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Out With Experimentation, ZS Sees New Commercial Models Settling In

After several years of experimentation, big pharma has settled on new commercial models for their U.S. sales teams and are in various stages of implementation, according to ZS Associates Managing Director Chris Wright. The preferred models have commonalities built around a mix of traditional sales reps, key account managers and multi-channel digital tools.

After years of experimentation, pharma companies in the U.S. now are committing to new sales organization structures with a clearer understanding of how best to address ongoing market challenges, including growing payer influence, greater hurdles to physician access, and institutionalization of decision making around treatment protocols.

That's the assessment of Chris Wright, managing director of ZS Associates, a commercial consulting firm and longtime monitor of pharma commercial strategy. ZS has been a consultant to many of the largest pharma companies on their responses to shifts in the marketplace, helping to replace the one-size-fits all business model built to support multi-billion-dollar blockbuster drugs with more flexible alternatives. Also driving adoption are changes in companies' specific portfolio mixes, with emphasis on expensive specialty drugs over larger primary care therapies, and greater focus on support for patients and concern about overall outcomes.

Sanofi's total patient care approach to diabetes and other parts of its business is a recent example of one kind of approach (*"Sanofi's North America Pharma Head Whitaker Implements Patient Solution Responses to Commercial Challenges" — "The Pink Sheet," Aug. 20, 2012*) and (*"Personalizing Patient Care:Sanofi Recasts Its Diabetes Efforts" — IN VIVO, July 2010*). GlaxoSmithKline PLC's revised incentive program for sales reps in diabetes and other parts of its business is another (*"GSK's New Commercial Model Will "Stay The Course" Regardless Of ACA's Future" — "The Pink Sheet" DAILY, Jun. 4, 2012*). The strategies differ, but the goals are similar.

Increasingly, however, the favored strategies are similar, with some nuances and different timelines. In general, the model incorporates a mix of traditional, but more flexible sales organizations, key account managers, who cater to an institutional customer base, and multi-channel digital marketing technologies. Marketing budgets, once set annually, are often now revised continually to adjust to shifting environments. The decline in number of sales reps has leveled off, as companies strike the appropriate balance of this mix; about 58,200 reps now work in the U.S., down from 81,800 at the end of 2009, and well over 100,000 at the peak in 2006 (*"Retooling The Sales Force Remains A Work In Progress" — "The Pink Sheet," Jan. 18, 2010*) and (*"Big Pharma Lays Off Fewer Sales Reps In 2013" — "The Pink Sheet," Jan. 21, 2013*). Other trends include increased outsourcing of sales and marketing support functions.

As Wright explained in a recent interview with ***"The Pink Sheet"*** DAILY, most companies' plans include three key elements: differential resourcing, which refers to tailoring portfolio mixes and sales strategies to reflect geographic-specific opportunities, based increasingly on input from local executives, and multi-channel marketing, which involves customizing the mix of marketing tools used to reach providers to individual preferences, with a heavy reliance on digital technologies to hold down costs (*"U.S. Promo Spend Continued To Fall In 2012" — "The Pink Sheet," Feb. 11, 2013*). The third component, key account managers, are individuals with responsibility for managing large group practices or hospital stakeholders, which make up an increasingly large part of the provider landscape; Wright notes that two-thirds of doctors are now employees of such organizations.

The commercial strategy for specialty drugs differs significantly from that of primary care, with a small number of thought-leader specialists influencing the bulk of their colleagues, a focus on support programs that directly benefit patients and improve their access to care, rather than on the less targeted direct-to-consumer advertising, and infrequent and targeted contracting with payers, opposed to frequent contracting and heavy reliance on across-the-board rebates.

***"The Pink Sheet"* DAILY: ZS has talked about the transformation of industry commercial models for some time. Can you briefly describe the experimentation phase and provide an update on the status of pharma commercial organizations?**

Wright: There was a long period of time where there was a lot of experimentation going on, and most pharma companies had innovation groups, which had the job of finding new commercial models. That era has finally ended. Most companies do know the model that they want.

The model's not so different from one company to the next. That's not surprising because the model has to be designed with the physician and accountable care organizations in mind. The market decides that and then, of course, the pharma companies are shaping themselves to it.

The implementation is just beginning, though, and companies are having some difficulty doing what they want. Getting people to work in one way is not always so easy. Some are a little further ahead; some are a little bit further behind.

The experimentation took place from about 2000 to about 2009. All different types of commercial models were attempted, and people would set up pilots for three, four, five, six months [then gave up, often too early].

***"The Pink Sheet"* DAILY: What does the future model look like?**

Wright: There are three fundamental pillars in the new model. All have a multi-channel nature to them. There's the differential resourcing. There's a multi-channel marketing. There's key account management. Different pharma companies stress them in different degrees.

Differential resourcing allowed them to vary the intensity of sales people based on geography. It was one channel, but it was adjusting the channel and providing flexibility in the channel. In the industry, people use different terms. Some call it flex force. Some call it geo-tailoring. This is all the same thing.

***"The Pink Sheet"* DAILY: That kind of experimentation has been going on for a couple of years, right?**

Wright: It started in 2008. Last summer, we did an audit of the top 40 pharma companies and found that more than 50% of the reps in the U.S. work in a differential resourcing organization.

Five years ago no one worked this way. I don't think 100% of reps will be organized this way because in certain kind of highly specialized sales forces, it's not necessary to do that. But anyway, it's an important evolution that's taken place, and it's a common thread among companies.

The second part is this multi-channel marketing. That word gets used in many different ways, though. Maybe I can just describe what I mean by it. The concept is the marketing version of differential resourcing. It's varying our marketing approach, our marketing channels, to the doctor's specific needs. As we see a doctor's willingness to engage in a digital channel, which could be as simple as reading emails from our company—it could be as simple as that. That's a big step forward, by the way.

And as the industry sees doctors engaging their company that way, they are able to further reduce the activities of sales people. Which I think is considered beneficial to everyone, except perhaps the sales person.

***"The Pink Sheet"* DAILY: Is multi-channel marketing becoming standard?**

Wright: When we demonstrated to top management, look, nobody sees that doctor, then they were able to stop making that request of the sales person, and that saved a lot of wasted money.

The same is going to happen with multi-channel marketing. Companies say until we know the doctor is engaging with our company via the other channels, we're not going to stop sending the sales person there. That's the transformation that's taking place right now.

Companies have been building these systems, and it's a very difficult thing, way harder than the Sunshine Act. That was hard for pharma companies to get that data organized. This is even harder. They're working on it, and some companies are much further ahead than others.

[The Physician Payment Sunshine Act refers to requirements that drug companies and other covered medical suppliers make public their financial arrangements with doctors and teaching hospitals].

***"The Pink Sheet"* DAILY: Why do you say it's so hard?**

Wright: Because they have to have the technology to track those cookies and the flow from the click stream and all of that. In the Sunshine Act, the complication there was just getting your own records together: Who attended the meeting? Who did we provide this sponsorship to, etc.?

The third part of the new commercial model is key account management. Key account management is a business-to-business selling technique. It's system selling. The salesperson now has to make a business case. A salesperson never made a business case to a doctor in the old model. It probably would have been illegal if they even tried. So, some of the skills necessary to be successful in the past differ from the skills that are necessary for the future. That means new skill sets, new kinds of messaging.

I'm not suggesting that balance is going to flip. There's not going to be thousands of people who do key account management because you don't need as many people in that skill. But pharma are kind of—they're in the beginning stages of—the early maturity of learning how to do it.

***"The Pink Sheet"* DAILY: What's your take on accountable care organizations?**

Wright: Regardless of what would happen with the Affordable Care Act, there will be ACOs. It's a business model. I think it was inspired by the regulations and the chance for incentives and whatnot, but it's a good business model anyway.

[ACOs are the latest evolution of integrated care networks, in which large providers team agree to be paid based in part on their ability to improve patient care while lowering cost of care.]

That said, pharma is sorting out ACOs and struggling. One thing about the key account management model in other industries is that there's a very clear win-win between the two businesses. So, somebody will come up with a program, a concept, which says 'We both make money, let's do it.' Pharma has a hard time talking like that with their customers.

It's not the same sort of freedom and creativity that other businesses have. Part of it is real, and part of it is perceived. I think part of it is a cultural work style that's present in the industry, for good reason.

They're very compliance minded, for good reason. They get in big trouble when they're not. Now, you might imagine what it's like when they try to engage an ACO in a business proposition, a proposition that says here's how it will work. We'll provide the medicine, you pay us this, and we will provide this service. These arrangements are scrutinized tremendously to the point where a lot of the creativity is taken out.

***"The Pink Sheet"* DAILY: You're saying it goes beyond what it needs to?**

Wright: The key account management, which is a third part of this commercial model, is the one that companies have the hardest time with, in part because it's a new way for them to work but more importantly they have a very difficult time coming up with a service program that their med-reg people will let them do.

As the ACOs become more deeply rooted, and people realize that there's efficiency in these two businesses working together, I think the regulatory environment will relax. We'll inch our way towards more productive relationships between the organizations (*"Pfizer Sales Force "Reset" Recognizes Realities Of ACO World, Exec Says" — "The Pink Sheet," Jun. 24, 2013*).

***"The Pink Sheet"* DAILY: I guess key account management teams have a number of people with different skills.**

Wright: Most companies have a couple hundred of these [key account managers]. That's it. You just don't need that many. There's a very important adapting the cost model thing that's going on. Most people talk about the patent cliff as being an event that has happened because of course so many big products it did happen to already. But there's still a lot more to go.

Also, the payers are becoming much more aggressive, especially in their approach to new products. Some 65% of payers state that they will put new products on their formularies in the third tier.

***"The Pink Sheet"* DAILY: Payers used to cover a new drug out of the box, at least until they made a decision about putting it on formulary, which took six months or longer. How has decision-making changed?**

Wright: They [payers] have a declared attitude of almost hostility towards these new drugs, and they really are like that now. Sixty-five percent of payers say that their default position with a new product is to put it on the third tier, or worse—third tier with a prior authorization.

In prior years, payers put new products [immediately] on tier 2, which is relatively good placement. Brands did enough pre-launch groundwork so that the percentage of lives covered was high. There would be a category review eventually, which might have some rebate to main-

tain that position. But the rebates were modest.

When a brand finds itself in tier 3, what it can do now is have a copay card program that pays down the difference between the tiers. The 'prior auth' requirement has come into play because of the copay cards—there is no purely economic way to address those. The doctor has to fill out the paperwork.

Then, six months to a year later, there is a formal category review. At that point, if demand from doctors for the new drug is not high (which might happen because the payers put in a high hurdle to begin with), or the drug is deemed too expensive or not differentiated, these are levers for the payer to demand bigger rebates. In competitive classes, the average rebate has gone from 25% to nearly about 40%, and this benefit all accrues to the insurance companies.

***"The Pink Sheet"* DAILY: This is a significant change for pharma.**

Wright: Yeah, they're changing the trajectory, which ultimately does mean the total commercial value of that drug will be less because the patent has an end point. That's why companies over these past 20 years have been so keen to launch products very fast. It's just the math of the data of value under the curve is so important.

At the same time, payers are becoming much more aggressive, and that is stunting the growth of new products. They've learned the magic of manipulating the co-pay through the tiering structure, and they're continuing on that quest, which effectively puts the patient into the game. They're having the patient be the voice to the doctor, and it works great.