The Foundation for Managed Care Pharmacy Presents

Benchmarking New Frontiers - Emerging Trends Research with Managed Care Pharmacy Experts

Detailed Findings September 2006
FMCP is the only non-profit charitable trust dedicated solely to supporting research and education activities in the field of managed care pharmacy
Who is HSM?

HSM is a national leader in health care market research and strategy development, including economic modeling solutions.
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Project Objectives

The objective was to obtain insights from leaders with informed opinions and/or decision-making roles (e.g., pharmacy director, medical director, etc.) related to a number of managed care activities and trends, including:

- Adoption of eHIT/ePrescribing
- Adoption and designs of Consumer Driven Healthcare offered
- Adoption and types of Reward for Performance (P4P) being used
- Disease Management
- Other trends of importance to pharmacy experts

Acknowledgments

HSM wishes to thank the following individuals at FMCP for providing the support and assistance necessary to undertake this study:

Cindy Pigg
Richard Fry
Methodology

Survey Launch:

- On June 29, 2006, FMCP sent an e-mail invitation to a total of 2,187 pharmacy experts encouraging them to complete a 20-30 minute Internet survey.

Survey Response:

- The survey was fielded for seven weeks (officially closed on August 17, 2006). During the fielding period, a series of e-mail reminders were sent to non-respondents, as well as respondents who appeared to have logged into the survey but then dropped off prior to completion.

- The Internet survey was completed by 219 respondents, resulting in a 10% response rate. The survey’s multiple skip patterns complicated the analysis to clearly delineate how many respondents actually completed the survey satisfactorily based on their decision-making role or involvement, versus those who simply discontinued. HSM subjectively determined respondents who completed at least one question past question 23 (the end of the general questions) will be considered “complete.”
Definitions of Key Terms

**CDH – Consumer Driven Healthcare** is high deductible plans (≥ $1,000 for individuals; $2,000 for couples and families) used in combination with a health savings account (HSA), health reimbursement arrangement (HRA), or flexible spending account (FSA).

**eHIT** – emerging health information technology (or technologies). eHIT attempts to refine information technology, heading toward paperless systems, electronic health/medical records improving information efficiency, and access to patient records for those who need it. Frequently this is seen by physicians as computerized physician order entry in a hospital or health system environment.

**ePrescribing** – a subset of eHIT, it is a practice by which clinicians use a computerized system (frequently a PDA) to prescribe medications by sending an order to a pharmacy. Such systems may offer clinicians assistance in diagnosis-based prescribing, step therapy guidelines, formulary and cost information, dosage and administration, safety information, etc. It does not refer to computerized physician order entry included as part of eHIT.

**P4P – Pay for Performance** (P4P) – a system of defined measures used to evaluate contracted individuals/organizations. Those who score well on standard measures (e.g., adherence to formularies, use of generics and low-tier prescription medication, appropriate and consistent use of diagnostic tests) are offered financial (or other) incentives for their performance.

**ASO** – Administrative Services Organization

**DM – Disease Management**

**EHR/EMR** – Electronic Health Records/Electronic Medical Records

**MA-PDP** – Medicare Advantage Prescription Drug Plan

**MTM** – Medicare Medication Therapy Management

**PDA** – Personal Digital Assistant (e.g., iPAQ, Pocket PC)

**PDP** – Medicare Part D Prescription Drug Plan

**Reference based pricing** – a reimbursement mechanism in which payers set a ceiling price for medications that exhibit similar therapeutic benefits.
Participant Overview
(Demographics)
Most Respondents Are Leaders Within Pharmacy

Q1: What is your title?  
$n = 219$

- VP/Dir./Chief Pharmacy: 44.3%
- Dir./Head Clinical Pharmacy: 13.2%
- Clinical Pharmacist: 10.0%
- Other: 9.6%
- Consultant: 8.7%
- Dir./Head Formulary Mgt: 3.2%
- C-Suite: 2.7%
- Managed Care/Pharma Contracting: 2.3%
- Marketing: 2.3%
- Network Pharmacy Contracting: 1.4%
- Medical Dir or Dir./Head of Quality: 1.4%
- Dir./Manager Clinical Services: 0.9%
Few Respondents Are Individually Accountable For Initiatives Discussed On Survey; However, Many Are Involved In Initiative Implementation

Q2: Which of the following best describes your role in each of these initiatives? n = 219

- DM
  - No role: 5.0%
  - Involved in implementation planning: 38.4%
  - Advisor: 31.5%
  - Key sole decision-maker: 21.0%
- P4P
  - No role: 3.2%
  - Involved in implementation planning: 24.7%
  - Advisor: 24.7%
  - Key sole decision-maker: 44.3%
- CDH
  - No role: 3.2%
  - Involved in implementation planning: 22.8%
  - Advisor: 22.4%
  - Key sole decision-maker: 49.8%
- ePrescribing
  - No role: 5.5%
  - Involved in implementation planning: 25.6%
  - Advisor: 26.5%
  - Key sole decision-maker: 37.0%
- eHIT
  - No role: 1.8%
  - Involved in implementation planning: 18.3%
  - Advisor: 18.7%
  - Key sole decision-maker: 57.5%
Respondents Represent A Broad Range of Organizations

Respondents were asked to identify the one description that best categorizes their organization. The largest segments of respondents work for health plans or PBMs. Among the non-PBM respondents, almost half (46.9%) are affiliated with a PBM.

<table>
<thead>
<tr>
<th>Description</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Plan with HMO and PPO</td>
<td>28.3%</td>
</tr>
<tr>
<td>Pharmacy benefit management (PBM)</td>
<td>27.4%</td>
</tr>
<tr>
<td>Network or mixed model HMO</td>
<td>8.7%</td>
</tr>
<tr>
<td>Other</td>
<td>8.2%</td>
</tr>
<tr>
<td>Benefit consulting firm</td>
<td>6.8%</td>
</tr>
<tr>
<td>Consultant</td>
<td>5.9%</td>
</tr>
<tr>
<td>Integrated delivery system/hospital system</td>
<td>4.6%</td>
</tr>
<tr>
<td>Group/Staff model HMO</td>
<td>3.2%</td>
</tr>
<tr>
<td>Specialty Pharmacy</td>
<td>2.3%</td>
</tr>
<tr>
<td>Large physician group</td>
<td>2.3%</td>
</tr>
<tr>
<td>PPO</td>
<td>1.4%</td>
</tr>
<tr>
<td>Retail pharmacy</td>
<td>0.5%</td>
</tr>
<tr>
<td>University</td>
<td>0.5%</td>
</tr>
</tbody>
</table>

Q4: Which best describes your organization? n = 214
Most of the respondent organizations with covered lives have fewer than one million lives. Of the very largest, the majority (61%) are PBMs.

Note: Several respondents (43) were not included in this chart because they either answered “0 lives” or appeared to be from organizations that do not directly manage lives.
Many Respondents Have All Lines Of Business – Commercial, Medicare and Medicaid

Respondents with Medicare lines of business have various types of plans. Among those without a Medicare line of business, 11.3% are planning to add this line of business in the future. Among the respondents with freestanding PDP lives, 28% expect to shift their PDP covered lives into MA-PDP lives in the future.

Q6: What lines of business does your organization cover?  
\[ n = 219 \]

Respondents could select all that apply

<table>
<thead>
<tr>
<th>Line of Business</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial</td>
<td>81.3%</td>
</tr>
<tr>
<td>Medicaid</td>
<td>51.6%</td>
</tr>
<tr>
<td>Medicare</td>
<td>67.1%</td>
</tr>
<tr>
<td>Freestanding PDP</td>
<td>32.0%</td>
</tr>
<tr>
<td>MA-PPO</td>
<td>16.9%</td>
</tr>
<tr>
<td>MA-PDP</td>
<td>42.5%</td>
</tr>
<tr>
<td>MA (Medicare Advantage) plans</td>
<td>39.3%</td>
</tr>
</tbody>
</table>
Executive Summary
Executive Summary

Collaboration

- Respondent organizations are most likely to collaborate on disease management, formulary management, ePrescribing, and increasing generic prescribing. Physician groups are most often collaboration partners on ePrescribing and eHIT efforts. There is less likelihood of collaboration on eHIT (most will or do keep it in-house). Nineteen percent do not collaborate on any initiative. ePrescribing, on the other hand, is most likely to be outsourced currently or in the future. The lack of resources drives the outsourcing decision (Slides 21, 29, 30, 31).

eHIT

- For most, getting information to physicians at the point-of-care is the most important reason for eHIT initiatives. (Slide 27).
- Electronic billing payment with providers is in place for many; DM and PDA programs are expected to increase as part of eHIT efforts. (Slide 33).

ePrescribing

- Most organizations are involved in some stage of ePrescribing (Slide 37).
- Over half of respondents are exploring or just getting started on ePrescribing. Ten percent are already operating and another similar number will be by the end of next year. Only five percent have decided it is not an effort they will undertake. Less than four percent of respondents’ organizations currently require the use of ePrescribing at this point, but 11% are offering provider incentives to encourage its use. Even for those with a Medicare line of business, half don’t know when they’ll have ePrescribing in place (Slides 39, 45, 46).
Executive Summary

ePrescribing
- Seventy-four percent of respondents look to ePrescribing as a means of improving formulary compliance by physicians/prescribers. (Slide 40)
- Almost three-quarters expect ePrescribing to reduce/prevent errors in prescribing or dispensing, and about two-thirds expect it to improve the quality of patient care (Slide 42).

Consumer Driven Healthcare
- Almost half offer CDH, most with an HSA, and respondents anticipate it will increase within their book of business. However, it is anticipated to be only about one-fifth of the total book of business by 2010 (Slides 50, 51).
- Shifting costs and responsibility to consumers are the stated objectives for CDH (Slides 55, 56).
- Employers are seen as driving the adoption of CDH (Slide 52).
- CDH designs are most likely to be traditional plan offerings with high deductibles, but a few claim to have unique designs. (Slide 51).
- Most CDH plans use a tiered formulary benefit, but about half require the deductible to be met first (Slide 57).
- Half are uncertain if the formulary will be differentiated for CDH and non-CDH lines of business, and most don’t yet know if they’ll have incentives to encourage preventive care, use of formulary, and generic products (Slide 58).
Executive Summary

Pay for Performance Incentives
- About a third of respondents provide P4P incentives for network physician services (although not all physicians are included), but only 11% do so for pharmacist services (Slides 63, 64).
- Respondents expect greater adherence to formulary and use of generics along with higher frequency of preventive screenings from P4P programs (Slide 65).
- It is no surprise that the barriers for P4P are the lack of ability to track physician performance, getting provider buy-in, and deciding on standards of performance (Slide 66).

Disease Management
- Respondent organizations are spending more on disease management and member education, with 40% adding to the number of disease states in which they offer services within the last year (Slide 68).
- Employers drive DM programs, along with a desire for better patient compliance and cost pressures (Slide 69).
- About half keep all their DM efforts in-house, and about half outsource all or some components (Slide 70).
Other Benefit Designs

- While few organizations use Reference-Based Pricing, those that do are more likely to be very large and large organizations (Slides 72, 73).
- Almost three-quarters measure formulary compliance improvements by tracking utilization by therapeutic class. Over two-thirds track total pharmacy spend (Slide 74).
- A similar number follow the increase in use of OTC/generic products, along with reductions in specific therapeutic areas. Patient savings are only tracked by about a quarter of respondents (Slide 74).
- To tighten management of pharmacy, organizations are using tactics that increase the cost differential to patients based on their use of products – tier differentials, generic incentives, move to coinsurance, more tiers. Over a third indicated adding either or both step edits and PAs (Slide 75).
- Over one-third have not seen any changes to loosen formulary management. 21% of respondents indicated they were seeing fewer classes containing an exclusive preferred product and/or more multiple brand options covered in the preferred tier (Slide 76).
Detailed Findings
General Trends

General Trends Overview

General Findings

- Of all respondents 93 have a role in eHIT, 138 in ePrescribing, 110 in CDH, 112 in P4P, and 173 in disease management (DM).
- Respondents were least likely to have any involvement in eHIT efforts and most likely to be involved in disease management.
- Collaboration with others is most likely to occur in the areas of ePrescribing, DM and formulary management. In eHIT and ePrescribing, collaboration efforts are most apt to be with physician groups (53% and 49% respectively) and hospital systems (35% and 22% respectively). PBMs are collaboration partners on ePrescribing for nearly half of respondents.
- Forty-six respondents added other emerging trends. At the top of the list were issues around the changes with Medicare Part D and those related to specialty pharmacy. Miscellaneous trends noted included:
  - DTC concerns
  - Medicaid reform
  - Mergers and acquisitions among health plans
  - Technology changes
  - Lack of technology compatibility amongst players with ePrescribing
  - Growth of CDH
  - Need for more consumer resources and support
Q75: Of all the trends in this survey, which single initiative do you consider most critical for your organization?

n = 181

- Unique Formulary Benefit Designs: 25.4%
- Disease Management Initiatives: 17.1%
- ePrescribing: 14.4%
- Medicare Medication Therapy Management (MTM): 13.3%
- Consumer Directed Healthcare (CDH): 12.7%
- eHIT: 9.9%
- P4P: 7.2%

General Trends

Unique Formulary Designs Are The Initiative Respondents Most Often Considered Critical To Their Organizations
In addition to trends discussed on survey, Medicare Part D, and specialty/biologics are on respondents’ radar screens.

Q76: Indicate any additional trend(s) or emerging issue(s) that you think will likely have a significant impact on the future of managed care pharmacy. 

n = 44

- Miscellaneous: 27.3%
- Medicare Part D impact/changes: 27.3%
- Specialty Rx: 22.7%
- Cost issues: 11.4%
- Related to patent expirations/generics: 6.8%
- New drugs/classes: 4.5%
Q17: Does your organization collaborate with other organizations/plans on any of the following activities? 

n = 219

- eIT: 22.4%
- ePrescribing: 41.1%
- Disease management: 45.2%
- Formulary management: 42.9%
- Increase in generic prescribing: 37.9%
- Other: 5.0%
- None: 18.7%
- Uncertain or Don't Know: 9.1%

Respondents could select all that apply.
Emerging Trends
General Findings

- Less than half of respondents’ organizations (44%) currently have an active eHIT program, and another 28.1% are currently discussing or working toward an active eHIT program.

- In eHIT efforts, 53% identified physician groups and 35% turn to hospital systems. Only 29% identified health plans as collaboration partners.

- In an effort to determine where on the spectrum eHIT efforts have been integrated with physicians, those who are actively involved with the effort at their organization rated their progress. There is still a long way for most to go before being able to claim paperless communications. 47% are closer to no electronic transactions (1-4 on a scale where 1= no electronic transactions and 10=100% paperless communications) and 28% are weighted toward 100% paperless communications (7-10 on the same scale) with provider practices within their own networks.

- Those directly involved with eHIT said their highest priorities for eHIT initiatives to accomplish are related to point of care interactions—to provide more information to physicians at point of care and to improve efficiency of work at the point of care.

- While eHIT success is measured a variety of ways, about half rely on the number of physicians involved in the program. This measure fits with the point of care goals identified as most important.

- When those with eHit responsibilities look to the future, they expect their e-prescribing efforts are most likely eHIT efforts to be outsourced (31% in future vs. 15% today).
eHIT Overview

- The reasons driving eHIT outsourcing choices are due to a lack of internal resources to maintain the effort. This is a significant difference driving the decision over cost savings.

- Those with involvement in eHIT initiatives said that electronic billing (62%) and claims payment (48%) are in place already and even more expect they will be in the next three years (18% and 27% respectively). While only a quarter (26%) have DM/utilization management programs currently in place as part of their eHIT efforts, 52% anticipate doing so in the next 3 years. Twenty percent said they do NOT expect PDAs to be used by physicians at the point of care but over half either already have them in place or expect to in the next 3 years.
Few Organizations Have Integrated Electronic Transactions With Network Providers

Q24: How well have electronic transactions been integrated into providers' practices within your network?

n = 94
Q25: Please select the 3 most important things you expect your organization's eHIT initiatives to accomplish

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Combined Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide more information to Physicians at point-of-care</td>
<td>59.6%</td>
</tr>
<tr>
<td>Improve efficiency of work in point-of-care system</td>
<td>54.3%</td>
</tr>
<tr>
<td>Reduce adverse drug events</td>
<td>38.3%</td>
</tr>
<tr>
<td>Improve formulary compliance and performance</td>
<td>37.2%</td>
</tr>
<tr>
<td>Build interoperable electronic health records/electronic</td>
<td>28.7%</td>
</tr>
<tr>
<td>Provide quality improvement programs</td>
<td>27.7%</td>
</tr>
<tr>
<td>Replace other non-electronic based programs</td>
<td>20.2%</td>
</tr>
<tr>
<td>Provide patient adherence programs</td>
<td>19.1%</td>
</tr>
<tr>
<td>Meet requirements set by MMA for the coverage of Part D lives</td>
<td>11.7%</td>
</tr>
<tr>
<td>Other</td>
<td>3.2%</td>
</tr>
</tbody>
</table>
About One-Fourth Of Respondents Ranked “Provide More Information To Physicians” As Most Important

Q25: Please select the 3 most important things you expect your organization's eHIT initiatives to accomplish

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Ranked # 1</th>
<th>Ranked # 2</th>
<th>Ranked # 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide more information to Physicians at point of care</td>
<td>26%</td>
<td>22%</td>
<td>12%</td>
</tr>
<tr>
<td>Improve efficiency of work in point of care system</td>
<td>17%</td>
<td>14%</td>
<td>26%</td>
</tr>
<tr>
<td>Reduce adverse drug events</td>
<td>17%</td>
<td>14%</td>
<td>26%</td>
</tr>
<tr>
<td>Improve formulary compliance and performance</td>
<td>15%</td>
<td>15%</td>
<td>11%</td>
</tr>
<tr>
<td>Build interoperable electronic health records/electronic</td>
<td>11%</td>
<td>11%</td>
<td>15%</td>
</tr>
<tr>
<td>Provide quality improvement programs</td>
<td>12%</td>
<td>5%</td>
<td>22%</td>
</tr>
<tr>
<td>Replace other non-electronic based programs</td>
<td>10%</td>
<td>7%</td>
<td>15%</td>
</tr>
<tr>
<td>Provide patient adherence programs</td>
<td>7%</td>
<td>5%</td>
<td>22%</td>
</tr>
<tr>
<td>Meet requirements set by MMA for the coverage of Part D lives</td>
<td>4%</td>
<td>1%</td>
<td>26%</td>
</tr>
<tr>
<td>Other</td>
<td>1%</td>
<td>1%</td>
<td>1%</td>
</tr>
</tbody>
</table>

Percentage of respondents who ranked item 1, 2 or 3
Q26: How do you measure the success of eHIT initiatives?

- # providers using the program: 49.5%
- Cost savings: 32.3%
- Improved formulary compliance: 30.1%
- Increase in generic utilization: 30.1%
- % patients treated w/ eHIT technology: 28.0%
- Enrollment in patient programs: 24.7%
- # patients cared for: 23.7%
- Reduction in adverse events: 22.6%
- Reduction in pharmacy/physician follow-up: 21.5%
- None of the above: 8.6%
- Ability to measure P4P: 7.5%
- Other: 1.1%
Organizations currently engaged in eHIT activities appear to be managing most of them in-house.

Q27: Do you currently outsource or keep in-house the following activities? n = 93

- IT Operations services: 6.5% outsource, 82.8% in-house
- Formulary Management: 11.8% outsource, 77.4% in-house
- Data Center Support Services: 11.8% outsource, 74.2% in-house
- Contract Management: 15.1% outsource, 71.0% in-house
- Provider Directories: 10.8% outsource, 67.7% in-house
- Document Management: 9.7% outsource, 61.3% in-house
- Pharmacy Information System: 22.6% outsource, 59.1% in-house
- e-Prescribing: 21.5% outsource, 15.1% in-house
- Other: 1.2% outsource, 98.8% in-house

Respondents could select all that apply.
The One Area Many Organizations Plan To Outsource Is ePrescribing

Q27: Do you in the future anticipate outsourcing or keeping in-house the following activities?

n = 93

0% 5% 10% 15% 20% 25% 30% 35%

IT Operations services 10.8%
Formulary Management 10.8%
Data Center Support Services 12.9%
Contract Management 14.0%
Provider Directories 10.8%
Document Management 11.8%
Pharmacy Information System 7.5%
e-Prescribing 11.8% 31.2%

Respondents could select all that apply
Q27: Reasons for outsourcing
n = 121

- Lack of internal resources to maintain the project/process: 30.6%
- Cost savings: 19.8%
- Streamline internal operations: 19.8%
- Lack of internal expertise: 19.0%
- Other: 10.7%

Respondents could select all that apply
Q28: Which of the following types of organizations are you working with?

n = 34

- Physician groups: 52.9%
- Hospital systems: 35.3%
- Associations: 17.6%
- Business coalitions: 23.5%
- Other health plans: 29.4%
- PBM's: 23.5%
- Other: 14.7%

Respondents could select all that apply.
**Q30: Which of the following do you expect will be operational within the next 3 years?**

**n = 82**

- Provider electronic billing: 62.2% currently offer, 18.3% will offer within 3 years, 3.7% not likely to offer, 15.9% don't know
- Provider electronic payment: 47.6% currently offer, 26.8% will offer within 3 years, 3.7% not likely to offer, 22.0% don't know
- Employer Portal: 40.2% currently offer, 23.2% will offer within 3 years, 8.5% not likely to offer, 28.0% don't know
- Broker Portal: 31.7% currently offer, 19.5% will offer within 3 years, 14.6% not likely to offer, 34.1% don't know
- Physician/Provider use of desktop computer systems: 26.8% currently offer, 26.8% will offer within 3 years, 17.1% not likely to offer, 29.3% don't know
- Disease management/utilization management programs: 25.6% currently offer, 52.4% will offer within 3 years, 3.7% not likely to offer, 18.3% don't know
- Other: 20.0% currently offer, 20.0% will offer within 3 years, 60.0% not likely to offer, 0.0% don't know
- Physician/Provider use of EMR/EHR patient data systems: 19.5% currently offer, 30.5% will offer within 3 years, 15.9% not likely to offer, 34.1% don't know
- Physician/Provider use of point-of-care PDA: 14.6% currently offer, 40.2% will offer within 3 years, 19.5% not likely to offer, 25.6% don't know
General Findings

- For ePrescribing, PBMs are important targets with nearly half (49%) of respondents turning to them as partners.
- Only 12% of respondents could indicate that their organization is involved with an RHIO for ePrescribing. Almost half (41%) didn’t know and 47% said their organization is NOT involved with one.
- ePrescribing was also addressed separately from eHIT initiatives. Overall survey respondents indicated that they are currently or planning to make investments in the development of technology necessary to support ePrescribing (31%) or have pilot studies to better understand ePrescribing (27%). One-fifth (21%) do not have any plans under consideration.
- Over half (53%) are either just getting started in the investigation and discussion of ePrescribing (33%) or else have not even started yet (20%). Similarly 21% said they are progressing but will not launch until 2008 and 21% said they have a program running (10%) or else are close and will be running by the end of next year (11%). Only 5% indicated their organization has determined their entity is not appropriate for involvement.
- Even half of those with Medicare lives are uncertain when they will implement ePrescribing for their Medicare line of business in spite of the looming Medicare ePrescribing requirement. Just over 21% expect to implement it or have it in place by the end of the year. Another 14% will do so by the end of 2007, followed by 13% in 2008. These projections lag behind the overall participant projections.
ePrescribing Overview

- The top two objectives for ePrescribing are about equally split between improving formulary compliance (74%) and reducing or preventing errors (70%). Several objectives related to improving patient care/outcomes followed-improving doctor patient interactions (60%), improve patient care (57%) and provide quality initiative such as adherence management (54%). Lower costs was mentioned by about half of the respondents (54%).

- Half of the top four outcomes considered critical for success are related to improving clinical care: Reduction in prescribing errors (72%); Improvement in quality of patient care (67%). Half are more financially driven goals: Improved patient adherence to formulary (49%); Improved efficiency of work processes (49%). Ability to increase use of generics followed at 40%.

- Most (55%) organizations do not yet have any policy regarding ePrescribing. Only 3% require it today. About a quarter (28%) encourage but do not require it. About 11% offer provider incentives to use ePrescribing. Only one organization expects to have a policy in place requiring ePrescribing in 2007.

- While few respondents identified expert outside organizations (n=28), those who did listed a combination of PBMs and ePrescribing business entities. The PBMs mentioned included Caremark, SureScripts, Allscripts, and Medco. ePrescribers noted were RXHub; Eprocrates; Dr First; Zix; and iScribe.
Of all the respondents who do have Medicare, 32% are currently using/planning to use Pilot studies to better understand ePrescribing (compared to 16.7% who were non-Medicare). Respondents with Medicare are also currently using/planning to use Training on ePrescribing to network prescribers and dispensers (23.8%), vs. 8.3% for the non-Medicare respondents.

Two significant responses resulted from the ePrescribing question ‘Is your organization participating with or part of a RHIO?’ The non-Medicare respondents indicated 68.4% “no,” while those with Medicare indicated “yes” (37.1%). For the “don’t know” responses, the non-Medicare indicated 18.4% and those with Medicare indicated don’t know 51.7% of the time.
Q16: What are your organization's current efforts or future plans for ePrescribing?

- Making investments in the development of technology necessary to support ePrescribing: 30.6%
- Pilot studies to better understand ePrescribing: 26.9%
- Do not have any plans under consideration: 21.0%
- Training on ePrescribing to network prescribers and dispensers: 18.7%
- Don't know: 17.8%
- Training on ePrescribing to internal personnel: 16.0%
- Provide educational materials about ePrescribing for plan members/beneficiaries: 15.1%
- Other: 13.2%
- Offer incentives to encourage the use of ePrescribing to network prescribers: 13.2%

Respondents could select all that apply.
Only A Few Organizations (12%) Are Participating With Or Are Part Of A Regional Health Information Organization (RHIO)

Q34: Is your organization participating with or part of a RHIO?

n = 126

- Yes 11.9%
- No 46.8%
- Don't know 41.3%

Respondents could select all that apply
Q35: How far along in the implementation of ePrescribing do you consider your organization to be?

n = 126

- Program already running and fully integrated: 10.3%
- Very far along - anticipate launch and integration by end of 2007: 11.1%
- Progressing, but launch and integration is expected by end of 2008: 21.4%
- Just getting started in the investigation and discussion process: 32.5%
- Haven't started yet - the organization is exploring possibilities: 19.8%
- Discussed and decided not appropriate for our involvement: 4.8%

Half Of Respondents (52%) Are Exploring/Just Getting Started Implementing ePrescribing; 21% Have Or Are Within About A Year Of Implementation
Primary Objectives Of Implementing ePrescribing

Below are the seven most frequently selected objectives among 14 mentioned.

Q36: What is/are the current objective(s) of your company's ePrescribing initiatives?  
\( n = 138 \)

- Improve formulary compliance by plan physicians/prescribers: 73.9%
- Reduce or prevent prescribing and dispensing errors: 69.6%
- Improve Doctor-Patient interactions by providing doctors with more point-of-care information: 60.1%
- Improve patient care: 57.2%
- Provide quality initiative such as adherence management: 54.3%
- Lower costs: 54.3%
- To meet requirements of the new Medicare Part D: 43.5%

Respondents could select all that apply.
Q32: Which of the following types of organizations are you working with on ePrescribing efforts?

n = 37

- Physician groups: 48.6%
- PBMs: 48.6%
- Other area health plans: 29.7%
- Hospital systems: 21.6%
- Other: 21.6%
- Associations: 18.9%
- Business coalitions: 18.9%

As Expected, PBMs Are Frequent ePrescribing Collaborators In Addition To Physician Groups

Respondents could select all that apply.
Q37: Please identify the three outcomes that are most critical in the success of your ePrescribing efforts

- Reduction in prescribing errors (72.0%)
- Improvement in quality of patient care (67.0%)
- Improved patient adherence to formulary (49.0%)
- Improved efficiency of work processes (49.0%)
- Increased use of generics (40.0%)
- Reduced adverse events associated with drug-to-drug interactions (20.0%)
- Other (4.0%)

Most Respondents Consider Reduction In Errors and Improvement In Quality Of Patient Care As Critical ePrescribing Outcomes

Respondents could select 3 answers
Q37: Please identify the three outcomes that are most critical in the success of your ePrescribing efforts

n = 113

- Improvement in quality of patient care was more frequently ranked the most critical outcome of ePrescribing efforts.

Reduction in prescribing errors
- Ranked # 1: 23%
- Ranked # 2: 31%
- Ranked # 3: 18%

Improvement in quality of patient care
- Ranked # 1: 42%
- Ranked # 2: 12%
- Ranked # 3: 12%

Improved patient adherence to formulary
- Ranked # 1: 7%
- Ranked # 2: 21%
- Ranked # 3: 20%

Improved efficiency of work processes
- Ranked # 1: 12%
- Ranked # 2: 18%
- Ranked # 3: 19%

Increased use of generics
- Ranked # 1: 14%
- Ranked # 2: 12%
- Ranked # 3: 14%

Reduced adverse events associated with drug to drug interactions
- Ranked # 1: 5%
- Ranked # 2: 15%
- Ranked # 3: 14%

Other
- Ranked # 1: 1%
- Ranked # 2: 2%
- Ranked # 3: 1%
Q38: What is your organization’s current policy around the use of ePrescribing among providers?

n = 120

- The organization does not have any policy regarding ePrescribing: 55.0%
- Encourages but does not require ePrescribing: 27.5%
- Offers provider incentives to use ePrescribing, but does not require ePrescribing: 10.8%
- Requires ePrescribing now: 3.3%
- Other: 2.5%
- Will require ePrescribing in 2007: 0.8%
Despite The Looming Medicare ePrescribing Requirement, Half of Respondents (50%) Are Uncertain When Their Organization Will Implement It

The following question was only asked of respondents with a Medicare line of business and involved in ePrescribing efforts.

Q40: When do you plan to implement ePrescribing for your Medicare line of business?

n = 80

Uncertain or don't know at this time: 50.0%

2006: 21.3%

2007: 13.8%

2008: 12.5%

2009: 1.3%

Other (Please describe): 1.3%
General Findings

- Nearly half (47%) of respondents said their organization offers a CDH product and are most likely to do so in combination with an HSA (61%)
- While half said they offer a CDH product, less than 10% of the lives are enrolled in a CDH plan. However, respondents expect membership to grow over the next few years with 10% in CDH plans by the end of next year and 21% by the end of 2010.
- Respondents said employers (60%) are the primary drivers of the adoption of CDH options. Consumers and beneficiaries lag behind significantly at 21%.
- When rating the uniqueness of their CDH offering on a scale of 1 to 10 where 1=traditional plan with high deductibles and 10=truly unique designs, less than 10% describe their offerings as unique (rating of 8-10) while a third (32%) rate them as traditional (rating of 1-3). Unique designs were described as preventive care benefits, incentives to stay healthy, or non-traditional pharmacy benefit designs such as low copays or mandatory use of mail-order.
- For most respondents, their organization’s objective for CDH is to stimulate beneficiary responsibility for their own health care (54%), ensure balance of quality healthcare with patient shared costs (50%) and place greater financial responsibility on the beneficiary (44%). Half (47%) said it was to reduce costs.
Consumer Driven Health Overview

- Pharmacy benefit designs with CDH have a tiered structure approach. Almost half said after the deductible is met, there is a tiered copay benefit for pharmacy while only 16% said they had a tiered copay with pharmacy expenditures excluded from the deductible.

- Half of respondents are uncertain whether their organization will differentiate the drug formulary for CDH and non-CDH coverage. Another fourth (24%) said their organization will not. Only 7% currently maintain different formularies for CDH plans and 18% said they expect to have different formularies in the future.

- Most don’t know if they will have additional incentives for medical or pharmacy benefits in CDH plan designs to encourage the use of preventive, adherence to formulary products, or generics. More (21%) are likely to have incentives for use of generics already in place.

- As the respondents look to the next 2 to 3 years, they are still turning to traditional cost saving strategies: Use of generics (66%), deductibles (60%), and use of formulary products (53%). However, several respondents are also looking for tiered network options, added benefit choices in menu-driven accounts, and unique designs that do not yet exist.
Consumer Driven Health Overview

- Responses for adoption of CDH varied significantly (15.6% for those with Medicare vs. 4.2% without Medicare).
- Fourteen percent of non-Medicare responses indicated “no” to whether their drug formulary offerings for CDH products will be different than what is offered to members not a part of a CDH design; 29.6% of Medicare respondents indicated no.
Almost Half Of Organizations (47%) Offer A CDH Product, Of Which The Largest Percent Are In Combination With HSAs (61%)
Q41-42: What percentage of your organization's total membership is currently enrolled in plans with some type of CDH?

- Today: 6.6% (n = 77)
- 2007: 9.8% (n = 109)
- 2010: 20.8% (n = 109)
Q20: Which of the following stakeholders are the primary drivers of the adoption of CDH?

n = 219

- Employers: 60.3%
- Consumers and beneficiaries themselves: 21.0%
- Health plans: 11.9%
- Government: 2.7%
- Other: 2.3%
- Clinical and performance guidelines (HEDIS): 1.8%
Many Organizations Have CDH Plans Beyond The Traditional High-Deductibles; However, Few Offer Truly Unique Designs

Among the organizations that consider their CDH plan as unique, the elements that contribute to this differentiation include a preventive care benefit or incentives to stay healthy and non-traditional pharmacy benefit designs (low copays or mandatory use of mail-order).

Q45: How would you rate your current CDH plans?

n = 103

- Traditional plan with high deductibles
- Truly unique designs

10.7% 9.7% 11.7% 11.7% 25.2% 12.6% 9.7% 5.8% 1.9% 1.0%
The Industry Is Mixed On Whether To Outsource The Financial Account Management Aspects Of CDH, Or Manage Them Internally

Q44: Do you provide HSA/HRA/FSA services or do you outsource them?  
\( n = 103 \)

- Provide in-house: 28.2%
- Outsource through bank: 11.7%
- Outsource through HSA company: 19.4%
- Other: 10.7%
- Don't Know: 30.1%
Q47: Please identify your 3 primary objectives in offering a CDH plan

For Most Respondents, The Objectives Of Offering CDH Are To Shift Accountability And Cost To Beneficiaries

- Stimulate beneficiary responsibility for own healthcare: 54.0%
- Ensure balance quality healthcare/patient shared costs: 50.0%
- Reduce costs: 47.0%
- Place greater financial responsibility on the beneficiary: 44.0%
- Increased use of generics: 32.0%
- Encourage the use of health spending accounts: 23.0%
- Increased use formulary vs. non-formulary products: 18.0%
- Improve the quality of patient care: 15.0%
- Encourage use of high deductible coverage: 11.0%
- Other: 5.0%

Combined percentage of respondents who ranked item 1, 2 or 3
Although Ranked Among The Top Three, “Reduce Costs” Is Less Often The Top Objective (Ranked #1) Than Other Factors

Q47: Please identify your 3 primary objectives in offering a CDH plan

- Stimulate overall beneficiary responsibility for their healthcare
- Ensure balance between quality healthcare/shared costs with patients
- Reduce costs
- Place greater financial responsibility on the beneficiary
- Increased use of generics
- Encourage the use of health spending accounts
- Increased use of formulary products vs. non-formulary products
- Improve the quality of patient care
- Encourage the use of high deductible coverage

n = 117

- Ranked # 1
- Ranked # 2
- Ranked # 3

Although Ranked Among The Top Three, “Reduce Costs” Is Less Often The Top Objective (Ranked #1) Than Other Factors.
Q48: In your CDH plans, how is your pharmacy benefit structured?

n = 95

- After deductible is met, members have a tiered copay: 49.5%
- Pharmacy expenditures in selected classes: 22.1%
- Tiered copay, w/ Rx expenditures excluded from the deductible: 15.8%
- Other: 10.5%
- Don’t know: 2.1%

Within CDH, Most Organizations Are Still Using a Tiered Copay Structure To Manage Pharmacy Benefits
Most Are Uncertain Whether To Align CDH Incentives To Encourage Use Of Preventive Care, and Formulary and Generic Products

Q50-52: Will the prescription drug/medical benefit component of your CDH design have any additional incentives to encourage the use of the following?

- Preventive Care:
  - 76.3% Yes
  - 10.3% Already exist
  - 12.4% No

- Formulary Products:
  - 57.7% Yes
  - 12.4% Already exist
  - 17.5% No

- Generics:
  - 50.0% Yes
  - 15.3% Already exist
  - 21.4% No
There Remains Much Uncertainty In The Impact CDH Although Over One Third Expect It To Lower Future Pharmacy Expenses

Q53 & 55: Do you expect the use of CDH designs to increase or decrease you plan's short and long-term pharmacy expenses?

\[ n = 97/96 \]

- Increase expenses
  - Beyond next 3 years (long term): 7.3%
  - Within next 3 years (short term): 7.2%

- Decrease expenses
  - Beyond next 3 years (long term): 41.7%
  - Within next 3 years (short term): 37.1%

- Have little or no effect on expenses
  - Beyond next 3 years (long term): 21.9%
  - Within next 3 years (short term): 21.6%

- Uncertain or Don't Know
  - Beyond next 3 years (long term): 29.2%
  - Within next 3 years (short term): 34.0%

Percentage of respondents who said “yes”
Respondents Still Are Not Sure Of The Impact Or Expect CDH Will Lower Overall Expenses

Q54 & 56: Do you expect the use of CDH designs to increase or decrease your plans short and long-term overall expenses?

n = 96

- Increase expenses: 5.2%
- Decrease expenses: 38.5%
- Have little or no effect on expenses: 22.9%
- Uncertain or Don’t Know: 33.3%

Percentage of respondents who said “yes”
Among The Top Three CDH Offerings Respondents Consider Important Are Savings Via Use Of Generics and Formulary Products

Although most respondents expect savings via use of generics and formulary products, nearly one-third (32%) expect to offer new and unique designs yet to be developed.

Q19: Which of the following do you expect to be important CDH offerings in the next 2 to 3 years?

- **Opportunity for greater savings for those who use generic drugs vs. brand-name drugs**: 66.2%
- **Higher-deductible HSAs**: 59.8%
- **Opportunities for greater savings for those who use formulary products vs. non-formulary products**: 53.4%
- **A greater number of options in tiered networks (e.g., 90/10 plan, 80/20 plan, 70/30 plan, etc.)**: 52.1%
- **Additional benefit choices in the healthcare menu for menu-driven accounts**: 47.0%
- **New unique design that do not currently exist**: 32.0%
- **Don't know/unsure**: 10.5%
- **Other**: 3.7%
- **No change**: 2.7%

*Respondents could select all that apply.*
Pay For Performance Overview

General Findings

- Less than half as many respondent organizations offer incentives for network physician services than for network pharmacist services. However, less than a third (31%) offer incentives to either. And those who do offer P4P incentives said they do so only to a sub-set of their providers. Only 13% offer it to all network physicians and 6% offer it to all network pharmacies.

- Nearly one-fourth of the respondents expect P4P to provide adherence and compliance management services with physicians (38%), nearly as many hope to both maximize use of generics (36%) or provide preventive screenings (35%). The most common expectation of pharmacists is that P4P will drive them to recommend cost-saving options to enrollees (29%).

- The top identified barriers to implementing P4P are tracking performance of providers (32%), finding ways to gain provider buy-in (31%) and determining standards of performance (31%)
Q21-22: Does your organization currently provide P4P incentives for the following?

- Network physician services: 31.1%
- Network pharmacist services: 11.0%

n = 219

Organizations Are More Likely To Offer P4P Incentives To Providers Than Network Pharmacies
Respondents Are Likely To Offer P4P Incentives To A Subset Of, Rather Than All, Their Network Physicians and Pharmacies

Q60: Are the P4P incentives offered to all participants in the network?  
\( n = 122 \)
Q61-62: What does your organization expect to gain by implementing a P4P program for network pharmacies/physicians?

n = 122

- Provide adherence and compliance mgt. services: 37.7% (30.3%)
- Maximize use of generic product: 36.1% (30.3%)
- Provide preventive screenings: 35.2% (13.9%)
- Maximize use of formulary products: 30.3% (24.6%)
- Recommend alt. cost-saving options to enrollees: 28.7% (26.2%)
- Manage and monitor patient therapy with prescriber: 24.6% (13.9%)
- P4P incentives not provided to network pharmacies/physicians: 41.0% (15.6%)
- Other: 4.9% (6.6%)

Respondents could select all that apply.
The Most Frequently Mentioned P4P Implementation Barriers Are Tracking Performance, Gaining Provider Buy-In And Determining Standards

Q63: Please select the three primary barriers to P4P implementation

n = 173

- Tracking performance of providers: 31.8%
- Finding ways to gain provider buy-in: 31.2%
- Determining standards of performance: 30.6%
- Process of re-contracting with providers: 17.9%
- Potential cost to the organization: 16.2%
- Lack of “best practices”: 12.1%
- Determining how to distribute the savings: 11.0%
- Impact on other program efforts: 8.1%
- Other: 4.0%

Combined percentage of respondents who ranked item 1, 2 or 3
Disease Management Overview

General Findings

- Over half of the respondents said they are spending more on both DM (55%) or member education (53%) and 40% said their organization has in the last year increased the number of disease states in which they offer services; 8.9% said they have decreased their spending in DM.

- DM is considered to be extremely or very important to about three-fourths (72%) of respondent organizations. It is considered important because of employer expectations (27%), a desire to enhance patient compliance (27%) and cost pressures (21%).

- About as many respondents said their organization outsourced aspects of their DM (43%) as said they handle all aspects internally (48%).

- The top three responses on attributes of importance for disease management programs were the desire for enhanced patient compliance, employer expectations/demands, and cost pressures.

- For Disease Management, 4.7% of Medicare respondents indicated they were spending fewer resources on member education programs; 0% was indicated for this response by non-Medicare respondents. Twenty-eight percent of non-Medicare indicated don’t know/unsure, and 8.4% of respondents with Medicare said “don’t know/unsure.”
Many Organizations Have Increased Their Resources Allocated Toward Disease Management and Member Education

Potentially attributing to the increase in DM resources spent, many respondents (40%) have increased the number of disease states in which they offer services within the last year.

Q67 & 68: Is your organization spending more or fewer resources on the following programs compared to last year?

<table>
<thead>
<tr>
<th>Program</th>
<th>More resources</th>
<th>Fewer resources</th>
<th>No change</th>
<th>Don’t know or unsure</th>
</tr>
</thead>
<tbody>
<tr>
<td>DM</td>
<td>52.7%</td>
<td>3.4%</td>
<td>24.7%</td>
<td>13.7%</td>
</tr>
<tr>
<td>Member Education</td>
<td>54.8%</td>
<td>8.9%</td>
<td>20.0%</td>
<td>11.6%</td>
</tr>
</tbody>
</table>

n = 146
Disease Management Is Considered An Important Offering, Driven By Employer Expectations As Well As Internal Objectives

Q64: How would you rate the importance of disease management programs to your organization?

n = 147

- Extremely important: 28.6%
- Very important: 43.5%
- Somewhat: 23.8%
- Not very important: 3.4%
- Not at all important: 0.7%

Q65: To what do you attribute the importance of Disease Management?

n = 106

- Employer expectations: 27.4%
- Desire for enhanced patient compliance: 27.4%
- Cost pressures: 21.0%
- Benefit consultant expectations: 6.8%
- CDH plans: 2.7%
- P4P programs: 5.5%
- Other: 5.9%

Respondents could select 2 answers
The Majority Of Organizations Administer Most If Not All Aspects Of Their DM Programs Internally

Q66: To what degree does your organization outsource your DM program activities?

n = 146
Other Benefit Design Overview

General Findings

- The most frequently monitored metric to track improvements in formulary compliance were those to be expected: Utilization of formulary products by therapeutic class (74%), reduced total pharmacy spend (68%); increased use of OTC/generics (68%); reduced pharmacy spend by class (58%). Two frequently cited metrics -- patient savings and reduced total medical spend -- were mentioned by less than 30% of respondents.

- Strategies to more tightly manage pharmacy spend shift costs to the individual. Fifty-eight percent are increasing tier differentials. Forty-six percent are increasing the savings for using generics. Thirty-eight percent are increasing co-insurance co-pays. Thirty-six percent suggested use of more tiers. Increased use of restrictions – step edits or prior auths - are seen by slightly more than a third of respondents (35% and 31% respectively). Adding zero co-pays for generics or select disease states were selected by 26% and 13% of respondents.

- Forty percent are not seeing any loosening of formulary management. Sixteen percent said they have loosened prior authorizations. Twenty-one percent are having fewer exclusive preferred products or adding brand option covered in the preferred tier.

- Only 46 added trends or emerging issues they believe will likely have a significant impact on the future of managed care pharmacy. These included Medicare Part D changes, specialty pharmacy, and cost issues in general.
Q70: How likely is it that your organization will start to use reference-based pricing within the next 3 years?

n = 135

- Very likely: 1.5%
- Likely: 6.7%
- Somewhat likely: 24.4%
- Not very likely: 29.6%
- Not at all likely: 14.8%
- Don't know or Unsure: 23.0%

Only A Handful Of Organizations Currently Use Reference-Based Pricing; Few Additional Ones Will In The Next 3 Years
Q69: Does your organization utilize reference-based pricing?

n = 148

- Very Large Organizations (n = 71): 26.9%
- Large Organizations (n = 38): 21.1%
- Small-mid size organizations (n = 84): 8.3%
Q72: When tracking improvements in formulary compliance, which of the following metrics are monitored?

- Percentage utilization of formulary products by therapeutic class: 73.8%
- Reduced total pharmacy spend: 68.1%
- Increased use of OTC/generic products: 67.5%
- Reduced pharmacy spend in particular therapeutic areas: 57.6%
- Patient savings: 28.8%
- Reduced redundancy or inefficiency in the system: 28.8%
- Reduced total medical spend: 26.7%
- Other: 6.3%

Respondents could select all that apply.
Q73: What significant changes have you seen in the way multiple-tiered formulary options are being used to more tightly manage pharmacy spend?

n = 183

- Increased cost differential between tiers: 57.9%
- Increased saving incentives to patients for selecting generics: 45.9%
- Increased prevalence of percentage co-pays: 38.3%
- Increased number of tiers: 35.5%
- More step edits: 35.0%
- More prior authorizations: 31.1%
- Addition of zero copay for generics: 26.2%
- Addition of zero copay for select disease states: 13.1%
- No changes: 12.0%
- Don’t know: 9.8%
- Other: 4.4%

Many of the same respondents selected both step edits and prior authorizations. Of the respondents who selected step edits, 62.5% also selected prior authorizations. As a result, 81 unique respondents (37%) selected one or both step edits and prior authorizations.
Q74: What significant changes have you seen in the loosening of formulary management?

$n = 183$

- No changes: 39.9%
- Fewer prior authorizations: 16.4%
- Lower patient out-of-pocket cost: 15.8%
- Fewer classes containing an exclusive preferred product: 15.3%
- Fewer step edits: 12.6%
- More multiple brand options covered in the preferred tier: 12.0%
- Don't know: 12.0%
- Other: 2.7%

Few of the same respondents selected both of these responses. Overall 21% selected one of the two or both.