based self management programs, consumer educationm, care transition programs in addition to home and community based long term service supports A new National Aging and Disability Business Center was established to provide training and technical assistance to enhance the business capacity of community-based organizations, positioning them to negotiate, secure, and successfully implement contracts with health care entities. This workshop will provide an overview of the Business Center – its goals, objectives, tools and resources. The symposium will show how this national approach will help these organizations make the business case for reimbursement for services that improve value, i.e, improve health, healthcare at lower per capita costs, Examples of successful partnerships will be described and the value propostion that exists as the result of these linkages.

PRIVATE INSURANCE VERSUS MEDICAID AND ADHERENCE TO MEDICATION IN OLDER ADULTS WITH FIBROMYALGIA

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Background: Fibromyalgia, defined as chronic, widespread musculoskeletal pain, affects 4 to 10 million Americans and up to 6% of the world population. Medication nonadherence results in $100 to $300 billion in US health expenditures annually. Previous studies have examined medication adherence in commercial health plans or public health plans, but relatively few have compared both populations. The purpose of this study was to estimate the effect of type of insurance on adherence to medication for older adults with fibromyalgia.

Methods: The retrospective cohort study analyzed medical claims of fibromyalgia patients collected between January 1, 2005 to June 30, 2011 from the Blue Cross Blue Shield South Carolina State Health Plan (BCBS) and Medicaid data. Older adults age 60 and older were included if they were prescribed duloxetine, milnacipran, or pregabalin (N=3,187). The primary outcome, medication adherence, was defined as having a medication possession ratio (MPR) of ≥ 80%. Independent variables included health insurance, FMS medication, selected comorbidities (FMS-related, musculoskeletal pain, or neuropathic pain), gender, age, and the interaction between health insurance type and treatment.

Results: Logistic regression showed older adults with fibromyalgia on Medicaid were over 3 times more likely to be adherent when compared to BCBS in both unadjusted (OR: 3.21, p<0.0001) and adjusted models (OR: 3.74, p<0.0001).

Conclusion: Most states do not require a Medicaid prescription co-pay; whereas, private insurers, like Blue Cross Blue Shield, require more out-of-pocket costs. Our study suggests that the co-pays for medications in private plans may present a barrier to patient adherence.

EVALUATING BASIC PENSION SCHEME IN SOUTH KOREA: FOCUSING ON ITS INTERGENERATIONAL EQUITY

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Basic Pension Scheme (BPS) in South Korea, which provides non-contributory pensions, was implemented in 2014 to ensure basic income security for older adults who below the poverty level. Since its implementation, the structural weakness and financial instability for the long term development has been pointed out. Taking note of intergeneration equity, this study conducts an analytic and detailed examination through Barusch's (2009) social justice framework as to whether BPS was established through fair and proper processes and will be implemented to equally benefit all generations. The social justice framework can explain whether BPS brings about inequitable distribution of power, resources, and individual access and how BPS resists inequity and unfairness. The four elements were evaluated: the fairness of the policy development process, the allocation rules, the effect on vulnerable populations, and policy's impact on social justice. The findings indicated that the process of making BPS did not proceed by an established rule and BPS focuses on only its short term effects for current older adults by ignoring its potential long-term consequences. Available funds for BPS is expected to be in danger of being exhausted and this will lead to either reducing the amount of payment or increasing contribution rates. Our findings also revealed that the financial resources for maintaining BPS do not disproportionally burden between current and future generations to fund. The government is required to prepare and provide the public with a long-term financial plan of BPS by designing a more equitable funding and benefit scheme.

THE AFFORDABLE CARE ACT'S MEDICAID EXPANSION: THE EFFECTS ON LOW-INCOME MID-LIFE ADULTS

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Purpose: This study aimed to examine how the state Medicaid expansion under the Affordable Care Act affected insurance status and access to healthcare among low-income mid-life individuals in 2014, the first year of Medicaid expansion.

Methods: The 2012 and 2014 Behavioral Risk Factor Surveillance System data were linked to state-level data including Medicaid expansion status. The analysis included a nationally representative sample of 298,376 mid-life adults (50–64) from 50 states and Washington, DC. Among them, 23.1% were low-income with family income below $25,000. Using multi-level modeling (individuals < states), this study compared low-income mid-life residents living in Medicaid expansion vs. non-expansion states. Additionally, pre- and post-Medicaid expansion data (2012 vs. 2014) were compared.

Results: Regardless of income status, U.S. mid-life adults' access to healthcare improved from 2012 to 2014. However, the rate of improvement was greater among low-income residents living in Medicaid expansion states. For example, the insured rate increased from 66.5% (2012) to 80.4% in 2014 (20.9% increase) among low-income mid-life residents in Medicaid expansion states, while it increased from 61.3% to 70.0% (14.2% increase) among their counterparts in non-expansion states. The conditional multi-level models indicate that after controlling for individual- and state-level covariates, low-income mid-life adults from Medicaid expansion states were more likely to have health insurance (OR=2.14, p<.001) and less likely to miss a doctor visit due to cost