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Sales Management

Make Rebates Work

Process-driven managed care rebating programs can drive profitability once again

Are pharmaceutical companies getting full value for the billions of dollars they pay managed care companies for market access? Unfortunately, the answer is often "no."

Healthcare payers exercise significant control over market access for pharmaceutical products by using tools such as tiered formulary plans and copays, adjudication, spillover, pharmacy reversals, and promotions. In response, pharmaceutical companies spend significant amounts on rebates designed to gain market access for their products. In 2008, these rebates totaled $40 billion—that's 20 percent of industry gross sales.

When used effectively, these rebates can improve sales and profitability. But much of the spending is wasted. According to ZS Associates' research, at least 15 percent, and possibly as much as 50 percent of all payer rebates exceed their expected rate of return. (The variance is due to differing product life cycle stages, market differentiation, and company focus on revenue as opposed to profit.)

Several factors account for this disconnect, but the primary reason is that while industry spends almost twice as much on rebates than on its sales force, many companies do not apply the same kind of objective, analytical decision-making to managed care rebates that they do to sales strategy. Furthermore, the contracting department often operates in a silo, and does not account for other variables that can influence outcomes.

How We Got Here

In recent years, as managed care companies have consolidated and gained market power, their influence has become both stronger and more variable. As a result, pharmaceutical companies receive less for more with their expensive rebates. And yet managed care rebates have increased 5 percent in the last five years. This trend will continue as payer consolidations persist and generics proliferate. In addition, healthcare reform and pressure to increase Medicaid rebates will only increase costs for pharmaceutical companies.

In response, pharma executives must revamp their rebating strategies by capitalizing on the wealth of data available today. They must use rigorous analytics to determine which products should be rebated, which payers to contract with, and be clear about the conditions needed for pull-through. While developing a process-oriented managed care rebating process is challenging, the effort can be well worth it. Executives must account for three critical elements when developing a well-integrated, results-driven managed care rebating program.

Rigorous, Objective Decision Making

Pharmaceutical market data available today offers companies a unique opportunity to quantify the impact of various rebating decisions on market access and profitability.

Data can help companies understand the "spillover" effect for different formularies, and determine the impact of formulary tier positions and copay variation within these tiers on market share. For instance, anonymous patient-level data can help companies calculate copay elasticity, helping them set more accurate and effective rebates. Copay elasticity varies by geography as well as patient demographic. Typically, a copay differential in excess of $20 will bias patient preferences, and, as a result, a $20 difference in copay can sometimes affect up to 20 percent of the baseline share for a particular product.

In the women's healthcare market, products such as oral contraceptives and prenatal vitamins come in many branded and generic versions. Patient decisions for these products are based heavily on copays; pharma companies pay rebates to get a favorable formulary "tier" (as opposed to taking copay amounts into account when modeling deals and contracts with payers). But many payers insufficiently reduce the differences in copay amounts between branded product and generic alternatives, and the rebate goes to waste.

In addition to helping determine proper rebates, leveraging data can help companies refine the relationship between managed care and sales effort. It can give companies a better understanding of the sales force activity and marketing investment required to pull through formulary access.

The complexity of negotiating contracts and the variety of data needed to evaluate them means pharmaceutical companies need to supplement available data with technological tools to evaluate managed care contracts in the context of an integrated marketing strategy.

The best tools share a common platform across the company. They must not only help predict likely outcomes for

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different contracting scenarios, but also inform the allocation of sales force and marketing resources (coupons, samples, direct-to-consumer marketing), given changes in managed care access.

A technology tool alone will not solve a pharmaceutical company's managed care rebating shortcomings, however. It needs to be part of a comprehensive promotion framework that can help determine when the company should change its managed care access and when it should complement or supplement managed care access with sales force or marketing investment.

The Spillover Effect

The "spillover" effect is an important factor to consider when developing a managed care-rebating program. As plans consolidate, spillover becomes more relevant. However, its effect isn't uniform, so it's important for companies to account for spillover's divergent impact in different locations. Despite its importance, companies rarely measure spillover objectively or include it in their contracting strategy.

Spillover is essentially how formulary changes in one payer plan affect market share within that plan but also across other plans, as there is a "spillover" in physicians' prescribing behavior. While not universal, the basic premise of spillover is that since physicians do not know the formulary information or copay for each of their patients, they make educated guesses when writing prescriptions.

Depending on their overall patient mix, physicians tend to write prescriptions that are filled at the pharmacy with minimum callbacks. Callbacks occur when patients make a "reversal," or refuse to pay for a prescription (a growing trend in today's economy. Spillover occurs when a physician's decision to stop prescribing a drug because of a restriction on one formulary influences that product's performance across the rest of his patient's plans.

When formulating contracts with payers, it is vital that pharmaceutical companies understand plan spillover. For instance, a high-controlling formulary plan may justify a high rebate; not contracting can prove debilitating to a product's market share. Conversely, contracting with a local plan in geographies where most managed care plans already favor a company's product may not further influence a physician's prescribing.

For instance, a Big Pharma company actually walked away from a contract with a commercial payer because they believed the rebate amount exceeded the potential sales return on the plan. What the company failed to foresee was the additional 30 percent "spillover loss" with other payers because it did not pay the initial rebate. Having a good handle on the spillover effect thus changes how a pharmaceutical company approaches rebates.

Until now, evidence about the existence of spillover has been largely anecdotal, and efforts to measure it have been crude. Today, there are ways to measure spillover accurately at the physician level, and executives must incorporate this data when making contracting decisions.

Companies that integrate their managed care contracting with overall sales and marketing strategy, and adopt robust promotional planning processes, will give themselves a competitive advantage

Marketing and Rebating Efforts

The cornerstone of any effective managed care-rebating program is alignment between a company's various marketing groups. Most companies put their contracting strategy in a silo isolated from sales force and marketing. A lack of communication between the sales, marketing, finance, and contracting teams causes many rebating programs to fail.

Take the case of Highmark Blue Cross Blue Shield, a regional payer that controls 50 percent of all covered lives in the Pittsburgh area. Since a contract with Highmark BCBS has a profound impact on a drug company's local market share, it fundamentally changes the level of sales force activity and marketing (samples, coupons, spot-TV) investment required to pull through the formulary access. Even contracting decisions with national payers can make smaller locales ripe for pull-through via sales force and marketing activity.

Companies that integrate their managed care contracting with overall sales and marketing strategy, and adopt robust promotional planning processes that encompass different decision-makers, will give themselves a competitive advantage. Furthermore, since managed care rebating decisions tend to be local rather than national in nature, it is best to evaluate them jointly and locally, rather than individually and nationally.

For example, the Boston area tends to have controlling payers such as BCBS (of Massachusetts) and Tufts, as well as large group practices that work with payers to support generics. Brands lacking good formulary access in Boston require less sales force investment than other areas in the country that may also lack good formulary access. The local strategy for Boston is therefore very different from any other part of the country. A local mindset can be especially beneficial when considering pull-through resources that are available in a given area to influence formulary access.

As payers consolidate and gain power and the government threatens to wade into the payer market, the ability to know precisely which payers a pharmaceutical company should work with, where, when, and how much it should rebate and how it should change its contracting and promotion strategy over time is not just useful, but imperative to ensuring long term profitability. PE

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