CONCLUSIONS: At a willingness-to-pay threshold of $50,000/QALY, mechanical thrombectomy and intra-arterial thrombolysis were extendedly dominated. Mechanical thrombectomy is an effective treatment for acute ischemic stroke and extends the useful treatment window for patients with large vessel occlusion, improving the interventional team’s ability to treat patients. Countless articles on this topic have appeared in the literature. Mechanical thrombectomy can lower the costs of inpatient and outpatient treatment. However, the costs are associated with the use of endovascular devices, which are not included in the analysis. The present study is not designed to evaluate the cost-effectiveness of mechanical thrombectomy. This study did not include the costs of inpatient and outpatient care. The cost-effectiveness of mechanical thrombectomy was evaluated based on the costs of endovascular devices and the costs associated with the use of these devices.

HEALTH CARE POLICIES & EXPENDITURES

PODIUM SESSION III:

HEALTH CARE COSTS IN ASTHMA PATIENTS

OBJECTIVES: To evaluate the association of allergic rhinitis (AR) with asthma exacerbations and healthcare costs in asthma patients. METHODS: Newly diagnosed patients 12-64 years of age with ≥2 asthma diagnoses, or 1 diagnosis and ≥1 asthma-related prescription claims, during the period 1/1/2008-3/31/2011, continuously eligible for 12 months before and 24 months after index asthma diagnosis were identified from a privately-insured claims database (N=14,000,000). The index date was defined as the date one year after the index asthma diagnosis, baseline period as 12 months before, and study period as 12 months after the index date. Two cohorts were selected from the sample: asthma-only (without any AR diagnosis), and asthma-AR (with ≥1 AR diagnosis and ≥1 intranasal corticosteroid claim during the study period). Through comparing demographic characteristics, comorbidities, healthcare costs (medical service and prescription drug costs) inflated to 2010 dollars, and asthma exacerbations (defined as either an inpatient or emergency department visit with asthma diagnosis or use of oral corticosteroid) during the study period. Conclusions: Our findings suggest that CMS is routinely considering cost-effectiveness evidence in NCDs for preventive care. Consistent with the PACE legislation, a cost-per-QALY threshold was not used.