MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT IN 2003
UTAH

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TABLE 1
OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
UTAH, 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]	283,424	(A)	25,361	(E)	258,063	(I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	276,409	(B)	23,595	(F)	252,814	(j)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	267,659	(C)	23,472	(G)	244,187	(K)
4. Beneficiaries who were all-year nursing facility residents[f]	3,164	(D)	2,830	(H)	334	(L)

Source: Data for this table are from the MAX 2003 file for Utah, released by CMS in 07/2007. 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 Utah in 2003 was $153,254,265, of which $64,294 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]

UTAH, 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	**267,659**	**12,008**	**29,172**	**78,682**	**147,797**	**0**	**1,737,769**	**94,620**	**228,650**	**492,720**	**921,779**	**0**
Age												
5 and younger	84,625	0	1,155	8	83,462	0	516,754	0	8,408	24	508,322	0
6-14	50,850	0	2,108	18	48,724	0	332,530	0	17,209	84	315,237	0
15-20	23,880	11	1,594	6,673	15,602	0	145,640	56	12,835	34,562	98,187	0
21-44	73,700	98	11,737	61,858	7	0	472,906	699	92,608	379,569	30	0
45-64	22,043	120	11,869	10,052	2	0	171,216	898	92,244	78,071	3	0
65-74	5,462	4,761	632	69	0	0	41,413	36,240	4,776	397	0	0
75-84	4,310	4,241	65	4	0	0	34,094	33,586	495	13	0	0
85 and older	2,789	2,777	12	0	0	0	23,216	23,141	75	0	0	0
Unknown	0	0	0	0	0	0 0		0	0	0	0	0
Gender												
Female	154,090	8,649	15,203	58,503	71,735	0	993,622	69,158	121,027	355,971	447,466	0
Male	113,172	3,359	13,969	20,177	75,667	0	743,171	25,462	107,623	136,745	473,341	0
Unknown	397	0	0	2	395	0	976	0	0	4	972	0
Race												
White	198,674	9,083	24,675	62,910	102,006	0	1,332,773	73,084	196,316	410,857	652,516	0
African American	5,492	121	588	1,237	3,546	0	32,185	937	3,786	6,896	20,566	0
Other/unknown	63,493	2,804	3,909	14,535	42,245	0	372,811	20,599	28,548	74,967	248,697	0
Use of Nursing Facilities[c]												
Entire year	3,164	2,510	651	0	3	0	30,859	23,853	6,981	0	25	0
Part year	2,144	1,428	693	12	11	0	18,392	11,992	6,212	98	90	0
None	262,351	8,070	27,828	78,670	147,783	0	1,688,518	58,775	215,457	492,622	921,664	0
Maintenance Assistance Status												
Cash	91,290	3,282	14,904	26,902	46,202	0	586,559	24,460	115,977	143,339	302,783	0
Medically needy	5,246	1,090	1,920	1,215	1,021	0	26,784	6,884	12,165	3,901	3,834	0
Poverty-related	92,905	3,178	6,806	17,892	65,029	0	550,410	24,289	49,758	93,946	382,417	0
Other/unknown	78,218	4,458	5,542	32,673	35,545	0	574,016	38,987	50,750	251,534	232,745	0
Dual Medicare Status[d]												
Full dual, all year	22,731	10,126	12,004	596	5	0	181,856	81,364	95,980	4,490	22	0
Full dual, part year	741	352	383	6	0	0	6,629	3,246	3,336	47	0	0
Non-dual, all year	244,187	1,530	16,785	78,080	147,792	0	1,549,284	10,010	129,334	488,183	921,757	0
Managed Care (MC) Status												
Fee-for-service (FFS) all year	187,359	8,840	19,279	64,252	94,988	0	1,436,328	82,553	191,782	435,630	726,363	0
FFS part year, with Rx claims	53,728	2,619	8,466	8,911	33,732	0	191,196	8,899	29,825	34,997	117,475	0
FFS part year, no Rx claims	17,170	239	813	3,215	12,903	0	57,622	770	2,724	10,812	43,316	0
MC all year, with FFS Rx claims	9,402	310	614	2,304	6,174	0	52,623	2,398	4,319	11,281	34,625	0

Source: Data for this table are from the MAX 2003 file for Utah, released by CMS in 07/2007. 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]

UTAH, 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	**65.6 %**	**9.7**	**$572**	**$59**	**$3,517**	**16.3 %**	**267,659**
Age							
5 and younger	67.8	3.4	101	30	1,753	5.8	84,625
6-14	58.6	4.1	270	66	1,845	14.6	50,850
15-20	65.5	6.7	427	64	4,091	10.4	23,880
21-44	61.5	8.9	626	71	3,797	16.5	73,700
45-64	74.7	31.3	2,066	66	8,017	25.8	22,043
65-74	83.1	44.7	2,367	53	9,017	26.2	5,462
75-84	89.6	48.8	2,359	48	11,900	19.8	4,310
85 and older	92.6	47.7	2,126	45	15,953	13.3	2,789
Unknown	0.0	0.0	0	0	0	0.0	0
Basis of Eligibility[e]							
Aged	87.8	46.5	2,292	49	11,515	19.9	12,008
Disabled	85.0	40.9	3,142	77	14,770	21.3	29,172
Adults	58.3	3.8	152	40	1,536	9.9	78,682
Children	63.9	3.7	149	41	1,701	8.8	147,797
Unknown	0.0	0.0	0	0	0	0.0	0
Gender							
Female	68.4	10.9	587	54	3,381	17.4	154,090
Male	62.1	8.0	554	69	3,713	14.9	113,172
Unknown	3.0	0.0	1	20	742	0.1	397
Race							
White	67.3	11.1	674	61	3,904	17.3	198,674
African American	62.1	7.5	428	57	3,060	14.0	5,492
Other/unknown	60.6	5.5	267	48	2,346	11.4	63,493
Use of Nursing Facilities[f]							
Entire year	98.1	75.9	4,173	55	32,382	12.9	3,164
Part year	97.3	67.4	3,638	54	25,939	14.0	2,144
None	65.0	8.4	504	60	2,986	16.9	262,351
Maintenance Assistance Status							
Cash	66.4	11.1	695	63	3,099	22.4	91,290
Medically needy	50.0	18.8	1,419	75	5,556	25.5	5,246
Poverty related	65.7	7.0	384	55	1,980	19.4	92,905
Other/unknown	65.7	10.5	596	57	5,694	10.5	78,218

Source: Data for this table are from the MAX 2003 file for Utah, released by CMS in 07/2007. 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]

UTAH, 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	**1.5**	**$88**	**16.3 %**	**34.4 %**	**44.0 %**	**7.1 %**	**7.1 %**	**4.0 %**	**3.4 %**	**$542**	**267,659**	**1,737,769**
Age												
5 and younger	0.6	17	5.8	32.2	55.4	6.5	4.6	1.1	0.3	287	84,625	516,754
6-14	0.6	41	14.6	41.4	45.6	5.7	4.9	1.6	0.8	282	50,850	332,530
15-20	1.1	70	10.4	34.5	43.1	9.2	8.8	2.9	1.5	671	23,880	145,640
21-44	1.4	98	16.5	38.5	39.7	7.9	7.3	3.6	3.1	592	73,700	472,906
45-64	4.0	266	25.8	25.3	30.1	6.9	11.4	11.4	14.8	1,032	22,043	171,216
65-74	5.9	312	26.2	16.9	14.8	7.5	18.1	20.1	22.5	1,189	5,462	41,413
75-84	6.2	298	19.8	10.4	12.2	7.5	22.0	25.2	22.6	1,504	4,310	34,094
85 and older	5.7	255	13.3	7.4	10.1	9.1	28.3	31.2	13.9	1,917	2,789	23,216
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	5.9	291	19.9	12.2	13.1	8.1	22.1	24.2	20.2	1,461	12,008	94,620
Disabled	5.2	401	21.3	15.0	20.8	9.2	18.8	16.5	19.7	1,884	29,172	228,650
Adults	0.6	24	9.9	41.7	44.4	7.5	4.8	1.3	0.4	245	78,682	492,720
Children	0.6	24	8.8	36.1	51.0	6.4	4.8	1.3	0.4	273	147,797	921,779
Unknown	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Gender												
Female	1.7	91	17.4	31.6	44.9	7.6	7.5	4.4	4.0	524	154,090	993,622
Male	1.2	84	14.9	37.9	43.0	6.4	6.6	3.4	2.7	565	113,172	743,171
Unknown	0.0	0	0.1	97.0	2.3	0.5	0.3	0.0	0.0	302	397	976
Race												
White	1.6	101	17.3	32.7	44.0	7.3	7.6	4.5	3.9	582	198,674	1,332,773
African American	1.3	73	14.0	37.9	41.3	7.0	7.3	3.5	3.0	522	5,492	32,185
Other/unknown	0.9	46	11.4	39.4	44.4	6.4	5.6	2.3	2.0	400	63,493	372,811
Use of Nursing Facilities[f]												
Entire year	7.8	428	12.9	1.9	4.8	5.2	24.7	39.7	23.7	3,320	3,164	30,859
Part year	7.9	424	14.0	2.7	7.0	6.7	24.7	32.2	26.7	3,024	2,144	18,392
None	1.3	78	16.9	35.0	44.8	7.1	6.8	3.3	3.0	464	262,351	1,688,518
Maintenance Assistance Status												
Cash	1.7	108	22.4	33.6	41.3	7.7	8.2	4.5	4.6	482	91,290	586,559
Medically needy	3.7	278	25.5	50.0	15.7	5.6	12.1	9.4	7.2	1,088	5,246	26,784
Poverty related	1.2	65	19.4	34.3	47.2	7.3	6.2	2.6	2.4	334	92,905	550,410
Other/unknown	1.4	81	10.5	34.3	45.3	6.2	6.6	4.5	3.0	776	78,218	574,016

Source: Data for this table are from the MAX 2003 file for Utah, released by CMS in 07/2007. 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]

UTAH, 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	**1.5**	**$88**	**$59**	**0.6**	**$68**	**$104**	**0.1**	**$3**	**$51**	**0.8**	**$18**	**$22**
Age												
5 and younger	0.6	17	30	0.2	11	58	0.0	1	47	0.3	5	14
6-14	0.6	41	66	0.3	34	113	0.0	1	65	0.3	6	20
15-20	1.1	70	64	0.5	56	109	0.0	3	80	0.6	12	21
21-44	1.4	98	71	0.6	76	128	0.1	3	59	0.7	18	25
45-64	4.0	266	66	1.8	203	111	0.1	8	56	2.1	54	26
65-74	5.9	312	53	2.7	239	87	0.2	6	31	2.9	67	23
75-84	6.2	298	48	2.8	225	81	0.2	6	24	3.2	68	21
85 and older	5.7	255	45	2.4	190	79	0.3	5	21	3.1	59	19
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Basis of Eligibility[d]												
Aged	5.9	291	49	2.6	220	83	0.2	6	26	3.0	64	21
Disabled	5.2	401	77	2.5	317	129	0.2	13	65	2.5	70	27
Adults	0.6	24	40	0.2	17	80	0.0	0	26	0.4	7	19
Children	0.6	24	41	0.2	18	75	0.0	1	52	0.3	5	16
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Gender												
Female	1.7	91	54	0.7	69	95	0.1	3	42	0.9	20	22
Male	1.2	84	69	0.6	67	120	0.0	3	67	0.6	15	24
Unknown	0.0	0	20	0.0	0	58	0.0	0	0	0.0	0	13
Race												
White	1.6	101	61	0.7	78	106	0.1	3	52	0.9	20	23
African American	1.3	73	57	0.6	57	103	0.0	2	50	0.7	15	21
Other/unknown	0.9	46	48	0.4	34	91	0.0	1	41	0.5	10	19
Use of Nursing Facilities[e]												
Entire year	7.8	428	55	3.4	328	96	0.2	6	29	4.1	93	23
Part year	7.9	424	54	3.4	319	95	0.3	8	30	4.2	97	23
None	1.3	78	60	0.6	60	106	0.0	2	54	0.7	15	22
Maintenance Assistance Status												
Cash	1.7	108	63	0.8	83	110	0.1	3	58	0.9	21	23
Medically needy	3.7	278	75	1.7	219	130	0.1	8	62	1.9	50	27
Poverty related	1.2	65	55	0.5	49	100	0.0	2	53	0.6	14	21
Other/unknown	1.4	81	57	0.6	63	97	0.1	2	39	0.7	16	22

Source: Data for this table are from the MAX 2003 file for Utah, released by CMS in 07/2007. 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 Utah, 0.7 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]

UTAH, 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	$17	$12	$0	$4	$51	$86	$63	$22	252,370	$12,892,722	103,220	38.6 %	770,965
Biologicals	0.1	0.1	0.0	0.0	61	26	14	20	409	239	1,340	714	1,886	771,177	1,251	0.5	12,574
Antineoplastic Agents	0.7	0.3	0.0	0.3	201	184	3	14	300	560	129	46	5,625	1,689,577	1,008	0.4	8,388
Endocrine/Metabolic Drugs	0.8	0.4	0.1	0.3	33	24	2	7	44	68	22	22	236,482	10,294,606	39,528	14.8	310,346
Cardiovascular Agents	1.5	0.6	0.0	0.9	57	40	1	16	37	65	20	18	304,567	11,264,037	24,013	9.0	197,857
Respiratory Agents	0.5	0.2	0.0	0.2	23	18	0	5	46	74	51	19	253,381	11,764,260	67,117	25.1	516,060
Gastrointestinal Agents	0.7	0.4	0.0	0.3	55	42	1	12	81	109	194	41	149,101	12,074,188	28,011	10.5	219,464
Genitourinary Agents	0.4	0.3	0.0	0.1	24	22	0	2	55	66	39	19	38,614	2,119,573	11,621	4.3	88,236
CNS Drugs	1.2	0.7	0.0	0.5	112	94	3	16	90	136	141	30	462,084	41,705,882	46,934	17.5	370,756
Stimulants/Anti-obesity/Anorexia	0.8	0.6	0.0	0.2	64	54	2	8	79	90	64	45	41,845	3,304,446	6,520	2.4	51,647
Miscellaneous Psychological/ Neurological Agents	0.6	0.6	0.0	0.0	124	123	0	1	196	202	0	43	7,196	1,408,998	1,335	0.5	11,352
Analgesics and Anesthetics	0.7	0.2	0.0	0.5	29	21	1	8	45	130	67	17	328,662	14,853,289	67,516	25.2	505,569
Neuromuscular Agents	1.0	0.5	0.1	0.5	80	64	2	14	78	131	45	29	198,549	15,545,902	23,779	8.9	193,216
Nutritional Products	0.4	0.0	0.0	0.3	5	0	0	5	14	15	17	14	104,345	1,498,964	39,408	14.7	283,692
Hematological Agents	0.8	0.2	0.1	0.5	94	83	3	8	112	372	24	15	44,753	5,021,282	6,403	2.4	53,495
Topical Products	0.3	0.1	0.0	0.2	11	7	1	3	35	59	51	18	134,789	4,667,425	57,488	21.5	428,998
Miscellaneous Products	0.4	0.2	0.0	0.2	65	49	6	11	160	215	288	67	11,383	1,822,654	3,804	1.4	28,092
Unknown Therapeutic Category	0.2	0.0	0.0	0.0	6	0	0	0	32	0	0	0	15,133	490,989	11,117	4.2	81,029
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.	2,590,765	153,189,971	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2003 file for Utah, released by CMS in 07/2007. 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 Utah, 0.7 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]

UTAH, 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	$18,079,044	13,076	4.9 %	126,925	0.8	$187	$142
ANTIDEPRESSANTS	11,090,205	35,982	13.4	325,861	0.5	64	34
ANTICONVULSANT	10,092,548	14,344	5.4	136,138	0.8	96	74
ULCER DRUGS	7,743,913	20,433	7.6	187,261	0.5	88	41
ANALGESICS - Narcotic	6,820,683	51,095	19.1	449,636	0.4	42	15
ANTIASTHMATIC	4,420,560	25,717	9.6	235,954	0.3	57	19
ANTIDIABETIC	4,100,299	10,733	4.0	101,116	0.7	62	41
ANALGESICS - ANTI-INFLAMMATORY	3,577,965	31,503	11.8	276,722	0.3	46	13
ANTIHYPERLIPIDEMIC	3,115,353	6,331	2.4	60,314	0.6	83	52
STIMULANTS/ANTI-OBESITY/ANOREXIANTS	2,496,049	6,200	2.3	58,213	0.5	79	43
Total	71,536,619	215,414		1,958,140	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2003 file for Utah, released by CMS in 07/2007. 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.