Medicare:27.3%, Medicaid:5.6%) in 352 hospitals met the selection criteria; 76.3% stayed for ≤3 days and 6% had ≥4 comorbidities. Median APA at index was $38,229 (Q1-Q3: $22,577-$66,551) with a mean of $52,487 (95% CI: $51,155-$54,540). The LOB adjusted amount had a median of $49,028 (Q1-Q3: 31,860-80,213) and a mean of $68264 (95% CI: 66,239-70,828). In comparison, the median and mean hospital costs were $17,212 (Q1-Q3:12,838-24,652) and $22,202(95% CI: 21,597-22806), respectively. The median APA varied substantially across primary payor ($49,428 for Commercial, $17,947 for Medicaid, 22,447 for Medicare, p<0.001), so did the median LOB-adjusted amount ($50,965 for Commercial, $35,820 for Medicaid, 41,986 for Medicare, p<0.001). In contrast, there was no significant difference in hospital cost by payor type. ***Conclusions:*** This study linked payments and costs from different data sources to assess the financial impact of treating STEMI on the hospitals. While hospital costs remain consistent across insurance payors, the hospitals received higher reimbursement from commercial insurance than Medicare/Medicaid. Further research on the potential impact on the quality of care for patients with public insurance is warranted.

HPR96
PRICE MONITORING OF ANTICANCER DRUGS UNDER PRICE CONTROLLED CATEGORY IN INDIA

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Objectives: Treatment of cancer involves huge costs and medicines contributes a major part of it. In order to improve access to anticancer drugs every country has adopted a suitable policy to monitor price. Similarly India has adopted a policy to monitor prices of all drugs under National List of Essential Medicines of India (NLEM-2012) including anticancer drugs. This study was conducted to explore how drug prices are being monitored during 2015 to 2024. ***Methods:*** A survey was conducted through internet search and searching websites of National Pharmaceutical Pricing Authority (NPPA) on Drug Price Control Order (DPCO) and notifications of NPPA during 1st April 2015 to 31st December 2023 to acquire data of drugs under price control and price of those drugs. Unit price as fixed by NPPA through notifications effective from 1st April 2015 and 1st April 2023 were compared and Unit price of the lowest strength used of a dosage form was considered for analysis. The data available was collected, collated and analysed statistically. ***Results:*** Results shows that 31 anticancer drugs are included under NLEM 2012 and all are included in the First Schedule of DPCO-2013. Out of 31 drugs, price of Folinic acid, Procarbazine and Daunorubicin were not available and were not included in further analysis. It reveals that price of six drugs were increased during this period and varied between 1.91 to 26.08 percent with an average of 8.13(SD 10.05). Price of twenty two drugs reduced during this time and varied between 0.41 to 46.98 percent with an average of 38.55(SD 16.89) percent. ***Conclusions:*** Price of anticancer drugs under NLEM was monitored by NPPA and price of 78.57 percent was reduced to a maximum of 46.98 percent and price of the rest was increased to a maximum 26.08 during this period making antineoplastic drugs affordable by common people.

HPR97
MORE PUBLIC FUNDING? A CHOICE EXPERIMENT ON THE HEALTHCARE FUNDING SYSTEM FOR OLDER POPULATIONS

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Objectives: The demand for healthcare for the older population is growing. The funding system and public–private mixture of healthcare has been shaped by various factors. This study elicited the public preferences for the healthcare funding system for older populations and examined the heterogeneity of preferences by classifying individuals into groups with similar preferences. ***Methods:*** Data were obtained from recruited participants among Japanese people aged 20 years or older who were registered with the survey panel managed by NTT Com. Online Marketing Solutions, Inc., a consumer research company. The experiments, which comprised a sample of 1,112 individuals, focused on the need for public funding. Using a random parameter probit model, the study valued several insurance attributes, namely, the share of public funding, income equity, intergenerational equity, and the local or national burden. In addition, the latent class type of DCE was used to reveal the heterogeneity of public preferences. ***Results:*** The results show that the public overall has a negative preference for an increase in public funding and positive preferences for an income-proportional burden, universal burden regardless of age, and an increase in the national government burden relative to the local burden. However, the latent class responded heterogeneously to insurance choices. For example, the latent segment comprising 23% of the total sample—the second-largest group consisting mainly of young males—preferred a greater increase in public funding. ***Conclusions:*** Several studies have analyzed public preferences on healthcare financing in developed countries. In this study, the public preferred equal burdens regardless of age. This finding was observed in similar research in other countries.

HPR98
THE EU REGULATORY FRAMEWORK FOR MEDICAL DEVICE EARLY FEASIBILITY STUDIES: WHAT DO WE KNOW TO DATE?

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Objectives: As part of the Harmonised Approach to Early Feasibility Studies for Medical Devices in the European Union (HEU-EFS) project, we analysed EU regulations, international standards, and guidelines to identify gaps that could affect a future EU EFS Program. We also conducted a specific analysis for digital health technologies (DHTs) that qualify as medical devices due to their unique lifecycles and features. ***Methods:*** A systematic review of the Medical Device Regulation 745/2017 (MDR), international standards from the International Standards Organisation (ISO), and guidelines for EFS and clinical investigations was conducted. To complement the regulatory and standards analysis, a comprehensive systematic literature review to identify international best practices was undertaken ***Results:*** The MDR covers clinical investigations generally rather than specifically addressing EFS requirements. We identified ISO standards relevant to EFS (n = 11), including those focused solely on clinical investigation design, and those with relatively detailed or minimal requirements for EFS. For DHTs, there is an absence of specific standards for clinical investigations and EFS. Regulatory guidance offers some relevant insights but does not conclusively address EFS studies. Pilot structures for advice under the MDR are currently in testing phases. Our analysis highlights the importance of iterative processes in EFS and stresses that early advice and ongoing engagement with competent authorities when undertaking these studies is essential ***Conclusions:*** EFS are possible in the EU system but are not specifically facilitated. Additionally, available guidance, standards, and templates do not address EFS-specific considerations. DHTs have unique conceptual characteristics, with a focus on validation, and the results of an EFS for these technologies can sometimes be used to achieve both market access (CE marking) and provisional reimbursement in certain EU Member States.

HPR99
DOES HTA UNDERMINE THE GOALS OF EMA AUTHORIZATION PATHWAYS? TIME TO AVAILABILITY OF DRUGS LICENSED UNDER CONDITIONAL MARKETING AUTHORIZATION COMPARED TO STANDARD MARKETING AUTHORIZATION

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Objectives: To expedite the drug approval process, the European Medicines Agency(EMA) has implemented programs, like the conditional marketing authorization(CMA), thatgrantaccess based on incomplete evidence at launch. However, while EMA focuses on the overall risk-benefit ratio of treatments, national payers in the European Union (EU) focus on their long-term benefits, cost-effectiveness and budget impact, thus reflecting a misalignment in incentives and missions. As part of the Horizon Europe project HI-PRIX (GrantAgreement: 101095593), this study investigated the time to availability ofCMAdrugs, compared to standard marketing authorization(SMA), in Italy, Germany, and Spain. ***Methods:*** Time to availability is defined as "inclusion of centrally approved medicines on the public reimbursement list in a country". CMA-licensed drugs from 2006-2022 were retrieved. Another group of SMA, drugs comparable in terms of therapeutic indication and time of approval, was identified. For each retrieved drug, the following data was collected: drug information at launch time (orphan status, indication, PRIME status); information on the approval (pathway, authorization date, clinical evidence at approval); reimbursement dates in each national context (using Farmadati, Lauer-Taxe, and BIFIMED data for Italy, Germany and Spain, respectively). ***Results:*** A total of 65 CMA-SMA matched-drugs were analyzed. In Italy, median time to availability was 515 (IQR: 413-766) days for CMA drugs, against median 455 (IQR: 324-664) days for SMA drugs. In Spain, median time was 696 (IQR: 462-1,051) days for CMA drugs, against median 500 (IQR: 378-693) days for SMA drugs. In Germany, median time was 38 (IQRCMA: 26-146; IQRSMA: 27-94) days for both pathways. ***Conclusions:*** The EMA approval process is being accelerated; payer access is not. Delays in payer coverage and access in major EU nations are counteracting the intent of specific authorization pathways by the EMA, like CMA. Will the Joint Clinical Assessment contribute to accelerating (and standardizing) time-to-access across member states?

HPR100
THE IMPACT OF PRICE NEGOTIATION ON THE PRICING OF INNOVATIVE DRUGS IN CHINA

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