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**DOCTORAL
STUDIES**

Massachusetts Institute of Technology (MIT)
PhD, Economics, Expected completion June 2014
DISSERTATION: "Essays on Health Care Economics and Productivity"

DISSERTATION COMMITTEE AND REFERENCES

Professor Amy Finkelstein
MIT Department of Economics
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Professor Michael Greenstone
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Professor Jonathan Gruber
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**PRIOR
EDUCATION**

Columbia University, *summa cum laude* (2003-2007)
BA, Economics (Departmental Honors)

CITIZENSHIP

United States

GENDER Male

FIELDS

Primary Fields: Public Finance, Health Economics
Secondary Field: Applied Econometrics

TEACHING EXPERIENCE	Principles of Economics (undergraduate) Teaching Assistant to Sunil Gulati, Columbia University	Spring 2006 - Spring 2007
RELEVANT POSITIONS	Research Assistant for Professor Amy Finkelstein, MIT Department of Economics and NBER Associate Economist, Federal Reserve Bank of New York Research Associate, Federal Reserve Bank of New York Research Assistant for Professor Raymond Fisman, Columbia University Graduate School of Business Research Assistant for Professors Alessandra Casella and Andrew Gelman, Columbia University Departments of Economics and Statistics	2009-Present 2008-2009 2007-2008 2005-2007 2006-2007
FELLOWSHIPS, HONORS, AND AWARDS	NBER Health and Aging Pre-Doctoral Fellowship George and Obie Shultz Research Support Grant (MIT) John Castle Graduate International Fellowship (MIT) Departmental Honors in Economics (Columbia University) Phi Beta Kappa (Columbia University) <i>Summa Cum Laude</i> (Columbia University)	2012-2014 2012 2009-2011 2007 2007 2007
PROFESSIONAL ACTIVITIES	Referee for <i>Journal of Public Economics</i> Webmaster of the MIT Graduate Economic Association (2010-2011)	
RESEARCH PAPERS	<p>“Technological Diffusion Across Hospitals: The Case of a Revenue-Generating Practice” (Job Market Paper)</p> <p>Productivity-raising technologies tend to diffuse slowly, particularly in the health care sector. To understand how incentives drive adoption, I study a technology that generates revenue for hospitals: the practice of submitting detailed documentation about patients. After a 2008 reform, hospitals were able to raise their total Medicare revenue over 2% by always specifying a patient’s type of heart failure. I find that hospitals only captured half of this revenue, indicating that large frictions impeded takeup. The key barrier is a principal-agent problem, since doctors supply the valuable information but are not paid for it. Exploiting the fact that many doctors practice at multiple hospitals, I find that approximately two-thirds of the dispersion in adoption reflects differences in the ability of hospitals to extract documentation from physicians. Adoption is also robustly correlated with the use of inexpensive survival-raising standards of care, suggesting that principal-agent problems drive disparities in quality more generally. These findings highlight the importance of agency conflicts in explaining variations in health care performance.</p>	

“Healthcare Exceptionalism? Productivity and Allocation in the U.S. Healthcare Sector” (with Amitabh Chandra, Amy Finkelstein, and Chad Syverson)

The conventional wisdom in health economics is that large differences in average productivity across hospitals are the result of idiosyncratic, institutional features of the healthcare sector which dull the role of market forces. Strikingly, however, we find that productivity dispersion in heart attack treatment across hospitals is, if anything, smaller than in narrowly defined manufacturing industries such as ready-mixed concrete. While this fact admits multiple interpretations, we also find evidence against the conventional wisdom that the healthcare sector does not operate like an industry subject to standard market forces. In particular, we find that hospitals that are more productive at treating heart attacks have higher market shares at a point in time and are more likely to expand over time. For example, a 10 percent increase in hospital productivity today is associated with about 4 percent more patients in 5 years. Taken together, these facts suggest that the healthcare sector may have more in common with “traditional” sectors than is often assumed.

**RESEARCH IN
PROGRESS**

“Do Incentives Affect Treatment Decisions in the Hospital? Evidence from a Medicare Reform”

When hospitals are paid more for certain treatment approaches, how much do their treatment decisions change? I exploit a Medicare reform that dramatically altered payment rates depending on whether patients were relatively healthy or sick. Looking at three treatment approaches for lung cancer patients, I demonstrate statistically and economically significant own-price elasticities and right-signed cross-price elasticities. Raising the payment for minor surgery by \$1000 would increase the surgery rate by about 10%, with marginal patients drawn about equally from major surgery and medical management. These findings suggest that payment reforms, including movements toward capitation and away from fee-for-service, may have large effects on the intensity of care that patients receive in the hospital.

“Private Managed Care or Public Insurance? Evidence on Cost and Quality from a Medicaid Policy Change”

Whether contracted private managed care organizations are higher quality or more efficient than public insurers is a major unresolved question in health care economics. To provide new evidence on this subject, I study individuals with disabilities who were covered by California’s Medicaid program. Over the course of a year, these individuals were automatically switched from the public fee-for-service system to private managed care organizations. A beneficiary’s switch date was based on his or her birthday, creating exogenous variation in exposure to private insurance. Exploiting this variation, I will compare indicators of quality, utilization, and fiscal cost between the public and private plans. Since people with disabilities tend to be especially reliant on medical care, this population is of particular policy interest.