STATISTICAL COMPENDIUM:
MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT IN 2003
NEW HAMPSHIRE

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OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
NEW HAMPSHIRE, 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]	130,614	(A)	24,088	(E)	106,526	(I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	127,821	(B)	21,341	(F)	106,480	(j)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	126,684	(C)	21,337	(G)	105,347	(K)
4. Beneficiaries who were all-year nursing facility residents[f]	4,595	(D)	4,436	(H)	159	(L)

Source: Data for this table are from the MAX 2003 file for New Hampshire, 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 New Hampshire in 2003 was $119,995,083, of which $94,813 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]

NEW HAMPSHIRE, 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	**126,684**	**12,219**	**16,582**	**18,197**	**79,686**	**0**	**1,107,201**	**120,406**	**171,462**	**135,527**	**679,806**	**0**
Age												
5 and younger	27,804	0	40	0	27,764	0	232,516	0	443	0	232,073	0
6-14	36,080	0	83	0	35,997	0	317,474	0	945	0	316,529	0
15-20	16,231	0	466	0	15,765	0	135,204	0	4,725	0	130,479	0
21-44	24,095	0	7,326	16,612	157	0	200,819	0	76,588	123,510	721	0
45-64	10,134	0	8,577	1,557	0	0	99,838	0	87,909	11,929	0	0
65-74	3,532	3,454	69	9	0	0	35,999	35,304	630	65	0	0
75-84	4,347	4,336	11	0	0	0	42,981	42,856	125	0	0	0
85 and older	4,439	4,429	10	0	0	0	42,343	42,246	97	0	0	0
Unknown	22	0	0	19	3	0	27	0	0	23	4	0
Gender												
Female	73,432	9,394	9,059	15,675	39,304	0	641,389	94,340	95,084	119,287	332,678	0
Male	53,252	2,825	7,523	2,522	40,382	0	465,812	26,066	76,378	16,240	347,128	0
Unknown	0	0	0	0	0	0 0		0	0	0	0	0
Race												
White	115,981	11,728	16,043	16,617	71,593	0	1,019,408	115,535	166,362	124,554	612,957	0
African American	2,358	44	189	448	1,677	0	19,705	456	1,789	3,132	14,328	0
Other/unknown	8,345	447	350	1,132	6,416	0	68,088	4,415	3,311	7,841	52,521	0
Use of Nursing Facilities[c]												
Entire year	4,595	4,331	261	0	3	0	47,996	45,126	2,834	0	36	0
Part year	2,550	2,157	368	5	20	0	22,843	18,832	3,713	58	240	0
None	119,539	5,731	15,953	18,192	79,663	0	1,036,362	56,448	164,915	135,469	679,530	0
Maintenance Assistance Status												
Cash	25,962	1,514	6,702	5,751	11,995	0	243,041	17,243	73,161	44,984	107,653	0
Medically needy	12,193	5,051	3,184	2,425	1,533	0	107,156	45,848	30,321	17,473	13,514	0
Poverty-related	60,193	483	494	3,573	55,643	0	486,742	3,921	4,223	20,527	458,071	0
Other/unknown	28,336	5,171	6,202	6,448	10,515	0	270,262	53,394	63,757	52,543	100,568	0
Dual Medicare Status[d]												
Full dual, all year	19,639	10,607	8,172	850	10	0	201,636	105,914	88,175	7,451	96	0
Full dual, part year	1,698	762	881	54	1	0	15,467	6,718	8,241	497	11	0
Non-dual, all year	105,347	850	7,529	17,293	79,675	0	890,098	7,774	75,046	127,579	679,699	0
Managed Care (MC) Status												
Fee-for-service (FFS) all year	112,910	12,219	16,534	17,414	66,743	0	1,019,902	120,406	171,153	130,716	597,627	0
FFS part year, with Rx claims	10,319	0	45	718	9,556	0	66,084	0	296	4,471	61,317	0
FFS part year, no Rx claims	3,455	0	3	65	3,387	0	21,215	0	13	340	20,862	0

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

NEW HAMPSHIRE, 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	**68.6 %**	**15.6**	**$947**	**$61**	**$6,516**	**14.5 %**	**126,684**
Age							
5 and younger	61.2	2.8	99	36	1,577	6.3	27,804
6-14	60.0	4.6	278	61	2,619	10.6	36,080
15-20	63.6	6.6	419	64	3,796	11.0	16,231
21-44	75.2	18.6	1,347	72	7,877	17.1	24,095
45-64	85.5	49.6	3,500	71	16,702	21.0	10,134
65-74	87.4	52.7	2,897	55	16,654	17.4	3,532
75-84	89.9	57.8	2,769	48	21,283	13.0	4,347
85 and older	93.8	54.7	2,284	42	25,931	8.8	4,439
Unknown	0.0	0.0	0	0	0	0.0	22
Basis of Eligibility[e]							
Aged	90.7	55.3	2,630	48	21,668	12.1	12,219
Disabled	85.7	45.4	3,476	77	19,437	17.9	16,582
Adults	71.5	11.8	643	54	2,803	23.0	18,197
Children	61.0	4.2	231	55	2,351	9.8	79,686
Unknown	0.0	0.0	0	0	0	0.0	0
Gender							
Female	71.2	18.4	1,041	57	6,693	15.6	73,432
Male	65.1	11.8	816	69	6,271	13.0	53,252
Unknown	0.0	0.0	0	0	0	0.0	0
Race							
White	69.7	16.5	1,001	61	6,906	14.5	115,981
African American	59.5	6.9	462	67	2,667	17.3	2,358
Other/unknown	56.7	5.7	325	57	2,180	14.9	8,345
Use of Nursing Facilities[f]							
Entire year	98.5	72.1	3,421	47	38,234	8.9	4,595
Part year	95.5	58.4	2,769	47	25,584	10.8	2,550
None	66.9	12.6	813	65	4,890	16.6	119,539
Maintenance Assistance Status							
Cash	75.3	18.7	1,232	66	7,837	15.7	25,962
Medically needy	82.4	39.7	2,340	59	14,283	16.4	12,193
Poverty related	58.5	3.7	192	52	1,662	11.6	60,193
Other/unknown	78.1	27.8	1,688	61	12,273	13.8	28,336

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

NEW HAMPSHIRE, 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	**1.8**	**$108**	**14.5 %**	**31.4 %**	**42.6 %**	**7.0 %**	**10.0 %**	**6.8 %**	**2.2 %**	**$746**	**126,684**	**1,107,201**
Age												
5 and younger	0.3	12	6.3	38.8	57.9	2.3	0.9	0.2	0.0	189	27,804	232,516
6-14	0.5	32	10.6	40.0	50.2	5.2	3.8	0.7	0.1	298	36,080	317,474
15-20	0.8	50	11.0	36.4	47.8	7.9	6.4	1.2	0.2	456	16,231	135,204
21-44	2.2	162	17.1	24.8	38.4	11.9	15.6	7.4	1.8	945	24,095	200,819
45-64	5.0	355	21.0	14.5	15.8	10.6	26.3	23.2	9.5	1,695	10,134	99,838
65-74	5.2	284	17.4	12.6	14.5	9.1	26.5	26.2	11.0	1,634	3,532	35,999
75-84	5.8	280	13.0	10.1	7.6	8.4	28.5	33.2	12.4	2,153	4,347	42,981
85 and older	5.7	239	8.8	6.2	7.7	8.5	32.4	35.6	9.6	2,718	4,439	42,343
Unknown	0.0	0	0.0	100.0	0.0	0.0	0.0	0.0	0.0	0	22	27
Basis of Eligibility[e]												
Aged	5.6	267	12.1	9.3	9.6	8.6	29.4	32.1	11.0	2,199	12,219	120,406
Disabled	4.4	336	17.9	14.3	19.2	11.9	26.3	20.9	7.6	1,880	16,582	171,462
Adults	1.6	86	23.0	28.5	42.8	11.4	12.2	4.2	0.9	376	18,197	135,527
Children	0.5	27	9.8	39.0	52.5	4.7	3.2	0.5	0.1	276	79,686	679,806
Unknown	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Gender												
Female	2.1	119	15.6	28.8	41.2	7.4	11.3	8.4	2.8	766	73,432	641,389
Male	1.3	93	13.0	34.9	44.5	6.4	8.3	4.5	1.4	717	53,252	465,812
Unknown	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Race												
White	1.9	114	14.5	30.3	42.3	7.2	10.5	7.2	2.4	786	115,981	1,019,408
African American	0.8	55	17.3	40.5	47.3	4.2	5.1	2.2	0.7	319	2,358	19,705
Other/unknown	0.7	40	14.9	43.3	45.9	4.4	4.2	1.9	0.3	267	8,345	68,088
Use of Nursing Facilities[f]												
Entire year	6.9	328	8.9	1.5	5.2	5.9	29.6	40.4	17.5	3,660	4,595	47,996
Part year	6.5	309	10.8	4.5	6.5	7.8	29.3	37.6	14.2	2,856	2,550	22,843
None	1.4	94	16.6	33.1	44.8	7.0	8.9	4.8	1.4	564	119,539	1,036,362
Maintenance Assistance Status												
Cash	2.0	132	15.7	24.7	43.4	9.1	13.0	7.8	2.0	837	25,962	243,041
Medically needy	4.5	266	16.4	17.6	19.7	9.3	23.8	21.6	7.9	1,625	12,193	107,156
Poverty related	0.5	24	11.6	41.5	50.7	4.3	2.7	0.6	0.1	206	60,193	486,742
Other/unknown	2.9	177	13.8	21.9	34.5	9.7	17.0	12.5	4.5	1,287	28,336	270,262

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

NEW HAMPSHIRE, 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	**1.8**	**$108**	**$61**	**0.8**	**$85**	**$106**	**0.1**	**$4**	**$59**	**0.9**	**$18**	**$20**
Age												
5 and younger	0.3	12	36	0.1	9	75	0.0	1	55	0.2	3	12
6-14	0.5	32	61	0.3	27	94	0.0	1	84	0.2	4	17
15-20	0.8	50	64	0.4	42	99	0.0	2	79	0.3	7	20
21-44	2.2	162	72	1.0	129	131	0.1	8	86	1.2	25	21
45-64	5.0	355	71	2.3	281	123	0.2	16	74	2.5	58	23
65-74	5.2	284	55	2.3	220	95	0.2	8	38	2.6	56	21
75-84	5.8	280	48	2.6	211	82	0.3	8	29	3.0	60	20
85 and older	5.7	239	42	2.4	176	74	0.3	7	24	3.0	56	18
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Basis of Eligibility[d]												
Aged	5.6	267	48	2.4	201	83	0.3	8	29	2.9	57	20
Disabled	4.4	336	77	2.0	268	132	0.2	17	82	2.2	51	24
Adults	1.6	86	54	0.6	68	106	0.0	2	54	0.9	16	18
Children	0.5	27	55	0.2	22	90	0.0	1	78	0.2	4	16
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Gender												
Female	2.1	119	57	0.9	93	100	0.1	4	49	1.1	21	20
Male	1.3	93	69	0.6	74	118	0.1	5	82	0.7	14	22
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Race												
White	1.9	114	61	0.8	90	106	0.1	5	59	0.9	19	20
African American	0.8	55	67	0.4	46	118	0.0	2	78	0.4	7	18
Other/unknown	0.7	40	57	0.3	32	102	0.0	1	56	0.4	6	18
Use of Nursing Facilities[e]												
Entire year	6.9	328	47	3.0	241	81	0.4	9	26	3.6	75	21
Part year	6.5	309	47	2.7	229	84	0.3	9	29	3.5	70	20
None	1.4	94	65	0.7	75	113	0.1	4	73	0.7	15	20
Maintenance Assistance Status												
Cash	2.0	132	66	0.9	105	118	0.1	5	69	1.0	22	21
Medically needy	4.5	266	59	2.0	208	103	0.2	11	52	2.3	47	21
Poverty related	0.5	24	52	0.2	19	89	0.0	1	73	0.2	4	16
Other/unknown	2.9	177	61	1.3	139	105	0.1	7	57	1.5	31	21

Source: Data for this table are from the MAX 2003 file for New Hampshire, 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 New Hampshire, 0.4 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 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]

NEW HAMPSHIRE, 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	$14	$11	$0	$3	$54	$106	$90	$20	140,672	$7,655,596	53,497	42.2 %	535,512
Biologicals	0.1	0.1	0.0	0.0	30	21	5	5	254	245	1,430	152	1,289	327,231	993	0.8	10,758
Antineoplastic Agents	0.5	0.2	0.0	0.3	131	114	1	15	251	457	88	60	5,296	1,329,370	974	0.8	10,148
Endocrine/Metabolic Drugs	0.7	0.3	0.1	0.3	33	26	2	5	47	79	21	18	170,649	7,980,650	23,772	18.8	241,584
Cardiovascular Agents	1.5	0.5	0.0	1.0	51	35	1	14	33	66	39	15	310,837	10,326,688	19,479	15.4	203,724
Respiratory Agents	0.5	0.3	0.0	0.2	31	26	1	4	56	77	77	19	173,623	9,728,810	31,127	24.6	316,250
Gastrointestinal Agents	0.7	0.3	0.0	0.4	48	34	1	14	73	125	147	35	114,780	8,410,051	16,618	13.1	173,879
Genitourinary Agents	0.4	0.3	0.0	0.1	23	21	0	2	56	68	43	18	27,558	1,545,959	6,470	5.1	67,866
CNS Drugs	1.4	0.8	0.0	0.5	116	98	6	12	86	125	127	23	420,385	36,147,569	30,295	23.9	310,608
Stimulants/Anti-obesity/Anorexia	0.7	0.5	0.0	0.2	55	47	1	7	78	92	60	39	44,219	3,446,467	6,259	4.9	62,576
Miscellaneous Psychological/ Neurological Agents	0.5	0.5	0.0	0.0	76	71	0	6	142	144	0	113	15,384	2,178,213	2,710	2.1	28,587
Analgesics and Anesthetics	0.7	0.2	0.0	0.5	36	27	1	8	52	135	65	16	210,171	10,946,656	30,241	23.9	304,520
Neuromuscular Agents	0.9	0.4	0.0	0.5	69	54	3	12	73	123	62	27	151,322	11,061,245	15,241	12.0	160,736
Nutritional Products	0.3	0.0	0.0	0.3	7	2	0	5	20	139	20	16	45,415	926,282	13,654	10.8	134,136
Hematological Agents	0.8	0.2	0.1	0.5	57	47	2	7	69	229	19	14	42,318	2,935,878	5,023	4.0	51,809
Topical Products	0.3	0.1	0.0	0.2	12	8	0	3	39	67	47	19	96,799	3,771,064	31,813	25.1	325,378
Miscellaneous Products	0.4	0.2	0.0	0.2	94	73	12	9	237	406	272	52	3,325	788,072	813	0.6	8,371
Unknown Therapeutic Category	0.2	0.0	0.0	0.0	12	0	0	0	61	0	0	0	6,475	394,469	3,146	2.5	32,723
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.	1,980,517	119,900,270	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2003 file for New Hampshire, 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 New Hampshire, 0.4 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]

NEW HAMPSHIRE, 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	$20,873,245	15,158	12.0 %	164,829	0.8	$160	$127
ANTIDEPRESSANTS	12,698,818	30,668	24.2	320,713	0.6	63	40
ANTICONVULSANT	9,349,560	13,304	10.5	143,915	0.8	83	65
ULCER DRUGS	6,571,702	15,251	12.0	162,378	0.5	81	40
ANALGESICS - Narcotic	6,427,583	33,403	26.4	345,853	0.4	48	19
ANTIASTHMATIC	5,668,297	26,818	21.2	280,690	0.3	59	20
ANTIHYPERLIPIDEMIC	4,223,986	6,862	5.4	74,967	0.7	85	56
ANTIDIABETIC	3,655,638	8,650	6.8	92,568	0.7	54	39
STIMULANTS/ANTI-OBESITY/ANOREXIANTS	3,172,793	7,248	5.7	75,257	0.5	78	42
ANALGESICS - ANTI-INFLAMMATORY	3,095,673	16,410	13.0	173,540	0.3	56	18
Total	75,737,295	173,772		1,834,710	n.a.	n.a.	n.a.

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