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

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TABLE 1
OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
INDIANA, 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]	949,303	(A)	136,129	(E)	813,174	(I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	912,523	(B)	118,319	(F)	794,204	(j)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	722,032	(C)	118,106	(G)	603,926	(K)
4. Beneficiaries who were all-year nursing facility residents[f]	25,722	(D)	23,997	(H)	1,725	(L)

Source: Data for this table are from the MAX 2003 file for Indiana, 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 Indiana in 2003 was $664,767,963, of which $16,402,516 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]

INDIANA, 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	**722,032**	**71,105**	**117,049**	**132,231**	**401,647**	**0**	**5,687,244**	**708,717**	**1,185,900**	**736,352**	**3,056,275**	**0**
Age												
5 and younger	164,245	0	2,155	0	162,090	0	1,192,981	0	19,290	0	1,173,691	0
6-14	181,000	0	5,625	12	175,363	0	1,446,012	0	52,934	67	1,393,011	0
15-20	82,728	9	4,114	14,490	64,115	0	614,490	52	39,186	86,008	489,244	0
21-44	158,522	156	46,009	112,281	76	0	1,089,700	1,178	467,319	620,878	325	0
45-64	64,378	168	58,797	5,410	3	0	634,595	1,191	604,293	29,107	4	0
65-74	26,066	25,686	349	31	0	0	270,911	267,796	2,878	237	0	0
75-84	25,155	25,148	0	7	0	0	250,650	250,595	0	55	0	0
85 and older	19,938	19,938	0	0	0	0	187,905	187,905	0	0	0	0
Unknown	0	0	0	0	0	0	0	0	0	0	0	0
Gender												
Female	428,270	52,304	62,635	115,157	198,174	0	3,332,484	529,288	642,606	653,359	1,507,231	0
Male	293,762	18,801	54,414	17,074	203,473	0	2,354,760	179,429	543,294	82,993	1,549,044	0
Unknown	0	0	0	0	0	0	0	0	0	0	0	0
Race												
White	552,838	59,488	95,332	99,643	298,375	0	4,657,222	589,835	979,908	613,190	2,474,289	0
African American	123,712	8,745	18,479	26,254	70,234	0	757,964	89,538	175,073	97,149	396,204	0
Other/unknown	45,482	2,872	3,238	6,334	33,038	0	272,058	29,344	30,919	26,013	185,782	0
Use of Nursing Facilities[c]												
Entire year	25,722	22,358	3,323	0	41	0	262,543	225,638	36,419	0	486	0
Part year	14,400	11,513	2,845	23	19	0	133,539	104,172	28,975	213	179	0
None	681,910	37,234	110,881	132,208	401,587	0	5,291,162	378,907	1,120,506	736,139	3,055,610	0
Maintenance Assistance Status												
Cash	288,249	18,655	75,280	85,105	109,209	0	2,249,048	205,678	788,248	470,817	784,305	0
Medically needy	0	0	0	0	0	0	0	0	0	0	0	0
Poverty-related	250,209	1,560	1,300	19,974	227,375	0	1,932,901	15,684	13,329	98,299	1,805,589	0
Other/unknown	183,574	50,890	40,469	27,152	65,063	0	1,505,295	487,355	384,323	167,236	466,381	0
Dual Medicare Status[d]												
Full dual, all year	111,846	64,720	46,194	898	34	0	1,149,507	645,182	496,766	7,241	318	0
Full dual, part year	6,260	3,469	2,682	108	1	0	63,966	34,941	27,908	1,105	12	0
Non-dual, all year	603,926	2,916	68,173	131,225	401,612	0	4,473,771	28,594	661,226	728,006	3,055,945	0
Managed Care (MC) Status												
Fee-for-service (FFS) all year	555,239	71,092	112,408	84,809	286,930	0	5,105,226	708,632	1,164,389	591,399	2,640,806	0
FFS part year, with Rx claims	57,988	13	2,798	21,759	33,418	0	254,718	85	15,453	77,948	161,232	0
FFS part year, no Rx claims	108,805	0	1,843	25,663	81,299	0	327,300	0	6,058	67,005	254,237	0

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

INDIANA, 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	**63.4 %**	**15.4**	**$898**	**$58**	**$5,068**	**17.7 %**	**722,032**
Age							
5 and younger	57.5	3.4	125	37	1,653	7.6	164,245
6-14	54.3	4.5	286	63	1,583	18.1	181,000
15-20	57.4	5.9	443	75	2,718	16.3	82,728
21-44	65.6	14.6	1,009	69	6,184	16.3	158,522
45-64	80.6	47.4	3,053	64	13,257	23.0	64,378
65-74	80.8	49.9	2,560	51	10,647	24.0	26,066
75-84	86.8	56.7	2,690	47	14,905	18.1	25,155
85 and older	92.9	56.8	2,435	43	19,581	12.4	19,938
Unknown	0.0	0.0	0	0	0	0.0	0
Basis of Eligibility[e]							
Aged	86.3	54.1	2,565	47	14,648	17.5	71,105
Disabled	81.2	40.8	2,995	74	14,829	20.2	117,049
Adults	59.3	6.7	262	39	2,252	11.7	132,231
Children	55.5	4.0	201	50	1,455	13.8	401,647
Unknown	0.0	0.0	0	0	0	0.0	0
Gender							
Female	65.3	17.4	919	53	5,058	18.2	428,270
Male	60.5	12.4	867	70	5,082	17.1	293,762
Unknown	0.0	0.0	0	0	0	0.0	0
Race							
White	69.2	17.6	1,022	58	5,527	18.5	552,838
African American	45.2	9.0	553	62	3,923	14.1	123,712
Other/unknown	41.3	5.8	328	56	2,605	12.6	45,482
Use of Nursing Facilities[f]							
Entire year	98.4	80.2	3,925	49	30,350	12.9	25,722
Part year	96.3	62.9	3,239	52	21,771	14.9	14,400
None	61.3	11.9	734	62	3,762	19.5	681,910
Maintenance Assistance Status							
Cash	65.2	18.5	1,167	63	5,881	19.8	288,249
Medically needy	0.0	0.0	0	0	0	0.0	0
Poverty related	55.7	4.0	204	51	1,303	15.7	250,209
Other/unknown	70.8	26.0	1,421	55	8,924	15.9	183,574

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

INDIANA, 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	**2.0**	**$114**	**17.7 %**	**36.6 %**	**38.1 %**	**6.9 %**	**9.3 %**	**6.6 %**	**2.4 %**	**$643**	**722,032**	**5,687,244**
Age												
5 and younger	0.5	17	7.6	42.5	51.9	4.0	1.4	0.2	0.0	228	164,245	1,192,981
6-14	0.6	36	18.1	45.7	45.2	5.0	3.5	0.4	0.1	198	181,000	1,446,012
15-20	0.8	60	16.3	42.6	44.4	7.0	4.9	0.9	0.2	366	82,728	614,490
21-44	2.1	147	16.3	34.4	33.9	10.5	13.5	6.2	1.5	900	158,522	1,089,700
45-64	4.8	310	23.0	19.4	14.9	9.6	23.7	22.8	9.6	1,345	64,378	634,595
65-74	4.8	246	24.0	19.2	14.2	8.3	22.8	24.8	10.6	1,024	26,066	270,911
75-84	5.7	270	18.1	13.2	10.0	6.9	24.6	31.2	14.1	1,496	25,155	250,650
85 and older	6.0	258	12.4	7.1	7.6	7.2	28.4	37.0	12.7	2,078	19,938	187,905
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	5.4	257	17.5	13.7	11.0	7.5	25.0	30.4	12.4	1,470	71,105	708,717
Disabled	4.0	296	20.2	18.8	20.7	10.9	23.7	18.8	7.0	1,464	117,049	1,185,900
Adults	1.2	47	11.7	40.7	38.2	9.5	8.8	2.5	0.3	404	132,231	736,352
Children	0.5	26	13.8	44.5	47.9	4.7	2.5	0.3	0.0	191	401,647	3,056,275
Unknown	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Gender												
Female	2.2	118	18.2	34.7	37.2	7.1	10.1	7.8	3.0	650	428,270	3,332,484
Male	1.5	108	17.1	39.5	39.3	6.5	8.2	4.9	1.6	634	293,762	2,354,760
Unknown	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Race												
White	2.1	121	18.5	30.8	41.1	7.4	10.2	7.6	2.9	656	552,838	4,657,222
African American	1.5	90	14.1	54.8	27.7	5.5	7.0	4.0	1.0	640	123,712	757,964
Other/unknown	1.0	55	12.6	58.7	30.0	4.0	4.4	2.2	0.6	435	45,482	272,058
Use of Nursing Facilities[f]												
Entire year	7.9	385	12.9	1.6	3.6	4.6	23.8	42.3	24.0	2,973	25,722	262,543
Part year	6.8	349	14.9	3.7	6.7	7.0	28.3	37.2	17.1	2,348	14,400	133,539
None	1.5	95	19.5	38.7	40.0	6.9	8.4	4.7	1.3	485	681,910	5,291,162
Maintenance Assistance Status												
Cash	2.4	150	19.8	34.8	33.9	8.4	12.3	8.0	2.7	754	288,249	2,249,048
Medically needy	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Poverty related	0.5	27	15.7	44.3	48.1	4.7	2.6	0.3	0.0	169	250,209	1,932,901
Other/unknown	3.2	173	15.9	29.2	31.0	7.5	13.8	13.2	5.4	1,088	183,574	1,505,295

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

INDIANA, 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**	**$58**	**0.8**	**$91**	**$107**	**0.1**	**$3**	**$46**	**1.0**	**$21**	**$20**
Age												
5 and younger	0.5	17	37	0.2	12	71	0.0	1	41	0.3	4	16
6-14	0.6	36	63	0.3	30	97	0.0	1	55	0.2	5	20
15-20	0.8	60	75	0.4	51	134	0.0	1	56	0.4	8	19
21-44	2.1	147	69	0.9	117	136	0.1	4	65	1.2	25	21
45-64	4.8	310	64	2.1	247	119	0.1	7	55	2.6	56	21
65-74	4.8	246	51	2.1	192	93	0.1	4	32	2.6	50	19
75-84	5.7	270	47	2.5	209	84	0.2	5	27	3.0	56	19
85 and older	6.0	258	43	2.5	195	79	0.2	6	26	3.3	57	17
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Basis of Eligibility[d]												
Aged	5.4	257	47	2.3	198	85	0.2	5	28	2.9	54	18
Disabled	4.0	296	74	1.8	240	135	0.1	7	63	2.1	48	23
Adults	1.2	47	39	0.4	34	85	0.0	1	31	0.8	12	16
Children	0.5	26	50	0.2	21	86	0.0	1	47	0.3	5	18
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Gender												
Female	2.2	118	53	0.9	92	97	0.1	2	38	1.2	23	19
Male	1.5	108	70	0.7	88	127	0.0	3	62	0.8	17	21
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Race												
White	2.1	121	58	0.9	96	106	0.1	3	45	1.1	22	20
African American	1.5	90	62	0.6	71	117	0.0	2	50	0.8	17	21
Other/unknown	1.0	55	56	0.4	43	102	0.0	1	50	0.5	10	19
Use of Nursing Facilities[e]												
Entire year	7.9	385	49	3.3	294	89	0.3	9	31	4.2	81	19
Part year	6.8	349	52	2.8	270	95	0.2	8	31	3.7	71	19
None	1.5	95	62	0.7	76	113	0.0	2	53	0.8	16	20
Maintenance Assistance Status												
Cash	2.4	150	63	1.0	119	120	0.1	3	53	1.3	27	21
Medically needy	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Poverty related	0.5	27	51	0.2	21	86	0.0	1	46	0.3	4	18
Other/unknown	3.2	173	55	1.4	136	99	0.1	4	38	1.7	33	19

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

INDIANA, 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	$16	$12	$0	$3	$53	$94	$79	$20	907,805	$48,085,529	306,288	42.4 %	3,095,422
Biologicals	0.1	0.1	0.0	0.0	35	28	1	6	300	299	1,857	267	9,109	2,736,690	7,020	1.0	78,063
Antineoplastic Agents	0.5	0.2	0.0	0.3	123	99	1	23	254	544	156	77	33,843	8,588,650	6,861	1.0	69,889
Endocrine/Metabolic Drugs	0.7	0.4	0.1	0.3	34	27	1	5	50	78	21	19	948,846	47,489,757	136,196	18.9	1,412,180
Cardiovascular Agents	1.5	0.5	0.0	1.0	50	35	0	15	33	65	20	16	1,835,377	60,808,463	114,586	15.9	1,216,753
Respiratory Agents	0.5	0.2	0.0	0.2	22	18	0	4	45	73	29	17	1,172,919	52,979,047	235,742	32.6	2,424,289
Gastrointestinal Agents	0.6	0.3	0.0	0.3	39	30	1	8	62	106	130	24	663,244	41,014,904	100,249	13.9	1,061,998
Genitourinary Agents	0.4	0.3	0.0	0.1	24	20	0	4	61	70	41	38	167,457	10,202,286	40,578	5.6	420,492
CNS Drugs	1.1	0.6	0.0	0.5	99	86	2	11	88	137	126	22	1,867,194	163,535,968	160,491	22.2	1,653,866
Stimulants/Anti-obesity/Anorexia	0.7	0.5	0.0	0.2	51	43	1	6	75	85	70	40	210,612	15,705,253	30,238	4.2	310,763
Miscellaneous Psychological/ Neurological Agents	0.5	0.5	0.0	0.0	78	74	0	3	141	147	44	76	83,657	11,828,248	14,569	2.0	152,275
Analgesics and Anesthetics	0.6	0.1	0.0	0.5	29	20	0	8	45	146	68	17	1,223,573	54,952,527	191,228	26.5	1,927,756
Neuromuscular Agents	0.8	0.4	0.0	0.4	59	47	2	10	72	127	45	24	763,195	54,805,412	88,193	12.2	935,709
Nutritional Products	0.5	0.0	0.0	0.5	11	1	1	9	21	35	19	20	287,703	5,941,825	57,611	8.0	563,025
Hematological Agents	0.7	0.3	0.1	0.4	102	92	2	8	139	332	22	21	295,227	41,030,730	38,496	5.3	403,985
Topical Products	0.3	0.1	0.0	0.2	11	7	1	3	37	61	48	19	547,177	20,427,029	174,923	24.2	1,825,041
Miscellaneous Products	0.4	0.2	0.0	0.2	75	54	8	13	180	347	244	58	35,417	6,359,486	8,162	1.1	85,036
Unknown Therapeutic Category	0.2	0.0	0.0	0.0	6	0	0	0	37	0	0	0	50,136	1,873,643	28,574	4.0	308,210
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.	11,102,491	648,365,447	n.a.	n.a.	n.a.

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

INDIANA, 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	$97,876,750	77,045	10.7 %	840,578	0.6	$184	$116
ANTIDEPRESSANTS	54,740,157	150,022	20.8	1,581,592	0.5	66	35
ANTICONVULSANT	45,512,599	70,460	9.8	767,102	0.7	88	59
ANALGESICS - Narcotic	32,357,035	207,442	28.7	2,144,874	0.4	40	15
ULCER DRUGS	29,904,802	106,934	14.8	1,161,864	0.4	62	26
MISC. HEMATOLOGICAL	28,872,561	15,765	2.2	170,477	0.6	289	169
ANTIDIABETIC	28,818,514	61,122	8.5	666,241	0.7	66	43
ANTIASTHMATIC	28,802,931	151,878	21.0	1,606,642	0.3	56	18
ANTIHYPERLIPIDEMIC	22,926,819	42,362	5.9	476,401	0.6	85	48
STIMULANTS/ANTI-OBESITY/ANOREXIANTS	15,660,757	38,582	5.3	408,600	0.5	75	38
Total	385,472,925	921,612		9,824,371	n.a.	n.a.	n.a.

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