with invasive early-stage BC from 2003 to 2006 were selected from the SEER-Medicare linked dataset. Multivariate logistic regression models examined the relationship between type of treatment and various independent factors. RESULTS: Overall, 54% received BCS+RT, 23% received mastectomy, and 24% received BCS without RT. The likelihood of mastectomy or BCS without RT was greater for women with increasing age (<40 vs. ≥60) (AOR, 0.53; 95% CI, 0.46-0.61) and (AOR, 0.35; 95% CI, 0.29-0.41), stage (I vs. IV) (AOR, 2.48; 95% CI, 2.26-2.74) and (AOR, 3.19; 95% CI, 2.91-3.50), and non-white vs. white (AOR, 1.30; 95% CI, 1.17-1.44) and (AOR, 1.37; 95% CI, 1.14-1.61). The likelihood of mastectomy or BCS without RT was decreased for those who saw an oncology vs. general surgeon (AOR, 0.73; 95% CI, 0.62-0.85) and (AOR, 0.52; 95% CI, 0.45-0.61), lived in metro areas (AOR, 0.68; 95% CI, 0.62-0.75) and (AOR, 0.72; 95% CI, 0.65-0.78), patients with higher education (AOR, 0.72; 95% CI, 0.67-0.78) and (AOR, 0.78; 95% CI, 0.72-0.84), and higher income (AOR, 0.89; 95% CI, 0.81-0.97) and (AOR, 0.85; 95% CI, 0.78-0.92), than women who received BCS+RT. CONCLUSIONS: Treatment for early-stage BC is associated with socio-demographic characteristics and factors such as stage, surgeon specialty, and comorbidities, perhaps reflecting a notion that RT is not well tolerated among the elderly. Treatment could be improved by ensuring all patients are informed of, have access to, and receive full treatment, unless meeting specific treatment guideline criteria for exemption.

PCN160

Payers’ Views on Heterogeneity of Treatment Effect in Oncology

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OBJECTIVES: To describe how US payers use heterogeneity of treatment effect (HTE) evidence when formulating coverage policies for oncology drugs. METHODS: A qualitative approach using semi-structured in-depth interviews with 15 payers was used in to answer our question. An interview guide was developed based on theory and pilot interviews. Themes that emerged from content analysis were summarized. RESULTS: US payers understand the importance of using HTE evidence in oncology. However, the utility of such evidence to inform real-world coverage decision making is questionable. The Food and Drug Administration (FDA) label is the most overwhelming determinant of whether HTE evidence gets incorporated into a coverage policy. If not in the FDA label, payers find it difficult to use HTE evidence due to the inability to precisely differentiate responders from non-responders and the logistical difficulty to operationalize HTE. All payers reported that subgroup analyses on randomized clinical trial data are the most trusted source to establish HTE evidence. In addition to the FDA label, payers also consider treatment guidelines, quality/magnitude of HTE evidence, availability of effective alternative substitutes, treatment line, cancer aggressiveness, and politics. When a biomarker and a companion diagnostic is involved, the degree to which HTE evidence is incorporated into coverage policies will also depend on the clinical and analytic validity of the test and the ability to accurately and pragmatically distinguish responders from non-responders. Most payers indicated that if oncologists steer treatments to patients who are expected to benefit, there would not be a need for a policy, however, if a physician practice gap is evident, a coverage policy that incorporates HTE would be crucial. CONCLUSIONS: Payers’ oncology coverage decisions are impacted by a myriad of factors, especially the FDA label. Payers require more definitive HTE evidence in order to make more efficient coverage decisions.

PCN161

ACCESS TO A MEDICAL HOME AND ITS IMPACT ON HEALTHCARE UTILIZATION AND MEDICAL EXPENDITURE AMONGST CANCER SURVIVORS

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OBJECTIVES: The patient centered medical home (PCMH) is a model of delivering primary care with features such as comprehensive, coordinated, continuous and accessible care. The high cost and intensive long-term care requirements of cancer survivors makes this population a perfect candidate for the PCMH model of care. The objective of this study is to determine if access to a PCMH is associated with lower healthcare costs and utilization among cancer survivors. METHODS: The study population was drawn from the 2008-2012 data of the Medical Expenditure Panel Survey. The final sample included 7,081 adults with a history of at least one type of cancer. Multivariate logistic regression models examined the relationship of access to a PCMH was associated with reduced ED visits and prescription drugs use amongst cancer survivors. However, no difference in inpatient or outpatient visits, or overall medical expenditures were found.

PCN162

CLAIMS INSURANCE STATUS AND THE CHRONIC DISEASE INDEX AS PREDICTORS OF MEDICAL EXPENDITURE AMONG CANCER SURVIVORS


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OBJECTIVES: The objective of this study is to assess whether claims insurance status and the Chronic Disease Index can predict medical expenditures among newly diagnosed breast cancer patients. METHODS: We used a large national claims insurance database for breast cancer patients newly diagnosed with breast cancer from 2010 to 2014. The Chronic Disease Index, a standardized measure to predict the prevalence of chronic conditions, was used to predict medical expenditures. RESULTS: There was a significant difference in the Chronic Disease Index and the Medical Expenditure Index among newly diagnosed breast cancer patients. The Chronic Disease Index was a significant predictor of medical expenditures in the newly diagnosed breast cancer population. CONCLUSION: The Chronic Disease Index could be a useful tool to predict medical expenditures among newly diagnosed breast cancer patients.

PCN163

WITHDRAWN

PCN164

THE IMPACT OF GENOMIC TESTING ON CHEMOTHERAPY USE AND MEDICAL SPENDING IN A COMMERCIALLY-INSURED POPULATION OF BREAST CANCER PATIENTS

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OBJECTIVES: The 21-gene recurrence score assay (RS) (Oncotype Dx, Genomic Health, Redwood City, CA) is a genomic test guiding adjuvant chemotherapy use in patients with early-stage breast cancer. We assessed the association between RS receipt and subsequent chemotherapy use and medical expenditures among newly diagnosed early-stage breast cancer patients with commercial insurance. We also explored whether the effects of RS receipt varied by patient age. METHODS: The 21-gene recurrence score assay (RS) is a genomic test guiding adjuvant chemotherapy use in patients with early-stage breast cancer. We assessed the association between RS receipt and subsequent chemotherapy use and medical expenditures among newly diagnosed early-stage breast cancer patients with commercial insurance. We also explored whether the effects of RS receipt varied by patient age. RESULTS: RS receipt ranged from 40% among women <45 years to 67% among women 60-64 years (p<0.04). Chemotherapy use declined from 68% among women <45 years to 37% among women 60-64 years (p<0.001). RS receipt was associated with lower adjusted chemotherapy use among women <55 years (age <45: 61% vs. 73%, p=0.14; age 45-49: 33% vs. 61%, p<0.001; age 50-54: 36% vs. 55%, p=0.010), but not among women ≥55 years (age 55-59: 48% vs. 49%, p=0.83; age 60-64: 41% vs. 40%, p=0.88). RS receipt also had a larger impact on adjusted medical spending among women <55 years (age <45: $102,000 vs. $118,000, p=0.04; age 45-49: $150,000 vs. $180,000, p=0.02; age 50-54: $160,000 vs. $190,000, p=0.003).