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STATISTICAL COMPENDIUM:
MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT IN 2005
CONNECTICUT

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TABLE 1
OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
CONNECTICUT, 2005

Inclusion Criteria (2005)	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]	529119 (A)	97885 (E)	431234 (I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	512238 (B)	81349 (F)	430889 (J)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	207088 (C)	81091 (G)	125997 (K)
4. Beneficiaries who were all-year nursing facility residents[f]	19649 (D)	18313 (H)	1336 (L)

Source: Data for this table are from the MAX 2005 file for Connecticut, released by CMS in 10/2008. This table was produced on 04/23/2009.

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 2005 (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 2005, because the MAX files do not include separate prescription drug claims for those beneficiaries. MC plans include health maintenance organizations (HMOs), prepaid health plans (PHPs), or other MC organizations that provide health care benefits under capitation arrangements. Beneficiaries included in the study population are those who were in fee-for-service or primary care case management (PCCM) programs. In addition, beneficiaries in selected states in which prescription drug benefits were not covered in the capitated benefit package in MC or PHP plans are also included (see footnote e for a list of these states). In those states, if a beneficiary spent part of the year in fee-for-service, PCCM, or in a PHP or MC plan in which drugs were not included in the capitation, and spent part of the year in a PHP or MC plan in which drugs were capitated, only the months with fee-for-service pharmacy benefits are included in the tables. For example, if a beneficiary was in an MC plan that did not include prescription drugs in the capitation for 3 months of the year, and in a PHP with capitated drug coverage for the remaining 9 months, only the 3 months would be counted toward the number of benefit months associated with the beneficary. Therefore, benefit months included represent the benefit months with fee-for-service pharmacy benefits.

d. The total Medicaid pharmacy reimbursement for Connecticut in 2005 was $487,208,293, of which $1,104,412 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 26 states in 2005 that had PHPs that did not include a pharmacy benefit: AL, AR, AZ, CA, CO, FL, GA, IA, KY, MA, MI, MS, NH, NV, NY, OH, OK, OR, PA, SC, SD, TN, TX, UT, WA, and WI. In addition, there were 8 states in which MC plans did not provide a pharmacy benefit (DE, IA, IL, NE, NY, TX, UT, and WV) and one state (NV) in which MC plans provided a pharmacy benefit for nonduals but not for duals. These lists were constructed from the CMS 2005 Medicaid Managed Care Enrollment Report http://www.cms.hhs.gov/MedicaidDataSourcesGenInfo/Downloads/mmcer05.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 2005. 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 N+B18D.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 beneficiary 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 2005. The dual eligible tables include all dual eligible benefit months in which the beneficiary had a fee-for-service pharmacy benefit.

Characteristics of non-dual eligible beneficiaries represented by Cell J are shown in Appendix Table A.1 and characteristics of non-dual eligible beneficiaries and their benefit months included in Cell J but excluded from Cell K are shown in Appendix Table A.2. Characteristics of dual eligible beneficiaries represented by Cell F are shown in Appendix Table A.3, and characteristics of dual eligible beneficiaries and their benefit months included in Cell F but excluded from Cell G are shown in Appendix Table A.4.

Bene(s) = beneficiary (or beneficiaries); CMS = Centers for Medicare & Medicaid Services; HMO = health maintenance organization; MAX = Medicaid Analytic Extract; MC = managed care; PCCM = primary care case management; PHP = prepaid health plan.

TABLE 2

CHARACTERISTICS OF MEDICAID STUDY POPULATION BENEFICIARIES, BY BASIS OF ELIGIBILITY[a, b]

CONNECTICUT, 2005

	Number of Beneficiaries						Number of Benefit Months					
Beneficiary Characteristics	All	Aged	Disabled	Adults	Children	Other/ Unknown	All	Aged	Disabled	Adults	Children	Other/ Unknown
All	**207,088**	**51,249**	**59,831**	**34,064**	**61,718**	**226**	**1,413,392**	**530,745**	**640,974**	**89,900**	**149,493**	**2,280**
Age												
5 and younger	21,959	0	0	1	21,958	0	47,206	0	0	1	47,205	0
6-14	22,726	0	1	2	22,723	0	56,288	0	12	4	56,272	0
15-20	17,513	1	979	1,460	15,073	0	53,086	12	8,690	3,043	41,341	0
21-44	53,460	0	23,239	28,223	1,941	57	323,241	0	248,533	69,552	4,613	543
45-64	39,645	4	35,242	4,230	23	146	397,892	48	380,205	16,084	62	1,493
65-74	16,879	16,349	369	140	0	21	181,475	176,579	3,522	1,143	0	231
75-84	17,338	17,330	1	6	0	1	182,763	182,680	12	59	0	12
85 and older	17,568	17,565	0	2	0	1	171,441	171,426	0	14	0	1
Unknown	0	0	0	0	0	0	0	0	0	0	0	0
Gender												
Female	125,850	37,476	31,215	25,841	31,092	226	874,156	390,990	340,434	66,878	73,574	2,280
Male	81,238	13,773	28,616	8,223	30,626	0	539,236	139,755	300,540	23,022	75,919	0
Unknown	0	0	0	0	0	0	0	0	0	0	0	0
Race												
White	107,642	36,027	34,065	14,701	22,672	177	835,194	366,837	368,860	39,889	57,837	1,771
African American	38,827	6,142	11,381	7,013	14,263	28	241,065	66,373	119,880	19,508	35,013	291
Other/unknown	60,619	9,080	14,385	12,350	24,783	21	337,133	97,535	152,234	30,503	56,643	218
Use of Nursing Facilities[c]												
Entire year	19,649	17,290	2,338	0	21	0	198,959	173,122	25,589	0	248	0
Part year	9,699	7,011	2,608	53	22	5	97,446	68,738	28,017	457	175	59
None	177,740	26,948	54,885	34,011	61,675	221	1,116,987	288,885	587,368	89,443	149,070	2,221
Maintenance Assistance Status												
Cash	70,658	5,193	12,028	23,044	30,393	0	325,530	58,642	135,916	63,898	67,074	0
Medically needy	23,887	8,942	11,863	968	2,114	0	218,321	89,000	120,616	2,663	6,042	0
Poverty-related	32,534	1,164	1,659	6,693	22,792	226	98,274	12,062	17,899	12,377	53,656	2,280
Other/unknown	80,009	35,950	34,281	3,359	6,419	0	771,267	371,041	366,543	10,962	22,721	0
Dual Medicare Status[d]												
Full dual, all year	74,939	45,180	27,604	2,081	50	24	791,716	468,027	304,439	18,603	384	263
Full dual, part year	6,152	2,813	3,215	124	0	0	68,631	31,316	35,942	1,373	0	0
Non-dual, all year	125,997	3,256	29,012	31,859	61,668	202	553,045	31,402	300,593	69,924	149,109	2,017
Managed Care (MC) Status												
Fee-for-service (FFS) all year	128,872	51,235	59,074	9,239	9,099	225	1,244,212	530,625	635,758	38,538	37,014	2,277
FFS part year, with Rx claims	14,861	13	623	6,327	7,897	1	41,017	109	4,585	16,576	19,744	3
FFS part year, no Rx claims	63,355	1	134	18,498	44,722	0	128,163	11	631	34,786	92,735	0

Source: Data for this table are from the MAX 2005 file for Connecticut, released by CMS in 10/2008. This table was produced on 04/23/2009.

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 2005. The “Full dual, part year” group includes beneficiaries who had such benefits for some, but not all, months of their enrollment. The "Non-dual, all year" group includes beneficiaries who were never dually eligible. Refer to footnote g of Table 1 for more information about how we determined dual eligibility status.

Bene(s) = beneficiary (or beneficiaries); Bene Mo(s) = benefit month(s); CMS = Centers for Medicare & Medicaid Services; FFS = fee-for-service pharmacy benefit; MAX = Medicaid Analytic Extract; MC = managed care; Rx = pharmacy benefit.

TABLE 3
ANNUAL MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT PER BENEFICIARY, BY BENEFICIARY CHARACTERISTIC[a, b]
CONNECTICUT, 2005

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	**57.5**	**29.3**	**$2,347**	**$80**	**$15,537**	**15.1**	**207,088**
Age							
5 and younger	13.1	0.3	17	55	2,908	0.6	21,959
6-14	14.1	1.2	115	94	2,080	5.5	22,726
15-20	23.8	2.5	234	95	3,478	6.7	17,513
21-44	51.6	20.2	2,098	104	12,220	17.2	53,460
45-64	86.4	54.4	4,918	90	23,775	20.7	39,645
65-74	89.3	50.0	3,502	70	18,747	18.7	16,879
75-84	91.3	56.3	3,529	63	27,843	12.7	17,338
85 and older	92.2	53.3	2,937	55	37,023	7.9	17,568
Unknown	0.0	0.0	0	0	0	0.0	0
Basis of Eligibility[e]							
Aged	91.0	53.3	3,323	62	28,106	11.8	51,249
Disabled	89.4	52.6	4,982	95	25,636	19.4	59,831
Adults	27.1	3.7	344	94	2,328	14.8	34,064
Children	15.6	1.0	90	88	2,605	3.5	61,718
Unknown	89.8	23.9	2,275	95	13,945	16.3	226
Gender							
Female	60.3	31.7	2,374	75	15,386	15.4	125,850
Male	53.3	25.6	2,305	90	15,771	14.6	81,238
Unknown	0.0	0.0	0	0	0	0.0	0
Race							
White	67.0	38.5	2,984	78	22,041	13.5	107,642
African American	51.2	22.3	1,937	87	11,042	17.5	38,827
Other/unknown	44.9	17.5	1,479	85	6,867	21.5	60,619
Use of Nursing Facilities[f]							
Entire year	94.7	72.7	4,566	63	56,199	8.1	19,649
Part year	95.6	67.2	4,619	69	36,872	12.5	9,699
None	51.4	22.5	1,978	88	9,877	20.0	177,740
Maintenance Assistance Status							
Cash	37.9	15.9	1,365	86	7,766	17.6	70,658
Medically needy	80.6	42.8	3,669	86	13,527	27.1	23,887
Poverty related	21.5	2.7	245	92	3,199	7.7	32,534
Other/unknown	82.7	48.0	3,675	77	28,016	13.1	80,009

Source: Data for this table are from the MAX 2005 file for Connecticut, released by CMS in 10/2008. This table was produced on 04/23/2009.

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 eight states (DE, IA, IL, 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 eight states (DE, IA, IL, NE, NY, TX, UT, and WV) the Rx share of expenditures for all Medicaid services shown in this column is higher than it would be if all expenditures for these other services, including services provided in capitated managed care plans and long-term-care services, were included.

e. Medicaid basis of eligibility is classified as: aged, disabled, adults, and children. The disabled group includes beneficiaries of any age who were determined to be eligible because of disability

or blindness. The children's group includes children receiving foster care and adoptive services.

f. Please refer to footnote f of Table 1 for methodology used to determine nursing facility residence.

Bene(s) = beneficiary (or beneficiaries); CMS = Centers for Medicare & Medicaid Services; FFS = fee-for-service; MAX = Medicaid Analytic Extract; OTC = over-the-counter; Rx = prescription(s) or pharmacy benefit; $ = Medicaid reimbursement.

TABLE 4

MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT PER BENEFIT MONTH, BY BENEFICIARY CHARACTERISTIC[a, b]

CONNECTICUT, 2005

				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	**4.3**	**$344**	**15.1**	**42.5**	**14.0**	**7.2**	**16.6**	**14.4**	**5.3**	**$2,276**	**207,088**	**1,413,392**
Age												
5 and younger	0.1	8	0.6	86.9	10.5	1.7	0.8	0.1	0.0	1,353	21,959	47,206
6-14	0.5	46	5.5	85.9	9.4	2.3	1.8	0.5	0.1	840	22,726	56,288
15-20	0.8	77	6.7	76.2	15.4	4.0	3.0	1.1	0.3	1,148	17,513	53,086
21-44	3.3	347	17.2	48.4	18.5	7.7	13.6	8.5	3.2	2,021	53,460	323,241
45-64	5.4	490	20.7	13.6	13.7	10.0	27.2	24.9	10.5	2,369	39,645	397,892
65-74	4.7	326	18.7	10.7	16.7	11.6	28.7	23.9	8.3	1,744	16,879	181,475
75-84	5.3	335	12.7	8.7	12.1	9.7	28.6	29.5	11.3	2,641	17,338	182,763
85 and older	5.5	301	7.9	7.8	8.7	9.0	31.0	33.7	9.8	3,794	17,568	171,441
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	5.2	321	11.8	9.0	12.4	10.1	29.4	29.2	9.9	2,714	51,249	530,745
Disabled	4.9	465	19.4	10.6	18.1	11.0	27.5	23.1	9.6	2,393	59,831	640,974
Adults	1.4	130	14.8	72.9	14.3	4.7	5.3	2.2	0.6	882	34,064	89,900
Children	0.4	37	3.5	84.4	10.9	2.4	1.6	0.5	0.1	1,075	61,718	149,493
Unknown	2.4	226	16.3	10.2	39.4	15.9	21.7	12.8	0.0	1,382	226	2,280
Gender												
Female	4.6	342	15.4	39.7	13.7	7.4	17.4	15.7	5.9	2,215	125,850	874,156
Male	3.9	347	14.6	46.7	14.3	6.8	15.3	12.3	4.4	2,376	81,238	539,236
Unknown	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Race												
White	5.0	385	13.5	33.0	12.8	7.5	19.6	19.3	7.8	2,841	107,642	835,194
African American	3.6	312	17.5	48.8	15.8	7.2	14.3	10.3	3.6	1,778	38,827	241,065
Other/unknown	3.1	266	21.5	55.1	14.9	6.7	12.8	8.3	2.1	1,235	60,619	337,133
Use of Nursing Facilities[f]												
Entire year	7.2	451	8.1	5.3	4.2	5.3	25.6	39.8	19.9	5,550	19,649	198,959
Part year	6.7	460	12.5	4.4	7.3	7.6	28.7	36.0	16.0	3,670	9,699	97,446
None	3.6	315	20.0	48.6	15.4	7.4	15.0	10.4	3.2	1,572	177,740	1,116,987
Maintenance Assistance Status												
Cash	3.4	296	17.6	62.1	13.0	5.1	9.8	7.3	2.6	1,686	70,658	325,530
Medically needy	4.7	401	27.1	19.4	15.9	10.5	25.9	20.3	7.9	1,480	23,887	218,321
Poverty related	0.9	81	7.7	78.5	13.8	3.5	3.0	1.0	0.2	1,059	32,534	98,274
Other/unknown	5.0	381	13.1	17.3	14.3	9.5	25.4	24.4	9.1	2,906	80,009	771,267

Source: Data for this table are from the MAX 2005 file for Connecticut, released by CMS in 10/2008. This table was produced on 04/23/2009.

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 eight states (DE, IA, IL, 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 eight states (DE, IA, IL, NE, NY, TX, UT, and WV) the Rx share of expenditures for all Medicaid services shown in this column is higher than it would be if all expenditures for these other services, including services provided in capitated managed care plans and long-term-care services, were included.

e. Medicaid basis of eligibility is classified as: aged, disabled, adults, and children. The disabled group includes beneficiaries of any age who were determined to be eligible because of disability or blindness. The children's group includes children receiving foster care and adoptive services.

f. Please refer to footnote f of Table 1 for methodology used to determine nursing facility residence.

Bene(s) = beneficiary (or beneficiaries); Bene Mo(s) = benefit month(s); CMS = Centers for Medicare & Medicaid Services; FFS = fee-for-service; MAX = Medicaid Analytic Extract; Rx = prescription(s) or pharmacy benefit; $ = Medicaid reimbursement.

TABLE 5

AVERAGE MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT PER BENEFIT MONTH, BY BRAND STATUS AND BENEFICIARY CHARACTERISTIC[a, b, c]

CONNECTICUT, 2005

	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	**4.3**	**$344**	**$80**	**1.9**	**$264**	**$142**	**0.1**	**$16**	**$117**	**2.3**	**$64**	**$28**
Age												
5 and younger	0.1	8	55	0.0	6	148	0.0	0	62	0.1	2	19
6-14	0.5	46	94	0.2	38	163	0.0	2	88	0.2	7	28
15-20	0.8	77	95	0.4	64	163	0.0	3	86	0.4	11	28
21-44	3.3	347	104	1.5	272	182	0.1	17	150	1.7	57	33
45-64	5.4	490	90	2.4	375	157	0.2	26	148	2.9	89	31
65-74	4.7	326	70	2.1	251	121	0.1	12	88	2.4	62	26
75-84	5.3	335	63	2.3	256	110	0.2	12	73	2.8	67	24
85 and older	5.5	301	55	2.2	221	103	0.2	13	71	3.1	67	22
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Basis of Eligibility[d]												
Aged	5.2	321	62	2.2	243	111	0.2	12	76	2.8	65	24
Disabled	4.9	465	95	2.2	360	165	0.2	24	146	2.6	81	32
Adults	1.4	130	94	0.6	96	174	0.0	9	201	0.8	25	32
Children	0.4	37	88	0.2	30	158	0.0	1	88	0.2	6	26
Unknown	2.4	226	95	0.9	166	186	0.1	13	193	1.4	47	33
Gender												
Female	4.6	342	75	1.9	260	134	0.2	16	108	2.4	65	27
Male	3.9	347	90	1.7	270	156	0.1	16	136	2.0	61	31
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Race												
White	5.0	385	78	2.1	289	137	0.2	20	119	2.7	76	28
African American	3.6	312	87	1.6	248	157	0.1	12	114	1.9	52	27
Other/unknown	3.1	266	85	1.5	216	147	0.1	9	107	1.6	42	26
Use of Nursing Facilities[e]												
Entire year	7.2	451	63	2.9	334	117	0.2	19	78	4.0	98	24
Part year	6.7	460	69	2.7	343	127	0.2	21	101	3.7	95	25
None	3.6	315	88	1.6	245	151	0.1	15	134	1.8	55	30
Maintenance Assistance Status												
Cash	3.4	296	86	1.6	231	148	0.1	14	127	1.8	52	29
Medically needy	4.7	401	86	2.1	306	147	0.1	23	153	2.4	73	30
Poverty related	0.9	81	92	0.4	63	159	0.0	4	140	0.5	14	30
Other/unknown	5.0	381	77	2.1	292	138	0.2	17	104	2.7	72	27

Source: Data for this table are from the MAX 2005 file for Connecticut, released by CMS in 10/2008. This table was produced on 04/23/2009.

a. Table 5 includes the beneficiaries represented by Cell C of Table 1. Benefit months are months during which beneficiaries had fee-for-service pharmacy benefits.

b. The Medicaid reimbursement amounts presented in this table do not reflect federally required rebates from drug manufacturers to the state.

c. Brand-name drugs, sometimes called “innovator single-source drugs,” are drugs whose patents have not yet expired. Off-patent brand-name drugs, sometimes called “innovator multiple-source drugs,” are brand-name drugs whose patents have expired. Generic drugs, sometimes called “non-innovator multiple-source drugs,” are off-patent drugs manufactured and sold by companies

other than the original patent holder. In Connecticut, 0.4 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)

d. Medicaid basis of eligibility is classified as: aged, disabled, adults, and children. The disabled group includes beneficiaries of any age who were determined to be eligible because of disability or blindness. The children's group includes children receiving foster care and adoptive services.

e. Please refer to footnote f of Table 1 for methodology used to determine nursing facility residence.

CMS = Centers for Medicare & Medicaid Services; MAX = Medicaid Analytic Extract; Rx = prescription(s) or pharmacy benefit; $ = Medicaid reimbursement.

TABLE 6

MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT, BY BRAND STATUS AND THERAPEUTIC CATEGORY[a, b, c, d]

CONNECTICUT, 2005

Therapeutic Category	Number of Rx per Benefit Month Among Users				$ per Benefit Month Among Users				$ per 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	Total Number of Rx	Total Rx $	Number of Users	As a Percentage of All Benes	Number of Benefit Months
Anti-infective Agents	0.4	0.1	0.0	0.2	$60	$49	$4	$7	$155	$355	$105	$31	258,630	$40,166,514	64,693	31.2	672,703
Biologicals	0.1	0.1	0.0	0.0	55	9	33	14	460	126	5,922	317	2,375	1,093,194	1,767	0.9	19,764
Antineoplastic Agents	0.5	0.2	0.0	0.4	115	85	1	29	215	563	401	75	20,956	4,498,444	3,792	1.8	39,247
Endocrine/Metabolic Drugs	1.0	0.4	0.1	0.5	57	42	4	10	59	115	53	20	534,543	31,431,870	51,741	25.0	551,841
Cardiovascular Agents	1.7	0.7	0.0	1.0	79	60	0	19	46	83	49	19	1,322,926	60,397,278	70,851	34.2	764,354
Respiratory Agents	0.7	0.5	0.0	0.2	51	45	2	4	70	97	64	16	354,834	24,958,770	47,052	22.7	493,164
Gastrointestinal Agents	0.8	0.5	0.0	0.3	78	67	0	11	102	145	69	36	416,461	42,275,162	50,213	24.2	541,477
Genitourinary Agents	0.6	0.4	0.0	0.1	40	35	1	4	71	87	59	25	105,638	7,458,830	17,515	8.5	188,483
CNS Drugs	1.7	0.9	0.0	0.8	176	146	2	28	104	167	147	35	1,293,619	134,382,861	71,654	34.6	761,468
Stimulants/Anti-obesity/Anorexia	0.7	0.5	0.0	0.2	79	70	1	8	111	144	105	39	19,787	2,205,082	2,977	1.4	27,874
Miscellaneous Psychological/ Neurological Agents	0.9	0.9	0.0	0.0	153	153	0	0	177	178	0	48	82,577	14,626,104	9,051	4.4	95,425
Analgesics and Anesthetics	0.8	0.2	0.1	0.6	63	26	18	19	80	158	247	35	492,011	39,461,945	59,575	28.8	625,398
Neuromuscular Agents	1.1	0.4	0.0	0.7	83	53	3	28	75	142	70	39	508,050	37,888,909	41,693	20.1	454,365
Nutritional Products	0.6	0.0	0.1	0.6	15	1	1	13	23	71	15	23	111,978	2,601,446	17,849	8.6	177,364
Hematological Agents	0.9	0.3	0.0	0.7	88	79	0	9	97	312	60	13	225,043	21,784,479	23,253	11.2	246,887
Topical Products	0.5	0.2	0.0	0.3	28	20	1	7	58	95	55	28	286,604	16,531,066	54,471	26.3	587,080
Miscellaneous Products	0.4	0.2	0.0	0.2	99	82	6	11	251	426	243	64	15,864	3,977,720	3,932	1.9	40,206
Unknown Therapeutic Category	0.5	0.0	0.0	0.0	8	0	0	0	18	0	0	0	20,535	364,207	4,033	1.9	43,404
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.	6,072,431	486,103,881	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2005 file for Connecticut, released by CMS in 10/2008. This table was produced on 04/23/2009.

a. Table 6 includes the beneficiaries represented by Cell C of Table 1. A beneficiary who used drugs from two or more categories was counted as a user for each category. Therefore, the sum of users across categories may exceed the total number of individual users. Benefit months are months during which beneficiaries had fee-for-service pharmacy benefits.

b. Medicaid reimbursement amounts presented in this table do not reflect federally required rebates from drug manufacturers to the state.

c. For information about these therapeutic categories, see Wolters Kluwer Health, http://www.medispan.com/marketing/ContentPage.aspx?contentId=09e0f1ed-80a9-4a87-8bc9-ad778d7b6615 (October 26, 2007).

d. Brand-name drugs, sometimes called “innovator single-source drugs,” are drugs whose patents have not yet expired. Off-patent brand-name drugs, sometimes called “innovator multiple-source drugs,” are brand-name drugs whose patents have expired. Generic drugs, sometimes called “non-innovator multiple-source drugs,” are off-patent drugs manufactured and sold by companies other than

the original patent holder. In Connecticut, 0.4 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 2005.

Bene(s) = beneficiary (or beneficiaries); Bene Mo(s) = benefit month(s); CMS = Centers for Medicare & Medicaid Services; CNS = Central Nervous System; MAX = Medicaid Analytic Extract; n.a. = not applicable; Rx = prescription(s) or pharmacy benefit; $ = Medicaid reimbursement.

TABLE 7

MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT, BY TOP 10 DRUG GROUP[a, b, c]

CONNECTICUT, 2005

		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	$90,803,086	49,104	23.7	537,779	0.9	$190	$169
ULCER DRUGS	34,258,446	47,342	22.9	516,396	0.6	111	66
ANTICONVULSANT	32,623,929	37,978	18.3	418,100	0.9	88	78
ANTIDEPRESSANTS	32,361,333	69,200	33.4	744,649	0.7	61	43
ANTIVIRAL	29,252,557	11,494	5.6	124,650	0.5	483	235
ANTIHYPERLIPIDEMIC	26,714,507	38,977	18.8	436,434	0.6	98	61
ANALGESICS - Narcotic	24,264,291	64,168	31.0	686,640	0.4	80	35
ANTIDIABETIC	20,861,655	43,244	20.9	475,312	0.7	66	44
ANTIASTHMATIC	17,015,596	48,422	23.4	510,997	0.4	81	33
MISC PSYCHOTHERAPEUTIC AND NEUROLOGICAL	14,624,894	10,593	5.1	112,130	0.7	177	130
Total	322,780,294	420,522		4,563,087	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2005 file for Connecticut, released by CMS in 10/2008. This table was produced on 04/23/2009.

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 2005. 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 2005. 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.