based on primary ICD-9-CM discharge diagnosis of ICH (431.xx). Patient-level information included demographics (including race/ethnicity: White, Black, Hispanic, Asian), hospital characteristics, comorbidities, primary payer, admission source, discharge destination, DRG, length of stay (LOS), and hospital charges. Costs were estimated by applying hospital-specific cost-to-charge ratios to charges. Adjusted LOS and cost (controlling for age, in-hospital mortality, and other covariates) by race/ethnicity were estimated using multivariate least-squares regression. **RESULTS:** Black, Hispanic, and Asian patients with a primary diagnosis of ICH at discharge were significantly younger, on average, than White patients (73.5 vs. 61.2, 63.9, and 67.9 years, respectively; $p < 0.01$ for all comparisons). Black and Hispanic patients experienced longer hospital stays ($p < 0.01$) and incurred higher costs ($p < 0.01$), on average, than White patients. Among Black and Hispanic patients, adjusted length of stay (mean costs) per discharge were approximately 2.3 days ($1400) and 1.7 ($3400) higher, respectively, as compared to White patients. Asian patients had longer adjusted stays (2.6 additional days, $p < 0.01$) and higher costs ($830, $p < 0.31$). **CONCLUSIONS:** There are meaningful differences in length of stay and cost of ICH hospitalizations among patients with different race/ethnicity. Improved acute treatment of stroke in this high-risk population may help to improve overall outcomes in these subgroups.

HIGH IMPACT

HI1

ADULT ECONOMIC STATUS AND OBESITY IN THE UNITED STATES: 2000–2002

Wu E[1], Xie J[1], Crémieux PY[1], Sullivan PW[2]
[1]Analysis Group, Inc, Boston, MA, USA, [2]University of Colorado Health Sciences Center, Denver, CO, USA

OBJECTIVES: To assess the association between overweight/obesity and employment to population ratio (E/P Ratio), hourly wage, and annual income in the U.S. **METHODS:** Adults (age 18–64) in the 2000–2002 Medical Expenditure Panel Survey (MEPS) were classified as normal weight (BMI:18.5–24.9), overweight (BMI:25–29.9), and obese (BMI: >= 30). Underweight (BMI < 18.5) individuals were excluded. E/P ratio, hourly wage, annual income, and poverty status of the overweight and obese adults were compared to that of the normal weight adults, respectively, adjusting for demographic characteristics using a stratification matching method. MEPS sampling weights were applied to ensure nationally representative estimates. The analyses were also conducted for population subgroups defined by gender, race, ethnicity, and physical activity. **RESULTS:** The study sample includes 35,989 adults, with 13,744 normal weight, 13,321 overweight, and 8,924 obese. The E/P ratio was 87.1% for the overweight sample, 1.8% higher ($p < 0.01$) than the normal weight sample; and 82.4% for the obese sample, 1.7% lower ($p < 0.01$) than the normal weight sample. The obese sample made $1.63 less per hour ($p < 0.01$), and $3338 less annually compared to the normal weight sample ($p < 0.01$). Compared to the normal weight sample, obese adults were more likely to be poor. No significant difference of annual income and poverty level were found between the overweight and the normal weight sample. Systematic differences between different population subgroups were found. **CONCLUSIONS:** Obese adults are less likely to be employed, have lower annual incomes and hourly wages, and are more likely to be poor than normal weight adults.

HI2

CLINICAL IMPACT OF PHARMACOTHERAPY VERSUS NON-PHARMACOLOGIC MANAGEMENT AMONG COMMERCIALLY INSURED PERSONS AGED ≥65 YEARS WITH OVERACTIVE BLADDER

Joyce AT[1], Jumadilova Z[2], Trocio J[2], Foltz Boklage S[3], Girase P[1]
[1]PharMetrics, a unit of IMS, Watertown, MA, USA, [2]Pfizer, Inc, New York, NY, USA, [3]PharMetrics, a unit of IMS, Fort Washington, PA, USA

OBJECTIVE: To examine the incidence of overactive bladder (OAB)-related clinical events for elderly patients receiving pharmacotherapy compared with those receiving non-pharmacologic management. **METHODS:** Data were obtained from the PharMetrics Patient-Centric Database on continuously benefit-eligible patients aged ≥65 years diagnosed with OAB between January 2002 and December 2003. Patients were categorized into 2 cohorts: those receiving pharmacotherapy, including long-acting tolterodine, or immediate- or extended-release oxybutynin and those receiving non-pharmacologic management. Patients were matched 1:1 by the estimated propensity score for OAB pharmacotherapy using a logistic regression model that included selected demographic and clinical characteristics. The incidence of clinical events, including assessment of depression, urinary tract infections (UTIs), and falls or fractures was evaluated. Crude event rates were reported, as well as the risk of an event using Cox proportional hazards models adjusting for important demographic and clinical characteristics. **RESULTS:** A total of 1681 matched pairs were identified. Mean ± SD age was 78 ± 8 years; 60% were women. After matching, differences in baseline patient characteristics between cohorts were not significant. The incidence of depression (10.2% for pharmacotherapy vs 11.0% for non-pharmacologic management; $p = NS$) and fractures (8.6% vs 10.1%; $p = NS$) was numerically lower in the drug-treated cohort, and the incidence of UTI was significantly lower (28.1% vs 36.5%; $p < 0.0001$). Adjusted rates using Cox proportional hazards models were similar, with no difference in the risk of depression (hazard ratio [HR] = 0.980; 95% confidence interval [CI], 0.795–1.208; $p = NS$) or fractures (HR = 0.863; 95% CI, 0.691–1.079; $p = NS$) between the cohorts, and the risk of UTI was 28% lower among pharmacotherapy patients (HR = 0.718; 95% CI, 0.636–0.810; $p < 0.0001$). **CONCLUSIONS:** Pharmacotherapy may impart selected clinical benefits for some elderly patients with OAB compared with non-pharmacologic management. Careful consideration should be given to the selection of treatment approaches in this high-risk population.

HI3

THE EFFECTS OF STATIN (HMG-COA REDUCTASE INHIBITOR) COPAYMENTS AND STATIN ADHERENCE ON MEDICAL CARE OUTCOMES AND EXPENDITURES

Gibson TB[1], Mark T[2], Axelsen K[3], Mackell J[4], King H[3], Baser O[1], McGuigan K[3]
[1]Thomson Medstat, Ann Arbor, MI, USA, [2]Thomson, Washington, DC, USA, [3]Pfizer Global Pharmaceuticals, New York, NY, USA, [4]Pfizer, Inc, New York, NY, USA

OBJECTIVES: We examined the effects of statin prescription drug copayments and statin adherence on cardiovascular utilization patterns, medical and prescription drug expenditures and other outcomes of statin therapy. **METHODS:** The 2001–2003 MarketScan database was used to study the health care utilization and expenditure patterns of continuously enrolled statin users in employer sponsored health plans. We analyzed the utilization patterns of 93,296 continuing users who had previously filled at least one statin prescription in 2000 and 24,128 users who were new to statin therapy in the first half of 2001. A two-stage estimation approach consisted of a multi-variate logit model estimating the relationship between copay-