Mental Health - Cost Studies

PMH20
THE IMPACT OF LONG ACTING INJECTABLE MEDICATIONS ON PATIENT OUTCOMES
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OBJECTIVES: Assess behavioral health care utilization and expenditures for patients receiving injectable medications. METHODS: A long acting injectable psychotropic medication is a sustained-action drug formulation administered through intra-muscular injection that allows slow release and gradual absorption. This was a retrospective study using behavioral health and pharmacy claims data. Commercial patients from a large national health plan diagnosed with bipolar and/or schizophrenia, substance-related disorders, or mood disorders who received a long acting injectable between January 1, 2012 and July 31, 2015 were identified. A second cohort was created using the same study period; however, only patients who received a long acting injectable during the same period were included in the base cohort, who did not receive a long acting injectable. Patterns of utilization and expenditures were compared between patients with injectables and patients without. Outcomes were measured over a 90 day period starting from either their initial injection (for patients with injectables) or their initial encounter (for patients without). RESULTS: Patients receiving an injectable incurred lower expenditures overall ($3,022 vs. $5,064, p<0.05) and had fewer intermediate stays (5.5 vs. 7.9, p<0.05) and outpatient visits (2.8 vs. 5.2, p<0.05) than patients who did not receive an injection. Similar patterns were also observed among patients who had 3 or more injectables ($1,959 vs. $3,223, p<0.05) and patients who were administered Naltrexone specifically ($3,130 vs. $5,474, p<0.05) than patients who did not receive any injections. Patients with a history of depression had lower follow-up period charges ($2,474 vs. $4,479) and had fewer intermediate behavioral health care stays (1.8 vs. 4.9, p<0.05) than patients who were new to the injectable treatment. CONCLUSIONS: Commercial patients receiving injectable medications tended to have lower charges, and fewer days in care, compared to patients who were new to injectable medications. Use of long acting injectable psychotropic medications to treat patients with select behavioral health conditions may be a more cost effective alternative to traditional drug therapies.

PMH21
USING PRIVATE CLAIMS DATA TO STUDY THE COST OF THE OPIOID CRISIS
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OBJECTIVES: Identify trends in healthcare costs and demand for services attributable to the opioid epidemic nationwide 2011-2015. METHODS: FAIR Health analyzed its database of billions of private healthcare claims records to identify claims with ICD-9-CM and ICD-10-CM diagnostic codes indicative of opioid abuse and dependence, and then aggregated the data by key fields such as state, procedure code and year of service, and determined cost by both charges and imputed allowed amounts. RESULTS: From 2011 to 2015, the national aggregated dollar value of charges for opioid abuse and dependence and imputed allowed amounts for all diagnoses rose over 1,000 percent. In 2015, private payors’ average costs for patients diagnosed with opioid abuse or dependence were 556 percent higher—almost $16,000 more per patient—than the per-patient average cost based on all patients’ claims. From 2011 to 2014, the greatest increase in services for patients diagnosed with opioid abuse and dependence was in alcohol and/or drug services/therapy, which increased 1,189 percent, followed by laboratory tests at 848 percent. Diagnoses of opioid abuse and dependence, and opioid-related complications, such as prolactinemia among patients receiving antipsychotics. METHODS: Commercially insured adults were identified from the Truven Commercial US claims database (2006Q1–2016Q3). For patients with hyperprolactinemia (hyperprolactinemia cohort), the index date was defined as 260 days before the first hyperprolactinemia indicator (hyperprolactinemia, amenorrhea, galactorrhea, gynaecomastia, hypogonadism, prolactin assay, mummic duct/galactogram). For patients without hyperprolactinemia (hyperprolactinemia-free cohort), the index date was selected as the date that patients were associated with significant increases in annual all-cause healthcare payments during the follow-up period. CONCLUSIONS: Annual all-cause healthcare payments in the 12 months following third-line therapy initiation can be substantial, as health care utilization and expenditures for TRD patients with obesity or pain-related diagnoses. Efforts to reduce this economic burden are warranted.

PMH22
HEALTHCARE COSTS ASSOCIATED WITH HYPERPROLACTINEMIA IN THE UNITED STATES
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OBJECTIVES: To assess the incremental healthcare costs associated with hyperprolactinemia among patients receiving antipsychotics. METHODS: Commercially insured adults were identified from the Truven Commercial US claims database (2006Q1–2016Q3). For patients with hyperprolactinemia (hyperprolactinemia cohort), the index date was defined as 260 days before the first hyperprolactinemia indicator (hyperprolactinemia, amenorrhea, galactorrhea, gynaecomastia, hypogonadism, prolactin assay, mummic duct/galactogram). For patients without hyperprolactinemia (hyperprolactinemia-free cohort), the index date was defined as the date that patients were associated with significant increases in annual all-cause healthcare payments during the follow-up period. CONCLUSIONS: Annual all-cause healthcare payments in the 12 months following third-line therapy initiation can be substantial, as health care utilization and expenditures for TRD patients with obesity or pain-related diagnoses. Efforts to reduce this economic burden are warranted.

PMH24
REDUCED RISK OF HYPERPROLACTINEMIA AMONG PATIENTS TREATED WITH ATYPICAL ANTIPSYCHOTICS THAT ARE ASSOCIATED WITH LOW OR NO PROLACTIN ELEVATIONS
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OBJECTIVES: To assess the incremental healthcare costs associated with hyperprolactinemia among patients receiving antipsychotics. METHODS: Commercially insured adults were identified from the Truven Commercial US claims database (2006Q1–2016Q3). For patients with hyperprolactinemia (hyperprolactinemia cohort), the index date was defined as 260 days before the first hyperprolactinemia indicator (hyperprolactinemia, amenorrhea, galactorrhea, gynaecomastia, hypogonadism, prolactin assay, mummic duct/galactogram). For patients without hyperprolactinemia (hyperprolactinemia-free cohort), the index date was defined as the date that patients were associated with significant increases in annual all-cause healthcare payments during the follow-up period. CONCLUSIONS: Annual all-cause healthcare payments in the 12 months following third-line therapy initiation can be substantial, as health care utilization and expenditures for TRD patients with obesity or pain-related diagnoses. Efforts to reduce this economic burden are warranted.