different amounts per health category even after adjusting for population size and needs.

**CONCLUSIONS:** The cluster analysis indicated that the health areas cannot be considered to behave similarly to one another, since there is more than one cluster in each year and the clusters are stable over time.

**PHP79**

MEDICATION USE SURVEY OF INPATIENTS WITH BASIC MEDICAL INSURANCE FROM 2010 TO 2012

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**OBJECTIVES:** The objective is to provide data support for government decision making by having a general view of the status of disease composition, patient flow and use of drug and treatment of inpatients with basic medical insurance in cities and towns based on sample survey on the medical service utilization and payment data. METHODS: Information from 2010 to 2012 was collected during the time of being released, according to systematic sampling method, extract a certain proportion of the insured patients’ hospitalizing information in sampling area. Then project the sample data to the country. Retrospective study using SQL server database. RESULTS: The basic medical insurance increased every year, reaching RMB425.3 billion in 2012, got 67.77% increase compared with 2010. Expenses increased primarily due to the growth of person-time in receiving treatment. The patient-time in receiving treatment reached 4945 times in 2012, 57.18% increases over 2010. In 2012 the average hospitalization expenses amounted to RMB8,601, an increase of 6.75% compared with RMB8,057 in 2010. Diseases in circulatory, respiratory, and digestive system as well as genitourinary system and skin and subcutaneous tissue took up most of the inpatient population. In the disease sub-category, the three most common diseases accounted for more than 20% of total diseases in patient-times. Due to the strengthened clinical management of antibiotic, expenses for miscellaneous anti-biotics decreased by year, with 22.46% in 2012, significantly lower than 28.99% in 2010. CONCLUSIONS: With the establishment and improvement of national health insurance system, the needs for insulin treatment are increasing; however, it is not met with substantive effect, but the resulting pressure on fund spending should be given more attention. With the continuous attention to the rational clinical treatment, irrationality of clinical medication use has improved, but there still remains room to improve.

**PHP80**

WHICH DISEASES ARE DRIVING THE INCREASE IN SPENDING FOR THE PRIVATELY INSURED POPULATION OF THE US?

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**OBJECTIVES:** This study examines disease-specific spending across the full range of conditions to identify which conditions are driving the growth in overall spending in recent years. **METHODS:** Truven Health MarketScan data for 8M employees and their dependents in FFS plans in 2007 and 2012 are analyzed. The samples were weighted to reflect the demographic composition of all US employer health plans in those years (as captured by the US Medical Expenditure Panel Survey). Total health care spending for each patient was allocated across diseases health plans in those years (as captured by the US Medical Expenditure Panel Survey). Total hospitalization expenses amounted to RMB8,601, an increase of 6.75% compared with RMB8,057 in 2010. Diseases in circulatory, respiratory, and digestive system as well as genitourinary system and skin and subcutaneous tissue took up most of the inpatient population. In the disease sub-category, the three most common diseases accounted for more than 20% of total diseases in patient-times. Due to the strengthened clinical management of antibiotic, expenses for miscellaneous anti-biotics decreased by year, with 22.46% in 2012, significantly lower than 28.99% in 2010. CONCLUSIONS: With the establishment and improvement of national health insurance system, the needs for insulin treatment are increasing; however, it is not met with substantive effect, but the resulting pressure on fund spending should be given more attention. With the continuous attention to the rational clinical treatment, irrationality of clinical medication use has improved, but there still remains room to improve.

**PHP81**

ACA’S IMPACT ON MERGERS AND WELLNESS: ASSESSING VALUE FOR MONEY

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**OBJECTIVES:** The Affordable Care Act (ACA) initiated healthcare reforms that stress “triple aim” goals: improving patient care, population health, and reducing costs. Hospital systems are forming mergers and have expanded their employee health and wellness programs. The objectives are to (1) summarize the literature on mergers, health outcomes, and cost-containment (2) describe value for money of health and wellness programs, (3) provide examples of successful mergers. **METHODS:** A systematic review was conducted to identify the costs and benefits of mergers and wellness programs. Articles after 2008 were compiled using search engines Pubmed, Google Scholar and Google Scholar. Key terms were “value for money”, “co-ops”, “health and wellness program”, “health plan”, “insurance plan”, “hospital”, and “merger.” Exclusion criteria were articles involving forms of consolidation and wellness programs not tied to insurance plans and without reported costs and/or health outcomes. A total of 29 relevant articles were retrieved. Findings revealed mergers prevent patients from trading-off quality and services for cost savings. However, studies suggest that anticompetitive effects of mergers will increase costs. Before the ACA, employers had wellness programs that were not standardized. The ACA encouraged improvement of these programs that funded expanded services and mandating quality. Studies show that wellness programs are growing in number and in innovative services, and incentives resulting are significant to non-significant return-on-investment (ROI). Few employers have measured the ROI and even fewer their health outcomes. However, successful programs have shown a median ROI between 2:1 and 3:1. Studies suggest that disease-management services account for significant health outcomes of which ROI is where savings do not. For example, the partnership between Piedmont and WellStar of Georgia supported implementation of care-management programs, with higher quality at lower costs. CONCLUSIONS: Although most are not reporting ROI, studies show the value of wellness programs should be based on health outcomes.

**PHP82**

IMPACT OF CLINICAL AND HEALTH ECONOMIC PUBLICATIONS ON COMMERCIAL SUCCESS OF PHARMACEUTICAL PRODUCTS IN THE U.S.

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**OBJECTIVES:** The study objective was to estimate the causal effect of the publication of drug-specific clinical and health economic outcomes research (HEOR) publications on sales of pharmaceutical products. **METHODS:** Quarterly sales data for twenty-two drugs, (biologics for rheumatoid arthritis (RA), new generation asthma drugs and statins) and contemporaneous publication counts of HEOR, clinical and meta-analytic studies funded by pharmaceutical companies were analyzed. Clinical studies were categorized by journal impact factor. The total analysis period spanned 2003-2013, with drug-specific exposure varying based on its branded status over that timeframe. Covariates included generic availability, safety and efficacy, and new indications (as a proxy for sales effort). First, a selection difference test was performed to determine whether treatment exposed cases were different from controls. The effect of interest was then estimated using difference-in-differences models. CONCLUSIONS: There was a significant increase in sales of $1 - $2.2 million. High-impact clinical publication also significantly increased sales in the short run (-$7.5 million). Publications on safety and quality impacts were associated with a decrease in sales in the short run (-$7.5 million). Meta-analyses were not found to have significant effects on asthma drug sales in the next quarter (-$7.5 million). Conclusions: HEOR and high-impact clinical studies were associated with an increase in quarterly sales in the statin market, where generic competition is high. These effects were seen to a lesser degree in the RA and RA markets, where generic competition is lower. Market characteristics that vary across the studied classes, such as branded and generic competition, may dictate returns from HEOR and clinical studies.

**PHP83**

PREVALENCE OF MEDICATION USE NOT CAPTURED BY PRESCRIPTION CLAIMS DATABASES AND AN ANALYSIS USING 2012 MEDICAL EXPENDITURE PANEL SURVEY DATA

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**OBJECTIVES:** Prescription claims databases are used for identifying patients for disease management programs and studying health outcomes. The growth in the use of drug samples and discount generic programs suggests that an increasing number of prescriptions being dispensed may be in level of per member per year (PMPY) spending (total and out-of-pocket) from 2007 to 2012. We examined the contributions of disease prevalence and cost per case. **RESULTS:** PMPY spending per prescription per member per quarter increased 34% from 2007 to 2012. We found a significant difference in disease prevalence and cost per case. Expenditures grew faster (5.9%) than other settings and prescription drug spending was lower (5.1%) in 2007. High-impact clinical publication also significantly increased sales in the short run (-$7.5 million). Meta-analyses were only found to have a significant effect on RA drugs (-$3.5 million). Publications on safety and quality impacts were associated with a decrease in sales in the short run (-$7.5 million). Conclusions: HEOR and high-impact clinical studies were associated with an increase in quarterly sales in the statin market, where generic competition is high. These effects were seen to a lesser degree in the RA and RA markets, where generic competition is lower. Market characteristics that vary across the studied classes, such as branded and generic competition, may dictate returns from HEOR and clinical studies.