mental scores or work productivity. Greater increases in pharmacy costs for the DTM cohort were partially offset by smaller increases in medical costs, resulting in similar total health care costs for DTM patients compared with controls.

ME2

THE EFFECT OF MEDICARE PART D PRESCRIPTION DRUG COVERAGE GAP ON MEDICATION ADHERENCE

Sait QA, C. U. Souder E, Hastings JK
University of Arkansas for Medical Sciences, Little Rock, AR, USA.

OBJECTIVES: To investigate the impact on medication adherence for patients with common chronic conditions who reach the Medicare Part D coverage gap versus those who do not. The study is unique because it included characteristics of Medicare Part D enrollees that are typically not available in administrative databases.

METHODS: A survey based on the Seniors’ Prescription Coverage, Use and Spending Survey and the Brief Medication Questionnaire was distributed to elderly persons seeking care at the pharmacies in the University of Arkansas for Medical Sciences Advanced Practice Nurse Nurturing Program in 2008, and had the following conditions: hypertension, hyperlipidemia, diabetes, asthma/COPD, or depression. Adherence was a composite measure based on responses to several questions asking if subjects skipped doses, took smaller doses or decided not to fill at all. Logistic regression was run to evaluate the impact of being in coverage gap on medication adherence, adjusting for age, sex, race, income, and education levels.

RESULTS: A total of 152 subjects (62% female, 44.1% greater than 75 years of age, and 92.7% white) completed the survey. A total of 44.7% reached coverage gap in 2007 or 2008 and 31.6% reported non-adherent, 45.4% had monthly income of $5000 to $49,999 and 12.2% had no college education. Subjects in the coverage gap were twice as likely to be non-adherent to medication regimens as compared to those not in the gap (adjusted odds ratio = 2.07, p-value = 0.051). CONCLUSIONS: There is likely significant impact of falling in the coverage gap on medication adherence for the elderly, which may have adverse health consequences. Decision makers ought to be cognizant of these implications.

ME3

IMPACT OF COST SHARING ON TREATMENT AUGMENTATION IN PATIENTS WITH DEPRESSION

Gibson TB1, Jing Y2, Bagelman E1, Cao Z1, Bates J1, Heiden T4, Forbes RA3, Doshi JA4
1Thomson Reuters, Ann Arbor, MI, USA, 2Bristol-Myers Squibb Company, Plainsboro, NJ, USA, 3Otis University Hospital, New York City, NY, USA, 4University of Pennsylvania School of Medicine, Philadelphia, PA, USA

OBJECTIVES: Patients with depression may not respond to first-line antidepressant (AD) therapy. Treatment options include changing from one AD to another and augmenting AD treatment with an antidepressant from a different class. A study that examines the impact of cost-sharing on treatment augmentation outcomes, adjusting for patient demographics and clinical characteristics.

METHODS: Subjects aged 18–64 in employer-sponsored plans with a diagnosis of depression and at least one antidepressant prescription during the 2004–2008 study period were included in this analysis. Patients were categorized into two arm groups: patients with cost-sharing and patients without cost-sharing. Logistic regression models estimated the probability of augmentation within 12 months as a function of a plan-level cost-sharing index for brand and generic antidepressants, controlling for demographics and clinical characteristics. Results were reported as odds ratios (OR) and 95% confidence intervals (CI).

RESULTS: A $10 increase in the cost-sharing index for antidepressants was associated with a 3% decrease in the odds of any augmentation treatment with an antidepressant from a different class. Adding a second antidepressant (OR 0.939, 95% CI 0.902–0.977, N = 47,269). A $10 increase in the cost-sharing index for antidepressants was associated with a 6% decrease in the odds of augmentation with a second antidepressant (OR 0.939, 95% CI 0.902–0.977, N = 47,269).

CONCLUSIONS: Prescription drug cost-sharing appears to influence the decision to augment AD treatment. Financial barriers may prevent patients from receiving additional care.

ME4

THE IMPACT OF MEDICARE PART D ON HEALTH CARE UTILIZATION AND HEALTH OF THE MEDICARE BENEFICIARIES

Li FX1, Alexander GC2, Crawford SY3, Pickard AS3, Hedeker DR4, Walton S5
1Baxter Healthcare Corporation, Deerfield, IL, USA, 2University of Chicago, Chicago, IL, USA, 3University of Illinois at Chicago, Chicago, IL, USA, 4University of Alabama at Birmingham, Birmingham, AL, USA, 5University of Missouri, Columbia, MO, USA

OBJECTIVES: To examine, using nationally representative data, the impact of Medicare Part D on out-of-pocket-costs, emergency room visits, hospitalization, and general health among civilian non-institutionalized Medicare beneficiaries.

METHODS: The primary data were from the Medicare Expenditure Panel Survey (MEPS) panel data, which included Medicare beneficiaries aged 65 and older in 2005. Near elderly respondents in MEPS (aged 55 to 63 years old) in 2005 served as the comparison group. Subjects in the coverage gap were compared to those not in the gap. Subjects were included if they had Medicare Part D and at least one prescription drug claim. The study was unique because it included characteristics of Medicare Part D enrollees that are typically not available in administrative databases.

RESULTS: A total of 152 subjects (62% female, 44.1% greater than 75 years of age, and 92.7% white) completed the survey. A total of 44.7% reached coverage gap in 2007 or 2008 and 31.6% reported non-adherent, 45.4% had monthly income of $5000 to $49,999 and 12.2% had no college education. Subjects in the coverage gap were twice as likely to be non-adherent to medication regimens as compared to those not in the gap (adjusted odds ratio = 2.07, p-value = 0.051). CONCLUSIONS: There is likely significant impact of falling in the coverage gap on medication adherence for the elderly, which may have adverse health consequences. Decision makers ought to be cognizant of these implications.

CONCLUSIONS: The incremental medical expenditure associated with alternative disease modifying anti-rheumatoid drug (DMARDs) choices in Rheumatoid Arthritis (RA). METHODS: Retrospective analysis of 24129 subjects from California Medicare Part D beneficiaries enrolled in Medicare Part D between January 1, 1998 to December 31, 2005. The analysis included all RA patients who were continuously enrolled in Medicare Part D during the entire study period.

RESULTS: The incremental acquisition cost of adalimumab ($1292.9, p < 0.001), etanercept ($1604.1, p < 0.001) and leflunomide ($467.3, p < 0.001) was significantly higher. Based on the IV-FE model, total expenditure associated with adalimumab ($2129.9, p < 0.001), etanercept ($1185.3, p < 0.001) and leflunomide ($868.8, p < 0.001) exhibited significant increase in magnitude of the parameter estimates, again with baseline as methotrexate. Under identification test based on Anderson’s canonical correlation LM statistic, strongly rejected the null hypothesis at the initial 5% level. CONCLUSIONS: The incremental acquisition cost associated with adalimumab, etanercept and leflunomide may not be offset by cost-savings reductions in outpatient utilization. Further research should follow Medicare beneficiaries for a longer period of time after its implementation or focus on beneficiaries with diseases that might be more sensitive to Medicare Part D.