**James Chase**
Editor in Chief, MM&M (moderator)

**Jeffrey A. Stahl, MD**
Founder, NextGen Management LLC

**Craig Lewis**
SVP, Global Business Insights & Commercial Operations, Shire Pharmaceuticals

**Linda Cavalier**
Independent Consultant

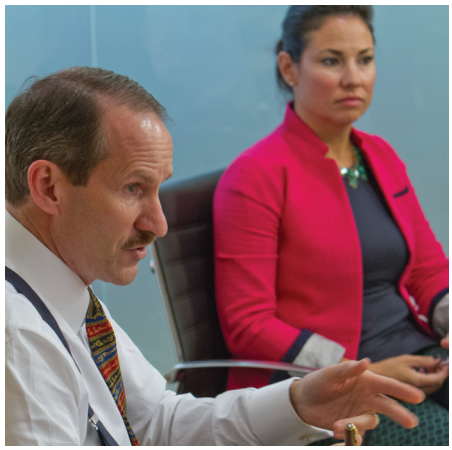
**Jim Smeeding, RPh**
Executive Director and Chief Strategy Officer, National Association of Specialty Pharma

**Christine Coyne**
Senior Director, Xiaflex Marketing, Auxilium Pharmaceuticals

**Robert Previdi**
Chairman & CEO, PSKW

# ISSUES WITH CO-PAY

Co-pay initiatives rank among the most hotly debated topics in healthcare marketing today. Pharmas and healthcare providers love them. Payers and PBMs... not so much. Why is that? **James Chase** takes the moderator's chair


ALL PHOTOS: BILL BERNSTEIN

**James Chase (MM&M):** Why do co-pay programs exist, what is their purpose?

**Robert Previdi (PSKW):** In a perfect world you let the doctor write the prescription and then you fill the prescription. It's hard enough to get a patient to take it without putting up financial barriers. But that's what's happening. Payers have gone from trying to put a formulary together that is going to help financially satisfy employer and employee groups to where they just make deals with pharmaceutical manufacturers. They pit one up against the other. They call it market share rebates or tiered positioning. If you want to get a preferred tier status you're going to pay for it in rebates. So, co-pay was a very simple idea to take the rebate directly to the patient.

**Jeffrey Stahl, MD (NextGen Management LLC):** I think most doctors realize, especially subspecialists like myself, that proven medication does positively impact both the patient's quality of life and longevity. At the end of the day it really does help the medical economics—that's patients who do better, patients who are compliant, less hospitalizations, less progression of disease, less events. I firmly believe in the co-pay program because I think it gives the medical choice back to the doctors and takes out of the discussion that profit-driven, clandestine motive that's being inserted by the insurance companies and the PBMs.



**Jim Smeeding (NASP):** From a pharmaceutical manufacturer today, who would not want to put the genie back in the bottle for market share rebates? I mean they're a waste of a lot of resources, they're extremely difficult to manage and therefore you find that we have to come up with other tactics to get the drug to the patient. We are kind of stuck in a Catch-22 here in terms of market share rebates and other activities such as co-pay reduction to increase market share and obviously lead to affordability.

**Craig Lewis (Shire):** The whole reason co-pay programs exist is to provide affordable access to medications that a physician would deem as being the right product that a patient might otherwise be deterred from taking because the cost is prohibitive. That stems from not only new therapies, but staying on the medication. For some people, a $60-$70 co-pay a month, multiplied by a number of other medications, is just insurmountable. What unfortunately a lot of the tiers have done is they've taken the prescribing leverage out of the physicians' hands and put it into an economic parameter.

**Smeeding:** Ninety-nine percent of America doesn't know that the reason a drug was preferred had nothing necessarily to do with the measurable therapeutic differences and has everything to do with the fact that it's the one we're making money on. If I sit with a payer and I say: "We got them to take a drug, we made it more affordable, they're more adherent and we decreased the cost of hospitalization. What don't you like about this?" Then they'll tell me, "Well, you know, Jim, it's not our preferred agent for various reasons." I say so you put an economic factor in there that is stopping you from delivering care that the patient deserves. When you stop focusing on the patient, you get off the track that we all need to be on.

**Stahl, MD:** Washington has managed to completely demonize the pharmaceutical industry in the eyes of the patients. No matter what you think about how effective they are going to be in Syria, they're very effective in terms of making the pharmaceutical industry look terrible. I'll tell you what I tell patients when they talk to me about costs of drugs. Number one, 85% of all the medications that I use on a daily basis as a noninvasive cardiologist, in other words my armor material to battle your disease, 85% were paid for and developed by private pharmaceutical research. There's a certain cost associated with that. If you look at the cost of medicine in the grand scheme of things, the lion's share really is hospitalization. That's where the money is. So, they could stop paying pharma for every drug they make and they could stop paying me for every patient I save and 75% of the cost is still there. It doesn't matter. That's the reality.

**Linda Cavalier (Independent Consultant):** If you think about treatment challenges too, I mean it's not just about reaching for a drug when someone's diagnosed with something initially. If you take depression as an example, where treatment resistance and treatment failure is extremely high, you have patients who have to try multiple

medications and combinations of medications and now can't afford a particular medication. This type of program allows them the ability to try and continue to get well.

**Stahl, MD:** I don't think pharma should be defensive about co-pay programs. It is a response to an unreasonable insertion of the PBMs and the insurance companies. You guys are not helping yourselves necessarily—you may be—but that's not how I look at it. You're helping me. You're helping me with patient compliance. You're helping me choose the appropriate medication.

**"Washington is very effective in terms of making the pharmaceutical industry look terrible"**

— Jeffrey Stahl, MD, cardiologist

**Previdi:** I don't think they are [being defensive]. I think if you want to see how effective co-pay programs are, turn one off. I mean we had one with a very popular brand and it was going off patent. Six months before it went off patent the manufacturer decided not to promote that brand anymore. I can't tell you the amount of responses we had, not from just patients, but from pharmacists. The pharmacists were the ones, because they're on the front lines, the ones that have to tell the patient I know you were prescribed this particular brand and I know you were getting relief but it's not available. Then you start to see the reality. They stop taking the product or they make decisions they shouldn't make. When they do that, that's when the real costs go up.

**Chase:** There is clearly a lot of conflict surrounding co-pay programs. But at the end of the day, doesn't every stakeholder want the same thing?

**Stahl, MD:** Absolutely not. What insurance companies are looking at is the short term. They are not looking at what's going to happen to the patient in eight, 10, 12 years. They are looking at short-term costs. So, I would say the insurance company and the PBMs are pulling the pins on the hand grenades and they're throwing it at one person—the patient. They're trying to get as much out of the patient as they possibly can, as quickly as they can.

**Chase:** How does the backlash against these programs really manifest itself on the payer side. What are they doing?

**Previdi:** They instituted a lawsuit against the top manufacturers, which was thrown out of court. They don't like [co-pay programs] because it affects their bottom line. It's as simple as that. Legislation has already prevailed in Massachusetts. The Congressional Budget Office announced a few months ago that they see the benefit of branded pharmaceutical products being prescribed because they're the ones getting to the 65-year-olds and older and they have to essentially pay on the back side for what wasn't invested in on the front side. Now they're taking a look at this and saying, "If I can get a patient on the right medication, I'll let a manufacturer throw some money at it so I can make sure that that patient takes the medication." If they don't, the costs are so much higher.

**Stahl, MD:** In terms of the actual penetration of the co-pay card, per se, e-prescribing, e-messaging, all this electronic stuff, is probably the best way to deal with patients actually using and receiving them. In our office we have an area where all the co-pay cards are stacked. It's a mess. We actually looked at the adjudication rate of these co-pay programs and they were almost 10 times as much when we did them electronically. It's written on the prescription. It's sent there. The patient doesn't have to take it, doesn't have to remember it.

**Cavalier:** And it is an issue. If it's a hassle to a pharmacist to process the coupon, they don't even want to try to figure it out. They're just going to say we don't accept these and the patient isn't going to get their medication or their co-pay and they're going to end up with an abandoned prescription. That is a problem. I think there are a lot of good solutions at hand to help prevent that from happening. It's just a matter of everybody coming together.

**Chase:** I think we sometimes talk about co-pay programs as if it's a one-size-fits-all situation. Every drug, every patient, every company is created differently. What are the issues with the system as it stands?

**Cavalier:** I'll give you one example. I used to work on Lipitor for many years. We had millions of patients come to the website a day. Let's say we wanted to make it really easy and not have a stack of cards falling over in the sample closet and put it on the web. So now



let's say a typical direct mail open would be 2%. Let's say 1% of patients that visit Lipitor.com once a day ask for a co-pay reduction card actually adjudicated the card. We'd be paying $45M-$50M a year in redemptions. I mean there's just no way it would be profitable to the brand. While we would obviously like to provide the benefit in an easy, facilitated way for the patient, it isn't reasonable. I think there are some of those types of considerations that you have to think about from a practicality perspective, in implementing on a very tactical level these kinds of programs. Then obviously, you're thinking about the lifecycle of the brand if you have a brand that you're launching. You have a very different need in terms of initiating trial and uptake versus a brand that maybe more established and you're trying to think more about patient adherence and longer-term compliance. If it's a chronic med versus a non-chronic med. And how you structure these offerings I think is the key to the success. You can offer a patient $2 off after they spend $75 and they can only get it two times over a three-month period, but you're not going to have a very successful program.

**Christine Coyne (Auxilium):** To Linda's point, you're looking at all those factors. You can't just throw a card out there. The reps basically come down to the lowest common denominator, which is let me tell you about our co-pay card. Not let me tell you about our product. I've worked in commoditized categories, small molecule, large molecule, specialty. The reps are there to help talk about the product that they have in their bag. Even in commoditized categories, I still think you should be talking about the product. The co-pay card should assist, I agree with Craig, in accessing the products and helping offset the burden, especially in economic times. You're making tradeoffs of do I feed my family or do I get my product that I need?

**Lewis:** I think co-pay cards and programs are an interesting tool but they really have to align with the brand strategy and what the objective is. Linda, I think you mentioned, the program should be structured much differently if it's a new treatment where you're trying to stimulate trial adoption, physician usage, as opposed to if it's a product that's been out there five or six or seven years where you're trying to maintain the product and make sure that you increase adherence. You will structure programs differently depending on what the objective is. Or I should say you should structure it differently.

The other big thing is I don't think organizations particularly do a great job of ensuring that all the key stakeholders within a company are all at the table. For instance, co-pay programs need to not be in conflict with the rebates. They can, and frequently one hand doesn't know what the other hand is doing. So, it's got to be a coalition between brand marketing and the managed care team and payer team, commercial analytics, finance. These can be very, very large expenditures. As much as we're in it for the patient you're in a for-profit organization. And this generally can be considered an expense of marketing. You may very well decide, for a given brand at its lifecycle, you don't want to expend the additional resources and drive that. It really has to align with your strategy.

**Stahl, MD:** You said not everybody knows what's going on. One hand doesn't…I can tell you, the patients don't understand what's going on because they don't understand the fact that manufacturers have to give rebates to a company that they've already paid for services. It's a direct conflict and is totally ludicrous.

**"Co-pay cards are an interesting tool but they really have to align with the brand strategy and what the objective is"**
— Craig Lewis, Shire

**Lewis:** It doesn't make sense.

**Stahl, MD:** It makes no sense. You're paying for service and then they're going to you, pharmaceuticals, and saying, "Listen, I have captive patients and I'm going to be the payer. Unless you pay me, I'm not going to allow them to get the service they paid for." And I think they have been very successful in terms of the PBMs and the insurance companies saying, "Hey listen, pharma's trying to take advantage of everybody." But on the other hand, it is a bait and switch. They're saying the insurance is being paid for by the employee. At the end of the day, it's the employee and they're paying for service. It is in direct conflict … if it's not a legal conflict, it's definitely a moral conflict.

The way they're fighting it is a lot more insidious, too. Where they have exclusionary lists, they simply exclude the drug. So you now have swaths of patients who have responded to a specific



medication. I think that explanation has to be brought up publicly. I think people have to understand. I think the reason pharma has been such an easy target is that there is a major problem among federal and state in terms of fairness levels of government, not only do they regulate pharmaceutical, they are consumers and the cost is substantial.

**Previdi:** We call what you're talking about with the patient "the co-pay surprise". The patient walks out the door, they have no idea what their co-pay is going to be. They don't even know how much a drug actually costs. They just know what they're going to pay. It gets even more crazy out there in the market with these high-deductible plans where the patient has to pay the first $1,000 out of pocket expense.

For the first time they're exposed to high-priced drugs they're like, "Oh my God, don't you have something cheaper?" I think it's a natural response. I think the best way to structure an offer is through a "pay no more than..." For example, pay no more than $20. The cap, whatever you want to make it, $50, $80, $100.

**"The reps basically come down to the lowest common denominator, which is let me tell you about our co-pay card"**

— Christine Coyne, Auxilium Pharmaceuticals

**Cavalier:** It's complicated. I think there's a lot of education that needs to happen [on the pharma side]. If you really want to structure something appropriately you have to have the ability to gather the right analytics, be able to analyze the right data appropriately, be able to understand somebody putting that in front of you to be able to even begin to structure these in a way that works for profit. I don't think that I've seen a lot of capability in that front. So, what ends up happening is you just end up looking at what is in the budget.

**Smeeding:** What did we spend last year ?…

**Cavalier:** And how many reps are there? It's not enough if we give each rep five cards, so we'll give them 10, but then that means we're going to be over budget if we give them $25 off. So, it literally goes like that.

**Smeeding:** I also think that technology, accessibility, as patients get more information, the tools that we have, whether it be e-prescribing or an app on your phone, has also made it a little more difficult to have predictions in regards to how many offers are redeemed, at what cost. One of the things that I still don't get, we see more and more manufacturers now understanding that they have to figure out how to work with the payer at some level.

We have a whole lot of data that shows very easily how many co-pays were redeemed, at what cost, whether or not the patients weren't redeeming them or were paying higher co-pays, either abandoned or are not compliant or adherent. I mean I get to see this stuff all the time. There's a ton of data there that will show whether or not there's benefit in the co-pay programs and whether or not that leads to adherence and compliance. Where is the alignment of incentives between payer and manufacturer? The PBM sooner or later would say that's a great program, I like that program. We should do more of that.

**Previdi:** In the early days, which was 2005 and 2006, you were just trying to explain to people what a co-pay program was. Then it went to why should we use you versus the other guys. Now almost everybody uses some type of co-pay program. I'd be interested to hear what determining factors kind of lead the manufacturers to put the right co-pay program in place. There's so much confusion out there.

**Coyne:** On a launch, right away you're looking at expectations and you say what do I have to do? How many millions of dollars do I have to make? How many vials, units, syringes do I have to sell? How am I going to do it? You start building the forecast from the ground up. How many people have incidence of it and so on and so forth.

Then you do price sensitivity analysis. What is the threshold where this person can accept the price of this co-pay given everything else? And we do large scale. We look at income, we look at demographics, we look at psychographics. So then you look at where are you supposed to break even after you launch it? Where are you going to make the profit? ■

*You can read more of this discussion, including the specific topics of co-pay cannibalization, channels and the future of co-pay programs, at mmm-online.com*