

Reframing the Pharmaceutical Manufacturer/Health Plan Relationship in Managed Care

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ABSTRACT: Managed care is stuck in a vendor stage of health care industry evolution that is organized, primarily, to beat back costs through contracted discounts and utilization management. At the same time, the potential exists for an altogether different managed care that is based on a more explicit mission of lowering

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costs through improved quality. The foundation for this alternative approach is evident in current practices involving disease management and clinical-quality improvement. Significantly, while health plans do not have the staff or capital to systematically adopt these practices, pharmaceutical companies are in a unique position to assist. To the degree health plans start building sophisticated, long-term strategic partnerships with pharmaceutical manufacturers into their business models, managed care will gain the capacity to advance beyond its vendor stage and make good on its original mission of promoting preventive health, improving individual outcomes, and realizing sustainable cost containment. For this to happen, it is suggested that health plans address "total cost-of-care savings" in their budget process, and the pharmaceutical manufacturers establish a "consultative service function" in their managed care divisions.

Introduction

Managed care has no shortage of crisis tendencies. Unlike headline or public-relations crises, these crises go to the heart of managed care's business model. These include:

- Racketeer Influenced and Corrupt Organizations (RICO) actions that call into question the legal basis of capitation and aligned incentives.
- Medical directors being sued for malpractice because their medical management function could involve the practice of medicine.
- Rising health maintenance organization (HMO) premiums feeding infrastructures that typically

cannot merge laboratory and pharmacy data.

- Financially bankrupt independent physician organizations that never had the requisite capitalization, provider buy-in, or systems infrastructure to manage risk.
- An industry leader such as Aetna being forced by Wall Street to sell its financial arm due to continued poor performance in its managed care business.

Falling back on the adage that genuine change happens a step at a time, this article will address one area where, if change does occur, it will build meaningful quality improvement into managed care. That one area is the health plan/pharmaceutical manufacturer (pharma) relationship.

Health plans (HMOs and PPOs) as a general rule distrust pharma, due to a perceived conflict of interest: financial support implies formulary positions are being "sold," while partnerships compromise "objective" pharmacy and therapeutic (P&T) committee deliberations. The common thinking is that pharma/vendor relationships should be at arm's length. This view is promulgated by health plan legal departments, and bear the stamp of top management. The end result is that two key industry sectors whose business interests turn on producing health do not work together effectively. This, it will be argued, represents a serious flaw in health plan business policy and undermines the evolution of a more progressive managed care industry strategy.

Distrust of pharma

As indemnity health insurance shifted to HMOs and PPOs during

the late 1980s and early 1990s, pharmaceutical manufacturers recognized that the sales function could no longer just focus on physicians and hospitals. Selling also had an institutional requirement and the focus needed to be on nonphysician decision makers. Consequently, manufacturers developed managed care divisions with a sales function centered on account management. Account executives [AEs] were hired to foster long-term relationships with managed care payers. It is this account-management activity that health plans have, in varying degrees, come to resist. Health plans' legal and senior-management thinking is fixed on the idea that pharma account management is manipulative in ways that drive pharmaceutical costs up.

HMOs do not want AEs traipsing around their organizations developing relationships with managers. Some health plans openly prohibit program or grant participation with pharma. Others have policies prohibiting medical and pharmacy directors from having meetings with pharma AEs. Moreover, for a number of national plans, any pharma dialogue has to happen at the corporate level — there can be no meetings or dialogue locally.

Clearly, there are exceptions to these generalizations. Nevertheless, where managed care's distrust of pharma occurs, the most important result is not that pharma marketing is inhibited, because manufacturers can always turn up the throttle in other ways, e.g., consumer advertising and physician detailing. It is that productive relationships that could emerge between two key industry sectors in such vital areas as population-based medicine and clinical-quality improvement have been systematically thwarted. This is a collaboration that managed care can ill afford to lose.

Health plan distrust of pharma is flawed for at least three reasons.

(1) There are too many checks and balances operating in P&T com-

mittees for pharma to inappropriately curry favor. P&T committees have a formal process to evaluate prescription products for formulary positions. Clinical research articles appearing in peer-reviewed journals are carefully considered. Usually, a P&T committee has a portion of its members who are not employed by the health plan — typically, a pharmacy professor and local consultant physicians. In addition, P&T decisions are grounded in objective criteria. Safety and efficacy data are scrutinized, and the notion of veering away from decisions based on safety and efficacy simply does not occur. When all things are equal with these criteria, cost becomes the third factor. There is no way that an AE cultivating relationships within a health plan, or the promise of some “partnership”, will alter the objectivity of a P&T decision.

(2) Health plans do not understand the total financial impact of prescription cost increases, and their poor relationships with physicians make health plans partially responsible for those cost increases.

It is a given in managed care that pharmacy and medical budgets are siloed, and health plans do not measure the impact of pharmaceutical use on hospital days or physician visits. It is also a given that doctors write the prescriptions and, if they prescribe inappropriately, they should be given the data to see it. Nevertheless, health plans generally do not provide such data — in part due to information-system inadequacies, and in part because poor relationships with physicians undermine health plan credibility. Should any other business have such a deficient understanding of the impact that a key component's costs have on total costs — the way health plans do with pharma — or have such poor working relationships with key suppliers — the way health plans do with physicians — it would be out of business quickly. Until the managed care

industry resolves its information systems and provider-relations problems, a portion of the blame for prescription drug increases must rest with health plans themselves.

(3) It is short sighted for health plans not to draw on the sophisticated talent and resources of pharmaceutical manufacturers. What is significant about health insurance under managed care is that health plans no longer use the “rubber stamp” approach to payment as was the case in the prior indemnity era. The health plan *raison d'être* is not to be a passive middleman between the payer of premium and the provider of medical care, but to add value. The challenge faced by health plans in the era of managed care is to add value in ways that improve quality and cost effectiveness in health care. For health plans that are notoriously understaffed and underbudgeted in such important areas as disease management, data analysis, and patient and provider education to not aggressively draw on the talent and resources of the pharmaceutical sector is very short sighted.

Managed care evolution

The concept of managed care industry evolution has received too little attention in the health care business and policy literature. Managed care in its early days, like managed care today, was predicated on vendor relationships: health insurers establishing contractual ties defined by discounted fee arrangements with physicians, hospitals, labs, pharmacies, and other medical service providers. The shift in health insurance from an indemnity approach to a vendor logic is the central development that marked the rise of managed care.

A key empirical question is how much additional yield in savings and cost effectiveness can be expected from managed care's vendor logic. The proposition put forth here is *relatively little*. That is, the additional yield from a continued emphasis on

vendor initiatives pales before the additional yield from a newfound emphasis on advanced managed care initiatives in population-based medicine, disease management, clinical quality improvement, and patient education. Here, three points bear noting.

First, the medical enterprise is inherently inflationary. Aging of the population, high-tech medicine, and

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high popular expectations suggest inflationary tendencies will not recede with more aggressive contracting. In fact, the likely result of more aggressive contracting is continued alienation of providers, cost shifting to members, and increased consumer frustration because new models of health care delivery are not keeping pace with scientific progress in medicine. Put baldly, the more managed care industry strategy remains based on a vendor logic at its core, the more health care industry evolution will be slowed.

Second, there is not much excess in the system that managed care’s vendor logic can realistically reduce. Areas characterized by excess involve disease-state conditions marked by pronounced system inefficiencies such as: diabetes, congestive heart failure (CHF), asthma, and depression. Estimates I have heard from consulting engagements, for example, suggest that: 1) 50 percent of diabetics in an insured population are not diagnosed; 2) 50 percent of CHF patients who have been stabilized by cardiologists and returned to the primary care physician for maintenance end up out of control and back in the hospital within a few months; and 3) at least 30 and possibly 40 percent of the average primary care physician’s patient base suffers from undiag-

nosed depression. That these costly excesses shape managed care’s cost structure is not news.

This brings up the third point: based on hundreds of interviews with health plan pharmacy executives, it is abundantly clear that pharmacy management executives want a fundamental change. They do not want to be budget czars. They want to get past silo management and budget ad-

ministration, and they believe strongly in a more proactive pharmacy function that is centered on disease management and clinical quality improvement. Pharmacy management, in short, wants a more enlightened role in integrated health care delivery, grounded in what might be called “advanced managed care.” One illustration of such a transformation is outlined in Figure 1.

Significantly, none of the “advanced managed care” components in this model are new. What is new is the argument for a managed care industry strategy to promote a new stage in its evolution: 1) Managed care needs to evolve from its vendor stage to a more advanced stage; 2) a

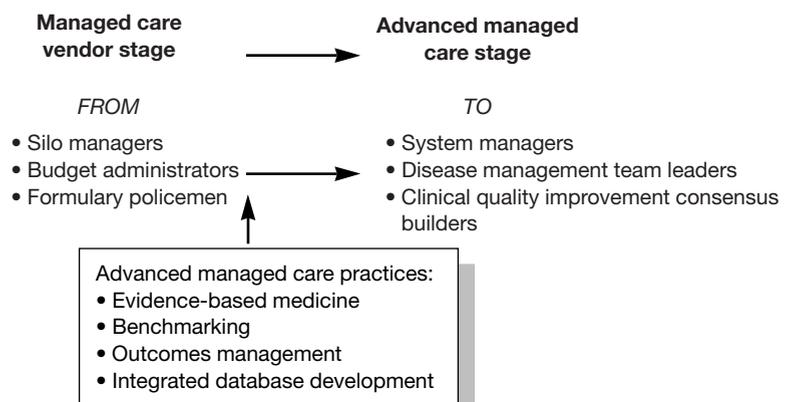
new industry strategy predicated on disease management and clinical quality improvement is necessary for the evolution to a more advanced stage of managed care; and 3) collaborative activity between health plans and pharma should be a driving force behind this new industry strategy.

Building partnerships

One lesson the health insurance industry should learn from other industries is how important collaborative relationships with suppliers can be for industry evolution. While supply-chain management has gained prominence due to the Internet and its ability to support real-time inventory control, an unfortunate byproduct of the Internet’s high-tech promise is that it obscures critical low-tech collaborative elements that make supply-chain relationships capable of pushing business to new levels. Indeed, as described by Womack, Jones, and Roos in their classic text, *The Machine That Changed the World*, Toyota’s legendary just-in-time operating system is based on a decidedly low-tech collaborative thrust.

- Toyota’s commitment to working with suppliers is for the long term, and it is focused on supplier ingenuity, dependability, and quality rather than price.
- Toyota reveals its fundamental business problems, even when

FIGURE 1 Pharmacy management



they involve proprietary issues, to suppliers, to involve suppliers in the solution.

- Toyota simplifies ties to suppliers rather than complicates them with bureaucracy. This encourages optimizing the total manufacturing process, not just design and purchasing.

By and large, health plan relationships with pharma flow in the opposite direction. Aside from health plans not wanting to sully their “objective” posture, most are not organized to take advantage of the resources pharma has to offer. This can be attributed to a lack of specificity for value-chain collaboration in managed care industry strategy and to the absence of budget frameworks to tackle population-based disease management and clinical quality improvement problems.

Since the Japanese assault on the U.S. automobile market in the mid-1970s, the Toyota emphasis on collaborative partnership with suppliers has become axiomatic, not just in the automotive industry but in countless others as well. A look at the business section of newspapers any week of the year will describe some structural collaboration between manufacturer and supplier — between an upstream and downstream entity — involving equity, integration of business processes, formation of joint work teams, and/or joint capitalization. There is simply no comparison between the way any major health plan works with pharma or physicians, and the way Toyota works with its key suppliers.

On this point, then — structural collaboration with key suppliers — managed care’s vendor logic has caused health insurers to fall behind leading management practices, representing at least one new opportunity for managed care today.

Reframing health plan component

Health plans need to evolve from the current vendor stage of managed

care to an advanced managed care stage. In addition, the process of industry evolution has to be initiated by health plans, because it is their dominance in the health care value chain that defines the managed care era, just like it was the medical profession’s dominance in the health care value chain that defined the prior indemnity era. What follows are four recommended changes in industry strategy that health plans would do well to embrace.

Provider relations. Arrest the deterioration in provider relations and build sustainable quality relationships with participating physicians around mutually shared core business objectives, including: clinical quality improvement, population-based medicine, disease management, and health promotion.

Information systems. Revamp and reinvest in information systems so medical and pharmacy management’s mission and responsibilities are tied to these same objectives. That means any well-designed health plan will: have a data warehouse; integrate pharmacy and lab data; formally promote electronic medical records in physicians’ practices; build pharmacoeconomic and outcomes metrics into routine medical and pharmacy management reporting; and assign ample database managers and analysts to medical and pharmacy management.*

Actuarial influence. Make the 1-to-2 year actuarial underpinning in current insurance pricing and member contracts explicitly long term —

* While considerable attention is paid to the 15–20 percent annual increases in prescription costs of the last few years, I suspect that few, if any, health plans have increased full-time equivalent (FTE) staffing of data analysts reporting to pharmacy directors. Almost invariably, then, while the third-largest component in a health plan’s cost structure has become the primary explanation for premium increases, the capacity for health plan pharmacy management to understand prescription costs relative to total costs remains inadequate.

3, 4, or even 5 years. HMOs especially, due to their mission, have to sell products that make it financially worthwhile to produce member health.

This will require that health plan chief executive officers tell their actuaries to re-examine established methodologies and to subordinate indemnity principles (simply adjusted for vendor practices) to “advanced managed care” principles.

It will also require that the National Association of Insurance Commissioners revise the conduct of their business by embracing long-term health care delivery clinical objectives in at least three ways:

- Redefine recommended guidelines for the states to use in granting health plan licensure and implementing ongoing regulations.
- Redefine actuarial assumptions that determine how states approve health plan benefit designs, premiums, and member contracts.
- Redefine financial assumptions for health plan reserve requirements, possibly building short-versus long-term population-based performance measures into how first-year versus out-year reserves are calculated.

Health plan business model. Build collaborative clinical partnerships with pharma and revised medical/pharmacy management relationships into the business model governing health plan strategic management. Key activities associated with health plans’ revised business model should include:

- Directing collaborative pharma initiatives to areas where pharma expertise and resources can improve clinical efficiencies, quality, and patient outcomes.
- Breaking down the separate cost center/silo behavior and making total patient care the essential unit of analysis.
- Adding pharma-related quality

improvement objectives to provider relations department day-to-day responsibilities.[†]

Reframing pharma managed care

While health plans have to step up and commit managed care to moving beyond today's vendor logic and "1-800-NO" industry behavior, they cannot do it by themselves. Pharmaceutical manufacturers have to step up as well. Here, three suggestions are presented for pharma to reframe its managed care focus to help health plans develop Toyota-like synergies with key components of their value chain.

Pharma managed care business model. Add a performance standard associated with health plan total cost-of-care savings to pharma managed care business models. To date, managed care divisions are driven by their own contracting function, centered on the need to secure formulary positions. Collateral activities involve product pull-through. Consequently, standards for determining how managed care divisions perform revert to product sales. This raises two points about the way pharma and health plan interests interact.

First, because health plans [actually, all third-party payers] are in the business of losing money — the only question is "how much?" — a product sales thrust puts pharma on a collision course with customers. Indeed, the better pharma does its job, the more health plans lose money. Would not the business model of pharma managed care divisions make better sense if part of their performance was aligned with how health plans *make* money?

[†]Provider relations departments in health plans continue to operate with a "vendor managed care" focus. The suggestion here is that health plan provider reps be retrained — possibly as part of a pharma partnership, and perhaps to include codetailing targeted physicians — to implement pharmacy-related *medical management* objectives under an "advanced managed care" focus.

Second, with product sales defining business objectives, pharma managed care divisions are almost locked into diminishing returns. This can be attributed to health plans' preoccupation with pushing down unit costs. It can also be attributed to the inevitable growth in the number of agents competing in therapeutic classes, and the eventual class effect. The end result is that the greater the pharmaceutical industry's experience with a therapeutic class, the more margins diminish. Here, again, a question similar to the one above should be asked: Wouldn't the business model of managed care divisions make better sense if some portion of pharma performance generated additional revenues with the experience accompanying product maturity?

Service line extension off product sales. Build a consultative service component into managed care divisional objectives. At this point, two services appear to be best suited for health plans, based on where most acknowledge they are well below optimal performance: clinical quality improvement and disease management. Key to pharma supporting such services is that it also has expertise from the experience with its products.

Companies selling drugs do have knowledge regarding side effects, usage patterns, patient compliance, and physician practice variation that could translate into improved outcomes and total cost-of-care savings.

Consequently, at the precise point in a sales cycle where product maturity begins to take hold, it is not unreasonable for pharmaceutical competitors to differentiate their offering with an additional service arrangement that ties consultative initiatives to a separate revenue stream.

Such revenue streams need not be risk arrangements. They could be performance arrangements that are linked to product contracts.^{**} Assume, for instance, that a 3-year product contract is ending and a health

plan is looking to drive down the unit cost from, perhaps, 100 to 70. A pharma managed care division could make an offer as follows.

"We will discount to 70, but we want to partner with you in ways that produce clinical efficiencies to your bottom line, and we want a piece of the action: We get appropriate use for all products in the class up by X percent, and 12 percent of our discount is reversed; we get patient adherence for all products in the class up by X percent, and 12 percent of our discount is reversed; we get physician practice variation for all products in the class down by X percent, and 12 percent of the discount is reversed."

Under this scenario, a new pharmacy benefit management (PBM) service would be to conduct impartial measurement and evaluation by quarter. Health plans need not fear that this would promote the manufacturer's product, because the contract is clear that pharma managed care promotes all products on formulary. Pharma creates a second revenue stream involving delivery system performance. Clearly, only one pharmaceutical manufacturer can contract with a health plan per therapeutic class, and the 12 percent in

^{**} Early pharmaceutical industry efforts to sell services as proposed — Stuart Disease Management (Zeneca) and Integrated Therapeutics Group (Schering-Plough) — have failed for reasons that include: 1) managed care industry strategy does not provide for health plans to buy consultative services from pharma; and 2) health plan budgets do not provide for pharma payment tied to service performance. A current example where these factors have been addressed is an innovative arrangement Pfizer established with Florida's Medicaid program. See Russell Gold et al, "Pfizer Ducks Pressure on Prices by Helping State Save on Medicaid," *The Wall Street Journal*, July 9, 2001, A1. A few months after Pfizer, Bristol-Myers Squibb signed a similar arrangement with Florida's Medicaid program. See Russell Gold, "Bristol-Myers Signs Florida Deal for Medicaid Health Initiatives," *The Wall Street Journal*, Sept. 6, 2001, B2.

FIGURE 2 Redefining and reorganizing account management

Change:	From	→	To
Institutional thinking defining account management	Product-centric		Customer-centric
	Transaction focus		Business-to-business focus
Organizational approach to account management	Formulary concern		Selling solutions
	Account executive		Account general manager
	Account teams without FTEs		Account teams with FTEs
	Matrix organization		Formal business unit
	Value-added		Advanced managed care consulting

this example — like the 70 percent — is subject to negotiation.

Re-engineer account management. A third recommendation is that the account management function be re-engineered to produce customer value and service revenue. Return on investment for pharma managed care divisions should now become somewhat less dependent on product sales and somewhat more dependent on service. In this sense, the transformation in pharma is not unlike the transformation that such manufacturers as IBM and GE achieved with business models targeting service revenues separate from product sales.[‡] Here, two specific developments are suggested: changing the institutional thinking that defines account management; and changing the organizational approach to account management. These changes are depicted in Figure 2.

Summary

Managed care industry evolution is locked in a vendor phase that continues to alienate providers and patients. One reason is that industry strategy has not pushed health plans to adopt business models predicated on population-based disease management and clinical quality improvement. A second is that health

[‡] See, for example, Matt Murray, "GE's Honeywell Deal Is More Than Sum of Airplane Parts," *The Wall Street Journal*, April 5, 2001, B6; and William M. Bulkeley, "These Days, Big Blue Is About Big Services Not Just Big Boxes," *The Wall Street Journal*, June 11, 2001, A1.

plans do not have the resources, and often the will, to achieve the transformation such business models call for.

The change in managed care industry strategy proposed here is for health plans to build Toyota-like partnerships in their value chain. While physicians and hospitals are important, pharma can play a special role. Health plan/pharma relationships, however, have to be symmetrical. They cannot simply be the pharma "fat cats" underwriting X, Y, Z health plan initiatives as part of a value-added campaign. Managed care needs specific budgeting that will permit pharma to generate revenues from quality-improvement activities, if such activities produce total cost-of-care savings.

Pharmaceutical managed care divisions, for their part, have to revise their business model. Rather than focus exclusively on product sales, focus should also be on an "advanced managed care" service line extension off of product sales. Examples of outcomes that could be pegged to managed care division revenues include benchmark "process" achievements: eliminating physician practice variation, increasing appropriate prescription drug utilization, and increasing patient adherence. Dollars that migrate to pharma would come from total cost-of-care savings and, as a practical matter, would probably have to be aligned with multiyear product contracts.

Significantly, all pharma service contracts should proscribe favoring

one pharma product over competitors. If an angiotensin receptor blocker, selective serotonin reuptake inhibitor, or antibiotic is called for, than product selection ought to be left to the doctor's discretion and sensitivity to formulary considerations. The pharma service line extension — based on the expertise a manufacturer has with the therapeutic class and disease state — would center on devising and implementing systems of quality improvement to promote consensus standards.

In this very preliminary model, actuarial science will need to move beyond the scholasticism of its indemnity logic and build an "advanced managed care production function" into recommendations it gives health plans and state insurance departments. In addition, PBMs will need to develop a new core competency centered on health care delivery process and outcome measurement, as well as performance evaluation.

The prize in all this is the production of total cost-of-care savings from clinical quality improvement. The challenge is for managed care to evolve by creating value that current industry strategy ignores. The reasons managed care might not advance are many. There are always reasons for "no." It is the responsibility of managed care executives though — no less than research scientists toiling away in labs — to get to "yes."

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