CANCER

ECONOMIC OUTCOMES IN HEPATOCELLULAR CARCINOMA AND METASTATIC LIVER DISEASE PATIENTS: A PRIVATE PAYER PERSPECTIVE
Pelletier EP1, Dembek CJ1, Gazelle GS2
1Boston Scientific Corporation, Natick, MA, USA. 2Massachusetts General Hospital, Boston, MA, USA

OBJECTIVES: Published data on costs associated with treating privately insured patients with hepatocellular carcinoma (HCC) or metastatic liver disease (MLD) are limited. This study evaluated health resource use and medical care costs in newly diagnosed HCC and MLD patients. METHODS: Patients diagnosed with HCC or MLD in 2002 were identified from a nationally representative private payer claims database by ICD-9 diagnosis codes, using the date of the first diagnosis as the “index date”. Patients were required to be 18 years of age or older, with no prior HCC or MLD diagnosis, and continuously enrolled in a health plan. Health resource use and medical care costs were tracked over one year. RESULTS: The study included 297 HCC and 846 MLD patients. The mean age for all patients was 56.8 years and 41% were male. MLD patients had significantly higher inpatient admissions versus HCC patients (2.1 vs. 1.5, P < 0.001), while the mean aggregate hospital days was significantly longer in HCC patients (16.5 vs. 14.2, P < 0.001). MLD patients also had significantly greater emergency room, outpatient hospital, and physician office visits (P < 0.05). Total mean medical costs were significantly higher in MLD patients ($39,786) versus HCC patients ($37,203, P < 0.001). These higher costs were due primarily to significantly greater ancillary costs in MLD patients ($54,671 vs. $5,903, P < 0.001), which include costs associated with chemotherapy. All differences remained significant after adjusting for differences in age and sex. CONCLUSIONS: Among managed care patients newly diagnosed with HCC or MLD, significantly higher 1-year health resource use and medical care costs were found for MLD patients. The difference in overall costs was due primarily to the higher use of ancillary services among MLD patients. These findings provide important new data for evaluating the economic impact of treating HCC and MLD patients.

PAYER PERSPECTIVE

MAMMOGRAPHY SCREENING USE AMONG MEDICARE BENEFICIARIES AGE 65 OR OLDER
Zuckerman IH1, Du D2, Royak-Schaler R1, Wang F3
1University of Maryland Baltimore, Baltimore, MD, USA. 2University of Tennessee College of Pharmacy, Memphis, TN, USA

OBJECTIVES: Estimate national trends in mammography screening use among elderly Medicare beneficiaries for the period of 1998 to 2001; determine the extent to which socio-demographic, clinical, and access factors are associated with disparities in screening use. METHODS: A secondary data analysis of the Medicare Current Beneficiary Survey (MCBS) was conducted. Community-dwelling women aged >65 years who completed the MCBS at least once during the survey years of 1998 to 2001 were included. Having had a mammogram in the past year was determined by a participant’s response to the question “have you had a mammogram or a breast x-ray since a year ago?”, or by a Medicare claim coded with a mammogram procedure in the calendar year. Multivariate logistic regression was used to estimate the association between the likelihood of having had mammogram in the past year and factors, such as socio-demographic, biological, and access factors. Sampling weights were used to reflect national estimates of Medicare beneficiaries. Standard errors were adjusted for clustering and stratification in the complex sampling design. RESULTS: A total of 10,757 females 65 years of age or older responded to the MCBS from 1998 to 2001 (weighted N = 34 million). Over half (54%, 95% CI 53%–55%) of the respondents had mammogram in the past year. Annual mammography screening rates increased over time, from 49% in 1998 to 58% in 2001. In adjusted models, there was no significant racial or ethnic disparity in mammography use, but the other socio-demographic factors remained significantly associated with lower odds of mammography use. CONCLUSIONS: Mammography screening rates increased notably between 1998 and 2001 in the Medicare population. While no racial or ethnic disparities in screening rates were noted in this study, lower income, less education, no insurance and being unmarried were identified as barriers to breast cancer screening for elderly Medicare beneficiaries.

PODIUM SESSION IV

COLONOSCOPY PROCEDURE RATES AMONG PRIVATE-PAY PATIENTS INCREASED SUBSTANTIALLY BETWEEN 2000 AND 2004
Amorosi SL, Lacey MJ
Boston Scientific, Natick, MA, USA

OBJECTIVE: In the late 1990s, a U.S. health policy initiative recommended that colorectal cancer screening begin at age 50 for all adults. Shortly thereafter, Medicare began paying for screening colonoscopy in average risk persons. In the years that followed, the mix of procedures performed to evaluate colorectal cancer screening began to change; colonoscopy procedure volume increased and other colorectal cancer screening procedures decreased. We conducted this study to evaluate trends in colorectal cancer screening procedure volumes in private-pay patients between 2000 and 2004. METHODS: A nationally representative private payer claims database was used to identify patient records with claims for colonoscopy, flexible sigmoidoscopy, double-contrast barium enema, and fecal occult blood test (FOBT). During 2000–2004. CPT and HCPCS procedure codes were used to identify patient records with claims for the procedures of interest. Only patients aged 18+ were included in the analysis. RESULTS: Patients in the study sample averaged 54 years of age and were 60% female. From 2000 to 2004 the proportion of screening procedures performed relative to the number of plan members increased 38% (8% to 11%). Relative