

**FIRST DO NO HARM**

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## THE Big Reset

***Pharm Exec's* industry  
forecast finds pharma  
leaders rebooting  
systems in the face  
of small growth and  
big changes**





# FIRST

## Do No Harm....

**Designing and deploying company copay offset programs without devaluing the brand**

By [Mason Tenaglia](#) and [Christopher Meister](#)

**C**opay offset cards—which reduce patient exposure to the cost of a branded medicine—have emerged as the preferred solution to preserving market share in an era of growing payer dominance over prescribing decisions. Having trouble with a formulary access at launch? Give patients an offset card. Competing with a generic therapeutic alternative? Offer the card—and avoid the switch. Seeking to generate uptake and accelerate conversions to a line extension? A new copay offset will create the incentive.

Yet despite their simplicity, offset programs can be costly to drugmakers, with spending likely to surpass \$3 billion this year. It is thus surprising how few companies have conducted a rigorous analysis of the return on this investment, particularly in brand adherence, or on the larger impact on patients over time. As copay offset programs expand and more companies enter the space, it is critical to step back and pose a few tough questions in return. For instance, what is the real, long term value of these offset programs—i.e., when, where, and for how long should they be used?

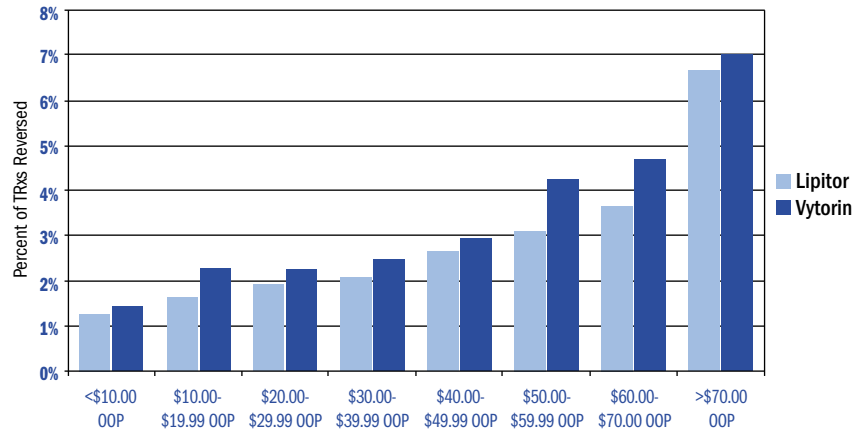
While offset programs look to be a quick, reasonably cost-effective way to cement patient loyalty, lowering out of pocket costs to a manageable \$20 or \$25 per scrip, there are many pitfalls. These range from implementing a “one-size-fits-all” solution, including every patient as an eligible (much as occurs in a free sample program), to simply bundling offsets with other elements of a larger direct marketing campaign. Over time, this can actually diminish the value of the brand at peak stages of the product life cycle, while wasting scarce resources that could be better spent through more targeted initiatives aimed at specific patient sub-classes.

If the bottom line in brand marketing is to increase patient and provider uptake of a medicine, then subsidized copay offsets are not always the optimal approach, as confirmed by the following caveats:

1. Not every patient is eligible (copay offsets are an illegal inducement for Medicare Part D beneficiaries)
2. Many who elect to use the cards won't get much value—perhaps under \$5

TABLE 1

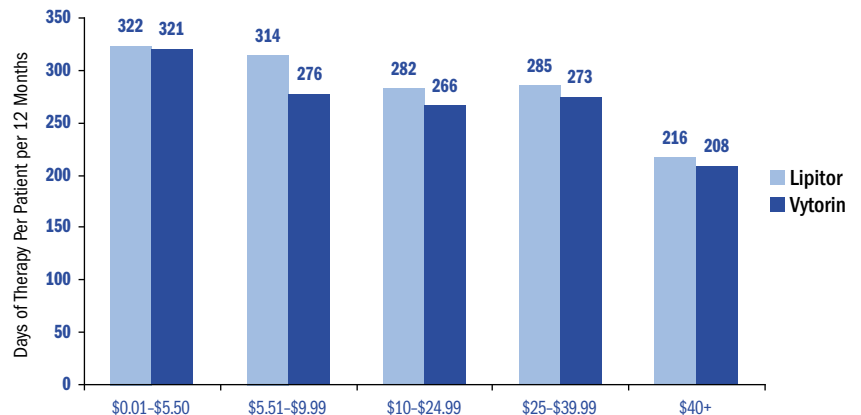
### Reversal Rates by Co-pay Cohort



Source: Wolters Kluwer Pharma Solutions 2009, Amundsen analysis

TABLE 2

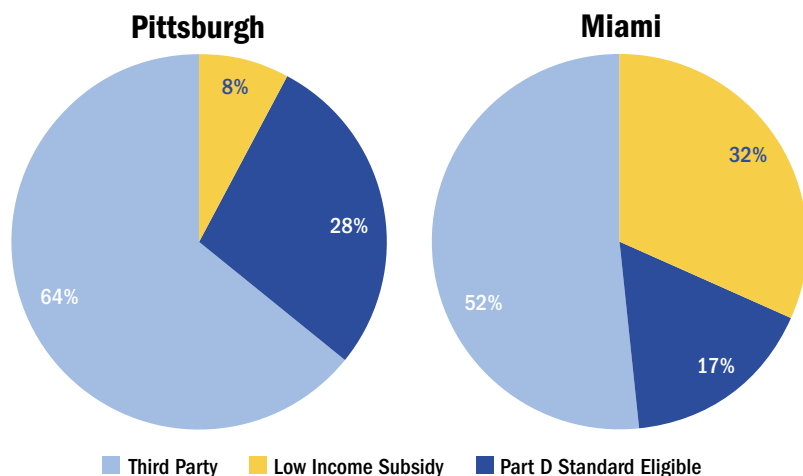
### Lipitor vs. Vytorin Adherence by Co-Pay Cohort



Source: Wolters Kluwer Pharma Solutions 2009, Amundsen analysis

TABLE 3

## Share of Prescriptions Covered by the Part D Low-Income Subsidy



Source: Wolters Kluwer Pharma Solutions 2009, Amundsen analysis

3. Many who do use them and extract high value would have filled the scrip anyway
4. Those who grow accustomed to the lower cost will face a copay “sticker shock” when faced with withdrawal of the benefit.

The irony is that over the last 15 years, pharmaceutical manufacturers have become highly sophisticated in their approach to institutional discounts, offering up incentives in the form of rebates to managed care companies and PBMs. The rationale for maintaining access in a world of progressively higher copays on expensive Tier 2 and 3 classified products is self-evident, and there are metrics to measure that. The precedent exists to do the same by building more analytical controls around the task of easing the patient burden through the copay offset.

A few industry players are creating a set of “first principles” for co-

pay offset programs, covering design, deployment, and monitoring issues. New data, widely purchased by the industry but not yet well understood by senior management, can inform the development of clear answers to these “how much, how long, and where” questions, and dramatically improve the investment return on this promotional strategy.

More importantly, these principles, combined with appropriate forethought and data analysis, can help minimize potential damage to a brand’s value from indiscriminate spending. It is great to change the trend line, but first, brand managers must make sure that *they do no harm to their brand franchise*.

### Keys to Successful Offsets

The key to minimizing harm and maximizing return on copay offset programs lies in three basic principles. These are grounded in the ability of manufactur-

ers to tap new streams of data that allow them to allocate and measure their direct-to-patient investments, on a timely basis.

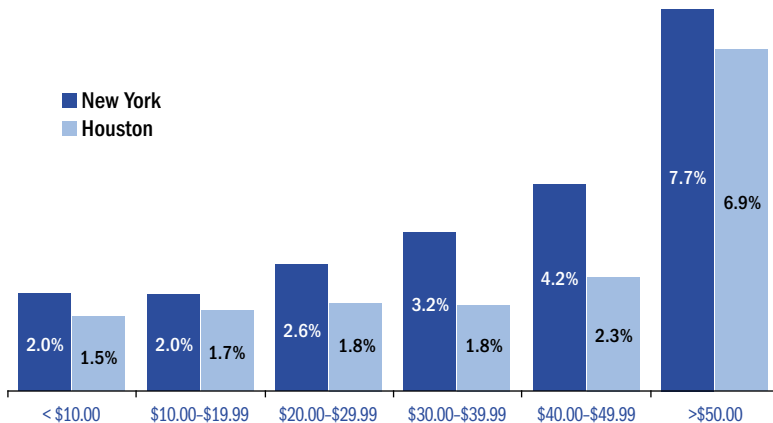
**Principle One—Offset programs should be designed to reflect consumer price sensitivity and brand adherence requirements.** The availability of dynamic claims or rejections and reversals data as well as anonymous patient longitudinal data (APLD) now makes it possible to understand patient price sensitivity at both the initial pharmacy transaction and for each subsequent refill. From these data it is possible to identify the inflection point at which patients increase their rate of abandonment of prescriptions, and what level of monthly out-of-pocket expense will have the most significant impact on patient adherence to continuing with the brand.

By capturing the entire stream of data for a patient (including scrips that must be reversed due to abandonment by the patient), pharmaceutical marketers can determine the optimal price to be offered. Many companies have targeted a \$20 or \$25 dollar maximum out-of-pocket payment for patients trying to emulate the typical Tier 2 copay. But who says this is the optimal level? Analysis of actual patient decisions when facing alternative copays can help identify this price point. To the surprise of many, the data show that the price sensitivity threshold (PST) is extremely different between therapeutic classes, and is often very different between two products in the same class.

Take, for example, the statin class. An analysis of patient reversals shows that the out-of-pocket payment level (OOP) at which Lipitor patients significantly increase abandonment is

TABLE 4

### Vytorin Abandonment Rates by Co-Pay Cohort



Source: Wolters Kluwer Pharma Solutions 2009, Amundsen analysis

around \$50. On the other hand, for Vytorin, which has a generic simvastatin as a near-alternative available, price sensitivity kicks in at just \$10. (See Table 1.)

Longitudinal tracking of patients who fill their first scrip makes it possible to understand the impact of patient out-of-pocket expenses on adherence. In the statin class, commercial Lipitor patients who most frequently fill at copays of \$20 can be expected to purchase 280 days of therapy over the next 360 days. When their copay is over \$50, the expected adherence drops to under 180 days. (See Table 2.)

Would a strategy of reducing \$50 copays to \$30 pay for itself by increasing patient adherence, thus building sales of the scrip? What about reducing it to \$20? What would the impact be on Lipitor adherence if class competitor Vytorin opted to offer a copay card that got the patient out-of-pocket payment down to just \$5?

Questions like these are now answerable through data. Using this data

it is now possible to design a copay offset program that will optimize prescription sales to new and continuing patients. It's also possible to determine the optimal potential length of the copay offset—be it three months, six months, or “evergreen.” The point is to never give away more revenue than you need to. The goal is to determine what actions are sufficient to get and keep the patient.

**Principle 2—Allocate resources to where they do the most good and the least harm.** Copay offset programs cannot legally be used by Medicare Part D enrollees. But while physicians may know which managed care plan is paying for their services, they usually have no clue as to the source of prescription coverage.

So what happens when a Part D patient gets a copay offset card? The simple answer is: for drug manufacturers, nothing good. If the patient gets to the pharmacy counter and finds that he or she is ineligible for this of-

fer, and then learns that the prescribed drug has a high copay, they will at best be disappointed. And if the prescribed drug hasn't been approved for Tier 2 copays, it can be much worse. In such cases, the patient may ask the pharmacist to call their doctor and return them to their old therapy. Or worse, they might follow the pharmacist's suggestion of a comparable generic or OTC product.

It may be possible for sales reps to direct the physician's office to provide copay offset kits only to commercial patients, but the simplest and best way to “Do No Harm” is to calibrate the allocation of kits and cards away from those territories that have a high percentage of patients on Medicare. For example, almost 50 percent of potential statin patients in Miami are enrolled in a Part D plan. (See Table 3.) In Pittsburgh, the number is only 30 percent. Across the typical 600 territory US pharma sales structure, the range of prescriptions coming from Medicare might be between 10 percent and 80 percent of the total.

A second problem that can be avoided is giving out cards where they will have little value. After all, what good is an offset card that reduces copay to \$25 if a patient's copay is actually only \$15? Or what if the card only saves the patient \$4? Using transactional data that includes copay, it's possible to identify the territories that have low probability of “value redemption,” or a prescription that exceeds the minimum set by the program. For programs in the dyslipidemia market that get copays down to \$25, the probability that one of these cards will have any value can range from 15 percent to 50 percent in any given sales territory.

The final harm to avoid is perhaps the most difficult to identify, and possibly the most counterintuitive. Brands can minimize losses in profit margin

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by allocating copay offset cards to the sales territories where copay actually matters—that is, where the copay offset will be used by patients who might, without assistance, abandon their prescription altogether. (See Table 4.) The abandonment rates—and more precisely, the differences in abandonment rates between low and high patient out-of-pocket expense levels—can be used to focus spending in geographic areas where patients are the most price-sensitive.

Ironically, those areas may be the places where copays are currently lowest, such as metro New York, where patients have been conditioned to low branded copays subsidized by employers. In other markets, such as Houston and Seattle, patients have been conditioned to pay \$45 to fill a prescription, and won't abandon many drugs until their out-of-pocket exceeds \$50 or more. Sales managers may not like the idea of distinct allocation of cards to where they are actually needed, because getting a patient's copay down to \$10 in Queens might cost the exact same amount as getting a Houston patient's prescription down to \$25. In Queens, however, it could make the difference between keeping a patient and losing

the prescription altogether. In Houston, it's just giving away margin unnecessarily.

### **Principle 3—Measure returns and modify the offer on a regular basis.**

This last principle, though seemingly simple, is one that requires strict discipline. It's critical to measure the returns on investment for copay offset programs with the same analytical rigor that is applied to managed care contracts. Manufacturers should compare test and control groups of patients and physicians receiving copay cards in order to determine whether program objectives (uptake, adherence, loyalty) are actually being achieved. In so doing, they might identify opportunities to modify the offer or focus resources to do the greatest good and the least harm.

### **Separating Risk From Benefit**

The valuable aspect of applying these principles is that it can make a significant difference in an offset program's financial returns. Results vary by class, but as many as one-third of all territories currently getting an equal allocation of a national copay offset program will

still have a negative return on the investment. Another third will have nominal returns. Worst of all, the remaining territories are probably not getting all the investment they need. Even minor modifications to the “one-size-fits-all” approach can reduce the probability of harm (avoiding Part D beneficiaries), and have immediate impact on market share in places like metro New York, where patients have become conditioned to low copays.

Care in the deployment of these programs is also mandated by the likely reactions of the purchaser community as their own business models change. The biggest harm to pharmaceutical manufacturers may occur in the long term, as managed care plans become conditioned to believe that, as they increase cost-sharing to patients, industry will react by increasing copay assistance programs. Managed care plans may also begin to see offsets as a threat to their ability to extract rebate dollars from the Tier 2 drugs. They could react by closing pharmacy networks or to mandate mail prescriptions, where they can decline to accept copay offsets.

Slowing the pace of spending on these programs might be the best course for the industry. Although a well-designed and rationally deployed copay offset program can provide a positive result for an individual brand, indiscriminate use of these programs by the industry, with no strategic differentiation, is a race to the bottom. The lasting consequence could diminish the value proposition for *all* branded pharmaceuticals.

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At The Amundsen Group, we believe that achieving high quality of access to prescription medications is critical to pharmaceutical brand success. Payers have become increasingly sophisticated at managing patient utilization, requiring greater concessions for formulary placement, and shifting more and more cost to both the manufacturer and the patient.

But securing high quality of access need not translate into reduced profits. With the wealth of transactional, longitudinal, and claims data available today, granular detail can be extracted and analyzed to transform a brand's access strategy. Understanding patient and physician behavior when confronted with increased cost-sharing, tougher restrictions, and other competitive threats across therapeutic classes and geographic markets, is the key to increasing product returns.

The Amundsen Group is a pharmaceutical strategy consulting firm that provides unparalleled analysis and insight to Brand, Managed Markets, and Market Research teams. We bring new insights to our clients through our:

- Extensive understanding of the US reimbursement landscape and knowledge of the payers who can influence brand performance
- Experience in measuring patient sensitivity to cost-sharing and other formulary management controls (e.g., prior authorizations and step edits)
- Expertise on geographic variations in payer, provider, and patient interactions
- Depth in linking, analyzing, and interpreting a variety of third-party healthcare data supported by our extensive IT infrastructure

Since 2004, The Amundsen Group has provided pharmaceutical clients with the critical metrics, analytics, and insights needed to ensure that their investments in managed markets and direct-to-patient initiatives generate the highest returns.



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