the positive response ratio was calculated by dividing the number of patients who followed the pharmacist advice to total number of patients to whom the advice was provided. The cost saving per patient per year was determined from available literature.

RESULTS: A total of 180 interventions were made by the pharmacists. Pattern management (60.0%, 55.5%) and diabetes patients with an abnormal A1C (61.3%, 33.8%) were the most frequent. The most accepted interventions were glaucometer training (2 cases, 100%), advising to correct hypoglycemic/hyperglycemic episodes (12, 66.7%), and instructing on the proper use of their injections (3, 60.0%). Cost savings of $1914/ patient/year were estimated as a result of the 6th and 5th intervention. Also, interventions 1, 2 and 3 resulted in cost-saving of $1161, $1203, and $1533 per patient per year respectively. CONCLUSIONS: Our model showed that pharmacist interventions can result in significant cost savings among diabetic patients.

PODIUM SESSION IV: MEDICARE STUDIES II

MDS

PREDICTORS OF ENROLLMENT IN MEDICARE PART D: MEDICATION BENEFICIARIES RATIONALE

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OBJECTIVES: The initiation of Medicare Part D in 2006 offers an ideal opportunity to study real-world decision-making and the role of adverse selection and other factors in insurance enrollment. Our objective was to identify predictors of Part D enrollment among individuals with a range of health conditions and insurance designs.

METHODS: The sample included all individuals in both the 2003 and 2006 Medical Expenditure Panel Survey (MEPS) data. Subsets of Medicare (MED) and commercially insured (MAIN) beneficiaries were enrolled in Medicare, as of December 2005. A multivariate logistic regression was used to assess the effects of sociodemographics, health status, 2005 supplemental insurance coverage, and 2005 person-level out-of-pocket (OOP) drug expenditures on the likelihood of enrolling in Part D in 2006. MEPS sample weights were used to calculate standard errors.

RESULTS: Out of 1,436 persons who met inclusion criteria, 657 (45.4%) enrolled in Part D during 2006. Compared to the non-Part D group, the Part D group was slightly older, had more non-whites, rural residents, and unmarried individuals, and was slightly less educated and poorer. The Part D group had more beneficiaries with Medicare coverage only (17.2% vs. 5.7%), fewer with employer-based coverage only (18.3% vs. 37.1%), and more with no private supplemental insurance (46.1% vs. 32.1%). In multivariate analyses, significant positive predictors of Part D enrollment were having Medicare supplemental insurance only (OR: 1.79; 95% CI: 1.25–2.59) and OOP drug expenditures ≥$2500 in 2003 (OR: 1.58; 95% CI: 1.03–2.41). Most beneficiaries with employer-based coverage in 2005 maintained that coverage in 2006 (91.8%). CONCLUSIONS: Based on first-year data, fears of only the sickest beneficiaries enrolling in Part D and employers withdrawing drug benefits to retirees seem to have been unwarranted. Existing coverage and high drug spending drove the decision to enroll in Part D in what appears to have been a rational way.

M64

PREDICTORS OF UTILIZATION OF ACE INHIBITORS AND ANGIOTENSIN II RECEPTOR BLOCKERS AMONG MEDICARE PART D ENROLLEES WITH DIABETES

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OBJECTIVES: The objectives were to describe angiotensin-converting enzyme inhibitors (ACEI) and angiotensin II receptor blockers (ARB) use among Medicare Part D enrollees for diabetes patients and to identify patient characteristics that predict ACEI/ARB utilization. METHODS: This is a longitudinal retrospective cohort study. The study sample included Medicare Part D enrollees from 6 states (Alabama, California, Florida, Mississippi, New York, and Ohio) aged 18 years or older with the diagnosis of diabetes. Medicare Part D claims data for the first 6 months of 2006 were evaluated for any utilization of ACEI/ARB. The outcome of interest was the percentage of at least one claim for an ACEI or an ARB during the first half of 2006. RESULTS: A total of 1,888,642 patients met our inclusion criteria. Mean age (tSD) was 71.6 (±11.6) years, 59.5% were female, and 66.4% were white. Approximately 58.5%, 5.5% had coexisting hypertension, nephropathy, and hypertension or nephropathy. Overall, 56.9% were receiving ACEI/ARB therapy. Logistic regression indicated that patients with coexisting hypertension or nephropathy and hypertension were 72% and 36% more likely to use ACEI/ARB compared to patients without hypertension or nephropathy. However, patients with nephropathy were 24% less likely to receive ACEI/ARB therapy. Females, older patients, and patients of nonwhite races were also more likely to use ACEI/ARB. Patients with myocardial infarction, sleep apnea, coronary artery disease, retinopathy or heart failure were more likely to have used ACEI/ARB, while the opposite was true for those with hypercholesterolemia, peripheral vascular, cerebrovascular, or chronic obstructive pulmonary diseases. All results were statistically significant at P = 0.001 level. CONCLUSIONS: Less than 60% of Medicare Part D enrollees with diabetes received ACEI/ARB therapy. Several patient characteristics can predict ACEI/ARB use. Opportunities exist for quality improvement interventions that could increase the outcomes for high-risk patients.

MD7

DOES MEDICARE HAVE AN IMPLICIT COST-EFFECTIVENESS THRESHOLD?

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OBJECTIVES: Despite the huge cost of the program, the Centers for Medicare and Medicaid Services (CMS) maintains that cost-effectiveness is not considered in national coverage determinations (NCDs) for medical technologies. Our objective was to assess whether cost-effectiveness of technologies that are the subject of Medicare NCDs in order to investigate whether an implicit cost-effectiveness threshold exists. In addition, we explored whether CMS has cited cost-effectiveness evidence in NCDs.

METHODS: We reviewed NCD decision memos from 1999 through 2007 (n = 103). A limited review was conducted on each coverage decision to find relevant economic evaluations. The economic evaluation that best represented each coverage decision was included in a review of the cost-effectiveness of medical technologies considered in NCDs. RESULTS: Sixty-four coverage decisions were identified from 103 decision memos. Fifteen were associated with a positive coverage decision and 14 with a