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# PACT WITH THE PAYER

How can Marketing and Managed Markets evolve an already complex relationship to flourish in this climate and meet the new demands of payers? Our expert panel, led by **James Chase**, has plenty of candid suggestions

**James Chase (*MM&M*):** To set the scene for our discussion, briefly define the relationship and the dynamic between the pharmaceutical marketing, sales and managed care functions. What's been the conventional approach and what factors are driving change?

**Kevin McDermott (*Aptalis Pharma*):** From my own experiences, the traditional relationship was seemingly always three-siloed. Usually when you sat down with sales, they had a long list of things that you hadn't delivered yet. They didn't focus on all the contracts and the access that you'd been provided. So there was always that tension to say, "What have you done for me lately?" instead of "Let's focus and pull through the access that we've worked so hard to achieve at this point." I've felt for brand directors over the years because they've had to fuel so many different enterprises. The tradition of blocking and tackling samples and literature chews up a whole bunch of brand budget. They've got all these mouths to feed and, with whatever is left over, we can have some access. I think there's always been a willingness and a desire for the brand leadership to put together a value proposition for pharmacy directors and medical directors. It's just that, I don't know if managed markets stood up and really had a good, keen understanding of what they needed to convince because it was all about the contract. Managed markets has done themselves some disservice of their time by distancing themselves from the clinical attributes. They've been getting the contracts and the access, and then it's up to somebody else to do well with it.


ALL PHOTOS: THADDEUS HARDEN

**James:** I'll briefly read to you three recent storylines from *MM&M*: 1. A Cegedim survey found that the biggest pain point among pharma execs is the evolving business model, in particular the increased focus on market access. Yet, just 16% of the same execs named MCOs as being their most important customers. 2. A PricewaterhouseCooper's survey concluded that pharma companies are failing to convince payers of the value of their drugs; 45% of payers said they now demand clear proof that a drug will lower overall patient care costs, yet less than half of manufacturers' health economics studies are designed to tackle this. 3. The annual State of Pharmaceutical Marketing Research survey singled out payer research as being an analytical weak point industry-wide. To say there are challenges ahead is putting it mildly—sounds more like a full-blown crisis to me.

**John Hosier (*Eisai*):** There are a lot of places we can go with that. You mentioned market research: When we (in the industry) do a payer ad board, we end up with more or less the same people around the table. You hear the same things from the same folks and so it becomes like everything else we do. So part of the challenge has been getting to a broader swath of payers that have the bulk of the patients, and getting to what their real motivations are. As for reducing overall healthcare costs, from a marketing perspective, it's always felt to me that I'm trying to convince the pharmacy benefit manager of why he needs to spend more money to save the medical benefit manager cash down the road. That's always very hard to be able to pull that story through.

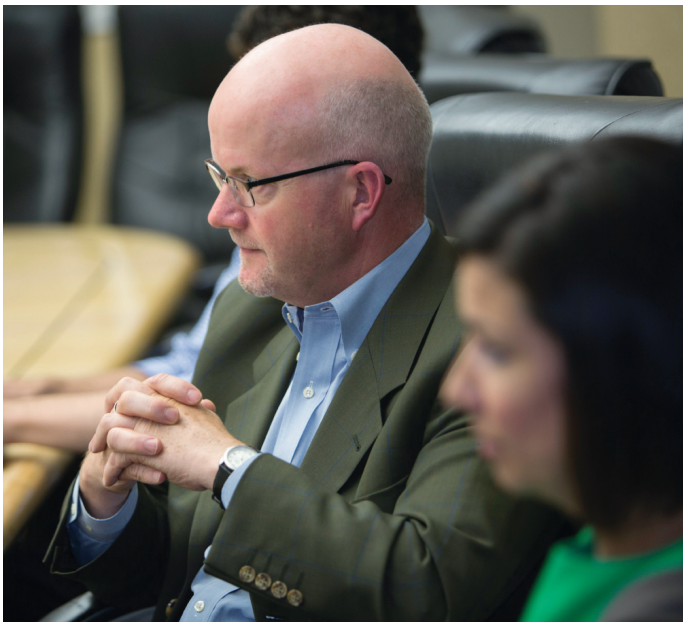
**Daniel Renick (*The Hobart Group*):** It speaks to the fact that the value propositions of most drugs on the market now are co-pay-heavy and data-light. In the past, when co-pays were lower and payers were less aggressive, that didn't matter so much. Going out and getting some share, and *then* working a deal… that worked for quite some time. But the collision of Part D with the recently increased pressures and broader economics has finally brought the thing to a head. It's changed substantially since 2006 and what we need to see is more data in the value props.; can you build (into trials) the outputs or endpoints that payers are going to want to see? Plus, there will be a whole host of folks who are going to act a lot more like payers in the future, so from a marketing standpoint, pharma needs to evolve its approach. And, frankly, the old model of bringing people in from the field and putting them through the marketing rotation just doesn't work anymore. No insult to those guys, they're the backbone of pharma, but they push out a couple of sales sheets and they win an award, and yet I find myself going into conversations with marketers and they don't have any idea what I'm talking about. It's too complex. They are like: "Could we look at the budget?" It's not going to work.

**"Our customers will know more about our products than we ever will — and we won't have access to that"**

— Kevin McDermott, *Aptalis Pharma*

**Christine Coyne (*Auxilium Pharmaceuticals*):** Some of the young marketers aren't ready for that level of commercial thinking. Pills, patches, gels… that's a little "old pharma," right? But when you get more sophisticated, like buy-and-bill, then you become a business generalist. Marketing's a misnomer. You're really a generalist at that time. It's like I have a team and I say, "You guys are P&L holders. You're responsible for the up and the down on this thing," and those types of things have to be taken into consideration. You own a business. That's what you're doing.

**John:** It's tough to teach that because if you start and stop at any point in the conversation, out of context, and you're in very dangerous water when you start talking about buy-and-bill products, and the business side of that and managing a P&L. It can be difficult. To Dan's point, on my side of the table we draw you guys the managed markets box, or a contract box, and by the time that box gets implemented or realized, the folks who made those decisions have



moved on to something else. "Yeah, we'll see the impact, the loss of coverage in three years… but that's not my problem." Take any organization and throw a stone down the hall of marketing and you're going to hit somebody who was a rep, then they were a trainer and a DM, or a DM and a trainer, and they came into marketing. Or they went into market research and then marketing. We get what we've always got because we keep going to the same pool. They never had a chance to learn everything else and then, bam, you're in a spot, and now you own the full P&L and, "Yeah…go figure out how to handle distribution channels." On the flipside, managed markets does the same thing. You can always kind of bounce around and then you do a little bit of reimbursement time, but you never sit… And a generalist? Oftentimes, you're not sitting in the other seats at the table so you can't translate to a marketer, salesperson, whomever… you can't talk their speak to be able to sell them on your idea because you've never done the job. I think that happens a lot.

**Daniel:** And the problem is, we probably could all agree, you get a plan. You get a brand plan. If you're not careful, every year there's only marginal movement.

**Kevin:** Where do you start this year's plan? With last year's?

**Mary Easterday (*McCann TL Managed Markets*):** Dust it off.

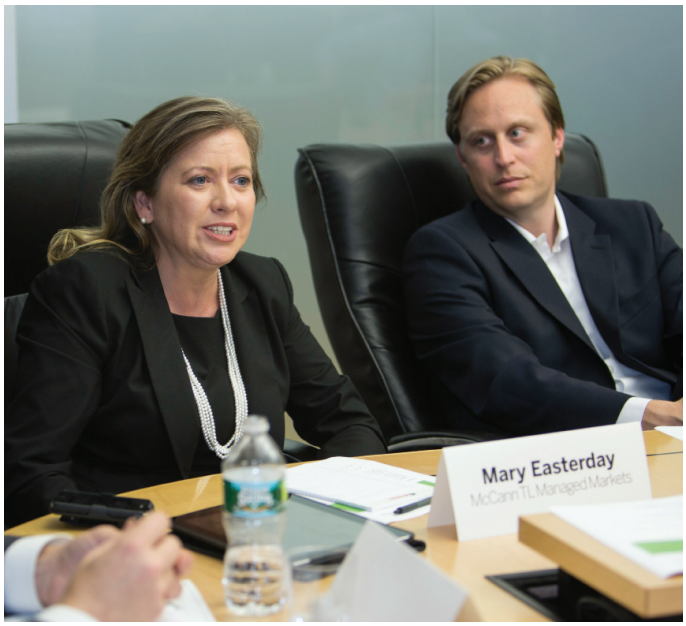
**Daniel:** If you've worked on big brands, where marketing budget is maybe $200 million, managed care might get $3-4 million. We certainly try to get all that we can but we would suggest that it needs to be quite a bit more to start with and then let the chips fall where they may as far as who gets the business. It's interesting to see, because pharma companies are starting to warm up to that notion of, "Well, maybe I do need to apply some analytics to my marketing mix because we're just starting with last year's plan." And when does it really truly change? My opinion is when price controls become more effective and they're already creeping in. There's a lot of price contained within Part D. It'll grow but it probably won't be at a federal level. The fact is that over half of the pharmaceutical growth since the mid 1980s has been through price increases.

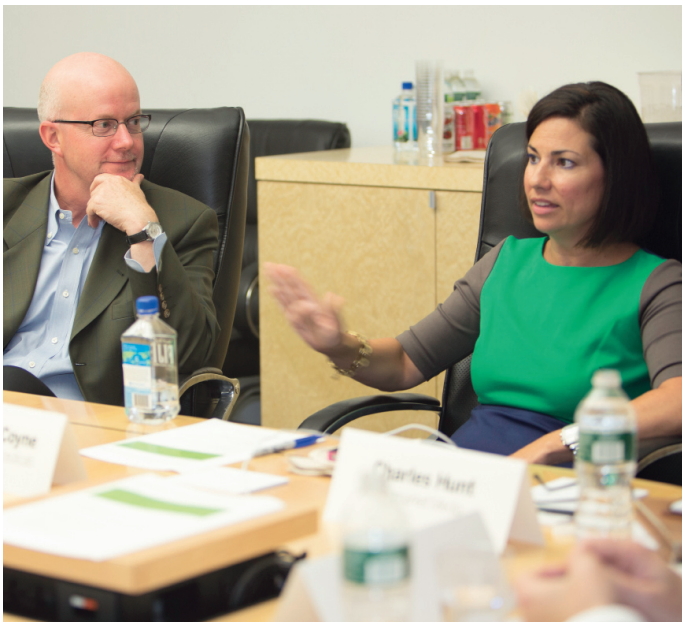
**Kevin:** The disconnect I think exists is that a lot of leaders of US affiliates or global companies have never had to operate in a managed-markets environment. As we like to say, their family tree is a telephone pole—they haven't branched out much and they don't really understand some of the implications. To me, the solution isn't between marketing and managed markets, it's about clinical. The disconnect in pharma is between commercial leadership and development. It's about getting scientists to pull back from their pet projects, step up and say, "What does the market really need?" And that means you may not need to work here anymore. I've seen many times, even when we get into Phase III design, that medical will say, "You know what? I'm FDA-focused. My job is to make that thing safe and efficacious, and get it out on the market, and that's it." And so, anything that you add in terms of complexity is, I think, what is causing pharma to continue to fire blanks at the market.

**John:** And if you get the drug approved before you figure out how to get it covered, at that point, it's already too late. It goes back to development teams. Their motivations are…well… they're different. At the end of the year, they're graded as to whether or not they got a drug approved and handed it off to commercial. (To them) it's not about how it's going to show up on a claim form, how it's going to be paid for and how it compares to what's already out there.

**James:** The silos of excellence strike again.

**John:** And everybody's been talking about it. It's no big secret. Even at Zeneca, before it was AstraZeneca, even back then they were talking about building SWAT teams. Everybody I know in the industry has talked about it. But what are you going to do? You've got different functional presidents.



**Daniel:** Their odyssey's around what it's been for years, which is get the drug across the beltline and make a bonus.

**Christine :** I've also seen it *not* work. I've definitely been a part of that in my early career. But as I cut my teeth and came up the ranks, I started guiding grants, and got to brands that were pre-commercialization. I was thinking, "No way, not on my watch! We've got to think about this early on." Smaller companies will listen.

## "Co-pay cards are like a high-school education—you get nothing for having one but if you don't, it's a problem"

— John Hosier, *Eisai*

**Daniel:** I agree with Christine that we see mid-size pharma do an especially nice job. With small pharma, sometimes it can be a budget constraint, and with large, it's too many problems with the system. But mid-size can do well.

**Kevin:** Over the last couple of years, there have been a lot of commercial surprises with products that should have done a lot better. Once they began uncovering the causes they found that access was at the top. But even so, they still believed that they can overcome any access issue with a good sales force and a few other methods.

**Daniel:** We have one client where the current COO for the US used to be head of managed markets, and in this era of "it's got to be an attorney or a financial guy," that's very, very unusual. Like most pharma companies with a decent-size portfolio, they have some brands that are challenged and others that do well. And you have a "spectrum" of products in your bag, so to speak, so each will require a different level of investment. But at least he's one guy that can sit down and say: "Look, just do what you can."

**Kevin:** I sat at the April AMCP [Academy of Managed Care Pharmacy] leadership conference, and the evidence requirements that are coming. The scary thing for pharma is that our customers will know more about our products than we ever will— and we're not going to have access to that. So how do we then turn to the market and get evidence in a naturalistic setting? That's where it's going to go, I think, because a lot of these organizations aren't going to make global decisions. They're going to make decisions for their particular area, whether geographic or demographic.

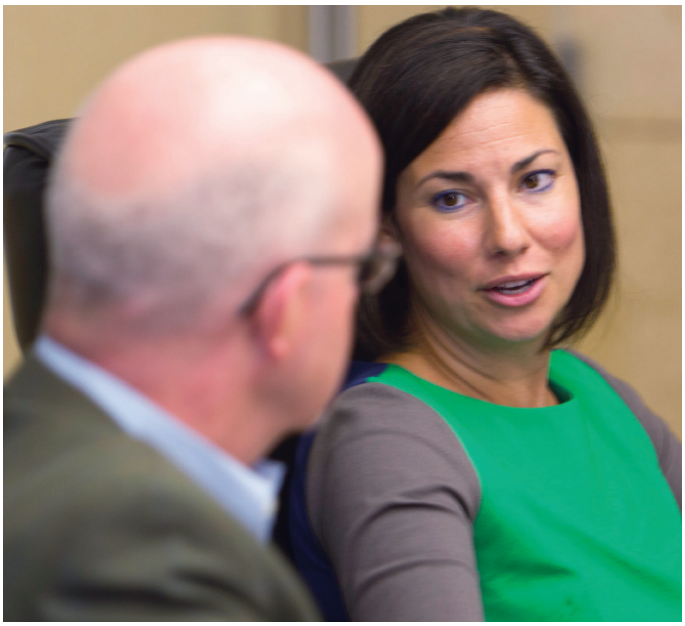
**Mary:** The bright side for the US is that we have no policy that's saying that the comparative effectiveness research (CER) has to be tied to any national coverage. I feel we have a number of years to really figure this out. When we don't have the data, there's still a way to be covered. There's still a way to get on. There's still a way to win. And, because the system's so fragmented, there are ways to win within select populations.

**James:** So basically, you're saying it *is* possible get to market quickly, and then look for access?

**Kevin:** But your products are not F15s taking off anymore. They're more like tankers full of fuel that just barely get off the runway. You're not going to get that traditional curve of adoption because you have to exploit the market instead of watching with the market.

**James:** Who's collecting the additional data to get you airborn?

**Daniel:** Payers. They now have a true interest in understanding what is the right drug and the right approach to therapy, e.g. "I don't care what the ADA says, or any of these goofy things… What's actually happening in my population? If I can get some diabetics on a GLP-1, is that better for them? I don't like the cost but maybe it's better for that whole group... because I'm now the bearer of risk." We see a lot of the future centered around patient-reported outcomes from



the real world, evaluated against pre-established endpoints. A payer population is remarkably stable over time, and by looking at outcomes that speak to the triple aim of better care, better quality and lower cost, we'll at least start to become our version of CER.

**James:** And is the Affordable Care Act adding new drivers?

**Mary:** I don't think ACA has a specific mandate but I know there was some language to encourage different reimbursement models, such as Medicare Shared Service. And every major national health plan seems to be experimenting with private commercial arrangements for select populations around accountable care, and reimbursement structures to motivate quality. As with pay for performance, we'll see disparate ways to measure some of the quality programs. For larger diseases, like diabetes and asthma, there are some standards, but the question remains: How complex will this be for, say, a physicians' group that's being held accountable for different standards?

**James:** Phase III intervention of a product in development is often given holy grail status in brand marketing. Does it ever happen?

**Christine:** I only hear who's chasing Phase IVs. I can't tell you how many I've chased. I'm tired of talking about it because I'm left with contracting groups, like yourself and IMS, and all sorts of health outcomes, to get the information that will help aid and abet whatever it is we need to do. The sad part is it's not even making meaning. I want t-shirts made up that say: "Make meaning." We're just chasing. I'm chasing access, chasing good formulary status. Whatever it is, I'm chasing it. But you get on some drugs and you say, "I really would like to make meaning to the patients, to tell them why they should use a product like this." But that's very, very tough to get to.

**John:** You know, where it happens consistently is not the homegrown assets but the one you're going out to buy. That's when you get everyone around the table. You have preregistration, where managed markets gets an opportunity to talk and sales gets an opportunity to talk and you're doing your due diligence. Everybody that's got a seat at the table. But with the homegrown assets, it's a different building or a different site and you don't get it until it's too late.

**James:** Is technology changing the game yet?

**John:** iPads and other tablets—they have a shot. Now everybody's focusing on closed loop marketing and the metadata that you get back from that. And they're all doing it wrong, I'm convinced of that. You get 17,000 lines of data back and it turns out we're not smart enough to figure out which line caused what, so it doesn't help us.

**James:** Big data got too big?

**Daniel:** It's a paralysis.

**John:** But I think you can use that technology now to get back towards more of a regional type marketing, and get away from the statistical prop that we've all created that's of value to no one.

**James:** Speaking of value, how do co-pay cards fit into all this?

**Christine:** With all due respect, a co-pay card is a necessary evil.

**Kevin:** Reps aren't well-suited to translating the value of a co-pay card. I mean, if you're going to do it, do something with it, versus, "The other reps had them so I had to have one." If they're not executed well and you haven't changed the payer landscape, you're stuck.

**John:** Co-pay cards are like a high school education—you get nothing for having one, but if you don't have one, it's a problem. Once you start throwing the cards out, it's difficult to pull them back.

*For more of the group's discussion, go to mmm-online.com.*