Defining **Optimization** of Patient Copay Programs

Over the years, we’ve seen an evolution of copay strategies, which begs the question: What is the “optimal” copay program for a brand?

There are many factors to consider when determining the “optimal” program including: how your program is impacting patients, how to structure your program to meet your brand goals, the pros and cons of using various delivery channels and how to set the necessary business rules. Read on to learn more about these important factors and more.
What is the Best Copay Offer for My Brand?

There are many factors that need to be considered

Developing the Best Offer
In our work with many brands over the years, we’ve seen a broad range of approaches to copay where brands have varied both the breadth and depth of their copay offers. We’ve seen programs that provide some level of assistance to a broad base of patients as well as other programs that provide more aggressive support to a smaller, more targeted group of patients in an effort to drive incremental volume. As copay programs have evolved, many brands are now going too far and offering much more of an incentive than is necessary, often driven to find that silver bullet by their desire to maximize the number of scripts the program generates, or as a reaction to match competition.

As the copay offers have become more and more aggressive, profitability has suffered and many brands are struggling with determining the best, sustainable approach moving forward. Today, the process of optimization often is finding the right offer amount to ease clients “off the ledge” from a $0 or $5 copay to a less aggressive incentive level that will bring back some profitability to the franchise. But, there are many factors that need to be considered and many “levers” that can be adjusted to “optimize” a program for a brand.

The Process of Optimization
The process of optimization should include these key steps:

Step 1. Having a deep understanding of how your current program is impacting your patients from multiple perspectives (incremental volume, abandonment, adherence etc.)

Step 2. Looking Outside Your Own Doors - Understand how your current offer is performing in relation to your competition

Step 3. Understanding what the “optimal offer” is for your brand (type, amount, cap, patient eligibility)

Step 4. Understanding the different types of offer channels and the pros and cons of each

Step 5. Having the correct business rules in place for processing your claims

Step 6. Setting the right expectations for the program and understanding the role it plays in your brand’s marketing arsenal

Step 7. Matching program performance to your brand objectives and budget
The Process of Optimization
Multiple steps to success

Let’s Dig Deeper

Step 1. Understanding How Your Current Program is Impacting Your Patients
The norm for most companies today when evaluating their copay program performance is to produce a few relatively simple ROI calculations to see the impact of the program on their gross to net and the ROI of the program. Many clients are happy with just a few major metrics as the drivers of their analysis. The big issue here is the ROI metric being used is often not very accurate. The ROI calculation is probably being overstated by at least 50%...why? Because the sales number being used is most likely “total program sales” and not “incremental sales”. This approach is often used because the claims data provided by copay vendors can’t isolate the incremental portion of the program. A claim is just a claim and they do not know if a potentially abandoned script was “saved” (or not) based solely on the adjudication data.

While we can safely say that, on average, the incremental volume driven by these programs is significant, it does vary quite a bit and a negative ROI can sometimes result for programs with aggressive copay offers. We hate it when we have to tell a client that they are actually losing money on a program that they thought was very profitable! Of course, the program profitability can often be fixed with some adjustments, but the key is to understand what the program is really generating above and beyond the business the brand would have generated anyway. To truly understand the program’s performance, we will need to dig deeper into the various components of the offer and of course consider the brand’s objectives, gross to net targets and a range of KPI’s such as abandonment, adherence etc.

Step 2. Looking Outside Your Own Doors
Even if your copay program is profitable, you should always have “Situational Awareness” and understand how your brand and program is performing vs. others you are competing with. Just because your competitor has a PNMT $0 or $5 copay offer in market does not mean they are meeting their patient acquisition and financial goals. Even if you feel your program is producing a good ROI you need to attempt to put that performance in perspective by doing a comparison vs. the category or sub-category performance.

You could find that other brands are getting the same result as your brand but spending half as much ... Or getting much better results with the same spending... You could also find that your performance is twice as good as theirs from a financial perspective which might change your mind about moving closer in their direction. Brands get into a “learned apathy” state of mind and can become happy with what they feel is the status quo. These copay programs are expensive and if you can find savings that can either be reinvested (expanding your current program) or freed up to invest in other programs you should be all over it! As the saying goes: “You don’t know what you don’t know until you know it!”

Brands often don’t benchmark because they don’t have the necessary data. You should make every effort to obtain information on how your competition is doing to gain a better understanding of how your brand is performing vs. others in the marketplace.

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Beyond Face Value
There should be a sound strategy for establishing a cap

Step 3. Examining and Optimizing Your Offer

Face Value and Program Type

Most brands spend the majority of their time deciding on the face value of the offer itself. The offer type (Pay No More Than vs. Pay As Little As vs. Save) is also an important factor and we have seen that many brands have gone to a PALA (pay as little as) instead of the PNMT (pay no more than) due to mandates from their legal departments about the percent of patient covered. That is, they need to exceed certain coverage thresholds before a PNMT offer can be used, such as more than 90% of patients must be covered at the face value of the card to say “Pay No More Than”.

The Importance of the Cap

While the face value of the offer is what is most prominent to the patient and physician, the cap is the area that can dramatically impact the level of coverage, the breadth of patients receiving a benefit and certainly a brand’s copay budget. The key here is to set the cap to achieve your objectives by covering the right patients and the appropriate breadth of patients to the advertised price on the card. There is no need to cover 100% of patients to the face value on the card (which may drive the program budget too high), but you need to cover a sufficient portion of the patients to minimize the potential for both abandoned scripts as well as patient complaints.

There should be a sound strategy for establishing a cap and you have to realize that trying to cover every patient to your advertised offer face value simply will not be affordable or efficient. You will have more success focusing the program funding on the patients who are likely to abandon without support.

Raising the cap to provide assistance to those with the highest copays may require you to raise the face value amount of your offer to stay within an established program budget. This may raise the OOP levels for the portion of the patient base with lower copays, but this approach may deliver more scripts, more incremental volume and more profit in the end. This is why $0 copays with large caps will wreak havoc with your program budget. You can generate substantial savings and incremental volume by bringing your face value to $10 (vs. $0) and spending that extra savings against patients with higher copays by increasing your cap.

One effective approach being used these days is not printing the cap on your card or offer. This way, if you need to adjust it mid-stream you don’t need to replace all your cards with new ones. You just change the cap on the back end and it is done. Some companies may have legal issues with this approach, but many have moved to this strategy as it is more flexible and can save them money.

Another key consideration is to evaluate the percent of the brand’s patient base enrolled in high deductible health plans (HDHPs). Although it varies by category, we see most brands have between 25% and 40% of their patient base impacted by HDHP’s. The face value, program type, cap value and budget need to be determined with these high deductible plans in mind as they will have a big impact on your cost and ROI.

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Step 3. Examining and Optimizing Your Offer

**Patient Eligibility**

Which patients should be eligible to use the copay offer?
- Commercially insured patients?
- Government patients?
- Insured Not Covered (INC) patients?
- Cash patients?

Commercially insured patients will typically be included as they are a major portion of the patient population and can be the least expensive to cover. In addition, the brand may determine that an offer for government patients may make sense given the brand’s objectives and patient base. But, these days it’s no longer only a one-time free trial that can be provided for government patients. Rather a patient can now opt-out of Medicare coverage for that brand and then a multi-part extended offer can be provided.

The insured not covered patients (INC) are primarily patients who have commercial coverage but need to meet their deductible before that coverage kicks in. The majority of insured but not covered (INC) patients are derived from the high deductible health plans (HDHP’s), and the remainder of patients are on plans that may not cover certain drugs. These are not true cash patients, although if you are not careful with your business rules they can be grouped with cash patients in your program. We believe the INC patient should be treated separately because, unlike a cash patient who probably will not have coverage and will most likely leave the brand once your offer runs out, the INC patient could eventually meet their deductible and be a much more loyal patient to your brand. Giving them some type of offer to help them through their non-coverage period will most likely be in your best interest.

Most brands for chronic conditions will find it worth their while to include INC patients in their offer structure. For acute brands... not as much, as you don’t have the repeat usage to recoup your investment. You need to be really careful here to structure a program that is profitable for every redemption because in all likelihood there will not be many renewals to recoup your spending.

**HCP Influences**

Many brands give too much credence to the perceived positive influence that copay programs have on physicians’ willingness to prescribe the brand. Having an offer will certainly show HCP’s that you are supporting the brand, but don’t for more than a second think that the HCP’s will remember the specifics of your offer! Given all the brands and all the offers the HCP’s see, your $0 copay offer will most likely not stand out in their minds the way you may have anticipated.

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Selecting Delivery Channels
Challenges and benefits

Step 4. Copay Delivery Channels

These days you have many ways to distribute your offers to potential patients. Brands need to have a decent understanding of what each delivery channel will add to the program. You may have a certain expectation that as you add more vehicles you are covering more of your patient population and therefore you’ll have a better result. That is not necessarily true as there is definitely overlap among these channels. Just remember certain channels skew towards certain age groups. For example the mobile channel (getting your offer through their phone) skews towards patients 30 and under and currently is not very successful with patients over 65 years of age.

Physical Copay Cards

These are the cards (paper or plastic) delivered by your sales force (or mailed directly to physicians in the case of a whitespace program). This is still the #1 delivery vehicle in the industry, although this channel has been declining due to the impact of the web. Rep delivered cards are still critical since they can help get reps in the door of those hard to reach HCP’s and these cards are also a physical reminder of the brand’s level of support for the patient.

You will certainly need to produce cards but how do you ensure that you produce the proper number of cards for your brand’s situation? Each brand should be doing an in depth analysis/modeling work to optimize the number of cards in market and the distribution of those cards. This ensures that the right quantities of cards get delivered to the right doctors based on each HCP’s prescribing habits and other key factors. Putting offers in the right HCP’s hands does make a difference!

Web Delivery

Although most brands provide a copay offer on their website, we do see variations in the execution of these offers. Many brands have the same offer on their website that they deliver via a physical card while other brands choose to have a more or less lucrative offer on the web vs. their physical cards.

Some brands provide a more lucrative offer via the web to help drive patients to the web to learn about their condition, while other brands provide a more lucrative offer via their physical cards to help ensure continued access for reps to the HCP’s.

Although there are pros and cons for providing offers that differ by delivery channel, we have not seen that either approach (more lucrative web offer vs. more lucrative physical card offer) performs better than just having the same offer across all vehicles. Unless there is a specific reason to drive your patient through a certain channel, it just adds complexity and a bit of confusion!

E-Prescribing

The continuing shift towards e-prescribing may be positive for the industry, but there are challenges when it comes to delivering your copay offer through this channel which is not necessarily good for your offer’s effectiveness. The patient’s script will be delivered directly to the pharmacy (good), but your brand’s offer is located in a seldom looked at notes field where it is likely to be missed by the pharmacist.

That is not optimal because the doctor may have failed to mention the discount to the patient (out of sight out of mind, as they say). If the patient doesn’t know the offer is there and the pharmacist missed it, then the discount will not be provided to the patient. And although this seems like it could be fixed easily within the system, addressing this issue within the NCPDP system will take time (estimated 5 years from being solved!)

In addition, the coverage of electronic coupon distribution networks is fragmented, so you may have gaps in coverage for your coupons that are delivered via e-prescribing. Also, of note, scripts that are electronically sent to the pharmacy will be filled regardless of whether the patient ever intended to fill that script. As a result, the reversal rates associated with the scripts that are e-prescribed are higher. Net/net is that distributing coupons via this channel can be an add-on to capture the HCP’s who have embraced this technology, but there will be inefficiencies in this channel for the next few years.
Meeting your program goals
Focus on aligning your rules with your brand objectives

Step 4. Copay Delivery Channels

**Electronic Coupon Delivery at the Pharmacy**

These electronic coupons provide the discount to the patient automatically at the pharmacy - the patients will receive your offer without even knowing it. The most well-known electronic coupon program is from Relay Health (a McKesson company). This is a good, but very expensive option which can be right for some brands that have major issues with managed care coverage, and very high abandonment. According to Relay Health, they cover 75% of the USA’s pharmacies. This becomes a very high cost option since transaction costs are high and all/most patients in these pharmacies will automatically have the offer applied (even if they would have filled at a higher price anyway).

**In-Pharmacy Coupons**

These coupons are produced and distributed to a network of pharmacies. The idea here is that the pharmacist would only use these coupons when they feel the patient is distressed by the price and may abandon their script. The jury is still out on whether or not this is really happening effectively at retail, as training the pharmacists and getting the coupons into their hands is much easier said than done. Simply sending out a bulletin on what the cards are and how they should be using them may not be read and may not produce good results. But if vendors can pull this off as they say they have, and the practice isn’t abused, this channel can be a very effective one in trying to lower abandonment and produce incremental scripts.

Step 5. Behind the Scenes Business Rules

The business rules that frame your program are of the utmost importance. Get them wrong and it could hinder your brand growth, redemptions, create confusion and cost you a bundle in the process. All business rules should be aligned with your objectives and budget!

A key item to focus on is how insured not covered (INC) patients are treated within the business rules. These patients are most likely commercially insured patients who are part of HDHP’s and therefore find themselves (especially in the beginning of the year) with a very high OOP they must meet before they can receive full coverage.

You certainly want to do everything you can to attract these patients but you need to set the business rules to appropriately balance the need to attract these patients with your profit goals. Your discounts need to be within reason and you need to try and stay profitable on most of your scripts (unless your objectives allow you to lose money on your INC patients until their deductibles are met, for example). With that said, this may mean that you can’t provide enough of a discount to attract many of these HDHP patients and that may be OK and you may not want to stretch your margins too far. There are some patients who may need more financial help than you can give.

Another big issue is the need to prevent pharmacists from processing commercial patients as cash payers and running your card as the primary payer. You can help yourself by making sure you close any rules loopholes and by structuring your cash offer so it’s less lucrative than your offer for INC patients or even regular commercial patients. You don’t want there to be another option for the clever pharmacist looking to get their customers the best possible price by circumventing the system and running their patients through your cash offer option.
Step 6. Setting the Right Expectations for Your Program

It’s important to set the right copay program expectations both in your mind and in the minds of your management team. Goals need to be set and then tracked. You should not set “artificial goals” such as goals for redemption or utilization rates as they mean nothing when it comes to how your program is really performing. You should be focused on tracking things like incremental volume and the program’s impact on your gross to net.

Some might think that focusing on acquisition and financial goals is not the true spirit of this type of patient assistance program. I’ve been told by many brands “the focus of our program is to help patients,” and there lies the beauty of tracking incremental volume as it is a true measure of how many patients were helped to fill their script (patients now on therapy who would not have been able to afford the medication without your help).

Although they may seem fairly simple on the surface, these programs can be complex and should be evaluated by many different types of measures including; sales, trial, adherence, ROI, as well as “helping patients”. All are important to forecast and track. Copay programs should help patients afford their medications while also building the brand franchise responsibly!

Step 7. Matching Program Performance to Brand Objectives and Budget

We have been preaching this message for many years now... That is, you need to match your program performance to your stated brand objectives and budget. This way you have the program working for you helping you meet your brand’s annual goals. If you don’t, you really don’t have any idea if your program is delivering what you would like to see from it. As we have previously discussed, you should have a number of goals for your program, including goals for each of the different channels you decide to employ. Progress against these goals should be monitored ongoing to ensure that the program is on track.

Summing it Up

Evaluating adjudication data by itself isn’t enough to truly “optimize” your program as it only gives a partial and somewhat tainted view of what is actually happening. All parts of the program need to be looked at in light of the brand’s goals and budget. Forecasts have to be made beyond the number of claims that are expected and a more holistic approach needs to be taken so you can understand the “halo” effect your program is having.

Program optimization is a detailed process that is rooted in the brand’s objectives and includes all the aspects we’ve reviewed above. The best optimization process takes not only good internal and industry data but analytical tools to execute well. The key is to review and forecast the impact of different copay structures so you can make informed decisions about how to set up and execute your copay program to best deliver on your objectives.
About

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 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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