Optimizing Your Co-Pay Patient Offer

Understanding your Incented but Ineligible patients will change the way you think about structuring your patient incentive co-pay program
What is Optimal?
There is a major flaw in the way most companies evaluate their co-pay incentive programs and it can cause a brand to spend much more then they have to.

How would you define the optimal co-pay program? Getting there involves much more than simply “designing” your next patient discount offer. It involves understanding your “patient universe”, matching your offer components to best meet your brand objectives, and selecting the optimal channels to reach these patients with your offer. Leveraging analytics and predictive modeling tools can streamline and optimize the effective planning of your patient co-pay program... and adopting a comprehensive view of the program impact, beyond simple “co-pay claims” is critical when trying to understand the true results of your program.

More Aggressive Offers May Generate More Claims, But...

More aggressive offers may generate more “claims”, but these offers may not deliver the desired impact on “sales”. Analyzing co-pay programs based solely on the claims generated is not a sound practice and may encourage the implementation of increasingly more and more aggressive offers...eventually driving the offer down towards a $0 price point.

Let’s take a look at a couple of examples...

For these two examples, let’s assume the brand and category sales are projected to be flat next year. The category does not have a generic in it and the brand’s current program is a Pay No More Than (PNMT) $20 with no cap on the payout. The program currently generates roughly 100,000 claims per year and based on the chart (see Figure 1), 15% of patients are ineligible for the offer because they already pay less than $20, leaving 85% of patients eligible for the discount provided.

Evaluating your program solely based on claims data is not a sound practice.

Claims Data Can Be Misleading
The claims data provided by co-pay vendors gives you a “post offer” look at the patients your offer has been able to attract. While this is valuable information, it’s not a good representation of your current patient base, nor does it paint a picture of the universe of patients trying to make their journey to optimal therapy utilizing your brand.

In addition, the “claims report” which looks at claims by co-pay group can be very dependent on what offer has been put in market:

- A “save $” program off will likely attract a higher percentage of lower co-pay patients
- A Pay No More Than (PNMT) $20 program will likely attract a greater percentage of the higher co-pay patients as will an offer that has a high cap or is open and attractive to cash patients.

### Understanding your Incented but Ineligible Patients
It will change the way you think

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Figure 1
Making Your Offers More Aggressive
You may be surprised at the impact

Example 1: Moving to a More Aggressive Offer
When it comes time to renew this program, the brand may be convinced that they need to increase their patient incentive offer by going to a PNMT $15 offer (no cap) because they were anticipating “sales” would increase. After making this change, the program generates 110,000 claims the following year (10,000 more than the previous year). This looks very much like they increased sales for their program... but was this new co-pay program structure actually more successful? Did they really sell more?

In this case, the answer is probably not. Although every brand’s situation is unique and every brand has their own price sensitivities, this type of change in offer amount typically attracts a very small percentage of additional patients from the higher co-pay groups and tends to reward the patients in the lower co-pay groups who would have filled the prescription regardless.

Where did the bulk of the additional ten thousand patient claims come from in this example? They came from the 5% of patients in the $15-$19 co-pay range. Previously, the patients in this co-pay group were not eligible to receive the discount and there is a high likelihood that previously, they were not abandoning their prescriptions due to price.

What Does the Better Offer Accomplish?
Now with the new, more lucrative offer, these patients are suddenly eligible and they are happy to take advantage of the extra $5 in savings the brand has provided. But, did this more aggressive offer

- Impact their purchase in a positive way?
- Stop them from abandoning the script?
- Increase their adherence rates?

Probably not... But these patients are saying “thanks very much for the extra $5!” Certainly in the case where there isn’t a generic present, that $5 likely means very little for many of those low co-pay patients. However, increasing all 110,000 claims by an additional $5 will add substantial dollars to the program budget and will drop the net margin a few percentage points even with the “supposed” increase in sales.

How many of these new claims were incremental you might ask? Likely... not many... Now what happens now that the brand has moved to a more aggressive offer?

Implementing more and more aggressive offers may encourage other brands to follow suit in an effort to be competitive. So these brands may match the PNMT $15 offer and the downward spiral of brand profitability continues!

Now hopefully you see where we are going with this. Did sales actually increase? Or was it only claims that increased? This is certainly an important distinction and one many brands can’t answer with any degree of certainty. The fact is, increased claims don’t necessarily mean increased sales volume and it’s important to be able to distinguish true incremental volume and halo effect in your numbers.

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Example 2: Moving to a Less Aggressive Offer

Now let’s look at the reverse scenario where the brand moves from a PNMT $20 program to a PNMT $25 offer. This offer is not as lucrative so you would expect claims to go down, right? The answer is yes, but maybe not by as much as you might think.

Using the table in Figure 1, we see only 80% of patients would be eligible for this new offer (versus 85% before). This decline in patient eligibility is the reason brand claims will probably decrease by a little, but that doesn’t mean sales will be impacted. Does a forecast of declining claims imply a negative impact on the brand? Not necessarily!

The question to be answered is what would happen to the 5% of patients in the $20-$24 co-pay bucket who may have received a co-pay card but are no longer eligible for the promoted price. If they fill their script, the fill will be seen in aggregate TRx data, but these scripts are no longer a part of co-pay claims data. So based strictly on co-pay claims, these patients were not impacted by the co-pay program. Is that reality? No its not.

Following the Patient Journey

Let’s follow the patient journey for a patient in the $20-$24 co-pay range. Let’s say the patient identifies with the condition, presents to a doctor and the doctor writes them a script, gives them a co-pay discount card and sends them off to the pharmacy. The patient gets to the pharmacy and presents the script and the co-pay card to the pharmacist.

The pharmacist enters the card information into the system and says “I have both good and bad news for you...the bad news is you can’t use this PNMT $25 discount card. The good news is... it’s because your co-pay amount offered by your insurance is $20 and less than the discount on your card!”

What are the chances this patient now abandons this script? There is an excellent chance these patients will indeed fill the script, completing the transaction at full revenue and without producing a claim. The card is technically “wasted” because it is not used, so in the co-pay program claims tracking world, that sale never occurred because no card was used and thus no claim was generated. This only gives a partial picture of what really happened... The true halo effect of the program is not recorded in the claims data and therein lies the root of the problem.

This is precisely why we refer to this class of patient as the “incented but ineligible” patient. By tracking the “incented but ineligible” (IBI) patients and their probable transactions, including their impact on the brand’s overall program sales, profitability, patient reuse and retention, we can get a much better understanding of the halo effect and true influence of each co-pay program.

Having a good understanding of Incented but Ineligible patients will allow you to make the right choice when determining the best offer for your brand. The Incented but Ineligible patients can have a significant impact on program results.
The Bottom Line
Understanding the IBI patient will help you optimize your program

Contribution from Ineligible Patients
Figure #3 shows a comparison of the profit impact in millions of 6 possible co-pay offers shown below the graph. The contribution from the “incented but ineligible” patients can be substantial and is shown in green.

Including the impact of the incented but ineligible patient provides a much more holistic view of program results.

The Impact of Your Offer on HCP Writing Habits
Industry research studies performed by Zitter Health Insights and others have provided perspectives on physician’s perceptions of co-pay offers. With all that the physicians are juggling in a busy practice, the majority of physicians:

- Don’t always know what brand’s co-pay cards they have in their back rooms
- Can’t always differentiate between many offers in a competitive category
- Think many offers are too confusing to understand, and
- Don’t always rank the offers high on their list of factors influencing their brand prescribing habits

There seems to be little evidence that having one co-pay offer versus a somewhat more or less aggressive one will have any major impact on what a physician chooses to prescribe. And unless the patient dictates the brand to prescribe based on price, the doctor will likely continue to prescribe what they think is the best therapy for the patient.

Summing it Up
Without understanding the IBI patient, brands may continue to move to more aggressive offers in an effort to remain competitive in both the patients’ and the physicians’ eyes.

More aggressive offers may generate more “claims”, but margins will suffer and the anticipated impact on “sales” may not materialize.

Three very important things to remember when optimizing your co-pay offer are:

1. Claims are only part of the story and an analysis using claims can be misleading and drive the wrong decisions.

2. Understanding the difference between claims and sales and the impact of the IBI patient are critical components to consider when developing and analyzing the optimal co-pay card program.

3. The key is to develop an offer that incents the broadest group of patients to fill without making the offer excessively lucrative, and thereby driving up the budget and needlessly rewarding patients who would have filled without an offer or with a less aggressive offer.
About

About the Author and Alpha 1C

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 the founder of Alpha1C, an innovative company headquartered in Sherman, CT, which does 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 owned and operated Performance Wave Inc. a software company which also specialized in modeling and forecasting. Performance Wave was sold in 1999. Later, he served as the General Manager for Demantra Inc., a leading provider of analytics and program measurement software (which is now part of Oracle). Al is now applying his knowledge and skills specifically to the food, drug, pharma and bio-technology industries.

In addition to evaluating thousands of sales and marketing programs across many different industries, Al has worked on, forecasted, and analyzed over 50 incentive programs in over 20+ therapeutic pharma and specialty pharma categories.

About Alpha 1C
Founded in 2012, 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. We have vast experience solving complex problems and providing key insights across more than 20+ core industries. For the last 6 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 work closely with your vendors and agencies to execute your brand’s vision

We apply truly innovative thinking and approaches 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.

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