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Should Pharmaceutical Incentive Compensation Plans Cap At-Risk Sales Rep Compensation?

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George A. Chressanthis, Ph.D., Principal Scientist, Axtria Inc.
Abhijit Paul, Director, Axtria Inc.

1. Introduction

1.1 Importance of Pharma Sales Forces and the Incentive Compensation (IC) Plan Design

Pharma company investment in the sales force represents one of the largest line items in the entire commercial budget. Pharma companies with very large sales forces (e.g., > 4,000 reps) each spend over $1 billion annually, despite the industry shift to specialty medicines, smaller physician call-target populations, growing managed care market access and control effects, increasing sales rep-physician access restrictions, higher use of alternative digital/social media channels, and rising biosimilar/generic drug competition. Spending on direct sales forces accounts for close to 50% of all sales and marketing costs. The reason for this continued investment in sales forces, despite their inefficiency (highest cost per target contact relative to other channels), sales reps represent the most effective channel (highest return per target contact in generating sales relative to other channels). In addition, sales reps represent an effective means to disseminate critical scientific/medical/clinical information to physicians, contrary to the naysayers about the future demise of sales reps in today's industry given environmental trends regarding the rise of specialty medicines and alternative digital/social media channels. Prior empirical studies affirm the relationship between the dissemination of scientific information by promotion (sales and marketing) with business performance.[1-4]

Having the right incentives in place is important to help guide the performance of the sales force. The most common current proportion of sales rep total compensation broken down by base salary and at-risk reward governed by the IC plan is 75%-25%. Therefore, at a $1 billion of annual investment for the largest company's sales forces, the at-risk portion of that spending is an approximate non-trivial $250 million per year. In addition, the IC plan is an important sales operations instrument to guide sales reps to implement the right behaviors and direct appropriate effort to ensure all sales force strategic outcomes according to pharmaceutical sales force theory and practice. The IC plan is also an effective control mechanism to minimize suboptimal sales rep behavior and effort, thus ensuring activities are focused and consistent with achieving company strategic objectives in line with the principal-agent theory and empirical evidence on compensation plan design. Prior research shows that an IC plan, when properly constructed, is a significant motivational instrument and driver of sales rep performance, especially among star performers.[5] Though star performers are smaller in proportionate size (around 20%) relative to the entire sales force, they generate a greater disproportionate share of sales.[5] So having the right IC design is vital if companies desire to maximize financial performance.

1.2 Why do Pharma Companies have Caps in their IC Plans?

If these incentives are critical to generating desired financial performance, why do pharma companies institute caps, or a maximum a sales rep can earn on the at-risk portion compensation in the IC plan design? Anecdotal evidence gathered suggests that about 25-30% of pharma companies have caps in their IC plan design. Some of these capped plans are due to companies instituting "ranked" plans that are inherently capped. Plans could also have "soft" caps under the pretense of an uncapped plan but where the upside is significantly limited and/or unattainable. Where caps on at-risk incentives exist, it is almost always driven as a cost control mechanism from the finance area, who tend to see the sales force as an expense to be managed rather than asset investment to grow the business.

Studies exist that suggest IC plan caps are counterproductive. One published article in the *Harvard Business Review* focused on sales noted that IC plans should never have caps as they discourage sales rep work effort that drives financial performance.[5] One prior published empirical study found an adverse effect on sales generation by having caps within the IC plan design. When the caps were taken away, coupled with other changes, sales revenue generated increased by 9% (from an individual sales rep-level analysis for a large contact lens manufacturer).[6] A theoretical study noted *the optimality of s-shaped incentive schemes and pay caps by incorporating salespeople's aversion to pay inequity into the standard agency model.*[7] However, this theoretical academic study is inconsistent with what is seen in practice and actual empirical work on the effect of compensation caps on stifling sales rep effort and reducing business performance.

So, the question to be researched here is simply this - why do at least 25% pharma companies place caps on IC plans if we know from theory and empirical evidence that when caps are removed, business performance can be significantly improved, especially driven by top performers? This paper will explain why pharma companies should drop all caps in their IC plan design. Evidence will be presented from actual pharma company IC plans, reveal the adverse financial and behavioral effects of having caps in the design, and what happens to financial performance when those caps are eliminated.

If having caps are inconsistent with a pay-for-performance sales culture, why then do companies have them? Below are a few reasons provided why caps may be instituted along with a corresponding counter-argument:

1. *Reason #1* - Uncapped plans may encourage unethical and/or illegal sales rep behavior in order to increase their at-risk compensation. Executives at a large pharmaceutical company made industry news in 2011 by announcing that their sales reps would no longer have their at-risk compensation based on prescription (Rx) volume generated by physicians.[8] The company's plan was to eliminate Rx-based incentives that could encourage sales reps to engage in "persuasive" activities and potentially lead to problematic sales and marketing practices. Instead, the at-risk compensation component would be calculated on the basis of metrics that measured sales rep "informative" activities in order to improve sales rep-HCP engagement that could help physicians and their patients. Reactions to the new IC program were mixed within the industry, with concerns that these types of programs would adversely affect sales. The company announced in May 2019 that effective in July 2019 for certain countries and in their specialty portfolio of products, individual sales targets will be employed to determine the capped variable payout element of a sales representative's compensation as a way to retrain and attract the best sales force talent, while continuing to deliver quality HCP interactions.[9] Extensive training, control, and compliance mechanisms would also be implemented to ensure the new compensation program is in sync with the company's value-based sales rep-HCP engagement approach.[9]

   Counterargument - Issues regarding unethical and/or illegal sales practices are not inherent with having an uncapped model but rather not having effective control mechanisms in place to minimize such adverse behavior contrary to the objective function of the company.

2. *Reason #2* - Uncapped plans make it more difficult for predicting the at-risk compensation expense (a budget control argument). A related argument is the presence of product demand uncertainty in order to pay for the at-risk compensation.

   Counterargument - These issues are about making sure there is a tight linkage between predictive sales-response modeling that connect sales rep effort to sales to compensation, and not inherent to instituting uncapped IC plans. Furthermore, robust demand forecasting and quantitative simulations can help mitigate potential budget risks.

3. *Reason #3* - An uncapped plan may incur a risk that sales reps will increase prescriptions well beyond what operations (manufacturing) have produced, resulting in physicians prescribing a product of which not enough is available (this is a bad situation pharma companies do not like to incur).

   Counterargument - This is not an issue inherent with an uncapped IC plan but rather not having strong forecasting processes that link sales and marketing efforts to prescriptions to production, with updates done in virtual real-time.

4. *Reason #4* - Pharma is a very conservative industry, with uncapped plans being perceived as "maverick," more common to industries like banking, medical devices, software sales, etc.

   Counterargument - Whether it is pharma or any other industry, the motivation of a sales rep is always driven based on their opportunity to earn more. This is true even for the top-performing sales reps, hence an uncapped plan is well-received even in the pharma industry.

5. *Reason #5* - Sales reps for many, if not most brands, drive a relatively small portion of incremental sales. Therefore, with such a high carryover, reps really cannot achieve "breakaway" uncapped results. Yes, you can always manufacture an uncapped payout curve, though showing a barely visible positive payout curve.

   Counterargument - While the influence of a sales rep on incremental sales might be relatively small, based on our anecdotal knowledge, we know that "a good brand is only as good if only the sales force is able to get the message out to the physicians."

6. *Reason #6* - The last argument is with an increasingly complex selling process that is more "team-based," individual sales rep rewards may give way to bonus rewards and thus may mean placing caps on the financial payout.

   Counterargument - There is nothing inherent with "team-based" rewards that preclude having uncapped at-risk compensation plans.

2. Case Studies of Pharma Company IC Plan Design with Caps and Tools Available to Implement Optimal IC Plans

2.1 Why Ask a Sales Rep to Stop Selling?

Why would you want a sales rep to STOP selling? An explanation and answer to this question is addressed by Abhijit Paul, Director at Axtria, who works with clients on developing pharma IC plans. The question posed at the beginning of this section is surely one that you would have

come across at least once while working either as an IC plan designer, commercial operations leader, sales leader, or brand manager. Ideally, a well-balanced sales compensation design should eliminate the need for caps. Capped payout IC plans are counter-intuitive to a pay-for-performance philosophy. Capped IC plans not only demotivate top performers but also encourage undesirable behaviors such as manipulating sales timing in the form of holding sales until the next measurement period once the sales rep reach the cap. However, depending on the market and the role of the salesperson, they likely can't really "hold" sales back. They can slow down or stop making calls, though, in an attempt to do so. This can also have adverse effects on HCPs getting the information they need to best serve patients.

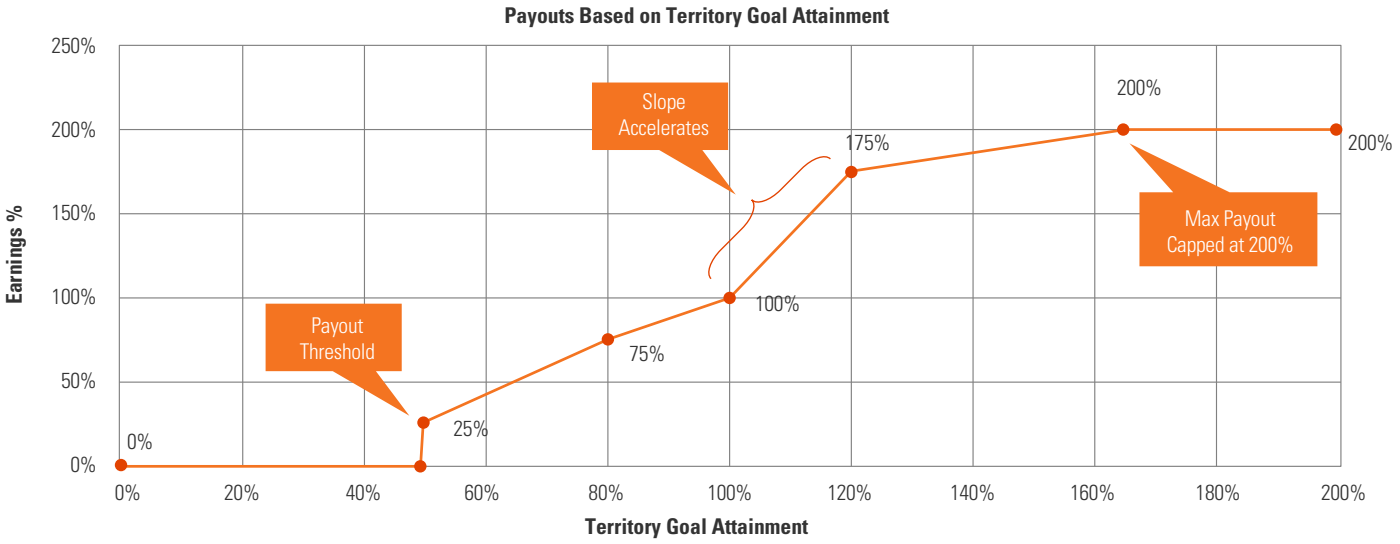
Company decisions on capping IC plans are anchored on the following points: a) IC philosophy/culture, b) forecast reliability, c) type of therapy area, and d) corporate integrity and compliance. However, for this whitepaper, we outline two case studies that will help us uncover the short-comings of an IC plan with a capped payout.

2.2 Case Study #1

Company A is a large pharma organization with a primary care brand. The overall brand strategy was to drive volume, given that the brand was in its growth stage. Company A embraced an IC strategy to use a volume-goal attainment plan to drive sales to maximize on opportunity. The message to the sales reps was anchored on the fact that the goal-based plan was fair/accurate, and the reps would have an accelerated pay rate once they achieved their sales target. While the IC plan was aligned to the overall brand strategy, there was an obvious fear - what if the goals were set poorly or the national forecast was not accurate, or a sales rep blew it out of the park.

Given this fear of the unknown, Company A decided to hedge by capping the payout curve at 200%. The premise of capping the payout curve to 200% payout at 165% sales attainment was based on anecdotal data derived from the assessment of historical sales attainment from the last 4-5 quarters. Given that the attainment percentage of top-performing territories had historically hovered in the range of 155%-160%. Company A's leadership felt that capping the pay curve at 165% attainment to 2x would be a good safety net in case of a windfall payout. Buy-in of the IC plan was good from the sales leadership as they felt everyone on the sales team had an opportunity to earn the payout entry threshold being set low (~50%), and the sales reps had an opportunity to make 2x payout at 160% sales attainment (see **Chart 1** below).

Chart 1: Case Study #1, Earnings Percentage (% of target) and Goal Attainment (% of goal) Relationship



Source: Axtria Inc. case study based on a primary care brand from a large pharma company.

The capped IC plan was received without any noise by the sales force. However, it drove some unwanted behaviors within the sales force. One significant adverse effect occurred with top performers who felt that selling beyond a certain point would not be rewarding, hence the best thing to do would be to slow down their sales effort. This phenomenon got magnified even more with a managed care favorability win received by the brand. Approximately 12-14% of the sales force landed into the excellence zone with their attainments hovering in the range of 160%-164%. These top performers started expressing a lack of motivation to their managers as they felt that the capped IC plan stifled them from earning more and that the IC plan lacked pay-for-performance. The general perception within the top performers was that the IC plan was designed to reward them for their hard work, but only up to a certain point. They felt that the opportunity to earn more money was eliminated, and thus there was no upside for top performers.

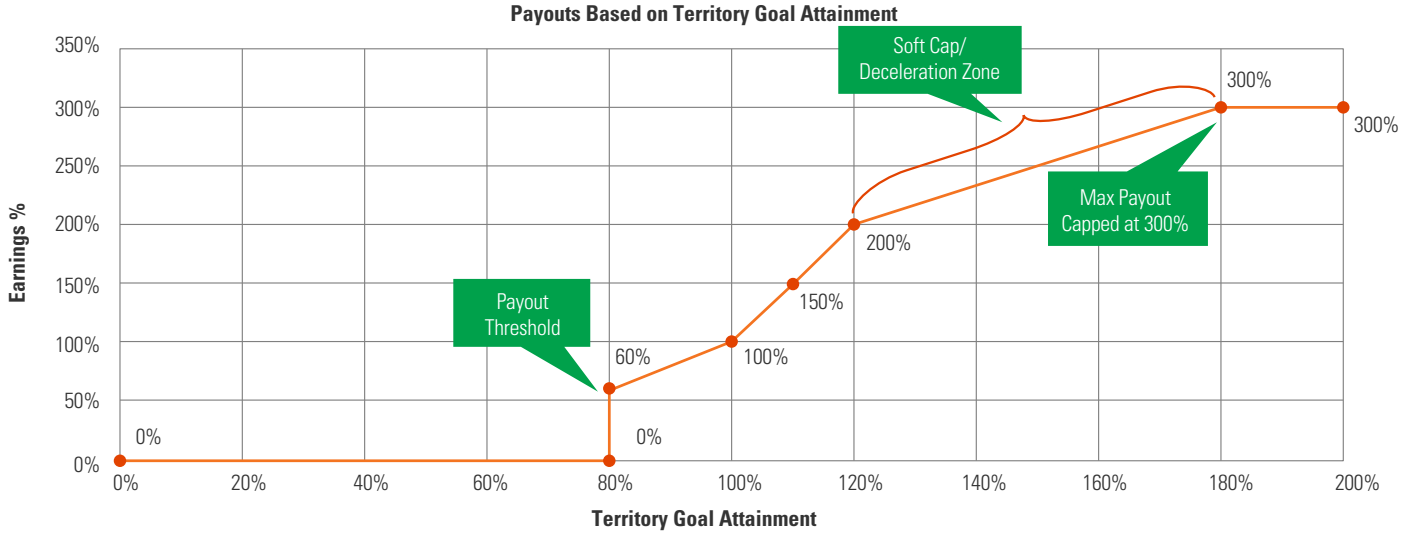
There are two important learnings from this case study.

1. Payout-curves should be designed with appropriate guardrails to make sure that the sales rep could always earn more. Capping the IC payout leads to unwanted outcomes, like a decrease in motivation, mistrust of the IC plan, loss of sales and/or profit, limits reps to reach their maximum potential, and reflects a lack of proper understanding and communication of the IC plan on the field.
2. The managed care win aspect to this case provides an interesting point because some people may see this as a reason to use IC plan caps. Instead, this type of big change should be accounted for in the forecast used to set sales force goals, while the IC plan should remain uncapped. Maybe the most important point of a highly leverage, uncapped IC plan is setting accurate goals with an accurate overall national forecast (which includes accounting for planned large managed care changes).

2.3 Case Study #2

Company B is a large pharma organization with a recently approved rare disease brand. Given the wide variability in patient opportunity at the territory level, a combination of individual territory level and a team goal attainment plan was considered. Identical to any rare disease brand, Company B's brand also exhibited a sales pattern with peaks and lows. In order to minimize the negative influence of this swinging pattern of sales, an average of six months was used as a historical baseline period. Company B wanted to hedge the risk of unforeseen payouts. Hence, the company introduced a payout cap at 300% for 180% of territory goal attainment (see **Chart 2**). Due to the nature of rare disease brands, which have low volume, the stakes are high as the brand/treatment cost is high. Small additional volume could significantly affect the goal attainment, and the value of each incremental volume can have a significant impact on brand net sales.

Chart 2: Case Study #2, Earnings Percentage (% of target) and Goal Attainment (% of goal) Relationship



Source: Axtria Inc. case study based on a rare disease brand in a large pharma company.

While the thought process to introduce a payout-cap was to provide a payout safety net, the sales team ended up getting disengaged early on at 120% attainment due to the pay rate being reduced or decelerated. Sales teams felt cheated as their perception was that they were not appropriately incentivized, even when Company B was achieving its sales target. They compared themselves against the other rare disease team within the company as well as benchmarking their payouts against other rare disease companies.

Since the rollout of the IC plan, the sales reps felt two things: 1) the IC plan was designed to reduce payouts, and 2) the effort spent in selling to a chain of stakeholders in a rare disease setting might not be rewarding, especially if the territory was right at the cusp of 120% attainment. Sales reps felt demotivated as their perception was that pay rate decelerators were hurdles for someone working for a rare disease brand. They also felt that the 3x payout that was sold to them was far-fetched and was a carrot that was hard to achieve. These sentiments were the same across the board. This raised eyebrows within the Company B's sales leadership and HR teams as the attrition rate jumped up in the range of 25-30%.

The learning from the above case study is that capped IC payouts can have debilitating effects on the sales team by giving way to a sales rep engagement problem that could eventually lead to rep dissatisfaction resulting in a high turnover rate. The high turnover rate ultimately affects the company in the form of lost revenue until the new rep gets up to speed (due to an external sales rep – physician relationship disruption) and the cost of training a new sales rep. Hence appropriate due diligence should be applied while designing payout curves for specialty and rare disease teams as the increase in costs due to higher sales rep turnover can significantly decrease sales revenue.

3. Conclusions

This white paper looked at a simple but important research question – why do pharma companies have IC plans that cap their at-risk sales rep compensation? This white paper provided reasons why such caps are not justified on both theoretical and empirical grounds, noted counterarguments to those who argue for IC caps, and offered two typical case studies that revealed both negative financial and behavioral effects of having caps on IC plans. The adverse effects from these case studies affirmed expectations from theoretical modeling and prior empirical evidence.

Yet, despite a wealth of theoretical analysis and practical empirical evidence on sales rep compensation that says IC plans should not have caps, a significant proportion of pharma companies have just that. Why? The likely #1 reason is budget control, and that can often stem from uncertainty around demand forecasting and its connection to sales force goals and payouts. Companies need a partner who is an expert in connecting these dots for them, and appropriately utilizing the IC budget to get the most out of the sales force. Uncapped IC plans are an important part of this, as is expertise in setting goals and understanding the relationship between goals, IC pay curves, and budget.

Despite comments and predicted industry trends to the contrary, the sales force is still an important instrument in today's environment in a pharma company's sales and marketing arsenal. The sales force is a critical means to disseminate important scientific, medical, and clinical information to healthcare professionals (HCPs) and other stakeholders seen by sales reps. The skills needed by sales reps have changed from the past, commensurate with the growth of specialty medicines that require more engagement with HCPs based on disseminating scientific information that ultimately drives health and economic outcomes. Pharma companies today are facing increasing price competition and calls to limit drug prices from a variety of sources that directly affect profitability needed to reinvestment into R&D. Thus, generating the greatest return from resource investments to promote brands and disseminate important information to all key healthcare system stakeholders that can affect all strategic outcomes is critical now more than ever for brand and company success.

The IC plan design is a vital instrument for ensuring the sales force is engaged in activities necessary to achieve strategic goals for the company. A poorly designed IC plan, such as one with caps, can produce numerous negative consequences, as illustrated in the two case studies outlined in this paper consistent with prior empirical studies and practical real-world evidence. Pharma companies need to partner with an organization that fully understands the connections between tactical processes like IC plan design with the attainment of strategic objectives that are derived through the sales force optimization process. Moreover, the growing complexity of the selling process with a greater number of decision-making stakeholders and the shift to specialty medicines, which has generated additional issues, will put increasing challenges on those constructing IC plan designs to ensure sales reps are driven to achieve (and surpass) planned goals. Working with a trusted strategic partner who has the necessary analytical tools, insight-driven solutions, easy-to-use platforms, and operational pharma experience across a wide variety of product portfolios and sales teams is still crucial to maximizing the returns from sales force investments.

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George A. Chressanthis, Ph.D.
Principal Scientist, Axtria Inc.
300 Connell Drive, Suite 5000
Berkeley Heights, NJ 07922
E: george.chressanthis@axtria.com

Abhijit Paul
Director, Axtria Inc.
300 Connell Drive, Suite 5000
Berkeley Heights, NJ 07922
E: abhijit.paul@axtria.com

Contact Us

+1-877-9AXTRIA
info@axtria.com

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