PH18
COSTS OF GLOBAL ENDOMETRIAL ABLATION (GEA) FOR TREATMENT OF HEAVY MENSTRUAL BLEEDING (MENORRHAGIA): ASSIMILATION AND COMPARISON OF RESULTS FROM PUBLISHED COST-EFFECTIVENESS MODELING STUDIES
Miller ID
Truven Health Analytics, Cambridge, MA, USA
OBJECTIVES: Most cost-effectiveness modeling studies of global endometrial ablation (GEA) for treatment of heavy menstrual bleeding (menorrhagia) are from a UK perspective. Costs and cost-effectiveness information about GEA from a US perspective are lacking. Study objectives were: 1) assimilate all cost-effectiveness modeling studies of GEA; 2) assimilate GEA costs across these studies at current levels (2012 US dollars) to proxy a US market perspective; and 3) perform international summarizations of the data.
METHODS: All published literature and health technology assessments of menorrhagia treatment cost-effectiveness published 2004-2012 were reviewed; studies with GEA as a comparator were selected for inclusion. GEA cost data were abstracted and converted to US dollars using purchasing power parity indices (PPP) and adjusted to 2012 levels using the US consumer price index (CPI). Statistical summarizations (minimum, maximum, mean, median) were performed for studies in their respective 1-, 2-, 5-, and 10-year analysis scenarios. RESULTS: From a total of eight cost-effectiveness modeling studies, 14 GEA cost data values were abstracted. All values pertained to either microwave endometrial ablation (MEA) or thermal balloon endometrial ablation (TBEA), or a composite weighted average of the two techniques. No studies reported costs associated with cryoablation, bipolar radiofrequency ablation, or hydrothermal ablation (HTA). Adjusted GEA costs from two 1-year analyses ranged from $1,011 to $3,929 (mean $2,458). From a study 2-year analysis was $2,580. Costs from four 5-year analyses ranged from $2700 to $3748 (mean $3359, median $3493). Costs from seven 10-year analyses ranged from $2495 to $4549 (mean $3264, median $3159). CONCLUSIONS: There was a large degree of heterogeneity in summarizing the cost-effectiveness of cost accounting in the GEA cost analyses summarized here. Although only proxy estimates of GEA costs in the US, results of this study serve as useful benchmarks for cost evaluations of GEA in the dramatically changing menorrhagia-treatment market.

PH19
A CASE-CONTROLLED, RETROSPECTIVE ANALYSES OF PRETERM LABOR AND PRETERM BIRTH IN PREMIEVER PERSPECTIVE HOSPITAL DATABASE (2003-2010)
Black L1, Carroll C1
1GlazierSmithKline, Research Triangle Park, NC, USA, 2GlazierSmithKline, RTP, NC, USA
OBJECTIVES: To assess a cohort of women who received a diagnosis of preterm labor (PTL)/preterm birth (PTB), and to compare the health care burden of these cohorts to term deliveries/infants. Secondary outcomes included summaries of resource utilization and costs. Maternal cases and controls and infant cases and controls were matched 1 to 1, based on year of delivery/birth, mother’s delivery age (mothers only), race, provider area, rural/urban, and payor type.
RESULTS: A total of 2,649 cases of preterm labor and a diagnosis of preterm birth from the PTB database were identified (9.4%) in 2003 and the most (15.5%) in 2009. Tocolytic drug use was recorded in 37% of cases. Cases with delivery had a mean length of stay (LOS) of 3.06 days (controls = 2.25 days) and mean per patient costs of $8032 (controls = $5311). There were 1134 live births with either a stillbirth or death in the birth weight ICD9 code. Total mean cost per case with in-hospital deaths included was $70,074 (controls = $45,504). More deaths occurred in the case cohort vs. controls. (Baseline December 1994 vs. 121, reduced $5527) Primary reasons for these deaths were attributable to excess inpatient and outpatient/physician office costs. For Medicaid, the excess costs were approximately equally distributed among all places of services. Among the privately-insured, the VL patients and controls incurred similar drug costs, however, VL patients had $454 more in work-loss costs (absenteeism: $367, disability: $87). (Comparisons significant at p<0.001).
CONCLUSIONS: With VL incidence estimates of 2.5 million, these findings suggest an annual payer burden up to $18 billion.

PH20
HEALTH-ECONOMICS ANALYSIS OF DISEASES RELATED TO THE DISTURBANCES OF ADAPTATION: A COST OF ILLNESS STUDY
Roncej K1, Kovacs GL1, Tirt T1, Agoston I1, Molics B2, Bodis J3
1University of Pecs, Pecs, Hungary
OBJECTIVES: The aim of this study is to perform the health-economics analysis of diseases related to disturbances of adaptation by a cost of illness study in Hungary. METHODS: Data were derived from the financial dataset of the National Health Insurance Administration (OEP) covering the year 2009. Four main groups were identified: 1) polycystic ovary syndrome, 2) respiratory distress syndrome of newborn (PDS), 3) retinopathy of preterm newborn (RPO) and 4) orthopedic dysplasia (HUF 31,134 or EUR€11,060 per patient/year). RESULTS: The annual health insurance expenditures of diseases related to the disturbances of adaptation are high (HUF 1689 million or EUR€6.02 million) and among that diseases respiratory distress syndrome of newborn has the highest burden of disease.

PH21
MEDICAL, DRUG, AND WORK-LOSS COSTS OF VENOUS LEG ULCERS
Rice BJ1, Desai U1, Cumming AK1, Birnbaum HC2, Skornicki M1, Parsons N2
1Analysta Group Inc., Boston, MA, USA, 2Organogenesis Inc., Canton, MA, USA
OBJECTIVES: To estimate medical, drug, and work-loss costs of venous leg ulcers (VLU) using de-identified administrative claims data.
METHODS: Beneficiaries with (VLU) and without VLU (controls) were identified using two databases: ages 65+ from a 5% random sample of Medicare beneficiaries (Standard Analytical Files, 2007-2010; VLU N=60,840, controls N=699,506) and ages 18-64 from a privately-insured population (OptumInsight, 2007-2011; VLU N=26,096, controls N=1,300,455). Patients were required to be continuously eligible during the 12 months before (baseline) and 12 months after (study period) the index date (i.e., the date of the most recent VLU diagnosis following 12 months without VLU diagnoses (VLU group); or the date of a random medical claim (controls)). VLU patients were matched to controls using propensity scores to account for baseline differences in demographics, comorbidities, resource utilization, and costs. Medical costs incurred during the study period were calculated for both Medicare and privately-insured patients. Because drug and work-loss (absenteeism or disability) data were unavailable for Medicare patients, these costs were estimated for the privately-insured sample only. Differences in study period costs were compared using Wilcoxon signed-rank tests.
RESULTS: During the study period, HUF 1,305,374 in VLU patients and HUF 881,861 in matched pairs of controls were analyzed. VLU patients incurred incremental medical costs of HUF 6,080 in Medicare ($18,246 vs. $12,165), with privately-insured VLU patients having excess medical costs of $7,012 ($13,552 vs. $6,540). Among the privately-insured, 89% of the cost differential was attributable to excess inpatient and outpatient/physician office costs. For Medicare, the excess costs were approximately equally distributed among all places of service. Among the privately-insured, the VLU patients and controls incurred similar drug costs, however, VLU patients had $454 more in work-loss costs (absenteeism: $367, disability: $87). (Comparisons significant at p<0.001).
CONCLUSIONS: With VLU incidence estimates of 2.5 million, these findings suggest an annual payer burden up to $18 billion.

PH22
COMPARATIVE DIRECT AND INDIRECT COSTS OF MENORRHAGIA TREATMENT WITH GLOBAL ENDOMETRIAL ABLATION OR HYSTERECTOMY
Bonafea MM1, Miller J, Meyer NM, Linhart GM
1Truven Health Analytics, Cambridge, MA, USA
OBJECTIVES: To describe the treatment patterns, health care utilization, medical, and productivity costs among commercially insured women initiating menorrhagia treatment with global endometrial ablation (GEA) or hysterectomy. METHODS: Women aged 30-55 years with diagnosed menorrhagia who initiated menorrhagia treatment with GEA or hysterectomy (index event) during 2006-2010 were identified in the Truven Health MarketScan® Commercial Claims and Encounters Database. One-year of continuous enrollment pre- and post-index were required to evaluate treatment patterns and characteristics. Health care utilization and costs (2011 USD) were assessed in the year following treatment initiation. Workplace absenteeism and short-term disability (STD) costs were assessed using a medical-records linked cost algorithm (RESULTS: In total, 61,602 study patients initiated menorrhagia treatment with GEA compared to hysterectomy (33.7%). Average age was similar between treatments (43.2 years), 77% of the cases were from Medicare beneficiaries. VLU patients and controls incurred similar drug costs, however, VLU patients had $454 more in work-loss costs (absenteeism: $367, disability: $87). (Comparisons significant at p<0.001). CONCLUSIONS: With VLU incidence estimates of 2.5 million, these findings suggest an annual payer burden up to $18 billion.

PH23
COST-EFFECTIVENESS OF 13-VALENT VERSUS 23-VALENT PNEUMOCOCCAL POLYSACCHARIDE VACCINE AND NO VACCINATION IN THE CZECH NATIONAL VACCINATION PROGRAM
Zigmond J1, Tichopad A1, Kolek V2, Roberts CS3, Hajek P4
1Zigmond J1, Tichopad A1, Kolek V2, Roberts CS3, Hajek P4
1VACCINATION PROGRAM POLYSACCHARIDE VACCINE AND NO VACCINATION IN THE CZECH NATIONAL VACCINATION PROGRAM

PH24
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IMPACTS ON CHILDREN AND IS CURRENTLY BEING EVALUATED FOR USE IN ADULTS IN THE CZECH REPUBLIC. THE OBJECTIVE OF THIS STUDY WAS TO ASSESS THE COST-EFFECTIVENESS OF VAGINAL PROGESTERONE GEL IN REVERSING PRETERM BIRTH: A DECISION ANALYTIC MODEL BASED ON THE PREVENTION RANDOMIZED CLINICAL TRIAL.

PIZZI L1, SELIGMAN N, BAXTER N, JURKOWITZ P, PRIZL K, MEARNS B, BERGHELLA V1
1Thomas Jefferson University, Philadelphia, PA, USA, 2University of Rochester Medical Center, School of Medicine and Dentistry, Rochester, NY, USA, 3Jefferson Medical College, Philadelphia, PA, USA, 4University of Minnesota, Minneapolis, MN, USA, 5Jefferson School of Pharmacy, Philadelphia, PA, USA

OBJECTIVES: Preterm birth (PTB) is a costly public health problem that causes significant maternal and perinatal morbidity and mortality. In the United States, 12% of PTB is attributed to vaginal progesterone gel (VP) in the prevention of preterm birth (FTP), we developed a decision analytic model using data from the PREGNANT trial. METHODS: PREGNANT was a multi-center, international RCT in which 459 women with singleton gestations and short cervix (<10mm by transvaginal ultrasound) were randomized to daily vaginal 8% gel (n=235) or placebo (n=224). Patient-level trial data along with cost data from the literature were used to develop the model (Figure 1). RESULTS: Births were categorized by gestational age at delivery: PTB at <28 weeks, PTB at 28-31 weeks, PTB at 32-36 weeks, or full term (<37 weeks). Costs ($US 2011) included cervical length screening, VP gel (treatment and adverse events), antenatal hospitalizations, cerclage, and antenatal hospitalization (maternal + neonatal costs). The main outcome measure was incremental cost-effectiveness, calculated as the difference in total costs between the VP gel group and the placebo group, divided by the difference in the number of PTB at <37 weeks. The VP gel group resulted in $407 per PTB avoided, with a 95% CI of $179 to $635. CONCLUSIONS: VP gel is cost-effective in the prevention of PTB in women with short cervix who were not at risk for in preterm birth in women with short cervix as compared to no treatment.