CHPRE Newsletter

July 2015

In the News

EvidenceNOW
Advancing Heart Health in Primary Care

CHPRE will lead the evaluation of a Virginia collaborative project – Heart of Virginia Healthcare

May 28, 2015

George Mason University's Center for Health Policy Research and Ethics (CHPRE) will lead the evaluation of a Virginia collaborative project that is one of seven grantees across the U.S. awarded as part of EvidenceNOW – Advancing Heart Health in Primary Care, an Agency for Healthcare Research and Quality initiative. The Virginia collaborative, which will be called Heart of Virginia Healthcare, will work with primary care practices to utilize patient-centered outcomes research findings to improve the percentage of patients successfully managing health issues such as high blood pressure and high cholesterol management.

The Virginia collaborative Principal Investigator will be Anton Kuzel, M.D., chairman and professor, Department of Family Medicine and Population Health, VCU School of Medicine. VCU received the three-year $10.7 million grant on May 1, 2015 to establish the statewide collaborative. The project will serve up to 300 practices in the commonwealth and focus on improving heart health.

Key implementation partners include: Virginia Center for Health Innovation (VCHI), Community Health Solutions, VHQC, and National Academy of State Health Policy.

Len Nichols, Ph.D, Director of the Center for Health Policy Research and Ethics (CHPRE) at George Mason University will be the lead evaluator for this three year project. His evaluation team will include Alison Evans Cuellar, Ph.D, Iwona Kicinger, Ph.D, Sonya Vlaicu, Ph.D., Hua Min, Ph.D, as well as survey and focus group specialists from Alan Newman Research in Richmond, VA. The CHPRE graduate research assistants that will be working on this evaluation are Sachin Garg, Mathur Gandham, and Meng-Hao Li.

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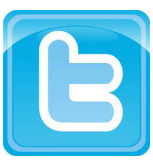

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For more about CHPRE go to **chpre.org**

CHPRE Issue Brief #3 | Reaction Article

What Price Should We Pay for Specialty Drugs?

Len M. Nichols, Ph.D, *CHPRE Director & Professor of Health Policy*

May 15, 2015 - Len Nichols gave a talk and released a new issue brief on policy options for specialty drug pricing at the Partnership for Quality Care's Policy Forum at Kaiser Permanente's new Center for Total Health in Washington, DC.

Read entire brief at chpre.org/issue briefs

Paper Suggests Making Drug Exclusivity Contingent on Reasonable Prices

June 15, 2015
John Wilkerson - InsideHealthPolicy.com

The government should condition exclusivity on companies charging reasonable prices for drugs, according to health economist Len Nichols, who served as the senior health policy adviser to the Clinton White House. Nichols' proposal would control drug prices, lead to paying drug companies for performance and force drug makers to disclose their profit margins, research spending and marketing spending.

A recent Kaiser Health tracking poll found that the public believes keeping drugs affordable for patients should be a priority for Congress, and the Campaign for Sustainable Rx Pricing plans to release a voter poll next week that the group's Executive Director John Rother said will show that voters are worried about rising drug prices. Nichols' proposal is one of the few to be put forth since drug spending grew 13 percent last year.

The government can't mess with patents because that would violate international trade agreements and unnecessarily hurt other industries. However, Congress may do what it wants with the exclusivity -- although biologics exclusivity also would be off limits were the United States to get its way on 12 years of exclusivity for biologics in the Trans-Pacific Partnership.

Nichols said exclusivity is a powerful incentive that Congress should use to influence drug prices.

"Most of the recently approved and coming specialty drugs that clinicians and payers are worried about paying for are biologics," Nichols writes in a policy paper for George Mason University's Center for Health Policy [Research & Ethics], which he heads. "Thus, threatening to revoke exclusivity for bad pricing behavior by specialty biologics is a powerful deterrent in the hands of policy makers."

Nichols proposes separate rules and thresholds for established companies with robust research programs

and for companies without products on the market. For established firms, Nichols suggests setting the threshold for the rate of return on sales at 20 percent above a company's cost of borrowing money, called the cost of market capital. Thus, if a company pays a 7 percent interest rate on the money it borrows, it could set a price that results in a profit margin of 8.4 percent, after subtracting the cost of production, marketing and current research and development. Gilead Sciences last year earned nearly a 50 percent profit on its hepatitis medications. Nichols said he'd prefer to limit how much spending on marketing that established companies could subtract to avoid encouraging them to market too aggressively, and he thinks up-and-comers should be allowed to subtract all marketing costs to encourage competition.

"Thus, the 'regulated' price preserves cash flow for a robust amount of R&D, the major purpose of new cash flow for an established firm," the paper states.

Drugs designated as breakthroughs could earn a rate of return on sales up to 40 percent above the cost of borrowing money, under Nichols' proposal.

"Remember the point of regulation is to keep launch prices below the profit maximizing one with which the firm would capture all of the social welfare value of the drug until competition -- however long it takes -- begins to erode profit," the paper states. "One could preserve incentives for 'breakthrough' investments by allowing them to earn 40% more than the cost of capital, compared to 20% more for a more modest clinical and social value drug. This calibration could evolve into a form of 'pay for performance' for new drugs," the paper adds.

To read more: http://chpre.org/latest-news

How to Lower Specialty Drug Prices

MORNING CONSULT

June 22, 2015
Len Nichols, Ph.D.

Gilead Sciences did us all a favor. Their business decision to charge $84,000 for Sovaldi, which cures Hepatitis C, elevated the issue of specialty drug pricing to a level of health policy awareness that rivals the King v. Burwell Supreme Court decision. Without the ruckus over high prices, not many would have noticed that Gilead earned a cool $12.1 billion in profit off its $24.9 billion in 2014 sales. Even for risky products like prescription drugs, with a rate of return that high, the price far exceeds what anyone would have considered justifiable.

Simply put, this level of profit is not required to induce innovation. These kinds of prices, increasingly charged for many complex drugs often targeted to relatively small patient populations (hence the name, "specialty" drugs), are so unaffordable for people and for governments that they threaten other vital health services and priorities. We must do better. As a nation, we cannot afford the monopoly power we are now granting to encourage innovation.

Drug price growth (6 percent per annum) and spending growth (12 percent per annum per person) are driving overall health care costs above GDP growth again, after five straight uncommonly good years. Specialty drugs made up 1 percent of prescriptions written but accounted for 25 percent of drug spending in 2013. Spending on these medications is growing faster than for all other drugs and will account for more than 50 percent of all drug spending by 2019. Regardless of whether one takes these drugs or not, we all pay the cost. Drug prices threaten premiums and pocketbooks everywhere.

There is no doubt that we need innovation. Drug development is expensive, time-consuming and risky in that most products never make it to market. But the tools we use to encourage innovation — patent protection of the basic science and additional market or data exclusivity once the product is declared safe and ready for sale — confer monopoly power and high profits. Our system is now set up to depend upon competition to drive down costs while providing patients with more treatment options and better value for their health care dollars.

This all has worked well enough for traditional drugs (antibiotics, cholesterol drugs, etc), wherein 85 percent of prescriptions are generic today. But drug companies have figured out it is more profitable to invest in specialty drugs precisely because competition for them is harder to create. Most specialty drugs are products of growing organisms instead of chemical compounds, and are often called "biologics." Examples include most anti-cancer drugs and new treatments for multiple sclerosis and rheumatoid arthritis.

Therein lies our great dilemma. The Affordable Care Act included a provision which tried to create the same kinds of competition in biologics that we have for traditional drugs. But it granted 12 years of exclusivity for biologics after launch, which is a very long time. That extra time confers enormous monopoly pricing power to drugmakers. At the same time, it took five years just to create regulations for biosimilars to be approved – the analogues to generics. The first biosimilar drug was finally approved for sale this spring –to compete with a drug that was launched in 1991. Case in point: we clearly do NOT have a robust biosimilar market today.

The truth is competition for biologics is hard to jumpstart, and prices are way too high. Yet, the stakes for patients and the health system more broadly are even higher, so there is no shortage of policy suggestions. Most proposals require substituting public money for private capital in order to reduce the private investment at risk and to enable the same high profit rates to be earned with lower prices. Other proposals range from the use of existing diagnostic programs to match patients with the right drugs to freeing government and commercial payers from covering some drugs to indication-specific pricing, especially those that either do not extend the quality or length of life very much.

All of these policies have merit. But a cleaner solution would avoid relying on federal bureaucracies to make complex judgments about which company's products are more promising or which clinical tests are required before access to potentially life-saving treatment is granted.

But to directly address the issue of monopoly pricing power that is difficult to challenge, what if we made market exclusivity contingent on pricing behavior? Suppose we allowed drugmakers to charge what they want for new drugs – after all this is America –but if they charge a price that is "too high," they will NOT get the market exclusivity they were expecting once the patent has expired. For drugmakers looking down the biologics pipeline, who depend on post-market exclusivity to have a monopoly for extended periods, this would be a serious matter indeed.

Pay-for-performance is ubiquitous at this point with providers and payers. Why should drug pricing be any different? We first need to ask ourselves how high is "too high?" I would suggest for new drugs that are not clinical breakthroughs – like most of the recent anti-cancer drugs that do not deliver extend life very long – a price is too high if it enables the firm to earn a profit rate on sales more than 20 percent higher than its own cost of capital in the competitive marketplace.

To read more: http://chpre.org/latest-news

CHPRE Issue Brief #3 | Reaction Article

Should Pharma Returns be Limited if Prices are too High? A Reader Poll

THE WALL STREET JOURNAL.

June 17, 2015
Ed Silverman, Wall Street Journal Blog

The debate over prescription drug prices has been peppered with complaints, criticisms and cries for legislation. But while some payers are pushing back and extracting discounts, little has so far changed. Now, a health economist is offering a proposal that he hopes can make a difference – revoke the exclusive time that drug makers have to market specialty medicines if prices are too high.

"We want companies to innovate and provide needed medicines. And I want to keep that golden goose alive," says Len Nichols, a health policy professor at George Mason University, where he heads the Center for Health Policy Research and Ethics. "But the prices are just too high for what our health system can afford… We need more socially responsible pricing behavior."

But how high is too high?

As Nichols explains it, a price is too high when a drug maker earns a rate of return that is 20% or greater than its current cost of capital, although he would set the threshold at 50% for new companies with new products. But he says that any drug maker earning a higher rate of return would risk losing exclusive marketing time. For biologics, which is how he refers to specialty medicines, this runs 12 years.

To read the rest of the blog go to http://chpre.org/latest-news/

CHPRE | In the News

High Court Ruling Offers Chance to Alter Health Law Debate

The New York Times

June 29, 2015
THE ASSOCIATED PRESS

WASHINGTON — The country finally has an opportunity to change the subject on health care, after the Supreme Court again upheld President Barack Obama's law.

There's no shortage of pressing issues, including prescription drug prices, high insurance deductibles and long-term care.

But moving on will take time, partly because many Republicans want another chance to repeal the Affordable Care Act if they win the White House and both chambers of Congress next year.

Also, it's difficult to start new conversations when political divisions are so raw, and there's a big disconnect between what people perceive as problems and the priorities of policymakers, business and the health care industry.

Democrats say a change in focus is long overdue.

"I do think the energy has already shifted," said Neera Tanden, president of the Center for American Progress, a think tank often aligned with the White House. "It would be great if the health care conversation moves to where people are, not relitigating these insurance issues."

Wishful thinking, say Republicans.

"The politics of this has gotten so unpleasant that we're locked into 'repeal-and-replace' for the next year and a half," said lobbyist Tom Scully, who ran Medicare in President George W. Bush's administration. "It may not be great for America, but that's the reality."

Scully says Republicans may be able to make substantial changes but not repeal Obama's law entirely.

What would a different health care conversation sound like? Some possibilities:

PRESCRIPTION DRUG PRICES

Nearly three-quarters of the general public see prescription drug costs as unreasonable, according to a recent Kaiser Family Foundation survey. That concern seems to be driven by new breakthrough drugs that can cost $100,000 a year and even more. Last year it was Sovaldi, a cure for liver-wasting hepatitis C infection. Next it could be skin cancer drugs in the approval pipeline.

Economist Len Nichols of George Mason University in Virginia says the cost of new medications is "unsustainable," but government price controls could stifle innovation.

Most patients are not exposed to those excruciating cost pressures because the vast majority of prescriptions are for lower-priced generic drugs. Overall, only 1 in 5 people taking prescription drugs say it is difficult to afford their own medications, the same survey found.

To read more: http://chpre.org/latest-news

With Merging of Insurers, Questions for Patients About Costs and Innovation

The New York Times

July 5, 2015
By Reed Ableson

The nation's five largest health insurance companies are circling one another like hungry lions closing in on prey.

On Friday, Aetna said it would acquire its smaller rival Humana to create a company with combined revenues of $115 billion this year. Anthem is stalking Cigna. UnitedHealth Group, now the largest of the five, is looking at its options. At the end of the maneuverings, three national behemoths are likely to emerge.

There is also a scramble among the smaller insurers. On Thursday, Centene, which specializes in offering Medicaid coverage, said it planned to buy Health Net, a for-profit insurer with headquarters in Los Angeles.

As insurers grow larger, will consumers benefit from the companies' ability to bargain with hospitals and doctors for lower prices? Will diminishing competition translate to fewer choices of plans? And what effect will mergers have on innovation in health care?

The answers depend largely on how successfully the other insurers, particularly those that were created or attracted by the Affordable Care Act, can compete with these much larger companies.

"All politics are local," the saying goes, and it is similarly so with insurance companies.

The big (and getting bigger) for-profit companies — which make most of their revenue from employer and Medicare and Medicaid plans — still face significant competition from the regional or state-based nonprofit Blue Cross and Blue Shield plans, particularly in the market for employer-based coverage.

"What people miss is the regional strength of regional Blue Cross plans," said Paul H. Keckley, the managing director for the Navigant Center for Healthcare Research and Policy Analysis.

Blue Cross Blue Shield plans, including the for-profit versions owned by Anthem in 14 states, have traditionally dominated the markets for individuals and employers. In more than 30 states, a nonprofit Blue Cross sells the most policies to large employers, with almost a dozen capturing three-quarters of the market, according to 2013 data from the Kaiser Family Foundation, the latest information it has compiled.

The large for-profit insurers do not have a significant presence in about a dozen states, including Massachusetts, Minnesota, Oregon and Washington, according to the Kaiser data. "They have national share, but they don't have big share in a lot of places," said Gary Claxton, an executive with the Kaiser Family Foundation.

The picture is different outside the employer market, however. In the business of selling private Medicare plans, which the insurers offer as an alternative to the traditional Medicare program, the five companies — particularly UnitedHealth and Humana — command about half the market, according to Kaiser data from 2015. The big for-profits are frequently the dominant players in an individual state, and the proposed combination of Aetna and Humana will create a larger force in that market.

In an interview about the proposed combination of Aetna and Humana, Mark T. Bertolini, Aetna's chairman and chief executive, emphasized the need to be large enough to invest the capital and resources necessary to be competitive in a rapidly changing environment.

"People who did not invest significantly enough in health care reform and a retail marketplace are going to struggle," said Mr. Bertolini, who, at the combined company, would assume the same roles he has at Aetna.

The smaller companies will have a harder time accomplishing the transition, he said.

One primary reason for the latest merger mania is the companies' need to have more clout in more local markets so they can negotiate better deals with local hospitals and doctors. Across the bargaining table are increasingly powerful local health systems that have been consolidating to become more efficient and to gain more say about the price of care and the networks they will join. "What it all comes down to is the relative market share between plans and the hospitals," said Len Nichols, a health economist at George Mason University.

But consumer advocates are skeptical that more consolidation is the answer. "In most markets, insurers are pretty consolidated already," said Claire McAndrew, who follows the private insurance market for Families USA, a consumer advocacy group in Washington. "I'm not sure if further consolidation is going to have a further impact."

The challenge for the nonprofit Blue Cross plans, meanwhile, is whether they will be able to offer a competitive alternative to a combined Aetna-Humana or Anthem-Cigna.

The nonprofit Blue Cross plans still face the same pressures that the for-profit companies do in needing to generate more revenue to offset their costs, said Bret Schroeder, a partner with PA Consulting Group. "They all have existing cost structures that are similarly high," he said, adding, "They are still faced with market forces" including decreasing revenues and more competition. The question is what Blue Cross plans like Wellmark in Iowa will do to compete better, he said.

To read more:
http://chpre.org/latest-news

Obamacare Debate Will Still Rage After Court Ruling

June 22, 2015
Melissa Attias, CQ Staff

For all the uncertainty the Supreme Court case over health law subsidies has cast on the future of the statute, one thing is almost certain: Any decision that fails to leave the law intact will put the fate of President Barack Obama's signature achievement in the hands of the next administration.

Michael Carvin, lead attorney for petitioners in King v. Burwell, with Oklahoma Attorney General Scott Pruitt, right, after the Supreme Court hearing in March. (Alex Wong/Getty Images)

A ruling against the government in King v. Burwell could scramble the system for distributing aid to the 6.4 million low- and middle-income people who have enrolled in health plans through the federal insurance exchange under the law and blow a hole in a health care overhaul Democrats have spent the last five years defending.

Republicans who find the law anathema still recognize it could be political suicide to allow the financial assistance to lapse, and they're planning accordingly.

Senior House Republicans presented their caucus with a framework for a legislative response June 17 that would repeal the individual and employer mandates while continuing financial assistance into 2017 through a combination of state block grants and subsidies. Other GOP lawmakers have offered bills, including one (S 1016) by Sen. Ron Johnson of Wisconsin, that would end the mandates while extending the law's subsidies through August 2017, well into the first term of Obama's successor.

A GOP-approved transition would reconceive Obamacare in a distinctly conservative way and be sold as a stepping stone to eventual replacement — something Democrats would surely oppose. The question is whether the parties, after the requisite sound and fury, could agree on a compromise that temporarily keeps the aid flowing with some strings attached and makes the health law a pre-eminent issue for the second straight presidential campaign.

"They can boot it down to '17 and say, 'Okay, we'll go pick it up after the next election. See if we get a president,'" says Rep. Jim McDermott of Washington, the top Democrat on the House Ways and Means Health Subcommittee.

Formulating contingencies for the case has been vexing because there's no way to predict how broadly the justices will rule on the question of whether subsidies should be available in 34 states that didn't create their own health insurance marketplaces, or exchanges. And any decision against the government may not take effect immediately.

But whatever the court does, a Congress so deeply divided over the law and its effects on the health sector is extremely unlikely to come to a quick agreement on how to respond. It's not clear, for example, how amenable conservatives in the House and Senate would be to even temporarily extending components of the law, or whether they would seek to convert the subsidies into another form of aid, such as tax credits. Texas GOP Sen. Ted Cruz has suggested he won't support a subsidy extension but would back language allowing states to opt out of the law's requirements.

The competing agendas raise the prospect for delays and disruption to insurance markets whose rules and regulations would vary dramatically state-by-state.

"If we could come up with an approach that really makes sense, I mean even this president would probably have to say, 'Oh, I hate it, but I'm probably going to have to take it,'" says Senate Finance Chairman Orrin G. Hatch of Utah.

"We've got to find a program that's too difficult for the president not to take."

Hoping For a Reprieve

That process could be particularly messy if justices rule against the subsidies but don't prescribe much of a delay before the aid disappears.

Do Something!

Republican governors in states now relying on the federal exchange would be under enormous pressure to set up their own marketplaces to maintain the subsidies, and likely would urge congressional Republicans to come up with a quick fix. They'd be joined by health plans that fear they will lose younger, healthier customers if subsidies disappear, skewing the risk pool and potentially driving up coverage costs.

"The first scream you hear after that ruling, if it happened, would be the insurance industry," says Jonathan Oberlander, a health policy professor at the University of North Carolina, Chapel Hill.

For most members of Congress, the first concern is avoiding blame for millions of people losing coverage and souring public opinion toward whichever party is deemed most responsible. If polls continue to show the vast majority of the public wanting Congress to act, that would boost pressure too.

The Obama administration may also make life difficult for the GOP by proposing an administrative fix that would allow states not in compliance with a ruling to take over some federal exchange functions and declare the market their own. Republicans fear that would further entrench the law, though it would offer a potential workaround to congressional gridlock.

Joseph Antos, a health policy expert at the conservative American

Enterprise Institute, foresees House Republicans passing legislation before the summer recess that includes age-related subsidies rather than a straight extension of those distributed under the health care law. The aid would be coupled with other policies allowing states to move away from the law's requirements.

Though Senate Democrats could filibuster such a bill or Obama could veto it, Antos says a showdown would be welcomed by Republicans who would portray Democrats as unyielding and incapable of accepting a reasonable proposal. Serious negotiations could then start in September, with Republicans bargaining down from the legislation they previously passed.

Democrats' opening gambit, meanwhile, will be to enact language to permanently extend the availability of subsidies for people in states affected by a decision. But when the give and take begins, they'll almost certainly have to concede to something on the GOP wish list in order to keep financial assistance coming.

Len Nichols, director of the Center for Health Policy Research and Ethics at George Mason University, thinks Democrats could live with a repeal of the law's requirement that employers offer health coverage or pay penalties. Scrapping the law's 2.3 percent excise tax on medical devices or a still-unappointed Medicare cost-cutting board — the subject of two bills (HR 160, HR 1190) scheduled to move through the House before recess — could also be on the short list.

Antos predicts the employer mandate, which the administration twice delayed enforcing and the left-leaning Urban Institute has suggested dropping, would be one of the easiest things to give up and still be an appealing trophy for Republicans.

"The word mandate gets their hearts thumping," he says. "That's what it's going to take."

Shades of a Budget Deal

Oberlander says crafting a compromise will be analogous to a budget deal, with party leaders looking for the "sweet spot" where they can cobble together enough votes from both sides to get a majority.

But Republicans and Democrats are already pointing fingers in case that turns out to be too heavy of a lift.

Senate Majority Leader Mitch McConnell of Kentucky predicted in an interview with conservative radio host Hugh Hewitt this month that Obama would veto whatever Congress sends him and put the pressure on governors to establish their own exchanges. Democrats insist it's up to Republicans to come up with a workable plan.

"From the Democratic point of view, that's their problem," says Rep. Gerald E. Connolly of Virginia. "We passed a bill. And it's a good one. And it's working. If they want to screw around with it with their ideologues on the Supreme Court, then it's back in their court."

Those arguments would almost certainly echo on the campaign trail as presidential candidates confront questions about next steps, no matter how the court rules. Competing visions for a post-ruling health care system will be one of the defining issues in the 2016 races.

Rep. Phil Roe of Tennessee, co-chairman of the GOP Doctors Caucus, bets that policymakers will be happy to settle on a transition plan rather than sow disruption.

"A lot of conservatives are saying, 'Just let it blow up.' Well there's a lot of collateral damage out there when you do that," Roe says. "I don't think that will happen."

But Nichols says he doesn't see how Republicans could agree on a patch that wins Obama's signature. And if the subsidies lapse, he predicts they won't reappear until after a new Congress and administration are sworn in.

"If King wins, the next Congress is going to be very busy," Nichols says. "The question is whether there will be a patch or they will be picking up from scratch."

Presentations | Len Nichols, Ph.D.

UPCOMING TALKS:

July 9, 2015 • Colorado Hospital Association's Annual CEO Retreat Len Nichols will deliver the keynote address: *"Health Reform post-ACA: How are WE Doing?"*.

July 21, 2015 • Altarum Institute's Annual DC Policy Briefing Len Nichols will deliver the keynote address: "*How is Payment Reform Really Working?*".

July 29, 2015 • Colorado Health Foundation's Annual Symposium Held in Keystone, Colorado Len Nichols will open the conference with framing remarks and then moderate a session entitled *"Connecting Systems to Health Outcomes"*.

PAST PRESENTATIONS:

June 16, 2015 • Academy Health
Len Nichols, Alison Cuellar, Ph.D., and Gilbert Gimm, Ph.D., each presented preliminary results of CHPRE's evaluation of the Patient Centered Medical Home program of CareFirst Blue Cross Blue Shield. Academy Health is the premier health services research organization in the US and the occasion was their annual research meeting in Minneapolis, MN. Alison presented econometric results in a regular panel session, Gilbert presented qualitative results in a poster session, and Len presented the econometrics to an invitation-only meeting of the Collaborative of PCMH Evaluators organized by the Commonwealth Fund. Good feedback was acquired by all and submissions of the revised results to refereed journals will be made this summer and fall.

June 4, 2015 • Virginia Health Care Conference
The Virginia Chamber hosted the 5th Annual Virginia Health Care Conference on June 4th in Richmond. A panel of CEOs discuss the sweeping changes and opportunities facing the global healthcare industry

More than 750 industry stakeholders and employers at this years conference. This year's program will featured advancing Virginia's triple aim of better health, better care, and lower cost amid sweeping changes in the health care industry.

Healthcare in High Gear - A panel of CEOs discuss the sweeping changes and opportunities facing the global healthcare industry

Moderated by: Dr. Len Nichols, Ph.D., Director, Center for Health Policy Research and Ethics, George Mason University

Panelists:
Nancy Agee, CEO, Carilion Clinic
Peter Bernard, CEO, Bon Secours Virginia
David Bernd, CEO, Sentara Healthcare
Pamela Sutton-Wallace, CEO, UVA Medical Center

May 19, 2015 • 2015 Michigan Health Policy Forum: Why Health Insurance Coverage Expansion is Good for the Economy
Chutes or Ladders? What Will the Next Move Bring for Michigan's Uninsured?

Michigan has made enormous strides to reduce the number of uninsured by enrolling 341,000 citizens through the Health Insurance Marketplace and over 603,000 citizens in the Healthy Michigan Plan. However, both of these programs are at risk in 2015.

MDCH Director-emeritus James Haverman explained the challenges facing Michigan's Health Insurance Marketplace and the Healthy Michigan Program. Business and legislative perspectives provided by Mr. Rob Fowler, President and CEO of the Small Business Association of Michigan and Sen. Mike Shirkey, Chair of the Michigan Senate Health Policy Committee and an architect of the Healthy Michigan Plan.

Len Nichols, PhD delivered the keynote address. He spoke on the benefits of health care coverage for the individual and for society as a whole.

http://michiganhpf.msu.edu/index.php/spring-forum-2015

May 15, 2015 • Partnership for Quality Care's Policy Forum: Sustainable Prescription Drug Pricing
The Partnership for Quality Care (PQC) held a forum to address the dramatically rising costs of prescription drug prices in the United States. "We believe it is important to engage in a broader discussion around specialty drug pricing and to look at this issue from an economic, scientific and social perspective," said Bernard J. Tyson, who is the PQC Chair and Chairman and CEO of Kaiser Permanente. "While the Partnership for Quality Care supports medical innovation, we are concerned about the impact specialty drug prices will have on the affordability and accessibility of health care in this country."

"This is not just affecting a handful of people – families across the country are already having to make tough cutbacks in order to fill necessary prescriptions, with little to no relief in sight," added PQC Secretary and Senior SEIU Advisor, Dennis Rivera. "This is particularly concerning since there are dramatically more 'must have' expensive drugs on the horizon, drugs that promise cures, longer and healthier lives that neither plans nor people can soon afford. It's unsustainable. What we need is a solution and we need one now."

At the center of today's discussion was not only how rising costs are affecting everyday Americans, but also how the pharmaceutical industry got to this point.

"Our policy problem is rooted in the reality that striking the right regulatory balance between encouraging innovation -- by granting temporary monopoly pricing power -- and ensuring affordability for patients and those who typically pay on their behalf (employers, health plans and governments), is very, very hard. In essence, our policy effort has not been commensurate with the complexity

Presentations | Len Nichols, Ph.D.

of the problem," said Len Nichols, PhD, Director of the Center for Health Policy Research and Ethics and Professor of Health Policy, George Mason University. "We have a compelling social interest in promoting competition as well as innovation, and we need to make clear that monopolies come with responsibility and accountability. Competition is more important to public policy than a blank check for innovation."

Echoing these points, Mitra Behroozi, Executive Director of the 1199SEIU Benefit Funds, said, "New advances in treatments for autoimmune disorders, cancers and hepatitis C have created a growing demand for expensive drugs. Our members are fortunate because, regardless of cost, they have access to these drugs through our comprehensive plans. But our dollars are limited and our need continues to grow."

"Producers at all times try to extract from buyers the maximum price the buyers can be made to pay...The producers of specialty drugs now are probing to find the maximum monetary value we, the rest of society, attach to human life," said Uwe Reinhardt, PhD, James Madison Professor of Political Economy, Woodrow Wilson School of Public and International Affairs, Princeton University. - *PRNewswire-USNewswire*

May 7, 2015 • Health Management Associates 30th Anniversary Retreat: Health Reform Beyond the ACA: Which Way from Here?

Health Management Associates is the premier health policy consulting firm for state and local governments all over the US. This 30th anniversary retreat brought the entire professional staff together for the first time since the ACA began to be implemented. Nichols' keynote was designed to review progress and pitfalls and outline the challenges and opportunities ahead.

April 24, 2015 • MAXIMUS webinar "Continuing the Conversation: Opportunities for State Innovation in Health Insurance Programs"

As a follow up to the live event on Section 1332 of the Affordable Care Act, MAXIMUS hosted this webinar with a panel of four influential thought leaders, discussing how Section 1332 can be used for innovation in state health insurance programs. John McDonough, Stuart Butler, Grace-Marie Turner and Len Nichols all presented their perspectives on the options states should be considering for greater flexibility in their programs. The webinar had a good turnout and the feedback has been very positive.

MAXIMUS Webinars http://www.maximus.com/webinars

Student News | Stephen Petzinger

HAP Student Selected as David A. Winston Health Policy Scholarship Recipient

Stephen Petzinger, a graduate student in the Masters of Science in Health and Medical Policy program, has been selected to receive one of ten $10,000 scholarships from the highly competitive and prestigious David A. Winston Health Policy Scholarship Program, offered by the Association of University Programs in Health Administration (AUPHA). During his time at Mason, Stephen has worked as a graduate research assistant to Dr. Len Nichols, Director of the Center for Health Policy, Research & Ethics (CHPRE). He currently serves as the President of the award-winning GMU AcademyHealth Student Chapter and has just accepted a Program Examiner position at the Office of Management and Budget (OMB) within the Executive Office of the President in Washington.

The Winston Health Policy Scholarship Program aims to increase the number and quality of individuals trained in healthcare policy at the state and federal level by awarding deserving health policy students financial support to further their education. It recognizes student excellence and achievement based upon the student's record, recommendations from faculty and colleagues, and evidence of their interest in and commitment to health policy. In the fall, in addition to the financial incentives of the program, Stephen will attend a 2-day health policy symposium, designed to provide Winston Scholars with an in-depth and unique view of health policy in Washington.

Stephen Petzinger

Events | **Health Policy Institute** | Held on June 7-10, 2015
Health Policy Seminar Series | Coming Fall 2015