Available online at www.sciencedirect.com

ScienceDirect

journal homepage: www.elsevier.com/locate/jval

ELSEVIER

ABSTRACTS

RESEARCH PODIUM PRESENTATIONS – SESSION I

USA AFFORDABLE HEALTH CARE ACT STUDIES

AH1
PROJECTING THE USE OF INPATIENT AND EMERGENCY DEPARTMENT SERVICES AFTER THE AFFORDABLE CARE ACT MEDICAID EXPANSION

Pickens G[1], Carls G[2], Eibner C[3], Jiang HJ[4], Karaca Z[4], Weiss A[1], Wong H[4]
[1]Truven Health Analytics, Cambridge, MA, USA, [2]Truven Health Analytics, Ann Arbor, MI, USA, [3]RAND Corporation, Arlington, VA, USA, [4]Agency for Healthcare Research and Quality (AHRQ), Rockville, MD, USA

OBJECTIVES: Medicaid expansion under the Patient Protection and Affordable Care Act (ACA) will add new enrollees to Medicaid programs in states that elect to expand eligibility. The objective of this study is to provide projections of inpatient hospital and emergency department (ED) use after ACA Medicaid expansion. **METHODS:** Hospital Inpatient and ED records were extracted from Healthcare Cost and Utilization Project State Inpatient Databases for the years 2007–2011and State Emergency Department Databases for the years 2007–2010. The enrollment estimates were based on the Centers for Medicare & Medicaid Services Medicaid statistics and information from the American Community Surveys for 2007–2011. Inpatient discharge records were aggregated by the state of the patient's residence, year, and major service lines including Medicine, Surgery, Maternity & Newborn, Injuries and Mental Health. Data were restricted to adults aged 19–64 years, because this age group is likely to contribute the vast majority of new Medicaid enrollees. Regression models estimated utilization measures from predictor variables. Hospital utilization metrics were total discharges, preventable admissions, and emergency department visits. Discharge and ED visit rates were estimated using the state- and year-specific Medicaid enrollment estimates. Data for Medicaid patients were aggregated by state, year, and type of service. **RESULTS:** Our models project that change in population composition alone results in a 22% increase in inpatient discharges and a 30% increase in ED visits, while use rates fall 6% and 0%, respectively. With the additional capacity, reimbursement, and innovation policy effects in place, inpatient discharges increase by 7% and ED visits by only 1%, while use rates fall 18% and 22%. **CONCLUSIONS:** Medicaid expansion will increase inpatient and ED volumes, but utilization rates will be below current levels. States can limit increases through provider capacity, Medicaid managed care, and increasing physician acceptance of Medicaid patients.

AH2
ESTABLISHING BENCHMARKS TO UNDERSTAND HOSPITAL UTILIZATION FOLLOWING MEDICAID EXPANSION UNDER THE AFFORDABLE CARE ACT

Weiss A[1], Carls G[2], Jiang HJ[3], Karaca Z[3], Pickens G[1], Wong H[3]
[1]Truven Health Analytics, Cambridge, MA, USA, [2]Truven Health Analytics, Ann Arbor, MI, USA, [3]Agency for Healthcare Research and Quality (AHRQ), Rockville, MD, USA

OBJECTIVES: In 2014, many states will initiate Medicaid expansion under the Affordable Care Act; some states will not. Medicaid expansion is expected to increase hospital utilization as previously uninsured adults become covered under Medicaid. Our objective is to define benchmarks for the rates of hospital inpatient and emergency department (ED) use following Medicaid expansion. **METHODS:** We obtained hospital use data from the Healthcare Cost and Utilization Project 2010 State Inpatient Databases and State Emergency Department Databases. We obtained state-level data on Medicaid program characteristics and population demographics and health status from Centers for Medicare & Medicaid Services Medicaid statistics, American Community Survey, and Behavioral Risk Factor Surveillance Survey. We examined whether hospital utilization rates differed based on states' stance on Medicaid expansion. We standardized the hospital use metrics by computing separate index values for the Medicaid and uninsured population metrics relative to the national mean so that all measures had similar scale. We then examined which state-level Medicaid program, demographic, and health status characteristics were related to the states' expansion stance. **RESULTS:** We found that several state health system infrastructure characteristics were strongly related to both expansion likelihood and hospital utilization. In particular, in states highly likely to adopt Medicaid expansion in 2014, we observed higher levels of Medicaid managed care organization penetration, a lower primary care physician supply challenge, a lower level of primary care case management, and a smaller expansion population size relative to the current Medicaid population. We also found that in those states that are currently committed to Medicaid expansion had substantially lower hospital inpatient and ED use among Medicaid-covered patients compared to states that have not committed to expand. **CONCLUSIONS:** Our results revealed a lower impact of Medicaid expansion on hospital utilization among states that have elected to expand than among states currently unlikely to expand.

AH3
ADJUSTING BUDGET IMPACT MODEL BASED ON NEW CHANGES DUE TO AFFORDABLE CARE ACT

Aggarwal S, Topaloglu H, Kumar S
Novel Health Strategies, Bethesda, MD, USA

OBJECTIVES: The Affordable Care Act (ACA) has introduced several major changes, which can impact product pricing, access and uptake in the United States. The objective of this analysis was to review all major new changes due to ACA and develop a target list of adjustments for budget impact model (BIM) for US payers. **METHODS:** The new pricing, access and coverage changes impacting the pharmaceutical and devices products were reviewed using the bill for ACA (H. R. 3590), 2011-2013 policy publications, reports by Congressional Budget Office and Government Accountability Office, and the latest Centers for Medicare & Medicaid Services (CMS) guidelines for Essential Health Benefits (EHBs). Primary discussions with US private payers and ex-CMS policy experts were conducted to understand key issues for medical products. A US budget impact model was adjusted to illustrate the type of changes and their impact on model results. **RESULTS:** The ACA has introduced major changes for product pricing, deductible, coverage and uptake. For pricing, two model adjustments are 50% discount for Part D population and increased rebate of 23.1% for Medicaid population. For deductible, the patient costs are capped at $12,700. For uptake, an additional population is eligible based on expanded access to 30 million uninsured Americans, with more than half of them being under the age of 35 years (~59%). For access, the 2014 definition of Essential Drug Benefits is likely to either expand or reduce coverage depending upon the State and class of drugs. For example, for NSAIDs in CA only 20 drugs, while in NY, 40 drugs are covered. Scenario analysis shows -10 % to +15% impact on total budget impact. **CONCLUSIONS:** Budget impact models in the US need to be adjusted based on the new changes introduced by the ACA.

AH4
WILL THE AFFORDABLE CARE ACT (ACA) IMPROVE RACIAL/ETHNIC DISPARITY OF EYE EXAMINATION AMONG UNITED STATES WORKING-AGE POPULATION WITH DIABETES?

Shi Q[1], Fonseca V[1], Zhao Y[2], Krousel-Wood M[1], Luo Q[1], Shi L[1]
[1]Tulane University, New Orleans, LA, USA, [2]College of Pharmacy, Xavier University of Louisiana, New Orleans, LA, USA

OBJECTIVES: This study aimed to examine and forecast the racial/ethnic disparity of eye examination rates among US adults with diabetes before and after the ACA. **METHODS:** Working-age adults (18-64 years) with diabetes were extracted from the Medical Expenditure Panel Survey Household Component 2011. For the years 2014 to 2017 after the ACA, samples were simulated from the 2011 population using the bootstrap method. Insurance coverage rates were separately predicted for each racial/ethnic group based on the Congressional Budgeting Office report and the proportions of diabetes patients potentially qualified for Medicaid under the ACA. Racial/ethnic groups were dichotomized as non-Hispanic whites (NHW) and minorities. Eye examination was defined as reporting ≥1 dilated eye examinations. Eye examination rates were weighted to national estimates and compared between racial/ethnic groups for each year. Confidence intervals were collected using the percentile bootstrap method. **RESULTS:** After the ACA implementation, health insurance coverage is forecasted to increase from 90% in 2011 to 98% in 2014 among NHW and reach 99% in 2017. The minorities are forecasted to have a 15% expansion of insurance coverage from 2011 (81%) to 2014 (96%), and slightly grow to 98% in 2017. In 2011, 63% of NHW had eye examinations and forecast an increase to 66% in 2014 and 66% in 2017. While the eye examination rate among the minority population will increase from 56% in 2011 to 59% in 2014, and remain at 59% in 2017. The racial/ethnic differences in eye examination are forecasted to persist (ranging from 6.25% in 2016 to 6.54% in 2015). **CONCLUSIONS:** The ACA is projected to reduce disparity in health insurance coverage by larger expansion of health insurance for minority populations than for their white counterparts. The racial/ethnic differences in eye examinations for patients with diabetes existed before ACA and are forecasted to persist after the ACA.

COMPARATIVE EFFECTIVENESS RESEARCH STUDIES

CE1
COMPARATIVE EFFECTIVENESS OF SMOKING CESSATION MEDICATIONS TO ATTENUATE WEIGHT GAIN FOLLOWING CESSATION

Yang M[1], Wang X[1], Chen H[1], Johnson ML[1], Essien EJ[1], Peters RJ[2], Abughosh S[1]
[1]University of Houston, Houston, TX, USA, [2]Universtiy of Texas Health Science Center at Houston, Houston, TX, USA