tions for both patients and providers, yet has received little attention since Part D went into effect. Our objective was to determine the impact of Medicare Part D on MA enrollment. METHODS: State-level data from the Centers for Medicare and Medicaid Services (CMS) were used to calculate overall Medicare enrollment (including dual eligibles), enrollment in managed care plans, and enrollment in MA plans with drug coverage (MA-PDs) and stand-alone prescription drug plans (PDPs) from January 2003–June 2006. States were classified as having low, medium, or high penetration based on tertile of penetration for the first quarter of 2003 (1Q03). The effect of Part D on managed care enrollment penetration in states with low, medium, and high penetration was assessed using linear regression. RESULTS: Nationwide, MA penetration increased from 14.0% in 4Q05 to 15.3% in 2Q06. MA penetration significantly increased following the implementation of Part D, but only in states which had low Medicare managed care penetration prior to Part D (p < 0.05). CONCLUSION: New MA enrollees living in areas that historically had little experience with managed care may face interruptions in health care or difficulties accessing care, at least initially. CMS should carefully monitor the health care patterns of new MA enrollees to ensure that beneficiary health is not compromised.

**Patient Gender and Associated Medication Adherence in an Older Population with Chronic Diseases**

Balkrishnan R1, Kong MC1, Anderson RT2

1The Ohio State University College of Pharmacy, Columbus, OH, USA; 2Wake Forest University School of Medicine, Winston Salem, NC, USA

OBJECTIVES: Medication nonadherence is an important problem in older populations, and is affected by numerous factors. The aim of this study was to examine the relationship between gender and medication adherence in older adults with chronic diseases. METHODS: A longitudinal cohort study was conducted in older adults (aged ≥65 years) who completed a health status assessment and were enrolled in a health maintenance organization. The study sample included patient cohorts with four major chronic diseases. Medication Possession Ratio (MPR) was used as a measure of medication adherence in Type 2 Diabetes Mellitus (n = 775 patients), asthma (n = 129 patients), and overactive bladder (OAB) (n = 275 patients). Persistence rate was used as the measure of medication adherence in glaucoma (n = 268 patients). RESULTS: For glaucoma patients, males had a significant 0.111-point (22.2% increase over mean) decrease in medication persistence (p < 0.05). In male asthma patients, there was a similar 0.13-point (38% increase over mean) decrease in medication adherence as measured by the Med-Total score (p < 0.05). A 0.051-point increase (0.8% increase over mean) in MPR was found in male patients receiving continuous antidiabetic pharmacotherapy (p > 0.05). In male OAB patients, there was a 0.025-point increase (6% increase over mean) in MPR for antimuscarinic medications (p > 0.05). CONCLUSION: This study found significant but unexplained associations between male gender and decreased medication adherence in glaucoma and asthma patients. No significant adherence differences were found between males and females for Type 2 diabetic and OAB patients. This suggests that gender can be a predictor of medication adherence but this effect varies depending on which chronic disease the patient suffers from. Further study of these gender differences is warranted in order to improve medication adherence and aid in disease intervention.

**Burden of Premenstrual Dysphoric Disorder on Health-Related Quality of Life**

Yang M1, Wallenstein GV1, Hagan MA2, Chang J3

1QualityMetric Inc, Lincoln, RI, USA; 2Berlex Laboratories, Inc, Wayne, NJ, USA

OBJECTIVES: Although several studies have described the burden of Premenstrual Dysphoric Disorder (PMDD) impacts women’s lives, few undertook a quantitative approach. This study is an attempt to quantify the burden of PMDD on health-related quality of life (HRQoL) in comparison to specific chronic conditions in the US general population. METHODS: The burden of PMDD on HRQoL was estimated by comparing SF-12 scores between women identified as being “at risk for PMDD” with SF-12 scores observed in the general US population. Additional comparisons were made to several chronic health conditions. SF-12 normative values of the general population were estimated through regression adjusted to match the age and disease comorbidity of the PMDD patient group. Significance tests between the means across samples were compared. Medical expenditures were estimated and compared for women who were “at risk for PMDD” and women with no reported chronic conditions. RESULTS: All SF-12 measures of PMDD were significantly below the adjusted US general population norms. The burden of PMDD was greater on mental/emotional than on physical HRQoL. The burden of PMDD on HRQoL was greater than that of chronic back pain; similar to type 2 diabetes, hypertension, osteoarthritis and rheumatoid arthritis; and largely comparable to depression. Age, PCS, and MCS scores were used to predict monthly medical expenditures using data from the annual Medical Expenditures Panel Survey (2001). The mean predicted monthly medical expenditure for women “at risk for PMDD” was $222.3 (SD = $107.3) and $134.0 (SD = $43.4) for women with no reported chronic conditions (p < 0.0001). CONCLUSION: PMDD is associated with substantial burden on physical and mental aspects of HRQoL, and may be related to increased medical expenditures.

**Quality-of-Life Weights for the U.S. Population: Self-Reported Health Status and Priority Health Conditions, by Demographic Characteristics**

Nyman JA1, Barleen NA1, Dowd BE2, Russell DW2, Coons SJ1, Sullivan PW3

1University of Minnesota, Minneapolis, MN, USA; 2Iowa State University, Ames, IA, USA; 3University of Arizona, Tucson, AZ, USA; 4University of Colorado Health Sciences Center, Denver, CO, USA

OBJECTIVES: Many of the large ongoing national surveys of the US population contain a question that asks for the respondent’s self-reported health status: “excellent,” “very good,” “good,” “fair” or “poor.” These surveys could be used to conduct cost-utility analyses of health care policies, treatments or other interventions if quality-of-life (QOL) weights for the self-reported health statuses were also available. The objective of this study was to produce nationally representative QOL weights for self-reported health status and for 10 priority health conditions, by a series of demographic variables. METHODS: The Medical Expenditure Panel Survey contains the questions from the EQ-5D health status measure. A recent study has calculated time-trade-off-derived QOL weights corresponding to the EQ-5D health states for a large US sample. We use these data to construct QOL weights for the five self-reported health status categories and 10 priority health conditions, by a series of demographic variables. RESULTS: Mean and median QOL weights were produced for self-reported health status, the 10 priority