

## PMH23

**A COMPARISON OF HEALTH CARE UTILIZATION AND COST OF CHILDREN AND ADOLESCENTS WITH BIPOLAR DISORDER TREATED WITH ATYPICAL ANTIPSYCHOTIC MONOTHERAPY VERSUS MOOD STABILIZER MONOTHERAPY**

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**OBJECTIVE:** To compare health care utilization and cost of children and adolescents with bipolar disorder treated with atypical antipsychotic (ATYP) versus with mood stabilizer (MS) monotherapy. **METHODS:** We conducted a retrospective cohort study using Pharmetrics administrative claims data from January 1, 1998 to December 31, 2002. The study population included youths (6 < AGE < 19). **RESULTS:** After matching on the propensity score, 486 subject pairs were retained. On average, ATYP monotherapy subjects had fewer bipolar-related office visits ( $p = 0.0041$ ), but similar bipolar-related outpatient hospitalization ( $p = 0.084$ ), bipolar-related days of hospitalization ( $p = 0.1707$ ), and bipolar-related emergency department visits ( $p = 1.00$ ). ATYP monotherapy subjects had a lower cost of bipolar-related office visits ( $p = 0.0246$ ) but higher medication costs ( $p < 0.0001$ ). There were no cost differences between groups for bipolar-related emergency department visits ( $p = 0.5477$ ), bipolar-related outpatient hospitalization ( $p = 0.9817$ ), and bipolar-related inpatient hospitalizations ( $p = 0.521$ ). Total bipolar-related medical service ( $p = 0.6501$ ) and general health-related medical service ( $p = 0.885$ ) costs were also not significantly different between the two groups. **CONCLUSION:** Compared to patients with MS monotherapy, patients with ATYP monotherapy had fewer bipolar-related office visits and higher medication costs, but similar total bipolar-related and overall medical service costs.

## PMH24

**INITIATING TREATMENT ON GENERIC ANTIDEPRESSANTS MAY NOT SAVE HEALTH CARE COSTS**

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**OBJECTIVE:** To compare health care costs associated with initiating treatment on escitalopram or one of several generic selective serotonin reuptake inhibitors. **METHODS:** A retrospective patient cohort with antidepressant fills was selected from a large claims database. Patients were included if they had a depression-related diagnosis and at least six months of health plan eligibility before and after the date of their first study antidepressant claim. Dependent variables included total health care costs and component pharmacy, medical (non-pharmacy ambulatory and inpatient), inpatient, and mental health treatment costs in the six months after initiation of antidepressant therapy. A propensity score analysis was used to account for selection bias in antidepressant choice (escitalopram versus other antidepressants). Incorporating this adjustment, generalized linear models were estimated to examine the association between antidepressant choice and subsequent costs. **RESULTS:** Sample members were approximately 40 years old, nearly one-third were male, and more than 85% were enrolled in a health maintenance organization or preferred provider organization. Although patients initiating treatment on escitalopram had higher pharmacy costs

(\$587 versus \$503,  $p < 0.01$ ), total health care costs (\$2327 versus \$2383,  $p < 0.05$ ) were lower in the six months after initiation compared with patients initiating with generic antidepressants. Component costs also varied among drug cohorts, but these differences were small with medical costs offsetting higher drug costs. **CONCLUSION:** Despite higher medication costs, total health care costs were lower for patients initiating treatment on escitalopram. These reductions in costs suggest that therapeutic substitution of generic for branded antidepressants might not be an effective cost-containment strategy and should be considered when making formulary decisions regarding antidepressants.

## PMH25

**HEALTH CARE USE AND COSTS OF PATIENTS WITH "PURE OBSESSIVE-COMPULSIVE DISORDER" VERSUS "PURE DEPRESSION": 9-YEAR (1997-2006), LARGE-SCALE, RETROSPECTIVE CLAIMS ANALYSIS OF FLORIDA MEDICAID ADULT ENROLLEES**

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**OBJECTIVE:** To compare 2-year health care use and costs of newly-diagnosed patients with "pure OCD" (P-OCD; OCD sans bipolar disorder, psychoses, or depression) to a matched sample with "pure depression" (P-D; depression sans bipolar disorder, psychoses, or OCD). **METHODS:** Retrospective (1997-2006) analysis of Florida Medicaid claims. Among patients with  $\geq 1$  OCD claim (ICD-9 300.3), we identified their first occurring ("index") OCD claim. P-OCD patients had no depression (ICD-9 296.2/296.3/296.9/300.4/309.0/309.1/311), psychoses (ICD-9 295/298) or bipolar disorder (ICD-9 296) in the 2 years before and after their index claim. P-D patients were identified similarly, except that the index claim was depression and the exclusion diagnoses included OCD rather than depression. Each P-OCD patient was matched to  $\geq 1$  P-D patient on sex, race/ethnicity, medical illness severity (Charlson Comorbidity Index), and age and year at index diagnosis. P-OCD patients without matches were excluded from analysis. We compared 2-year health care utilization and costs post-index diagnosis. **RESULTS:** Among 2,924,412 enrollees, 156 met criteria for P-OCD and 16,055 for P-D. Of these, we matched 135 P-OCD patients to 1510 P-D patients (21 P-OCD patients could not be matched). Total 2-year, median number of health care claims was approximately 2 times greater (P-OCD 126.0 versus P-D 68.4,  $p < 0.0001$ ), and costs were approximately 3 times higher (P-OCD \$25,666 versus P-D \$7732,  $p < 0.0001$ ) among P-OCD patients. P-OCD patients had significantly more outpatient visits for medical treatment (median 2-year number of outpatient visits P-OCD 86.0 versus P-D 56.0,  $p = 0.0007$ ) and approximately 2 times higher median outpatient medical costs (P-OCD \$4820 versus P-D \$2525,  $p < 0.0001$ ). **CONCLUSION:** Although patients were matched on medical illness severity, P-OCD patients used significantly more outpatient medical services and incurred two times greater outpatient medical costs than counterparts with P-D. Findings suggest that much of the care for OCD may occur within the outpatient medical setting.