Auditing and Monitoring Your Copay Claims

Why it’s important to audit your copay claims as the first step in a 3 step copay optimization strategy
Copay Programs are Complicated
Comprehensive auditing, planning and tracking are vital

Copay is Now a Part of Everyday Life
Every Pharma marketer knows that a key component of their overall marketing plan today is a patient copay discount program. Copay programs benefit patients by discounting the medication and making it more affordable, leading to increased adherence, reduced abandonment rates, and decreased prescriber call backs from the pharmacy. These benefits have made these programs an essential part of many brands go-to-market strategy.

We are often asked about the best approach to optimizing copay programs. In this white paper, we’ll review the importance of adopting a 3-step copay program optimization approach:

Step 1: Auditing and monitoring claims: Identifying and correcting waste in your program
Step 2: Planning the copay offer: optimizing the offer details to deliver the results you want
Step 3: Tracking progress: Using comprehensive copay dashboards to keep your program on track

This white paper focuses primarily on the important first step: Auditing and monitoring claims. It also includes an overview of steps 2 and 3 to show the complete process you should follow.

Copay Programs Are Complicated!
Although copay programs may seem relatively simple on the surface to the untrained eye, they have many layers which make them extremely complex. These patient incentive programs are nothing like the straightforward coupons packaged goods manufacturers give their potential consumers, where a $1 off coupon would be provided in the hopes it will drive some new demand and incremental volume from impulse purchases.

Far from it...the successful pharma marketer must balance the needs of the patient, the complicated managed care landscape, as well as internal objectives and brand goals.

Types of Patient Groups
To start, marketers must deal with three different types of patient groups (Insured/commercial, non-insured/cash, and Government insured/Medicare) as well as some potential sub-groups. For the commercially insured patients, marketers must think through a labyrinth of different situations, each needing to be addressed by very specific copay program business rules.

Within the commercially insured patient “group” there are 4 sub-types:
1. Insuredcovered patients (ICP) - no restrictions
2. Insuredcovered patients (ICP) - restrictions (prior authorization or step edit)
3. Insured/not-covered patients (INC) - high deductible health plan (HDHP)
4. Insured/not-covered patients (INC) - Not on Formulary

Each of these patients must be addressed by your copay offer within the business rules of the copay program you are running with your different vendors. So, when adding non-insured/cash and the Government insured/Medicare patients to the mix, you can have up to six different patient types which would need to be addressed!

You might be wondering about the legality of providing a copay offer to a government patient...but this precedent has now been set by several manufacturers that have had Medicare patients sign a release to “opt-out” of Medicare pricing for the brand in question so they can then become a “cash paying patient” and eligible to receive the brand’s cash discount. This adds another level of complexity that must be considered.

The pharma marketer really has their hands full with these types of programs! The real issue is if a mistake is made either in the business rules around patient eligibility or in the offers themselves, you are going to blow through your budget faster than a greyhound chasing the rabbit.

These programs are complex and take a great deal of planning, analysis and tracking – more than many pharma marketers (or companies themselves) can provide.
Pharmacy Claims Audit

Every pharma marketer needs to know how their copay program should be set up and how it is (or will be) executed at the pharmacy level. If you have an existing copay program in market, the most important first step is to do a copay claims audit to determine how your program is being executed at the pharmacy level and if the execution matches the business rules created for the program.

Your program rules should drive the way pharmacies enter and process copay claims and should govern the benefits and the adjudication process for your programs. Unfortunately, especially in retail pharmacies and in HCP offices, there is a “manual component” where the claims are inputted manually. As a result, the pharmacist or HCP can unknowingly or knowingly alter the course of how your claim is being processed.

The way the claims process should work is that the patient should hand their prescription to the pharmacist or HCP (for buy and bill programs) who should identify the type of insurance the patient has (or ID them as insured not covered or non-insured). Then, instructions on the card should be followed to complete the claims process. If that happens, there shouldn’t be any issues...But from what we have seen on average that only happens about 80% of the time.

Depending on the category and the way the business rules have been set up, as many as 20%+ of claims may currently be processed incorrectly. And for buy and bill or categories such as dermatology, the percentages could be much higher. We like to refer to this issue as simply “incorrectly processed claims”. When examining these claims, we see that most of the time these processing “errors” result in significantly more money being paid to either the patient or to the pharmacy than originally intended. So, I ask you... is the claim being incorrectly processed or is there something else happening here?

You Can’t Sit Back and Watch

No matter what your answer is to that question, the fact is that incorrectly processed claims cost you a lot of money and they can quickly eat up your budget and divert funds away from the patients with the highest chance of staying adherent. The only way you can stop this practice in your programs is to do a claims audit to identify the claims and the pharmacies with the most errors and then take action to correct the “processing errors”.

There are many ways in which claims can be incorrectly processed. The program rules you put in place with the copay vendor should be followed at the dispensing level, but there are instances where this is not the case. It could be that the pharmacist is trying to help the patient get the best price and they will try running your offer different ways to get there.

Based on their experience, they may have seen that they get different prices when they change the patient’s insured status in the system to take advantage of an offer intended for a cash patient for example.

Or, the pharmacist may simply be pressed for time. Running a card for a commercially insured patient takes longer since this requires several steps including checking insurance status first, while running the patient as a cash payer has only one step. As a result, a pharmacist may choose to process a claim as cash just to save some time during busy periods. The inexperienced pharmacist may not know the outcome of this change and how that change may have shifted the cost from the patient or PBM over to the brand. The experienced pharmacist should know they are moving significant extra cost to the manufacturer; however they may feel that “the big pharma company can certainly afford it”.

Incorrectly processed claims cost you a lot of money
Some Errors Are Intentional
You also have some out-and-out pharmacy fraud which can come in the form of “pop-up” pharmacies which aren’t real pharmacies at all, rather just operations that get a license from the state and immediately start pushing out fake pharmacy claims. If they get their hands on your copay cards they will start to send out bogus claims on products that were never purchased. They know they have a high probability of being reimbursed by the pharma manufacturer without questions. If they run into any issues they just close up shop and open up somewhere else in a few weeks. In that time they have pulled significant amount of funding out of your budget.

Cash Cards Can Quickly Eat Up Your Budget
There is also the major problem of incorrectly processing “cash cards” (the separate discount cards issued from companies such as GoodRx or even from the pharmacies themselves) which can shift significant costs to the brand versus the PBM. Brand teams may think that because it’s not their card that it will have no impact on their program. But they do! The “processing errors” that occur here could be the result of a lack of training by either a pharmacy chain or independent pharmacy on the correct way to process the cash cards. Other times errors may be something more than that.

Double Dipping Not Allowed
The pharmacists should clearly be able to see that the business rules on both cards say not to use both cards together as no “double dipping” is allowed. Double dipping is not what your program had intended and it will have a definite negative budget impact for you. The problem comes in when a cash card is processed for an uninsured cash patient and then the pharmacist enters the BIN and program information on the commercial copay offer/card as well. The commercial copay program sees a discount was given by a primary payer (assumed to be an insurance company). But in this case, it’s seeing the cash card discount. Not knowing the difference, it concludes that this is a commercial patient and subsequently delivers the discount meant for a commercial patient to the uninsured cash patient. Most times that discount is for the maximum payout since the patient is uninsured.

And to add insult to injury, some of those payments may not be going to the patients at all (as they are not expecting a lower price). Rather, some unscrupulous pharmacists or pharmacies may be taking that extra discount as profit. This can happen in just about every program and when it does, brands need to identify it quickly to keep it to a minimum.

The result of pharmacies “incorrectly processing” copay claims can be devastating for the brand in the form of significant extra costs which are not accounted for in the brand forecasts, and Gross to Net estimates. These costs quickly build into the millions of dollars, so brands should not sit back and ignore the problem as it does exist at some level in almost every program.

If you think you don’t have major issues with cash cards because you don’t have a “cash offer” in your copay program... think again!
Benefit / Rate Change Review

At the time you are doing the claims audit, we recommend also doing a Benefit/Rate Change Review. This involves benchmarking your program against the marketplace so you can see if you are paying pharmacies too much for your copay program claims which they are processing. If you find you are out of alignment, then you can change your billing to pharmacies which could save you significant budget dollars both in the short term and over the long run. These adjustments can be implemented immediately so savings in this area can be almost instantaneous.

Isn’t my copay vendor already doing these things for me?

In recent years some of the larger vendors have invested in their own auditing departments and have begun reviewing and identifying claims errors at a high level. However, they only catch a percentage of what is happening. The reason is that these copay vendors focus their time and efforts primarily at the pharmacy level aggregated across all their programs and not at the individual program level (each program having unique business rules and offers). The copay vendors are looking for the largest offenders at the pharmacy level, but issues related to a specific brand’s program may not be easily visible without the additional deeper program specific claims audit described in this white paper.

Look at Manual Intervention Points

As I pointed out earlier, a major issue for a specific brand’s program is with the manual intervention that happens at the pharmacy level (especially at retail locations and in HCP office locations). At this point in the process, the business rules can be either knowingly or unknowingly circumvented by the pharmacist and policing this activity at the individual program level is much too costly for copay vendors.

Use an Objective 3rd Party

Having a copay claims audit done through an objective 3rd party can dig deeper than the traditional process followed by copay vendors to identify claims that have been incorrectly processed. In addition, there are situations where it is beneficial to leverage expertise outside of the vendor you are using – particularly if you are looking for processing errors!

These comments are in no way meant to disparage copay vendors as they need to be on top of many details related to the implementation of your copay program. However, using an objective 3rd party to conduct a detailed claims audit in conjunction with the pharmacy level audits your copay vendor is already performing can be the best approach to ensuring that both the macro and micro level claims analysis is being completed effectively.

Sophisticated modeling and analysis are required to identify incorrectly processed claims at the program level. Once the potentially incorrectly processed claims are identified, pharmacies can be contacted to correct the claims and educated on the proper techniques moving forward. The most powerful deterrent is for the pharmacies to know through communication that the brand is consistently reviewing their submission of claims and identifying potential issues.

The threat of “turning them off” so they will not receive payments for any copay claims, or even just changing your pharmacy specific payment terms should be enough to change a legitimate pharmacy’s actions. Those calls would not be made by the brand, rather the red-flagged claims would be identified and turned over to your copay vendor for investigation or the objective 3rd party could do the follow up as well.

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How to Conduct a Claims Audit
A journey begins with one step

Getting Started

The first step in any claims audit is to request the last 12 months of claims through your current copay vendor for each program you are running. This data request would need to include both approved and reversed claims for a comprehensive analysis. Claims would be run through proprietary models to identify and “tag” any potential issues for the brand or brands.

A few of the things not to forget in your audit:

1. Review changes or anomalies in prescription starting prices which would increase the cost of the copay benefit payment
2. Ensure coordination of benefits with other entities
3. Validate enrollment activities and match to adjudication activity
4. Validate purchasing of product (867 data) and align it with submissions of claims to confirm that the pharmacies submitting claims have purchased the medications

Which brands are most at risk?

Although any brand can be heavily impacted by “incorrectly processed” claims at the pharmacy level, there are two areas which historically have had the biggest issues. They are dermatology brands and products delivered via “buy and bill”. This is because areas like this get the HCP and pharmacist more involved in manually processing the claims. Since they will benefit from the claims going through at the highest amount possible, issues arise. If your brand is in one of these two areas, you should be doing a claims audit yesterday!

The Retrospective Review

With the proper systems and models in place and with the help of a trained eye, a thorough claims audit can reveal flaws in your execution that can be quickly corrected by changing your business rules and contacting pharmacies to rerun claims.

A comprehensive review of the last full year of claims will provide excellent insights into how your program is being executed, where potential waste is in your program and how much of your budget is being wasted. These insights will enable you to implement processes moving forward to minimize the issues. Unfortunately, any processing errors that you find during this retrospective review that are more than two weeks old will not be able to be recovered since those claims will already have been paid. And for this reason, we also recommend doing ongoing weekly monitoring of claims once your initial claims audit has been completed.

Weekly Monitoring

Once you have the insight from the claims audit, it’s time to get to work setting up a process to review your claims on a weekly (or even a daily) basis. This is the only way to catch the issues with time enough to make the pharmacy calls and get the claims processed correctly. To implement this, a direct feed from your copay vendor to your auditor would be required so the claims could be put through the “processing error” ID engine as often as needed. Claims that generate the red flags would be pulled out and either sent back to your copay vendor to investigate or would be addressed by your auditor.

The investigative follow up calls to the pharmacies need to be done by individuals with special expertise in claims processing. It is important to make sure that your copay vendor or your auditor has staff members with this expertise so these calls can be made quickly and efficiently.
What is the Optimal Copay Offer?
The in-depth knowledge you gain through the auditing and claims monitoring process is a critically important foundation from which to design or re-design the structure and rules for your patient incentive program - step 2 of optimization. Now it’s time to take the knowledge gained from the audit and sort through the mounds of data necessary to perform an effective optimization analysis so you can get the correct offer in place.

The optimal offer is defined as the one that best meets your current brand objectives and makes dollars available to the right set of patients at the right time in their therapy. That offer may change on an annual basis depending on brand lifecycle, the competitive environment and other factors.

This is a simple answer but being able to pull it off and do the work to determine the “optimal offer” involves an in-depth analysis requiring the proper data, the proper analytical process and tools and an objective 3rd party view of your brand’s situation.

Examining and Optimizing Your Offer

**Face Value** – The face value of the program is the “Pay as little as $10” offer that the patient sees. Depending on managed care coverage, the impact of high deductible health plans (HDHP) and your cap, a good portion of your patients may never pay that marketed amount. It is, however, what the HCPs and patients see so it is still important. It is also important to make sure that at least 75% of your patients pay that amount or you will have social media pushback from your patient base.

**The Offer Cap** - The importance of properly setting the cap for your program can’t be overstated. Setting the cap too low means you are not giving your targeted patients enough to encourage trial and adherence. Setting the cap too high means you are paying more than necessary, driving your ROI down. A cap that is too high can also increase the number of claims being incorrectly processed or increase fraud.

Don’t Fall into the Trap

The trap most brands get into these days is actually over-funding or misaligning their caps in their programs. But how do you get your cap right? An example might be that you have a $5 face value with a $200 cap. $5 may be a more lucrative face value than a patient needs for trial. If the correct offer is $20, then you are wasting $15 on every claim. In addition, with the impact of high deductible health plans, you are likely to have many more patients who need extra funding due to high out of pocket costs.

If you know you could attract most patients at $20 instead of $5, you could change your face value to $20 and take the $15 savings on every claim to fund an increase in your cap from $200 to a higher amount (say $250 for this analysis). Adjusting your cap for those patients with high out of pocket amounts promotes more truly incremental patients – a goal of any marketer trying to build their brand.

Guessing Doesn’t Work

Many brands have been playing the price is right game with their funding. That is, they are guessing what offer is best. If it’s not behind door #1 then maybe its door #2? Just like the TV show, that strategy can many times leave you with lemons.

So how do you know what the optimal offer is? It should be determined through a detailed analysis using brand and industry data. Having the industry and brand data to analyze is great but you also need the right technology and tools to manipulate all the inputs to arrive at actionable conclusions that deliver on your brands objectives. For more detailed background on designing the optimal offer, please refer to the additional white papers we have prepared on this topic.

Once you’ve done your audit and chosen the best copay offer structure to meet your brand goals, you need to stay on top of program performance, identify any issues early and course correct as needed.

Patients and HCPs over-fixate on the advertised face value of the offer, but it is not the most important driver of the patient’s final out of pocket price.
The Well Executed Dashboard

Often several vendors can be involved in the execution of copay programs for a brand or company, with each vendor having their own reporting system/portal. Having disparate reports or various portals to access leaves the manufacturer with a disjointed and incomplete view of performance. Often trends and issues can be masked unless a comprehensive view across programs and vendors is available.

What is needed is a well-executed copay dashboard that brings all the related spending and performance metrics from various vendors into one central location along with other key data such as TRx trends, financial measures and HCP segmentation data. A well-executed copay dashboard will aggregate and map all the pertinent data behind the scenes greatly simplifying the reporting and tracking process.

Some dashboards also provide a “guided analysis” for the busy manager. This analysis provides an “Executive Overview” focusing on the key findings in a few concise slides. This keeps management abreast of the major conclusions in a greatly abbreviated timeframe.

Unlike the individual copay vendor portals, a well-executed copay dashboard will provide the complete picture - showing the interaction between programs, impact on financial metrics, progress vs. goals...and much more!

Summary and Conclusion

Copay programs are often put together without the proper understanding of all of the factors that could impact the brand in both positive and negative ways. There are many layers to these programs, and you can have many different types of programs which all need to work in concert with each other to be effective. Getting out of sync in any area can result in millions in wasted spending.

The 3-step process I’ve outlined in this paper details the major steps for optimizing your patient incentive program. This process provides a much deeper understanding of how the copay program is being executed at the pharmacy level and what levers can be adjusted to achieve the desired outcomes. Depending on the brand situation, there are also some other additional analyses that can be done such as taking a deeper dive into market, pharmacy, or HCP level issues.

The entire optimization process isn’t something that can be done in a few weeks, rather it is what needs to be done on an ongoing basis.

Going to an outside 3rd party to help with the 3-step optimization process provides a fresh set of eyes and thinking on your current programs and makes additional tools and processes available to you.

When picking an objective 3rd party to help you through this process it’s important to find one that has the capabilities to handle all 3 steps of the optimization process, as learning from each step should inform the next step. Viewing the optimization process holistically is the most effective approach and will give you the best ROI.

What’s the use of just doing a claims audit if it’s not part of a bigger process that can potentially uncover millions of dollars in savings, fix your issues and get (and keep) your entire program on track?

A claims audit is part of a bigger process that can potentially uncover millions of dollars in savings, fix your issues and get (and keep) your entire program on track.
About Al Kenney

Al Kenney has 30 years experience in sales, marketing, and analytics within the pharmaceutical, OTC, food, direct marketing, and software industries. Al’s expertise lies in the areas of marketing, sales, business process redesign, data, software application design, program implementation, forecasting, and the analysis and measurement of marketing and sales spending. Al is now applying his knowledge and skills specifically to the pharma and bio-technology industries.

Al is the founder of Alpha 1C, an innovative company focusing on strategic marketing, predictive modeling and measurement. Prior to this, Al spent eight years in the software industry specifically focused on advanced analytics, supply chain, and forecasting. He founded, owned and operated Performance Wave Inc. a software company which also specialized in modeling and forecasting pricing and product assortment for both major Consumer Goods manufacturers and retailers. Performance Wave was sold in 1999. Later, he served as the General Manager for Demantra Inc., a leading provider of scenario optimization and program measurement software (which is now part of Oracle).

In addition to evaluating thousands of sales and marketing programs across many different industries, Al has analyzed and optimized well over 100+ Copay incentive programs in over 80+ pharma, bio-pharma, and specialty pharma categories.

About the Author

About Al Kenney and Alpha 1C

About Alpha 1C

We are marketing, sales, and analytical industry professionals with a deep background in strategy, predictive forecasting, and post event tracking and analysis for sales and marketing programs (with a major focus on copay).

We have vast experience solving complex problems and providing key insights across more than 20+ core industries. For the last 7 years, we have been focusing our solutions primarily on the Pharmaceutical and Bio-Tech marketplaces.

Alpha 1C provides key insights to brand teams allowing them to make more informed decisions that provide a better ROI. We are known for goals based predictive models which recommend the best options for you based on your stated objectives and budget.

We apply truly innovative thinking and a solid approach to your complex business problems and utilize our easy to use predictive analysis tools so you can quickly identify the information you need to run your business more productively and utilize the most profitable solutions to meet your business goals.

Alpha 1C has unparalleled experience in:

- Strategic Marketing
- Marketing Program Optimization
- Predictive Modeling & Forecasting
- Sales and Marketing Program Measurement and Reporting
- Brand Building

Our work is easily paid for through the efficiencies and insights we bring to your business.

Alpha 1C is headquartered in Sherman, CT and was founded in 2012.

To learn more you can contact Al Kenney @ al@alpha1c.com

or call 860-354-7979

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