eDetailing: An Alternative Sales Detail
Terry Davidson graduated RBS in December 2003 with a concentration in Pharmaceutical Management. He has 10 years of healthcare and pharmaceutical experience. He currently works in the marketing department for Ortho Biotech (J&J) and can be reached via email at tdavidson00@yahoo.com.

Pharmaceutical marketers are increasingly tapping into the Internet to develop effective communication and selling strategies. Thanks to Internet and related technologies, many companies are refocusing their communication efforts and re-evaluating their budgeting of promotional dollars. While traditional marketing programs such as face-to-face physician detailing may continue to be the primary means for marketing to physicians, companies are experimenting with a number of new Internet initiatives, like e-detailing. E-detailing is a broad and continually evolving term describing the use of electronic, interactive media to facilitate sales presentations to physicians. Pharmaceutical companies are using this method to communicate key marketing messages to physicians and to drive traffic to their product Web sites.

Sampling and traditional detailing efforts by pharmaceutical companies make up the bulk of direct-to-physician promotional spending. For years, pharmaceutical companies have relied heavily on their sales forces to deliver marketing messages to physicians. The number of sales representatives in the marketplace has steadily increased over the past decade with approximately 85,000 in the field today, according to IMS Health. With so many representatives, companies are struggling to get physicians’ time and attention. The problem is compounded because most pharmaceutical companies are targeting the same high-prescribing physicians.

Often, sales representatives spend hours in a waiting room and never actually see the physician. Those who do get past the receptionist are often limited to a brief hallway discussion. Delivering an effective product detail to a physician in such a short time frame can be difficult. Moreover, capturing the physician’s undivided attention while they’re trying to treat patients adds to the challenge.

Continuing the tradition
Within the last semester, the pharmaceutical management program has experienced quite a few firsts—a new web site, an official charter for the pharmaceutical management club, and this newsletter. None of this would have been possible without the support of Dr. Hassan and the drive of the students. We hope that in the coming semesters we can keep the tradition going and cultivate new ideas.

The mission of this newsletter is to introduce the reader to industry issues and stories which will further their knowledge base. This first issue highlights many of the current issues in the industry and will give the reader an historical prospective on other issues.

We hope that everyone enjoys this collaborative effort and will contribute to the learning experience in the coming months.

Rohit Sood
Editor, Pharmaceutical Management Club News
Rutgers Business School

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Pharmacoeconomic Models

Andrew Witriol is an Industry Scholar and the co-founder of the Pharmaceutical Management Club. He is currently interning at Organon USA in the Marketing department developing a pharmacoeconomic model to support a 2005 drug launch. Prior to graduate school, he worked at Accenture as a management consultant in the Health and Life Sciences practice. He can be reached at awitriol@pegasus.rutgers.edu.

A pharmacoeconomic model “identifies, measures, and compares the costs and outcomes of pharmaceutical products and services.” Pharmacoeconomics studies are designed to compare the medical costs and health outcomes of a new therapy with the costs and outcomes of existing therapies or medical interventions. The proper development and interpretation of a pharmacoeconomic model can help to improve public health through better decision making and allocation of resources by estimating healthcare costs for a provider, based on a specific therapy for a particular patient population. The results of a pharmacoeconomic study, along with safety and efficacy data and acquisition price help Managed Care Organizations (MCOs) and Pharmacy and Therapeutic (P&T) committees determine the drugs to be placed on formulary.

Since the mid 1990s, the number of pharmacoeconomic studies and the amount of resources devoted to pharmacoeconomics has increased significantly. Most pharmaceutical companies have created departments dedicated to the creation of pharmacoeconomic models while MCOs have initiated programs to educate employees on how to interpret such models. Additionally, many industry experts note that there has been a significant increase in the availability of peer-reviewed and published pharmacoeconomic models in medical literature reflecting an increase in importance of such models.

There are many benefits of using pharmacoeconomic models for pharmaceutical companies as well as MCOs and other payers. Besides using pharmacoeconomic models to show cost effectiveness of a particular drug, pharmaceutical companies are looking to use pharmacoeconomic models during the early phases of drug development. The strategy is to develop and periodically maintain a model that forecasts the disease state, patient population and therapy benefits for when the drug is launched. The model highlights the disease progression, competitor products, including effectiveness and overall costs. Additionally, early development of a pharmacoeconomic model assists with the identification of the target audience and population, and enables a pharmaceutical company to conduct a SWOT analysis of current therapies against the potential new therapy. Ultimately, the results of this ongoing pharmacoeconomic model will be used to determine whether the development of a new drug should be continued or cancelled based on analysis of future sales or market penetration.

A pharmacoeconomic model can also help an R&D division prioritize development of new chemical entities (NCEs) based on market potential and clinical benefits over competitors. Finally, pharmaceutical companies are using pharmacoeconomic models to guide the direction of research and development towards an NCE by identifying gaps in current markets and modeling the impact of hypothetical improvements in clinical measures.

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| Revenue | 307,106 | 521,657 | 746,625 |
| Profit | 1,526 K | 2,608 K | 3,733 K |

Example of a Pharmacoeconomic Model

From a managed care perspective, using pharmacoeconomic models will allow for informed formulary decisions based on cost effectiveness rather than cost containment. Pharmacoeconomic models will allow managed care organizations to continuously evaluate alternative therapies and to update formulary placement to reflect the most cost effective medicines on the market. Additionally, pharmacoeconomics can be used by MCOs and PBMs to influence drug pricing with pharmaceutical companies. If an MCO has used pharmacoeconomics to identify a particular drug to be the most cost effective for the average patient, that information can be used by PBMs to negotiate favorable drug pricing as a result of the favorable formulary placement. For drug classes where many drug therapies...
exist, a PBM can leverage pharmacoeconomic analysis to demand larger rebates for preferred drug use.

Objectivity remains a primary concern amongst those who create and those who review pharmacoeconomic models. Determining whether pharmaceutical companies, academic institutions or managed care organizations are the appropriate party to create non-biased pharmacoeconomic models remains an issue. A pharmaceutical company may not be the best group to create these models due to the financial incentive to provide favorable results for their product. Academic institutions can be financially dependent on grants from pharmaceutical companies for research and development, hence creating an indirect conflict of interest. Finally, managed care organizations may be in the best position to create non-biased pharmacoeconomic studies since they are the ultimate recipients of such studies.

With the current practice of pharmaceutical companies creating and submitting pharmacoeconomic models, pharmaceutical companies can choose to disregard a study that does not exhibit favorable results for a particular product. If facing sub-optimal results, pharmaceutical companies can tweak assumptions and figures used to create a model that better favors their interests. Manipulating data and complicating assumptions and figures can be interpreted as unethical because an analysis of real-life data could yield drastically different results.

The importance of pharmacoeconomic models will continue to rise as the techniques for developing and interpreting pharmacoeconomic models become better understood by both pharmaceutical companies as well as healthcare payers. With more “me too” and “me too, better” drugs being developed by pharmaceutical companies in various therapeutic areas, the need for pharmacoeconomic models will rise. There will be increasing pressure for drug companies to better communicate the overall financial and clinical benefits of a particular drug to various healthcare providers and payers. However, with the rise in the number of pharmacoeconomic models and increasing impact in formulary decisions, more specific guidance will need to be passed by industry experts and regulators to ensure the usability and integrity of such models.

Managed Care: Historical Perspective

Kartik Shukla is currently an Industry Scholar in the MBA in Pharmaceutical Management program at Rutgers Business School. He is a graduate of Ernest Mario School of Pharmacy and currently employed as a retail pharmacist with Walgreens Corporation. His e-mail address is t41mn@pegasus.rutgers.edu.

When most people hear of the word managed care they think of it as a new phenomenon, a creation of the computer age, and a way for companies to simply control costs. However, if we examine the history of managed care we come away with a much different, kinder image.

Managed care was actually founded back in 1910 at the Western Clinic in Tacoma with the noble purpose of helping people get affordable health care. At this time, the great infrastructure of America was first being laid and thousands of workers were needed to gather at a single site, like the Empire State building in New York. Inevitably with the long hours of strenuous work and poor working conditions many of these workers became sick and it soon became apparent that if any of these projects were to be completed, a system would have to be developed to care for these workers in a cost-effective manner; hence the birth of managed care. A typical worker at one of these sites could now have access to a managed care facility and its in-house physician, often located on the actual work site, for as little as twenty cents.

The latest demand for managed care stems from the private sector’s need to offer cost-effective and at the same time comprehensive and high quality insurance to their employees. The popularity of managed care has caught on to the level that even the government is using it to control costs of Medicaid and for the soon-to-be-launched Medicare-sponsored prescription drug benefit plan.

Managed care is administered through what is known as Health Maintenance Organization, or HMO. An HMO is defined as a pre-paid organization that provides care to members who voluntarily enroll in its employer sponsored plan. In exchange for a monthly fee that is shared by the employer and the employee and fixed co-pay for each doctor visit and prescription, the HMO pays the full cost of the doctor visit as well as the cost of the prescription. By agreeing to join the HMO, the employee is limited to selecting doctors, hospitals and pharmacies within its affiliated network. The HMO controls cost by contracting in advance the cost of service that it will reimburse the providers of healthcare services. This contracted price is much lower than the cost that an individual member would pay if he/she was a cash paying customer without health coverage. The providers
of service in exchange for lowering their fees are assured a large and steady supply of patients from the HMO.

Similar to the HMO, a PPO or Preferred Provider Organization is also another method of delivering healthcare services. It works on a similar concept to the HMO but affords the member a higher quantity of healthcare providers. Some PPOs even cover services provided by non affiliated providers provided that the member is willing to pay higher co-pay.

Some of the biggest critics of managed care have been physicians who in general have seen their compensation severely diminished by managed care. The two most popular methods of determining payments have been capitation and Fee-for-Service (FFS). Under capitation, managed care pays the provider a fixed fee per member per month. This means that the physician is paid the same amount of money every month for a member regardless of whether the member receives services or not and regardless of how expensive or time consuming this service is. The clear disadvantage is the element of chance. A physician may end up with a disproportionate group of patients that have complex diseases requiring a huge investment of time and resources.

FFS is defined as distribution of payment on the basis of expenditure of resources. Here a physician who is treating sicker patients gets paid more, due to the greater investment of time, energy, and skills that the physician must deploy. This fee as mentioned earlier is mandated to be at a substantially lower level than what a typical cash paying customer would be required to pay.

As the healthcare system in the United States evolves and more treatment options and medications are added, the costs of healthcare will continue to skyrocket. This along with the evolving prescription drug benefit for Medicare will assure the popularity and importance of managed care.

The Agency Side

Mari Boggiano’s experience includes six years at an agency on Madison Avenue developing pharmaceutical marketing programs targeting physicians, consumers, and managed care organizations. Currently an Industry Scholar in the MBA program at RBS, Mari just completed a 6-month internship at Johnson&Johnson. After graduating in May, Mari hopes to expand her career in pharmaceutical brand management. She can be contacted at mari_boggiano@yahoo.com.

Many of us at Rutgers Business School aspire to work for Pfizer, J&J, Novartis, and other global pharmaceutical companies; however, working within one of these companies is not our only option. On the contrary, a possibly more fun way to join the industry is one not often considered—joining a pharmaceutical marketing agency.

The word “agency” often encompasses more than a typical advertising agency and can span the full marketing mix. For example, medical education agencies gather advisory boards, design CME events, and craft educational programs. Online marketing groups build web sites, CD-ROMs, and other digital media programs (in my experience, these were the groups whose talented creative and programming staff rode scooters through the office and had multi-colored hair and/or body piercing). Public relations agencies promote brands and build awareness about therapeutic categories. Managed care divisions consult to brand managers and build materials to improve formulary positioning and reimbursement. In fact, even the advertising agencies themselves usually focus on medical professionals or consumers; a few do both.

At an agency, you work with one or more pharmaceutical clients to build their marketing plans and communication tools. It is exciting, varied, challenging, and rewarding work.

Managing client relationships is no easy task, especially in today’s pharmaceutical industry where co-marketing alliances can double the number of people you have to please. Account work, typically considered the role of the “Client Services” team, can task your customer service skills and patience. However, building partnerships with your clients can be very rewarding beyond perks such as client dinners and entertainment events. Furthermore, the creative nature of the work provides continual stimulation.

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- Celebrating the thrill of winning a pitch worth millions of dollars after two intense weeks of strategizing, crafting slides, and practicing presenting. To win one, we typically lost three.

LIFE AT AN AGENCY

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<tr>
<td>Can be a marketer without having to be a salesperson first</td>
<td>Workdays typically start late, but often extend into the night. 50-60+ hours per week are not unusual.</td>
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<tr>
<td>Exciting, hip work culture</td>
<td>Clients are difficult to please; creative work is subjective</td>
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<tr>
<td>Strong salaries and, in many cases, an annual bonus</td>
<td>A never-ending series of deadlines and crises</td>
</tr>
<tr>
<td>The thrill of preparing for and winning a pitch</td>
<td>May require a good deal of travel, including weekends</td>
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<tr>
<td>Ever-changing work with fresh challenges and a great deal of autonomy</td>
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To give you a flavor of what agency life is like, the following are a few of my experiences:

- Celebrating the thrill of winning a pitch worth millions of dollars after two intense weeks of strategizing, crafting slides, and practicing presenting. To win one, we typically lost three.
“I’m not a doctor but I’ve played one on CD.” When the voice talent cancelled at the last minute, my crew convinced me to lend my voice for the female doctor role in a sales force audio script I had written. At other times, coworkers even modeled for print ads when needed.

Pulling a painful all-nighter supervising a freelance graphic designer drop copy I had written into a layout.

Having MedAd News name a brand web site my team launched the year’s top healthcare site.

To investigate agency positions, here are a few tips. Foremost, MedAd News issues its agency review each April: access this issue through the Rutgers online library to find rankings and profiles of the top agencies, including contact information. Most agencies have websites listing open positions and HR contacts. Also, when using online job sites, the best search keyword is “communications”. Headhunters and recruiting agencies websites listing open positions and HR contacts. Also, when using online job sites, the best search keyword is “communications”. Headhunters and recruiting agencies are also a prime way to gain referrals to agency jobs.

As MBA graduates, our options are many! For those of you who are pharmaceutical management concentrations, I encourage you to look beyond pharmaceutical companies in your job search to the many supporting services that also offer varied, rewarding positions with high growth potential where you can leverage all of your business skills. Good luck!

**POSSIBLE MBA JOBS**

**Account Executive / Project Manager:** Put all your business school skills to use. Overseen program design and implementation, manage budgets and project deliverables, cultivate clients and—most difficult of all—manage staff who may or may not report to you.

**Market Researcher:** Build and implement market research tools, scan competitive activity, and help craft brand strategies and tactics.

**Sales / Business Development Manager:** Forge new client relationships, strategize and present at new business pitches, and lead Request for Proposal efforts that include writing and estimating.

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**Quest For A Suitable Match**

Meghna Mehta is an Industry Scholar in the Rutgers Business School Pharmaceutical Management Program. Prior to joining the program, Meghna spent eight years in various capacities in the pharmaceutical industry in India. Meghna can be reached at meghmehta@pegasus.rutgers.edu.

It all began in early 1980s. The truism of Darwinism had just dawned upon the industry. ‘Survival of the fittest’ heralded the first wave of pharmaceuticals mergers and acquisitions. The ensuing consolidation wave has led the top 10 pharmaceutical giants’ market share rise from 28 percent in 1990 to 49 percent in 2000. Such has been the intensity and the force of alliances, that between 1996 and 2001, the revenue generated for the ten largest global pharmaceutical firms by in-licensed products has grown from an average of 19% in 1996 to 22% in 2001. No wonder, at its peak in 2000, pharmaceutical deals worth US$109.3 billion were executed.

All along, the M&A activity has been primarily driven by the urge to a) create marketing muscle b) consolidate for cost reduction c) stuff the pipeline and d) expand geographically. Pharmaceutical giants like Johnson & Johnson and Pfizer have perfected the art of making picture perfect alliances. It’s a race for market share and quest to remain at the top that is driving these firms to go scouting for the potential alliances. It’s all because of consolidation that Pfizer has 10 percent market share and is a market leader while it was no where on the scene in top 10 ranking in 1990. It's an interesting study- Merck, a believer in organic growth and a leader in 1990 (3.8 percent market share) had slipped to the 3rd position after Pfizer and GSK in 2002. No wonder, today M & As are an integral part of the pharmaceutical firms’ growth strategy.

Pharmaceutical alliances come in varying shapes and sizes. Leading the pack are the following types of alliances:

1. **Joint Ventures:** Formed by having a separate operating company to research, develop and/or market a product or a group of products. E.g. TAP pharmaceuticals is a joint venture between Takeda-Abbott to develop and market products from Takeda’s R&D in North and Latin America

2. **Co-Development/Co-Marketing/Co-Promotion Agreement:** Two companies cooperate in taking one or more compounds through various stages of development and commercialization. Merck KGaA's agreement with Bristol-Myers Squibb for the antidiabetic Glucophage (metformin), which BMS obtained the rights to in the USA, while Merck retained rights in the rest of the world, and both companies have cooperated in developing lifecycle extensions, such as combination and extended-release formulations.

3. **Pharma-Biotech Alliances:** Pharmaceutical companies have strengthened their pipelines via alliances with biotechnology companies. In return for providing innovative compounds and/or technologies, biotech companies gain finance, clinical development, regulatory approval,
manufacturing and marketing assistance. This form is increasingly becoming common with Big pharma courting small and mid-sized biotech firms like never before.

It might be worth noting here that not all is perfect in the land of M&A. Not all of these alliances live up to expectations. Industry sources say somewhere between half and three-quarters of all deals have failed and should have been attempted differently. Only 30% of any post-merger initiatives undertaken ever realize their synergies. Industry experts believe that there are three reasons why pharmaceutical mergers fail: the poorly structured deal, too high premium, and improper integration.

Much has changed on the pharmaceutical M&A landscape, but “Big Pharma’s” quest to find the perfect match remains unabated in 21st century. It is not always that a big fish tries to gobble the small fish as seen in the recent Sanofi-Aventis stand-off. Sanofi’s €47.8 billion ($60 billion) bid for Aventis is colored by political backing as never before seen. If it closes, the deal will create the 3rd largest player in the world pharmaceutical market with 9% market share.

The 21st Pharma M&A world is in the midst of a third wave of consolidation. Mega pharmaceutical players have been furiously building alliances with small and large biotech companies, medical device companies to create a greater scale, leverage and spread their risk. Pharmaceutical companies are forging therapeutic area alliances to enter into new therapeutic areas like Cancer, CNS, and immune-related disorders and spruce up their therapy area product lines. This clearly reflects Big pharma’s strategy of reducing risk of new drug development by forging alliances at the late stage of drug development, thereby enhancing the probabilities of drug success.

Summing up, mergers and acquisitions have become a way of life for “Big Pharma”. It’s the life-style suitable for the industry’s short-term and long-term health and, hence, the quest for the suitable match continues.

e-Detailing continued

In this crowded and competitive environment, pharmaceutical companies must develop new strategies to improve the efficiency of their direct-to-physician marketing initiatives. According to IMS Health, the cost of traditional detailing was “more than $5 billion in 2002, an 11% increase, and the cost of calling on physicians in hospitals topped $800 million, a 24% increase from the previous year.”

A Cap Gemini Ernst & Young study states that the average cost of detailing a doctor face-to-face is estimated to be between $150 and $200 per visit, while e-detailing costs are closer to $100 per e-detail. Physicians are becoming more selective in choosing which representatives to see. Despite new channels for pharmaceutical promotion, the physician-salesperson interface remains a critical ingredient of the pharmaceutical marketing mix. Relationships, or lack thereof, between the physician and salesperson have a direct impact on the future sales of the product. Physicians rely on drug salespeople for information regarding the drug’s dosing, indications, efficacy, safety, and cost. Physicians want to be knowledgeable of all therapeutic options so they can make more informed treatment decisions.

Pharmaceutical companies are adopting e-detailing with the belief that it may capture the attention of the physician and better utilize their marketing budgets. Early studies by iPhysicianNet have shown that online detailing sessions have reduced the cost of sales calls and still influenced prescribing behavior. Pharmaceutical companies are still experimenting with e-detailing as they continue to measure their return on investments (ROI) for e-detailing, but many companies are well beyond the pilot phase. Companies such as Aventis, Novartis, and Eli Lilly are investing heavily in e-detailing programs and trying to develop their own databases.

Example of an Online E-Detailing Survey: © OBGYN.net
A pharmaceutical company’s decision to adopt e-detailing is driven by a number of factors. First, increased physician use of the Internet has made pharmaceutical companies look at the Internet as another opportunity to reach physicians. Second, with physician time at a premium, pharmaceutical companies are seeking to provide physicians with viable alternatives to learn about their products and reduce the risk of losing share of voice. Third, with other pharmaceutical companies already adopting the technology, pharmaceutical companies are almost forced to “play” for fear of losing market share to competitors.

Companies will thus need to discover how to effectively integrate e-detailing into the marketing mix. Pharmaceutical companies will be more successful if they learn to integrate their on- and off-line direct-to-physician campaigns. Physician-specific data collected from Web sites, sales visits, e-details, and other contact points need to be captured in one database. Once the data are centralized, pharmaceutical companies will be better positioned to personalize marketing messages to fit physician needs. This is important since a number of physicians indicated they want relevant information for their practice and felt they were not always getting it. As physicians participate in e-detailing campaigns and information is gathered, the salesperson can use that information to tailor their messages to the physician.

The Medicare Modernization Act: Effects
Jennifer Uptegrove is an Industry Scholar in the Pharmaceutical Management program at Rutgers Business School. This summer, she will be interning at Roche in the Marketing Research Department. She is the President of the Pharmaceutical Management Club at RBS and can be reached at jaflynn@pegasus.rutgers.edu.

On December 9th, President Bush signed the Medicare Modernization Act of 2003 (MMA) into law. This legislation will provide a voluntary prescription drug benefit for the elderly and disabled beginning in 2004, and a temporary discount card program in the meantime. This benefit will provide a coverage option for the 38% of Medicare beneficiaries who currently do not have a prescription drug benefit, and will cover all of the 15% of Medicare beneficiaries who currently receive their drug benefits through Medicaid. Although this legislation will provide meaningful relief to seniors and the disabled, it is not without a price. The Congressional Budget Office (CBO) estimated the cost of the drug benefit at $395 billion over 10 years, although recent White House estimates have the cost at closer to $540 billion.

The main feature of MMA is an outpatient drug benefit which will be administered through a variety of private providers. To enroll, beneficiaries would be required to pay a low monthly premium estimated to be around $35, and an annual deductible of around $250. After meeting their deductible, seniors would face co-payments at a variety of levels: 25% on spending up to $2,250, 100% on spending between $2,250 and $5,100, and 5% on spending over the $5,100 cap. Beneficiaries whose income is below 135% of the federal poverty level (FPL) will be exempt from all costs except for low, fixed co-payments, and those between 135% and 150% FPL will have lower deductibles, premiums, and co-payments than other Medicare beneficiaries.

The Medicare bill is likely to have a sizable impact on a variety of groups. States will definitely see a change, as the 6.4 million dual eligibles who receive their prescription drugs through Medicaid are switched onto the new federal plan. Although states will have to refund the majority of their estimated savings to the federal government, they are still expected to save $17 billion over the first 10 years of the program. The effect of the bill on dual eligibles switched from Medicaid to Medicare will depend on the Medicaid program their state previously offered. Several states offer programs more generous than the new Medicare benefit, and those seniors may actually see their costs increase. The great majority of dual eligibles, however, will benefit by switching to the new free-market plan, and states may choose to supplement the benefit with their cost savings.

States will also see savings as they are able to transition seniors who are currently on state-run pharmacy assistance programs into the new Medicare benefit. According to the Commonwealth Fund, in 2001, the 28 states who had such programs spent $1.5 billion on them. States may choose to continue these programs as they are, but are more likely to use the savings to create a wrap-around benefit for Medicare beneficiaries.

Pharmaceutical manufacturers will most likely see an increase in profits, as more people are given access to affordable prescription drugs. However,
profits are far from guaranteed, as steep discounts to drug benefit providers will be necessary in order to earn a spot on the formulary. Theoretically, competition in an open market is the best way to drive down prices, and if this is true in the pharmaceutical industry, companies might not benefit as much as some have projected.

So what does this benefit mean to those of us at Rutgers? Well, for starters, MMA will definitely serve to expand the market for pharmaceuticals, and lead to the need for new departments and employees to manage pricing and interactions with the privately-run plans. New marketing positions may be created to target the millions of seniors who can now afford to buy cutting-edge pharmaceuticals through Medicare. Any decrease in pharmaceutical profits could decrease wage levels or lead to cuts in head count, but since the impact on industry profits is purely speculative at this point, I wouldn’t let that worry you too much. On the other hand, if revenues do increase, funneling the excess back into R&D could also lead to even more drug discoveries and quicker market expansion. Overall, it seems likely that we will benefit from this legislation, as any increases in the size of the market for pharmaceuticals will only increase the number of job opportunities available for us.

From the Director

Almost four years have gone by since we started the pharmaceutical management track in our MBA program. We knew at that time that it would be a hard battle to establish the track as an acceptable program to the pharmaceutical companies as their regular source of recruitment for fresh MBAs because of the industry’s tradition to recruit mostly from the Ivy League schools. Well, after four years of hard work by the faculty, the administration of the school, and with the help from the sponsoring companies, we have been able to penetrate the barrier.

We have graduated two classes of MBAs with concentrations in pharmaceutical management. Many of these graduates have successfully competed against MBAs from the very top schools in the country to secure jobs in the leading pharmaceutical companies such as Pfizer, Bristol-Myers Squibb, Johnson & Johnson, Novartis, Roche, Organon, Shering-Plough, Eli Lilly, Wyeth, and many others. During the past summer, the demand for our pharmaceutical students in the industry for summer interns exceeded the supply. All of the above indicates that the program has begun to get its well-deserved recognition in the industry.

The students are also making a substantial contribution to enhance the goodwill of the program by organizing the activities of the pharmaceutical management club, publishing this newsletter, participating in national case competitions, peer advising the new applicants to the program, and many others. We do appreciate the students’ hard work and help.

Finally, we express our gratitude to our sponsoring companies – Bristol-Myers Squibb, Eisai, Johnson & Johnson, Merck, Novartis, Organon, Pfizer, and Roche – for their continued financial as well as non-financial support. We are also indebted to the Health Care Institute of New Jersey for their help in forming this partnership between academia and the industry. We could not have done it without their help.

Mahmud Hassan, Ph.D.
Director, Pharmaceutical Management program
Professor, Finance and Economics