CENTER FOR HEALTH POLICY RESEARCH AND ETHICS
GEORGE MASON UNIVERSITY

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CHPRE Newsletter

October 2015

Len Nichols Appointed to HHS Advisory Committee on Physician Payment Models

Len Nichols, director of the Center for Health Policy Research and Ethics and professor of health policy, has been appointed to the newly formed Physician-Focused Payment Model Technical Advisory Committee.

The committee, which was established by the Medicare Access and CHIP Reauthorization Act of 2015, will provide comments and recommendations to the Secretary of Health and Human Services on physician payment models. The 11 committee members were appointed by the Comptroller General.

"With the shift in physician payments for Medicare, this committee will have the opportunity to help shape what future payment models look like," said Thomas Prohaska, dean of the College of Health and Human Services. "Dr. Nichols' expertise in payment reform and health policy will allow him to provide valuable insight and ideas to the committee and HHS."

Nichols will serve a two-year term that ends in October 2017. Committee members may be appointed to subsequent three-year terms when their term expires.

WELCOME BACK!

CHPRE staff hosted a mixer for Graduate Research Assistants to welcome back all the research assistants who work across the various CHPRE grants and projects.

(from left to right) Iwona M Kicinger, Mathur Gandham, Meng-Hao Li, Brad Kells, Len Nichols, Sachin Garg, Sriteja Burla, Reyhaneh Mogharab Nia, Kyung Min Lee, Chanup Jeung, Treniese Polk, Charlotte Devereaux and Maryam Mohammad

This issue:

Upcoming Session:

November 12, 2015
12:00 – 1:30 pm
Using Machine Learning to Predict High-Need Medicaid Enrollees
Che Ngufor, PhD
Mayo Clinic - Biomedical Statistics & Informatics Division
Merten Hall, Room 1204

Washington Health Policy Institute
June 5-8, 2016

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

CHPRE & HAP | Health Policy Seminar Series

Health Policy Seminar Series #1

Effects of the Affordable Care Act on Health Disparities • September 21, 2015

The Affordable Care Act (ACA) of 2010 was expected to reduce some of the persistent racial and ethnic disparities in the U.S. health care system by expanding insurance coverage to new populations. Using data from the National Health Interview Survey (NHIS), Dr. McMorrow compared uninsurance rates for white, African American, and Hispanic adults in 2013 and 2014, focusing on the periods before and after the open enrollment period when state Medicaid expansions took effect. Dr. McMorrow presented several findings from the study, including differences in uninsurance rates that narrowed for African American and Hispanic adults compared to white adults, and remaining gaps in health insurance coverage for Hispanic adults.

Stacey McMorrow is a senior research associate in the Health Policy Center at the Urban Institute in Washington, DC. Her research uses quantitative methods to study the factors that affect individual health insurance coverage and access to care as well as the impacts of state and national health reforms on employers and individuals. Her current work focuses on the Affordable Care Act and state Medicaid expansions to explore the effects of greater insurance coverage on access to care, service use, and health outcomes for different populations. Her prior work has been published in Health Affairs, the New England Journal of Medicine, and the American Journal of Public Health. Dr. McMorrow received her Ph.D. in Health Economics and Policy from the Wharton School at the University of Pennsylvania.

Health Policy Seminar Series #2

Estimating the Supply Side and Provider Effects of Health Care Reform • October 21, 2015

The Affordable Care Act (ACA) includes two major sets of provisions—the first expands health insurance coverage, and the second affect how Medicare pays health care providers. The ACA and recent payment reforms have changed Medicare payments to health care providers, by shifting from "pay-for-volume" to "pay-for-value" models. RAND developed the Health Care Payment and Delivery Simulation Model (PADSIM) to examine how changes in payment policy affect providers. In this seminar, Dr. White will describe the model, and present findings that address two questions: 1) how has the ACA and Medicare payment reforms affected health care spending trends since 2010?, and 2) how will Medicare's new physician payment system affect future spending trends?

Dr. Chapin White is a Senior Policy Researcher at RAND Health. His work uses both quantitative and qualitative methods, and he focuses on provider payment reform, microsimulation modeling, spillover impacts of policy, and the impacts of the Affordable Care Act (ACA). Prior to joining RAND, Dr. White spent 3 years as a senior health researcher at the Center for Studying Health System Change, and 5 years as a Congressional Budget Office (CBO) analyst. His work at CBO focused on modeling the Affordable Care Act (including coverage provisions, and changes in tax policy and provider payment), geographic variation in health spending, medical malpractice, and tax benefits for not-for-profit hospitals. His work has been published in a number of peer-reviewed journals, including Health Affairs, Health Services Research, and the New England Journal of Medicine.

Jeb's Obamacare Repeal-And-Replace Plan Is More Repeal Than Replace

Conservatives will love it. But careful if you actually get sick.

THE HUFFINGTON POST

October 13, 2015
By Jonathan Cohn and Sam Stein contributed reporting.

Jeb Bush on Tuesday will introduce a plan to repeal and replace the Affordable Care Act. But "replace" may not be quite the right word.

The Bush plan calls for a familiar mix of conservative ideas on health care, according to campaign documents obtained by The Huffington Post. It would eliminate the coverage scheme of "Obamacare" -- the tax credits, regulations on insurance, and individual mandate that have led to a historic reduction in the number of uninsured Americans.

In its place, Bush would introduce a new kind of financial assistance for people buying insurance on their own -- specifically, tax credits pegged to age but not to income, and not designed to guarantee access to the same level of coverage as Obama's health care program does.

The Bush plan also would give control of Medicaid, the insurance program for low-income Americans, over to the states.

What would this all mean in practice? It's impossible to say with any precision, at least without more details about the dollar amounts involved.

Still, the outlines of Bush plan look a lot like like some other plans now in circulation on the right, like the so-called 2017 Project Plan and a proposal from Rep. Tom Price (R-Ga.). These plans envision less government spending and regulation, but would likely result in some combination of fewer people with insurance and less financial protection for people who have coverage. Experts contacted by The Huffington Post said they expected Bush's plan, if enacted, would play out in a similar way.

Here's why. The basic concept of the Affordable Care Act, like all universal health care plans, is to set some basic standards for private insurance, then provide financial assistance to people who cannot afford such policies on their own. Those standards include requirements that all plans include "essential benefits" -- in other words, not just hospitalization, but also services like rehabilitation, mental health, prescription drugs, and maternity care.

The Affordable Care Act also prohibits insurers from denying coverage or charging higher premiums for people with pre-existing conditions. In addition, it sets limits on out-of-pocket spending -- with even tighter limits for people with lower incomes, on the theory that the working poor simply don't have the money to absorb high out-of-pocket costs.

These regulations are why the insurance plans that people buy through the Affordable Care Act's exchanges can be so much more expensive than the plans many people bought before the law existed -- and why, under the Affordable Care Act, the government must spend so much subsidizing coverage for people who can't pay those higher premiums.

The Bush plan would weaken those standards on insurance: People buying coverage would have more freedom to buy less-generous policies that cover only catastrophic costs. And the tax credits that Bush would provide, by design, guarantee access only to these catastrophic policies.

That's cheaper than subsidizing the "silver" plans that the Affordable Care Act treats as its standard -- a result conservatives would certainly cheer. But without ACA levels of assistance, poorer people who want more comprehensive coverage probably wouldn't have the money to buy it. Once they got sick, they'd be stuck with more punishing out-of-pocket expenses. And because these are people with lower incomes, they'd have less money to cover those costs.

"Repealing Obamacare and replacing it with fixed tax credits would hurt low-income folks who finally just got decent insurance," Len Nichols, a former Clinton administration official and widely respected health economist at George Mason University, told The Huffington Post.

Bush's designs on Medicaid would likely have a similar effect. While the campaign has not specified how much money the states would get under Bush's scheme, conservative plans to hand control over to the states generally call for less spending on the program. Medicaid is already under-funded. If states had even less money with which to manage it, they'd almost surely have to restrict eligibility or cover fewer services -- either of which would mean less financial protection, in this case for the very poor.

One more key footnote to the Bush plan is its protection for people with pre-existing conditions, which is different from the guarantee in the Affordable Care Act. The Bush plan calls for guaranteeing access, but only for people with "continuous" coverage. That means people whose insurance has lapsed -- say, because they lost a job and couldn't afford premiums for a few months -- could be subject to denial because of their current medical problems.

The Bush plan has some noteworthy and interesting wrinkles, befitting a politician who has promoted himself as the most serious policy candidate in the GOP race. (His plan may not have much detail, but it's considerably more substantive than what his rivals have produced.) Among other things, Bush calls for establishing targets and incentives for states to improve medical outcomes.

In addition, Bush calls for replacing the Affordable Care Act's "Cadillac tax" with a cap on the tax exclusion for employer insurance. It's a more direct and efficient way of accomplishing the same goal as the Cadillac tax, although -- as Phil Klein of the Washington Examiner has noted -- Bush would design the cap in such a way that it would affect fewer plans, at least initially.

Read the rest of the article.
www.chpre.org/

Doubts Emerge on Clinton Drug Price Plan

September 26, 2015
By Robert King

Hillary Clinton believes TV commercials touting new drugs contribute to high drug prices, but the Democratic front-runner's plan to curb such ads may not do the trick, some experts say.

Clinton unveiled a plan this past week to combat rising prices, proposing reforms long championed by Democrats such as allowing Medicare the power to negotiate over drug prices.

Her plan also took on consumer TV ads of drugs. It stops direct-to-consumer advertising subsidies and makes drug companies reinvest marketing dollars into research and development of new drugs.

"Almost every country in the industrialized world bans or severely restricts direct to consumer advertising because it increases prescription drug costs, and can include confusing, misleading or incomplete information or exaggerated claims if not regulated effectively," her campaign said.

But proposing a plan and getting it implemented is another story. Congress has continually thwarted attempts to hinder or further regulate direct-to-consumer ads.

"Congress typically decides that any business has a right to talk about their product to whoever they want," said Daniel Mendelsohn, the CEO of the health research firm Avalere Health.

Mendelsohn said that there wasn't much new in Clinton's plan, and that a push toward demonstrating the value of a drug would be a better move.

"That is what health plans are expecting of drug companies at this point," Mendelsohn told the Washington Examiner on Friday. "To get your drug approved by a health plan you have to show the value to specific populations and that is where the commercial market is going."

The Clinton campaign did not immediately return a request for comment.

The goal of Clinton's plan is to shift resources from marketing to research and development, which could have an indirect impact on prices in the future, said Len Nichols, a health economist and professor at George Mason University.

"Shifting resources from marketing to R&D at least increases the chances we'll have more innovation and competition in the long run," he told the Examiner on Friday.

Another expert said consumer advertising is far from the only form of marketing drug companies use. Some companies rely much more on promoting their products directly to doctors through a sales force, a process called "detailing."

"The government does regulate that type of marketing as well, but it represents a much bigger chunk of spending than television ads aimed at patients," said Michael Sinkinson, a professor at University of Pennsylvania's Wharton School.

Mendelsohn said some drugs are advertised to consumers more than others. An antibiotic routinely used in a hospital, for instance, wouldn't need to hit the airwaves, he said.

Clinton would also change how the Food and Drug Administration regulates ads by requiring any prescription drug ad to be cleared before reaching the public.

The FDA has the authority to regulate prescription drug ads to consumers, but not over-the-counter product ads. Federal law prohibits a drug maker from making a misleading or inaccurate ad.

The agency, however, currently doesn't have a program that reviews a drug ad before it reaches the public. "We see many ads about the same time the public sees them," the agency said on its website. "Many drug companies voluntarily seek advice from us before they release TV ads."

However, if the agency is made aware of an ad in violation then it can go after the drug maker. Normally the agency sends the drug maker a letter asking for the ad to be stopped or corrected.

Common violations include ads that don't disclose all of the product's risks, or tout an unapproved use. The agency has also tried to tackle social media advertisements. Posts on popular social media sites such as Facebook or Twitter have to include risk information.

That is what got reality TV star Kim Kardashian in trouble earlier this year. An Instagram post for a birth control drug she was promoting neglected to include any risk information.

Clinton's plan was unveiled a few weeks after Clinton's closest competitor, Independent Vermont Sen. Bernie Sanders, issued legislation that tackles high drug prices.

Sanders' bill does not include anything on consumer ads, but does include some of the same reforms in Clinton's plan.

Her plan was also unveiled amid a public backlash against Martin Shkreli, who dramatically raised the price of a decades-old treatment for parasites.

How the Government Could Punish That Hedge Fund Bro Who Wanted to Raise a Drug's Price 5,000 Percent

Slate

September 23, 2015
By Jordan Weissmann

This week, the prize for most-hated man in America goes to Martin Shkreli, the rap-lyric-spouting former hedge funder who has found a potentially lucrative and socially useless niche in the business world by buying up the rights to old pharmaceuticals that treat rare diseases, then radically raising their prices. In August, his company, Turing Pharmaceuticals, purchased Daraprim, a 62-year-old drug that treats toxoplasmosis, a potentially deadly parasitic infection affecting infants, AIDS patients, and cancer patients, among others. As the New York Times reported, Turing promptly raised Daraprim's cost from $13.50 to $750 per pill. Shkreli's various justifications for the move—that the drug was supposedly underpriced to begin with, and that his company was absolutely, 100 percent going to use its profits to produce better versions of the treatment (even though many doctors didn't seem to think one was needed)—did little to mute the uproar. Last night, amid all the scrutiny, he budged a bit and said Turing would lower the price, though not by how much.

Assuming his conscience doesn't send Daraprim's price all the way back to $13.50 a tablet, Shkreli will be able to get away with his price gouging for a simple reason: Even though the drug's patents are long-expired, nobody else makes it. Thus, he has an effective monopoly over a life-saving treatment that lacks an alternative. One could argue that this speaks to the fundamental flaws of American oversight of the pharmaceutical industry. While the rest of the developed world uses price controls to keep medication affordable, the U.S. allows drug companies to charge whatever they please, with the hope that once their patents expire, competition from generics will drive down costs. To some slight extent, that's worked—about 8 out of every 10 prescriptions filled in this country are for generic drugs. But as production has become concentrated in the hands of fewer and fewer manufacturers, the prices of some generics have rapidly risen in recent years. And the costs of some specialty medications, like Daraprim, have skyrocketed.

So, is there anything to be done, short of completely rejiggering American pharmaceutical regulation (which, let's be honest, isn't happening any time time soon)? Last year, a group of doctors offered one clever potential solution to this issue in the New England Journal of Medicine. When the price of an unpatented drug shoots up, they argued, the Food and Drug Administration should actively go out and look for another company willing to make a generic version and put it on a fast track through the official approval process. The government already does something similar to deal with drug shortages, which have cropped up more frequently in the past several years, and the idea could also help with cases like Daraprim.

Here's why: Theoretically, another company could take notice of Shkreli and Turing's stunt and decide try to make a profit by selling its own generic version of Daraprim for a cheaper price. The problem is it would take a while. Largely thanks to a lack of office funding, the approval process for generic drugs has been slowed by a massive backlog of applications. "Even if a company wanted to enter tomorrow, it would still have to wait three years," Aaron Kesselheim of Harvard Medical School, who wrote the article with Jonathan Alpern of Regions Hospital in St. Paul, Minnesota, and William Stauffer of the University of Minnesota's Department of Medicine, told me. By promising to expedite things, though, the government would remove that roadblock, and maybe lure some competition into the market. During our talk, Kesselheim suggested that Washington could also offer other incentives, such as promising to buy some of the newly manufactured drugs through the Veterans Health Administration.*

The biggest hurdle, Kesselheim suggested, could be regulators themselves: "The problem here is the crisis relates to drug costs, and the FDA doesn't see itself as an agency that gets involved in drug costs." But, he added, there's no reason that mindset couldn't change.

Some experts have suggested that it's unlikely that another company would try to steal Turing's market share because the market itself is so small—in 2011, before several price increases, fewer than 13,000 Daraprim prescriptions were filled. Moreover, even if a company were to try to undercut the drug's current price, that might mean selling it for $300 a pill instead of $750. Hence, they say the only solution to the rising cost of generics, especially for specialty drugs, is more direct government regulation. "Given the size of this market, [encouraging competition] may not be a practical solution," Alan Sager of Boston University's School of Public Health said when I asked him about Kesselheim & co.'s proposal. "When we encounter natural monopolies, we regulate. Adam Smith didn't have just one string on his violin."

Nonetheless, recruiting generic manufacturers seems like a concept at least worth trying. As of now, companies that manage to corner the market for an obscure but essential old drug are more or less guaranteed a window of obscene profitability. Even if public outrage might dissuade some from trying—see Shkreli's second thoughts, or the recent case of Rodelis Therapeutics—there's still every reason to expect some companies will attempt to pull off the trick. But by showing that it's willing to go out and solicit other players into the market, the government might make gouging helpless cancer and auto-immune disease patients a slightly riskier proposition, and convince investors to put their money elsewhere.

It might not be the perfect fix. But, as George Mason University health policy professor Len Nichols put it to me, "We're hostage to the reality that we depend on competition to keep prices down." Until Congress finally does something bolder with pharma regulation, we might as well try to introduce as much competition as we can.

Read the rest of the article.

Modernizing Medicare: Supporting Minorities and Low-Income Patients

August 10, 2015
By Doug Holtz-Eakin and Len Nichols

Forbes

Medicare turned 50 at the end of last month and has proven to be a popular and indispensable component of the social safety net. Still, like any 50-year-old, the program needs to learn some new tricks to bring it more comfortably into the modern age, where budget pressures, rising health costs and equitable access to quality care must be addressed. Specifically, Medicare's reliance on the fee-for-service model has contributed to rising budgetary pressures. Considerable research has shown that fee-for-service plans are one way our system incentivizes quantity of treatment over quality.

In addition to the payment reform pilot projects that both predate and have been expanded by the Affordable Care Act, there is another powerful exception; one part of Medicare this is already not fee-for-service: Medicare Advantage (MA). MA offers seniors a one-stop option for all three legs of the Medicare stool: hospital care, outpatient physician visits and prescription drug coverage. It's also popular; enrollment in MA has increased every year since 2004 and reached 16 million individuals in 2014, which represents 30% of the Medicare population.

MA may be younger than Medicare, but it still has some issues

In order to address quality of care issues that are especially germane to low-income beneficiaries, the government ranks the performance of MA plans on a 5-star scale. The MA Stars program is designed to inform beneficiaries of the quality of the various plan options, and beginning in 2012, plan payment adjustments have been made based on their star rating, with higher-rated plans receiving bonuses.

The problem is that as currently structured, the Stars system gives unfairly low grades to plans enrolling the lowest-income enrollees. That's because a significant fraction of the performance measures are driven in part by patients' socioeconomic conditions and determinants of health, not actual plan or provider performance. Importantly, the majority of measures of performance are not adjusted for patient characteristics or socioeconomic status.

Since MA plans tend to have lower co-pays and deductibles than traditional Medicare, they attract a high number of lower-income and minority beneficiaries. Also, low-income enrollees are less likely to have supplemental coverage (employer plans or Medigap plans) that covers these costs. Among minority beneficiaries, Hispanics are twice as likely and African–Americans are 10% more likely to enroll in MA.

The consequences of a flawed rating system. Unless the rating system adjusts for the risk factors these populations bring to the table, the outcome measures will be biased against plans that serve them. That, in turn, leads to lower (or no) bonuses and higher premiums. Poor performance measurement turns into lack of access to the MA plan of their choice. At the same time, there are concerns that an inverse problem is occurring at the other end of the MA income scale: plans that serve healthier, high-income patients receive relatively higher ratings and income than they should, such that we end up subsidizing patients who don't need as much help.

This concern has led to calls for either establishing a separate rating system for plans in which enrollees are disproportionally low-income, or at least providing a score adjustment for such plans in order to compensate for those patient differences. As a rough calculation, it appears that removing the socioeconomic bias could mean higher payments to lower-income beneficiaries – to the tune of over $330 annually. That is real money that could align the incentives of the program with twin goals of efficiency and equity.

The Center for Medicare and Medicaid Services recognizes these potential problems and is committed to fixing them. The Congress is increasingly aware of the issue and, hopefully, will have comparable resolve. As Medicare moves into its second 50 years, all parts of the program need to work fairly, especially in support of the least affluent and most vulnerable populations.

Drug Prices Soar, Prompting Calls for Justification

The New York Times

July 23, 2015
By Andrew Pollack

As complaints grow about exorbitant drug prices, pharmaceutical companies are coming under pressure to disclose the development costs and profits of those medicines and the rationale for charging what they do.

So-called pharmaceutical cost transparency bills have been introduced in at least six state legislatures in the last year, aiming to make drug companies justify their prices, which are often attributed to high research and development costs.

"If a prescription drug demands an outrageous price tag, the public, insurers and federal, state and local governments should have access to the information that supposedly justifies the cost," says the preamble of a bill introduced in the New York State Senate in May.

In an article being published Thursday, more than 100 prominent oncologists called for support of a grass-roots movement to stem the rapid increases of prices of cancer drugs, including by letting Medicare negotiate prices with pharmaceutical companies and letting patients import less expensive medicines from Canada.

"There is no relief in sight because drug companies keep challenging the market with even higher prices," the doctors wrote in the journal Mayo Clinic Proceedings. "This raises the question of whether current pricing of cancer drugs is based on reasonable expectation of return on investment or whether it is based on what prices the market can bear."

Pressure is mounting from elsewhere as well. The top Republican and Democrat on the United States Senate Finance Committee last year demanded detailed cost data from Gilead Sciences, whose hepatitis Cdrugs, which cost $1,000 a pill or more, have strained the budgets of state and federal health programs. The U.A.W. Retiree Medical Benefits Trust tried to make Gilead, Vertex Pharmaceuticals, Celgene and other companies report to their shareholders more about how they set prices and the risks to their businesses from resistance to high drug prices.

The trust cited the more than $300,000 per year price of Vertex's cystic fibrosis drug Kalydeco and roughly $150,000 for Celgene's cancer drug Revlimid.

Even former President Bill Clinton, in a speech to pharmaceutical executives in Philadelphia last month, said it would be in the industry's best interest to say more about its costs and pricing.

"Explain, explain, explain and disclose, disclose, disclose," Mr. Clinton said, according to The Philadelphia Inquirer. "Don't expect everybody to love you, but at least they will hear your side of the story."

The pharmaceutical industry has already had the veil lifted on various practices. Drug companies now have to report the payments, including meals and entertainment, that they make to doctors for research, consulting and giving promotional speeches. The companies have also had to disclose more results of their clinical trials and in some cases have started to provide raw data to outsiders.

It is unclear if cost and pricing will become the next such area. The state bills, which are supported by some health insurers and consumer groups, have not progressed. The two senators, Republican Charles E. Grassley of Iowa and Democrat Ron Wyden of Oregon, have not reported the results of their inquiry. And shareholders of Gilead, Vertex and Celgene voted down the resolutions proposed by the U.A.W. trust, though the trust says it reached settlements with Eli Lilly and with two other drug companies it would not identify.

The pharmaceutical and biotechnology industry trade groups say the transparency bills would be costly to comply with and would provide misleading information.

Even some people concerned about drug prices say that the cost to develop a particular drug has little to do with that drug's price and that knowing such information will not keep prices down.

"The past R&D cost is really kind of a red herring," said Len Nichols, a health care economist at George Mason University, referring to research and development. "The current revenue doesn't pay for past R&D; it pays for current R&D."

Prices for cancer drugs, some of which extend lives by only a couple of months, routinely exceed $100,000 a year, and some new ones exceed $150,000. And it is not unusual for the list prices of existing drugs to rise 10 percent or more year after year, far beyond the rate of inflation. The prices of older drugs for multiple sclerosis have risen from about $10,000 per year in the late 1990s to more than $60,000 now, according to a study, even as competition in the market has intensified with the introduction of new products.

Cost transparency bills have also been introduced in California, Massachusetts, North Carolina, Oregon and Pennsylvania.

Three of the bills require disclosures for drugs costing $10,000 or more per year. The others have different criteria. Besides development costs, some of the bills would require disclosure of the costs of manufacturing, marketing and advertising. At least some of the bills also ask for a history of price increases, the profit attributable to the drug and how much a company spends in providing financial assistance to patients using the drug.

Two of the bills would allow the states to act on the information, not just require disclosure. Pennsylvania's would allow insurers to refuse to pay for a drug if the manufacturer did not file the required report. In Massachusetts, a state commission would be able to set a maximum price for a drug if it determined that the price set by the manufacturer was significantly high compared with the benefits, costs or prices in other countries.

Most of the bills have not been acted upon, though hearings were held in California and Oregon.

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

The New York Times

July 5, 2015
By Reed Abelson

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.

The large for-profits also face more competition from some of the market's newest entrants, which have benefited under the Affordable Care Act. The law created a new species of insurer, the consumer-oriented co-op plans. But the introduction of statewide online marketplaces also helped attract new players, including large health systems like Ascension, the nonprofit Catholic system, and North Shore-LIJ in New York.

Read the rest of the article.

Presentations | Len Nichols, Ph.D.

September 10 **"Health Reform and Insurance Company Choices Amid the Chaos"**

Rocky Mountain Health Plans Board Retreat
Grand Junction, CO

September 17 **"Health Care Leadership and Community Stewardship: Transitioning for Patient Care to Population Health"**

Minnesota Hospital Association
Brainerd, MN

September 18 **"What Price Should We Pay for Specialty Drugs"**

Alliance for Health Reform
Washington, DC

September 29 **"Why Health Reform Will Not Go Away"**

Virginia Health Care Association
Hampton Roads, VA

October 1 **"Why This Time Is Different: The Economics Forcing System Reform"**

Partnership for Quality Care Annual Meeting, Washington, DC

October 5 **"Forces Supporting and Resisting (Inevitable) Payment and Delivery Reforms"**

Harbage Consulting Annual Retreat, San Diego, CA

October 13 **"What Price Should We Pay for Specialty Drugs"**

Mid-Atlantic Business Group on Health
Baltimore, MD

October 15 **"Past Present and Potential Futures of the US Health Care System"**

National Governors' Association, Medicaid Leadership Institute
Potomac, MD

October 16 **"What Price Should We Pay for Specialty Drugs?"**

Pharmaceutical Manufacturers Association of America
Washington, DC

October 22 **"What is Driving Health Care Cost Growth and What Can You (or Anyone) Do About It?"**

Teachers Retirement System of Texas
Austin, TX

October 29 **"What Price Should We Pay for Specialty Drugs?"**

Campaign for Responsible Drug Pricing
Des Moines, IA