2002), and after the exclusivity period (February–August 2002) was: $1.89, $1.91, and $1.97 respectively, using an assumed percentage rebate. Similarly, average estimated payment per unit (post-rebate) for fluoxetine 20 mg capsules (generic) in the 2 latter periods was: $1.96 and $0.79 respectively. Additional payments related to cost-savings not realized were estimated to be $1,772,677. **CONCLUSIONS:** Regulations that limit competition within the generic marketplace immediately following branded patent-expiration may result in lost opportunities for savings within publicly-financed prescription programs.

DP3

PHYSICIAN ATTITUDE TOWARD ACADEMIC DETAILING AND OTHER DRUG COST-CONTAINMENT STRATEGIES IN A STATE HEALTH INSURANCE PROGRAM

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OBJECTIVES: The overall purpose of this study was to determine West Virginia (WV) physicians' attitude toward cost-containment strategies and generic prescribing, and to assess their level of awareness and receptivity towards academic detailing. **METHODS:** The top 2000 physicians by prescribing volume in the WV state employees health insurance program were surveyed using a self-administered mail questionnaire. Physician attitudes toward popular pharmaceutical cost-control strategies (formulary, prior-authorization, co-pays, generic and therapeutic substitution, and incentives for formulary adherence), generic prescribing, and the potential of academic detailing for appropriate and cost-effective pharmaceutical use was assessed using Likert-type 7-point scales. Generic prescribing frequency and patient acceptance/inquiry for generic drugs and the preferred format of academic detailing visits were also obtained. **RESULTS:** A total of 455 (23%) usable responses were obtained after 2 mailings. On a scale of 1 to 7 (highly inappropriate to highly appropriate), generic substitution, increased patient co-pays for branded drugs, and therapeutic substitution had the highest mean appropriateness scores of 5.30 (+1.68), 4.49 (+1.71), and 4.36(+2.01), respectively. All other strategies were considered inappropriate with incentives to physicians for prescribing from formularies considered the most inappropriate. Physicians were neutral to mildly positive toward generic drug prescribing, and reported a mean proportion of 46% generic prescriptions written and a 78% patient acceptance of generic prescriptions when written. Physicians were generally aware of academic detailing and mildly positive about it with 69% of surveyed physicians expressing willingness to meet with academic detailers. A once-a-month frequency of visit and up to 20 minutes per visit was favored by almost half of those physicians interested in academic detailing. **CONCLUSIONS:** Overall, WV physicians are less supportive of cost-control strategies that impose restrictions on their prescribing and more supportive of strategies that do not impose on their prescribing. Study results indicate that WV physicians are receptive to academic detailing.

DP4

ARE SICK PEOPLE LESS RESPONSIVE TO PRESCRIPTION BENEFIT CHANGES?

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OBJECTIVES: To estimate the difference in responsiveness to drug benefit changes between sick and healthy populations under different drug benefit plans. **METHODS:** Prescription spending in 2001, demographic, co-pays and chronic condition information of 107,710 primary participants between ages 18 to 64 was obtained from Caremark PBM claims system. Existence of chronic conditions identified through pharmacy claims utilization algorithms was used as a proxy for sick people. A 2-part model was used to estimate the prescription spending on copay changes. The first part used a logistic regression to estimate the probability of incurring of any prescription. The second part used an OLS regression on log of total spending for the utilizing participants. **RESULTS:** Under a 1-Tier copay plan, if the co-pays increase from $5 to $10, the reduction of total spending is 6.4% more for sick people than for healthy people. Under a 2-Tier plan, if the co-pays increase from $5 to $10 for generic and $10 to $15 for brand, the reduction of total spending is 10.2% more for sick people than for healthy people. Under a 3-Tier plan, if the co-pays increase from $5 to $10 for generic, $10 to $15 for brand formulary and $15 to $20 for brand non-formulary, the reduction of total spending is 10.4% more for sick people than for healthy people. **CONCLUSIONS:** Based on the specific data set, this research shows that sick people are more responsive to drug benefit changes. Since cost-sharing designs are frequently used to contain total drug spending, understanding drug benefit designs for heterogeneous populations is crucial to achieve the optimal balance of sponsor savings and participants' health.

DIABETES

DB1

IMPACT OF PARTICIPANT COST-SHARE ON COMPLIANCE RATES IN PARTICIPANTS WITH DIABETES

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OBJECTIVE: To retrospectively assess the impact of participant cost-share levels on medication compliance rates