe some existing sources of data for studying physician behavior. Data on physician behavior are collected mainly from two types of sources: administrative data systems that are intended to facilitate reimbursement, and direct surveys of physicians. I also cover sources of data on physician characteristics that may be linked in to add explanatory variables. Of course, my list is limited by my own knowledge, and I welcome tips on other sources not mentioned here.

An obvious place to start looking for administrative data is with insurers. Medicare, Medicaid and commercial insurers all collect data on physicians' reimbursable activities—office visits, diagnostic and surgical procedures and so on. There are a few issues to consider with these data. One is how to obtain them. For Medicare and Medicaid, you need to go through CMS, and a great place to start is with ResDAC (For more on ResDAC see our Spring 2009 newsletter and their website <http://www.resdac.umn.edu/>). Know, however, that CMS is bound by a federal privacy law that protects physicians' (and patients') identities and that custom data requests can be expensive. You might obtain commercial insurers' data from the firms themselves or from aggregators, such as Thompson Medstat and Ingenix. I have not yet been successful at prying data away from any insurers directly (although I'm aware of other researchers who have)—the trick here seems to be finding a research project of mutual interest and benefit. It is easier to obtain data from the aggregator firms, but usually requires money. Be wary of using commercial insurer data for studies of individual physicians: these data typically identify physicians using Tax ID numbers, which can belong to one, two or many physicians (e.g. a whole group practice) without any indication of which. Another issue is that, in most cases, data from any one payer will not cover the entirety of a physician's practice, and it is not possible to gauge the extent of the problem without additional data.

One fantastic Medicare-related data resource for cancer treatment is the SEER-Medicare linked database (<http://healthservices.cancer.gov/seermedicare>). These reasonably-priced (at least relative to typical CMS data requests) data include a set of patient demographic and clinical variables collected at the time patients join a cancer registry (through 2005 currently) and all associated Medicare FFS claims records (covering 1991 through 2007 currently). Although the cancer registries that contribute the patient denominator are geographically dispersed and ad hoc, they are scattered around the country and most are large enough to cover reasonably-sized markets. What makes these data particularly useful for studying physician behavior is that they include all types of Medicare claims (including physician office Part B claims) and encrypted unique physician identifiers (currently UPINs). Moreover, the National Cancer Institute has an arrangement with Medical Marketing Service (<http://www.mmslists.com>), a supplier of the American Medical Association's (AMA) Physician Masterfile, which allows researchers to

easily purchase (again at a reasonable price) and link in data on physician characteristics. Working with the SEER-Medicare data is straightforward (as far as claims data go); although some of the files are quite large, they are well-documented. Although these data do not track cancer patients who are not Medicare FFS beneficiaries and have not yet been linked to Medicare Part D, the SEER-Medicare data do offer comprehensive data on Medicare cancer patients treated by a large sample of physicians over a long time period.

One of my favorite sources of data on physician behavior is hospital discharge data. Unlike insurer-based data, these data consist of records for every patient hospitalized in a given state (with a few exceptions, such as federal hospitals). More recently, many states have been collecting comparable data for emergency department encounters and outpatient surgical visits. A great resource for hospital discharge data (and its cousins) is the Agency for Healthcare Research and Quality's Healthcare Cost and Utilization Project (HCUP) (<http://www.hcup-us.ahrq.gov/home.jsp>). Hospital discharge data generally include information on patient demographics, payer, clinical diagnoses and procedures, and most states have unique hospital identifiers that can be linked with hospital data from the American Hospital Association and Medicare. Most states also include geographic identifiers (usually down to the ZIP Code level) that can be used to link in other useful variables. Importantly, a few states also include identifiers (usually state license numbers) for the attending and operating physicians associated with each discharge. These include Florida, New York, Arizona, Pennsylvania, Virginia and Wisconsin. Arguably the best deal going for data like these is from Florida, which currently charges a mere \$100 per year of data for a complete set of statewide hospital discharge data (<http://www.floridahealthfinder.gov/Researchers/OrderData/order-data.shtml>) and has a very easy ordering process. Data from New York and Arizona are also fairly inexpensive, while the other three states mentioned have substantially higher prices. All of these states have physician identifiers in their data from at least the mid-1990s, enabling researchers to construct rather long panels. These data do have limitations. They contain no information on physician office visits or prescription drugs. The ability to risk-adjust for patient health conditions or to observe specific physician actions is constrained by their granularity. Also, obtaining data with unique patient identifiers (to track patients across hospitalizations) requires either extensive paperwork (New York) or more money (Pennsylvania and Virginia). One key to using these data successfully is to find a clinical condition that is treated exclusively in an inpatient setting (or an ambulatory surgical setting where such data are available). For such conditions, these data contain a census of hospitalized patients in a given state and consequently enable powerful studies of physician behavior.

*(Continued on next page)*

## Finding Data *Continued from page 7*

We are just starting to see the move toward electronic medical records (EMR) yield datasets for research that allegedly offer a quantum leap in detail over existing administrative data sources. I have no personal experience using these data (yet), and I'm not sure whether they will be useful for studying physician behavior (e.g., will they include physician identifiers?). Nonetheless, their potential is large enough to warrant a mention of two vendors I have seen at research meetings. Geisinger Health System, an integrated medical system based in Danville, PA, has spun-off its EMR resources into a stand-alone business called MedMining (<http://www.medmining.com>). GE Healthcare is also leveraging the EMR data it collects through its Centricity EMR product ([http://www.gehealthcare.com/usen/hit/products/centricity\\_practice/emr\\_index.html](http://www.gehealthcare.com/usen/hit/products/centricity_practice/emr_index.html)). My understanding is that neither of these is free, but both firms seemed interested in at least considering "partnering" with researchers.

Compared with administrative data, information collected on physician behavior from direct surveys is usually deeper (more information per physician) but narrower (fewer physicians). Unfortunately, the data from most surveys of physicians are kept private. There are a few excellent surveys, however, that are available to researchers broadly. The National Center for Health Statistics' (NCHS) National Ambulatory Medical Care Survey (NAMCS) (<http://www.cdc.gov/nchs/ahcd.htm>) is an annual national survey of what happens inside physicians' offices to specific patients. The survey collects records on a sample of patient visits (including patient demographics, health conditions and medical care services) and on characteristics of the physicians and their practice settings. One notable feature of these data is that they include information on prescribed medications. Moreover, these data are free, and downloadable directly from the NCHS website all the way back to 1973 (although the survey format has changed some over time). These data are limited in that they don't include many patients per physician respondent, the physician identifiers are scrambled, which prevents linkage with outside physician datasets, and the sampling strategy (along with the scrambled identifiers) precludes tracking physicians over time.

Another free and rich physician survey is the Center for Studying Health System Change's Community Tracking Study (CTS) Physician Survey (<http://www.hschange.org/index.cgi?data=04>). Whereas the NAMCS primarily covers actual treatment decisions made by physicians, the CTS Physician Survey asks physicians to describe aspects of their practice, including "their ability to obtain medical services for their patients, quality of care, information technology, financial incentives, care management, acceptance of new patients, provision of charity care, practice characteristics, income and career satisfaction." Like the NAMCS, the CTS Physician Survey is national in scope, and it comes in two flavors: a public version that is downloadable from the web, and a restricted use version that offers additional detail but requires additional effort to access. Although dated, a physician survey that is similar to the CTS Physician Survey is the Young Physicians Survey ([http://](http://www.icpsr.umich.edu/cocoon/ICPSR/STUDY/02829.xml)

[www.icpsr.umich.edu/cocoon/ICPSR/STUDY/02829.xml](http://www.icpsr.umich.edu/cocoon/ICPSR/STUDY/02829.xml)), which was conducted in 1987, 1991 and 1997 (the sample in 1997 was drawn from respondents in 1991) to collect data on physicians' practice arrangements.

Obtaining data to study physicians' prescribing behavior is particularly challenging. My impression is that the dataset academic researchers use most frequently to study this is the NAMCS. Because physicians in the United States generally do not get reimbursed specifically for writing prescriptions, insurer claims data may not be a reliable source for tracking prescribing by physicians. That being said, it appears that the Medicare Part D data that are being made available to researchers will include prescriber identifiers (<http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/Downloads/PDEDDataElements.pdf>). Additionally, data on physician prescribing patterns is available from the firms that collect and compile pharmacy transaction data, such as IMS Health and Wolters Kluwer Health. Both market data at the physician-level of quantities of specific medications filled by patients of these physicians stratified by time period (e.g., monthly) and payer type (e.g., cash, Medicaid, commercial, and, recently, Medicare). What these data generally do not include are patient-level variables. IMS Health has a specific group dedicated to academic research (e-mail: [academicaffairs@us.imshealth.com](mailto:academicaffairs@us.imshealth.com); they have a webpage too, but the URL is too onerous to show here) that I have found to be responsive. The future of these data is cloudy, however; recent court rulings appear to impede the ability of these firms to collect physician prescribing data, at least in Maine, New Hampshire and Vermont if not other states.

Data on physician behavior, particularly administrative data, tend to be limited in the amount of information they contain about physicians, such as demographics and training. In some cases, these datasets can be supplemented with other data on useful and interesting physician characteristics. The first place to look for data on physicians is the AMA Physician Masterfile, which includes information on all licensed physicians in the U.S.—not just those who are members of the AMA. This information includes birth date, gender, race, primary and secondary specialty, medical school(s) attended and year of graduation, residency and fellowship program(s) attended and date(s) of completion, and board certification status. Physicians' residency program information, which is reported directly from the programs, includes both residency type (e.g., psychiatry) and site (e.g., Massachusetts General Hospital). The file also contains information on training outside of the U.S. Researchers looking to obtain a subset of the Masterfile should go through one of the marketing firms that licenses the database for resale (<http://www.ama-assn.org/ama/pub/about-ama/physician-data-resources/ama-database-licensing/more-about-ama-database-licensing.shtml>). Besides supplementing data on physician behavior, the Masterfile is also the starting point in identifying a sampling frame for many surveys of physicians.

*(Continued on page 9)*

## Third Biennial ASHEcon Conference


Cornell University, Ithaca, NY

June 20-23, 2010

Important dates are now posted on the ASHEcon website for the ASHEcon conference to be held at Cornell University June 20-23, 2010. We urge you to get your abstracts and organized sessions in early. The two prior conferences have been rated very highly by those in attendance as a result of the quality of the papers presented and the ability to network with other health economists. Please note that the deadline dates are later than usual which means that these are hard deadlines. We look forward to your participation in this great event.

**Abstract/Session Submission Deadline:** January 15, 2010  
Program inclusion announcement: February 15, 2010  
Draft Program: February 28, 2010  
**Early Bird Deadline:** February 28, 2010  
Program Changes: April 30, 2010

For more details visit the ASHEcon website at: [Healtheconomics.us](http://Healtheconomics.us)

A photograph of a large, historic stone building with a prominent clock tower and a steeple, likely a Cornell University building. The scene is framed by autumn-colored leaves in the foreground. The word "ashe" is written in a large, red, cursive font on the left side of the image. Below it, the text "American Society of Health Economists" is written in white on a black background. Further down, the dates "JUNE 20-23, 2010" are printed. At the bottom left, there are logos and names of sponsors: "SPONSORED BY: COLLEGE OF HUMAN ECOLOGY DEPARTMENT OF POLICY ANALYSIS AND MANAGEMENT SLOAN PROGRAM IN HEALTH ADMINISTRATION" and "COSPONSORED BY: SYRACUSE UNIVERSITY AND UNIVERSITY OF ROCHESTER".

**ashe**  
American Society of Health Economists  
JUNE 20-23, 2010

SPONSORED BY:  
COLLEGE OF HUMAN ECOLOGY  
DEPARTMENT OF  
POLICY ANALYSIS  
AND MANAGEMENT

SLOAN PROGRAM IN  
HEALTH ADMINISTRATION

COSPONSORED BY  
SYRACUSE UNIVERSITY AND  
UNIVERSITY OF ROCHESTER

## HEALTH, HEALTHCARE and BEHAVIOR

JUNE 20-23, 2010 ITHACA, NEW YORK



Cornell University  
College of Human Ecology Sloan Program

## Fun and Games *Continued from page 5*

highest earnings and another to the buyer group with the highest earnings. Separate prizes are needed because the scale of earnings is so different across the two sides of the market. During the game, sellers often carefully discuss their pricing strategies, while buyers often become very invested in whether they are assigned type 1 or type 2 in a certain round. When it comes time to discuss the game in class, students are very willing to talk about their strategies and their earnings. Beyond making learning fun, the game also helps the lesson of adverse selection “stick” with the students. They often refer back to it in later discussions of insurance market failure, and the game often gets mentioned in their answers to essay questions on exams.

Outside of my own personal experiences, a few instructors at other institutions have shared their experiences with me. Dominic Hodgkin at Brandeis University successfully used the game in a class of 19 undergraduates in his Health Economics class, and he wrote that “both the discussion and the game went well, and several students commented that they enjoyed learning this way.” Julie Cullen at UC-San Diego wrote that the game “went really well – I only had time to run 4 rounds in 35 minutes, but got in 1 with imperfect information and already the low risk types were not served...(T)he students really seemed to enjoy it.” Melayne McInnes at South Carolina says “Jeff McCullough (now at U of Wisconsin) told me about using the game in classes with health professionals. I have had success with it in small Honors and larger, non-Honors undergraduate sections.”

If you are interested in sharing your experiences with me, feel free to email me at [jmmell@wm.edu](mailto:jmmell@wm.edu). The final version of the paper is available for download from the SEJ.

### References:

- Holt, Charles A., and Sherman, Roger. 1999. “Classroom Games: A Market for Lemons.” *Journal of Economic Perspectives*, 13 (1): 204-215.
- Mellor, Jennifer M. 2005. “Illustrating Adverse Selection in a Classroom Game.” *Southern Economic Journal*, 72 (2): 502-515.
- Cutler, David J., and Zeckhauser, Richard M. 1997. “Adverse Selection in Health Insurance.” In *Frontiers in Health Policy Research, Volume 1*, ed. Alan Garber. Cambridge, Massachusetts: The MIT Press, 1-31.

Jennifer M. Mellor is an Associate Professor of Economics and Director of the Schroeder Center for Health Policy at the College of William and Mary in Williamsburg, VA.

## Comments from the Executive Director

I have a few items I want to bring to your attention. Some will overlap the comments of your President, but we both feel they are of sufficient importance to be a bit repetitive. To put it mildly, things are happening in ASHEcon.

**First**, I want to publicly thank Editor Melayne and Coeditors Kosali and Tony for the great job they did on the last newsletter. I believe they have set a high standard of performance and I know that they will continue at this level.

**Second**, the ASHEcon Third Biennial Conference at Cornell University is coming up soon. This conference is sponsored by Cornell University and cosponsored by the Syracuse and Rochester Universities. The dates are June 20-23. Please get these on your calendars. You will soon be receiving information about the Scientific Committee. The dates of abstract submission are on page 9 and also on the ASHEcon website. The format of the meeting will be very similar to that of first and second meetings. The workshops will be held Sunday, with the formal meeting beginning Sunday evening with a plenary session and reception. Concurrent sessions will be held all day Monday and Tuesday and Wednesday until approximately 1:00 PM. The second plenary session will be late Tuesday afternoon, followed by an informal dinner. We think the venue and program are really shaping up. We expect this conference to meet the high standards established at Madison and Duke. However, this ultimately depends on your participation. We hope all of you plan to attend and participate, whether you are faculty or students, industry or government economists. Watch the ASHEcon web site for more information including announcements of important dates and deadlines.

**Third**, President Mike has included some information regarding our separation from iHEA and the resulting independent organization. I will provide a few more details. By the time you receive this newsletter, we will have completed application for ASHEcon, which already has status as a registered organization in the state of Illinois, to be a not for profit entity or 501c3. A formal separation from iHEA will occur as planned by the end of the 2010 year. As an independent organization ASHEcon needs an organization to manage membership activities, conference planning and operation, the ASHEcon web site, and other activities undertaken by ASHEcon. A special committee was appointed by the board to work with me to make a recommendation to the full board as to who this should be and how it should be done. That committee consisted of the past, current presidents and the president elect. After reviewing a number of possibilities, the choice was reduced to two organizations. We requested proposals from each organization which I followed with site visits. After a series of discussions the committee directed me to seek a formal contract with the management of the National Tax Association. I am very pleased with this decision. There are many similarities between the NTA and ASHEcon. Memberships are similar in numbers; they operate two conferences per year, neither as large as the biennial conference, but their larger conference is very similar in structure. We believe they are very capable of

handling the operations of ASHEcon and we believe we can afford their services. Hopefully the contract will be of a nature that is acceptable to the board.

**Fourth**, we hope all of you will become members or organization members. There are many benefits to being a member. Abstract submission fees and conference registration fees are considerably lower than for non members. Membership is necessary for all presenters of papers and posters. The Education Committee is soon to launch an interactive educational component to the ASHEcon website. That will component of the website will require membership for entry. Organization membership offers a variety of benefits probably the most important of which is the scholarships for students in organizations. Finally, the membership fees are very beneficial to the financial condition of ASHEcon. They are the major source of revenue in non conference years. The importance of this cannot be exaggerated as we become an independent organization, so if you are not a member please join soon. Information is readily available on the ASHEcon website.

**Fifth**, ASHEcon will be hosting a luncheon and reception and continue to plan the two iHEA sessions at the AEA meetings in Atlanta in January. Watch the website for details. As you can see, many things are happening with ASHEcon. The next few years are very important years in the development of ASHEcon. In addition to all of these other ongoing activities, we have applied for membership in the ASSA, which will give us our own sessions at the AEA meetings. Finally, with much of our energies going into the planning of the Cornell meeting, we do not forget that we will be at the University of Minnesota in 2012. We hope to see you in Atlanta and if not there, at Cornell. Regards,

*Dick Arnould*

## Finding Data *Continued from page 8*

If you're on a budget and want to verify a physician's identity or specialty, you can harvest information from public state licensure websites (e.g., <http://www.op.nysed.gov/opsearches.htm>) and physician profile websites (e.g., <http://www.nydoctorprofile.com>). At least one state, Florida, makes the underlying licensure database available for free download (e.g., <http://ww2.doh.state.fl.us/mqaservices/PublicServices.asp?Index=2>).

The licensure databases contain only very basic physician data but cover all physicians, while the profile sites contain more detailed information on a subset of physicians.

Although not as prevalent as data on, say, hospitals, there are some good sources of data on physician behavior, a few of which are free or inexpensive to acquire. Because physicians play such a central role in the delivery of medical care, I anticipate the availability of new data sources and increasing numbers of empirical studies addressing important economics issues related to physician behavior. ■

### References:

Pauly, Mark (1980). *Doctors and Their Workshops: Economic Models of Physician Behavior*. Chicago, IL: The University of Chicago Press.

Andy Epstein is an Assistant Professor at the Division of Health Policy and Administration, School of Public Health, Yale University.