

Ideas and Initiatives in the Managed Care Marketplace

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From the Editor

This is the first installment of a new column that will appear in this journal on a regular basis. Craig Stern, RPh, PharmD, MBA, FASCP, FASHP, FICA, FLMI, a member of the editorial board of The American Journal of Managed Care, will offer a quarterly commentary on issues of current interest to the managed care market. Dr. Stern's commentary will reflect the perspectives of various pharmacy stakeholders, including payers, providers, and customers.

During the year, this column will review trends, ideas, and specific products, considering the impact, benefits, and liabilities to the various managed care players. The column also will consider future growth and development of issues expected to have an impact on the pharmacy benefit.

The purpose of the column is to clarify evolving points of view and offer insights into the marketplace. Your comments and suggestions are welcome and will ensure the appropriateness of topics and ideas for future columns.

Several new healthcare trends, particularly trends in therapeutics, emerged or expanded in 1995. Examples of these expanding trends are disease-state and outcomes management, reassessment of the integration of the clinical and financial components of drug therapy, for-profit dominance of the healthcare delivery system, and creation of new roles for pharmacists and other healthcare providers. Since each of these trends has prompted other initiatives, I will discuss each separately but assess their combined effect on the marketplace.

Disease-State and Outcomes Management

Disease-state and outcomes management have become the new mantra of the healthcare industry. Yet

each provider, manufacturer, pharmacy benefit manager (PBM), and managed care organization has adopted a different view of disease management and outcomes initiatives. Integrated healthcare networks have channeled resources into information systems that track a patient throughout the system, providing a seamless continuity of care regardless of the organization or provider with which the patient is currently involved. Providers (eg, hospitals, clinics, and pharmacies) are focusing on specific diseases to improve the overall management of a cohort of patients. Pharmacy benefit managers are using their databases to identify high-risk or high-cost patients within specific diagnoses to improve patient compliance and use of pharmaceuticals as a means of decreasing drug costs and utilization of emergency medicine and hospital services. Drug manufacturers are providing educational programs and preferred contracts to improve the care of patients using their products. Several drug manufacturers have fielded "disease management companies" as service providers to improve the overall management of specific diseases.

Because disease-state management has not been clearly defined, a conflict has developed among managed care organizations, healthcare providers, and drug manufacturers. As a result, the payer is confused about what is actually being provided and how to differentiate among the various offerings. Providers and managed care organizations who label total quality management programs as disease-state management further confuse the situation by offering a portfolio of unbundled services that the payer cannot evaluate or understand. While the payer frequently thinks of a group health product as bundling various services, unbundling offers a variation on fee-for-service focused on diseases rather than providers or specialty services. Drug manufacturers, on the other hand, often offer disease-state management as a marketing tool to improve market share. If this is their new strategy for achieving improved price-to-earnings ratios, drug manufacturers could improve it by

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differentiating their products from those of providers and PBMs, or calling it something different. The market could then determine the competitive benefits of one drug manufacturer's products versus another's, rather than contending with the issue of manufacturers providing the same services as providers.

The use of disease-state management as a cost-containment tool by disease management companies, PBMs, and managed care organizations increases the payer's confusion. In this context, disease-state management serves as a quality-improvement tool whose benefit is based on delivering better information to providers. With this arrangement, costs are controlled by correcting specific provider practices. Thus the benefits of these programs are front-loaded in that most cost containment occurs in the initial phases and is followed by marginal improvements in cost and quality (ie, continuous quality improvement). The payer who expects sustainable improvements in quality and cost is faced with a large initial cost for performance and a high cost-to-benefit ratio thereafter. The market cannot be ignorant of such unbalanced returns when most industries have had experience with total quality management concepts.

In this situation, payers should focus on those companies that provide improved services at lower costs owing to the efficiencies and productivity enhancements of their total quality management programs. Payers should not support the long-term interests of disease management companies with limited horizons. Since PBMs and managed care organizations are largely undifferentiated, investors may be most interested in companies that are differentiated by their TQM programs. Such companies may have better earnings and continued access to equity markets for capital for expansion.

Since most disease-state management programs provide improved service through a total quality management mechanism, the use of outcomes measures is an important component of these programs. The type of outcome measured must be consistent with the program's desired goals, but the lack of consistency in the use of the term *outcome* leads to further confusion on the part of the payer. Among the types of outcomes identified are:

- Pharmacoeconomic outcomes (eg, cost-benefit, cost-effectiveness, cost-minimization);
- Improved clinical outcomes resulting from improved procedures or better drugs;
- Improved process outcomes resulting from improved processes of care.

Both the payer and patient tend to focus more on process outcomes than pharmacoeconomic or clinical outcomes. These tangible outcomes have been selected in customer service surveys, HEDIS measures, and other measures of interest to human resources managers making health benefit purchasing decisions. The market as a whole values companies and industries devoted to service excellence.

Pharmacoeconomics

Pharmaceutical companies contend that drug therapy is the most cost-effective treatment. Traditional arguments comparing brand-name drugs with surgery provide considerable support for this contention. However, rapidly rising costs in home infusion therapy in some regions challenge the contention by setting price points that approximate the cost per day of hospital stays. Additionally, new biotechnology agents carry prices that push the envelope of therapy and require evaluation as either capital investments or new lines of business. The evolution of decision analysis and pharmacoeconomics provides a framework for evaluating new and competitive products.

Pharmacoeconomics offers a new marketing strategy for drug manufacturers to establish interest in their products and position them as cost-control advocates even in the face of comparatively expensive therapies. However, the increasingly competitive marketplace requires information on all treatment and non-treatment options to make informed decisions. Drug purchasers are becoming more discerning and critical of pharmacoeconomic data. Therefore, successful integration of clinical and financial information into the manufacturer's marketing strategy can be achieved only if payers embrace studies that establish the benefits of individual agents compared with other options.

Equity markets may show short-term interest in pharmacoeconomic studies demonstrating comparative benefits of individual drugs, but the need for newer strategies to establish future cash flows is imperative. The old strategy of raising prices to improve earnings has recently gained renewed attention. Government indices reported all price inflation at 3.7% for 1995, while the National Association of Chain Drug Stores noted a price rise of 4.6% for the same period. In contrast, IMS (a major source of drug industry information) reported a 1.7% price increase in 1995 composed of an 11.5% decrease in generic prices, a 3.7% increase in brand-name prices for the first three quarters of 1995, and a 3.3% increase in brand-name prices for the fourth quarter of 1995. Price increases are an attempt by the drug industry to recapture lost

revenues at a time when public outcry over drug price inflation has abated. Although drug manufacturers may be comforted by industry revenues that continue even in the face of managed care, how long can this go on without alternative means to boost revenue?

Drug manufacturer-provider partnerships are rarely found, except in some of the new Columbia/HCA provider agreements and some drug manufacturer-hospital agreements for intravenous drugs and supplies. The increasing need to integrate suppliers and providers to improve efficiency and control costs has not generally led to the kind of partnerships seen in the retail and service industries. In these industries, suppliers manage ordering, inventory, and delivery to gain the efficiencies and cost containment of just-in-time systems (eg, Procter and Gamble's relationship with Walmart). Unlike the retail industry, pharmaceutical companies have not established long-term partnerships with distributors. Although consolidation of drug manufacturers has broadened the product portfolio of many companies, co-marketing and licensing agreements have not reached the point at which companies can establish sole provider arrangements or quasi-manufacturer/distributor arrangements. Conversely, the expanded offerings of drug wholesalers and the expansion of wholesalers into provider markets (eg, Cardinal's purchase of Medicine Shoppe and Pyxis) have elements of retail models.

For-Profit Dominance

The dominance of for-profit provider groups in hospitals, integrated health networks, and physician groups has brought market competition to healthcare delivery. Through restructuring, downsizing, and reengineering, providers have attempted to make the market more efficient and productive. Consolidations and closures have removed some overcapacity from the market. At the same time, providers are seeking capital for expansion to achieve the market share needed to gain competitive advantage. The need for capital is acutely evident in the growth of physician groups and management service organizations (MSOs). These groups emphasize short-term financial return and long-term growth and require professionals at all levels, including pharmacists, to produce returns on invested capital.

Representative of the new trends in hospital and integrated healthcare network dominance, Columbia/HCA has sought to increase economies of scale by increasing market share through improved purchasing agreements and contracts with managed care groups. This strategy has paid off in a 24% increase in net earnings for the fourth quarter of 1995, an 8% increase

in hospital revenue (double the industry revenue per hospital), and a 4.5% increase in hospital admissions. In the words of Victor Campbell, Columbia senior vice president, "The company's network strategy is working. Increasingly we are getting new and better contracts with more managed care networks." In addition, gains in hospital admissions have come at the expense of competitors. As a result, individual hospitals and small networks will find it difficult to compete head to head with large networks unless they focus on a market niche. Pharmacy and other ancillary services will be under ever-increasing pressure, even more so than today, to improve efficiency and productivity. The more traditional methods of drug distribution and delivery will face both internal competitors for resources and external competitors for outsourcing services.

The for-profit motive also brings the specter of consumer oversight and public accountability. Several consumer groups, such as the Center for Health Care Rights in Los Angeles, California, have questioned the quality of care for Medi-Cal patients enrolled in health maintenance organizations. The primary criteria used is the number of physician visits per year, which serves as a proxy for access to healthcare providers. Since no standards currently exist for visits per year, or any other applicable access standard, consumer findings indicate only comparative access among potential providers. These initial consumer studies have ignored pharmacy providers, but it is likely that all levels of providers eventually will be reviewed. Furthermore, since patients visit pharmacies at least three times more often than they visit physicians, the benefits of pharmacy provider visits may become more visible as an additional proxy for access. The competitive use of access measures, including physician and pharmacy visits, also portends the increased scrutiny of costs and benefits associated with each provider.

New Roles for Healthcare Providers

All healthcare providers are being pressured to differentiate their roles and services. Services that can be rendered by less credentialed healthcare providers are being assigned to physician assistants, nurse practitioners, nursing aides, and pharmacy technicians. Automation for repetitive and redundant services allows providers to apply to healthcare many of the productivity enhancements used by the engineering and defense industries. The legal and regulatory fights of physicians, nurses, and pharmacists to limit the influence of these "extenders" may hasten the transition from professional to automated solutions for routine activities.

The need to retrain healthcare providers for new roles comes at an expense. If payers are unwilling to pay for retraining providers at all levels (eg, pharmacists to clinical practitioners, nurses to nurse practitioners, specialists to primary care physicians), then capital must be come from equity markets or the healthcare industry itself. Capital does not come without strings attached. As other industries restructure, the burden of retraining has fallen on individuals and companies, rarely on the equity markets. As a result, the benefits of retraining must be concrete and have obvious returns for individuals or companies to part with their own capital.

The movement of pharmacists from technical responsibilities toward consulting roles is a case in point. The "pharmaceutical care" role of pharmacists is predicated on the acceptance and broad-scale initiative of pharmacists across practice settings, the retraining of pharmacists and retooling of pharmacies to deliver services, and new or modified reimbursement formulas. The demands of the new pharmaceutical care practitioners for additional reimbursement presumes that either the payer will pay additional fees or the current healthcare model will shift funds from other providers to compensate pharmacists. Since physicians, nurses, and other healthcare professionals are all vying for a fixed pool of funds, shifting of funds at the expense of these professionals would not be met with enthusiasm. Additionally, arguments that certain services (eg, patient drug compliance and drug education) can be provided less expensively by pharmacists than physicians puts the pharmacist in the role of physician extender. The use of extenders, whether pharmacists, physician assistants, or nurse practitioners, requires that certain physician roles be modified or eliminated, with the net result of fewer physician hours to compensate. All healthcare providers must come to an understanding that there will be an overall net decrease in the physician population and an overall increase in extenders. Ultimately, the extenders may be at future risk for elimination by automation once their activities have been categorized and regimented.

Recent studies indicating significant inefficiencies or waste in the drug delivery system can be viewed as

an opportunity for pharmacy practitioners to validate their desired roles. However, these studies also indicate what payers have surmised—that healthcare and drug delivery systems are inefficient and often ineffective, which leads to higher costs and inequalities. Correcting these inefficiencies allows all healthcare professionals, especially pharmacy practitioners, to provide a more consistently quality-based service at a lower cost. Although payers traditionally have not been willing to pay for correcting the system, they will reward those companies and providers who can deliver the benefits of an improved system. Thus the methods and capital required for changing inefficient systems rests with the healthcare industry. As stated earlier, cost-containment companies or companies that stand to benefit from universal coverage probably have the most interest in funding such improvements or entertaining new methods for attaining their desired goals.

Conclusions

As the healthcare marketplace becomes more competitive, new programs and practice roles will be judged on their perceived value as well as return on investment. An open market requires information to make decisions, which opens the medical community to additional scrutiny at all levels. However, since the healthcare market is still in transition, companies continue to register healthy returns in the face of payer demands for cost containment and initiatives for managed care.

While pharmacists and other healthcare providers seek expanded roles, payers and patients are demanding better services at lower prices. Current models for delivering healthcare products and services leave little flexibility for introducing new services and accumulating the capital required to make the transition to new roles. Yet the market has seen new entrants over the past few years in the form of PBMs and disease-state managers, and investors have shown interest in funding cost-containment programs. In this atmosphere of change, payers and investors provide a barometer for new ideas. Their interests fuel the future of pharmacy providers and the healthcare environment in which they practice.