Employee Basic Medical Insurance (EBM1) claims of Tianjin city from April 2008 to March 2010 were used to compare the patients’ outpatient visit, total spending on drug, and OOP spending before and after the implementation of the EMP. The intervention group consisted of patients who visit the primary care institution which implemented EMP at least once before and after EMP and did not visit the control group care institution which did not implement EMP, vice versa for the control group. A difference-in-difference approach was used to estimate the effects adjusting for patients’ socio-demographic characteristics and disease severit- y. Non-linear regression was used to estimate the outpatient visit tohtub model was used to estimate the cost. RESULTS: Totally, 23,362 patients from 49 interventional primary care institution and 4148 patients from 42 control institution were involved in the study. The regression results showed that the annual patients’ outpatient visits (0.5%, p = 0.793) and the visits to primary care institution (0.2%, p = 0.951) had no change after implementing EMP compared to the control group. The patient’s average total spending (0.6%, p = 0.850), drug spending (1.6%, p = 0.703) and OOP spending (1.0%, p = 0.711) did not change. The total collected data of outpatient visit and tobit regression was used to estimate the outpatient visit and tobit model was used to estimate the cost.

PHIP1 IMPACT OF 2014 ESSENTIAL HEALTH BENEFIT BENCHMARK PLANS ON US MANAGED CARE
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OBJECTIVES: Beginning in 2014, the Affordable Care Act requires new health plans to cover essential health benefits (EHB), including pharmaceutical products, according to the state level benchmark plans. The objectives of this analysis were to understand state level benchmark plans, the number of drugs of plans, access to drugs on patient choice and health outcomes. METHODS: Benchmark plans for the top five states (i.e., FL, IL, NY, TX and CA), covering ~11 million lives, were obtained from the CMS. For each plan, the categories, classes and number of covered drugs were collected into one database. Analysis was conducted at the entire population level, state level and for top classes of drugs. The comments from patient groups were reviewed to understand the impact of EHB on patient choice and health outcomes. RESULTS: Benchmark plans had up to five states per plan belonging to 158 classes as defined by USP. While four states (FL, IL, NY and TX) had a similar number of covered drugs (median of 892 drugs), CA had a significantly lower number of covered drugs, amounting to 28% less than the other four states. On average, 10% of the drugs were in the class called “No USP Class”, highlighting the limitation of EHB in covering a comprehensive set of medications. Other state differences included such list as Anti-Infectives and Pain medications. CONCLUSIONS: Review of new benchmark plans shows some states can have a significantly lower patient choice of therapies. There is a need for new policy measures to ensure that all patients have equal access to new treatments.

PHIP5 AN ASSESSMENT OF THE THERAPEUTIC BIOLIGIC PRODUCTS LICENSED BY THE FDA AND THE EMA
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OBJECTIVES: Therapeutic biologic products (BLA) are produced in living cell cultures or through genetic engineering of proteins. To date the FDA BLA definition includes allergens, blood products, cellular and gene therapy tissue products, and vaccines. This study assessed trends in BLAs licensed by the FDA and the European Medicines Agency (EMA) in the period 1995-2014. METHODS: Regulatory information for BLAs was derived from the agencies' webpages. We extracted data for BLAs approved before the establishment of the EMA licensing process from the UK Medicines and Healthcare products Regulatory Agency (MHRA). Insulins and some hormones that are approved by the FDA using the drug application system, were excluded from analysis. BLA were classified using the WHO anatomical therapeutic chemical classification. Descriptive statistics and chi-square tests were conducted in the study. RESULTS: 115 BLA were licensed by the FDA and the EMA in the period 1995-2014. The FDA licensed 89.2% and the EMA 73.0% of the BLA (p < 0.0001), with 26.6% of the BLAs licensed only by the FDA and 14.8% by the EMA. There were 5 BLA licensed by MHRA and the FDA. The EMA refused to license 4 BLAs. There were 62 BLAs (53.9% of the total) licensed by both agencies. The FDA licensed first 67.0% of the BLAs and the EMA 21.0%. The FDA licensed the BLAs in a median of 181 days before than the EMA. The largest number of BLAs corresponded to antineoplastic and immunomodulating agents (48.7% of BLAs). Insulin and blood forming organs (13.0%), and alimentary tract and metabolism (9.6%). CONCLUSIONS: The study found differences in the number of BLAs licensed by the FDA and the EMA. The FDA approved faster and licensed significantly more BLAs than the EMA. Future research should evaluate the effect in patient outcomes and cost of differences in BLAs availability in US and Europe.

PHIP7 THE IMPACT OF NEW DRUG PRICING POLICY ON MARKET COMPETITION AMONG OFF-PATENT DRUGS IN SOUTH KOREA
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OBJECTIVES: This study aims to evaluate the impact of the new pricing policy implemented as of April, 2012 in South Korea on market competition among off-patent drugs since the reform has taken an objective to introduce market competition mechanisms among off-patent drugs. According to the new pricing scheme, prices of brand-name and generic drugs are to be set to the same level after the patent expires. METHODS: The data used for this study were extracted from the National Health Insurance Claims database. We established a monthly panel dataset pertaining to pharmaceutical consumption between January 2011 and June 2013 (30 months). Proxies of market competition were considered as dependence variables such as price dispersion, market share of originators and relative ratio of utilization (originator/generics). Independent variables including policy effect, number of generic drugs, vintages of the first generic drugs, month for generic drugs, and market value. RESULTS: The new pricing policy has resulted in no competition mechanism. Rather the policy shows more favorable to originators than generic drugs. Price dispersion has significantly decreased to 0.92 after the new pricing regulations. Market share of the originators has not significantly changed. However, originator-to-generic utilization ratio significantly increased to 6.12 (p < 0.001) after the new policy. This study offers different results to the government’s intention. CONCLUSIONS: Price competition cannot be suc- cessfully achieved as the measures to increase the market share of generics, the bigger market share should be delivered through demand-side measures such as the reference pricing or compulsory substitution to lowest drugs applied in some European countries.

PHIP8 THE ROLE OF COST-EFFECTIVENESS STUDIES IN DRUG PRICING DECISIONS: A CASE REVIEW FROM JORDAN
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OBJECTIVES: To assess a public price for a drug in Jordan, Jordan food and Drug association (JFDA) drug pricing committee ought to review the lowest price in the country of origin, the price of a predefined 13 countries and in KSA. In 2012, the evidence was not required to inform the committee. We sought to assess the role of CE studies in pricing drugs in Jordan. METHODS: A retrospective review of all applications submitted to the JFDA between November 2011 and December 2013 was conducted. For each plan, the categories, classes and number of covered drugs was collected and pooled into one database. Analysis was conducted at the entire population level, state level and for top classes of drugs. The comments from patient groups were reviewed to understand the impact of EHB on patient choice and health outcomes. RESULTS: Benchmark plans had up to five states per plan belonging to 158 classes as defined by USP. While four states (FL, IL, NY and TX) had a similar number of covered drugs (median of 892 drugs), CA had a significantly lower number of covered drugs, amounting to 28% less than the other four states. On average, 10% of the drugs were in the class called “No USP Class”, highlighting the limitation of EHB in covering a comprehensive set of medications. Other state differences included such list as Anti-Infectives and Pain medications. CONCLUSIONS: Review of new benchmark plans shows some states can have a significantly lower patient choice of therapies. There is a need for new policy measures to ensure that all patients have equal access to new treatments.

PHIP19 THE DIFFERENCE BETWEEN THE MAXIMUM RETAIL PRICE AND TENDER PRICE: A COMPARATIVE STUDY ON BRANDNAME AND GENERIC DRUGS
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OBJECTIVES: The purpose of this paper is to examine the difference between the maximum retail price and tender price of brandname and generic drugs. METHODS: A large database analysis was used. The database was formed by merging two sub-databases, one was the tender prices of 94 antimicrobial drugs and circularity system drugs collected from the centralised tendering of drug purchases across all the provinces/autonomous regions, municipality directly under the central government of mainland China over the period of 2005-2013, the other was the corresponding maximum retail prices issued by the National Development and Reform Commission of China. The percentage differences between the maximum retail price and tender price (provincial average) was then calculated by year for antimicrobial drugs and circularity system drugs, respectively. The generic-brandname ratio of the concerned percentage differences was calculated. RESULTS: The percentage difference between maximum retail price and tender price for generic drugs was large, while the corresponding difference in brandname drugs was much smaller. The generic-brandname ratio of the concerned percentage differences increased from 1.7 in 2005 to 5.7 in 2013, except a mild decrease in 2009 and a moderate decrease in 2012. CONCLUSIONS: It may be the time to lift price control on drugs in China since the maximum retail price issued by the national government was too high as compared with tender price to exert effect on generic drugs, while for brandname drugs the maximum retail price was too close to tender price, which also consequentially diluted the significance of maximum retail price. KEYWORDS: Maximum retail price; Tender price; Price reform, large database analysis.

PHIP20 ANALYSIS OF THE DRUG PRICE REVIEWS PERFORMED BY THE CANADIAN PATENTED MEDICINE PRICES REVIEW BOARD (1998-2014)
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OBJECTIVES: Canada has established Patented Medicine Prices Review Board (PMPRB) in 1987 with the objective of regulating prices of patented medicines sold in Canada to ensure prices are not excessive. When drugs’ prices meet the guidelines, they will be accepted, otherwise, the sponsor company will decrease them. The