

## In Focus

### A New Formula for Your Formulary

time immemorial, cash has been king. Cash can be invested or leveraged into many times its face value. Cash makes many things possible. In today's economy, where many businesses have debt and liquidity challenges, the king now has a prime minister that goes by the name of cash *conservation*. While cash always has been valuable, it is downright precious today.

It is thus a rare benefits manager who is not laboring under the lash of "save money, but treat our remaining employees fairly." After all, the Employee Free Choice Act may soon be at your doorstep. So you cut staff, cut consulting expenditures, renegotiated your ASO fees and insured plan rates and did away with the 401k match. Money was saved, but your CFO needs more.

So now what do you do? You're already getting high network usage and 50% provider "discounts". You're also in a prescription drug group purchasing arrangement, so you're getting market leading drug discounts. Your deductibles, co-pays and payroll deductions make the Mercer averages appear sugar-daddy generous. You audited 6% of your former dependents out of the plan and you're not covering any spouses who have a shred of benefits eligibility elsewhere. So where is the next round of savings going to come from?

Well, how about if you start buying prescription drugs the same way your company buys other materials and supplies? We don't mean like commodities. We mean based upon their quality and their cost. Why not buy drugs based upon the objective clinical evidence and not based upon slick marketing and advertising and hidden sales incentives.

The strategy we're referring to is called "evidence-based/least cost prescription drug management". Here's the logic: It's generally accepted that the drugs that are on your PBM's formulary list are those that the PBM scored the highest in two ways: 1) how well the drugs work and 2) how much rebate income they generate.

Did you ever wonder what the formulary would look like if the scoring emphasized instead: 1) how well the drugs work and 2) how much the drugs cost the employer and the patient? Well wonder no more; the notion of evidence-based/least cost prescription drug management has become a reality and will begin saving you cash as soon as you implement it.

So let's break this down. Where does the "evidence" come from? Well, it comes from several sources like the Oregon Health and Science University's Centers for Evidence-Based Policy that focuses solely on clinical equivalence and efficacy. Other sources include the Cochrane Central Register of Controlled Trials, the Cochrane Database of Systematic Reviews, DARE, and MEDLINE. When the efficacy data are combined with a plan's specific drug cost information, it is possible to identify those drugs that work well *and* are also the least expensive in a given therapeutic class. Sound like a bit of heaven on earth?

A simple example can bring the concept close to home. Let's consider Advair, a widely-promoted and, hence, a widely used Asthma drug.

- Advair consists of two ingredients; (1) an anti-inflammatory drug (steroid) and (2) a bronchodilator (long-acting beta agonist). Prolonged and frequent use of bronchodilators is considered unsafe and indicative of poor disease management.
- Advair, an expensive, profitable and rebate-driven combination product, is routinely used "first line" and is the top asthma drug for many health plans in terms of total dollars spent.
- The National Asthma Education and Prevention Program (NAEPP) treatment guidelines recommend anti-inflammatory medications (steroids) be used "first-line" and that long-acting rescue medications be added later, only if needed.
- Applying prior authorization process has resulted in significant decreases in the use of Advair while improving the use of single-entity controllers (steroids).

Now a 30-day supply of Advair costs approximately \$190. A single-entity inhaled steroid costs \$120. Substituting the evidence-based inhaled steroid for Advair saves the plan \$70 per patient per month and probably is safer and more medically appropriate for the patient as well.

Obviously, performing accurate drug efficacy/least cost analysis can be done by your PBM. So, why aren't they doing this analysis and bringing forward this solution? The answer is that they are still playing the game the way the market told them to play – reduce or eliminate dispensing and administration fees and maximize discounts and rebates. And, now that they are deep in this game, they are living with rebate contracts that make it difficult to impossible to promote reductions in the use of "preferred" drugs.

So if you can't go to your PBM for evidence-based /least cost drug formulary options, where does a benefits manager go? The answer is to independent pharmacologists and pharmacy benefits experts with a proven track record for doing just this. Usually, this independent expertise and the required functional support can easily be integrated into an existing PBM arrangement. Unfortunately, many drug industry experts don't have the independence or delivery experience required to do this correctly. There is so much money changing hands in this area that it is difficult to find an organization that is not already heavily invested in the status quo. For example, according to the March 5, 2009 New York Times don't even think about dialing up Harvard's Medical School. That's where Pfizer and Merck are furiously battling to see which can pay more to the School's professors.

It is easy to estimate overall impact of an evidence-based/least cost prescription drug management approach. A quick review of your recent claims history including some details relative to your plan's top 200 drugs is all that is needed. Generally, the savings are in the range of 10% of plan costs and can be as high as 15%. Creating and executing a pharmacy management strategy that emphasizes evidence-based/least cost formulary drugs has a number of moving parts, so experience is almost as important as independence. Moreover, telling your PBM that you "want one of those" is likely to get you something called a "preferred" or "performance" formulary that sure sounds like, but is really nothing like what we're advocating.

The Chelko Consulting Group has the right relationship with independent pharmacologists and industry experts with the delivery experience to restructure your plan to emphasize low cost, yet efficacious drugs for your plan members. This approach will not only generate the cash your company needs, but it will also lead to improved clinical outcomes for your plan members. How many opportunities like this do you have?

#### They Said It?

David Tian, 24, a first-year Harvard Medical School student: "Before coming here, I had no idea how much influence companies had on medical education. And it's something that's purposely meant to be under the table, providing information under the guise of education when that information is also presented for marketing purposes."

Responding to the statement that the faculty members of Harvard Medical School may lead the nation in the amount of money received from industry, Dr. Jeffery S. Flier, Dean of the Harvard Medical School said: "One entirely appropriate source (of money), if done properly, is industrial funds."

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