STATISTICAL COMPENDIUM:
MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT IN 2003
ALASKA

LIST OF TABLES

FOR DUAL ELIGIBLE BENEFICIARIES

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TABLE 1
OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
ALASKA, 2003

Inclusion Criteria (2003)	Number of Dual and Non-dual Eligible Beneficiaries (Cell)		Number of Dual Eligible Beneficiaries (Cell)[g]		Number of Non-dual Eligible Beneficiaries (Cell)	
1. Beneficiaries who were eligible for Medicaid during at least one month[a]	128,651	(A)	12,167	(E)	116,484	(I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	128,493	(B)	12,012	(F)	116,481	(j)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	128,493	(C)	12,012	(G)	116,481	(K)
4. Beneficiaries who were all-year nursing facility residents[f]	468	(D)	397	(H)	71	(L)

Source: Data for this table are from the MAX 2003 file for Alaska, released by CMS in 04/2007. This table was produced on 11/01/2007.

a. MAX data element "Eligible Months Count" was used to determine an individual's Medicaid eligibility. All individuals who had a value greater than zero were considered as beneficiaries and counted in Cell A.

b. Counts in Cell B were obtained by excluding from Cell A beneficiaries who never had pharmacy benefit coverage during their Medicaid enrollment in 2003 (based on MAX data element "Eligible Restricted Benefits Flag").

c. Cell C represents the study population for Tables 2 through 7. Cell C was obtained by excluding from Cell B beneficiaries who were in managed care (MC) plans that included prescription drugs in their capitated benefit package during all months of Medicaid eligibility in 2003, because the MAX files do not include separate prescription drug claims for those beneficiaries. MC plans include health maintenance organizations (HMOs), prepaid health plans (PHPs), or other MC organizations that provide health care benefits under capitation arrangements. Beneficiaries included in the study population are those who were in fee-for-service or primary care case management (PCCM) programs. In addition, beneficiaries in selected states in which prescription drug benefits were not covered in the capitated benefit package in MC or PHP plans are also included (see footnote e for a list of these states). In those states, if a beneficiary spent part of the year in fee-for-service, PCCM, or in a PHP or MC plan in which drugs were not included in the capitation, and spent part of the year in a PHP or MC plan in which drugs were capitated, only the months with fee-for-service pharmacy benefits are included in the tables. For example, if a beneficiary was in an MC plan that did not include prescription drugs in the capitation for 3 months of the year, and in a PHP with capitated drug coverage for the remaining 9 months, only the 3 months would be counted toward the number of benefit months associated with the beneficary. Therefore, benefit months included represent the benefit months with fee-for-service pharmacy benefits.

d. The total Medicaid pharmacy reimbursement for Alaska in 2003 was $100,632,749, of which $3,899,584 was excluded from our analysis because those claims were made for beneficiaries who were outside the study population or took place during months that were excluded from the analysis.

e. Enrollees in prepaid health plans (PHP) or managed care (MC) plans that did not provide a pharmacy benefit are treated as having fee-for-service pharmacy benefit coverage. There were 19 states in 2003 that had PHPs that did not include a pharmacy benefit: AL, AR, CA, CO, FL, GA, IA, KY, MA, MI, NY, OR, PA, SD, TN, TX, UT, WA, and WI. In addition, there were 7 states in which MC plans did not provide a pharmacy benefit: DE, IA, NE, NY, TX, UT, and WV. These lists were constructed from the CMS 2003 Medicaid Managed Care Enrollment Report [http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/Downloads/mmcer02.pdf] and by checking PHP and MC pharmacy coverage as necessary through state, PHP, and MC web sites. As a further check, we analyzed prescription drug claims for those reported as being in managed care all year in the MAX files (see Appendix Tables A.1 and A.3) to determine whether the annual number and cost of claims per person for those beneficiaries were comparable to those of beneficiaries reported as being in fee-for-service all year. If they were, that provided additional evidence that prescription drugs were not included in the managed care capitated benefit package.

f. Cell H represents the study population for Tables D.8 through D.10D. Cell L represents the study population for Tables ND.8 through ND.10D. All-year nursing facility residents are the beneficiaries who resided in nursing facilities throughout their enrollment in 2003. These beneficiaries were identified by comparing the number of months during which the MAX files contained at least one claim from nursing facilities to the number of Medicaid eligible months. If the former is greater than or equal to the latter, the beneficiary was considered an all-year resident. If the former is less than the latter but not equal to zero, the beneficiary was considered a part-year resident. Part-year residents are treated seperately because they are likely to be short-term residents and the level and pattern of their pharmacy benefit use may differ substantially from longer-term residents. The number of part-year residents and their benefit months are presented in footnotes to Tables D.8 through D.10D and ND.8 through ND.10D. Residents of mental hospitals for the aged, inpatient psychiatric facilities for individuals under age 21, or intermediate care facilities for the mentally retarded are not counted as nursing facility residents in the nursing facility tables.

g. Pharmacy benefit use and reimbursement among full dual eligible beneficiaries are presented in Tables D.2 through D.7D, Tables D.11 through D.13, and Supplemental Tables 1 through 1E corresponding to the sample of beneficiaries in Cell G. To determine Medicaid-Medicare dual eligibility status, two MAX data elements ("Eligible Medicare Crossover Code -- Annual New Values" and "Eligible Restricted Benefits Flag") were used in combination. The dual eligible tables include all dual eligible benefit months in which the benficiary had a fee-for-service pharmacy benefit.

Beneficiaries represented in Cell G, the dual study population, include all dual eligible beneficiaries who had a fee-for-service pharmacy benefit at least during one month in 2003. The dual eligible tables include all dual eligible benefit months in which the beneficiary had a fee-for-service pharmacy benefit.

Characteristics of non-dual eligible beneficiaries represented by Cell J are shown in Appendix Table A.1 and characteristics of non-dual eligible beneficiaries and their benefit months included in Cell J but excluded from Cell K are shown in Appendix Table A.2. Characteristics of dual eligible beneficiaries represented by Cell F are shown in Appendix Table A.3, and characteristics of dual eligible beneficiaries and their benefit months included in Cell F but excluded from Cell G are shown in Appendix Table A.4.

Bene(s) = beneficiary (or beneficiaries); CMS = Centers for Medicare & Medicaid Services; HMO = health maintenance organization; MAX = Medicaid Analytic Extract; MC = managed care; PCCM = primary care case management; PHP = prepaid health plan.

TABLE 2

CHARACTERISTICS OF MEDICAID STUDY POPULATION BENEFICIARIES, BY BASIS OF ELIGIBILITY[a, b]

ALASKA, 2003

Beneficiary Characteristics	Number of Beneficiaries						Number of Benefit Months					
	All	Aged	Disabled	Adults	Children	Other/ Unknown	All	Aged	Disabled	Adults	Children	Other/ Unknown
All	**128,493**	**6,942**	**13,175**	**27,197**	**81,179**	**0**	**1,120,623**	**70,954**	**137,576**	**190,699**	**721,394**	**0**
Age												
5 and younger	31,240	0	341	0	30,899	0	265,719	0	3,181	0	262,538	0
6-14	37,529	1	790	5	36,733	0	350,267	3	8,552	28	341,684	0
15-20	18,788	6	712	4,739	13,331	0	156,853	18	7,383	33,264	116,188	0
21-44	24,604	53	4,570	19,767	214	0	184,896	256	48,021	135,642	977	0
45-64	8,872	68	6,154	2,649	1	0	86,073	562	64,070	21,435	6	0
65-74	3,809	3,204	569	36	0	0	39,281	32,959	5,996	326	0	0
75-84	2,725	2,688	36	1	0	0	28,343	27,994	345	4	0	0
85 and older	925	922	3	0	0	0	9,190	9,162	28	0	0	0
Unknown	1	0	0	0	1	1 0		0	0	0	1	0
Gender												
Female	70,993	4,449	6,653	20,317	39,574	0	609,676	45,810	70,335	141,128	352,403	0
Male	57,497	2,493	6,522	6,880	41,602	0	510,920	25,144	67,241	49,571	368,964	0
Unknown	3	0	0	0	3	0	27	0	0	0	27	0
Race												
White	54,644	2,773	7,462	12,303	32,106	0	472,517	27,174	77,246	85,008	283,089	0
African American	6,748	176	765	1,340	4,467	0	58,420	1,754	7,826	9,718	39,122	0
Other/unknown	67,101	3,993	4,948	13,554	44,606	0	589,686	42,026	52,504	95,973	399,183	0
Use of Nursing Facilities[c]												
Entire year	468	347	121	0	0	0	4,562	3,373	1,189	0	0	0
Part year	447	291	152	3	1	0	4,102	2,605	1,460	27	10	0
None	127,578	6,304	12,902	27,194	81,178	0	1,111,959	64,976	134,927	190,672	721,384	0
Maintenance Assistance Status												
Cash	51,849	5,894	12,027	15,943	17,985	0	472,381	61,836	125,980	123,315	161,250	0
Medically needy	0	0	0	0	0	0 0		0	0	0	0	0
Poverty-related	65,605	112	7	8,918	56,568	0	550,901	699	58	50,176	499,968	0
Other/unknown	11,039	936	1,141	2,336	6,626	0	97,341	8,419	11,538	17,208	60,176	0
Dual Medicare Status[d]												
Full dual, all year	11,979	6,195	5,652	126	6	0	124,901	63,860	59,963	1,036	42	0
Full dual, part year	33	23	10	0	0	0	303	216	87	0	0	0
Non-dual, all year	116,481	724	7,513	27,071	81,173	0	995,419	6,878	77,526	189,663	721,352	0
Managed Care (MC) Status												
Fee-for-service (FFS) all year	128,493	6,942	13,175	27,197	81,179	0	1,120,623	70,954	137,576	190,699	721,394	0
FFS part year, with Rx claims	0	0	0	0	0	0 0		0	0	0	0	0
FFS part year, no Rx claims	0	0	0	0	0	0 0		0	0	0	0	0

Source: Data for this table are from the MAX 2003 file for Alaska, released by CMS in 04/2007. This table was produced on 11/01/2007.

a. Table 2 includes the beneficiaries represented by Cell C of Table 1. Benefit months are months during which beneficiaries had fee-for-service pharmacy benefits.

b. Medicaid basis of eligibility is classified as: aged, disabled, adults, and children. The disabled group includes beneficiaries of any age who were determined to be eligible because of disability or blindness. The children's group includes children receiving foster care and adoptive services. The total includes some beneficiaries with unknown basis of eligibility and some whose age categories are not consistent with basis of eligibility.

c. Please refer to footnote f of Table 1 for methodology used to determine nursing facility residence.

d. The "Full dual, all year" group includes beneficiaries who had Medicare coverage as well as Medicaid fee-for-service pharmacy benefits during all months of Medicaid enrollment in 2003. The “Full dual, part year” group includes beneficiaries who had such benefits for some, but not all, months of their enrollment. The "Non-dual, all year" group includes beneficiaries who were never dually eligible. Refer to footnote g of Table 1 for more information about how we determined dual eligibility status.

Bene(s) = beneficiary (or beneficiaries); Bene Mo(s) = benefit month(s); CMS = Centers for Medicare & Medicaid Services; FFS = fee-for-service pharmacy benefit; MAX = Medicaid Analytic Extract; MC = managed care; Rx = pharmacy benefit.

TABLE 3

ANNUAL MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT PER BENEFICIARY, BY BENEFICIARY CHARACTERISTIC[a, b]

ALASKA, 2003

Beneficiary Characteristics	Percentage with at Least One Rx	Mean Number of Rx	Mean Rx $	$ per Rx	Mean $, All Medicaid FFS $[c]	Rx $ as a Percentage of All Medicaid FFS $[d]	Number of Beneficiaries
All	**57.4 %**	**11.3**	**$753**	**$67**	**$6,511**	**11.6 %**	**128,493**
Age							
5 and younger	53.4	2.3	134	58	4,208	3.2	31,240
6-14	44.4	2.7	223	81	3,209	7.0	37,529
15-20	52.4	4.1	350	86	6,266	5.6	18,788
21-44	68.2	14.5	1,129	78	7,944	14.2	24,604
45-64	82.0	49.4	3,495	71	15,485	22.6	8,872
65-74	84.6	46.9	2,441	52	12,439	19.6	3,809
75-84	89.5	58.8	2,609	44	21,120	12.4	2,725
85 and older	90.1	72.1	2,613	36	31,617	8.3	925
Unknown	0.0	0.0	0	0	0	0.0	1
Basis of Eligibility[e]							
Aged	86.6	54.2	2,477	46	18,353	13.5	6,942
Disabled	85.3	51.1	4,075	80	22,636	18.0	13,175
Adults	63.3	7.2	418	58	4,462	9.4	27,197
Children	48.4	2.5	178	70	3,568	5.0	81,179
Unknown	0.0	0.0	0	0	0	0.0	0
Gender							
Female	61.1	13.4	801	60	6,681	12.0	70,993
Male	52.8	8.7	694	80	6,301	11.0	57,497
Unknown	33.3	0.3	4	11	4,300	0.1	3
Race							
White	63.2	15.7	1,084	69	6,954	15.6	54,644
African American	56.0	11.6	738	64	5,228	14.1	6,748
Other/unknown	52.8	7.7	484	63	6,279	7.7	67,101
Use of Nursing Facilities[f]							
Entire year	97.4	87.2	5,261	60	102,466	5.1	468
Part year	97.5	83.8	4,456	53	58,101	7.7	447
None	57.1	10.8	723	67	5,978	12.1	127,578
Maintenance Assistance Status							
Cash	66.2	21.3	1,424	67	8,472	16.8	51,849
Medically needy	0.0	0.0	0	0	0	0.0	0
Poverty related	49.6	2.5	173	70	3,632	4.8	65,605
Other/unknown	62.1	16.9	1,048	62	14,411	7.3	11,039

Source: Data for this table are from the MAX 2003 file for Alaska, released by CMS in 04/2007. This table was produced on 11/01/2007.

a. Table 3 includes beneficiaries represented by Cell C of Table 1.

b. The Medicaid reimbursement amounts presented in this table do not reflect federally required rebates from drug manufacturers to the state.

c. In seven states (DE, IA, NE, NY, TX, UT, and WV) the expenditures in this column include only Rx drug expenditures for those enrolled in capitated managed care plans, and not expenditures for other services covered by the plans or long-term-care services not covered by the plans. As a result, the amounts shown in this column for all Medicaid fee-for-service expenditures are lower than they would otherwise be.

d. In seven states (DE, IA, NE, NY, TX, UT, and WV) the Rx share of expenditures for all Medicaid services shown in this column is higher than it would be if all expenditures for these other services, including services provided in capitated managed care plans and long-term-care services, were included.

e. Medicaid basis of eligibility is classified as: aged, disabled, adults, and children. The disabled group includes beneficiaries of any age who were determined to be eligible because of disability or blindness. The children's group includes children receiving foster care and adoptive services.

f. Please refer to footnote f of Table 1 for methodology used to determine nursing facility residence.

Bene(s) = beneficiary (or beneficiaries); CMS = Centers for Medicare & Medicaid Services; FFS = fee-for-service; MAX = Medicaid Analytic Extract; OTC = over-the-counter; Rx = prescription(s) or pharmacy benefit; $ = Medicaid reimbursement.

TABLE 4

MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT *PER BENEFIT MONTH*, BY BENEFICIARY CHARACTERISTIC[a, b]

ALASKA, 2003

Beneficiary Characteristics	Mean Number of Rx	Mean Rx $	Rx $ as a Percentage of All Medicaid FFS $[c]	Number of Rx, Percentage with: None	More than 0, but 1 or Less	More than 1, but 2 or Less	More than 2, but 5 or Less	More than 5, but 10 or Less	More than 10	Mean $, All Medicaid FFS $[d]	Number Beneficiaries	Benefit Months
All	**1.3**	**$86**	**11.6 %**	**42.6 %**	**41.7 %**	**4.9 %**	**5.8 %**	**3.2 %**	**1.8 %**	**$747**	**128,493**	**1,120,623**
Age												
5 and younger	0.3	16	3.2	46.6	50.9	1.9	0.6	0.0	0.0	495	31,240	265,719
6-14	0.3	24	7.0	55.6	40.1	2.4	1.6	0.2	0.1	344	37,529	350,267
15-20	0.5	42	5.6	47.6	44.4	4.5	2.8	0.6	0.1	751	18,788	156,853
21-44	1.9	150	14.2	31.8	42.6	8.9	9.8	4.7	2.2	1,057	24,604	184,896
45-64	5.1	360	22.6	18.0	23.4	10.6	20.8	17.0	10.3	1,596	8,872	86,073
65-74	4.5	237	19.6	15.4	24.5	12.2	24.7	14.4	8.8	1,206	3,809	39,281
75-84	5.7	251	12.4	10.5	22.2	12.1	25.3	17.7	12.1	2,031	2,725	28,343
85 and older	7.3	263	8.3	9.9	18.3	9.7	25.3	17.4	19.4	3,182	925	9,190
Unknown	0.0	0	0.0	100.0	0.0	0.0	0.0	0.0	0.0	0	1	1
Basis of Eligibility[e]												
Aged	5.3	242	13.5	13.4	23.0	11.9	24.8	15.7	11.3	1,796	6,942	70,954
Disabled	4.9	390	18.0	14.7	25.4	10.8	21.4	17.0	10.7	2,168	13,175	137,576
Adults	1.0	60	9.4	36.7	45.5	8.0	7.2	2.2	0.4	636	27,197	190,699
Children	0.3	20	5.0	51.6	44.7	2.3	1.2	0.2	0.0	402	81,179	721,394
Unknown	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Gender												
Female	1.6	93	12.0	38.9	42.9	5.5	6.6	3.8	2.3	778	70,993	609,676
Male	1.0	78	11.0	47.2	40.2	4.2	4.9	2.3	1.3	709	57,497	510,920
Unknown	0.0	0	0.1	66.7	33.3	0.0	0.0	0.0	0.0	478	3	27
Race												
White	1.8	125	15.6	36.8	42.6	5.8	7.3	4.7	2.9	804	54,644	472,517
African American	1.3	85	14.1	44.0	41.5	4.9	5.3	2.4	2.0	604	6,748	58,420
Other/unknown	0.9	55	7.7	47.2	41.0	4.2	4.7	2.0	1.0	715	67,101	589,686
Use of Nursing Facilities[f]												
Entire year	8.9	540	5.1	2.6	5.3	6.0	25.2	33.8	27.1	10,512	468	4,562
Part year	9.1	486	7.7	2.5	8.5	6.0	25.5	32.4	25.1	6,331	447	4,102
None	1.2	83	12.1	42.9	41.9	4.9	5.7	2.9	1.7	686	127,578	1,111,959
Maintenance Assistance Status												
Cash	2.3	156	16.8	33.8	37.5	7.3	11.1	6.6	3.7	930	51,849	472,381
Medically needy	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Poverty related	0.3	21	4.8	50.4	45.4	2.8	1.3	0.2	0.0	433	65,605	550,901
Other/unknown	1.9	119	7.3	37.9	39.5	6.4	7.9	4.7	3.6	1,634	11,039	97,341

Source: Data for this table are from the MAX 2003 file for Alaska, released by CMS in 04/2007. This table was produced on 11/01/2007.

a. Table 4 includes the beneficiaries represented by Cell C of Table 1. Benefit months are months during which beneficiaries had fee-for-service pharmacy benefits.

b. The Medicaid reimbursement amounts presented in this table do not reflect federally required rebates from drug manufacturers to the state.

c. In seven states (DE, IA, NE, NY, TX, UT, and WV) the expenditures in this column include only Rx drug expenditures for those enrolled in capitated managed care plans, and not expenditures for other services covered by the plans or long-term-care services not covered by the plans. As a result, the amounts shown in this column for all Medicaid fee-for-service expenditures are lower than they would otherwise be.

d. In seven states (DE, IA, NE, NY, TX, UT, and WV) the Rx share of expenditures for all Medicaid services shown in this column is higher than it would be if all expenditures for these other services, including services provided in capitated managed care plans and long-term-care services, were included.

e. Medicaid basis of eligibility is classified as: aged, disabled, adults, and children. The disabled group includes beneficiaries of any age who were determined to be eligible because of disability or blindness. The children's group includes children receiving foster care and adoptive services.

f. Please refer to footnote f of Table 1 for methodology used to determine nursing facility residence.

Bene(s) = beneficiary (or beneficiaries); Bene Mo(s) = benefit month(s); CMS = Centers for Medicare & Medicaid Services; FFS = fee-for-service; MAX = Medicaid Analytic Extract; Rx = prescription(s) or pharmacy benefit; $ = Medicaid reimbursement.

TABLE 5

AVERAGE MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT PER BENEFIT MONTH, BY BRAND STATUS AND BENEFICIARY CHARACTERISTIC[a, b, c]

ALASKA, 2003

	All Rx			Patented Brand-Name Drugs			Off-Patent Brand-Name Drugs			Generic Drugs		
Beneficiary Characteristics	Number of Rx	Rx $	$ per Rx	Number of Rx	Rx $	$ per Rx	Number of Rx	Rx $	$ per Rx	Number of Rx	Rx $	$ per Rx
All	**1.3**	**$86**	**$67**	**0.6**	**$68**	**$110**	**0.1**	**$4**	**$45**	**0.6**	**$14**	**$24**
Age												
5 and younger	0.3	16	58	0.1	12	113	0.0	1	43	0.1	3	18
6-14	0.3	24	81	0.2	20	128	0.0	1	72	0.1	3	24
15-20	0.5	42	86	0.2	35	145	0.0	2	67	0.2	5	23
21-44	1.9	150	78	0.9	121	133	0.1	6	55	0.9	23	25
45-64	5.1	360	71	2.5	286	114	0.3	15	49	2.3	59	26
65-74	4.5	237	52	2.1	177	84	0.4	13	36	2.1	46	22
75-84	5.7	251	44	2.7	185	69	0.5	15	29	2.5	51	21
85 and older	7.3	263	36	3.3	187	57	0.7	17	24	3.3	59	18
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Basis of Eligibility[d]												
Aged	5.3	242	46	2.5	179	73	0.5	14	30	2.4	49	21
Disabled	4.9	390	80	2.5	318	126	0.3	16	54	2.1	56	27
Adults	1.0	60	58	0.4	44	112	0.1	3	49	0.6	13	22
Children	0.3	20	70	0.1	16	119	0.0	1	55	0.1	3	21
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Gender												
Female	1.6	93	60	0.7	72	98	0.1	4	42	0.7	17	23
Male	1.0	78	80	0.5	64	133	0.1	3	52	0.4	11	25
Unknown	0.0	0	11	0.0	0	0	0.0	0	0	0.0	0	11
Race												
White	1.8	125	69	0.9	100	111	0.1	5	47	0.8	20	25
African American	1.3	85	64	0.7	69	102	0.1	3	40	0.6	13	22
Other/unknown	0.9	55	63	0.4	43	111	0.1	3	44	0.4	9	22
Use of Nursing Facilities[e]												
Entire year	8.9	540	60	4.2	406	97	0.8	30	38	4.0	102	26
Part year	9.1	486	53	4.3	366	85	0.8	23	31	4.0	96	24
None	1.2	83	67	0.6	66	111	0.1	4	46	0.6	13	24
Maintenance Assistance Status												
Cash	2.3	156	67	1.1	124	110	0.2	7	45	1.1	26	24
Medically needy	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Poverty related	0.3	21	70	0.1	17	125	0.0	1	55	0.1	3	21
Other/unknown	1.9	119	62	0.9	93	99	0.1	6	42	0.8	19	23

Source: Data for this table are from the MAX 2003 file for Alaska, released by CMS in 04/2007. This table was produced on 11/01/2007.

a. Table 5 includes the beneficiaries represented by Cell C of Table 1. Benefit months are months during which beneficiaries had fee-for-service pharmacy benefits.

b. The Medicaid reimbursement amounts presented in this table do not reflect federally required rebates from drug manufacturers to the state.

c. Brand-name drugs, sometimes called “innovator single-source drugs,” are drugs whose patents have not yet expired. Off-patent brand-name drugs, sometimes called “innovator multiple-source drugs,” are brand-name drugs whose patents have expired. Generic drugs, sometimes called “non-innovator multiple-source drugs,” are off-patent drugs manufactured and sold by companies other than the original patent holder. In Alaska, 5.4 percent of drug claims have missing values for brand status. Thus, the sum of the three groups in this table may be smaller than all prescriptions combined. For information about this classification method, see Wolters Kluwer Health, http://www.medispan.com/marketing/ContentPage.aspx?contentId=09e0f1ed-80a9-4a87-8bc9-ad778d7b6615 (October 26, 2007)

d. Medicaid basis of eligibility is classified as: aged, disabled, adults, and children. The disabled group includes beneficiaries of any age who were determined to be eligible because of disability or blindness. The children's group includes children receiving foster care and adoptive services.

e. Please refer to footnote f of Table 1 for methodology used to determine nursing facility residence.

CMS = Centers for Medicare & Medicaid Services; MAX = Medicaid Analytic Extract; Rx = prescription(s) or pharmacy benefit; $ = Medicaid reimbursement.

TABLE 6

MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT, BY BRAND STATUS AND THERAPEUTIC CATEGORY[a, b, c, d]

ALASKA, 2003

Therapeutic Category	Number of Rx per Benefit Month Among Users				$ per Benefit Month Among Users				$ per Rx				Total Number of Rx	Total Rx $	Users[e]		
	Total	Patented Brand-Name	Off-Patent Brand-Name	Generic	Total	Patented Brand-Name	Off-Patent Brand-Name	Generic	Total	Patented Brand-Name	Off-Patent Brand-Name	Generic			Number of Users	As a Percentage of All Benes	Number of Benefit Months
Anti-infective Agents	0.2	0.1	0.0	0.1	$17	$13	$1	$3	$70	$117	$84	$27	109,131	$7,590,925	44,058	34.3 %	437,363
Biologicals	0.3	0.3	0.0	0.0	401	401	0	0	1161	1,161	0	0	1,058	1,228,189	348	0.3	3,061
Antineoplastic Agents	0.6	0.3	0.1	0.3	177	159	4	14	281	554	68	48	5,440	1,525,980	833	0.6	8,643
Endocrine/Metabolic Drugs	0.8	0.4	0.2	0.3	35	24	5	6	42	60	30	24	131,773	5,587,803	16,217	12.6	159,324
Cardiovascular Agents	1.9	0.7	0.1	1.1	65	42	4	18	33	59	30	17	252,175	8,411,069	12,400	9.7	129,801
Respiratory Agents	0.5	0.3	0.0	0.2	30	24	1	4	61	84	70	24	111,028	6,784,497	22,727	17.7	229,917
Gastrointestinal Agents	0.8	0.5	0.0	0.3	77	64	2	12	98	130	140	42	98,268	9,657,317	12,131	9.4	124,861
Genitourinary Agents	0.5	0.4	0.0	0.1	23	21	1	2	51	58	42	18	21,646	1,094,882	4,805	3.7	47,310
CNS Drugs	1.5	0.9	0.0	0.5	124	107	4	13	83	115	112	25	275,747	22,853,962	18,397	14.3	184,631
Stimulants/Anti-obesity/Anorexia	0.6	0.4	0.1	0.1	56	45	4	7	87	102	74	46	22,380	1,953,304	3,359	2.6	34,785
Miscellaneous Psychological/ Neurological Agents	1.3	1.2	0.0	0.0	172	172	0	0	137	138	0	15	5,726	783,804	433	0.3	4,561
Analgesics and Anesthetics	0.6	0.2	0.0	0.4	41	30	2	9	67	157	48	23	169,285	11,404,447	28,659	22.3	280,483
Neuromuscular Agents	1.0	0.5	0.1	0.5	65	50	3	12	64	103	40	27	116,289	7,498,334	11,147	8.7	114,766
Nutritional Products	0.5	0.0	0.0	0.4	7	0	1	6	16	34	22	15	32,927	529,515	7,578	5.9	70,920
Hematological Agents	1.0	0.4	0.3	0.4	205	194	6	5	204	529	22	14	29,978	6,109,598	2,865	2.2	29,736
Topical Products	0.2	0.1	0.0	0.1	10	7	1	3	44	76	58	22	61,801	2,745,688	25,979	20.2	261,814
Miscellaneous Products	0.3	0.2	0.0	0.1	55	40	7	8	187	239	191	87	3,817	713,033	1,253	1.0	12,871
Unknown Therapeutic Category	0.2	0.0	0.0	0.0	9	0	0	0	54	0	0	0	4,798	260,818	2,879	2.2	29,657
TOTAL NO. OF RX AND RX $	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	n.a.	1,453,267	96,733,165	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2003 file for Alaska, released by CMS in 04/2007. This table was produced on 11/01/2007.

a. Table 6 includes the beneficiaries represented by Cell C of Table 1. A beneficiary who used drugs from two or more categories was counted as a user for each category. Therefore, the sum of users across categories may exceed the total number of individual users. Benefit months are months during which beneficiaries had fee-for-service pharmacy benefits.

b. Medicaid reimbursement amounts presented in this table do not reflect federally required rebates from drug manufacturers to the state.

c. For information about these therapeutic categories, see Wolters Kluwer Health, http://www.medispan.com/marketing/ContentPage.aspx?contentId=09e0f1ed-80a9-4a87-8bc9-ad778d7b6615 (October 26, 2007).

d. Brand-name drugs, sometimes called “innovator single-source drugs,” are drugs whose patents have not yet expired. Off-patent brand-name drugs, sometimes called “innovator multiple-source drugs,” are brand-name drugs whose patents have expired. Generic drugs, sometimes called “non-innovator multiple-source drugs,” are off-patent drugs manufactured and sold by companies other than the original patent holder. In Alaska, 5.4 percent of drug claims have missing values for brand status. Thus, the sum of the three groups in this table may be smaller than all prescriptions combined. For information about this classification method, see Wolters Kluwer Health, http://www.medispan.com/marketing/ContentPage.aspx?contentId=09e0f1ed-80a9-4a87-8bc9-ad778d7b6615 (October 26, 2007).

e. A user is a beneficiary who had at least one prescription filled in a given therapeutic category during 2003.

Bene(s) = beneficiary (or beneficiaries); Bene Mo(s) = benefit month(s); CMS = Centers for Medicare & Medicaid Services; CNS = Central Nervous System; MAX = Medicaid Analytic Extract; n.a. = not applicable; Rx = prescription(s) or pharmacy benefit; $ = Medicaid reimbursement.

TABLE 7

MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT, BY TOP 10 DRUG GROUP[a, b, c]

ALASKA, 2003

		Users			Among Users		
Top 10 Drug Groups	Total Medicaid Rx $	Number	As a Percentage of All Beneficiaries	Number of Benefit Months	Number of Rx per Benefit Month	$ per Rx	Rx $ per Benefit Month
ANTIPSYCHOTICS	$13,736,845	7,335	5.7 %	78,440	1.2	$151	$175
ANTIDEPRESSANTS	7,401,109	16,943	13.2	173,688	0.8	55	43
ULCER DRUGS	6,976,426	11,252	8.8	117,628	0.7	91	59
ANALGESICS - Narcotic	6,580,748	30,489	23.7	303,783	0.3	64	22
ANTICONVULSANT	6,081,520	7,021	5.5	74,668	1.0	81	81
ANTIASTHMATIC	4,487,721	20,806	16.2	215,017	0.3	67	21
MISC. HEMATOLOGICAL	4,311,227	882	0.7	9,545	1.1	425	452
ANALGESICS - ANTI-INFLAMMATORY	3,807,064	17,225	13.4	173,660	0.3	70	22
ANTIDIABETIC	2,932,835	5,633	4.4	59,730	0.9	53	49
ANTIHYPERLIPIDEMIC	2,705,159	4,075	3.2	44,277	0.9	69	61
Total	59,020,654	121,661		1,250,436	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2003 file for Alaska, released by CMS in 04/2007. This table was produced on 11/01/2007.

a. Table 7 includes the beneficiaries represented by Cell C of Table 1. A user is a beneficiary who had at least one prescription filled in a given drug group during 2003. A beneficiary who used drugs from two or more groups was counted as a user for each group. Therefore, the sum of users across drug groups may exceed the total number of individual users. Benefit months are months during which beneficiaries had fee-for-service pharmacy benefits.

b. Medicaid reimbursement amounts presented in this table do not reflect federally required rebates from drug manufacturers to the state.

c. The top 10 drug groups were determined based on total Medicaid reimbursement in the state for 2003. For information about these drug groups, see Wolters Kluwer Health, http://www.medispan.com/marketing/ContentPage.aspx?contentId=09e0f1ed-80a9-4a87-8bc9-ad778d7b6615 (October 26, 2007).

Bene(s) = beneficiary (or beneficiaries); Bene Mo(s) = benefit month(s); CMS = Centers for Medicare & Medicaid Services; MAX = Medicaid Analytic Extract; Rx = prescription(s) or pharmacy benefit; $ = Medicaid reimbursement.