HEALTH CARE USE & POLICY STUDIES – Formulary Development

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USE OF ECONOMIC EVIDENCE TO INFORM DRUG REIMBURSEMENT DECISION MAKING: THE CASE FOR ONTARIO

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OBJECTIVES: The Ontario Drug Benefit (ODB) Formulary is the publicly funded provincial drug plan in Ontario. Drugs are included subsequent to a review of submitted clinical trials and pharmacoeconomic evidence by the Committee to Evaluate Drugs (CED). The objective of this analysis was to examine the degree to which economic evidence was utilized to inform drug reimbursement decision making in Ontario.

METHODS: Retrospectively, CED recommendations for drug reimbursement were reviewed. During the period 2007 to November 2012, 82 drug requests were classified into seven categories (i.e., evaluation and management, procedures, imaging, tests, durable medical equipment, other, and unclassified). Economic evidence development, real-world, real-life setting.

RESULTS: A total of 14 surveys were completed. Feedback and actionable information consisted of suggestions on clinical study design (36%), need of additional Health Economics and Outcomes Research (HEOR) studies (20%), and insights regarding pricing & reimbursement (11%). Feedback from HTAC influenced important interactions with global experts early in development; moreover, all suggested that additional time be allowed to prepare for HTAC meetings. All clinical input to HTAC Leads indicated they would recommend it to a colleague. CONCLUSIONS: The most frequent HTAC advice involved suggestions to improve clinical study design. HTAC also recommended performing additional HEOR studies. In many instances, feedback from HTAC influenced leadership committee decision-making, such as licensing agreements.

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SOURCES OF SPENDING VARIATION IN PROFESSIONAL SERVICES AMONG TEXAS HOSPITAL REFERRAL REGIONS: AN ANALYSIS OF PRIVATE INSURANCE POPULATION

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OBJECTIVES: Health care expenditure in the United States is expected to be 19% of GDP by 2017. Economic evidence about cost for a substantial portion of health care spending. The study aims to decompose the source of spending variation in professional services across Texas hospital referral regions (HRRs) due to quantity, price, health risk and cost of doing business. METHODS: The study used 2011-2012 professional claims data for insured members enrolled in indemnity medical insurance plans of Blue Cross/Blue Shield (BCBS) of Texas, largest commercial insurance provider in Texas. Professional claims were classified into seven categories (i.e., evaluation and management, procedures, imaging, tests, durable medical equipment, other, and unclassified) using the Berenson- Eagles- Types of Service (BTES) code and Health Care Procedure Coding System (HCPCS) procedure codes. Geographic variation in spending per capita for each category was decomposed into quantity, price, cost of doing business and health risk.

CONCLUSIONS: There was variation in price (56.9%), followed by price (19%), cost of doing business (8.4%) and health risk (4.1%). Across categories, variation due to price was observed to be the highest for procedures (28.2%) and evaluation and management (22.4%) categories. Quantity accounted for majority of variation for imaging (80.5%), tests (83.2%), durable medical equipment (80.9%) and other (76.8%) categories. Contribution of health risk in explaining variation was relatively small for all professional subcategories (0.3% to 7.0%).

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ANALYSIS OF AVERAGE MANUFACTURER PRICES OF NEW DRUGS APPROVED IN THE UNITED STATES (1990-2012)

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OBJECTIVES: Reimbursement of brand drugs is typically set as a percentage of manufacturers’ listed prices. This study evaluates trends in the average prices at market entry of oral solid forms of new molecular entities (NMEs) approved by the FDA Food and Drug Administration (FDA) in the period 1990-2012. METHODS: Drug regulatory information derived from the FDA. Daily defined dosages (DDD) were collected from the World Health Organization. Average wholesale prices (AWP) per unit at market entry derived from the Redbook. Prices were converted to 2013 dollars using the consumer price index. Descriptive statistics, 95% confidence intervals and t-tests were performed in the analysis. RESULTS: The FDA approved 576 NMEs during the study period; 506 were marketed as of Dec 31, 2013 and thus included. A total of 146 drugs had a solid oral form at approval. The analysis was conducted with complete DDD and price information. There were 141 NMEs approved in the 1990s, 80s and 70s in the period 2000-2013. The average AWP per DDD was $65.55 (95% CI: $62.99-$68.11, 55.53-$66.55) in the 2000s, and $112.83±$175.27 (95% CI: $36.02-$189.64) in the period 2000-2013. The average AWP per DDD was significantly higher (p<0.001) for FDA priority review drugs ($59.61±$13.90, 55.53-$66.55) in the 1990s, $43.80±$8.23 (n=83, n=83) than for standard review drugs ($28.52±$5.19, 20.13-36.90) in the 1990s, $45.84, n=224) than for discontinued drugs ($8.15±$5.30, 5.76-$10.53, £26.54±$7.25, 16.57-$36.53). Last, the AWP was significantly higher ($34.91±$8.10) in the period 2008-2013 than in the period 2000-2007 ($28.52±$5.19, 20.13-36.90, p<0.001).