constituents through August 1, 2007, of which evidence from 27 were extracted using our criteria. Stakeholder comments on the HTA process and decision methodology were distilled into 12 categories, ranging from impact of severity/rarity of disease on acceptability of cost-effectiveness thresholds to over-reliance of QALYs in decision-making. Compared to attributes reported for other countries, NICE’s criteria and methods for health economic assessment and decision-making varied substantially, such as that of the model perspective, e.g., payer versus societal. CONCLUSION: We found that aspects of NICE technology appraisals garner criticism common to many stakeholders. This underscores the need to reconsider how current health economic and decision methodology might be improved. Furthermore, country-level heterogeneity in HTA processes and methods suggests the need to determine why these variations arise, and whether they reflect societal preferences or misunderstandings of appropriate methods.

**PHP17**

**HOW MANDATORY PRICE REDUCTION OF REIMBURSED PHARMACEUTICALS COULD RESULT IN INCREASED PHARMACEUTICAL EXPENDITURE?**

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**OBJECTIVE:** Political objectives may alter economic rationale in health care decision-making. The Hungarian government had promised to reduce the prices and copayment of pharmaceuticals, therefore 15% price cut was mandated to all reimbursed pharmaceuticals from April 2004. Three months later the regulation was abrogated by the Constitution Court. As the government did not want to communicate a price increase, the level of copayment remained the same, while the reimbursement level was increased. It took two years to increase the copayment back to the original level by a 7.5% reimbursement reduction in February 2005, and by a further 7.5% reduction from February 2005 to July 2006. Our objective was to measure the impact of price cut on the public pharmaceutical budget. **METHODS:** An estimated public pharmaceutical spending was calculated based upon projections from the expenditure in previous periods. Only pharmaceuticals with reimbursement in April 2004 were included into the analysis. The estimated expenditure was compared to the real expenditure. Hungarian Forint was converted to US$ by employing the quarterly exchange rate. **RESULTS:** In Q2 2004 the mandated price cut resulted in $39.65 million savings in the pharmaceutical expenditure. In Q3-2004 the reduced copayment generated $29.98 million increase in the drug budget. Between Q1 2005 and Q2 2006 the impact of reduced copayment was $42.42 million. **CONCLUSION:** The mandated price cut and its subsequent abrogation resulted in $32.75 million increase in the Hungarian public pharmaceutical expenditure between April 2004 and June 2006, as the government did not dare to withdraw its promise on cheaper pharmaceuticals. Our estimate is conservative, as the mandated price cut influenced spending not only on pharmaceuticals with reimbursement in April 2004, but via reference pricing also the spending on new pharmaceuticals with initial reimbursement between April 2004 and June 2006.

**WITHDRAWN**

**PHP19**

**EFFECT OF PRESCRIPTION DRUG COVERAGE ON HEALTH AMONG CHRONICALLY ILL ELDERLY POPULATION**

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**OBJECTIVE:** To estimate the effect of prescription drug insurance on health, as measured by self-reported poor health status, functional disability, and hospitalization among elderly with at least three chronic conditions. **METHODS:** Analyses are based on a nationally representative sample of non-institutionalized elderly (>64 years of age) from the Medicare Current Beneficiary Survey (MCBS) for years 1992–2000. Estimates are obtained using multivariable regression models that control for observed characteristics and unmeasured person-specific effects (i.e., fixed effects). Fixed effects analysis uses within person variation in drug coverage to estimate the effect of gaining or losing coverage on outcome of interest (i.e., health). **RESULTS:** In general, prescription drug insurance was not associated with significant changes in self-reported health, and hospitalization. However, prescription drug coverage decreased functional disability slightly (4% improvement), although this was not statistically significant. **CONCLUSION:** Findings suggest that prescription drug coverage may have some health benefits for chronically ill.

**PHP20**

**PREDICTORS OF ENROLLMENT IN MEDICARE PART D: THE EXPERIENCE OF MEDICARE DRUG DEMONSTRATION PARTICIPANTS WITH RHEUMATOID ARTHRITIS AND MULTIPLE SCLEROSIS**

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**OBJECTIVE:** During the 16 months preceding the start of the Medicare prescription drug program (Part D), 22,359 vulnerable Medicare beneficiaries with rheumatoid arthritis (RA) or multiple sclerosis (MS) participated in the Medicare Replacement Drug Demonstration (MRDD), which provided access to specialty biologic medications. We examine beneficiary characteristics associated with Part D enrollment among this population in early 2006. **METHODS:** Predictors in multivariate logistic regressions included female gender, age, race (white, black, or other), region of the U.S., urban residence, Hierarchical Condition Category score (HCC; a measure of comorbidity), use of the MRDD benefit, subsidy level under the MRDD, self-report of other drug coverage during the MRDD, and death within six months of the start of Part D. **RESULTS:** Among 14,963 MRDD beneficiaries with RA, 12,174 (81%) enrolled in Part D plans during the first half of 2006. Ninety percent (6646) of the 7396 beneficiaries with MS enrolled in a Part D plan—about 50% higher than the rate of enrollment in the general Medicare population. Female gender (OR = 1.5, 1.3–1.6), MRDD benefit use (OR = 2.6, 2.4–2.8), higher HCC score (OR = 1.07, 1.03–1.10), other drug coverage during the MRDD (OR = 1.6, 1.5–1.7), were associated with Part D enrollment. There were regional differences as well. Older age (OR = 0.9, 0.9–0.9) and death within 6 months (OR = 0.3, 0.3–0.4) were associated with not enrolling in Part D. Separate regressions for the RA and MS populations produced similar results. **CONCLUSION:** With the inception of Medicare Part D, most MRDD beneficiaries with RA and MS enrolled in Part D plans. Beneficiaries who had used their MRDD benefit and had worse health status—those who appear to need prescription drug coverage most—were more likely to enroll. Disproportionately high enrollment suggests that...