Carve Outs & Pharmacy: Fashion or Fad?

As pharmacists learn more about capitation and other risk-based forms of reimbursement, the words “carve out” are becoming critically important in contracts and negotiations. Here are some of the pros and cons of carving services out of fixed-rate plans.

Managed care organizations are finding they can reduce overall costs by contracting out for certain parts of the health benefit. This process of “carving out” portions of the benefit plan takes several forms, each with differing implications for pharmacy services. In this article, I review the pragmatic basis for carve outs and give examples of successful efforts.

**TYPES OF CARVE-OUT PROGRAMS**

Carve outs can take two forms: Removal of discreet parts of the health benefit or just of the services related to a specific drug or disease. Entire services might include pharmacy or mental health. Disease- or treatment-specific can be diabetes mellitus, oncology, or maternity care; others are drug-specific or situation-specific.

**Mental Health Carve Outs**

Mental health programs are commonly carved out of general health

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Annual Meeting of the Academy of Managed Care Pharmacy in San Francisco. Goldsmith, president of Health Futures Inc. in Bannockburn, Ill., said the decline in premium costs has resulted “in a lot of organizational scrambling around.”

Health care providers almost unanimously agree, he explained, that the future shape of the metropolitan health care environment will include three to six vertically integrated, sole-source, full-spectrum providers from which payers and consumers will choose. Such vertically integrated providers will be fully capitated and employ physicians and other needed providers.

This view persists despite the fact that “consumers are telling us they don’t want closed panels. They want broad inclusive networks and they want to make the decisions about who will provide their care. They want to continue relationships with hospitals and doctors who have served them well, and they want database information with which to make those decisions,” Goldsmith said.

VERTICAL VS. VIRTUAL INTEGRATION

Health care is too complicated for the vertical integration model, borrowed from more mature industries, such as automobiles, to function well. “A $3 billion enterprise is no better or cheaper than a smaller entity of loosely linked networks,” he said. In fact, “dis-economies of scale” occur when giant entities attempt to deliver cost-effective care at the patient level.

As evidence, he points out that staff-model HMOs such as Kaiser Permanente and Group Health Cooperative of Puget Sound, which own hospitals and employ physicians, are now disassembling that model to some extent. They are contracting with hospitals and physicians outside their own plan because they can get quality care more cost effectively.

Goldsmith said what must occur in health care is not vertical integration, but “virtual integration.” He defines the latter this way: “Strategic collaboration based on developing and marketing products through contractual arrangements rather than common ownership.” By sharing economic risk and sharing values across the partnership, these virtually integrated organizations will become the dominant framework for delivery of care, Goldsmith said.

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—Jeff C. Goldsmith

The old model under which managed care first emerged will no longer work, he warned. For one thing, in 1980, as managed care was just entering its boom cycle, it enrolled only the healthiest people. Now, the sickest members of society at highest risk are participating in managed care, such as Medicaid and Medicare patients.

Second, managed care formerly operated under the high-priced umbrella of “totally unmanaged” indemnity insurance. Such is no longer the case. “Indemnity insurance is a dying business,” Goldsmith maintained, and managed care “has won the battle. It is no longer the counterculture force.” That means instead of merely being cheaper than somebody else, it must demonstrate value.

Finally, the savings that managed care previously achieved by lowering hospital stays and passing on the reduced costs in the form of lower premiums “is less and less viable as a strategy.” Hospitalization rates have dropped among all providers, and the gap between HMO and other providers’ premiums has narrowed. In some cases, PPO prices are even lower than HMOs’ because of steep discounts offered by “panicked physicians and hospitals who don’t want to be left out,” Goldsmith said.

IMPLICATIONS FOR THE FUTURE

What does all this mean for managed care plans? To survive the coming shakeout, they must move away from managing price toward cultivating consumer satisfaction and away from component management toward risk management. “Instead of waiting until someone gets sick, you try to manage that sickness in a proactive way,” he said. One step is to set up means of identifying high-risk populations—and then to develop protocols for lessening that risk.

This prospective rather than event-based approach will focus on continuous low-intensity interaction with patients and their families, Goldsmith explained. And the health care provider team will include, but not be dominated by, a physician as well as other caregivers such as pharmacists. This team will develop protocols and clinical pathways and create a “seamless continuity of care.” No longer will consumers see their interaction with the health care system “as one huge succession of dropped batons,” he quipped.

Pharmacists will be important in this new system. They have opportunities to encourage behavioral change and monitor appropriate use of medications in a way that will avoid hospital and nursing-home stays, Goldsmith said. “I see use of pharmaceuticals increasing as we move into this risk-driven, rather than event-driven, world,” he said.

Goldsmith, a noted proponent of medical innovation, said biotechnology and genetic diagnosis will enable earlier intervention before diseases become symptomatic. “Pharmacy has a crucial role to play, not only in educating patients about these developments, but in informing the decision-making framework and applying pharmaceutical innovation to improve people’s lives.”

KNUDSEN: CHARACTERISTICS OF A SUCCESSFUL SYSTEM

The second keynote speaker, Kermit B. Knudsen, M.D., did not wholly agree with Goldsmith’s contenions
ETHICAL ISSUES ASSOCIATED WITH NEW, HIGH-COST DRUGS

New therapeutic agents can significantly alter patient treatment options. Often, these agents are substantially more expensive than other pharmaceuticals. The question of how to provide access to these agents without breaking the pharmacy budget is a difficult one to answer.

The decision to allow the use of high-cost pharmaceuticals is typically left to the pharmacy and therapeutic (P & T) committee. The committee is generally given criteria to determine which patients would be eligible for the drug. This situation was complicated by the manufacturer having a lottery system for the drug. First, patients had to be selected by the manufacturer, and their physician would then present the case to the P & T committee.

Other options may be used to evaluate the use of high-cost products. Bruce Fallik, of Rocky Mountain Health Care Corp., indicated that many expensive therapies are available through prior authorization. Treatment guidelines are also commonly used by his company, according to Fallik.

Pharmaceutical manufacturer lottery and distribution systems create new issues for managed care organizations. Manufacturers may market and distribute their products directly to consumers, circumventing managed care organizations. This may create patient expectations that the drug would be covered by the health plan, but this is not always the case. Craig Stern, of Pro Pharma, indicated that some high-cost drugs available through lottery systems may be viewed as investigational agents, even though FDA has approved them. Thus, plans that prohibit the use of investigational agents may deny coverage to lottery-type drugs. Employer groups also are faced with coverage decisions when manufacturer's agents are out of network providers. Larry Barenbaum, of Rx Image, suggests that it is difficult to deny coverage for a product made available through manufacturer distribution systems because the products tend to be one-of-a-kind drugs. Decisions about product use will not necessarily affect the pharmacy budget because the products are administered in the physician’s office or through home health agencies.

Direct provision of pharmaceuticals by manufacturers is certainly not pleasing to managed care organizations. Kimes believes that many manufacturers will attempt to take their AIDS drugs directly to the patient, allowing little ability to manage these drugs. In an effort to thwart resistance to manufacturer distribution systems, Glaxo Wellcome’s arrangement with Quantum Health Resources (QHR) does not prohibit large managed care organizations or hospitals from purchasing the drug from QHR.

The development of standard policies and procedures for expensive therapies will be difficult, states Kimes. Each drug is different, and political and social issues often enter into the decision-making process. Managed care organizations should be proactive in determining drug-coverage and patient-eligibility criteria in an attempt to head-off potential problems. However, this may become increasingly difficult as more expensive therapies are approved for marketing.

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Pharmaceutical Implications

"Capitation agreements work best when there is a long-term contract, and pharmacists should expect to lose money the first year, break even the second, and hopefully have positive gains the third year," says Mary Sevon, president of Sevon and Associates. Currently, not a lot of pharmacy capitation agreements exist. Many pharmacies are unwilling to enter into capitation agreements for pharmaceutical products because pharmacists traditionally have had little control over medication selection.

For insurance to properly work, one must also have a sufficiently large number of patients so that expected claims rates can be calculated with some certainty. Patients with certain diseases are more likely to consume medical resources; thus, insurance companies have sought to exclude these patients using pre-existing condition clauses, limiting coverage for products or services, and putting limits on total expenditures. Even if coverage is to be provided, a premium rate for these patients is difficult to calculate because of the small number of patients involved. According to Pat Kimes, Humana combined underwriting across regions for patients with hemophilia because of the small number of patients, but expenses were high.

Reinsurance: Another Option

Insurance companies often do not assume total financial risk for an insured population. They will seek other companies to buy some of the risk, a process called reinsurance. Typically, reinsurance policies are not activated until total plan expenses exceed a given figure, often in the millions of dollars. Thus, primary insurers will have a "stop loss" safety net to keep from going broke. Theoretically, reinsurance can be purchased for just about any type of insurance policy, although the premium for reinsurance varies greatly depending on the situation.

In the case of capitiated pharmacy programs, reinsurance does not appear to be a viable alternative. Davis stated that reinsurance rates were too high to be economically feasible for the Tennessee capitiated drug program. According to Stern, the corridor for reinsurance of the pharmacy component is too narrow, and consequently, very expensive. On the other hand, most managed care organizations can find reinsurance for the entire health plan. Thus, pharmaceutical costs associated with treating very expensive conditions, such as AIDS and transplants, may be shifted to reinsurers if total costs are sufficiently high.

CASE-RATE & DISEASE-STATE MANAGEMENT

Unlike prospective carve-out options, "case-rate plans are fairly common," says Melek. In situations with a high risk of utilization, employer groups are looking to transfer the risk to providers.

Typically, a case-rate plan would become effective after a patient was diagnosed with a disease. "A set amount would be paid to the provider to assume responsibility for all aspects of getting the patient through the disease or through a specified period of time," says Melek. In this scenario, costs are fixed. Common case rate programs include some orthopedic procedures, maternity care, and recently oncology, based upon a given type and stage of cancer.

Although case-rate programs involve small numbers of patients, actuaries have been able to obtain sufficient data over several years to predict program costs accurately. Thus, employers purchasing this type of coverage have reasonable confidence that the premiums will not be exorbitant and providers are not likely to go out of business during the middle of a contract period. Prescription drugs in a case-rate situation can be covered under the general health plan or handled separately, depending on the disease. For managed care organizations and employers, case-rate agreements can certainly limit the upside risk for diseases that can be catastrophic.

Case-rate management could be called disease-state management (DSM). The goal of DSM is to examine the entire treatment protocol and identify the best pathway to achieve desired clinical outcomes without wasting resources. Larry Barenbaum, of Rx Image, suggests that DSM programs may have an impact on future carve-outs for pharmacy benefits. However, Barenbaum believes that current information systems are not sufficient to support DSM programs because databases lack accuracy, and the limited cross-over between data sets prevents risk adjustments based upon disease. Certainly, more work is needed to allow insurers, pharmacists, and the pharmaceutical industry to administer DSM effectively.

WHERE PHARMACISTS CAN HELP

As DSM systems are being developed, pharmacists can play many roles in carve outs and capitation plans, says Sevon. She believes that pharmacists must learn to manage the patient by actively practicing pharmaceutical care. "Managed care organizations are not willing to pay pharmacists for 'warm and fuzzy' cognitive services, but they will reward providers that can reduce pharmacy-specific costs."

Many case managers will solicit input from pharmacists regarding care, but few pharmacists are actually case managers. Many opportunities exist for pharmacists to become involved in helping coordinate care, especially for those patients using high-cost pharmaceuticals.

Pharmacists' expertise regarding drug therapy and disease management can be valuable assets to managed care organizations in helping control overall plan expenses.

References