The Schaeffer Center is focused on developing evidence-based solutions that will enable the healthcare system to deliver quality care—at the right time and in the right setting—at a cost that is affordable for families and our nation. The Center is committed to informing policymakers, healthcare stakeholders and the public about its research and recommendations in order to move our nation toward value in health for all.”

Leonard D. Schaeffer, Advisory Board Chair
The past few years have brought unprecedented challenges—of course COVID-19, but also the ongoing addiction crisis, a rapidly aging society, fiscal pressures, new drug pricing challenges and disparities in care exacerbated by the pandemic. The next few years will test policymakers in new ways as the nation implements the Inflation Reduction Act.

For more than a decade, policymakers and stakeholders have relied on the Schaeffer Center for evidence-based research and analysis that informs the debate. Congress, the Centers for Medicare & Medicaid Services, the Government Accountability Office, the White House, the National Institutes of Health and other government entities all rely on Schaeffer Center research.

In this year’s annual report, we frame our strategic approach using our policy impact cycle. Four interconnected steps guide us: identifying problems in the healthcare system, shaping the debate, designing policy solutions, and evaluating the effectiveness and consequences of reforms. At all steps, the Schaeffer Center is a vital and trusted resource for policymakers.

For example, our investigators have developed a portfolio of research illuminating the role of intermediaries in the pharmaceutical supply chain over the past seven years. Through research, white papers, events and op-eds, we examined the pharmaceutical distribution system’s inefficiencies and have shaped the debate surrounding potential reforms. Policymakers have taken notice, seeking testimony from our experts and citing our findings in their policy discussions.

Our research aims to foster medical progress while democratizing access. Biomedical innovation has brought new technologies and breakthrough cures for disease, helping many patients live higher quality lives. But the knowledge such progress requires has been skewed because of a lack of diversity in clinical trials. We are developing solutions to expand clinical trial recruitment, including through our partnership with the Alzheimer’s Therapeutic Research Institute to include historically underrepresented patient populations.

Schaeffer Center expertise also informs cannabis policies. This past year, two more states legalized recreational marijuana, making it legal for almost 50% of the U.S. population. But little attention is brought to the public health impacts of this trend. Schaeffer experts are evaluating these consequences—and national and international leaders are turning to them to help develop public health-minded regulation.

We are fortunate to have so many supporters of our mission. We are grateful to Leonard Schaeffer and his wife, Pamela, our Advisory Board, and the partnership with USC’s Price School of Public Policy and Mann School of Pharmacy and Pharmaceutical Sciences. Their support, and the excellence of our fellows, ensure that the Schaeffer Center is a beacon guiding policymakers toward better value in health and healthcare delivery.

Dana Goldman
Erin Trish
Co-Directors, USC Schaeffer Center

“Through research, white papers, events and op-eds, we examined the pharmaceutical distribution system’s inefficiencies and have shaped the debate surrounding potential reforms. Policymakers have taken notice, seeking testimony from our experts and citing our findings in their policy discussions.”

Erin Trish and Dana Goldman
The Schaeffer Center policy impact cycle illustrates four pathways that we leverage to inform policy discussions: identifying the problem, shaping the debate, designing policy solutions and evaluating outcomes.

The following sections feature examples of our research and impact in different stages of the cycle. Whether Schaeffer experts are putting new ideas into the public discourse or evaluating the outcomes of policy, through this cycle we can effectively transform the system and improve value in health.
Quantifying Failures in the Pharmaceutical Distribution System

Schaeffer Center scholars expose practices by intermediaries in the pharmaceutical distribution system that force patients to overpay for vital medications. Built over the past five years, this body of work has reordered priorities in the public debate.

While generic medicines are usually considered a bargain, a white paper co-authored by Erin Trish and Karen Van Nuys shows that patients are often overpaying for these inexpensive drugs. The researchers reveal how pharmacy benefit managers (PBMs), insurers and other intermediaries are costing patients, employers and the government 20% more than necessary.

These tactics include co-pay clawbacks, which pocket the difference when a patient’s co-payments exceed the drug’s cost to the insurer; spread pricing, when PBMs charge higher prices to health plans than the amount reimbursed to pharmacies; and formulary designs that favor branded drugs over generics.

The researchers estimate that such practices add up to billions in overpayment. Another study found that Medicare Part D plans paid $2.6 billion more in 2018 for 184 common generics compared with prices paid by cash-paying Costco members.

The generic market was jump-started as part of a federal deal granting branded drug manufacturers patent protection to incentivize new therapies. In exchange, once that patent expires, cheaper generic versions enter the marketplace. Therefore, such overcharges reflect a breakdown in the pharmaceutical innovation ecosystem.

“The same lack of transparency causing outrage over high and rising spending on branded drugs is also creating issues in the generic drug space,” Trish notes.

In addition to increasing transparency in transactions, the authors suggest ways to deter anticompetitive practices. PBM fees should be fixed per transaction, while employers and government purchasers deserve stronger auditing rights.

“If patients are being cheated on what are supposed to be inexpensive generic drugs, one wonders what must be happen ing in other parts of the healthcare market where profit margins are much higher,” Van Nuys says.

One of those is the market for insulin, needed by millions of Americans for diabetes—and for which out-of-pocket costs have more than doubled in the past decade.

An article by Van Nuys, Trish and Neeraj Sood again revealed the culpability of PBMs. While insulin manufacturers have granted increasingly large discounts to intermediaries, PBMs are pocketing these savings instead of passing them on to consumers.
The Federal Trade Commission cited these studies in its decision to probe PBM practices. In addition, the Schaeffer Center submitted formal comments to the agency on the topic.

Policymakers have taken note. Senators Maria Cantwell (D-Wash.) and Chuck Grassley (R-Iowa) introduced legislation aimed at promoting market transparency by stopping PBMs from hiding profits from health plans and pharmacies. It also targets spread pricing and co-pay clawbacks.

Eliminating Pharmacy Deserts

Pharmacies are increasingly vital locations for essential health services, yet an estimated 100 million Americans lack convenient access to one. Dima Qato coined the term “pharmacy desert” to call attention to the issue, which has become even more acute as many pharmacy chains limit hours and shutter locations nationwide. Since publishing her initial research, she has met with public health and policy officials across the country to discuss the issue and ways to solve it.

Her research reveals that predominately Black or Latino neighborhoods have fewer pharmacies than white or diverse neighborhoods, further contributing to persistent health disparities. To resolve this inequity, Qato suggests that policies should focus on pharmacy access and not just prices.

Increasing Medicaid and Medicare pharmacy reimbursement would help, her research indicates. Another possibility is revising the definition of Federally Qualified Health Centers to include pharmacies. She recommends that government agencies employ targeted grants and tax benefits to encourage pharmacies to open in under-served areas. Incentives could also be used to promote home-delivery services.

Lack of access also persists when it comes to emergency contraception, especially in the wake of the Supreme Court striking down Roe v. Wade. Qato finds that, even in Los Angeles County, only 10% of pharmacies offer pharmacist-prescribed preventive hormonal contraception. Dispensing mandates requiring pharmacists to provide contraceptive services to women and girls of all ages without identification would address this barrier.

Qato helped create an interactive map of every pharmacy location in the United States to show exactly which neighborhoods are pharmacy deserts. The mapping tool is part of a collaboration between USC and the National Community Pharmacists Association, which represents independent pharmacies across the country. The high-tech map may provide a framework to promote transparency and accountability—including in regulation of PBMs, which contribute to inequitable pharmacy reimbursement and pharmacy closures.
My colleagues and I have shown that [Netflix-style] subscription models can improve outcomes and save money at the same time. Compared to traditional fee-per-dose reimbursement, subscriptions can better balance the public health interest in gaining rapid, widespread and affordable access to these drugs, while assuring manufacturers generate enough revenues to justify the drugs’ development costs.

Dana Goldman

The researchers note that, while formulary restrictions can be appropriate, such policies should be continuously reviewed to ensure that patients have timely access to effective medications.

Prioritizing Value and Access in the Pricing Debate

As advances are made in treating Alzheimer’s and other devastating diseases, urgent need remains for fresh approaches that maximize access to new therapies without breaking budgets. Since our inception, the Schaeffer Center has devised innovative payment methods to align cost with value. For example, the life-threatening condition hepatitis C can be cured in more than 95% of patients—provided they receive leading-edge antiretroviral therapies instead of standard, less effective drugs. However, with treatment costs of up to $30,000, these drugs are usually denied to Medicaid beneficiaries. As demonstrated by research from Dana Goldman, Darius Lakdawalla, Karen Van Nuys and others, treating hepatitis C patients saves considerable long-term costs by preventing the disease from spreading and eliminating the need for even more expensive treatments as the condition worsens.

Goldman and colleagues developed a Netflix-style solution in which payers could “subscribe” or license hepatitis C drugs, thereby paying a drug company up front for medication for several years in exchange for unlimited access to treatment. Neeraj Sood later served on a National Academy of Sciences committee exploring the advantages of this pricing scheme. In the years since, policymakers have reached out to Schaeffer Center experts about the potential of this subscription model. Recent research led by William Padula highlights another solution in the form of partnering Medicaid with Medicare. The team evaluated Maryland’s “total coverage” proposal, through which the state receives a credit from Medicare to offset Medicaid investments in hepatitis C treatments. The researchers modeled the costs and benefits of different payment scenarios nationally and found that when Medicare chips in for Medicaid beneficiaries receiving hepatitis C drugs to offset the cost, savings can add up to nearly $1.1 billion over 25 years. Meanwhile, although the Food and Drug Administration has approved two new treatments for Alzheimer’s disease after decades of clinical trial failures, Schaeffer Center researchers found that current payment models pose challenges to patient access since costs may accrue sooner than benefits do. New payment approaches may be needed to address this difference in timing.

Using the Future Elderly Model to estimate the benefits of disease-modifying therapies for Alzheimer’s patients, Lakdawalla, Jakub Hlávka and colleagues have found that even in the least optimistic scenarios for efficacy, patients younger than 65 at the time of treatment benefit the most. Yet, standard payment models, which require a total up-front payment, have misaligned incentives for the payer. This is because most of the health benefits to these patients will accrue after they are in Medicare. New strategies, including installment payments that would be made over the course of the patient’s life, could encourage earlier access to these drugs, benefiting patients and society.
Shape the Debate:
Disseminate Data-Driven Research to Focus Attention

Expanding Access to Clinical Trials

While valuable treatments are available for diabetes, heart disease and hypertension, significant disparities in health outcomes and life expectancy still exist. Several factors contribute to such disparities, but lack of representation in clinical trials plays a significant role. Not only hampers understanding of the tested therapies’ effects on large portions of the population but also prevents many from benefiting from leading-edge treatments. According to analysis using the Schaeffer Center’s Future Elderly Model and led by Bryan Tysinger, eliminating just 1% of health disparities through improved diversity in clinical trials would result in hundreds of billions of dollars in gains for society. The analysis was a foundational element of the National Academies of Sciences, Engineering and Medicine committee report to advance enrollment of underrepresented populations in clinical studies. Dana Goldman served on the committee.

Instituting financial incentives to spur the industry to action—including tax credits, fast-track eligibility or extended market exclusivity—would help turn the problem around, wrote Goldman and two committee colleagues in a STAT “First Opinion.” Recruiting participants in clinical trials for Alzheimer’s is more challenging than other disease areas, hampering therapeutic progress to combat the condition. “The steepest barriers to more efficient Alzheimer’s clinical trials are those that are keeping potential volunteers from ever participating in the first place,” says Julie Ziesselmotzou, who co-authored a paper in Alzheimer’s & Dementia that identifies actionable and inclusive solutions to accelerate innovation in Alzheimer’s treatments. “Reducing these barriers to support progress on Alzheimer’s treatments—even modest progress—would have a profound impact on the communities affected by this disease.”

To spearhead and evaluate new methods of widening participation and accelerating trial times, the Schaeffer Center joined with USC’s Alzheimer’s Therapeutic Research Institute to establish the Clinical Trial Recruitment Lab (CTRL). “We suffer from two interconnected issues: the slow pace of trials and a lack of diversity,” Goldman says. “The Clinical Trial Recruitment Lab will address both of these issues and potentially transform pharma-ceutical and medical device development.” Launched with a $5.8 million grant from Gates Ventures and the American Heart Association, CTRL will be led by Goldman, Paul Aisen and Rema Raman. CTRL will launch pilot studies to test innovative, scalable strategies to minimize barriers that prevent patients from accessing clinical trials. It will also develop a fellowship program in partnership with Howard University’s Department of Economics.
“Medicare and private insurers pay for treatments for diabetes, heart disease and high blood pressure. If saving lives is the objective, then logic, clinical evidence and compassion dictate that they should also pay for preventing and treating obesity, starting now. … Not only does preventing obesity and obesity-related diseases eliminate unnecessary suffering and death, it also makes financial sense.”

Dana Goldman and Anand Parekh

Treating Obesity as a Disease

By 2030, nearly half of American adults will have obesity—a disease that already contributes to 300,000 deaths across the nation each year. While therapies are available, Medicare does not cover weight-loss treatments, and less than 10% of the privately insured have coverage. As a result, only 5% of eligible patients are prescribed anti-obesity medications.

This is particularly vexing because Schaeffer Center research demonstrates that treatments preventing or significantly reducing obesity would have significant value for patients and society. Our research has shown that obesity poses a bigger risk to public finances than smoking and that the lifetime consequences of obesity force Medicare to spend nearly 34% more on people with the condition than on those of lower weight. The personal toll is even higher, as obese people enjoy fewer disability-free life years and experience higher rates of diabetes, heart disease and stroke.

Stigmatizing people who have obesity does not help. An op-ed in The Hill by Dana Goldman and Anand Parekh, chief medical advisor for the Bipartisan Policy Center, observes that “the medical establishment spent nearly a quarter trillion dollars in 2020 treating conditions where obesity was a driving cause, but spent alarmingly little on preventing or treating obesity itself. Not only does preventing obesity and obesity-related diseases eliminate unnecessary suffering and death, it also makes financial sense.”

Lifting the limits Congress placed on Medicare coverage of obesity therapies—from which private insurers took their cue—would make a profound difference. “Currently, coverage is limited to behavioral counseling in primary care settings and weight-loss surgery for people with severe obesity and other related conditions—leaving most people with obesity with too few effective options,” Goldman and Parekh write.

“Medicare and private insurers pay for treatments for diabetes, heart disease and high blood pressure,” Goldman and Parekh note. “If saving lives is the objective, then logic, clinical evidence and compassion dictate that they should also pay for preventing and treating obesity, starting now.”

Policymakers are making strides to change Medicare reimbursement policy. The bipartisan Treat and Reduce Obesity Act would lift the restriction on FDA-approved prescription drugs for chronic weight management and allow coverage of weight-loss counseling from qualified specialists. Likewise, the Medical Nutrition Therapy Act would expand Medicare coverage to enable dietitians and nutritionists to address obesity. Currently, medical nutrition therapy services are covered only for patients with diabetes or kidney disease. Schaeffer Center research demonstrates that the true value of such interventions would ultimately lie in longer, healthier lives—benefits that could result in significant medical cost offsets as well as improved health.

Reforming the Dialysis Market

Fifteen percent of the U.S. population has chronic kidney disease. At its most severe, end-stage kidney disease (ESKD) requires patients to receive dialysis regularly or have a kidney transplant. According to the Centers for Disease Control and Prevention, some 750,000 Americans have ESKD, with more than 70% of that number needing regular dialysis treatment. Although dialysis is life-saving in the short term, five-year mortality rates still exceed 60%.
Eugene Lin and Erin Trish are helping shape the conversation among policymakers about dialysis costs, care and outcomes. Most patients with ESKD receive health insurance through Medicare, which provides coverage for patients with kidney failure regardless of age. However, a growing number are covered through private payers. In research published in *JAMA Internal Medicine*, Lin, Trish and colleagues found that monthly spending on ESKD-related outpatient dialysis services was three times higher in the individual market than through Medicare. This raises concerns that dialysis centers are steering patients into the individual market—and costing the healthcare system more in the process. “Such a large pay differential financially rewards dialysis facilities with more patients covered by the individual market,” Lin adds. “Facilities that encourage steering through subsidizing premiums would likely see a large increase in profits.”

Congresswoman Katie Porter (D-Calif.) cited the team’s research in a report calling for robust oversight of the dialysis industry. Since two large companies dominate that industry, Lin and Trish note that any effective oversight must grapple with the dialysis market’s heavy consolidation. This need became even greater when the 21st Century Cures Act allowed patients with kidney failure to enroll in Medicare Advantage, the private-sector alternative to traditional Medicare. Lin and Trish found that Medicare Advantage plans pay 27% more than Medicare for the median price of outpatient dialysis treatment. Without significant reforms to increase competition, such high markups will ultimately increase premiums and reduce benefits. Spurred by an increasing share of dialysis clinics being owned by nephrologists, Lin evaluated whether this conflict of interest impacted patient outcomes. He found that patients treated by physician-owners were more likely to receive home dialysis and less likely to receive expensive medications.

“Leaving out large portions of the population in these studies inevitably leads to disparities, because different populations exhibit different behaviors and experience different social determinants of health. By gathering this information, we hope to create precision public health interventions that meet individual needs rather than relying on our current one-size-fits-all approach.”

Ritika Chaturvedi

Average Monthly Cost of Outpatient Dialysis

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1,000 people are enrolled in A LiR, a nationally representative, comprehensive digital health dataset.
Setting Public Health Frameworks for Cannabis Regulation

Nearly half the nation allows adults to use cannabis recreationally, and all but 13 states have legalized it for medical purposes. Yet, no nationwide standards exist for quality or safety since cannabis remains prohibited at the federal level.

A white paper co-authored by Rosalie Liccardo Pacula and Seema Choksy Pessar highlights how the weakness of state-level cannabis regulations—especially when compared to other countries—leaves consumers at risk. In addition, industry innovation has not only increased the potency of cannabis products but has also outpaced state regulations and our knowledge of the drug’s health impacts.

We do, however, know that prolonged use of high-potency cannabis products is associated with numerous health issues, including short-term memory and coordination difficulties, impaired cognition, psychosis, anxiety and depression. Pacula also notes a rise in cannabis-related emergency department visits.

To better regulate legal cannabis markets and products, she and fellow researchers suggest four strategies for state and national lawmakers: limiting the amount of cannabis’ main intoxicant, THC, in products; restricting the amount of THC that can be sold in a single transaction; taxing products based on their potency; and implementing seed-to-sale data-tracking systems. Above all, Pacula urges such measures be implemented at the federal level to ensure that public health—and not just profit—is a market consideration.

Pacula’s research also closes gaps in knowledge about the use of medical cannabis. Most information about this has come from patients’ survey responses. But for research published in JAMA Network Open, she, Alexandra Kritikos and colleagues examined point-of-sale data from more than 80,000 purchases made between 2016 and 2019 as part of the New York state medical cannabis program. Cannabis flower and edibles were still barred from the medical market at that time, but other products were allowed.

The analysis found considerable variation in the products chosen for most medical conditions, as well as high variability in labeled doses of THC. This suggests a lack of consistent guidance from clinicians and pharmacists. The researchers also noted an absence of clinical data on appropriate dosing in numerous disease areas.

Combined with earlier research by Pacula showing that electronic medical records often underreport the number of medical cannabis users, this study suggests the need for improved medical guidance and oversight of dosing. “We suspect the lack of clinical guidelines on dosing of cannabinoids for
The cost of hospital-acquired infections has risen to nearly $48 billion annually.

10-milligram THC servings can be purchased in a single transaction in most states with recreational cannabis. By comparison, a keg provides 165 servings of beer.

500

47%

of Americans now live in a state with legal recreational cannabis.

“Allowing the industry to self-regulate in the U.S. has generated products that are more potent and diverse than in other countries and has led to a variety of youth-oriented products, including cannabis-infused ice cream, gummies and pot tarts. Current state regulations and public advisories are inadequate for protecting vulnerable populations who are more susceptible to addiction and other harm.”

Rosalie Liccardo Pacula

particular medical conditions has made medical providers uncomfortable talking to their patients about their medical cannabis use,” Pacula says.

As more states and countries legalize cannabis, U.S. and international policymakers are relying on Pacula’s expertise. Frequently quoted in the media about cannabis and addiction policy, she has presented her research before the United Nations Commission on Narcotic Drugs. The German government asked her to share her findings as that nation considers cannabis legalization, and officials working in Canada have reached out to her about implementing their cannabis laws.

Preventing Hospital Complications

Hospital-acquired conditions (HACs) such as adverse drug effects, infections and pressure injuries cost the U.S. nearly $48 billion annually. Avoidable complications affect more than 3.7 million patients every year. HACs are also the third-leading cause of death nationwide.

William Padula is a nationally recognized expert leading the charge to design policies that prevent these conditions from occurring in the first place, saving both lives and money. Although hospitals and the Centers for Medicare & Medicaid Services (CMS) have made progress in recent years toward reducing HACs, they are missing a chance for even greater impact. This is because hospital systems, in response to the threat of payment reductions from CMS, tend to create initiatives that treat issues as different and distinct. This leads to nurses and practitioners dividing the issue into too many parts rather than addressing it holistically.

As Padula, Dana Goldman and David Armstrong argue in an editorial for Mayo Clinic Proceedings, many HACs have overlapping risk factors. So a better way to prevent them is to focus on factors that overlap between outcomes—such as nutrition or mobility. To reduce complexity bias—the tendency to choose the most complex of two competing approaches—they write that CMS should consider rewarding health systems for good performance, rather than enforcing only punitive measures. They believe that hospitals that become designated as Centers of Excellence—that is, go beyond providing a baseline standard of care—would meet eligibility criteria for these reward-based payments.

Pressure injuries, a common but preventable HAC, affect approximately 2.5 million patients in the U.S., cost the healthcare system $26.8 billion and result in 60,000 deaths annually.

Padula’s findings have gained attention from federal policymakers and health system administrators. His checklist for pressure injury prevention was written into law as the standard of care for Veterans Affairs facilities nationwide in 2022.

Paying Attention to Medicare Part D Switching

Enabling beneficiaries to switch Medicare Part D plans through open enrollment is important not only because plan coverage changes over time, but also because people’s health and prescription needs evolve. Yet the option is only effective if consumers take action to modify their plans—and most beneficiaries do not. The resulting costs can be large.

Nobel Laureate Daniel McFadden and colleagues developed a data model to address the separate stages of attention and choice. In research published in American Economic Review, they used this model to characterize the inertia keeping people in plans even after better alternatives become available.

The team found lack of attention is an important reason for this inaction, but concerns about the costs of switching also play a role. Consumers pay attention to the
Converting Medicare Advantage (MA) to a competitive bidding system offers an opportunity to make the program more efficient and produce significant federal budgetary savings, potentially without shifting costs (on average) to beneficiaries. Greater program efficiency should be achievable by incentivizing MA organizations to compete on price for a standardized product, instead of competing primarily on benefit generosity. 

Paul Ginsburg, Erin Trish and Loren Adler

possibility of switching plans when they are triggered by potential financial consequences, mainly premium increases and exposure to a gap in coverage. Furthermore, attention seems to decrease with age and experience in Part D. McFadden’s data model is important for designing policies that ensure consumers are in the optimal Part D plan each year.

Reforming Medicare Payment Systems

With Medicare spending growth expected to exceed gross domestic product growth over the next decade, reform is drastically needed—especially with nearly 10,000 baby boomers aging into the program every day. Medicare Advantage offers the choice of receiving Medicare benefits through private health plans with the aim of promoting competition to lower costs and enhance care. The option is popular, with almost half of Medicare beneficiaries currently enrolled. However, it is costlier to the government than if these beneficiaries had remained in traditional Medicare. Medicare Advantage is flawed by a complex structure of bench-marking that results in excessive profits for plans, overly complex choices for consumers and uneven subsidization. In considering ways to enhance Medicare Advantage so it can remain viable, the Medicare Payment Advisory Commission (MedPAC) has taken up a solution proposed by the USC-Brookings Schaeffer Initiative for Health Policy. Paul Ginsburg, Erin Trish, Loren Adler and colleagues developed strategies that include standardizing Medicare Advantage offerings. They suggest replacing the current structure with a more efficient one that makes most Medicare Advantage insurance products uniform and revises the contracting process to truly spur price competition. Under the proposal, Medicare Advantage plans would offer three levels of benefits: standard, standard-plus and an enhanced benefits tier. MedPAC discussed the Schaeffer initiative proposal at a presentation on standardizing benefits held in September 2022. The discussion focused on applying the strategy to Medicare Part A and B services. Part A covers inpatient, nursing facility and nursing home care as well as hospices and home health. Part B covers preventive services and those deemed medically necessary. “The MedPAC, which advises Congress on Medicare issues, presentation represents the first time that the idea of a standard benefit design in Medicare Advantage has been taken up,” notes Ginsburg, who served as the commission’s founding executive director and as commissioner and vice chair from May 2016 to May 2022. “Although standardizing benefits was part of the competitive bidding proposals that the Schaeffer Initiative carried out with, our work also outlined the merits of standardization to increase competition among plans even under the current system of administered prices.” Meanwhile, Alice Chen presented a potential solution for reforming traditional Medicare at a meeting of the Physician-Focused Payment Model Technical Advisory Committee in Washington, D.C. The com-mittee cited her work in a recent report. Chen and colleagues propose reforming Medicare through a multitrack, population-based payment model that accommodates all types of providers. A white paper sketches out their blueprint for addressing key challenges of accountable care organization models, which should be flexible enough to accommodate side contracts with appropriate outside entities. The strategy would establish stronger participation incentives along with firm benchmarks in meeting long-term financial and clinical accountability. It would also advance health equity by using risk adjustments to allocate more resources to underserved and socially disadvantaged communities.

Paul Ginsburg
Evaluate Outcomes:
Measure the Costs, Benefits and Distributional Impact of Reform

Examining the Impact of the No Surprises Act

Informed by findings from the USC-Brookings Schaeffer Initiative for Health Policy, and implemented in January 2022, the No Surprises Act shields insured patients from excessive billing for numerous out-of-network medical services. Among the most common surprise-billing scenarios were emergency procedures performed by out-of-network specialists at in-network facilities—which patients could not have known about in advance. The act also established an independent dispute resolution process to determine appropriate reimbursement levels.

Between 2016 and 2022, Schaeffer Initiative experts authored 40 analyses on the subject, including journal articles, white papers and blog posts. Our researchers are now evaluating the law’s impact and consequences while crafting recommendations to protect patients from situations overlooked by the legislation.

Research co-authored by Erin Duffy and Erin Trish finds that the law could lower rates for emergency medicine procedures by reducing the bargaining power of hospitals and physician groups. The study, published in *JAMA Health Forum*, builds on previous research showing that negotiating leverage allowed emergency medicine providers and other specialists to charge significantly higher rates than other caregivers. These higher rates often applied to in-network services as well.

The researchers found that average out-of-network prices for emergency services before the No Surprises Act were 112% higher than qualifying payment amounts (QPAs), while in-network payments were 14% more. Self-funded employer plans were even more generous, allowing payments 120% higher than the QPA estimate for out-of-network care and 13% more for in-network services.

“There is a large body of literature that’s shown that emergency medicine providers and other types of specialists most likely to surprise bill were receiving significantly higher rates—even for in-network services provided—because of their outsized negotiating leverage,” Duffy says. “Our results suggest that using the qualifying payment amount to arbitrate out-of-network payment disputes will likely affect payment rates that insurers and affected clinicians negotiate for in-network services as well.”

Under the No Surprises Act, disputes between payers and providers are settled through arbitration. Duffy, Trish, Loren Adler and Benjamin Chartock evaluated trends in dispute resolution outcomes in Texas—a state that implemented a dispute resolution system in 2020—to understand which factors affected decisions. They find that decisions were largely anchored to the established median in-network allowed
According to a 2017 Health Affairs study of the No Surprises Act, the risk of a surprise bill was high.

- Of surveyed adults who said they initially wanted the COVID-19 vaccine reported that they no longer wanted it after they were passed over:
  - 16% said they no longer wanted the vaccine after being passed over.

“Before the No Surprises Act, several states enacted laws to prevent surprise bills but consumers were still vulnerable to harm from higher premiums. The economic evidence indicates that the No Surprises Act will help keep insurance premiums steady—or even lower them—without limiting patients’ access to in-network providers or reducing providers’ payments to below-market rates.”

Erin Trish

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amount, rather than a much higher alternative benchmark set at the 80th percentile of charges.

“If arbitration outcomes continue to follow the median in-network price benchmark, Texas’ law should result in significant savings to consumers not only by eliminating surprise bills but also by reducing cost-sharing and premiums,” Adler says.

“Prior to the No Surprises Act, some emergency physician groups leveraged a market failure to command high prices,” Trish notes. “This law helped address this market failure, which will not only protect patients from surprise bills, but may also help bring down emergency physician prices more broadly.”

Adler, Duffy, Trish and Ginsburg joined health policy experts from across the U.S. in submitting three amicus briefs that provided analysis and research on the issue of surprise bills and the No Surprises Act.

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“Does Working From Home Enhance Public Health?”

Even though many jobs must be done in person, working remotely has been on the rise since the COVID pandemic. Matthew Kahn, author of Going Remote: How the Flexible Work Economy Can Improve Our Lives and Our Cities, suggests that, instead of exacerbating disparities, this trend may lead to health benefits reaching beyond those able to work from home.

Workers who commute only two days a week could save an average of five hours weekly, opening up new opportunities for improving mental and physical health. Cutting down on commutes can reduce pollution while lessening people’s stress and giving them more personal time. Employees could also be more free to live where they want. Those with asthma, for example, could move to areas with cleaner air. More people moving also creates local service-sector jobs in towns where they relocate. However, Kahn cautions, area policymakers must ensure that living costs do not rise disproportionately for current residents.

Allowing staff to work from home could benefit companies as well, he notes. In addition to increased productivity stemming from employee well-being, better health among workers could result in lower health coverage costs. Kahn thus urges employers to support staff preferences for working at home whenever possible.

Rewriting the Pandemic Playbook

Directed by Neeraj Sood, the Schaeffer Center COVID-19 Initiative has fostered insights and strategies to not only mitigate the damage of COVID-19 but also prepare for future pandemics.

By early February 2022, COVID-19 had cost the U.S. 1 million excess lives. Analysis by Hanlie Heun-Johnson and Bryan Tyanger finds that the average person lost 13.5 years of life—a statistic that rose as the pandemic’s second year inflicted increased losses among younger adults. Despite widespread vaccine availability, adults under age 65 make up 56% of the 16 years lost.

Much of the early public health strategy hinged on minimizing infections, with the hope that the population would build up antibodies through vaccination or prior infection to help stop the virus from spreading. Research led by Sood shows that achieving herd immunity was unlikely. Published in JAMA Network Open, his study estimates that, in April 2021, 72% of adults in Los Angeles County had either been vaccinated or accumulated antibodies through past infection. Yet the county still experienced significant surges, while health disparities grew.

“Testing the symptomatic, ensuring access to new treatments and encouraging...”
Chronic pain itself remains a significant public health problem. But evidence suggests it is possible to reduce opioid use while managing pain and maintaining function and quality of life. The most effective way to curb opioid addiction is to start upstream with how opioids are being prescribed. Nudges can be a great way of changing behaviors.

Jason Doctor

Nudging to Improve Prescription Practices

Low-cost interventions developed by Jason Doctor to nudge physicians away from unnecessary prescribing continue to improve patient safety. Officials nationwide have contacted him about how to implement such nudges, which are now used by agencies in California, Kentucky, Maryland, Oregon and other states.

California law requires naloxone, an opioid overdose reversal drug, to be prescribed alongside opioids for at-risk patients. Doctor worked with Kaiser Permanente to evaluate its success in using best practice alerts to increase naloxone prescriptions and reduce medical opioid use. Whenever Kaiser Permanente physicians prescribe opioids, they receive on-screen nudges that explain the risks of opioid prescribing, remind them to order naloxone and offer safety recommendations.

The results, published in JAMA Network Open, show a 23% drop in opioid prescriptions and a 27% increase in naloxone prescriptions. Female physicians are more likely to adjust opioid prescribing compared with male peers, and younger physicians are likelier to change habits than their older counterparts. The researchers also found that primary care physicians changed their habits more than nonprimary care physicians.

Doctor has also worked to reduce opioid prescriptions through strategies such as sending letters to physicians whose patient suffers a fatal overdose. These letters, issued by a county medical examiner, also prompted the reduction of prescriptions for benzodiazepines. Benzodiazepines are commonly prescribed for conditions ranging from anxiety to sleep disorders, but can be deadly when combined with opioids, other prescription drugs or alcohol.

Doctor’s findings, published in JAMA Internal Medicine, show that the daily use of 2 mg doses of these drugs declined by 3.7% among physicians who received the letter compared to those who didn’t. Federal, state and local policymakers, and public health officials have reached out to Doctor about how to best implement these letters in their communities.

In response to new federal guidelines for prescribing opioids issued by the Centers for Disease Control and Prevention that allow physicians to ignore the previous recommended dosage ceiling, Doctor points to the need for a universal strategy for ensuring patient safety.

“To rectify this, Doctor suggests implement- ing a deprescribing plan before a physician prescribes opioids. The approach may also involve mental healthcare, community support and social services.

“A straightforward commitment to reduce opioid use, a specific set of recommenda- tions to get there and a network of support is the right prescription,” Doctor writes.
The Schaeffer Center pursues innovative solutions rooted in evidence-based research to measurably improve value in health. Our research programs feature portfolios in key priority areas to advance this mission.

Research Programs

**Aging and Cognition**

While the healthcare profession has achieved remarkable progress in lengthening life expectancy, these benefits bring considerable challenges—from Alzheimer’s and other age-related diseases to increased injuries, disabilities and poverty risks. Our Aging and Cognition program studies the fiscal and health consequences of our aging population, including race and ethnic differences between Alzheimer’s risk and use of prescriptions for chronic conditions. Policymakers rely on our research and modeling tools to improve the lives of older adults and keep people as healthy as possible throughout their lives.

Co-Directors: Mireille Jacobson, PhD, and Julie Zissimopoulos, PhD

**COVID-19 Initiative**

COVID-19 has cost millions of lives worldwide, overwhelmed healthcare systems, devastated economies and changed society for years to come. The Schaeffer Center quickly responded to the pandemic, launching studies working with local public health officials to understand the virus, how it spreads and how to mitigate harms. Our COVID-19 Initiative continues working to improve public health, develop analyses and strategies to ease damage from the pandemic, reveal COVID’s hidden costs, understand disparities in vaccination rates and leverage knowledge gained to better prepare for future pandemics.

Director: Neeraj Sood, PhD

**Behavioral Sciences**

We combine insights from psychology, economics and other social sciences to understand how people make decisions and apply that knowledge to find ways to steer clinicians and patients toward better choices. For example, our team has evaluated prescribing decisions related to antibiotics and opioids and developed nudges to inform prescribing behavior without reducing physician autonomy. During the COVID-19 pandemic, we looked at what was driving vaccine uptake and the use of protective behaviors to help public health professionals better communicate and develop more effective programs.

Co-Directors: Wändi Bruine de Bruin, MSc, PhD, and Jason Doctor, PhD

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Director: Neeraj Sood, PhD

**Healthcare Markets Initiative**

U.S. healthcare markets maintain many inefficiencies, resulting in both overdose and underuse of care. The challenge is developing appropriate incentives that eliminate the shortcomings that lead to some services being too expensive and reimbursements for others being too low. The Healthcare Markets Initiative advances market-based solutions to healthcare policy challenges in a variety of areas including rare diseases, medical devices and digital health. Our researchers analyze the most appropriate market incentives for motivating individuals and stakeholders to improve the functioning of the healthcare system.

Director: Matthew Kahn, PhD

**Health Policy Simulation**

Our Health Policy Simulation work has set the gold standard for researchers to effectively model future trends in health and longevity. The pioneering Future Elderly Model (FEM) models trends in health, functional status, health spending, pharmaceutical innovation, labor supply and earnings for individuals over age 50 in the U.S. Our team has created a global network of collaborators who are building out country-level FEM-based models in 20 countries. An extension of FEM, the Future Adult Model, models similar trends for individuals ages 15 to 50.

Director: Bryan Tjisering, PhD

**Population Health**

From combating the opioid crisis to eliminating pharmacy shortage areas to understanding the changing role of the emergency department, improving health starts at the community level. The Schaeffer Center conducts vital research aimed at reducing health disparities among the most underserved and vulnerable among us. Our investigators use high-tech mapping to help identify and eliminate pharmacy deserts in both rural and urban areas to ensure access to essential medications. Other experts are studying the impact of cannabis legalization on public health, as well as devising strategies to strengthen overdose prevention and analyzing policies designed to address addiction.

Director: Seth Seabury, PhD

**Value of Life Sciences Innovation**

Biomedical advances are at the forefront of transforming healthcare through innovations that benefit countless people. But as spending on new medications and devices increases, so do calls to rein in costs—which risks stunting medical discoveries essential to saving and improving lives. The Value of Life Sciences Innovation program exemplifies the Schaeffer Center’s focus on evidence-based analyses that encourage breakthroughs while developing pricing and reimbursement strategies that are focused on value to help ensure that patients have access to the therapies they need.

Executive Director: Karen Van Nuijs, PhD

**USC-Brookings Schaeffer Initiative**

The USC-Brookings Schaeffer Initiative for Health Policy unites the Schaeffer Center’s data and analytic strengths with Brookings Institution’s economic policy expertise. It unites the Schaeffer Center’s data and analytic strengths with Brookings Institution’s economic policy expertise. It aims to inform the national healthcare debate with rigorous analysis leading to practical recommendations. Initiative experts have played pivotal roles in major health policy debates, including the 2017 Affordable Care Act (ACA) repeal-and-replace debate and the issue of surprise billing and how to solve it. The Initiative currently focuses on implementing the No Surprises Act, Medicare and ACA Marketplace enrollment policies, drug pricing and mental health coverage.

Director: Richard G. Frank, PhD

**journal articles by Schaeffer Center experts since 2009**

**white papers published since 2017**
Insured patients have long endured financial strain from surprise medical bills stemming from receiving care from out-of-network providers they didn’t choose. Since the USC-Brookings Schaeffer Initiative for Health Policy’s launch in 2016, its experts—including Loren Adler, Erin Duffy, Paul Ginsburg, Matthew Fiedler and Erin Trish—have published research to shed light on the market failure that causes surprise billing and developed data-driven policy recommendations. Stakeholders, policymakers and journalists nationwide turned to the Initiative’s researchers to help define the problem and unpack the impact of proposed solutions.

**Identify the Problem**

Schaeffer Initiative experts showed that providers most likely to surprise bill garner contracted payment rates that are substantially higher compared to the rates other specialists receive relative to Medicare prices. To show how pervasive the practice is, the researchers analyzed settings where little prior data existed. For example, Duffy and colleagues found that 8% of episodes at in-network ambulatory surgery centers resulted in a potential surprise bill—and the average amount of that bill almost doubled between 2014 and 2017. A separate study found that 40% of air-ambulance rides resulted in a potential surprise bill. These higher rates impact more than the patient who receives the unexpected bill. They also add to overall healthcare spending. Schaeffer research found that if payments for these services were reduced, health insurance premiums could drop by up to 5.1%, amounting to savings of as much as $38 billion for those with private health insurance.

**Shape the Debate**

This research and analysis became the foundation of an evidence-based playbook and Schaeffer Initiative experts established themselves as an unbiased resource on this topic. Over the last seven years, they authored 12 journal articles and white papers and more than 20 op-eds and blog posts. They have been asked to testify at congressional hearings and have joined meetings of policymakers, staff members and analysts to discuss the problem and proposed solutions. The media have also turned to these experts as a trusted source, resulting in over 500 media mentions.

**Design Policy Solutions**

While everyone agreed that patients should be protected, how the market failure should be solved was unclear. Over the entirety of the debate, Schaeffer Initiative fellows analyzed a range of federal and state proposals to solve surprise billing, highlighting the benefits and shortcomings of various approaches. Multiple analyses helped draw attention to concerns that some arbitration-style approaches would lead to higher costs—and proposed solutions that might help mitigate these effects. For example, Initiative experts demonstrated that approaches taken by New York and New Jersey could actually increase healthcare prices. Many of these pieces contributed to the adoption of the No Surprises Act.

**Evaluate Outcomes**

The law, however, is not perfect. The Schaeffer Initiative has now turned to examining how the No Surprises Act is being implemented and calling attention to its gaps. For example, Initiative experts are evaluating the arbitration process between providers and insurers. “We need to understand how arbitration to resolve out-of-network billing disputes is working in practice,” Trish says. “It is important to protect patients, but we also need to avoid a solution that provides perverse incentives and ultimately increases spending.”

This includes remedying the omission of ground ambulances, which still leaves patients vulnerable to balance billing for certain emergency care. In response, Congress created the Advisory Committee on Ground Ambulance and Patient Billing (GAPB). Adler serves on GAPB, which is charged with making recommendations on how best to protect patients. The Schaeffer Initiative is also addressing a loophole that allows hospitals to be out of network, despite having a contract with the affected patient’s insurer, and permits higher cost-sharing rates. In addition, Initiative researchers have contributed expert briefs in litigation surrounding the No Surprises Act and are contributing strategies for improving the law’s arbitration processes. These extensive, far-reaching efforts aim to ensure that the No Surprises Act—and similar laws at the state level—succeeds in reducing healthcare costs and protecting patients from unexpected bills.
Data and Microsimulation

The Schaeffer Center’s microsimulation team and data core leverage the information and tools necessary to help answer significant questions in health policy with evidence-based solutions. The team—which includes programmers, microsimulation modelers, statisticians, analysts and a data resource administrator—has expertise in the methods and programming necessary to rigorously analyze big data. Schaeffer Center fellows and students rely on this team for support on a range of projects.

Data Core and Data Security
Data core programmers strive to develop best practices for data analysis and improve the quality and productivity of research by providing organized data resources, training and staff expertise. Schaeffer Center fellows and students rely on this team for support on a range of projects.

The data library maintained at the Schaeffer Center includes survey data, public and private claims, contextual data and electronic health network data feeds. The Schaeffer Center data core is a pioneering information resource and computing environment that meets exacting standards of excellence in data security. It manages a mix of security measures, from an air-gapped workstation to state-of-the-art, Health Insurance Portability and Accountability Act (HIPAA)-compliant systems that include 24/7 monitoring to ensure private health data resources are protected.

Health Policy Microsimulation
For more than a decade, the Schaeffer Center has been at the forefront of developing, pioneering, economic and demographic microsimulation tools to effectively model future trends in health and longevity and answer salient questions in health policy. The centerpiece effort is the well-validated Future Elderly Model (FEM), which projects a robust set of health and economic outcomes for the U.S. population age 50 and older. The FEM was originally set up to answer questions about the long-term economic viability of the Social Security and Medicare programs.

Schaeffer Center researchers have used the FEM to explore an increasingly wide variety of policy questions, ranging from the fiscal future of the U.S. to the role that biomedical innovation can play in future health outcomes and disease burdens. This includes some of the most pressing health issues of our time, including the COVID-19 pandemic, Alzheimer’s disease, obesity and diabetes. Furthermore, our investigators use the FEM to study issues across the life course, from adverse childhood experiences to challenges at the end of life.

The microsimulation team continues to build a global network of collaborators who are developing country-level FEM-based models in nations around the world. Twenty countries—including Mexico, Taiwan and Ireland—are part of this network, which is focused on modeling the costs and implications of Alzheimer’s disease and related dementias. This effort will allow researchers to compare demographic, health and economic trends on a global scale—and is especially important given that the number of individuals age 65 years and older is projected to double by 2050.

In research published in a special issue of Health Economics, investigators leveraged the FEM to forecast long-term trends in disease dynamics from 15 countries. Focusing on the consequences of policy and behavioral factors in healthy aging—including trends in chronic disease, education and behavioral factors like smoking—they produced forecasting models that can be used by policymakers and stakeholders. Researchers involved in the project include two winners of the Nobel prize in economics, Daniel McFadden and James Heckman. In total, eight papers were published as part of the special issue.

The FEM was also leveraged for a National Academy of Sciences report on diversity in clinical trials. The committee that authored the report relied on FEM projections to calculate the burden from lost life, increased disability and lost productivity arising from disparities in diabetes, heart disease and hypertension.

Models have also gone local, with simulations conducted for California and Los Angeles County to help policymakers at the state and county levels understand trends and the impact of policy decisions. Modelers are also evaluating urban-rural disparities and other demographic trends across the country.

Ultimately, the goal is to offer a tool to help policymakers weigh the pros and cons of potential policies using actual evidence about impact when deciding where to put resources. Findings using the FEM and Future Adult Model have been published in top journals and cited—or commissioned—by government agencies, the White House, the National Academies of Sciences, Engineering and Medicine, and private organizations interested in aging policy. In fact, President Biden’s Build Back Better plan cited two papers that used Schaeffer Center’s microsimulation modeling to project the benefits of early childhood education.

Data Partnerships and Collaborations
In addition to serving as a resource for Schaeffer Center researchers, the data core and microsimulation team partners with local, state, federal and international collaborators to develop data projects and models. Key collaborations include the National Academies of Sciences, Engineering and Medicine and the Los Angeles County Department of Public Health.
Financial Report

For fiscal year 2022 (July 1, 2021–June 30, 2022), the operating budget includes compensation for faculty, scholars and staff, programmatic expenses, and general operating costs. Faculty salaries covered by the schools are not included in these totals. Expenses by function are outlined in the graph below left.

In fiscal year 2022, the Schaeffer Center funded $55.6 million in operating expenses from $18.6 million in current revenue. University support does not include faculty salaries covered by the schools. Since its inception, the Schaeffer Center has raised $770 million, the majority from federal grants.

Conflict of Interest Policy

The USC Leonard D. Schaeffer Center for Health Policy & Economics conducts innovative, independent research that makes significant contributions to policy and health improvement. Center experts pursue a range of priority research areas focused on addressing problems within the health sphere. Donors may request that their funds be used to address a general research priority area, including:
- Improve the performance of healthcare markets
- Foster better pharmaceutical policy and regulation
- Increase value in healthcare delivery
- Improve health and reduce disparities throughout the life span

Schaeffer Center funding comes from a range of sources, including government entities, foundations, corporations, individuals and endowment. At all times, the independence and integrity of the research is paramount and the Center retains the right to publish all findings from its research activities. Funding sources are always disclosed. The Center does not conduct proprietary research. As is the case at many elite academic institutions, faculty associated with the Schaeffer Center are sought for their expertise by corporations, government entities and others. Those external activities (e.g., consulting) are governed by the USC Faculty Handbook and the university’s Conflict of Interest in Professional and Business Practices and Conflict of Interest in Research policies. All outside activities must be disclosed via the university’s online disclosure system, disclose, and faculty must adhere to all measures put in place to manage any appearance of conflict.

Supporters

Numerous public and private funders provide grants, gifts and sponsorships that help advance our work. Thank you!

Your generosity contributes to the work of the Schaeffer Center—from ground-breaking, multidisciplinary research to national conferences and fellowships—all of which helps us pursue innovative solutions to improve healthcare delivery, policies and outcomes.

The Schaeffer Center gratefully acknowledges the following fiscal year 2022 supporters:

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Blue Cross Blue Shield of Arizona
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California Association of Hospitals and Health Systems
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USC Dornsife Center for Economic and Social Research
USC Mann School of Pharmacy and Pharmaceutical Sciences
USC Price School of Public Policy
Utrecht University
Felix George Vladimir
Wake Forest University
Sharon Webb and Philip Lebherz
Elizabeth and Timothy Wright
Research Training Program

In partnership with the USC Mann School of Pharmacy and Pharmaceutical Sciences and USC Price School of Public Policy, the USC Schaeffer Center prepares the next generation of health policy researchers to bring innovation and expertise to higher education, government, healthcare and research institutions. The Center’s Research Training Program has developed a network of scholars from throughout the U.S.

National Institutes of Health-Funded Pilot Opportunities

USC Alzheimer’s Disease Resource Center for Minority Aging and Health Economics Research
Aiming to increase the number, diversity and academic success of junior faculty who are focusing their research on the health and economic well-being of minority elderly populations, the USC Alzheimer’s Disease Resource Center for Minority Aging and Health Economics Research has cultivated 30 early-career scholars since its launch in 2012. It is funded through a grant from the National Institute on Aging with additional support from the USC Office of the Provost, Price School of Public Policy, and Mann School of Pharmacy and Pharmaceutical Sciences. Collaborating centers include the USC Roybal Center for Behavioral Interventions in Aging, USC Edward R. Roybal Institute on Aging, USC Roybal Center for Financial Decision Making and Financial Independence in Old Age, USC Alzheimer Disease Research Center, and USC/UCLA Center on Biodemography and Population Health.

USC Center for Advancing Sociodemographic and Economic Study of Alzheimer’s Disease and Related Dementias
An interdisciplinary research center established through a partnership with the Schaeffer Center, University of Texas at Austin Population Research Center and Stanford Health Policy, the USC Center for Advancing Sociodemographic and Economic Study of Alzheimer’s Disease and Related Dementias (CeASES-ADRD) works to advance innovative social science research in Alzheimer’s disease and related dementias, increase and diversify the number of researchers working in the field, and disseminate findings for impact. Funded through the National Institutes of Health, this mission is accomplished through network meetings, workshops, pilot project support and the annual Science of ADRD for Social Scientists Program.

USC Roybal Center for Behavioral Interventions in Aging
By developing and testing interventions based on insights from behavioral science to promote healthy aging, the USC Roybal Center for Behavioral Interventions in Aging aims to strengthen the ability of clinicians to recommend the safest, most effective treatments for patients. The center conducts research that advances healthy aging for older adults who are economically insecure, culturally diverse and underserved by human services organizations. It funds pilot projects proposed by senior and junior researchers from academic and research institutions focused on the consequences of current patterns of practice and development of interventions that will improve care delivery, quality of care and value to aging adults.

Additional Opportunities

Price School Diversity Initiative for Visiting Distinguished Scholars
The USC Price School is partnering with historically black colleges and universities as part of a pilot program to promote research, engage diverse populations, provide mentorship opportunities, foster dialogue among faculty and students, and bring innovative work to our research centers. Scholars have the opportunity to partner with Schaeffer experts on issues related to health policy.

Clinical Fellowships
The clinical fellow program fosters collaboration between Schaeffer Center fellows and exceptional early-career scholars, clinical researchers and thought leaders. The program provides training and support for grants, papers and ongoing research projects.

Predoctoral Fellowships
Predoctoral students in related programs in the USC Mann School of Pharmacy and Pharmaceutical Sciences, USC Price School of Public Policy, and USC Dornsife College of Letters, Arts and Sciences conduct research under the guidance of a Schaeffer Center fellow, gaining knowledge and experience relevant to their doctoral program.

Postdoctoral Fellowships
Postdoctoral scholars working in aging-related areas who have received their PhDs from 2019 to present and are paired with a USC Schaeffer Center mentor and given resources to conduct a tailored research project. They receive one-on-one mentoring to support their individual research agendas and collaborate with other Schaeffer Center researchers.

USC Schaeffer Center Summer Internships
Each summer, the USC Schaeffer Center welcomes outstanding graduate, undergraduate and high school students to gain hands-on experience and mentorship in health policy research and data analysis as well as an introduction to the broader field of health economics through a three-week intensive internship program. Interns are paired with a USC Schaeffer Center mentor and given resources to conduct a tailored research project.

Research Assistantships
Students from relevant disciplines—such as economics, public policy, health policy, statistics, medicine and psychology—work directly with Schaeffer Center fellows on specific research projects, attaining valuable experience and skills to further their research proficiency. Through our programs, we develop innovators for positions in higher education, research, government and healthcare. Distinctions include:

• One-on-one mentorship and opportunities to collaborate with distinguished investigators in the field
• Dedicated, full-time administrative and data support at the USC Schaeffer Center, and access to university-wide educational and career-development resources
• Equipping trainees with sophisticated data-analysis tools and resources
• Numerous professional development opportunities, including support for grant writing, publication in peer-reviewed journals, and travel for attending and presenting at major conferences
• Assistance in securing influential positions in prestigious academic, public and private settings.

2022 Research Training Program Participants

• Postdoctoral Fellows
  - Boston (Brandeis University)
  - Boston (Harvard)
  - Chicago (University of Chicago)
  - Irvine, California (UC Irvine)
  - Warsaw, Poland (SwPS University)
  - Washington, D.C. (Howard)
• USC-AD RCMAR Scientists
  - Atlanta (Spelman)
  - Columbus, South Carolina (USC)
  - Los Angeles (USC)
• CeASE-ADRD Pilots
  - Los Angeles (RANH)
  - Los Angeles (USC)
  - Philadelphia (University of Pennsylvania)
• Roybal Center for Behavioral Interventions in Aging
  - Los Angeles (Altamed)
  - Los Angeles (USC)
  - San Diego (UC San Diego)
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  - Columbia, South Carolina (USC)
  - Los Angeles (USC)

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  - Los Angeles (USC)
Events and Seminars

Building a Modern Behavioral Crisis Response System: The Role of Federal Policy
January 10, 2022
Mental health crises are often new phenomena, but broad awareness about them, as well as the need for holistic and effective response services, is increasingly being prioritized by policymakers and communities across the country. The USC-Brookings Schaeffer Initiative for Health Policy brought together a panel of experts, moderated by Schaeffer Initiative Director Richard G. Frank, PhD, to discuss policy initiatives that can more effectively and humanely address mental health crises.

Panelists included:
Ayseko Delany-Brunson, PhD, director, Behavioral Health Division, The Council of State Governments, Justice Center
Kama Enomoto, MA, director of brain health, MetLife Health Institute
Cathleen Lundberg Drutman, JD, relied justice, Supreme Court of Ohio
Harr Swarzenski, JD, MPH, executive director, National Academy for State Health Policy
Vikki Wachtmeister, MPH, principal, Medcard Consulting LLC

Global Projections of Dementia: United States, Ireland, Japan and Mexico
March 9, 2022
Forecasting the health of populations is integral to setting evidence-based policies that improve population health, ensure high-quality care and advance equity. The Schaeffer Center held a seminar, moderated by Julie Zissimopoulos, PhD, co-director of the Center’s Aging and Cognition Program, on the projections of population-level cognitive impairment and dementia in the U.S., Japan, Ireland, and Mexico, with an expert panel discussing how simulation modeling can be used for projecting costs and health outcomes of new therapeutics for Alzheimer’s and related dementias.

Panelists included:
Kenny Eggleston, PhD, senior fellow, Freeman-Spogli Institute for International Studies, Stanford University
Hinke Han-Johnson, PhD, research scientist, USC Schaeffer Center
Peter Hoy, PhD, research assistant professor, Public Health & Primary Care and School of Nursing & Midwifery, Trinity College Dublin
Byron Syngar, PhD, director, Health Policy Microsimulation, USC Schaeffer Center

Wall Street Comes to Washington Healthcare Roundtable
April 13, 2022
The COVID-19 pandemic has profoundly disrupted American society—especially healthcare. The USC-Brookings Schaeffer Initiative hosted the 36th Wall Street Comes to Washington Healthcare Roundtable to bridge the worlds of Wall Street and Washington health policy. Schaeffer Center Senior Fellow Paul Ginsburg, PhD, moderated an expert panel of equity analysts to discuss market trends shaping the healthcare system and the impact of federal policies on healthcare companies.

Panelists included:
Ricky Goldwasser, MBA, managing director, Morgan Stanley
George Hill, managing director, Deutsche Bank
Ann Hynes, MBA, managing director, Mesirow

A Conversation on America’s Mental Health Crisis
June 3, 2022
The COVID-19 pandemic has fueled increasing concern about the state of Americans’ mental well-being. Digital advances, such as telemedicine, offer the promise of personalized and accessible care, but also raise questions about disparities and privacy. The Schaeffer Center and Price School of Public Policy hosted a conversation with Schaeffer Center Co-Director Dana Goldman, PhD, and David Ebersay, CEO and co-founder of Lyra Health, to discuss these trends.

Estimating the Value of Diagnosing and Treating Alzheimer’s Disease
May 9, 2022
Alzheimer’s disease is the seventh-leading cause of death in the United States and the most common cause of dementia among older adults—and its impact is only growing. The Schaeffer Center hosted a panel discussion, moderated by Peter J. Neumann, ScD, director of the Center for the Evaluation of Value and Risk in Health at Tufts Medical Center’s Institute for Clinical and Health Policy Studies, on the need for affordable diagnostic tests, the challenge of determining the size of the treatable, eligible population and how innovative payment models would help ensure that the healthcare system has ample capacity and resources.

Panelists included:
Johul Höök, PhD, fellow, USC Schaeffer Center
Soren Mattke, MD, DSc, research professor of economics, USC Dornsify College of Letters, Arts and Sciences
Yifan Xiu, MPH, PhD student, health economics, USC Price School of Public Policy, and Resources

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June 3, 2022
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Revising Payment to Medicare Advantage Plans to Reflect the Rapid Growth in Enrollment  
July 15, 2022

In recent years, Medicare Advantage (MA)—private health plans that beneficiaries can enroll in as an alternative to traditional Medicare—has grown rapidly. But this expansion has come with consequences. Basing payment on the experience of those who remain in traditional Medicare has proven challenging to pursue in a fiscally responsible manner. The USC-Brookings Schaeffer Initiative hosted a conversation moderated by Schaeffer Center Senior Fellow Paul Ginsburg, PhD, on the implications of the rapid growth in MA.

Panelists included:
- Matthew Flidler, PhD, fellow, USC-Brookings Schaeffer Initiative for Health Policy
- Clove Fields, MD, co-founder and chief medical officer, VillageMD
- Neena Sacharow, MD, PhD, assistant professor, director of the Center for Healthcare, Centers for Medicare & Medicaid Services
- Erin Trish, PhD, co-director, USC Schaeffer Center
- Goel R. Widdell, MD, senior fellow, Project HOPE

The Urgent Need for a New Generation of Antibiotics  
December 8, 2022

The Schaeffer Center and the USC Price School brought together public health experts to discuss how the development of new antimicrobials to replace antibiotics and other critical medications that are beginning to lose their effectiveness. The panel, moderated by Schaeffer Center Senior Fellow Neeraj Sood, PhD, examined incentives and policy solutions that could encourage innovation and accelerate development of these lifesaving medications.

Panelists included:
- Gennady Nesterov, PhD, nonresident fellow, USC Schaeffer Center
- Henry Skinner, PhD, MHA, executive director, ARM Action Now
- Brian Spellberg, MD, chief medical officer, Los Angeles County + USC Medical Center
- Amanda Seitz, senior fellow, Project HOPE

Making Behavioral Health Work  
December 13, 2022

In September 2022, the U.S. Department of Health and Human Services (HHS) released its Roadmap for Behavioral Health Integration, which sets out policies for better integration of mental health and substance use care into the larger health-care system. The USC-Brookings Schaeffer Initiative hosted HHS Secretary Xavier Becerra, JD, for a panel discussion led by Vikki Wachino, deputy administrator at the Center for Medicaid and CHIP Services, on federal efforts to advance the integration of behavioral health into healthcare.

Panelists included:
- Jameta Bordeaux, PhD, MPH, assistant professor of nursing, health policy and management, and women’s gender and sexuality studies, Georgia State University
- Karen Chor, former president, Project Lightning, Georgetown University
- Richard G. Frank, PhD, director, USC-Brookings Schaeffer Initiative for Health Policy
- Hsueh-Ming Lin, MD, PhD, professor of psychiatry, University of Maryland School of Medicine
- Andrea Palm, MSW, deputy secretary, U.S. Department of Health and Human Services

Seminar Series

Our Seminar Series features prominent academics, researchers, policymakers, and industry leaders discussing timely themes in health policy and economics. The seminars prioritize informal discussions with an audience. The 2022 seminars included the following featured speakers:


Sustaining Global Pharmaceutical Innovation and Access  
April 30, 2023

Hosted by the London Business School and the USC Schaeffer Center, this one-day symposium brought together more than 30 experts to discuss pharmaceutical innovation in a global context. Conversations centered around issues of global innovation, accelerating clinical trial development and rewarding value in global pharmaceutical markets. Funding for this conference was provided by the USC Schaeffer Center.

The Science of Alzheimer’s Disease and Related Dementias (ADRD) for Social Scientists Program  
October 27–28, 2023

Los Angeles

This conference provided an opportunity for social science researchers to learn the biomedical and clinical foundations of ADRD, advance interdisciplinary collaborations and promote data sharing. Twelve globally recognized experts provided scientific lectures geared specifically toward social scientists. Forty-two social scientists at all career stages representing 25 institutions attended the conference. Participant fields of expertise included economics, sociology and gerontology. Funding for this conference was provided by the USC Schaeffer Center.

Revisiting the Role of U.S. Hospitals in the Age of COVID and Beyond  
November 1–2, 2022

Washington, D.C.

In the years leading up to the pandemic, financial pressures on hospitals required many to shrink, merge or even close. This was coupled with longstanding trends to rethink healthcare delivery. Throughout the pandemic, hospitals demonstrated their dedication and resilience, but balancing competing needs has been an unprecedented challenge. The Aspen Institute’s Health, Medicine & Society Program and the USC Schaeffer Center formed an advisory panel to consider the future role of hospitals beyond the COVID pandemic. Over two days, the panel met to propose policy recommendations that support the evolving role of hospitals in providing efficient, equitable and high-quality care across populations, disease states and public health emergencies.

Curing What Ails Healthcare Markets  
November 30–December 1, 2022

Los Angeles

A distinguished group of policymakers, academics and healthcare leaders convened to consider the long-term policy issues that impact healthcare markets and ways to make those markets more efficient. Over the course of two days, the group discussed a variety of topics, including the future of value-based pricing in the U.S., the federal government’s role in accelerating or decelerating innovation, and how emerging health technologies can improve or worsen equity. Funding for this conference was provided by the USC Schaeffer Center.
National Academies Participation

Mireilla Jacobson
Review of the Department of Veterans Affairs Monograph on Health Economic Effects of Service Dogs for Veterans with Post-Traumatic Stress Disorder, National Academy of Sciences, Engineering and Medicine

Darius Lakdawalla
Addressing Visceral Fat Disease: A Strategic Plan and Blueprint for Action, National Academies of Sciences, Engineering and Medicine

Rosalie Liccari Pacula
Technical Expert Committee on Public Health Risks Associated with Cannabis Use and Cannabis-Related Disorders, World Health Organization, Review of Specific Programs in the Comprehensive Addiction and Recovery Act, National Academies of Sciences, Engineering and Medicine

Neeraj Sood
Community Wastewater-Based Infectious Disease Surveillance, National Academies of Sciences, Engineering and Medicine

Julie Zissimopoulos
2020 Alzheimer’s Disease-Related Dementias Summit Sub-Committee, National Institute of Neurological Disorders and Stroke, Committee on Developing a Behavioral and Social Science Research Agenda on Alzheimer’s Disease and Alzheimer’s Disease-Related Dementias, National Academies of Sciences, Engineering and Medicine

Federally Funded Centers

Center for Advancing Sociodemographic and Economic Study of Alzheimer’s Disease National Institute on Aging

Minority Aging Health Economics Research Center National Institute on Aging

RAND-USC Schaeffer Opioid Policy Tools and Information Center National Institute on Drug Abuse

Royal Center for Behavioral Interventions in Aging National Institute on Aging

Select Committee Participation (Including Non-Academy Committees)

Emma Aguilá
Understanding the Aging Workforce and Employment at Older Ages, National Academies of Sciences, Engineering and Medicine, National Advisory Council on Innovation, Health and Health Disparities, National Institute on Minority Health and Health Disparities

Wândi Bruine de Bruin
Respiratory Protection for the Public and Workers Without Respiratory Protection Programs at Their Workplaces, National Academies of Sciences, Engineering and Medicine

Paul Ginsburg
Committee on Emergence Science, Technology and Innovation in Health and Medicine, National Academy of Medicine, Medicare Payment Advisory Commission

National Academy of Medicine

Eileen Crimmins
Elected 2012
Paul Ginsburg
Elected 2011
Dana Goldman
Elected 2009
Leonard Schaeffer
Elected 1997

Elected 2016
Eileen Crimmins

Elected 1997
Leonard Schaeffer

Elected 2009
Dana Goldman

Elected 1997
Leonard Schaeffer

Elected 1981
Daniel McFadden

Elected 1997
Leonard Schaeffer

Elected 1997
Leonard Schaeffer

Elected 1997
Leonard Schaeffer

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Director of Health Policy, USC Schaeffer Center, Associate Professor and Chair, Department of Pharmaceutical and Health Economics, USC Mann School of Pharmacy and Pharmaceutical Sciences

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Michael B. Nigel, PhD
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Rosalie Liccari Pacula, PhD
Elizabeth Garman Chair in Health Policy, Economics and Law and Professor, USC Price School of Public Policy

Vasilios Papadopoulos, DPharm, PhD, Dsc (Non)
Dean, John A. and Tinaplen Dean’s Chair in Pharmaceutical Sciences and Professor of Pharmacology and Pharmaceutical Sciences, USC Mann School of Pharmacy and Pharmaceutical Sciences

Dima M. Qato, PharmD, MPH
Hygia Centennial Chair and Associate Professor, USC Mann School of Pharmacy and Pharmaceutical Sciences

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Neeraj Sood, PhD
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John Stoffel, MBA, MPH, RPh
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Director, USC/GEF Stem Cell Center for Self-Reported Science, Professor, USC Dornsife College of Letters, Arts and Sciences

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Karen Mulligan, PhD  
Research Assistant Professor, USC Price School of Public Policy

William Padula, PhD  
Assistant Professor, USC Mann School of Pharmacy and Pharmaceutical Sciences

Sze-chuan Suen, PhD  
Assistant Professor, USC Viterbi School of Engineering

Bryan Tysinger, PhD  
Director, Health Policy Microsimulation, USC Schaeffer Center, Research Assistant, USC Price School of Public Policy

Karen Van Nus, PhD  
Executive Director, Value of Life Sciences Innovation Program, USC Schaeffer Center

Distinguished Fellows

Sir Angus Deaton, PhD  
Presidential Professor of Economics, Princeton University

Vic Fuchs, PhD  
James J. Heckman, PhD  
Presidential Professor of Economics, University of Chicago

Karen Van Nus, PhD  
President and CEO, National Pharmaceutical Council; Former Senior Advisor to the Secretary of Health and Human Services
About the USC Mann School

USC Mann School of Pharmacy and Pharmaceutical Sciences
One of the top pharmacy schools nationwide and the highest-ranked private pharmacy school, the USC Mann School of Pharmacy and Pharmaceutical Sciences continues its century-old reputation for innovative programming, practice and collaboration. Founded in 1905 as the USC College of Pharmacy, the school was known as the USC School of Pharmacy from the mid-20th century until 2022, when it received a $50 million endowment and was renamed on behalf of inventor and entrepreneur Alfred E. Mann.

The school created the nation’s first Doctor of Pharmacy program, the first clinical pharmacy program and clerkships, the first doctorates in pharmaceutical economics and regulatory science, and the first PharmD/MBA dual-degree program, among other innovations in education, research and practice. The USC Mann School is the only private pharmacy school on a major health sciences campus, which facilitates partnerships with other health professionals as well as new breakthroughs in care. Uniquely, it owns and operates four pharmacies with a fifth coming in early 2024. The school is home to the D. K. Kim International Center for Regulatory Science at USC, the Titus Center for Medication Safety and Population Health, and the Center for Quantitative Drug and Disease Modeling, and is a partner in the USC Leonard D. Schaeffer Center for Health Policy & Economics, the USC Institute for Addictions Science, the USC Ginsburg Institute for Biomedical Therapeutics, the Southern California Clinical and Translational Science Institute, and the USC Center for Drug Discovery, Delivery and Development. The school is home to the D. K. Kim International Center for Regulatory Science at USC, the Titus Center for Medication Safety and Population Health, and the Center for Quantitative Drug and Disease Modeling, and is a partner in the USC Leonard D. Schaeffer Center for Health Policy & Economics, the USC Institute for Addictions Science, the USC Ginsburg Institute for Biomedical Therapeutics, the Southern California Clinical and Translational Science Institute, and the USC Center for Drug Discovery, Delivery and Development. The Mann School pioneered a national model of clinical pharmacy care through work in safety-net clinics throughout Southern California and is a leader in comprehensive medication management. Vassilios Papadopoulos has served as dean since October 2016.

About the USC Price School

USC Price School of Public Policy
Since 1929, the USC Sol Price School of Public Policy has defined excellence and innovation in public affairs education. Ranked third nationwide among 285 schools of public affairs, the Price School’s mission is to improve the quality of life for people and their communities, here and abroad. For nine decades, the Price School has forged solutions and advanced knowledge, meeting each generation of challenges with purpose, principle and a pioneering spirit. The school’s three pillars—social and healthcare policy, governance and urban development—cutter across 16 interdisciplinary research centers and six primary fields of study: health policy and management, public policy, public management, nonprofit leadership, urban planning and real estate development. With interconnected yet distinct disciplines housed under one roof, the Price School brings multiple lenses to bear on critical issues.

Solving societal issues of such complexity requires not only great minds but also great action. USC Price fosters collaboration and partnerships to better understand problems through varied perspectives. The school uses the influence of California and greater Los Angeles as a resource for setting new paradigms. These challenges also call on a new generation of creative thinkers to explore beyond the status quo. The school’s graduates go on to shape our world as leaders in government, nonprofit agencies and the private sector.

Dana Goldman was appointed dean in July 2021 after serving as interim dean the previous year.
About the USC Schaeffer Center

The Leonard D. Schaeffer Center for Health Policy & Economics

The Leonard D. Schaeffer Center for Health Policy & Economics was established in 2009 at the University of Southern California through a generous gift from Leonard and Pamela Schaeffer. The Center reflects Mr. Schaeffer’s lifelong commitment to solving healthcare issues and transforming the healthcare system.

Improving our healthcare system requires creative solutions, robust research methods and expertise in a variety of fields. A collaboration between the USC Price School of Public Policy and the USC Mann School of Pharmacy and Pharmaceutical Sciences, the Schaeffer Center brings together health policy experts, a seasoned pharmacoeconomics team, faculty from across USC—including the Keck School of Medicine, the Dornsife School of Social Work and the Viterbi School of Engineering—and affiliated researchers from other leading universities to solve the pressing challenges in healthcare.

In 2016, the Schaeffer Center partnered with the Center for Health Policy at the Brookings Institution to establish the USC-Brookings Schaeffer Initiative for Health Policy. This unique partnership benefits from the strengths of both organizations, producing data-driven health policy analysis with cogent policy solutions aimed at strengthening the U.S. healthcare system. The Schaeffer Center offers the human and technical capacity necessary to conduct breakthrough interdisciplinary research and exceptional policy analysis, with more than 50 distinguished scholars investigating a wide array of topics. Through partnerships with scholars and universities across the country and around the world, coupled with an unparalleled infrastructure and data source collection, the Schaeffer Center has built a hub for health economics and policy work. The Schaeffer Center actively engages in developing excellent research skills in new investigators who can become innovators of the future while supporting the next generation of healthcare leaders in creating strong management, team building and communication skills.

The Schaeffer Center’s vision is to be the premier research and educational institution recognized for innovative, independent research that makes significant contributions to policy and health improvement. Its mission is to measurably increase value in health through data-driven policy solutions, research excellence, and private and public-sector engagement. With an extraordinary breadth and depth of expertise, the Schaeffer Center has a vital impact on the positive transformation of healthcare.