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STATISTICAL COMPENDIUM:
MEDICAID PHARMACY BENEFIT USE AND REIMBURSEMENT IN 2006
CONNECTICUT

LIST OF TABLES

TABLE 1
OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
CONNECTICUT, 2006

Inclusion Criteria (2006)	Number of Dual and Nondual Eligible Beneficiaries (Cell)	Number of Dual Eligible Beneficiaries (Cell)[g]	Number of Nondual Eligible Beneficiaries (Cell)
1. Beneficiaries who were eligible for Medicaid during at least one month[a]	533568 (A)	99708 (E)	433860 (I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	515207 (B)	81610 (F)	433597 (J)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	221482 (C)	81211 (G)	140271 (K)
4. Beneficiaries who were all-year nursing facility residents[f]	19578 (D)	18295 (H)	1283 (L)

Source: Data for this table are from the MAX 2006 file for Connecticut, released by CMS in 6/2009. This table was produced on 02/11/2010.
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 2006 (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 2006, 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 2006 was $213,864,463, of which $1,334,015 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 29 states in 2006 that had PHPs that did not include a pharmacy benefit: AL, AR, AZ, CA, CO, DC, FL, GA, HI, IA, KY, MA, MI, MS, NC, NH, NV, NY, OK, OR, PA, SC, SD, TN, TX, UT, VA, WA, and WI. In addition, there were 10 states in which MC plans did not provide a pharmacy benefit (DE, IA, IL, NC, NE, NY, TN, TX, UT, and WV). These lists were constructed from the CMS 2006 Medicaid Managed Care Enrollment Report 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 2006. 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 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 2006. 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, 2006

Beneficiary Characteristics	Number of Beneficiaries						Number of Benefit Months					
	All	Aged	Disabled	Adults	Children	Other/ Unknown	All	Aged	Disabled	Adults	Children	Other/ Unknown
All	**221,482**	**50,863**	**60,695**	**40,496**	**69,152**	**276**	**1,493,809**	**527,158**	**645,429**	**119,943**	**198,454**	**2,825**
Age												
5 and younger	24,935	0	0	0	24,935	0	65,479	0	0	0	65,479	0
6-14	25,490	0	1	1	25,488	0	75,023	0	12	1	75,010	0
15-20	19,342	1	1,017	1,715	16,609	0	64,814	4	8,866	3,928	52,016	0
21-44	58,423	0	22,774	33,501	2,084	64	343,489	0	243,372	93,729	5,825	563
45-64	41,685	4	36,373	5,080	35	193	410,977	40	388,170	20,567	115	2,085
65-74	16,820	16,112	502	186	1	19	180,632	174,110	4,723	1,613	9	177
75-84	17,060	17,021	27	12	0	0	179,257	178,879	274	104	0	0
85 and older	17,727	17,725	1	1	0	0	174,138	174,125	12	1	0	0
Unknown	0	0	0	0	0	0	0	0	0	0	0	0
Gender												
Female	134,415	37,081	31,521	30,814	34,724	275	920,407	387,468	341,429	90,467	98,221	2,822
Male	87,067	13,782	29,174	9,682	34,428	1	573,402	139,690	304,000	29,476	100,233	3
Unknown	0	0	0	0	0	0	0	0	0	0	0	0
Race												
White	112,329	35,536	34,462	17,303	24,823	205	859,221	361,891	370,142	52,273	72,758	2,157
African American	41,398	6,105	11,723	8,038	15,496	36	260,950	65,871	122,262	25,917	46,534	366
Other/unknown	67,755	9,222	14,510	15,155	28,833	35	373,638	99,396	153,025	41,753	79,162	302
Use of Nursing Facilities[c]												
Entire year	19,578	17,161	2,390	2	25	0	199,376	172,784	26,305	3	284	0
Part year	9,875	7,107	2,703	44	20	1	99,176	69,806	28,758	448	152	12
None	192,029	26,595	55,602	40,450	69,107	275	1,195,257	284,568	590,366	119,492	198,018	2,813
Maintenance Assistance Status												
Cash	81,585	4,994	11,619	28,232	36,740	0	379,073	56,518	131,163	91,266	100,126	0
Medically needy	21,458	8,167	10,584	793	1,914	0	191,878	79,763	103,985	2,238	5,892	0
Poverty-related	35,547	1,229	2,345	8,272	23,425	276	125,053	13,506	25,712	16,833	66,177	2,825
Other/unknown	82,892	36,473	36,147	3,199	7,073	0	797,805	377,371	384,569	9,606	26,259	0
Dual Medicare Status[d]												
Full dual, all year	74,756	44,870	27,274	2,537	55	20	788,414	465,180	299,505	23,067	444	218
Full dual, part year	6,455	2,657	3,688	109	1	0	72,032	29,754	41,090	1,179	9	0
Non-dual, all year	140,271	3,336	29,733	37,850	69,096	256	633,363	32,224	304,834	95,697	198,001	2,607
Managed Care (MC) Status												
Fee-for-service (FFS) all year	136,228	50,860	60,019	11,984	13,092	273	1,278,281	527,146	641,405	51,495	55,425	2,810
FFS part year, with Rx claims	17,291	2	513	7,499	9,274	3	55,417	9	3,359	22,930	29,104	15
FFS part year, no Rx claims	67,963	1	163	21,013	46,786	0	160,111	3	665	45,518	113,925	0

Source: Data for this table are from the MAX 2006 file for Connecticut, released by CMS in 6/2009. This table was produced on 02/11/2010.

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 2006. 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, 2006

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	**51.5**	**16.8**	**$960**	**$57**	**$14,410**	**6.7**	**221,482**
Age							
5 and younger	14.9	0.4	18	50	2,879	0.6	24,935
6-14	15.3	1.1	111	99	2,169	5.1	25,490
15-20	24.0	2.3	241	105	3,749	6.4	19,342
21-44	47.2	13.7	1,054	77	11,025	9.6	58,423
45-64	81.8	39.5	2,663	67	22,247	12.0	41,685
65-74	81.8	31.3	891	29	17,698	5.0	16,820
75-84	79.2	24.8	605	24	26,775	2.3	17,060
85 and older	71.9	14.1	378	27	37,574	1.0	17,727
Unknown	0.0	0.0	0	0	0	0.0	0
Basis of Eligibility[e]							
Aged	77.6	23.2	613	26	27,745	2.2	50,863
Disabled	85.5	38.9	2,764	71	24,611	11.2	60,695
Adults	26.7	2.9	167	57	2,346	7.1	40,496
Children	16.7	1.0	91	93	2,713	3.3	69,152
Unknown	81.9	20.9	2,029	97	14,825	13.7	276
Gender							
Female	53.5	17.9	945	53	14,221	6.6	134,415
Male	48.3	15.2	983	65	14,703	6.7	87,067
Unknown	0.0	0.0	0	0	0	0.0	0
Race							
White	58.5	19.4	1,001	52	20,714	4.8	112,329
African American	47.7	15.5	1,011	65	10,448	9.7	41,398
Other/unknown	42.0	13.4	859	64	6,381	13.5	67,755
Use of Nursing Facilities[f]							
Entire year	71.4	13.1	905	69	57,908	1.6	19,578
Part year	83.9	31.4	1,686	54	36,509	4.6	9,875
None	47.8	16.5	928	56	8,839	10.5	192,029
Maintenance Assistance Status							
Cash	35.1	10.9	609	56	6,742	9.0	81,585
Medically needy	71.8	23.3	982	42	12,482	7.9	21,458
Poverty related	23.8	2.4	135	57	3,221	4.2	35,547
Other/unknown	74.2	27.2	1,653	61	27,255	6.1	82,892

Source: Data for this table are from the MAX 2006 file for Connecticut, released by CMS in 6/2009. This table was produced on 02/11/2010.

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 ten states (DE, IA, IL, NC, NE, NY, TN, 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 ten states (DE, IA, IL, NC, NE, NY, TN, 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, 2006

				Number of Rx, Percentage with:							Number	
Beneficiary Characteristics	Mean Number of Rx	Mean Rx $	Rx $ as a Percentage of All Medicaid FFS $[c]	None	More than 0, but 1 or Less	More than 1, but 2 or Less	More than 2, but 5 or Less	More than 5, but 10 or Less	More than 10	Mean $, All Medicaid FFS $[d]	Beneficiaries	Benefit Months
All	**2.5**	**$142**	**6.7**	**48.5**	**21.5**	**7.5**	**13.3**	**7.4**	**1.8**	**$2,137**	**221,482**	**1,493,809**
Age												
5 and younger	0.1	7	0.6	85.1	12.7	1.6	0.6	0.1	0.0	1,096	24,935	65,479
6-14	0.4	38	5.1	84.7	11.1	2.1	1.6	0.4	0.1	737	25,490	75,023
15-20	0.7	72	6.4	76.0	16.4	3.3	3.1	1.0	0.2	1,119	19,342	64,814
21-44	2.3	179	9.6	52.8	20.6	7.7	12.1	5.3	1.5	1,875	58,423	343,489
45-64	4.0	270	12.0	18.2	19.8	11.5	26.7	18.1	5.6	2,257	41,685	410,977
65-74	2.9	83	5.0	18.2	26.5	12.6	25.9	15.0	1.8	1,648	16,820	180,632
75-84	2.4	58	2.3	20.8	33.6	11.9	21.0	11.3	1.2	2,548	17,060	179,257
85 and older	1.4	39	1.0	28.1	44.6	9.6	11.9	5.3	0.6	3,825	17,727	174,138
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	2.2	59	2.2	22.4	35.3	11.3	19.4	10.5	1.2	2,677	50,863	527,158
Disabled	3.7	260	11.2	14.5	23.7	12.5	27.4	16.7	5.2	2,314	60,695	645,429
Adults	1.0	57	7.1	73.3	15.8	4.5	4.6	1.5	0.3	792	40,496	119,943
Children	0.3	32	3.3	83.3	12.6	2.1	1.5	0.4	0.1	945	69,152	198,454
Unknown	2.0	198	13.7	18.1	37.0	15.9	22.8	6.2	0.0	1,448	276	2,825
Gender												
Female	2.6	138	6.6	46.5	22.3	7.7	13.6	8.0	1.9	2,077	134,415	920,407
Male	2.3	149	6.7	51.7	20.2	7.4	12.8	6.4	1.5	2,233	87,067	573,402
Unknown	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Race												
White	2.5	131	4.8	41.5	24.6	8.5	14.9	8.4	2.2	2,708	112,329	859,221
African American	2.5	160	9.7	52.3	19.9	7.1	12.2	6.9	1.6	1,657	41,398	260,950
Other/unknown	2.4	156	13.5	58.0	17.2	6.3	11.2	6.0	1.2	1,157	67,755	373,638
Use of Nursing Facilities[f]												
Entire year	1.3	89	1.6	28.6	50.6	9.2	5.9	3.4	2.4	5,686	19,578	199,376
Part year	3.1	168	4.6	16.1	34.2	11.2	20.5	13.2	4.8	3,635	9,875	99,176
None	2.6	149	10.5	52.2	17.8	7.2	13.7	7.5	1.6	1,420	192,029	1,195,257
Maintenance Assistance Status												
Cash	2.4	131	9.0	64.9	14.9	5.0	9.0	4.9	1.2	1,451	81,585	379,073
Medically needy	2.6	110	7.9	28.2	26.4	11.3	21.6	10.7	1.9	1,396	21,458	191,878
Poverty related	0.7	38	4.2	76.2	16.5	3.6	2.9	0.7	0.1	916	35,547	125,053
Other/unknown	2.8	172	6.1	25.8	28.8	10.8	19.8	11.8	3.0	2,832	82,892	797,805

Source: Data for this table are from the MAX 2006 file for Connecticut, released by CMS in 6/2009. This table was produced on 02/11/2010.

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 ten states (DE, IA, IL, NC, NE, NY, TN, 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 ten states (DE, IA, IL, NC, NE, NY, TN, 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, 2006

	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	**2.5**	**$142**	**$57**	**1.0**	**$107**	**$106**	**0.1**	**$10**	**$91**	**1.4**	**$26**	**$19**
Age												
5 and younger	0.1	7	50	0.0	5	139	0.0	0	93	0.1	2	19
6-14	0.4	38	99	0.2	28	174	0.0	1	86	0.2	7	33
15-20	0.7	72	105	0.3	59	202	0.0	3	100	0.4	10	28
21-44	2.3	179	77	1.0	139	145	0.1	11	110	1.3	29	23
45-64	4.0	270	67	1.6	200	125	0.2	20	116	2.2	50	22
65-74	2.9	83	29	1.2	61	49	0.1	6	50	1.6	16	11
75-84	2.4	58	24	1.0	42	43	0.1	4	40	1.3	11	9
85 and older	1.4	39	27	0.5	28	53	0.1	3	41	0.8	8	9
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Basis of Eligibility[d]												
Aged	2.2	59	26	0.9	43	47	0.1	4	44	1.2	12	10
Disabled	3.7	260	71	1.5	197	132	0.2	17	112	2.0	46	23
Adults	1.0	57	57	0.3	40	114	0.0	6	147	0.6	11	19
Children	0.3	32	93	0.1	25	180	0.0	1	90	0.2	6	29
Unknown	2.0	198	97	0.8	144	184	0.1	16	187	1.2	37	32
Gender												
Female	2.6	138	53	1.1	103	97	0.1	10	89	1.5	26	18
Male	2.3	149	65	1.0	114	120	0.1	9	96	1.3	26	21
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Race												
White	2.5	131	52	1.0	95	94	0.1	10	89	1.4	26	18
African American	2.5	160	65	1.0	125	125	0.1	9	98	1.4	26	19
Other/unknown	2.4	156	64	1.0	123	118	0.1	8	91	1.3	25	19
Use of Nursing Facilities[e]												
Entire year	1.3	89	69	0.4	65	158	0.1	6	90	0.8	18	22
Part year	3.1	168	54	1.2	124	107	0.1	11	88	1.8	32	18
None	2.6	149	56	1.1	113	102	0.1	10	91	1.4	26	18
Maintenance Assistance Status												
Cash	2.4	131	56	1.0	99	101	0.1	8	89	1.3	23	18
Medically needy	2.6	110	42	1.1	79	74	0.1	10	89	1.4	20	14
Poverty related	0.7	38	57	0.3	29	101	0.0	3	101	0.4	7	19
Other/unknown	2.8	172	61	1.1	130	114	0.1	11	92	1.6	31	20

Source: Data for this table are from the MAX 2006 file for Connecticut, released by CMS in 6/2009. This table was produced on 02/11/2010.
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, 0.2 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.medi-span.com/master-drug-database.aspx
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, 2006

Therapeutic Category	Number of Rx per Benefit Month Among Users: Total	Patented Brand-Name	Off-Patent Brand-Name	Generic	$ per Benefit Month Among Users: Total	Patented Brand-Name	Off-Patent Brand-Name	Generic	$ per Rx: Total	Patented Brand-Name	Off-Patent Brand-Name	Generic	Total Number of Rx	Total Rx $	Users[e]: Number of Users	As a Percentage of All Benes	Number of Benefit Months
Anti-infective Agents	0.3	0.1	0.0	0.2	$52	$45	$0	$6	$152	$390	$114	$28	164,274	$24,921,932	47,342	21.4	481,670
Biologicals	0.1	0.1	0.0	0.0	94	85	7	1	703	723	2,105	118	901	633,190	636	0.3	6,762
Antineoplastic Agents	0.4	0.1	0.0	0.3	76	66	0	10	181	441	135	38	10,263	1,859,997	2,281	1.0	24,383
Endocrine/Metabolic Drugs	0.8	0.3	0.0	0.5	30	23	1	6	38	74	42	13	345,597	13,179,217	40,741	18.4	435,417
Cardiovascular Agents	1.3	0.5	0.1	0.7	34	23	3	8	25	42	54	11	781,108	19,710,787	53,245	24.0	584,303
Respiratory Agents	0.6	0.4	0.0	0.2	29	24	1	3	47	68	61	14	242,216	11,474,780	38,611	17.4	399,995
Gastrointestinal Agents	0.6	0.4	0.0	0.2	44	37	3	3	76	95	429	18	247,460	18,761,165	39,135	17.7	427,979
Genitourinary Agents	0.4	0.3	0.0	0.1	15	11	2	2	36	44	48	16	55,454	1,994,677	12,171	5.5	132,013
CNS Drugs	1.3	0.5	0.1	0.7	87	68	5	14	68	124	66	22	831,213	56,834,600	61,228	27.6	652,847
Stimulants/Anti-obesity/Anorexia	0.6	0.4	0.0	0.2	62	56	1	5	104	129	116	32	13,807	1,438,258	2,634	1.2	23,367
Miscellaneous Psychological/ Neurological Agents	0.5	0.5	0.0	0.0	79	79	0	0	149	149	0	30	24,901	3,710,168	4,267	1.9	47,205
Analgesics and Anesthetics	0.6	0.1	0.0	0.5	35	14	10	11	56	138	271	22	312,521	17,346,703	47,415	21.4	497,967
Neuromuscular Agents	0.9	0.3	0.0	0.6	46	29	1	16	51	99	63	27	337,846	17,383,478	34,422	15.5	375,310
Nutritional Products	0.5	0.0	0.1	0.4	10	1	1	8	21	42	15	20	64,745	1,335,042	13,758	6.2	136,142
Hematological Agents	0.6	0.2	0.0	0.5	61	56	0	5	99	364	19	11	121,939	12,076,076	18,188	8.2	197,377
Topical Products	0.4	0.1	0.0	0.2	16	11	1	4	43	74	53	20	162,415	7,046,792	40,784	18.4	437,144
Miscellaneous Products	0.3	0.2	0.0	0.1	77	68	3	6	234	360	192	49	10,991	2,572,522	3,333	1.5	33,232
Unknown Therapeutic Category	0.2	0.0	0.0	0.0	17	0	0	0	83	0	0	0	3,037	251,064	1,338	0.6	14,994
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.	3,730,688	212,530,448	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2006 file for Connecticut, released by CMS in 6/2009. This table was produced on 02/11/2010.

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.medi-span.com/master-drug-database.aspx.

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, 0.2 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.medi-span.com/master-drug-database.aspx.

e. A user is a beneficiary who had at least one prescription filled in a given therapeutic category during 2006.

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, 2006

		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	$37,343,257	35,236	15.9	386,815	0.7	$135	$97
ANTIVIRAL	20,017,556	8,118	3.7	87,688	0.5	475	228
ANTICONVULSANT	15,531,101	31,463	14.2	346,687	0.7	61	45
ULCER DRUGS	14,466,775	36,591	16.5	405,520	0.5	77	36
ANTIDEPRESSANTS	11,827,874	49,699	22.4	538,507	0.6	39	22
ANALGESICS - Narcotic	11,084,839	49,036	22.1	526,500	0.4	59	21
ANTIHYPERLIPIDEMIC	9,409,085	33,112	15.0	374,305	0.5	48	25
ANTIDIABETIC	9,158,215	35,100	15.8	389,239	0.5	43	24
ANTIASTHMATIC	8,079,502	39,599	17.9	414,180	0.4	55	20
HEMATOPOIETIC AGENTS	7,520,989	14,171	6.4	152,505	0.5	101	49
Total	144,439,193	332,125	n.a.	3,621,946	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2006 file for Connecticut, released by CMS in 6/2009. This table was produced on 02/11/2010.
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 2006. 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 2006. For information about these drug groups, see Wolters Kluwer Health, http://www.medi-span.com/master-drug-database.aspx.
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.