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they cannot. The ultimate measure of back pain is degree of disability and need for surgical intervention, both of which were identical in our study groups.

Second, Dr. Mitchell raises the issue of casemix/severity bias between the two groups. As we clearly stated in our article, "...we believe that no substantial underlying illnesses in either group may have contributed to a difference in comorbidities, chronic illnesses, and severity of illness."<sup>1</sup> This conclusion was based on overall utilization of health-care services' frequency and cost during the study period. Chronically ill patients visit physicians more often, are hospitalized more frequently, and incur more costs than healthy patients. Yet, in our two study groups there were no differences in these parameters.

Third, Dr. Mitchell indicates our statement concerning precertification of more than six visits for chiropractic to be misleading. In retrospect, she is probably correct. The mean number of chiropractic visits for our study group was 5.1 with a range of 2 to 21 visits. The key point was that ongoing medical necessity was a requirement for more than six chiropractic visits to be approved.

In summary, we do not concur with Dr. Mitchell's assessment of our study comparing the cost and patient outcomes of back and neck pain in patients treated with chiropractic and those treated conventionally. We made every effort to ensure that there were no demographic differences or variations in comorbidities in the two populations. Both populations rated their satisfaction with results equally and the surgical rates were identical. The principal difference was the lower cost of patients treated with chiropractic care.

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1. Mosley CD, Cohen IG, Arnold RM. Cost-effectiveness of chiropractic care in a managed care setting. *Am J Man Care* 1996;2:280-282.

#### TO THE EDITOR:

The study regarding restrictive formularies by Horn et al<sup>1</sup> in the March 1996 issue of *The American Journal of Managed Care* generated both positive and negative reactions from those with vested interests. Both sides may be arguing their points without a critical piece of information.

The "open-formulary" HMO in question did not use a restrictive formulary but did use a variety of formulary management efforts. These efforts included (1) increased pharmacist support of the Pharmacy & Therapeutics Committee; (2) a complete revision of the formulary of recommended drugs; (3) enhanced physician education by pharmacists; (4) increased drug use evaluation activities; and (5) concentration of educational efforts on five drug categories accounting for more than 50% of overall costs. The Pharmacy & Therapeutics Committee focused on total medical costs when making formulary recommendations. This sometimes included selecting a more costly brand-name medication over a less expensive medication. They reduced the list of recommended medications to less than 300 different medications (not including different strengths), although physicians could prescribe other medications. The HMO pharmacists also obtained prior approval from most physicians to automatically change patients to the recommended formulary medications.

Over an 18-month time frame, the cost of drugs per member per month *decreased* by approximately 5%. Significant changes in medication use occurred. For example, the use of antiulcer medications decreased by 25%. The market share of the preferred antiulcer medication increased by 30%. One ACE-inhibitor captured 97% of the market.

These efforts demonstrated that formulary management of a drug program through educational activities by pharmacists can result in significant drug cost savings without placing severe restrictions upon physicians or patients. The study by Horn et al *suggests* that these activities also may result in improved patient care and decreased total costs.

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1. Horn SD, Sharkey PD, Tracy DM, et al. Intended and unintended consequences of HMO cost-containment strategies: Results from the Managed Care Outcomes Project. *Am J Man Care* 1996;2:253-264.

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