breast cancer in 2008, for HCV treatments in April 2014, and, for an appraisal of new HCV treatments in December 2014. CONCLUSIONS: CTA approved a wide range of technologies but have only started appraising pharmaceuticals very recently. Gaining CTA approval is far from a formality with over half of appraisals being not recommended. As management of rising healthcare costs continues to become an increasing challenge, CTA will likely increase greater numbers of high-cost pharmaceuticals using cost-utility analyses with their recommendations potentially becoming increasingly influential.

**HEALTH CARE USE & POLICY STUDIES – Health Care Costs & Management**

**PHP61**

**HEALTHCARE RESOURCE UTILIZATION AMONG HISPANIC ADULTS RELATIVE TO NON-HISPANIC WHITE ADULTS IN THE US**

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**OBJECTIVES:** To characterize differences between Hispanic and non-Hispanic white adults in the United States with regard to healthcare resource utilization and costly health conditions. METHODS: Demographics and healthcare resource utilization among Hispanic and non-Hispanic white adults (≥20 years) were compared from a cross-sectional study using de-identified data from the 2013 National Health Interview Survey. The most costly health conditions for each population were identified from the 2010-2011 Medical Expenditure Panel Survey (MEPS). RESULTS: While sex distribution was similar in both cohorts, the Hispanic cohort was generally younger (P<0.001; 50.1% men vs 50.5% of non-Hispanic whites), had a greater risk of diabetes (9.3% vs 4.2%; P<0.001) and household income (P<0.001), although employment was higher (63.5% vs 57.5%; P<0.001). Relative to non-Hispanic whites, greater proportions of Hispanics were found to be smokers (P<0.001; distributed by the Centers for Disease Control and Prevention (CDC)), and were more likely to receive influenza vaccination (94.8% vs 90.4% ≥ 65 years; P<0.001). The use of medication was characterized by the number of people reporting use of ≥ 2 medications in the last 30 days. CONCLUSIONS: Hispanic adults were characterized by lower frequency and lower average amount paid. Medications were selected for further analysis into a patient-centered medical home (PCMH) model. Indirect financial resources that assist in collecting cost data may also promote diffusion of the PCMH model.

**PHP64**

A SYSTEMATIC REVIEW OF COST-EFFECTIVENESS ANALYSIS (CEA) STUDIES FROM THE PATIENT’S PERSPECTIVE

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**OBJECTIVES:** Patient-centered outcomes have become increasingly important and patient-centeredness is believed to drive healthcare decisions. However, the influence of patient’s perspective in economic evaluation studies remains unknown. This study sought to systematically review CEA studies conducted from the patient’s perspective. METHODS: A search of Cochrane EBM Database, ACP J Club, and PubMed through May 2014 for CEA studies that used patient’s perspective. Essential characteristics of these economic studies were extracted and compared. The reporting quality of studies using the SPIRIT guidelines was assessed. RESULTS: A total of 21 of 32 studies retrieved met the inclusion criteria. These studies, in average, met 17 of 24 reporting criteria specified in CHEERS. The studies included the US (5), Europe (6), Asia (2) and Oceania (9). The studies evaluated a large number of high-cost pharmaceuticals using cost-utility analyses with their recommendations (CEAs). Patient’s perspective in economic evaluation studies remains unknown. This study found that the quality of these studies was not optimal. Conclusions: The increasing focus on patient-centered outcomes in health policy research, use of patient’s perspective in economic studies should be advocated.

**PHSP**

**EFFECT OF PATIENT’S COST SHARING ON EXPENDITURES: AN INSTRUMENTAL VARIABLES APPROACH**

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**OBJECTIVES:** In observational studies, identification of the impact of increased cost sharing on expenditures is plagued by an individual’s self-selection into copayment and deductible levels based on their health state. The objective of this study was to evaluate the effect of increasing patient’s cost sharing on future third party expenditures using an instrumental variables (IV) approach to mitigate selection bias. METHODS: Data from the Medical Expenditure Panel Survey’s Longitudinal Household Component (2011-2012), a nationally representative survey of the U.S. civilian non-institutionalized population, was used. Analysis accounted for the survey’s clusters, strata, and sampling weights. Respondents included in the study if they were at or above the age of 18 and if they had insurance coverage. We evaluated the effect of patient’s out-of-pocket payments on total third party expenditures in the following year, using a limited information maximum likelihood IV estimator. The three excluded instruments determining self-selected levels of cost sharing were, attitudes toward health insurance, attitudes that might influence decisions to use health services, and perceived physical health status. We evaluated the validity of our IV estimation assumptions on instrument relevance and exogeneity using several tests. Other covariates adjusted in the models included age, sex, race, ethnicity, family size, income, geographic-location, and comorbidities in 2011. RESULTS: The mean age of the sample was 46 with a majority of female (52%), Caucasian (81%), and non-Hispanic (85%). The endogeneity test rejected the null hypothesis that there was no endogeneity. The IV estimated that one dollar increase in patient’s cost sharing increased future third party expenditures by $12.6 (95% CI = 5.7 to 19.4). In contrast, naive estimates ignoring endogeneity obtained a modest increase of $0.6 (95% CI = 0.2 to 1.0). CONCLUSIONS: Health policy effect of increasing patient’s cost sharing to reduce health expenditures may have an opposite effect and increase future expenditures.

**PHP66**

ECONOMIC IMPACT OF WASTE IN PRESCRIBING, DISPENSING, AND MEDICATION CONSUMPTION IN THE UNITED STATES

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**OBJECTIVES:** Personal and other medication waste is an important issue in small primary care practices (<10 full-time equivalent [FTE] providers), which serve a large number of outpatients. Therefore, the objective of this study was to estimate the cost of achieving and sustaining PCMH recognition for small primary care practices. METHODS: Using semi-structured interviews, we developed a cost collection tool and disseminated it to a self-selected cohort of 11 small primary care practices that had previously achieved PCMH recognition from the NCQA. We assessed the cost of transformation between 2008 and 2011 using the tool. The cost of transformation was divided into four categories: the cost of NCQA patient centered recognition activities, the application cost of obtaining recognition, the cost of changes to practice culture, and the costs of changes to care coordination managed and weighted by the number of FTE providers in each practice in order to make the results comparable across practices. RESULTS: Three practices completed the tool, and reported average costs per FTE provider was $1,725 in the year before recognition was achieved, and $38,216 in the recognition year itself. The most costly patient-centered activity (weighted average) in the pre-transformation year was “providing self-care support” ($4,663/FTE provider), while “improving and improving performance” ($5,950/FTE provider) was the highest cost in the transformation year. CONCLUSIONS: The cost of recognition as a PCMH is a substantial but not insurmountable barrier to practice transformation. This information can inform decisions by payers and policymakers to direct financial resources to primary care practices as they transform to the PCMH model. Indirect financial resources that assist in collecting cost data may also promote diffusion of the PCMH model.