

Abstracts

A13

control group included 25 propensity score matched clients (95,054 lives) not enrolled in the program. In the study group, the average total cost per prescription (normalized to 90-day supply) was significantly lower in 90-day retail than in mail service and 30-day retail (\$165.9 vs. \$170.65 vs. \$185.9). The generic utilization rate in 90-day retail was higher than in mail service but lower than 30-day retail (38.36% vs. 37.38% vs. 39.75%). From the pre to post period, in study group, PMPM total, plan and member costs among eligible lives increased by 7% (from \$29.54 to \$31.60), 6.5% (from \$22.29 to \$23.73) and 7.3% (from \$7.11 to \$7.63). In the control group, PMPM total, plan and member increased by 10.1% (from \$30.16 to \$33.22), 10.4% (from \$22.33 to \$24.65) and 9.3% (from \$7.72 to \$8.43). It was estimated that this 90-day retail program had PMPM cost savings of \$0.89, \$0.79 and \$0.10 for the total, plan and members. **CONCLUSIONS:** A 90-day retail program was found to have decreased total, health plan and member prescription drug costs.

HE2

ESTIMATING OUT-OF-POCKET PHARMACEUTICAL EXPENDITURES UNDER THE NEW MEDICARE DRUG LAW FOR PATIENTS WITH MENTAL DISORDERS—AN ANALYSIS OF CLAIMS DATA FROM RETIREE MEDICAL PLANS

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OBJECTIVES: Estimate out-of-pocket pharmacy expenditures for elderly retirees with employer-sponsored coverage, under the standard Medicare drug plans that began on January 1, 2006. **METHODS:** Data came from the Medstat MarketScan Medicare Database, for 2004. Data included all medical and pharmacy claims for 1,220,902 seniors enrolled in retiree plans offered by large employers. (About 30% of non-institutionalized Medicare enrollees have retiree coverage.) Payments covered by the Medicare program and by private insurance were included. Analyses focused on 30,681 patients with diagnoses of depression, anxiety disorder, or schizophrenia in 2004. We estimated the out-of-pocket payments that would have been incurred by these beneficiaries, if the Medicare drug law had been in effect during 2004. We also estimated how long it may take to enter the “donut hole” where coverage stops (i.e., that period during which total pharmacy expenditures range from \$2251 to \$5100). **RESULTS:** Mean total pharmacy payments for these mental health patients were higher than payments for other patients with retiree coverage (\$4491 for depression patients, \$3364 for anxiety patients, and \$5321 for schizophrenia patients, versus \$2587 for the average Medicare beneficiary). The average mental health patient filled over 50 prescriptions for all medical problems. More than 30% would have entered the donut hole. Schizophrenia patients would have entered after about 4 months (in April). Depression patients would fall into the donut hole after about 6 months, while anxiety patients would enter after about 9 months, on average. Average out-of-pocket pharmacy payments under the new law would have ranged from \$1858 for anxiety patients to \$2407 for schizophrenia patients. **CONCLUSIONS:** Most patients with these psychiatric conditions will face high out of pocket costs, and will be faced with a donut hole of no coverage. Implications for adherence to pharmacotherapy and overall health should be considered by doctors and policy makers.

HE3

DIFFERENTIAL RACIAL AND ETHNIC DISPARITIES IN HEALTH EXPENDITURE AND SELF-PERCEIVED HEALTH STATUS IN THE UNITED STATES

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OBJECTIVES: The research objective is to examine whether there are racial and ethnic disparities in health expenditures and health status. Health expenditure and health status are examined together because theoretically higher spending on health care services should lead to better health status. **METHODS:** The data were drawn from a nationally representative sample of non-institutionalized U.S. civilians in the Medical Expenditure Panel Survey (1996 and 2001). The racial and ethnic disparities were examined separately by comparing non-Hispanic whites, non-Hispanic blacks, and Hispanic whites (Hispanic blacks were excluded due to small sample size). Disparities in self-perceived health status (poor, fair, good, very good, and excellent) were compared across racial and ethnic groups using an ordered logistic regression. Disparities in health expenditure were compared using linear regression (A two-part model was also used to confirm the findings). **RESULTS:** The study sample included 31,258 non-Hispanic whites, 7349 non-Hispanic black, and 11,248 Hispanic whites. There was an overall significantly better self-perceived health status among non-Hispanic whites than non-Hispanic blacks and Hispanic whites: non-Hispanic blacks were 79.29% as likely to report a better self-perceived health status category compared to non-Hispanic whites ($P < 0.01$); Hispanic whites were 77.06% as likely to report a better self-perceived health status category compared to non-Hispanic whites ($P < 0.01$). Overall, non-Hispanic blacks and Hispanic whites spent \$690 less ($P < 0.01$) and \$1365 ($P < 0.01$) less than non-Hispanic whites every year. The racial disparities in health expenditures and self-perceived health status were significant after adjusting for confounders; ethnic disparities in health expenditures were still significant but ethnic disparities in health status were not significant. **CONCLUSIONS:** Compared with non-Hispanic whites, non-Hispanic blacks have lower health expenditure and worse self-perceived health status; Hispanic whites have lower expenditures but similar self-perceived health status. Further analysis is warranted to examine the causes for different patterns of racial and ethnic disparities.

HE4

RACIAL/ETHNIC DISPARITIES IN LENGTH OF STAY AND COST OF INPATIENT CARE FOR INTRACEREBRAL HEMORRHAGE: EVIDENCE FROM THE HEALTH CARE COST AND UTILIZATION PROJECT DATABASE

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Evidence from US national health surveys suggests that age-adjusted prevalence of stroke risk factors varies considerably by race/ethnicity. What is not known is whether resource use among hospitalized stroke patients, and the associated cost of inpatient care, differ by race/ethnicity. **OBJECTIVE:** To assess racial/ethnic differences in hospital length of stay and cost related to inpatient treatment of intracerebral hemorrhage (ICH) in US hospitals. **METHODS:** The 2002 Health Care Cost and Utilization Project database was used to examine short-stay acute-care hospital discharges among adult ICH patients. This dataset includes all discharges from 995 hospitals in 35 states. Patients were identified