Secrets to Developing the Optimal Co-Pay Offer

Co-pay programs are key strategic elements of a brand’s marketing plan. Understanding the **Who, What, When, and How** will ensure that you are viewing co-pay as a strategic element of the brand’s annual plan.
What is the Best Co-pay Offer for My Brand?
It’s all about your strategy

Developing the Best Offer
For years now we have been asked the same seemingly simple question “what is the best co-pay offer for my brand?” As if this is something we’re supposed to know off the top of our heads. Unfortunately there is no one co-pay offer across the industry that will work for every brand in every situation. By now everyone should know the best offer is different for every brand as each has different attributes and competes in a very different and constantly changing market. Even if we were to determine the perfect offer for the brand today, that offer should be revisited in a minimum of every six months. Seemingly small impacts in the category or even in within your company can have a major impact on the offer which should be put in market.

In this whitepaper, we will provide our perspective on developing the optimal co-pay program with insights we’ve gained by working with many pharmaceutical clients over the years. We’ll cover the following:

- **The Big Picture**: the importance of having a clearly defined strategy and objectives
- **Key components of the offer itself** (who, what, when, how)
- **The limitations** of traditional co-pay analysis & the importance of adopting a more comprehensive approach to co-pay program planning

The Big Picture
**How important is it to get my co-pay program correctly structured?**
It is of vital importance that the brand get its co-pay program structured correctly since a poorly thought out program can cost you as much as 50% of your overall budget.

Based on current industry estimates of $3 Billion in spending on co-pay related discounts that means on an annual basis $1.5 Billion can be lost and is up for grabs. This is why it is imperative that companies comprehensively evaluate current programs in an effort to better plan and forecast new co-pay programs. Brands should always be proactive and not reactive (as they often have been) to ensure that every penny of this huge spending machine is being put towards patients who need it most. Brands can drive growth by doing a better job of this and matching their spending to the real needs of their patient base.

**Clearly define your strategy and objectives**
Before we dive into the different components of your offer, it is important to set the strategy and objectives for the co-pay program. Do you want to drive Sales, Profit, ROI, Adherence, and Trial? Asked that way, most brand managers would say yes on every count, but answering yes to all five key drivers doesn’t accurately reflect your combined objectives. All of them are obviously important, but some may be more important than others. To solve this issue, start with 100 percentage points and think about what you want to achieve next year. Assign a portion of the 100% to each of the five key objective areas. Once complete, you’ll have a strategic guideline for moving forward.
Let’s Think Strategically
Now that you’ve got those percentages in place, let’s think strategically about where you want to spend your budget dollars. For example, you might say you want to spend them with the patients who have higher co-pays and may not be able to afford therapy. Or with patients who need help navigating their high deductible health plans especially early in the year. Think it through and the answer will begin to guide you towards the type of offer you should be putting in market.

Incremental Business
Also keep in mind that in most cases the most effective program is the one that drives the most incremental business. Coming up with the program that drives the most incremental business might be difficult without some outside help, but you can certainly get started by following your gut feel. For example, the best chance the brand has to generate incremental business is to give financial assistance to the patients who need it to stay on therapy. And it makes sense that you’ll have more money to spend on those patients if you don’t give it to patients who don’t actually need it. For example, a pay no more than $10 program buys down the co-pay on a patient with a $15 co-pay...is this necessary? Maybe, if you are competing with a $5 generic in your category, but most likely, it’s not necessary. These dollars may be better allocated in a different manner.

What is the best program and offer?
The best offer is 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.

This is a simple answer but being able to pull it off and do the work to get you there involves an in-depth analysis which most brands and vendors are not in the best position of doing themselves. Why? Because you need to gather the proper data, put the right analytical and planning process in place and take an objective 3rd party view of your brand’s situation.

Key Components of the Offer
Once you’ve finalized the strategy and objectives of the co-pay program, you can move on to determining the key components of the program.

Who are you trying to reach?
Let’s start at the very beginning: understanding your potential patient universe first. Everyone should be familiar with the “patient journey” which visually demonstrates the path that patients follow from symptom recognition through diagnosis and treatment:

The Patient Journey

The Key Question
How many category patients will finish their journey with a therapy recommendation which leads them to your brand and what role will your co-pay program play in attracting and retaining them?
Who is Your Target Audience?
Finding the patients that matter most

How to Structure Your Program
You can structure your co-pay program to attract some or all of the patient groups shown in the figure below. Varying amounts of data are available on the various patient groups which will help you determine the optimal target audience for your program.

One word of caution: data for those patients currently filling your brand with a co-pay offer is readily available from co-pay vendors. Beware of relying on these claims reports as a primary means of understanding the distribution of co-pays or the adherence curve for your patient base.

Claims data reflects the use of cards and the distribution of patients is heavily influenced by the structure of the program and the magnitude of the offer itself.

These claims reports do not provide a perspective on the adherence curve or the distribution of co-pays for the brand in the absence of the co-pay card.

Key Components of the Offer – Who, What, When, How....
Now that you’ve determined broadly who the target audience is for your co-pay program, let’s take a look at the specific components of the offer:

- **Who** (specifically) will be eligible for the offer? (Patient Eligibility)
- **What** will you offer? (Program type, Offer Amount, Cap)
- **When** will the target audience be able to use this offer? (Frequency)
- **How** will it be made available? (# Offers in market, Vehicles)

Each of these components plays a very important role in the design of your program and even minor adjustments in any one of these areas can impact your ability to achieve your goals.

The diagnosed patient universe/population is the potential audience for the brand and the co-pay program itself.

Diagnosed patients are comprised of three major groups:

1. Patients who have been diagnosed but are not currently on any drug therapy or are treating with OTC products
2. Patients who are prescribed / filling scripts for competitive products
3. Patients who are prescribed / filling scripts for your brand

Figure 2

<table>
<thead>
<tr>
<th>Diagnosed Patients</th>
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<tbody>
<tr>
<td>Treating with OTC (not Rx)</td>
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<tr>
<td>Competitive Rx Brands Prescribed</td>
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<tr>
<td>RX Not Filled</td>
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<tr>
<td>Comp. Rx Filled</td>
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<td>Used Copay Offer</td>
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<tr>
<td>No Copay Offer</td>
</tr>
<tr>
<td>Your Rx Brand Prescribed</td>
</tr>
<tr>
<td>RX Not Filled</td>
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<tr>
<td>Brand Rx Filled</td>
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<tr>
<td>Used Copay Offer</td>
</tr>
<tr>
<td>No Copay Offer</td>
</tr>
</tbody>
</table>

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Patient Eligibility

Will you make your offer available to only commercial patients? How about cash or “insured not covered” (INC) patients, or even government patients (free trial)? Broadening the eligibility will allow more patients to take advantage of the offer, but this may come at an excessive cost that may not provide a desirable return. For example cash paying patients can be attracted to your brand due to its offer and may stay on therapy as long as the offer is active. Remove that offer and you may find the cash patient has left your franchise.

This is important to consider as well as what offer will be good enough to get the cash patient while also remaining profitable (attracting an unprofitable cash patient may not be your objective). Here we need to pay attention to what your competitors are offering to cash patients to understand what type of offer you might need to employ. If your competitors have no cash offer for example, you may need only a small incentive to attract them to your franchise. If competitive offers for cash patients are strong, then you may need to have a minimally profitable offer to compete and this may not be something you want to do.

Making your program available to a broad target audience:

Pros
Every eligible patient receives financial assistance

Cons
A broad patient base will mean many of these patients either do not need assistance or will only remain on therapy with your brand for the duration of the offer. This creates a situation where you have less assistance to provide to the patients who really need it.

Program Type

You can structure a “save”, “pay no more than”, “pay as little as”, “free trial”, or a “percent off” and possibly many other types of co-pay programs. Each of these structures has different pros and cons:

The “Save” program
Here the brand has an offer that can be used by every patient that they deem “eligible”, for example “commercial and cash patients”. If you are eligible you will get the savings.

Pros
Every eligible patient receives financial assistance

Cons
Even patients who may have purchased anyway will receive this discount which will lower the potential for incremental volume and will reduce your ability to allocate funds to patients who really need it. In addition, what might seem to be an attractive offer (save $100), may backfire if patients conclude that your drug is too expensive.

Best used for
#1 brand in category with great managed care coverage that just needs a co-pay vehicle for their salesforce

The “Pay No More Than (PNMT)” program
Here the brand offers a set price (for example $25 together with a cap) so patients and physicians can better understand the potential OOP costs. PNMT programs are now falling out of favor with the legal departments of major pharma companies because, when combined with a cap, the offer may be misleading. For example if a patient with a co-pay of $100 tries to utilize a PNMT $25 card with a $50 cap, they will find that their OOP is $50 not $25 (the company capped their

It’s very important to have a structured process in place that allows a brand to effectively plan, forecast, evaluate, learn, and optimize!
Choosing the Right Program Type

The pros and cons of it

liability at $50 so this patient would need to pay the first $25 and then the last $25 for a total of $50. This can appear misleading, so many companies are transitioning to “Pay as Little As” (PALA) offers which better describes what the offer really is.

Pros
Gives patients a specific amount that they can expect to pay

Cons
Can be misleading if combined with a cap

Best used for - brands that have no liability caps in their offer

The “Pay as Little As (PALA)” program
This program runs essentially the same as the PNMT program described above. The offer type contains a set co-pay amount and then utilizes a cap to limit liability for all patients named as eligible.

Pros
Sets an expectation of potential OOP in both the patients’ and physicians’ minds making it easier to understand their potential out of pocket costs for the drug ongoing

Cons
Not paying close attention to the cap amount and the percent of patients that will actually receive the OOP amounts communicated can have disastrous consequences. If you have a high percentage of patients who don’t receive the discount that they feel they were promised, then you will have unhappy patients and abandonment rates will increase

Best used for
Most brands and brand situations, for example getting your brand down to the next lowest co-pay tier or to match a competitor’s managed care coverage or offer. Just be careful to think through your cap!

The “Free Trial” program
A free trial program differs from a $0 co-pay program because here you enter into an agreement with a provider to deliver free pills to the patient at an agreed upon price per dose (usually WAC plus 10%). This is different from a $0 co-pay program where the claim is adjudicated and the primary payer is tapped first and then the secondary payer (brand sponsored) is charged the balance based on the business rules. A free trial can be given to a government insured patient - but only one time.

Pros
Every eligible patient receives a free trial of the drug (brand decides on duration). Obviously free is a good program if your objective is to generate new trial

Cons
Cost is high and the program usually needs to be backed up with a secondary co-pay offset program to help with adherence.

Best used for
New product launch or brand re-launch for a new indication. Use in conjunction with another co-pay program on subsequent uses to drive adherence.

The “Percentage Off” program
Here your offer can be “receive 25% off” the cost of your drug.

Pros
Every eligible patient receives financial assistance. The offer is easy to understand on the surface. If compared to the save program structure, the percent off distributes more assistance to the patients with the higher co-pays instead of giving all patients the same dollar amount of assistance.

Cons
It is difficult to understand the true patient OOP costs
Best used for - brands that want to deliver an incentive to all their eligible patients and brands that want that incentive to increase in dollar amount as co-pays increase.

Not paying close attention to the cap amount and the percent of patients that will actually receive the OOP amounts communicated can have disastrous consequences.
What about the Offer Amount and Cap?

Don’t go too high or too low

**Offer Amount**
This is the amount of the cost or benefit to the patient. For example: $20, $30 and so on. Just remember, there can be a big difference in cost and usage depending on which program type you match the amount up with. For example a “save $10” and a “pay no more than $10” program will have completely different impacts on both your patients and on your budget. Things to consider here, in addition to co-pay strategy and objectives, would available budget and pre-offer co-pay distribution.

**Cap**
This is the maximum liability amount you will allow to be paid out in your program’s business rules. Obviously a “save $10” program comes with its own cap which is $10, but when executing a “PNMT $10” program you will have to set your own cap. As we have found in many cases, setting that cap incorrectly can cost millions in profitability:

**Cap too low**
Set the cap too low and you will have many complaints and unhappy patients who could feel they are being misled. In studying cap level efficiencies, we see that a program can deliver very effective results as long as no more than 15% of the brand’s patient base has an additional OOP above and beyond the stated offer.

**For Example ...**
For example, if you have a “PNMT $25” offer, you should target having 15% or fewer patients who would actually have an OOP of more than $25. Exceed 15%, and the productivity of your program will begin to decline and complaints will increase. So you can set your cap to cover most (85%) but not all of your patients and still get the same impact from your offer. In the example on bottom left of this page, the PALA $25 with a $50 cap leaves 27% of patients with an additional OOP above and beyond the offer. This level is too high!

**Cap too high or no cap at all**
Setting the cap so that your offer and cap equal your WAC price (if executing a PALA program) puts you in a position to easily blow past your budget maximum. Having a cap that covers all costs for your PALA program (necessary in a PNMT program but not a PALA program) is just a budget inefficiency that could be put to better use. So using the same program as previously referenced and raising the cap coverage to $70, we now leave 11% of patients with additional OOP. That’s within a good range for high performance but could still be optimized at $65, leaving 15% of patients with an additional OOP amount.
When to Stop the Offer

Understand your brand’s patient adherence curve

Offer Frequency

Deciding on offering a one-time benefit (such as a free trial) or allowing the patient to get a discount on multiple occasions or even for the life of their therapy is a big decision. The major factor impacting that decision will be the pre-offer patient adherence curve for the brand. Brands must develop a patient retention curve not impacted by their co-pay offer so they can begin to measure incremental business generated through promotional activities. When deciding offer frequency, the pre-co-pay card offer patient retention curve is of utmost importance! Examining the curve in light of program strategy / objectives will help determine the optimal offer frequency.

Scenario 1

For example in Scenario #1, we see a curve that keeps going down each month until it gets to zero patients left.

In this this case, you might want to offer an incentive that keeps going throughout the patient’s therapy. There could be a percentage of patients who may have abandoned the script that now have been retained. But, the discount must be provided on all fills to retain these patients, making it more difficult to generate an acceptable return on the program.

Scenario 2

In scenario #2, we show a situation where the patients drop off in the first 3 months and then the curve “flattens out”.

In this instance you should consider ending your offer after the second refill since patients tend to stay on therapy after this point. In this case, the patient incentive would be used to get a higher percentage of patients on therapy and then after the 2nd refill they would continue to refill.

Brands must develop a patient retention curve not impacted by their co-pay offer so they can begin to measure incremental business generated through promotional activities.
How Many Cards to Produce
It requires a careful balancing act

Offers in Market
How many physical cards will you need to produce if any? Maybe you prefer to do everything electronically? Again, putting too many offers in market can cost you a bundle, but not having enough to make an impact can be even worse. Getting enough exposure to drive the business, but not too much to blow your budget is a careful balancing act. In our opinion, most brands “under coupon” and then wonder why they aren’t seeing the impact they were hoping for.

Getting enough exposure to drive the business, but not too much to blow your budget is a careful balancing act.

Delivery Vehicles/Channels
There are many ways you can choose to deliver your offer. These can be physical adjudicated cards of many types, in pharmacy coupons, e-prescribing, or even electronic discounts delivered within the NCPDP adjudication system (which the patient may never even know about). Choosing the right mix of vehicles to effectively deliver your offer to your patients is also a key driver of your “optimal program”. The key word here is “mix” because we have seen that you need to deliver your offer through several different channels (optimal mix depends on the brand) in order to have the most impact. One thing that is very important to remember here is that you should think about co-pay programs the same way you would in any other industry. Like the phraseology or not, co-pay offset programs are “promotional vehicles” in the sense that they announce a discount to the physician and to the patient…and that knowledge and understanding is what, in turn, drives incremental volume.

For example, when you are in the supermarket and pass the big end aisle display with a buy one get one free advertised…On average, that display combined with the discount may drive 10X more volume and the consumers who have purchased feel good will towards both the retailer and the manufacturer. Take away the sign with the buy one get one offer and maybe you’ll get twice the sales. Now take away the display and your incremental volume is reduced to al-

most nothing. The same type of thing happens with electronic discounts given at the point of adjudication. If the patient doesn’t know about a discount happening “behind the scenes” you will see little incremental volume.

Patient Mix
Your patient mix can change substantially based on your eligibility requirements and the type of co-pay offer you have in market. In column #1 below, we show a brand’s out-of-pocket ranges in $5 increments. The second column shows that brand’s pre-offer patient distribution ($100 WAC, and average $50 co-pay across all patients pre-card). Columns #3 and #4 show how that mix can change based on the offer put in front of those patients.

<table>
<thead>
<tr>
<th>Patient Copay OOP in $5 Ranges</th>
<th>Distribution of Patients - Pre Offer</th>
<th>Distribution of Patients after “Save $10” Offer</th>
<th>Distribution of Patients after “PALA $75” Offer</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0-$4</td>
<td>0%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>$5-$9</td>
<td>2%</td>
<td>9%</td>
<td>0%</td>
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<tr>
<td>$10-$14</td>
<td>3%</td>
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</tbody>
</table>

Figure #7

| Average copay | $50 | $25 | $65 |

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For Example ...
For example the third column shows how the distribution of patients might change as a result of brand placing a “Save $10” offer in market. You can see the patients with the lower co-pay (average of $25) are happy to take advantage of this offer as it further lowers their already low co-pay OOP costs. Change your offer to a “PALA $75” (in the 4th column) and the result is the brand winds up with patients who averaged a $65 co-pay taking advantage of that offer.

The key is never to forget your existing available patient universe based on your managed care situation (vs. the distribution based on co-pay claims). Remember those numbers are highly influenced by your current offer.

With an offer of “PALA $75”, you will have a much higher percent of patients at the higher co-pay ranges. This would also mean your cash patient might have to pay a $100+ retail price. With a “Save $10” offer the result might be attracting very few if any cash patients, while your category numbers may tell you that 20% of all patients are cash payers. Knowing that and looking at what your competitors are doing you might decide to enhance your offer to attract more cash patients if you can do so at a profitable margin.

The Limitations of a Traditional Co-pay Program Analysis

Adopting a more comprehensive approach to co-pay program planning

As an ancient Roman analyst probably once said 2,000 year ago “all roads lead to the data.” There is a lot of data needed to perform an effective analysis and it is not available in one place: not from your co-pay vendor, not from syndicated data suppliers like IMS, not even within the doors of your own company. This means it’s going to be a good amount of work to understand and gather all the data needed. But once that data gathering phase is complete, there will be a wealth of information at your fingertips for analysis and planning.

Claims vs. Transactions

Traditional analysis of co-pay programs often focuses on claims tracked by the co-pay vendor. Understanding the difference between claims and transactions is critical. A comprehensive analysis would include transactions as well as claims as defined below:

**Claims** - the number of payments you made/discounts you gave to patients who used your offer. It does not include any subsequent uses they may have had after your offer expired or any purchases made by patients who may have presented your offer with their script to the pharmacy but were ineligible to receive your discount. Increasing your co-pay program claims doesn’t necessarily mean you are increasing your business and expanding your franchise.

**Non Claim Purchase** - a purchase (transaction) without a card attributed to your co-pay program which does not result in a claim. All non-claim purchases are good because they are at full revenue and increase your margin.

**Total Transactions** - all sales attributed to the co-pay program (claims plus non-claims attributed to your program = total transactions).

Finding the Right Combination

Now that we’ve gone through all the key components of a potential co-pay offer, we need to determine the best combination of these elements given your brand’s objectives. In order to determine the optimal combination, a thorough analysis of past programs should be undertaken.
Determining the True Value of Your Program
You may be underestimating it

True Value

Brands may underestimate the true value of their programs by not forecasting transactions that are likely to occur after the offer ends. For example: a drug that treats a chronic condition offering a PNMT $10 program for three uses. This can attract patients into the franchise, but is it correct to assume that none of these patients will stay on brand therapy after the offer ends? Depending on what your pre-offer brand retention curve looks like, that could be an incorrect assumption and one that would make your program appear to be a much lower performer based on the number of claims it will generate because these additional sales will not show up in your claims data.

(no offer in this example on the 4th use), the patients return back to the original “non-promoted” retention curve you started with. See figure #9 which shows increase in adherence for an offer good for 6 renewals.

Understand the Misleading KPI’s

There are many commonly used KPI’s for planning or evaluating co-pay programs. It is important that you understand the limitations of KPI’s often included in “traditional” co-pay program analysis. Here are a few of the commonly used KPI’s and examples of why each one could be misleading.

Cost per Claim

This is the cost the brand has paid on average for each claim using your co-pay card. Many stakeholders feel the underlying objective here is to reduce this number to produce a better outcome. This KPI can be very deceiving... let’s take a look at an example. Your PNMT $30 offer delivered 100,000 claims, but you decide to move to a PNMT $25 program fully expecting that your cost per claim will go up because your offer is better. That is not necessarily a sound assumption as you have now made the offer available to some patients who were not eligible for the PNMT $30 offer before. Each of those newly eligible patients received a $5 discount and that discount may bring your overall cost per claim number down. In this case, cost per claim goes down while your budget goes up. Cost per claim also has little to do with the most important KPI which is incremental units. So, cost per claim should be used only as a budgeting guideline, with caution, and in conjunction with other measures.

Sales from Claims

The industry’s most common way of currently calculating sales from co-pay programs is to multiply the # of claims by the WAC price. This is misleading since this only includes claims and does not incorporate “transactions.”
Avoid the Roadblocks to Effectiveness
Understanding your KPIs and true cost

Sales from Claims—A Few More Thoughts

The other concerning aspect is that, in our opinion, the sales from claims measure is responsible for “the race to the zero co-pay” that is occurring in the industry. By evaluating a program based on claims, brands are driven to more and more aggressive offers that will result in increased claims. With that in mind, we’ll ask a question...What offer will produce the highest gross sales for the brand? The answer is of course a “free or PNMT $0” offer. This will get you the greatest patient takeaway based on raw claims. It’s also the best way to ensure you pay a claim on every one of your filled scripts equal to the full amount up to your contracted managed care threshold... but is that really necessary?

Sales from claims can also be misleading because you are not taking into consideration what would happen to patients with low co-pays if your offer were increased. For example, refer to the patient co-pay OOP ranges in the table in figure 7. With this distribution of patient co-pays, if you went from a PNMT $10 program to a PNMT $20 program, you would be excluding seven percent of patients who already have between $10 and $19 co-pays. The likelihood of these patients still filling their script would be extremely high. By using the claims numbers to calculate your program sales, you leave out the very important patient group representing 7% of your patients who are now “incented but ineligible”. By evaluating your program in this way, you lose the complete perspective of your co-pay program’s true value.

Margin

What’s the best offer to increase your margins on your co-pay program? It’s to have the smallest offer you can and still meet your objectives... if only Save $1 would do it! Here your margin looks good but your sales will be so low that you may be looking for a new job next year! We’re sure this isn’t the result you want. Focusing too much on margin can negatively impact your brand. A more important KPI is net profit representing the amount of money you can deposit into the bank as a result of your investment expenditure. After all, as the old saying goes, “it’s not what you earn, it’s what you keep!”

Number of Claims

Claims generated from a co-pay program is a very deceiving metric as we have already pointed out. But, it’s only one side of the equation (the side you pay for) and it gives you no insight into the complete halo effect of the program. Is getting more claims out of your co-pay program better and getting fewer claims not as good? If you move from a PNMT $20 program to a PNMT $25, your claims may decrease slightly. Does this mean your brand is losing sales? Absolutely not! The only way to understand this dynamic is to monitor both sides of the equation (claims and non-claim fills).

A Major Roadblock to Effectiveness

A number of major companies have divided the budget for co-pay programs, placing the discount portion of the spending and the accountability for these dollars under a corporate umbrella and leaving the administrative portion of the budget with the brand group. The patient discount represents 85% - 90% of the overall spend, so if brand managers are completing an ROI analysis on just the portion of the spending they control, they are incorporating only 10 -15% of the total cost. This obviously makes the ROI’s look much better than they really are (by 10x to 20x!)

Brands should take a more holistic approach when it comes to their budgets so they can be corporately responsible. Making brands account for every penny of spend as they would with their own finances helps keep the checks and balances in place and the whole corporate system works more efficiently. Keeping the brands accountable for their total spend will avoid the “It doesn’t matter because it’s not part of my budget” syndrome!

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# Summing it All Up

The secrets of planning effective patient co-pay programs

## 4 Steps to Success

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
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<tbody>
<tr>
<td>1</td>
<td>Start at the very beginning by defining your objectives and goals. Define the strategy and agree on what you are trying to accomplish with your brand’s co-pay program. - The best offer is the one that meets your goals - To answer the “How”, you need to understand the patient journey / universe and learnings from past programs.</td>
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<td>2</td>
<td>Understand the key components of the co-pay-offer (Who, What, When, How). Because small changes can have a big impact on: - The patient mix you attract to your brand - Your brand’s overall profitability</td>
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<td>3</td>
<td>Understand the limitations of “traditional” co-pay program analysis and the misleading KPI’s that are often used. - Claims &amp; Sales - Cost / Claim - Margin - # of Claims</td>
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<tr>
<td>4</td>
<td>Adopt a More comprehensive approach to planning. - Transactions vs. Claims - Include a forecast for the “incented but ineligible” patients - Importance, cost, and impact of insured not covered (INC), cash, &amp; government patients - The impact of competitive programs on your program</td>
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Co-pay programs are key strategic elements of a brand’s marketing plan. Understanding the Who, What, When, and How as defined in this whitepaper will ensure that you are viewing co-pay as a strategic element of the brands annual plan. Remember to take the comprehensive view to evaluate and plan your program - Beware of the simplistic metrics and analyses typically used!
About Al Kenney

Al Kenney has 27 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. Before Alpha 1C, Al spent six years as a partner at M2 Worldwide, a strategic marketing consulting firm. Prior to that, 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

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. Our easy to use predictive analysis tools help you quickly identify the information you need to run your business more productively and profitably.

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.

To learn more you can contact
Al Kenney @ al@alpha1c.com
or at 860-354-7979