ASHEcon
American Society of Health Economists

Newsletter of the
American Society of Health Economists

"ASHEcon is dedicated to promoting excellence in health economics research in the United States by providing a forum for emerging ideas and empirical results."

Volume 6, 2012

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Welcome Letter
Tony LoSasso

Greetings ASHEcon members!

It is an honor to write to you as the new executive director of your organization! As I embrace this handoff from Dick Arnould, I want to take a moment to thank him for the tireless work he did, much of it behind the scenes, to build ASHEcon into the thriving organization it is today. In our first years as an independent organization, Dick's exemplary stewardship and the leadership of an incredibly dedicated board have together given us a membership of 1000-strong and put our organization on a sound financial footing. Our membership base and solid finances will enable us to plan future successful conferences, starting with USC in 2014, as well as other initiatives of value to you, the members.

I want to emphasize this last point: our members are the lifeblood of our organization and my goal is to do my very best to serve you. My inbox is always open – tony@ashecon.org - and I urge you to contact me with your suggestions, compliments, or complaints to make our organization and its activities more valuable to you. Or just to say hello.

I am incredibly enthusiastic about the future of our organization. The field of health economics continues its remarkable ascent in the discipline. Interest in the field among graduate students is at an all-time high. More "mainstream" economists than ever are doing work on health-related topics. Indeed, you are unlikely to find a current issue of the AER or AEJ-Policy that doesn't contain a health economics article. Having attended many sessions and discussed probably too many papers (5) at our 4th biennial meeting last summer at the lovely University of Minnesota campus, I am convinced that the quality of the papers and posters continues to rise.

I hope to see many of you at the AEA meetings in San Diego at our ASHEcon luncheon on Friday January 4th, where we will see findings from the most

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Useful Data for Pharmaceutical Research - *by Jonathan Ketcham and William Encinosa*

So you're interested in conducting empirical research on the economics of the pharmaceutical industry? The standard advice to "consult your physician before starting" is good advice here, too. The data range from massive, widely-available datasets used by a large number of competing research teams down to small, custom-built datasets never seen by anyone but their creators. These data are rife with the Rumsfeldian known unknowns and unknown unknowns. In this column we provide a brief overview of these data to offer entry points for researchers seeking to initiate empirical studies of the pharmaceutical industry. Despite the hurdles that must be cleared, we are uniformly enthusiastic about the value of its contributions to health care policy and to economists working even outside of health care.

US claims data

We begin by discussing multi-payer, multi-pharmacy prescription drug claims data. The two largest source for these data for the US and globally are IMS and Source Healthcare Analytics (formerly Wolters Kluwer Health). The backbones of both companies' US data are claims data augmented by data from wholesalers to project up to nationwide totals. Both companies are actively engaged with academic researchers and offer a wide range of products. Within the US, these allow researchers to

- Evaluate total prescriptions, spending, and out-of-pocket spending across time and geographic areas for individual drugs and classes of drugs.

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Welcome Letter - Tony LoSasso
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recent survey of health economists by Mike Morrisey, John Cawley, and Kosali Simon, and at the joint iHEA/ASHEcon reception the evening of the 4th.

While we plan and work for a bright future for our organization I would like to leave you with a few principles that will guide us. We will grow not just for the sake of increasing our membership headcount; we'll grow because of our field's continuing reach and salience to both to the academy and to the policy world. We will be responsive to the needs of our members; if something doesn't work, we'll do our best to fix it. Above all we'll strive to provide true value to our members by providing the means to disseminate new research, make new connections, and continue the lifelong learning process.
Warm Regards,

Tony

Message from the Executive Director - *Dick Arnould*

We are now through another biennial conference. With your assistance and participation it was very successful. As you know, the conference was held June 10-13, 2012, at the Carlson School of Management on the campus of the University of Minnesota. Over 500 papers were presented orally and over 100 were presented in the poster session to the 750 people in attendance. Those who responded to the post conference evaluation questionnaire gave the conference a very high rating—82% rated it very good or excellent; another 14% rated it good. In fact, this conference was given ratings in virtually every category that are comparable to or exceeded the ratings of the earlier biennial conferences. The conference report will be out soon. A few loose ends remain. However, I am happy to report to you that the conference program and related activities were a great success, and it was a great financial success as well. This is very important because profits are necessary to provide funds to continue and expand the activities of ASHEcon between conferences, which includes planning future conferences. This is the last ASHEcon conference for which I will be involved in the planning. After the Third Biennial Conference at Cornell, I informed the Board of Directors that I did not wish to continue serving as the Executive Director of ASHEcon beyond the 4th Biennial conference in Minnesota. I agreed to stay on to finish activities related to that conference but will formally step down December 31, 2012. I am very happy that the Board has chosen my good friend, Tony LoSasso, to be the new Executive Director. I am also happy that he is taking over an association that has operated very successful conferences and other programs and now is financially successful. However, since I am stepping down at the end of year I believe this gives me license to reminisce about ASHEcon.

In 2002, Tom Getzen, Executive Director of the International Health Economics Association, and I had a discussion about the possibility of forming a domestic US association. Tom recognized that many countries already had health economics associations, but the US, with the largest contingent of health economists, had none. Tom and I decided that I should first determine the level of interest. After a meeting of a small group of health economists in San Francisco in 2003 and a somewhat larger meeting in San Diego in January of 2004, it was clear that there was substantial interest in forming a US association of health economists. With the help of many of you, we named the organization the American Society of Health Economists, proceeded to develop a mission statement, appointed members to the first board of directors, and I was asked to be the Executive Director. During the first few years, ASHEcon legally operated as a committee of iHEA. This permitted ASHEcon to have not-for-profit status.

From there to here is mostly very positive history with which all of you are familiar. The biennial conferences became the forums for health economics research, the stated mission of ASHEcon. The biennial conferences held at the University of Wisconsin (2006), Duke University (2008), and Cornell University (2010) were great successes. ASHEcon became a separate not-for-profit year end 2010, as had been planned years earlier. The conference at the University of Minnesota (2012) was the first ASHEcon managed as an independent organization. We are proud (and relieved) that the conference was a great success. And the annual luncheons at the ASSA meetings have been equally successful. These conferences and luncheons have and will continue to fulfill the mission of ASHEcon.

The success of ASHEcon is the result of the very strong support all of you have given to the organization and to me. When any assistance was needed someone always stepped forward. When financial support was needed many of you made donations to the Founders

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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.

Message from the Executive Director - *Continued from page 2*

Circle. These contributions greatly assisted ASHEcon in its first year of independent operation. I am happy to be stepping down at this time. I am proud of the state of the organization. I will not miss the long hours involved in planning the conferences, which I hope to continue to attend. What I will miss is working with you, the officers and members of the board, the chairs of the local conference committees who devote much time to planning conferences, and the members in general who have given so much to the establishment of ASHEcon. Thanks you for your participation and support.

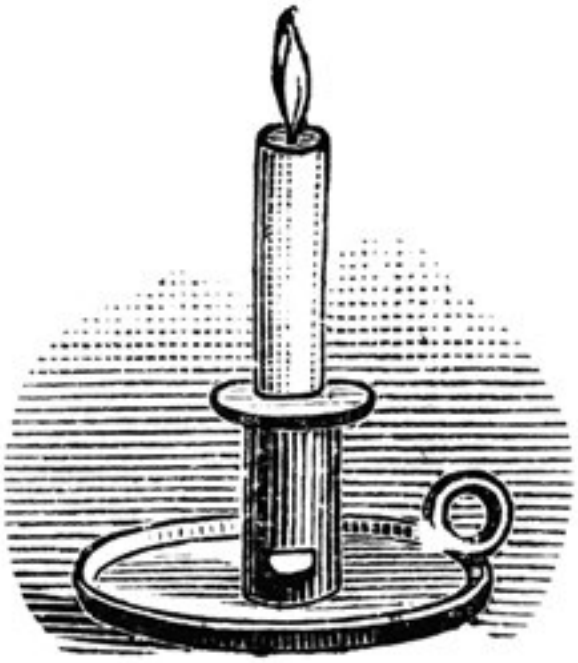
So in closing this reminiscence, that already has rambled on too long, I thank you for giving me the opportunity to play a role in starting ASHEcon and bringing it to the successful position it now commands. ASHEcon is now in a financial position to continue the ongoing biennial conferences, luncheons at the ASSA meetings, and also to think of new activities. I think Tony will do an excellent job taking ASHEcon to its next plateau. I wish him the most success.

Regards,

Dick Arnould

In Memory of Judith Shinogle

Judith Shinogle, Senior Research Scientist at Maryland Institute for Policy Analysis and Research, and Adjunct Associate Professor of Public Policy, University of Maryland Baltimore County, was tragically killed in an auto accident, May 20, 2012. Judy was a great friend to many of us, a close colleague to many, and a member and frequent volunteer to the American Society of Health Economists. She was scheduled to present a paper and serve as a discussant at the 4th Biennial Conference in Minnesota. Her death came as a shock to all of us who knew her. The Board of Directors of ASHEcon opened its June meeting with a moment of silence in her honor. In addition, those in attendance at the conference honored her life by standing for a moment of silence at the opening plenary. She touched many lives and will be greatly missed.



Finally, the Board of Directors of ASHEcon passed a resolution June 9, 2012, to collect funds to be added to a fund being generated at UMBC to support a scholarship in her honor.

I am happy to say that ASHEcon sent a check to the Judith Shinogle Memorial Fund for $1,475.

The note that follows is the gracious response we received from Judy's sister:

Dear Professor Arnould,

I am Judy Shinogle's younger sister. David Salkever recently shared with me the information about the generous gift collected at this past June's Minnesota conference. It was so meaningful to read how the people at the 2012 American Society of Health Economists Conference donated $1475 toward her UMBC Memorial Fund. If possible, please express our (my family's) gratitude to others who donated to Judy's fund and helped with the collection and distribution to UMBC.

We are finishing the final revisions of the MOU delineating our requests for how this fund will be used. I think it will be awarded sometime after next July for the first time.

As you may or may not know, Judy was a role model for me in so many ways. For example, when I was completing my dissertation, she provided a great deal of emotional and intellectual support. I am very grateful to her for guiding me in my life, and I am now integrating her spirit into both my personal and professional life.

With much appreciation,

Mary

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Long-Standing and Looming Litigation Issues in Biopharmaceutical Industries

by Ernst R. Berndt

Litigation has long been a highly visible phenomenon in US health care industries, and particularly so in biopharmaceuticals. Along with numerous other industrial organization economists (and even a few macroeconomists), in the mid-1990s I was introduced to biopharmaceutical pricing issues in the now legendary Brand Name Prescription Drug Litigation. A variety of retail pharmacy plaintiffs claimed violations of both the Sherman and Robinson-Patman Acts, alleging that brand drug companies conspired to avoid granting retailers discounts offered to health maintenance organizations. The entire November 1997 issue of the International Journal of the Economics of Business was devoted to discussions of the underlying "fascinating scientific and policy issues" (4(3): 237). Although many parties settled in the late 1990s, others continued to litigate. One of the last unsettled cases was resolved just recently on August 16, 2012 when a magistrate judge granted summary judgment, dismissing Robinson-Patman claims against five branded pharmaceutical companies alleged by independently owned retail pharmacies (Drug Mart Pharmacy Corp. v. American Home Products Corp., 2012 U.S. Dist. LEXIS 11582).

Although not (yet) as long-lived, another enduring biopharmaceutical pricing set of cases is the Pharmaceutical Industry Average Wholesale Price Litigation. Many of these cases were consolidated before Judge Patti B. Saris in the Massachusetts US District Court in the mid-2000s. Various plaintiff payers and benefit funds alleged they were misled and therefore overpaid for prescription pharmaceuticals because of the defendants' publication of the misnamed Average Wholesale Price, a list price that is not an average nor is it even a wholesale transaction price. Both plaintiffs and defendants have prevailed in various states' Medicaid v. brand and generic manufacturer cases involving self-administered tablet and capsule drugs, some settlements have occurred, various decisions are in the appeal process, and other trials are looming. One aspect of this case involved physician-administered drugs, such as cancer chemotherapies and musculoskeletal injections or infusions. With such drugs, the physician may buy the drug and then bill the insurer or patient, realizing a "spread" between the acquisition and reimbursed prices. Litigation has focused on the transparency of this spread, and whether its existence and magnitude have changed physicians' choice of treatment, potentially adversely affecting payers' costs and patients' health outcomes.

The most recent set of cases involving biopharmaceutical pricing matters concerns branded drug companies issuing coupons enabling consumers to reduce their copayment when filling a prescription. While copayment coupons have long been used by patent-protected brand drugs (particularly for the more costly biologic specialty drugs), the most recent incarnation involves copayment coupons issued by Pfizer for its statin drug Lipitor that lost patent protection on November 30, 2011 and faced limited 180-day competition from generics through May 2012. Although plaintiffs' claims are still evolving, one allegation is that while coupons reduce patients' direct acquisition costs, insurers' and payers' costs increase from their use, eventually resulting in higher drug insurance premiums for consumers. As numerous drugs lose patent protection in the near future, many likely facing limited 180-day generic competition, we can expect to see increased prevalence of coupon programs, and more of these issues being litigated.

Intellectual property issues are a common focus of biopharmaceutical litigation. Although few economists have sufficient life science or chemistry training to assess the validity of composition of matter patent claims involving the active pharmaceutical ingredient, patents have economic value, and the protection they afford inventors provides strong economic incentives to invest in R&D. Economists have offered testimony in intellectual property cases estimating damages to the patent holder should generic entry occur, whether any harm is irreparable, if the drug is commercially successful and if it is, whether its commercial success derives from a nexus with the claims made in the patent. Other litigated issues concern the value of patents held by firms involved in merger and acquisition activities, in transferring assets between divisions of multinational firms in non-arms length transactions, and royalty disputes.

A related body of litigation that raises pricing issues concerns settlement terms between brand and generic manufacturers when one or more of the brand's patents are challenged. Some settlements have the brand making a payment to the generic challenger, with the generic agreeing not to launch its product until some mutually agreed-upon date. Here the dispute is typically not between brand and generic. Rather, several consumer groups and governmental antitrust authorities allege this "reverse payment" or "pay for delay" agreement results in delayed generic entry, thereby delaying consumers' access to lower priced generics. Both brand and generic manufacturers dispute this, arguing that not only do such settlements save on litigation costs, but they can also result in generic entry occurring earlier than would otherwise be the case. In this context, a recent March 2012 Journal of Health Economics (31(2):312-39) article by

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Useful Data for Pharmaceutical Research - *by Jonathan Ketcham and William Encinosa*

Thank you to David Bradford and Sean Nicholson for organizing this symposium on the Economics of the Pharmaceutical Industry.

- Track patients over time as they fill and refill prescriptions.
- Track a given prescription over time as it is approved, rejected, reversed, or revised, e.g. due to prior approval requirements.
- Link an individuals' prescription drug claims with health insurance claims, for a subset of patients.

We leave it for individual researchers to talk with the representatives and determine which is best suited for the specific objectives of the study. These companies both have summary data on pharmaceutical sales over time from a number of other countries as well.

Several other sources of claims data exist that cover multiple payers and pharmacies. One used by researchers is the Truven Health Analytics MarketScan® Research Database, which has drug claims for close to 170 million patients with employer coverage between 1995 and 2012, linkable to inpatient, outpatient, and plan benefit data. Qualified PhD students can apply for free 2003-04 data at http://info.thomsonhealthcare.com/?elqPURLPage=241. A burgeoning source used in fewer publications to date are IT vendors with fully-functioning electronic medical records or more narrow pharmaceutical IT such as e-prescribing, electronic formularies and decision support (e.g., Allscripts). Researchers have also used claims and/or sales data collected by a single pharmacy chain or a single payer (e.g., CVS Caremark, Walgreens).

Government secondary data

Some state Medicaid agencies have made individual-level data available (e.g., California), while the State Utilization Data releases summary-level state Medicaid data, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Prescription-Drugs/Medicaid-Drug-Rebate-Program-Data.html. Unfortunately, no central source provides information on state formulary coverage and prior authorization requirements, requiring researchers to assemble such datasets on an ad hoc basis. Other state-level data include the prescription drug monitoring programs, e.g. to evaluate opiod abuse, although researchers' access to such data varies across states (http://www.deadiversion.usdoj.gov/faq/rx_monitor.htm).

Medicare drug claims data for Part D enrollees (but excluding Medicare Advantage data) are available and linkable to Part A and B claims, http://www.ccwdata.org/data-dictionaries/index.htm.
This link is important given that many drugs administered in the office or hospital (like chemotherapy, biologicals, infused drugs, etc.) are covered by Part B rather than Part D. For cancer, the Surveillance, Epidemiology and End Results (SEER) data can be used to link prescribing to more detailed clinical information not available in claims, like cancer stage. Finally, Veterans Affairs has a range of prescription drug data, including the Federal Supply Schedule that provides the government's contracted prices for individual drugs.

Individual/household surveys:

The government also has several surveys that include data on prescription drug use. Survey data facilitate tracking patients over multiple years and locations but for a far smaller sample than covered by claims data, particularly for less common drugs. The Medicare Current Beneficiary Survey (MCBS) has drug data but is known to have substantial underreporting, http://www.resdac.org/cms-data/file-family/Medicare-Current-Beneficiary-Survey-MCBS. The Medical Expenditure Panel Survey (MEPS), http://meps.ahrq.gov/mepsweb/, has less severe reporting biases; while respondents may under-report the number of different drugs taken, they have been shown to over-report the number of fills of each drug. MEPS can be used to make national estimates on drug utilization and expenditures, including the uninsured, a subset hard to capture elsewhere. Also, MEPS has several questions that ask the respondents why they may have delayed or forewent medications. Otherwise, unlike claims data, drug adherence is difficult to measure in surveys. The Health and Retirement Study (HRS), http://hrsonline.isr.umich.edu/index.php, asks questions on drug adherence, which then can be linked to wealth and asset variables in HRS. The National Home and Hospice Care Survey Data surveys home health and hospice facilities and has a medications file at the patient level, http://www.cdc.gov/nchs/nhhcs/nhhcs_questionnaires.htm.

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Useful Data for Pharmaceutical Research

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Similarly, the National Nursing Home Survey has a medications file, http://www.cdc.gov/nchs/nnhs/drug_database.htm. At the office visit level, the National Ambulatory Medical Care Survey (NAMCS) is one of the rare surveys that can be used to study physician prescribing behavior, http://www.cdc.gov/nchs/ahcd/ahcd_questionnaires.htm, although the availability of prescriber IDs in the Source and IMS data also allows for this.

Drug information

Economists interested in pharmaceuticals also benefit from acquiring some basic clinical knowledge. For example, to define markets, researchers must understand which drugs represent clinical substitutes by using some therapeutic classification system. Fortunately a number of resources are available. Classification systems include the World Health Organization's Anatomical Therapeutic Chemical (ATC) classification system and the Uniform System of Classification (USC) established by IMS and the Pharmaceutical Marketing Research Group.

Researchers have used two commercial products to acquire more information about specific drugs. These include First Data Bank and Cerner Multum. These databases include therapeutic classification systems, clinical information, drug vintage, and many other attributes. The Food and Drug Administration's Orange Book includes every drug's US approval dates.

Researchers interested in providing some insights to welfare from changes in drug utilization may benefit from accessing existing cost-effectiveness studies. One source for these is the Cochrane library (http://www.thecochranelibrary.com/view/0/index.html).

Industry information

A number of resources provide the institutional details needed by economists interested in policy and/or industrial organization. Information on drug manufacturers is available through their SEC filings on EDGAR, as well as through Damodaran online http://pages.stern.nyu.edu/~adamodar/. The industry itself releases information, such as on global research and development spending, through Pharmaceutical Research and Manufacturers of America (e.g., http://www.phrma.org/sites/default/files/159/phrma_industry_profile.pdf). The National Council for Prescription Drug Programs (NCPDP) provides information on every pharmacy's location and chain affiliation, http://www.ncpdp.org/. Trends in employers' prescription drug coverage are accessible through The Kaiser Family Foundation's (KFF) Employer Health Benefits Survey http://ehbs.kff.org/. Information on state-level legislative actions is available through the National Conference of State Legislatures (http://www.ncsl.org/issues-research/health/pharmaceuticals-facts-policies-and-ncsl-resources.aspx).

Promotion and advertising

Data on pharmaceutical promotion and advertising is limited. Most of the research on the effects of detailing has been done by surveying individual physicians about their experiences. IMS has some data on detailing efforts. The FDA tracks information on the provision of free samples but does not make this available to researchers. Patient-level information on receipt of samples is available in MEPS. Direct-to-consumer drug advertising expenditure data is available at the national and local market levels for many drugs (see http://kantarmediana.com/intelligence). Other sources of DTC data are homegrown, such as The Pharmaceutical Advertising (PhADS) laboratory at Cornell University.

A few known data limitations

Claims data, by definition, are missing the growing set of "pure cash" prescriptions available first through Wal-Mart and now through most major chains and grocery stores. As a result, researchers using

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Message from Frank Sloan

Since we only meet as a large group once every other year, I am glad to take this opportunity to communicate with our membership. Much of this communication will consist of questions to you, the members.

First, we had a successful meeting in Minneapolis, judged by several criteria. We have had a chance to read the evaluations of the conference. Although the evaluations were favorable on the whole, there were two areas that merit further attention. One is the poster sessions. We have not allocated a specific time for poster presenters to speak with conference participants. Would doing this represent an improvement even if this was at the cost of a plenary session?

Second, although the plenary sessions were rated favorably by most respondents, there were relatively few "fives," the highest potential score. And the highest scores went to Gruber-Parente "debate." This raises a general question about what conference participants expect. Do you find it more useful to have plenaries on specific topics, perhaps not as focused as a particular research paper, but more like a JEL article (of course, without all the references)? What about having plenary talks from persons who are not primarily members of the health economist community—economists or prominent non-economists? Do you have specific suggestions of persons (and topics) we should invite for this?

We have a continuing need to work on our membership rolls. Do you have specific suggestions of persons we should invite to become members? I would write the

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Long-Standing and Looming Litigation Issues in Biopharmaceutical Industries - *Continued from page 4*

C. Scott Hemphill and Bhaven N. Sampat finds that "evergreening" attempts by brand manufacturers aiming to extend patent term by claiming numerous additional patents on a drug have been essentially equally offset by generic firms' "prospecting", or hoping occasionally to strike gold when filing numerous patent challenges. They find that over the last decade in the US, this litigation "arms race" has led to a stalemate, with effective patent life having hardly changed at all – still about 12 years.

Another area with extensive litigation involves allegedly false and misleading marketing efforts. Although physicians in the US are allowed to prescribe drugs for conditions not approved by the Food and Drug Administration (called "off-label" uses), pharmaceutical manufacturers are prohibited from promoting off-label uses to prescribers. Health economists have offered testimony on linking the extent of off-label use to alleged inappropriate marketing, and the effects of such marketing on prescribers, patients, payers, and on the manufacturers' revenues and profits.

Finally, although their effects are likely greater on hospitals and physicians than on pharmaceutical firms, provisions of the 2010 Congressional health care reform legislation incentivizing providers to better coordinate and integrate health care appear to be fostering consolidation from small to larger multispecialty physician groups, between physician groups and hospitals, and among hospitals. While such consolidation may enhance coordinated care, it might also increase the local market power of physician groups and hospital networks, thereby leading to price increases. Notably, in June 2012 the Federal Trade Commission announced creation of a new position, Deputy Director for Health Care and Antitrust, and appointed to that new position ASHE member and Northwestern University Kellogg School faculty member Leemore Dafny. Stay tuned – you might get a call asking for expert advice!◆

Ernst R. Berndt is the Louis E. Seley Professor in Applied Economics at the MIT Sloan School of Management and a Research Associate at the National Bureau of Economic Research. He has served as an expert witness on behalf of various plaintiffs and defendants in the biopharmaceutical industry, and as an independent expert to the court.

Useful Data for Pharmaceutical Research *Continued from page 6*

claims data are faced with increasingly inaccurate estimates of an individual's total prescriptions filled. Likewise generally missing are data on patient rebates, which are growing, and always missing are rebates accrued by PBMs. Based on SEC filings we estimate such PBM rebates are approximately 14% of the gross price for branded drugs. As a result, research on prices is necessarily circumspect. A related challenge to economists is defining what the relevant price is from the many transactions underlying a single prescription filled. Finally, in many datasets and surveys it is often difficult to identify drugs administered in hospitals or physicians' offices; in a few cases they can be identified if HCPCS codes are reported.

Conclusion

The pharmaceutical industry presents opportunities for economists to study a wide range of broadly important, policy relevant topics. Researchers must be prepared to face a steep learning curve regarding institutional details, as well as large fixed costs in acquiring and managing data. We hope this column has provided some information to lower those fixed costs and promote greater research on these topics. ◆

Message from Frank Sloan *Continued from page 6*

person an invitation if you give me permission to do so. Are there economists who are not "card carrying health economists," but who do some research on a health economics topic whom we should invite to become a member?

Do you think there are a sufficient number of journal outlets for publishing health economics and related research, which are likely to be recognized by your employer (and/or colleagues) for purposes of evaluating your pay, promotion, and/or tenure? Finally, are you in favor of off year conferences on a specific topic or closely related topics? If you are in favor of off year conferences, which topics would interest you and if we had a conference on this topic, would you attend? The registration fee would need to cover most of the cost to ASHEcon but would be much less than the cost of registering for a regular conference.

Thanks!

A future message will summarize responses I receive from this newsletter's questions.

Best,

Frank

fsloan@duke.edu

Integrated Health Interview Series (IHIS): A Half Century of Free, Online, and Harmonized U.S. Health Data - *www.ihis.us*

The United States boasts the longest-running and most comprehensive health survey in the world: the National Health Interview Survey (NHIS). Covering almost every imaginable health topic, from AIDS testing to workplace hazards, NHIS microdata on health conditions, health care access and use, and health behaviors are available from the 1960s to the present. Representative of the U.S. non-institutionalized population, NHIS's large (approximately 100,000 persons per year) samples are a rich resource for tracking progress toward public health goals (such as Healthy People 2020), monitoring health disparities, and evaluating the effect of public policy (such as the Affordable Care Act). Yet, until very recently, NHIS public use data were under-utilized for studying long-term change; most researchers analyzed NHIS data from a single year. The scope of the material--saved in over 500 public use files, documented in thousands of pages of text per year, ensconced in tens of thousands of variables whose names, content, and codes changed over time--discouraged long-term analysis. Now, a free, online, consistently-coded version of NHIS data--the Integrated Health Interview Series (IHIS, at www.ihis.us)--lets researchers easily study U.S. health issues dynamically, across a half-century of dramatic change.

Funded by grants from the National Institutes of Health, IHIS offers the advantages of the IPUMS and other integrated datasets created at the Minnesota Population Center and used by over 60,000 researchers around the world. In IHIS, variables have consistent codes across time, without loss of information; a user-friendly website displays the topics available in each year; variable-specific documentation addresses comparability issues; the data extract system pools samples on the fly and allows analysts to download exactly the years and variables needed for their research projects.

IHIS currently provides over 12,000 integrated variables on health status and conditions, health care access and use, health behaviors, mortality status, and the sociodemographic characteristics of survey respondents. By the end of 2012, all household- and individual-level data available in the original NHIS public use files will be available through IHIS. Value-added features include the creation of easy-to-use summary variables, detailed user notes on appropriate methods, and modification of survey design variables to permit pooling data across time and sample design periods. Individualized help is available by e-mail to users who have questions or encounter problems.

The largest number of IHIS data users have been graduate students and faculty members in public health or a social science discipline. Economists lead the way among the social scientists, at 11% of all IHIS users. The most commonly reported product created using IHIS is an article, with theses and policy reports also common.

IHIS is well-suited to classroom use as well as individual research. While large numbers of advanced graduate students use IHIS for class assignments and theses, even undergraduates and new graduate students with no previous data analysis experience can frame and test hypotheses using the IHIS online tabulator. By Spring 2012, the website will post examples of classroom exercises using IHIS data and will highlight key variables (for example, those used to track Healthy People 2020 goals), so casual users are not overwhelmed by the amount of material. At the same time, sophisticated data users who build their careers upon health research will find a wealth of topics to study in depth--many of which fall under the rubric of health economics. And, best of all, the data are absolutely free! ◆

Miriam L. King, PhD
IHIS Project Manager
University of Minnesota

Don't forget the ASHEcon luncheon at the ASSA meeting January 4, 2013 in San Diego and the joint IHEA/ASHEcon reception that evening!

ASHEcon
American Society of Health Economists

The NIH Common Fund Health Economics Program

by Sarah Duffy

Early in his tenure as the Director of the National Institutes of Health (NIH), noted physician-geneticist Francis S. Collins, MD, PhD, cited health economics research as critical for efforts to improve health care while slowing the growth of cost. He indicated the need to go beyond clinical trials to understand such topics such as real-world health care delivery and payment incentives that will ultimately improve outcomes. He convened a distinguished group of physicians, and economists, psychologists to discuss opportunities for economics research to have a profound impact on health outcomes, and the NIH Common Fund Program in Health Economics was the result.

The Health Economics Program is one of 25 NIH Common Fund programs. Enacted into law by Congress through the 2006 NIH Reform Act, the NIH Common Fund is managed through the Office of Strategic Coordination in the Office of the Director's Division of Program Coordination, Planning, and Strategic Initiatives (DPCPSI). The Common Fund supports cross-cutting, trans-NIH programs that require participation by at least two NIH Institutes or Centers (ICs) or would otherwise benefit from strategic planning and coordination. Common Fund programs are expected to transform the way health research is conducted and are intended to be catalytic in nature. Although several NIH ICs fund health economics research, their research agendas typically focus on specific diseases or body systems. This focus can preclude funding research on topics that require studying providers or health care systems that treat a variety of diseases and conditions, such as the efficiency of health care production or the design and testing of innovative health care delivery strategies. The ability to conduct such research is critical at a time when public and private insurers, large employers, and various research and policy centers are rapidly devising new ways to structure, organize, and pay for treatment and preventive services. The Health Economics Program affords NIH the opportunity to fund such timely and high-impact research.

Dr. Richard Hodes, Director of the National Institute on Aging (NIA) and Dr. Thomas Insel, Director of the National Institute of Mental Health (NIMH), lead the implementation group, which is made up of representatives from the Office of the Director and 18 NIH Institutes and coordinated by Dr. John Haaga of NIA and Dr. Philip Wang of NIMH. The group collaborates to determine areas of study, hold meetings and workshops, write funding opportunity announcements, provide technical assistance to potential applicants, and make funding recommendations to Dr. James Anderson, the Director of DPCPSI. Initial review of the applications is conducted by NIH Center for Scientific Review in specially created study sections and secondary review by the national advisory councils of the relevant Institutes and Centers.

To date, the program has released six Requests for Applications (RFAs). The first four, which solicited research on the efficient delivery of effective health care services, the economics of prevention, the use of economic incentives to encourage the use of findings from comparative effectiveness research, and the market for long-term care insurance, have resulted in a total of 21 funded projects. Two other RFAs requested projects ancillary to health care delivery and financing pilots, demonstrations, and other experiments to increase the scientific yield from those efforts. Applications from those two RFAs are currently under review.

For more information, please visit the Health Economics Common Fund Web site at http://commonfund.nih.gov/healtheconomics/. ◆

The National Institute of Health, Mark O. Hatfield Clinical Research Center, in Bethesda, Maryland

Two new NIH Funding Opportunity Announcements that should interest many ASHEcon members:

RFA RM12-023 Diffusion of Medical Technology and Effects on Outcomes and Expenditures (U01)
http://grants.nih.gov/grants/guide/rfa-files/RFA-RM-12-023.html

RM-12-024 Determinants and Consequences of Personalized Health Care and Prevention (U01)--
http://grants.nih.gov/grants/guide/rfa-files/RFA-RM-12-024.html

For both, letters of intent are due **January 28, 2013** and applications are due **February 28, 2013.**
Both are also publicized on the website of the NIH Common Fund in health Economics:
http://commonfund.nih.gov/Healtheconomics/grants.aspx

Plenary Lectures from ASHEcon 2012 Conference Published in IJHCFE

Missed ASHEcon 2012 Conference, or want a re-cap of some of the invited lectures?

The International Journal of Health Care Finance and Economics (Volume 12, Number 3) recently published three of the invited lectures delivered at the 2012 ASHEcon meeting. The published lectures were delivered by Stephen Parente, Randall Ellis, and Mark Pauly at the conference. Topics covered range from the past and future of market based health care reform to thought-provoking, big picture questions for health economists to the state of competitive efficiency in private health insurance markets. If you attended ASHEcon, you know how interesting and informative these lectures were – the published versions may be particularly helpful for teaching purposes. If you missed ASHEcon 2012 Conference, these published lectures will give you a taste of what you missed – and an incentive to attend next time! ◆

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