PHP3 GEOGRAPHIC VARIATION IN MEDICARE PART D PLAN ENROLLMENT, PREMIUMS, COPAYMENT, AND COINSURANCE

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OBJECTIVES: Part D represents the single most significant expansion of a public insurance program in 40 years. The program provides drug coverage through multiple private insurance plans. A key question is whether Medicare beneficiaries choose plans based on expected premiums and out-of-pocket costs. Studies show that about 72% of seniors consider the amount charged for each prescription as an important factor in deciding on drug plan enrollment. This study also explores the extent to which potential differences exist on service region. The objectives of this study were to: 1) examine differences in Medicare Part D premiums, copayments and coinsurance by geographic region; and 2) determine whether lower premiums, copayments and coinsurance were primary drivers for enrollment decision making in regions of selection. METHODS: A retrospective study design was employed using data obtained from the Centers for Medicare and Medicaid Services. The data was entered into SPSS 18.0 and descriptive and inferential statistics were utilized to examine differences. RESULTS: A total of 17 million enrollees constituted the study sample. Across all regions Medicare Part D plans utilized fixed-dollar copays more often than coinsurance for generic and brand name drugs. The average premium for Northeastern, Midwestern, Southern and Western region enrollees were $34, $37, $35 and $33, respectively (p<0.05). Furthermore, the average copay/coinsurance for Northeastern, Midwestern, Southern and Western enrollees was $15/5%, $14/6% and $13/6% respectively (p<0.05). Overall, the most popular benefit designs, chosen by 75% of enrollees, offered a premium of $39, a copay of $33 and a coinsurance of 25%. CONCLUSIONS: Findings of this study suggest that seniors may make their Part D plan choices based on the criteria of low premium, low copay and/or low coinsurance. Further work is required to achieve the ultimate objective of the study. In conclusion, our study found that the cost per QALY gained in the treatment of rheumatoid arthritis, psoriatic arthritis, ankylosing spondylitis, Crohn’s disease and psoriasis. The weight was assigned to prevalence value for each of the diseases considered. Boston Matrix has been developed to establish the relationship between demand (prevalence of the disease) and health supply (e.g., willingness to pay - WTP of the health care authorities).

Finally, a League Table has been built in order to compare the cost-effectiveness of Adalimumab with other innovative molecules. A sensitivity analysis based on the variability of Economic Evaluation model of Adalimumab has been performed. RESULTS: The total economic value of Adalimumab in Italy amounted to €72,700. The sensitivity analysis showed a cost per QALY gained ranging between €19,487 and €32,453. The analysis of the Boston matrix, developed for each pathology, indicates that the cost per QALY gained of Adalimumab is always lower than the common WTP with respect to the threshold value for health care interventions for all the main pathologies treated by this molecule. Results of this study are helpful for decision makers, who should ensure that patients have equal access to a cost-effective treatment, as well as promote research and development of innovative molecules with greater cost-effectiveness ratio.

PHP34 ELICITING PREFERENCES FOR REIMBURSED DRUGS SELECTION CRITERIA IN COTE D’IVOIRE

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OBJECTIVES: Côte d’Ivoire, a West African country, has decided to set up a formula- lary as part of its universal health insurance (UHI) program. One of its goals will be to facilitate access to safe and efficacious drugs. To guarantee transparency throughout the formulary listing process, it is important to select and value rele- vant criteria to determine the objective of the study. In this study, we investigate the preferences of healthcare professionals (physicians) when selecting reimbursable drugs and to analyze trade-offs between criteria for formulary listing in Côte d’Ivoire. METHODS: Choice sets based on four attributes (cost effectiveness of treatments, severity of the disease for which the treatments are indicated, age of the population affected by diseases considered, and social class affected by diseases considered [poor, rich]) were presented in a self-completion questionnaire. RESULTS: Analysis of questionnaire responses showed that ‘cost effectiveness’, ‘severity of disease’, and ‘social class’ were significant attributes in responder’s preferences for reimbursable drugs. More specifically, responders’ clinical choices were more sensitive to drugs that are very cost effective, that target very severe disease, and that target diseases in poor people. CONCLUSIONS: This explorative study enabled us to elicit the preferences of a sample of healthcare professionals (physicians) for reimbursable drug selection criteria in Côte d’Ivoire using the discrete-choice experiment method. Further work is required to achieve the ultimate ob- jective of developing a formulary for Côte d’Ivoire.

HEALTH CARE USE & POLICY STUDIES – Health Care Costs & Management

PHP35 DETERMINANTS OF PARTICIPATION IN MAMMOGRAPHY SCREENING IN TAIWAN

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OBJECTIVES: Mammography screening has been considered as an effective way for early detection of breast cancer to reduce the mortality of breast cancer. In Taiwan, mammography screening has been offered biennially free for women aged 50-69 years since July 1, 2004. Nevertheless, the participation rate of mammography screening is still low among women eligible for the benefit, and factors that influence beneficiaries’ decision on participation remained unknown. Thus, the study aimed to examine major determinants associated with participation in mammography screening among eligible women in Taiwan. METHODS: The Tai- wan Longitudinal Health Insurance Dataset of 2005 was conducted for the study. Women between ages 50 and 69 years on January 1, 2004 or going to be aged 50 years during July 1, 2004 to December 31, 2009 were identified as study subjects. Age, socio-demo- graphic characteristics, previous experience of Pap test, health-related conditions were analyzed to evaluate the association with the likelihood of participation in mammography screening using Cox proportional hazard model. RESULTS: There were 106,760 beneficiaries during the observation period. Women who were with higher wage income level, being employed, receiving Pap test in last two years, with history of benign breast disease, and having higher Charlson Comorbidity Index score were significantly more likely to participate in mammography screening. Women who were older, with breast cancer history, and residing southern part of Taiwan were significantly less likely to participate in mammography screening.

CONCLUSIONS: Age, socio-demographic characteristics, experience of Pap test and health-related conditions seemed to be determinants of participation in mammog- raphy screening. Trends in participation and determinants of non-participation need to be evaluated in the future for policy makers to address the low participation rate of mammography screening among beneficiaries.

PHP36 COMPREHENSIVE VALUE ESTIMATION OF ADA利IMUAB-BASED TREATMENTS: A CASE STUDY

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BACKGROUND: The value of a drug can be expressed as the needed cost to increase a health unit. An estimation of an index that summarize the value of a molecule with multi-indication, however, is a complex process. OBJECTIVES: Covet study had the specific objective of a comprehensive economic evaluation of adalimumab.

METHOdS: Economic approaches based on propensity score matching to address the moral hazard and adverse selection issues. RESULTS: The sensitivity analysis showed a cost per QALY gained ranging between $19,487 and $32,453. The analysis of the Boston matrix, developed for each pathology, indicates that the cost per QALY gained of Adalimumab is always lower than the common WTP with respect to the threshold value for health care interventions for all the main pathologies treated by this molecule.

PHP37 ARE HOSPITAL INPATIENT COSTS LOWER FOR MEDICARE ADVANTAGE ENROLLEES THAN MEDICARE FEE-FOR-SERVICE BENEFICIARIES?

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OBJECTIVES: This paper compares the private health plans that enroll Medicare beneficiaries—known as Medicare Advantage (MA) plans—in cost to the traditional Medicare fee-for-service (FFS) program by employing a series of methodolog- ical approaches based on propensity score matching to address the moral hazard and adverse selection issues. METHODS: The Healthcare Cost and Utilization Proj- ect (HCUP) State Inpatient Databases (SID) were used in this analysis. We use hos- pital inpatient data for 2008 and 2009 from California, Florida, Massachusetts, New York, Tennessee and Wisconsin. The SID provide detailed diagnoses and proce- dures, total charges and patient demographics for all participating states. Our key covariates of interest is MA enrollment and the total cost of hospital care associated with each hospital visit. To obtain costs, we applied hospital specific HCUP cost-to-charge ratios. We adjusted these costs with the CMS area wage index. We obtained infor- mation about hospital characteristics using the American Hospital Association Annual Survey Database, and county level information from the Area Resource File. We estimate a baseline risk-adjusted cost model to compare the total health care costs two cohorts in inpatient settings. To assess the robustness of our baseline results, we re-estimated our risk-adjusted cost model following various propensity score matching methods. RESULTS: Inpatient cost for MA enrollees was generally lower than the inpatient cost for Medicare FFS beneficiaries when moral hazard and adverse selection was controlled. For example, our estimate shows that the total health care costs per inpatient visit for MA enrollees are higher by 2.6% in Florida, and lower by 12.6% in California when compared to Medicare FFS. We also observed the prevalence of many chronic conditions among MA enrollees was generally lower than among Medicare FFS beneficiaries. CONCLUSIONS: We found wide geographic variations in hospital inpatient costs, and in prevalence of chronic conditions between MA enrollees and Medicare FFS beneficiaries.

PHP38 OUT-OF-POCKET DRUG EXPENDITURE AMONG USERS OF THE AMBULATORY CARE SERVICES AT THE MEXICAN INSTITUTE OF SOCIAL SECURITY (IMSS)

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OBJECTIVES: To quantify out-of-pocket drug expenditure among ambulatory care users and to identify the variables associated with the payment for medicines during 2010 at the Mexican Institute of Social Security. METHODS: Data from the institutional health survey 2010 was used to estimate the total outpatient drug out-of-pocket expenditure among ambulatory care users. Statistical analysis was performed to test for mean expenditure differences by age and gender. A binary logistic regression model was constructed to identify the main factors related to payment for prescribed medicine. Data was aggregated according to the marginality index estimated by the Mexican National Council of Population to consider socio-economic regional variations. The exchange rate was $12.34 pesos per dollar. RESULTS: A total of 71.9% of the health care users received...