PHS127 HEALTH SERVICES UTILIZATION AND COSTS AMONG EMPLOYED ADULTS WITH DEPRESSION
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OBJECTIVES: Depression is a major cause of increased work absence and low productivity increasing the total healthcare costs. Continuing to work while suffering from depression (presenteeism) may actually improve patient condition through collegial support and reduce healthcare costs, however, there is not enough evidence to support this. The objective of this study was to compare health services utilization and healthcare costs among employed patients with depression who engage in presenteeism and absenteeism.

METHODS: A retrospective observational study was conducted using the 2011 and 2012 Medical Expenditure Panel Survey (MEPS) data. Participants were employed adults (age ≥18) who were employed throughout the year were assessed for presenteeism and absenteeism through survey responses. Logistic regressions were used to assess the association between absenteeism/presenteeism and office-based visits, inpatient hospital stays, and the total healthcare cost. Separate risk scores were derived for Commercial and Medicare using DxCG’s all medical predicting concurrent medical risk. The dependent variables - medical reimbursement amount, was measured separately as concurrent, prospective, and change variable (taking first difference) at each plan level. Separate risk scores were derived for Commercial and Medicare using DxCG’s all medical predicting concurrent medical risk.

RESULTS: Presenteeism was associated with lower health services utilization that can potentially be cost-saving in the long run. Employers and the medical community should work together for depression management among employees and reduce the clinical and economic burden of depression.

PHS128 MEDICAL RESOURCE UTILIZATION OF ACUTE MYOCARDIAL INFARCTION PATIENTS WITH READMISSION: A RETROSPECTIVE ANALYSIS OF HOSPITALIZATION DATA FROM BEIJING MEDICAL INSURANCE DATABASE
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OBJECTIVES: To describe and compare the first hospitalization cost and the readmission cost of Acute Myocardial Infarction (AMI) patients at Beijing urban area hospitals. METHODS: Retrospective data on hospitalization of AMI patients was selected from Beijing’s public and residents medical insurance database. We identified and selected 10% of patients first diagnosed as AMI during January 2012 - December 2012 and then followed those patients to September 2013. 1253 patients were identified in our study and then 335 patients (26.7%) reoccurred during the observation period. All information of patient demographic characters, length of stay and clinical costs were collected. The descriptive statistics were used. The costs of 2013 were converted into 2012 year price with discount rate 3.5%. RESULTS: We analyzed the 335 patients with recurrence of AMI (mean age 66.14±15.04 years. 82.39% male), among which 100 patients were readmitted to hospital over three times. The median followed time was 14.17QR(11.35–18.57, mean 14.29±4.68 ) months. The median hospitalization cost was $32,148.42QR(14,033.26–6,254.97, mean 42,905.99±36,473.35) at the first time, $29,189.83QR(12,111.81–64,323.44, mean 41,281.34±34,909.03) at the second time, and $25,386.72QR(13,751.55–49,162.27, mean 34,885.87±30,949.72) at the third time and more, respectively (p<0.05). The median length of stay was 11 days (IQR 7-16, mean 13.75±11.34days) in the first hospitalization, 11 days (IQR 7-16, mean 13.91±12.67, in the second hospitalization, and 13 days (IQR 9.18–16.32, mean 15.97days) in the third hospitalization or more, respectively (p<0.05). CONCLUSIONS: Patients with readmission took a relatively high percentage of all AMI hospitalized patients and caused heavy cost. Readmissions over three times had lower cost and longer length of hospital stay than the first and second hospitalization.

PHS129 EFFECTS OF OVERWEIGHT AND OBESITY ON HEALTH SERVICE USE AND EXPENDITURES AMONG U.S. ADULTS WITH CHRONIC RENAL DISEASE
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OBJECTIVES: Chronic kidney disease, overweight and obesity are growing public health challenges in the U.S. with large financial implications. To examine healthcare utilization, data were obtained from end-stage renal disease population by body mass index. METHODS: This was a retrospective cross-sectional study of 225 U.S. adults with end-stage renal disease. The Medical Expenditure Panel Survey, a representative sample of the U.S. households was utilized. End-stage renal disease cases with clinical classification code value of 158 were pooled for calendar years 2002 to 2011. Self-reported body mass index was classified as underweight (BMI < 18.5), normal weight (18.50 ≤ BMI < 24.99), overweight (25 ≤ BMI < 29.99) and obese (BMI ≥ 30). The annual ambulatory care visits and expenditures were estimated by body mass index among end-stage renal disease adults. RESULTS: 1.9% of end-stage renal disease adults were underweight (excluded due to small sample size), 28.0% were of normal weight, 39.0% and 33.1% were obese and non-zero hospital night stays were 25, 2, and 20 days for normal weight, overweight and obese end-stage renal adult cases. The average annual expenditures were $21672 ± $4903, $44810 ± $25906, and $71992 ± $41046 among normal weight, overweight and obese end-stage renal disease adults. CONCLUSIONS: Obese patients had longer hospital stay than overweight patients and resulted in higher health care expenditures. End-stage renal disease patients who were obese may be more sicker. With the rising prevalence of chronic kidney disease, overweight and obesity significantly increased, the relationship of body weight with chronic kidney disease in health care use and associated spending needs further exploration in larger studies.

PHS130 PREDICTING MEDICAL REIMBURSEMENT AMOUNT - WHAT FACTORS DRIVE THE MEDICAL COST TREND
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OBJECTIVES: Healthcare costs in the U.S. are the highest worldwide and are rapidly increasing. As a result of this upward trend, employers and health insurance companies are trying to contain the rising cost. METHODS: A retrospective observational study on Medicare claims data that were linked to MCBS. The Negative Binomial generalized linear model was used to quantify the relationship between VI and hospitalization controlling for confounding factors such as age, gender, race, income, education, marital status, smoking, body mass index, and chronic conditions. RESULTS: At baseline, 29.9% of Medicare beneficiaries had mild VI, 66% had moderate-to-severe VI. Over time, the rate of hospitalization declined for those with mild VI or no VI, but was constant for those with moderate-to-severe VI. The rate of hospitalization was higher in beneficiaries with body mass index ≥ 25 compared to those with normal BMI. CONCLUSIONS: Moderate-to-severe VI was associated with an increased rate of hospitalization among older adults. Our results suggest that further research is required to determine whether interventions to limit or prevent visual impairment would be an effective measure to reduce hospitalization.

PHS131 OUT-OF-POCKET HEALTHCARE EXPENDITURES AMONG PATIENTS WITH CHRONIC OBSTRUCTIVE PULMONARY DISEASE
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OBJECTIVES: To describe outpatient (OOP) expenditures for hospitalizations, ambulatory care visits and prescription medications and to determine if there is the difference in OOP expenditures by insurance status among subjects with Chronic Obstructive Pulmonary Disease (COPD). METHODS: Data for this study were drawn from the 2012 Medical Expenditure Panel Survey (MEPS). The sample included adults (age ≥18 years) with a COPD diagnosis (ICD-9 codes 491, 492, and 490) who received COPD services at least once in 2012. The dependent variable was annual OOP expenditures and the independent variable was health insurance type (private, public, or no insurance). Descriptive statistics and inferential tests were conducted using SAS ProcSurvey for complex sampling design. RESULTS: Study subjects’ (N=587, unweighted, N=5,882,925 weighted) total means SEI OOP COPD expenditures were $2,362.4±95.1 per person. Subjects with no insurance had total OOP expenditures ($2,921.3±835.9) that were 2.8 to 4.0 times higher than those who were privately ($2,414±22.5) or publicly ($1,565±22.9) insured. Inpatient expenditures (N=31, unweighted, N=32,314±1,414) were significantly higher for subjects with no insurance ($4,631.7±50), and lower for subjects with private ($168.9±9.1) and public insurance ($150.6±4.7). Ambulatory care visit (N=385, unweighted, N=3,831,352 weighted) OOP expenditures for subjects with insurance ($77.9±14.9) were over 2 times higher than OOP expenditures for those privately or publicly insured ($35.6±3.3, $28.6±2.3, respectively). Of those who had prescription expenditures (N=468, unweighted, N=4,906,191 weighted), patients with private and those with no insurance paid similar OOP amounts ($222.2±14.8, $222.4±14.8, respectively), while those with public insurance had lower OOP expenditures ($161.5±24.4). CONCLUSIONS: When compared to subjects with private or public insurance, those with no insurance had higher OOP expenditures for COPD-related total, inpatient and ambulatory care services and lower OOP expenditures for prescriptions. Increasing the use of appropriate COPD medications among the uninsured may result in cost-savings due to reduced hospitalizations.

PHS132 COST STUDY ON PROVINCIAL GENERAL HOSPITALS
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OBJECTIVES: To examine several factors associated with medical reimbursement amount. Further research is needed to help understand what other factors are important which may help shed light on potential options for ‘bending the cost curve’.