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Pharmaceutical Marketing

Show Me the Money: Why Companies Overpay MCOs— and How They Can Stop

Drug companies pay MCOs too much in rebates and get too little in return—but “fair share” analysis can help, for some drugs, drive as much as \$100 million in additional revenues.

By Anil Shrivastava, David Bellaire and Ashish Singh

The influence of MCOs weighs heavily on the margins of pharma companies today—and it's growing. As pharma products go off patent, drugs become less differentiated and formulary positioning becomes more important as a factor that drives drug sales. Meanwhile, MCOs are gaining power. Their leverage will increase as the Medicare Modernization Act pushes consumers into their fold. Consolidation helps, too. By 2003, the top 10 MCOs accounted for approximately one-quarter of the US private health insurance market, up from little more than 10% in 1994. Over the same period, 275 mergers and acquisitions took place in the sector and market size doubled, to \$582 billion. Finally, the spread of more sophisticated tools such as e-Rx and evidence-based guidelines will give MCOs greater ability to enforce their cost-saving decisions on physicians and patients.

Drug companies, reacting to the margin pressures applied by MCOs and other challenges to their businesses, have sought to save costs by cutting sales forces, pruning unproductive development commitments, trimming back promotional investments, and similar measures. Recent news for, Pfizer, Wyeth, BMS and Bayer all highlight substantial cuts to the commercial infrastructure for dealing with doctors and patients.

But pharmaceutical companies have done little to curb their substantial investment in rebates to position drugs on MCO formularies. Indeed, at many companies, rebates to MCOs have been growing despite the lack of a clear commercial case that such investments deliver sufficient returns. In our experience, many drug firms can boost margin growth 10-15% by negotiating lower rebates or securing higher market share from MCO investments

they already make.

Changing rebate strategy requires a pharmaceutical company to answer two critical questions.

First, what is a product's fair share? The answer depends on several variables – most notably, the product's fundamental competitiveness, the level of rebates paid, its position on formulary and the MCO's willingness and ability to increase share. While measures behind each of these variables are not cut-and-dried, objective criteria exist to assess how they affect each product on an MCO's formulary. A drug's competitiveness, for example, is generally based on its efficacy and its "share of voice" (SoV), a measure of the combined promotional effort that includes investments in sales force, advertising and samples. The length of time a drug has been on the market and its brand power are also factors in share of voice. Efficacy can be confirmed through published medical studies. For products with established competitive reputation and awareness, the key factors determining fair share are formulary position and the MCO's ability to control share, a function of how much leverage the MCO exerts over its prescribers and beneficiaries.

The second critical question is, if a product is falling below its fair share, how can a drug firm secure the right level of performance? Renegotiating rebates can be a means to this end, but companies can often more effectively redeploy resources from rebates into different sales and mar-

keting investments. An important consideration for pharma companies as they assess fair share and related options is the diminishing influence of share of voice in certain categories. Share of voice is losing power as the prime determinant of total market share in drug categories where most products now are considered nearly equal in effectiveness.

Gauging MCO control

In order to evaluate the effectiveness of their rebates, drug companies also need to measure the degree of control an MCO exerts over its prescribers and beneficiaries. Two key factors to measure: the proportion of beneficiaries under formulary and restrictiveness of that formulary.

At some MCOs, control is strikingly low. For example, some groups have as few as 10% of beneficiaries under meaningful formulary controls. Others tolerate above-average levels of patient "switching" or prior authorization of non-formulary drugs by physician prescribers. Highly advertised brands for which patients ask by name and doctors prescribe as "dispense as written" particularly benefit in this way.

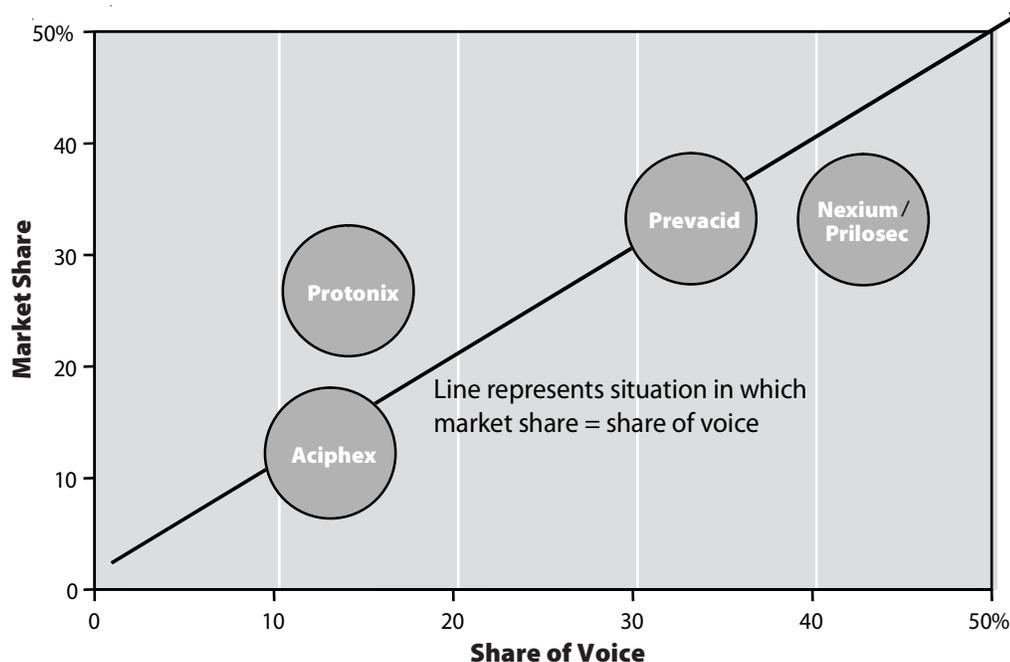
The problem with investments in rebates with MCOs that exert lower control is that they often fail to increase share sufficiently to justify rebating for formulary status.

Many open-PPO and similar products across state-specific or regional plans show little control. Indeed, plan design and formulary control vary widely across MCO accounts. At Horizon BCBS, for example, only 20% of patients are fully aware of co-pays when given prescriptions vs. 40-50% at other regional payers. Similarly, Horizon doctors report half as much communication from Horizon about over-prescription off-formulary or strict prior-authorization rules compared to other local payers. Research by Bain & Company shows similar trends at a number of the BCBS plans.

Where an MCO has limited power to deliver market share gains for the drugs on its formulary, rebate monies are usually better redeployed to sales and mar-

Share of Voice Doesn't Routinely Correspond to Market Share

EXHIBIT 1; Product market share as a function of Share of Voice among proton pump inhibitors



For products considered virtually equivalent by surveyed formulary P&T committees, Share of Voice (SOV) = combined investment of sales force, advertising and samples.

SOURCE: IMS, Scott-Levin; full year data from 2003

keting programs aimed at prescribers and beneficiaries. Even so, many manufacturers continue to direct up to half their rebate investments to lower-control MCOs.

Conversely, MCOs with more patients under formulary and more restrictive formularies have the potential to exert greatest control. An MCO that operates a greater number of formulary tiers and larger co-pay differentials encourages consumer trade-offs (three tiers are now standard, with more restrictive arrangements and related beneficiary incentives increasingly common). Proton pump inhibitors (PPIs) provide a prime example. Many physicians and patients consider the drugs in this category to be interchangeable. Even so, share of voice does not always correspond to the share of prescriptions filled; although that is the standard assumption among manufacturers (*see Exhibit 1*). Instead, consumers increasingly base their buying decisions on out-of-pocket price. Recent Bain analysis reveals that every 5% difference in PPI co-pay leads to a 2.5% differential in share.

Similarly, newer health savings account (HSA) plans like Humana Inc.'s RxImpact increase the amount consumers see as out-of-pocket expense. Many of these plans pass on virtually the full price of the drug charged to the payer. Again, the consumer incentive to save is being put to work: if a drug offers a lower price to the payer, the consumer will see it directly and usually act on it. Early data shows over 65% of consumers act on higher prices

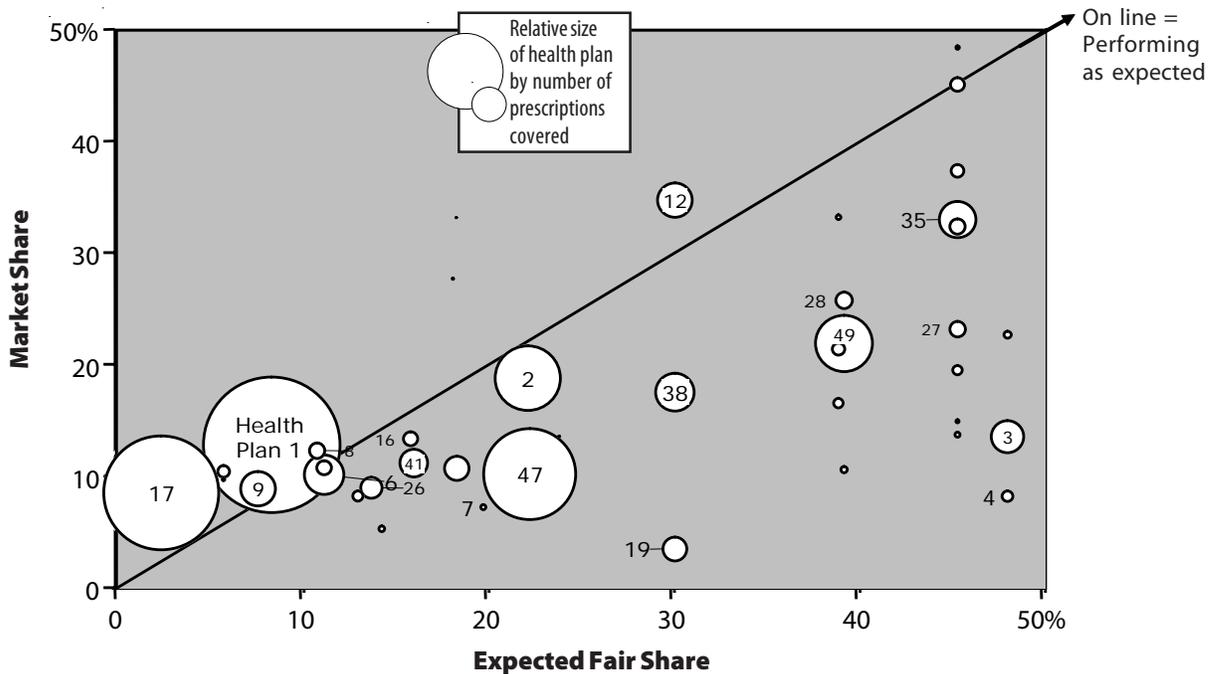
and switch for lower cost medicines or opt not to buy the prescription over 40% of the time.

Electronic prescribing tools (eRx), clinical practice and treatment guidelines, step-therapy protocols and related tools are likely to have a similar impact. Among these, eRx holds the greatest promise—or concern, depending on one's point of view. MCOs and formulary managers will be able to "inform" the selections made by physicians at the point of care. The likely result will be to make it easier and more straightforward for MCOs to guide physicians to particular medicines and steer patients to fulfill prescriptions through mail order, for instance, if that channel is more affordable to patients in a particular market than retail.

For manufacturers of branded products – those investing heavily in sales, marketing and promotional activities – the intervention of third parties in direct care delivery practices is a source of concern. Such interventions are beginning to have an impact. Independent Health Foundation of western New York and Presbyterian Healthcare Services in New Mexico, for instance, have used consistent reviews of prescribing patterns and clear communications with doctors to press for stricter compliance with prior-authorization rules governing which medicines doctors should prescribe first. Doctors independently report that they initiate co-pay discussions with 70% to 80% of patients covered by the plans.

Many Drugs Fail to Achieve "Fair Share" with MCO Customers

FIGURE 2: Expected vs. actual market share for representative ARB drug in top 50 US health plans



SOURCE: IMS; Expected Bain Fair Share Regression Models, 2004

Securing Fair Share

Where, then, does that leave pharma companies looking to position their products to best advantage on MCO formularies? All other things being equal, a brand with similar share of voice and equal efficacy should achieve the same market share as other brands on the same tier of the formulary.

The real world is not so simple, of course. A host of factors can drive a drug's market share above the level that its formulary position alone would predict. We have found a clear correlation, for instance, between factors such as positive product news or increased spending on detailing and direct-to-consumer (DTC) advertising, and an increase in market share above the level implied by formulary position. Positive news about aripiprazole's (*Abilify*) efficacy boosted its share; so did AstraZeneca PLC's investments in DTC advertising for esomeprazole (*Nexium*)—three times those of its nearest competitor.

Despite these observations, Bain research clearly shows that most brands fail to achieve fair share (see *Exhibit 2*). Underperformers are predominantly those in follower positions in more commoditized categories. The implications are clear: either these drugs should be getting more from their contracts to position their products on an MCO's formulary, or they should reduce their rebates to a level commensurate with their market share with a particular payer.

Making the Most of Rebates

Most companies trying to determine what rebate to offer, in what form and for what position on the formulary have few analytical and economic models to help them. An

example in the hypertension category demonstrates the challenge. The manufacturer paid for a position on a specific tier, but didn't get the expected share. The brand's negotiating team is well aware of this shortfall. But contract reviews are not systematic, negotiations tend to require fast turnaround and senior executives often do not participate. As a result, the company ends up paying for access, but not for market share—which effectively means the drug company is paying money for nothing. A more effective approach encourages pay for performance, by increasing the amount of the rebate paid by the drug company to an MCO, often in accelerating increments, as share rises.

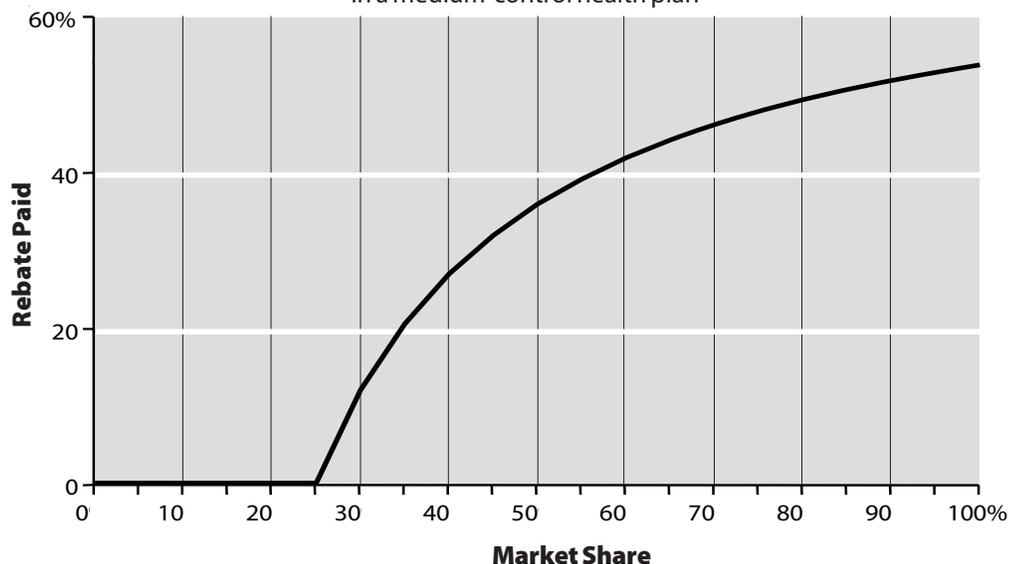
How? The first step for pharma companies is to figure out how much to pay for what level of performance. By analyzing performance capabilities and economics of the MCO—both for the target manufacturer's product and its in-class competing products—a manufacturer can determine where to position the drug on a formulary and set brand rebates to gain the highest returns on its rebate investments.

The objective of this evaluation is to produce a set of "indifference curves", which plot the gains and tradeoffs to a pharma company seeking to increase share through higher rebates. Within a certain range of share positions, for example, a brand can gain share by lowering prices—and paying marginally higher rebates to the MCO—while competitors lose share. The indifference curves help a drug firm set the level of its investment in rebates: an increase in rebates that follows the line plotted by the indifference curve should result in commensurate market share. If a drug's market share falls below the line, the pharma company is not getting its fair share.

To see how this works in operation, consider the positioning of one glaucoma medicine (see *Exhibit 3*). The pharma company was able to map the expected increase in market share for each step up in rebates it was paying to the MCO. The key set of calculations for the company used the break even cost for its glaucoma medicine—the point at which increased revenues would exceed increased rebate and marginal drug expense—and factored in the degree of control the MCO has in delivering share gains, based on past performance. Building on these underlying economics, the pharma company plotted a "breakeven rebate line," showing the expected increases in market share with each

Product Indifference Curves Map Share Gains to Rebates

EXHIBIT 3: Market share as a function of rebates for a glaucoma product in a medium-control health plan



SOURCE: Bain Drug/Rebate formulary economics model, 2005

step up in rebates paid to the MCO. If the product's market share fell below the line, the MCO's profits from rebates would have increased at the expense of the drug company paying to position its product on the formulary.

This is not an academic exercise. By plotting any offer and MCO response, the drug company can know if it will make or lose money on the contract, or if it is asking for something unreasonable from the MCO. The same analytic approach allows pharma companies to compare the rebates and share positions of its product portfolio with the same payer. Specifically, each product has its own breakeven curve that describes the trade-offs between rebates and market share. As they accumulate, these analyses raise a number of opportunities, as well as implications for the way drug firms manage their marketing activities. By tracking several products carried by the same MCO, the analyses provide the company with a more detailed evaluation of that MCO's ability to deliver share. This becomes a key consideration for pharma companies as they seek to focus investments with MCOs that have the greatest leverage over their formularies.

Having all indifference curves at hand should also allow the manufacturer to see how combined offers across its products might be accepted and where it can give away margin on one product to gain on another (see Exhibit 4).

That's easier said than done—thanks to the structural challenges and incentives within most drug companies. Giving away margin on one drug that has come up through

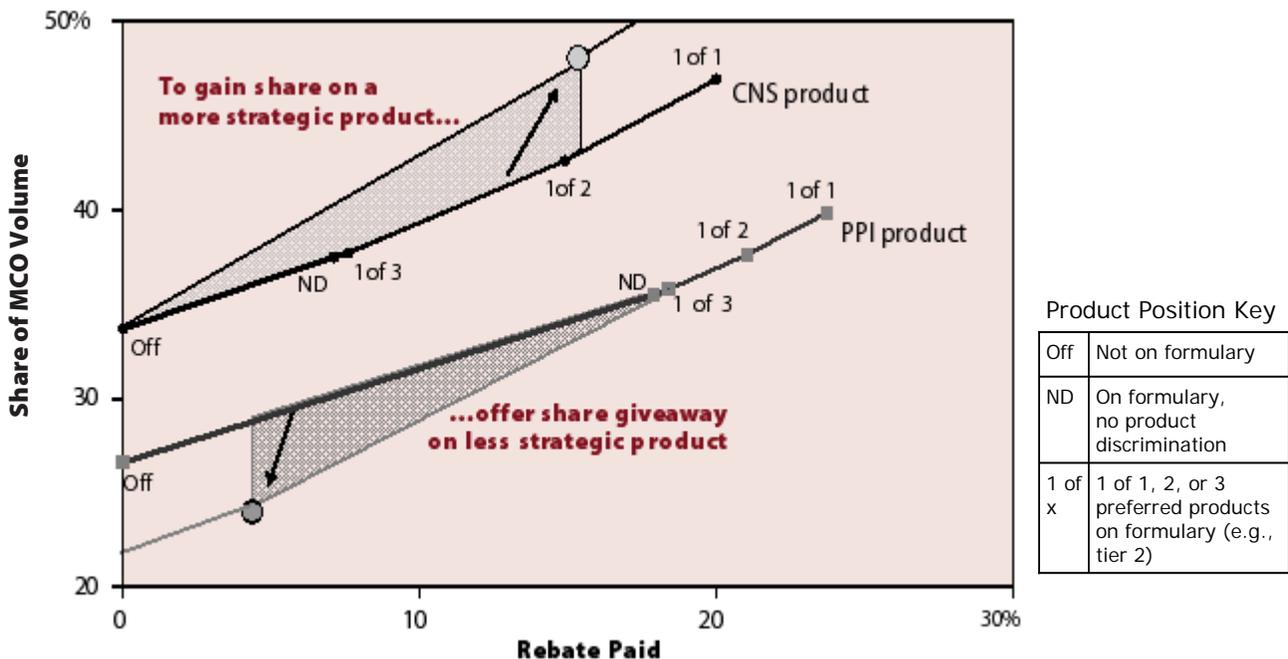
the development and commercialization ranks in order to benefit another drug within the same organization usually generates stiff resistance. Each brand team is committed to delivering on its individual brand P&L; anything that causes a particular brand's prospects to become less positive creates intense resistance, and rightly so. This is just one of the reasons why top management with overall responsibility for the product portfolio needs to be involved in decisions about trading off market share or margin within the portfolio. And the outputs generated by fair-share analysis across a portfolio of drugs can provide a basic tool for taking this debate to the next level. Providing analyses for informed trade-offs raises the possibility, at least, of marketing a portfolio of drugs, rather than each medicine on its own.

Enforcing Contracts

Drug companies frequently find themselves pressed to make sophisticated, real-time portfolio trade-offs in their dealings with MCOs. In this environment, they need ways of auditing contract compliance. One difficulty is that local markets vary widely in terms of benefit design, product coverage, prior authorization and co-pay levels and differentials. Even so, after adjusting for region-specific differences, drug companies often find products performing below fair-share expectations in certain local markets. In some instances, MCOs meet contrac-

Making Trade-offs for Optimal Portfolio Positioning

FIGURE 4; Two representative products in a portfolio positioned for a medium-control MCO



SOURCE: Bain Drug/Rebate formulary economics model, 2005

tual obligations by making up for share losses in some regions with slight share gains in others. Pharma firms pay a price for this kind of balancing. Such practices can damage local manufacturer market reputations and affect prescriber perceptions regarding access.

When companies audit MCO performance by region or metropolitan statistical area (MSA), it's not uncommon to identify transaction patterns that are inconsistent with MCO contracts. For instance, detailed transaction analyses for hypertensive products show that for a given payer in the Denver MSA, one product had a rejection rate 29% higher than the leading product. The cause that is cited in these rejections is difficulty with prior authorization by the payer, despite the fact that the product with the higher rejection rate contracted for equal formulary treatment.

The model for such regional comparisons draws on claims submission and transaction data from pharmacy systems providers, managed care plans, PBMs, and transaction clearinghouses such as WebMD, NDCHealth, QS/1 and Verispan. In some cases, regional benefit design differences also need to be factored in. Despite required efforts, the yield can be significant. Some manufacturers have uncovered up to \$100 million in revenue gains from targeted interventions based on this type of statistical analysis and modeling for high-volume primary care medicines.

Show Me the Money

The key to intervention is finding situations where a brand consistently is getting less than its fair share and where the value to be secured through intervention and renegotiation is substantial. Tracking tools linked to value potential can enable manufacturers to focus their efforts where they should make the greatest gains in market share. Monitoring MCO contract performance also enables manufacturers to spot early-warning signals that a brand is falling below expected performance, often avoiding more costly intervention and MCO discontent at a later date.

So, when should a pharmaceutical manufacturer intervene to assure that MCOs or drug benefit managers comply with formulary contracting terms? One warning sign is when product market share in a region or a specific MCO account falls below the national average. Is the plan somehow limited in its ability to enforce formulary position, creating disadvantages for some products that should

benefit instead from share gains? Are plan or benefit managers rejecting prescription transactions for products contractually entitled to the same treatment as other in-class products on the same tier of the formulary? Or is product underperformance unrelated to plan treatment and a result instead of shortcomings in the manufacturer's regional or account sales force, as MCOs and benefit managers sometimes claim?

Most manufacturers have difficulty ascertaining the answers to these questions—if indeed they are asked at all. As a result, when products perform below expectations in certain accounts or regions, the concern often flies under the radar. It's worth putting the problem on the radar, however. Companies need to invest in monitoring and data gathering, as well as analytical and modeling capabilities. They need more experience at isolating the factors that cause variations in product performance across different formularies. And they need the information as well as the reflexes to intervene when it's evident that a product is falling below its fair share.

The pharmaceutical industry is only beginning to create the right tools and techniques to work in a more competitive world where MCOs are gaining influence. Just as consumer goods manufacturers have grappled with growing channel power in the last two decades, drug firms now need better ways to assign MCO investment, pick the right battles with the sector and preserve the value of their products.

Fair share evaluation and related interventions offer an effective and practical means for making the most of the investments with MCOs. And they provide the forum for more productive dialogues between account teams, brand managers, sales and finance executives to calibrate MCO spending. Drug firms must regain some of the market power and negotiating leverage they are increasingly losing to MCOs.

Securing a brand's fair share doesn't lessen the importance of cost management, product development, pricing, patent protection and related actions by pharma companies. But the tools to track and negotiate fair share do provide a new set of resources to improve performance and returns.

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