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

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TABLE 1
OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
IOWA, 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]	382,714	(A)	70,736	(E)	311,978	(I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	373,080	(B)	62,143	(F)	310,937	(j)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	361,494	(C)	62,139	(G)	299,355	(K)
4. Beneficiaries who were all-year nursing facility residents[f]	12,391	(D)	11,866	(H)	525	(L)

Source: Data for this table are from the MAX 2003 file for Iowa, 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 Iowa in 2003 was $336,933,544, of which $57,152 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]

IOWA, 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	**361,494**	**33,521**	**61,988**	**73,385**	**192,600**	**0**	**2,943,447**	**337,254**	**677,050**	**462,491**	**1,466,652**	**0**
Age												
5 and younger	81,152	0	1,943	174	79,035	0	592,007	0	19,181	1,308	571,518	0
6-14	84,289	0	5,082	99	79,108	0	696,024	0	56,085	713	639,226	0
15-20	43,046	0	4,010	6,511	32,525	0	329,197	0	43,956	41,106	244,135	0
21-44	87,106	0	23,218	62,120	1,768	0	658,092	0	258,067	389,549	10,476	0
45-64	30,442	0	25,816	4,468	158	0	310,609	0	279,618	29,742	1,249	0
65-74	10,205	8,951	1,242	8	4	0	107,943	95,164	12,701	42	36	0
75-84	12,145	11,605	536	4	0	0	123,741	117,762	5,952	27	0	0
85 and older	13,109	12,965	141	1	2	0	125,834	124,328	1,490	4	12	0
Unknown	0	0	0	0	0	0 0		0	0	0	0	0
Gender												
Female	210,199	24,578	31,865	57,963	95,793	0	1,702,546	250,655	350,233	372,201	729,457	0
Male	151,295	8,943	30,123	15,422	96,807	0	1,240,901	86,599	326,817	90,290	737,195	0
Unknown	0	0	0	0	0	0 0		0	0	0	0	0
Race												
White	246,584	24,236	48,151	51,115	123,082	0	2,122,442	253,323	541,822	340,909	986,388	0
African American	25,791	610	4,080	5,668	15,433	0	196,016	6,685	44,062	34,033	111,236	0
Other/unknown	89,119	8,675	9,757	16,602	54,085	0	624,989	77,246	91,166	87,549	369,028	0
Use of Nursing Facilities[c]												
Entire year	12,391	11,118	1,272	0	1	0	133,647	119,242	14,393	0	12	0
Part year	7,449	6,367	1,059	14	9	0	66,143	54,806	11,171	107	59	0
None	341,654	16,036	59,657	73,371	192,590	0	2,743,657	163,206	651,486	462,384	1,466,581	0
Maintenance Assistance Status												
Cash	151,166	5,845	39,476	43,807	62,038	0	1,257,841	66,390	431,908	285,709	473,834	0
Medically needy	10,979	2,204	2,286	5,221	1,268	0	82,835	21,060	19,977	33,518	8,280	0
Poverty-related	108,703	806	674	12,985	94,238	0	778,284	8,607	7,020	65,454	697,203	0
Other/unknown	90,646	24,666	19,552	11,372	35,056	0	824,487	241,197	218,145	77,810	287,335	0
Dual Medicare Status[d]												
Full dual, all year	58,948	30,415	28,085	427	21	0	624,731	307,142	314,378	3,077	134	0
Full dual, part year	3,191	1,790	1,386	14	1	0	34,521	19,397	14,973	143	8	0
Non-dual, all year	299,355	1,316	32,517	72,944	192,578	0	2,284,195	10,715	347,699	459,271	1,466,510	0
Managed Care (MC) Status												
Fee-for-service (FFS) all year	275,462	33,521	61,438	48,940	131,563	0	2,491,474	337,254	673,358	342,290	1,138,572	0
FFS part year, with Rx claims	44,787	0	510	14,402	29,875	0	162,268	0	3,478	49,462	109,328	0
FFS part year, no Rx claims	17,819	0	40	3,402	14,377	0	56,733	0	214	9,628	46,891	0
MC all year, with FFS Rx claims	23,426	0	0	6,641	16,785	0	232,972	0	0	61,111	171,861	0

Source: Data for this table are from the MAX 2003 file for Iowa, 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]

IOWA, 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	**72.9 %**	**16.4**	**$932**	**$57**	**$5,466**	**17.0 %**	**361,494**
Age							
5 and younger	72.1	4.2	181	43	1,686	10.7	81,152
6-14	62.7	5.4	351	65	2,081	16.9	84,289
15-20	65.1	7.0	440	63	3,707	11.9	43,046
21-44	75.8	15.5	1,040	67	5,873	17.7	87,106
45-64	85.3	48.9	3,151	64	13,724	23.0	30,442
65-74	87.0	56.0	2,790	50	12,718	21.9	10,205
75-84	90.4	58.8	2,579	44	16,056	16.1	12,145
85 and older	93.5	54.2	2,088	39	19,069	10.9	13,109
Unknown	0.0	0.0	0	0	0	0.0	0
Basis of Eligibility[e]							
Aged	91.1	57.4	2,498	44	16,752	14.9	33,521
Disabled	86.4	41.1	2,949	72	15,611	18.9	61,988
Adults	72.2	8.2	377	46	2,255	16.7	73,385
Children	65.6	4.5	222	50	1,460	15.2	192,600
Unknown	0.0	0.0	0	0	0	0.0	0
Gender							
Female	75.9	18.8	983	52	5,478	17.9	210,199
Male	68.7	13.1	861	66	5,448	15.8	151,295
Unknown	0.0	0.0	0	0	0	0.0	0
Race							
White	76.1	19.2	1,108	58	6,334	17.5	246,584
African American	69.5	9.2	509	55	3,185	16.0	25,791
Other/unknown	64.8	10.8	567	52	3,725	15.2	89,119
Use of Nursing Facilities[f]							
Entire year	95.9	73.9	3,298	45	30,844	10.7	12,391
Part year	96.5	62.1	2,811	45	20,513	13.7	7,449
None	71.5	13.3	805	61	4,217	19.1	341,654
Maintenance Assistance Status							
Cash	76.7	16.6	1,019	61	4,315	23.6	151,166
Medically needy	53.5	18.1	1,087	60	3,938	27.6	10,979
Poverty related	61.3	3.7	162	44	1,185	13.7	108,703
Other/unknown	82.6	31.1	1,692	54	12,705	13.3	90,646

Source: Data for this table are from the MAX 2003 file for Iowa, 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]

IOWA, 2003

				Number of Rx, Percentage with:							Number	
Beneficiary Characteristics	Mean Number of Rx	Mean Rx $	Rx $ as a Percentage of All Medicaid FFS $[c]	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]	Beneficiaries	Benefit Months
All	**2.0**	**$114**	**17.0 %**	**27.1 %**	**42.2 %**	**8.4 %**	**11.4 %**	**7.8 %**	**3.1 %**	**$671**	**361,494**	**2,943,447**
Age												
5 and younger	0.6	25	10.7	27.9	59.3	6.5	4.3	1.4	0.6	231	81,152	592,007
6-14	0.7	43	16.9	37.3	48.6	6.2	5.7	1.4	0.7	252	84,289	696,024
15-20	0.9	58	11.9	34.9	45.9	8.4	7.8	2.3	0.8	485	43,046	329,197
21-44	2.0	138	17.7	24.2	39.9	12.0	14.2	6.9	2.9	777	87,106	658,092
45-64	4.8	309	23.0	14.7	17.2	9.8	24.8	23.5	9.9	1,345	30,442	310,609
65-74	5.3	264	21.9	13.0	13.5	8.8	23.7	28.4	12.6	1,202	10,205	107,943
75-84	5.8	253	16.1	9.6	9.7	7.5	26.3	34.1	12.7	1,576	12,145	123,741
85 and older	5.6	218	10.9	6.5	8.3	8.0	31.6	35.7	9.8	1,987	13,109	125,834
Unknown	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Basis of Eligibility[e]												
Aged	5.7	248	14.9	8.9	9.8	7.9	27.7	33.8	12.1	1,665	33,521	337,254
Disabled	3.8	270	18.9	13.6	25.1	11.7	24.6	18.5	6.4	1,429	61,988	677,050
Adults	1.3	60	16.7	27.8	44.1	11.5	10.4	3.8	2.4	358	73,385	462,491
Children	0.6	29	15.2	34.4	52.6	6.3	4.7	1.3	0.6	192	192,600	1,466,652
Unknown	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Gender												
Female	2.3	121	17.9	24.1	41.7	8.9	12.3	9.1	3.8	676	210,199	1,702,546
Male	1.6	105	15.8	31.3	42.8	7.7	10.2	5.9	2.0	664	151,295	1,240,901
Unknown	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Race												
White	2.2	129	17.5	23.9	42.1	9.0	12.7	8.9	3.6	736	246,584	2,122,442
African American	1.2	67	16.0	30.5	46.3	8.0	8.8	4.6	1.8	419	25,791	196,016
Other/unknown	1.5	81	15.2	35.2	41.3	7.0	8.7	5.7	2.0	531	89,119	624,989
Use of Nursing Facilities[f]												
Entire year	6.9	306	10.7	4.1	5.3	5.7	26.9	39.8	18.2	2,860	12,391	133,647
Part year	7.0	317	13.7	3.5	5.6	7.0	27.6	38.4	17.9	2,310	7,449	66,143
None	1.7	100	19.1	28.5	44.3	8.5	10.5	6.0	2.2	525	341,654	2,743,657
Maintenance Assistance Status												
Cash	2.0	123	23.6	23.3	44.0	9.7	12.6	7.4	3.1	519	151,166	1,257,841
Medically needy	2.4	144	27.6	46.5	19.4	7.9	14.1	9.7	2.5	522	10,979	82,835
Poverty related	0.5	23	13.7	38.7	49.8	5.8	4.0	1.1	0.5	165	108,703	778,284
Other/unknown	3.4	186	13.3	17.4	32.7	9.4	18.0	16.3	6.2	1,397	90,646	824,487

Source: Data for this table are from the MAX 2003 file for Iowa, 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]

IOWA, 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	**2.0**	**$114**	**$57**	**0.8**	**$86**	**$103**	**0.1**	**$4**	**$42**	**1.1**	**$24**	**$22**
Age												
5 and younger	0.6	25	43	0.2	18	82	0.0	1	40	0.3	5	17
6-14	0.7	43	65	0.3	35	101	0.0	1	57	0.3	6	23
15-20	0.9	58	63	0.4	46	103	0.0	2	58	0.4	10	23
21-44	2.0	138	67	0.9	106	123	0.1	5	61	1.1	26	24
45-64	4.8	309	64	2.0	234	114	0.2	11	51	2.5	64	25
65-74	5.3	264	50	2.2	192	89	0.3	8	31	2.9	63	22
75-84	5.8	253	44	2.2	179	81	0.3	9	26	3.2	65	20
85 and older	5.6	218	39	1.9	146	76	0.4	8	22	3.3	63	19
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Basis of Eligibility[d]												
Aged	5.7	248	44	2.1	174	82	0.3	8	25	3.2	65	20
Disabled	3.8	270	72	1.7	209	126	0.2	10	59	1.9	50	26
Adults	1.3	60	46	0.5	44	88	0.0	1	34	0.8	14	19
Children	0.6	29	50	0.3	23	84	0.0	1	47	0.3	6	20
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Gender												
Female	2.3	121	52	0.9	90	95	0.1	4	35	1.3	27	22
Male	1.6	105	66	0.7	81	116	0.1	4	58	0.8	20	24
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Race												
White	2.2	129	58	0.9	97	104	0.1	5	44	1.2	27	23
African American	1.2	67	55	0.5	51	103	0.0	2	45	0.7	14	21
Other/unknown	1.5	81	52	0.6	61	97	0.1	2	34	0.8	17	21
Use of Nursing Facilities[e]												
Entire year	6.9	306	45	2.5	213	85	0.4	10	26	3.9	82	21
Part year	7.0	317	45	2.7	227	85	0.4	11	26	3.9	79	20
None	1.7	100	61	0.7	77	107	0.1	3	49	0.9	20	23
Maintenance Assistance Status												
Cash	2.0	123	61	0.8	93	110	0.1	4	53	1.1	25	23
Medically needy	2.4	144	60	1.0	109	107	0.1	5	43	1.3	30	24
Poverty related	0.5	23	44	0.2	17	78	0.0	1	40	0.3	5	18
Other/unknown	3.4	186	54	1.4	139	99	0.2	6	35	1.8	40	22

Source: Data for this table are from the MAX 2003 file for Iowa, 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 Iowa, 0.6 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]

IOWA, 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	0.3	0.1	0.0	0.2	$15	$11	$0	$4	$47	$81	$69	$21	532,017	$25,238,467	184,244	51.0 %	1,703,738
Biologicals	0.2	0.2	0.0	0.0	109	97	3	9	627	619	1,190	631	6,691	4,196,652	3,585	1.0	38,353
Antineoplastic Agents	0.6	0.3	0.0	0.3	151	133	4	14	251	465	178	49	15,823	3,974,143	2,563	0.7	26,330
Endocrine/Metabolic Drugs	0.8	0.4	0.1	0.3	33	24	2	6	43	68	20	21	559,351	24,175,229	76,844	21.3	740,747
Cardiovascular Agents	1.7	0.6	0.1	1.0	53	35	1	17	32	63	20	16	1,008,140	32,399,000	58,120	16.1	607,235
Respiratory Agents	0.5	0.2	0.0	0.3	24	18	0	6	48	81	38	21	539,552	25,809,365	116,255	32.2	1,093,369
Gastrointestinal Agents	0.7	0.3	0.0	0.4	43	30	1	12	63	115	129	29	362,622	22,747,889	52,262	14.5	532,892
Genitourinary Agents	0.5	0.3	0.0	0.1	26	24	0	2	58	72	47	20	101,345	5,871,450	22,921	6.3	224,077
CNS Drugs	1.3	0.7	0.0	0.6	110	89	4	17	85	128	140	30	1,109,926	94,075,332	85,868	23.8	856,031
Stimulants/Anti-obesity/Anorexia	0.8	0.6	0.0	0.2	61	51	2	9	78	90	70	44	135,387	10,522,165	17,600	4.9	172,371
Miscellaneous Psychological/ Neurological Agents	0.7	0.7	0.0	0.0	116	115	0	1	158	164	0	28	25,543	4,043,100	3,387	0.9	34,827
Analgesics and Anesthetics	0.6	0.1	0.0	0.5	30	20	1	9	48	147	76	19	551,778	26,530,688	94,040	26.0	893,901
Neuromuscular Agents	0.9	0.4	0.1	0.4	67	52	3	12	75	129	43	29	397,395	29,981,472	42,963	11.9	445,933
Nutritional Products	0.6	0.0	0.0	0.5	12	1	1	11	22	36	24	21	135,004	2,999,479	26,548	7.3	243,899
Hematological Agents	0.8	0.2	0.2	0.4	71	60	5	6	85	254	23	16	132,394	11,262,443	15,270	4.2	157,832
Topical Products	0.3	0.1	0.0	0.2	11	7	0	3	36	62	43	20	279,678	10,180,038	99,802	27.6	957,732
Miscellaneous Products	0.4	0.2	0.0	0.2	64	46	8	10	172	268	256	57	11,294	1,943,025	3,071	0.8	30,445
Unknown Therapeutic Category	0.2	0.0	0.0	0.0	7	0	0	0	38	0	0	0	24,136	926,455	14,042	3.9	129,066
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.	5,928,076	336,876,392	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2003 file for Iowa, 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 Iowa, 0.6 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]

IOWA, 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	$54,072,036	38,896	10.8 %	427,604	0.7	$170	$126
ANTIDEPRESSANTS	30,850,784	76,214	21.1	801,489	0.6	61	38
ANTICONVULSANT	24,085,077	29,746	8.2	328,369	0.8	90	73
ULCER DRUGS	16,393,530	47,106	13.0	505,210	0.5	67	32
ANTIASTHMATIC	15,761,578	66,306	18.3	690,956	0.4	60	23
ANALGESICS - Narcotic	14,698,738	82,482	22.8	850,407	0.4	48	17
ANTIDIABETIC	12,897,289	27,055	7.5	292,131	0.8	58	44
ANTIHYPERLIPIDEMIC	10,587,785	18,095	5.0	201,608	0.7	78	53
STIMULANTS/ANTI-OBESITY/ANOREXIANTS	8,902,255	18,067	5.0	191,167	0.6	78	47
ANTIHYPERTENSIVE	7,976,510	32,224	8.9	347,807	0.7	33	23
Total	196,225,582	436,191		4,636,748	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2003 file for Iowa, 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.