PODIUM SESSION III: MEDICARE STUDIES

MD1 IMPACT OF MEDICARE PART D COVERAGE ON HEALTH OUTCOMES IN END-STATE RENAL DISEASE

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OBJECTIVES: To evaluate the impact of Medicare Part D coverage on health outcomes in dialysis patients. METHODS: A retrospective analysis (2006-2009) of the United States Renal Data System was conducted for Medicare-eligible dialysis patients. Cardiovascular disease morbidity, health care utilization and expenditures, medication adherence, and mortality rates were compared, categorized based on patients’ Part D coverage in 2007 for those who: 1) did not reach the coverage gap (cohort 1); 2) reached the coverage gap but did not receive catastrophic coverage (cohort 2); 3) reached catastrophic coverage (cohort 3); and 4) did not reach the coverage gap but received a low-income subsidy (cohort 4). Cox proportional hazard models, Kaplan-Meier methods, logistic regressions, generalized linear models, and generalized estimating equations were used. RESULTS: A total of 11,732 patients were identified. After adjusting for demographic and clinical factors, patients in cohort 2 and cohort 4 had 40% and 38% increased risk of cardiovascular disease (odds ratio (OR)=1.40, 95% confidence interval (CI):1.19-1.65, OR=1.36, 95% CI:1.09-1.71); and had 33% and 32% higher death rates compared to those in cohort 4, respectively (hazard ratio (HR)=1.33, 95% CI:1.25-1.42, HR=1.32, 95% CI:1.22-1.43). Patients in cohort 2 were more likely to be nonadherent to medications for diabetes (relative risk (RR)=6.91, 95% CI:1.54-8.73), hypertension (RR=3.59, 95% CI:1.32-4.14), hyperlipidemia (RR=3.55, 95% CI:2.18-5.74), dyslipidemia (RR=3.52, 95% CI:2.96-4.16), and hyperparathyroidism (RR=4.25, 95% CI:1.82-9.56) after reaching the coverage gap. These patients had total medical costs that were 5% higher (OR=1.05, 95% CI:0.96-1.16) due to increased rates of hospitalization (OR=1.26, 95% CI:1.12-1.41) and outpatient visits (OR=1.12, 95% CI:1.02-1.59), despite lower pharmacy costs (OR=0.86, 95% CI:0.83-0.89) compared to patients in cohort 4. CONCLUSIONS: Reaching the Part D coverage gap was associated with decreased medication adherence and unfavorable clinical and economic outcomes in dialysis patients.

MD2 SKELETAL-RELATED EVENTS AND MORTALITY AMONG SEER-MEDICARE PATIENTS WITH METASTATIC PROSTATE CANCER: THE IMPLICATIONS OF MEASUREMENT APPROACH

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OBJECTIVES: To investigate the survival impact of skeletal-related events (SRE) as a cluster of events and by type of SRE, including pathological fracture (PF), spinal cord compression (SCC), and bone surgery (BS), using three claims-based approaches. METHODS: We analyzed prostate cancer (PCa)-specific and all-cause mortality among elderly SEER-Medicare men diagnosed with metastatic PCa between 2000 and 2007. FF, SCC, and BS were identified from Medicare claims and used to define SRE using a base case and alternative approaches (AltA). The approaches included: 1) base case: SRE follows claims with a bone metastasis (BMD); 2) AltA-1: SRE includes BM diagnosis code on the SRE claim; and 3) AltA-2: SRE is not anchored to BM. A Cox model provided covariate-adjusted hazard ratios (HR) for the full sample (FS) and in a propensity-score matched sample (PSMS). RESULTS: Application of inclusion/exclusion criteria resulted in 7,062 patients in FS (1,776 in PSMS). PCa-specific mortality was 54% during median (mean) follow-up of 659 (837) days. Using the base case approach, the prevalence of FF, SCC, and BS was 17%, 1.9%, and 1.9%, respectively. FF prevalence was 9.7% for AltA-1 and 17.1% for AltA-2. The HR (95% CI) associated with any SRE was 1.27 (1.16-1.39) for the base case approach, 1.31 (1.18-1.45) for AltA-1, and 1.07 (0.98-1.16) for AltA-2. Results were qualitatively similar for all-cause mortality. The HRs for SCC and FF were statistically significantly associated with PCa-specific mortality across approaches. The results for BS were sensitive to the SRE definition. Results for SCC and FF were unchanged from the base case approach when using the PSMS. CONCLUSIONS: The prevalence of SREs and their association with survival in the elderly depends on the definition of SREs. A validated claims-based measure of SRE is warranted to better understand the burden of SRE among PCa patients.

MD3 ASSOCIATION BETWEEN INHALED ANTICholinERGIC USEn AND ALL-CAUSE MORTALITY AMONG ELDERLY MEDICARE BENEFICIARIES WITH RESPIRATORY DISEASES

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OBJECTIVES: To evaluate the association between inhaled anti-cholinergic (IAC) use and all-cause mortality among elderly individuals with respiratory conditions after controlling for co-occurring chronic physical and mental health conditions and self-reported perceived health status. METHODS: Retrospective cohort analysis of survey data from multiple years (2000-2009) of the Medicare Current Beneficiary Survey (MCBS). Generic and brand names of IACs were used to identify IAC utilization from the self-reported prescription medication file. All cause mortality was assessed by using the death certificate in the enrollment file. Unadjusted group differences in mortality and IAC utilization rates were tested using chi-square statistic. Logistic regressions independent variables entered in separate blocks were used to analyze the association between IAC use and all-cause mortality after controlling for co-occurring chronic conditions, demographic, socio-economic, health, functional status, smoking and obesity. Self-reported health status was used as a stratifying variable to control for selection bias associated with IAC use. All analyses accounted for the complex design of the MCBS. RESULTS: Of the 20,042 elderly Medicare beneficiaries used IAC, IAC use was significantly higher among those who reported fair to poor health compared to those with excellent to good health (adjusted ORs 18.0%). IAC use was associated with greater risk of mortality in the overall model. However, findings from the stratified regression indicated that IAC use was beneficial for those with fair to poor health [AOR: 0.62, 95% CI: 0.45, 0.85]. CONCLUSIONS: Among elderly individuals with respiratory conditions who were interviewed for this research felt that treatments of posterior non-infectious uveitis (orphan condition), opinions on a treatment for posterior non-infectious uveitis (orphan condition), opinions on a treatment for posterior non-infectious uveitis (orphan condition). The evolving payer landscape due to the implementation of ACA will lead to administrative burden and inconsistent access.

PODIUM SESSION III: PRICING STUDIES

PR1 PAYER PERSPECTIVES ON DRUG PRICING, COVERAGE, AND REIMBURSEMENT IN OPHTHALMOLOGIC ORPHAN CONDITION IN THE UNITED STATES

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OBJECTIVES: Traditionally, treatments for orphan conditions have faced fewer pricing and reimbursement hurdles by managed care organizations in the United States. Given the downward pressure on health care spending and anticipated full implementation of the Affordable Care Act, we sought to better understand whether payer perspectives were evolving to more restrictive coverage and downward pricing pressure for treatments of orphan conditions like posterior non-infectious uveitis. METHODS: We conducted 20 in-depth, qualitative, 60-minute interviews with key decision-makers (medical and pharmacy directors) at managed care organizations in the United States. Interviews included questions related to current orphan drug policy, awareness of posterior non-infectious uveitis (orphan condition), opinions on a treatment for posterior non-infectious uveitis currently under development, and potential pricing and reimbursement based on anticipated clinical trial endpoints. RESULTS: Of the 20 medical and pharmacy directors interviewed as part of this research, 10 (50%) felt that orphan treatment coverage policies will evolve independent of future health care changes due to the full implementation of the Affordable Care Act. When asked to consider factors that impact coverage policies for a novel orphan treatment for posterior non-infectious uveitis, 14 (70%) felt that the clinical effectiveness and clinical utility of the product is the most important factor for coverage, although budget impact may increase coverage specifications. CONCLUSIONS: The evolving payer landscape due to the implementation of ACA indicated increasing levels of scrutiny about coverage of orphan drugs, but payer perspectives were evolving to more restrictive coverage and downward pricing pressure for treatments of orphan conditions like posterior non-infectious uveitis will be covered, though the budget impact of treatment may increase utilization management at the pharmacy level.

PR2 SHORTCOMINGS OF EQ-5D IN A VALUE-BASED PRICING FRAMEWORK

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OBJECTIVES: To examine the association between inhaled anti-cholinergic (IAC) use and all-cause mortality among elderly individuals with respiratory conditions after controlling for co-occurring chronic physical and mental health conditions and self-reported perceived health status. METHODS: Retrospective cohort analysis of survey data from multiple years (2000-2009) of the Medicare Current Beneficiary Survey (MCBS). Generic and brand names of IACs were used to identify IAC utilization from the self-reported prescription medication file. All cause mortality was assessed by using the death certificate in the enrollment file. Unadjusted group differences in mortality and IAC utilization rates were tested using chi-square statistic. Logistic regressions independent variables entered in separate blocks were used to analyze the association between IAC use and all-cause mortality after controlling for co-occurring chronic conditions, demographic, socio-economic, health, functional status, smoking and obesity. Self-reported health status was used as a stratifying variable to control for selection bias associated with IAC use. All analyses accounted for the complex design of the MCBS. RESULTS: Of the 20,042 elderly Medicare beneficiaries used IAC, IAC use was significantly higher among those who reported fair to poor health compared to those with excellent to good health (adjusted ORs 18.0%). IAC use was associated with greater risk of mortality in the overall model. However, findings from the stratified regression indicated that IAC use was beneficial for those with fair to poor health [AOR: 0.62, 95% CI: 0.45, 0.85]. CONCLUSIONS: Among elderly individuals with respiratory conditions who were interviewed for this research felt that treatments of posterior non-infectious uveitis (orphan condition), opinions on a treatment for posterior non-infectious uveitis (orphan condition). The evolving payer landscape due to the implementation of ACA will lead to administrative burden and inconsistent access.