Assessment of Reimbursement Capabilities within the Pharmaceutical Industry

Quorum was asked to conduct an analysis of the reimbursement departments of pharmaceutical and biotech companies. Our main focus was to show how these companies handled reimbursement issues for thier products. Another aspect was to note how each company structured its reimbursement department. It became clear that each drug had a specific barrier to reimbursement based on the healthcare setting and payer mix. The way the company dealt with these barriers defined the marketing and reimbursement objectives for that company.

Reimbursement Barrier Characteristics

Three categories of reimbursement barriers were created from our research of a company's product(s). Each category takes on a different level of reimbursement barriers, either real or perceived, depending on the primary setting of patient care. Forces in the retail pharmacy setting drive the first category. The main barriers in this market are the contractual negotiations and formulary list approval. The second category is formed by the physician office and out-patient setting where insurer coverage policy is the largest barrier to market a drug. The third category is the in-patient and the institution setting, where costs versus benefit financial models are used. Unique marketing and patient care settings define each category.

Retail Pharmacy Setting

In the retail pharmacy setting, reimbursement issues are geared towards private insurance barriers. This includes contractual arrangements and formulary approval. These barriers need to be dealt with so that the drug being marketed is on an even playing field with similar drugs. This setting usually does not contend with the constraints of Medicare policy.

Pharmaceutical companies develop tactics and strategies that focus on private insurance formularies and contractual agreements to reduce the impact on reimbursement. Due to these barriers, marketing strategies may focus on direct to consumer tactics. Extensive assistance and patient support programs might also be available which are structured to help patients navigate their health insurance policies. Other pharmaceutical companies have begun to offer discount prescription drug programs for indigent patients since drugs in this market have a direct impact on the patients' wallets.

Physician Office and Out-patient Setting

In the physician office and out-patient settings the reimbursement barrier is driven by insurance policy guidelines, especially Medicare and Medicaid policies. In order to obtain reimbursement, providers must follow coverage guidelines that may dictate the utilization for a particular product. These policies directly affect the type of medical treatment a patient receives and are considered top priority reimbursement issues and are handled on a pro-active basis.

We determined that manufacturers marketing drugs in this setting have produced the most complex and sophisticated reimbursement departments to ensure that policy guidelines are addressed and made a priority for the company. A few pharmaceutical companies have created multi-leveled reimbursement departments to tackle these issues on different fronts. These levels include hotline staff who keep tabs on policy changes; a sales force who are aware of coverage policies that affect their providers; Medicare Economic Managers (Payer Teams) who build relationships with Medical Directors and keep tabs on the insurance policies within their territory; and Corporate Account Managers, who work with the corporate accounts and their reimbursement problems. By creating a multi-level reimbursement orce, the changes in reimbursement policies are managed and the impact of the changes can be reduced.

In-patient and Institution Settings

In-patient and institution settings present a different set of barriers for drug coverage. Most insurers, including Medicare, reimburse a flat all-inclusive rate. Manufacturers are often in the position of conducting a cost versus benefit model, whereby the benefit (i.e., patient quality of life, length of stay, etc.) outweighs the short-term financial cost. Policy guidelines have little influence on drug decisions in this setting, because the provider is reimbursed a per diem or all-inclusive rate and not subject to line item payments.

In this scenario, outcomes studies and financial cost models become effective in the reimbursement discussions with a provider. Generally the reimbursement amounts in this setting are fixed and the manufacturer must prove that the provider will not have a negative impact. In general, a multi-level reimbursement force is not required to tackle these issues since they are not policy driven.

As we began to learn more about the various reimbursement departments, we concluded that the differences between highly structured versus less structured reimbursement departments depends on the type of reimbursement issues and patient care settings the pharmaceutical company had to contend with when launching the drug. These factors influenced the way the reimbursement department was structured.

Reimbursement Department Spectrum

Highly Structured Reimbursement Department

Pharmaceutical companies who implement strategies from the very beginning are aware of the magnitude that reimbursement issues can have on a drug. These pharmaceutical companies have created highly structured and multi-leveled reimbursement departments to tackle the Medicare and Medicaid policy barriers.

One structure that seemed to be repeated, if in varying degrees, was the sharing of reimbursement responsibilities internally within the company as well as with a select team in the field. Like most manufacturers, the field force consists of a Vice President of Sales, Regional Managers, district managers and sales representatives. The sales force is educated on the resources its company offers to assist customers with reimbursement issues.

Within the company, product managers interact with a Director of the Field Payer Team to overcome reimbursement issues on both a local and national level. The director is responsible for coordinating reimbursement tactics for the Payer Team. The Payer Team has one to two people allocated by region. The Team is expected to identify reimbursement problems, educate payers on their products, serve as a resource to the sales force and customers, and provide input on insurer coverage policies. Overall, the Team's performance is judged by the reimbursement success of the product.

In addition to the Payer Team and Director, a manufacturer will employ the resources of a reimbursement call center/hotline. The call center's responsibility is to educate providers on proper coding and coverage parameters. The call center is available to troubleshoot problem claims for customers. It is an excellent resource for the sales representatives as well since it tracks changes in policy. The Payer Team and the call center staff typically work together to determine the significance of local issues.

Within this structure, each tier of the reimbursement department is responsible for different aspects of the reimbursement world, but they are not autonomous. The information that is gathered is shared between and within the departments.

Moderately Structured Reimbursement Department

Some companies do not require a highly structured reimbursement department wiht a Payer Team component. The internal reimbursement department and reimbursement hotline provides enough support for reimbursement issues that may arise for their products. The need for multiple levels of personnel to create and carry out reimbursement strategies is not required so a more simplified department emerges.

This structure still supports an possibly an Associate Director, is responsible for developing and initiating reimbursement related strategies. They play a similar role that the Payer Team did in the Structured Reimbursement Department in that they identify reimbursement problems, educate payers on their products, serve as a resource to the sales force and customers, and provide input on insurer coverage policies.

The field force, Corporate Account Managers and sales representatives, are knowledgeable on reimbursement policies with public and private insurers. However, they do not personally assist providers or patients with policy concerns or questions. Any question or problem would be directed to the Reimbursement Hotline who can assist the provider or patient with individual concerns.

The reimbursement hotline generally provides the same level of service as it would in a highly structured department. The difference is that the hotline does not coordinate activities with a Payer Team. Instead, the hotline works directly with the internal reimbursement department.

This structure allows reimbursement information to flow between the reimbursement department and product management. It is not as structured, but it does recognize that policy changes will affect reimbursement.

Less Structured Reimbursement Department

Under this scenario, there is no formal reimbursement department; in fact there might not even be a reimbursement department. The Product Managers usually handle reimbursement issues, as they arise. The field force focuses only on sales. They would not handle any reimbursement issues, nor would the be well educated on the reimbursement components for their products. IF there is a reimbursment hotline it would be centered on the needs of the patient.

The key to successful reimbursement departments lie in how these responsibilities are delagated and integrated within companies and characterizes the way the company structures its reimbursement department.

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Quorum Consulting