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

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TABLE 1
OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
CONNECTICUT, 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]	511,681	(A)	96,731	(E)	414,950	(I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	495,229	(B)	80,573	(F)	414,656	(j)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	213,999	(C)	80,380	(G)	133,619	(K)
4. Beneficiaries who were all-year nursing facility residents[f]	19,877	(D)	18,627	(H)	1,250	(L)

Source: Data for this table are from the MAX 2003 file for Connecticut, released by CMS in 05/2007. 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 Connecticut in 2003 was $397,842,148, of which $124,101 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]

CONNECTICUT, 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	**213,999**	**52,301**	**59,134**	**34,312**	**68,252**	**0**	**1,436,122**	**543,539**	**632,303**	**88,997**	**171,283**	**0**
Age												
5 and younger	24,630	0	0	5	24,625	0	56,809	0	0	12	56,797	0
6-14	26,037	0	1	7	26,029	0	67,208	0	12	20	67,176	0
15-20	17,974	1	862	1,512	15,599	0	53,367	6	7,447	3,439	42,475	0
21-44	55,124	46	24,411	28,712	1,955	0	336,492	385	260,694	70,676	4,737	0
45-64	37,619	118	33,524	3,945	32	0	375,896	1,024	361,002	13,788	82	0
65-74	16,888	16,435	335	117	1	0	182,347	178,251	3,136	957	3	0
75-84	17,988	17,975	1	12	0	0	189,232	189,128	12	92	0	0
85 and older	17,728	17,726	0	2	0	0	174,758	174,745	0	13	0	0
Unknown	11	0	0	0	11	0	13	0	0	0	13	0
Gender												
Female	129,608	38,294	30,952	25,903	34,459	0	888,041	401,602	335,614	65,521	85,304	0
Male	84,391	14,007	28,182	8,409	33,793	0	548,081	141,937	296,689	23,476	85,979	0
Unknown	0	0	0	0	0	0 0		0	0	0	0	0
Race												
White	113,692	37,797	33,675	15,462	26,758	0	860,864	386,465	363,982	41,126	69,291	0
African American	40,021	6,095	11,280	6,888	15,758	0	243,208	66,389	118,829	18,427	39,563	0
Other/unknown	60,286	8,409	14,179	11,962	25,736	0	332,050	90,685	149,492	29,444	62,429	0
Use of Nursing Facilities[c]												
Entire year	19,877	17,638	2,217	1	21	0	203,340	178,759	24,343	3	235	0
Part year	9,295	7,102	2,157	19	17	0	92,067	69,251	22,567	136	113	0
None	184,827	27,561	54,760	34,292	68,214	0	1,140,715	295,529	585,393	88,858	170,935	0
Maintenance Assistance Status												
Cash	38,667	5,821	14,345	6,281	12,220	0	269,037	65,786	161,791	14,545	26,915	0
Medically needy	41,401	12,946	25,470	903	2,082	0	415,022	135,797	270,148	2,822	6,255	0
Poverty-related	34,087	1,064	1,369	5,904	25,750	0	99,957	11,229	14,566	11,385	62,777	0
Other/unknown	99,844	32,470	17,950	21,224	28,200	0	652,106	330,727	185,798	60,245	75,336	0
Dual Medicare Status[d]												
Full dual, all year	75,023	46,142	27,151	1,693	37	0	793,446	479,326	298,954	14,904	262	0
Full dual, part year	5,357	2,547	2,773	36	1	0	59,793	28,591	30,813	377	12	0
Non-dual, all year	133,619	3,612	29,210	32,583	68,214	0	582,883	35,622	302,536	73,716	171,009	0
Managed Care (MC) Status												
Fee-for-service (FFS) all year	131,585	52,281	58,286	9,220	11,798	0	1,246,128	543,423	627,295	33,035	42,375	0
FFS part year, with Rx claims	15,272	16	670	6,244	8,342	0	43,538	94	4,296	16,790	22,358	0
FFS part year, no Rx claims	67,142	4	178	18,848	48,112	0	146,456	22	712	39,172	106,550	0

Source: Data for this table are from the MAX 2003 file for Connecticut, released by CMS in 05/2007. 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]

CONNECTICUT, 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	**55.4 %**	**26.2**	**$1,859**	**$71**	**$13,485**	**13.8 %**	**213,999**
Age							
5 and younger	13.3	0.4	23	55	2,428	0.9	24,630
6-14	13.5	0.9	68	75	1,707	4.0	26,037
15-20	22.0	2.1	163	78	3,015	5.4	17,974
21-44	51.0	19.4	1,776	92	11,382	15.6	55,124
45-64	85.1	49.3	3,953	80	20,805	19.0	37,619
65-74	89.0	47.2	2,965	63	16,865	17.6	16,888
75-84	90.8	51.6	2,913	56	24,863	11.7	17,988
85 and older	92.1	49.5	2,448	49	33,017	7.4	17,728
Unknown	0.0	0.0	0	0	0	0.0	11
Basis of Eligibility[e]							
Aged	90.7	49.5	2,774	56	25,121	11.0	52,301
Disabled	88.7	48.4	4,077	84	22,920	17.8	59,134
Adults	24.6	2.6	215	83	2,025	10.6	34,312
Children	15.0	0.8	61	73	2,156	2.8	68,252
Unknown	0.0	0.0	0	0	0	0.0	0
Gender							
Female	58.4	28.5	1,888	66	13,470	14.0	129,608
Male	50.8	22.6	1,814	80	13,509	13.4	84,391
Unknown	0.0	0.0	0	0	0	0.0	0
Race							
White	64.3	34.4	2,362	69	19,029	12.4	113,692
African American	48.5	19.9	1,539	77	9,283	16.6	40,021
Other/unknown	43.2	14.8	1,122	76	5,821	19.3	60,286
Use of Nursing Facilities[f]							
Entire year	94.4	65.7	3,741	57	49,708	7.5	19,877
Part year	95.8	62.8	3,851	61	32,649	11.8	9,295
None	49.2	20.1	1,556	78	8,626	18.0	184,827
Maintenance Assistance Status							
Cash	57.8	27.7	2,116	76	12,499	16.9	38,667
Medically needy	84.1	41.3	3,154	76	11,382	27.7	41,401
Poverty related	18.1	1.9	145	78	2,368	6.1	34,087
Other/unknown	55.3	27.6	1,807	66	18,535	9.7	99,844

Source: Data for this table are from the MAX 2003 file for Connecticut, released by CMS in 05/2007. 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]

CONNECTICUT, 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	**3.9**	**$277**	**13.8 %**	**44.6 %**	**14.6 %**	**7.2 %**	**16.4 %**	**12.9 %**	**4.3 %**	**$2,010**	**213,999**	**1,436,122**
Age												
5 and younger	0.2	10	0.9	86.7	11.1	1.4	0.6	0.1	0.0	1,053	24,630	56,809
6-14	0.4	26	4.0	86.5	9.6	2.0	1.5	0.3	0.1	661	26,037	67,208
15-20	0.7	55	5.4	78.0	15.3	3.0	2.9	0.7	0.2	1,015	17,974	53,367
21-44	3.2	291	15.6	49.0	18.8	7.8	13.5	8.0	2.9	1,865	55,124	336,492
45-64	4.9	396	19.0	14.9	15.6	10.8	27.5	22.6	8.6	2,082	37,619	375,896
65-74	4.4	275	17.6	11.0	17.2	12.2	29.4	22.9	7.2	1,562	16,888	182,347
75-84	4.9	277	11.7	9.2	12.9	10.3	30.3	28.4	9.0	2,364	17,988	189,232
85 and older	5.0	248	7.4	7.9	10.1	9.7	33.1	31.5	7.6	3,349	17,728	174,758
Unknown	0.0	0	0.0	100.0	0.0	0.0	0.0	0.0	0.0	0	11	13
Basis of Eligibility[e]												
Aged	4.8	267	11.0	9.3	13.4	10.7	31.0	27.7	8.0	2,417	52,301	543,539
Disabled	4.5	381	17.8	11.3	19.8	11.8	27.8	21.1	8.1	2,144	59,134	632,303
Adults	1.0	83	10.6	75.4	14.1	4.4	4.4	1.6	0.3	781	34,312	88,997
Children	0.3	24	2.8	85.0	11.2	2.0	1.4	0.3	0.1	859	68,252	171,283
Unknown	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Gender												
Female	4.2	276	14.0	41.6	14.5	7.4	17.6	14.2	4.7	1,966	129,608	888,041
Male	3.5	279	13.4	49.2	14.8	6.9	14.6	11.0	3.5	2,080	84,391	548,081
Unknown	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Race												
White	4.5	312	12.4	35.7	13.4	7.6	19.6	17.5	6.3	2,513	113,692	860,864
African American	3.3	253	16.6	51.5	15.9	6.8	13.6	9.4	2.7	1,528	40,021	243,208
Other/unknown	2.7	204	19.3	56.8	16.1	6.7	12.2	6.7	1.5	1,057	60,286	332,050
Use of Nursing Facilities[f]												
Entire year	6.4	366	7.5	5.6	5.6	6.7	28.5	38.6	15.0	4,859	19,877	203,340
Part year	6.3	389	11.8	4.2	8.0	7.5	30.9	35.2	14.1	3,296	9,295	92,067
None	3.2	252	18.0	50.8	15.9	7.3	14.4	9.1	2.6	1,398	184,827	1,140,715
Maintenance Assistance Status												
Cash	4.0	304	16.9	42.2	16.5	7.9	17.0	12.3	4.1	1,796	38,667	269,037
Medically needy	4.1	315	27.7	15.9	19.3	12.0	27.7	18.9	6.1	1,135	41,401	415,022
Poverty related	0.6	50	6.1	81.9	12.5	2.6	2.2	0.6	0.1	808	34,087	99,957
Other/unknown	4.2	277	9.7	44.7	12.6	6.5	16.3	14.9	4.9	2,838	99,844	652,106

Source: Data for this table are from the MAX 2003 file for Connecticut, released by CMS in 05/2007. 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]

CONNECTICUT, 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	**3.9**	**$277**	**$71**	**1.9**	**$225**	**$119**	**0.1**	**$7**	**$56**	**1.9**	**$45**	**$24**
Age												
5 and younger	0.2	10	55	0.1	8	118	0.0	0	44	0.1	2	20
6-14	0.4	26	75	0.2	22	118	0.0	1	58	0.2	4	25
15-20	0.7	55	78	0.4	46	120	0.0	2	78	0.3	7	24
21-44	3.2	291	92	1.6	241	151	0.1	8	83	1.5	41	28
45-64	4.9	396	80	2.5	325	132	0.2	10	68	2.3	60	26
65-74	4.4	275	63	2.2	220	102	0.1	6	44	2.1	48	23
75-84	4.9	277	56	2.3	218	94	0.2	6	36	2.4	53	22
85 and older	5.0	248	49	2.2	191	88	0.2	5	30	2.7	52	19
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Basis of Eligibility[d]												
Aged	4.8	267	56	2.2	210	95	0.2	5	36	2.4	51	21
Disabled	4.5	381	84	2.3	314	139	0.1	11	73	2.1	56	27
Adults	1.0	83	83	0.5	69	143	0.0	2	78	0.5	13	25
Children	0.3	24	73	0.2	20	121	0.0	1	69	0.2	4	23
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Gender												
Female	4.2	276	66	2.0	222	111	0.1	6	49	2.0	46	23
Male	3.5	279	80	1.7	228	134	0.1	8	70	1.7	43	26
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Race												
White	4.5	312	69	2.1	249	116	0.2	9	56	2.2	54	24
African American	3.3	253	77	1.6	210	131	0.1	5	57	1.6	37	24
Other/unknown	2.7	204	76	1.4	172	121	0.1	3	55	1.2	28	24
Use of Nursing Facilities[e]												
Entire year	6.4	366	57	2.9	288	101	0.2	7	32	3.3	71	21
Part year	6.3	389	61	2.9	310	108	0.2	8	38	3.3	69	21
None	3.2	252	78	1.6	206	126	0.1	7	68	1.5	39	26
Maintenance Assistance Status												
Cash	4.0	304	76	2.0	247	124	0.1	9	71	1.9	49	26
Medically needy	4.1	315	76	2.1	258	125	0.1	8	67	1.9	48	25
Poverty related	0.6	50	78	0.3	41	130	0.0	2	78	0.3	7	24
Other/unknown	4.2	277	66	2.0	222	113	0.1	6	44	2.1	48	23

Source: Data for this table are from the MAX 2003 file for Connecticut, released by CMS in 05/2007. 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 Connecticut, 0.2 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 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]

CONNECTICUT, 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	0.4	0.2	0.0	0.2	$53	$48	$0	$4	$141	$230	$85	$27	246,538	$34,805,809	63,545	29.7 %	660,206
Biologicals	0.1	0.1	0.0	0.0	45	11	0	34	412	140	1,197	1,031	1,394	573,785	1,147	0.5	12,648
Antineoplastic Agents	0.5	0.2	0.0	0.3	132	104	1	27	274	505	182	100	20,146	5,510,407	4,039	1.9	41,690
Endocrine/Metabolic Drugs	0.9	0.4	0.1	0.4	45	35	2	8	48	80	19	20	484,903	23,272,631	49,003	22.9	520,059
Cardiovascular Agents	1.6	0.6	0.0	1.0	66	47	1	18	40	73	42	19	1,173,597	47,276,571	66,736	31.2	720,526
Respiratory Agents	0.7	0.4	0.0	0.3	41	33	2	6	57	78	72	23	350,302	19,949,871	47,043	22.0	491,894
Gastrointestinal Agents	0.7	0.4	0.0	0.3	72	58	0	13	97	134	73	43	369,646	35,748,028	46,223	21.6	498,428
Genitourinary Agents	0.5	0.4	0.0	0.1	34	33	0	2	65	76	38	18	90,827	5,868,706	15,821	7.4	170,526
CNS Drugs	1.7	0.9	0.0	0.7	152	126	4	21	91	136	124	30	1,228,653	111,801,892	69,290	32.4	737,009
Stimulants/Anti-obesity/Anorexia	0.6	0.3	0.0	0.2	52	40	3	9	84	116	83	38	14,597	1,229,574	2,487	1.2	23,531
Miscellaneous Psychological/ Neurological Agents	0.7	0.7	0.0	0.0	106	106	0	0	148	149	0	33	44,906	6,634,729	5,931	2.8	62,338
Analgesics and Anesthetics	0.8	0.4	0.0	0.4	61	52	2	8	78	147	86	19	484,776	37,815,559	58,837	27.5	619,983
Neuromuscular Agents	1.2	0.5	0.1	0.5	77	60	3	14	67	112	49	25	493,999	33,157,053	39,370	18.4	428,621
Nutritional Products	0.6	0.0	0.0	0.6	13	1	1	11	21	66	15	19	107,116	2,205,855	17,230	8.1	173,249
Hematological Agents	0.9	0.2	0.1	0.6	70	61	1	7	81	267	20	13	194,162	15,690,104	21,241	9.9	224,984
Topical Products	0.5	0.2	0.0	0.2	22	15	1	5	46	69	52	23	269,091	12,310,019	52,682	24.6	566,992
Miscellaneous Products	0.4	0.2	0.0	0.1	84	67	10	7	238	372	271	51	12,935	3,080,251	3,574	1.7	36,812
Unknown Therapeutic Category	0.3	0.0	0.0	0.0	21	0	0	0	84	0	0	0	9,369	787,203	3,632	1.7	37,338
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.	5,596,957	397,718,047	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2003 file for Connecticut, released by CMS in 05/2007. 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 Connecticut, 0.2 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]

CONNECTICUT, 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	$71,891,069	47,420	22.2 %	522,342	0.9	$158	$138
ANTIDEPRESSANTS	30,983,178	65,110	30.4	699,552	0.7	62	44
ULCER DRUGS	30,152,876	44,198	20.7	480,630	0.6	109	63
ANTICONVULSANT	28,356,348	37,365	17.5	410,378	0.9	78	69
ANTIVIRAL	23,432,382	9,831	4.6	106,169	0.5	434	221
ANALGESICS - Narcotic	21,936,477	58,001	27.1	620,684	0.4	80	35
ANTIHYPERLIPIDEMIC	18,118,866	28,596	13.4	319,962	0.6	92	57
ANTIDIABETIC	16,347,916	37,954	17.7	415,548	0.7	59	39
ANTIASTHMATIC	12,594,799	45,747	21.4	482,149	0.4	64	26
ANALGESICS - ANTI-INFLAMMATORY	12,001,420	40,391	18.9	443,828	0.4	77	27
Total	265,815,331	414,613		4,501,242	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2003 file for Connecticut, released by CMS in 05/2007. 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.