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

LIST OF TABLES

TABLE 1
OVERVIEW OF BENEFICIARY SELECTION CRITERIA FOR STUDY POPULATION
ILLINOIS, 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]	2404599 (A)	354875 (E)	2049724 (I)
2. Beneficiaries who had Medicaid pharmacy benefits during at least one month[b]	2382678 (B)	334628 (F)	2048050 (J)
3. Beneficiaries who had fee-for-service pharmacy benefit coverage during at least one month[c, d, e]	2345876 (C)	334535 (G)	2011341 (K)
4. Beneficiaries who were all-year nursing facility residents[f]	40126 (D)	32601 (H)	7525 (L)

Source: Data for this table are from the MAX 2006 file for Illinois, released by CMS in 6/2009. This table was produced on 02/12/2010.
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 Illinois in 2006 was $939,722,885, of which $1,277,384 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]

ILLINOIS, 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	**2,345,876**	**184,722**	**332,922**	**493,278**	**1,334,240**	**714**	**22,300,845**	**1,589,945**	**3,662,357**	**4,111,547**	**12,931,285**	**5,711**
Age												
5 and younger	527,433	4	2,427	12	524,990	0	4,920,786	36	26,273	56	4,894,421	0
6-14	580,314	0	11,673	68	568,573	0	5,874,272	0	131,938	395	5,741,939	0
15-20	284,874	1	15,280	33,550	236,032	11	2,709,395	8	164,443	279,270	2,265,604	70
21-44	508,581	31	97,203	407,453	3,748	146	4,515,309	208	1,080,140	3,410,251	23,773	937
45-64	211,043	370	157,655	51,753	728	537	2,133,976	2,133	1,704,566	418,241	4,445	4,591
65-74	95,228	57,083	37,661	398	66	20	918,349	484,774	430,041	3,016	405	113
75-84	85,979	76,422	9,474	39	44	0	775,618	667,084	107,985	286	263	0
85 and older	52,378	50,811	1,549	5	13	0	452,812	435,702	16,971	32	107	0
Unknown	46	0	0	0	46	0	328	0	0	0	328	0
Gender												
Female	1,391,395	130,926	174,579	415,639	669,537	714	13,046,078	1,128,280	1,945,250	3,523,895	6,442,942	5,711
Male	954,481	53,796	158,343	77,639	664,703	0	9,254,767	461,665	1,717,107	587,652	6,488,343	0
Unknown	0	0	0	0	0	0	0	0	0	0	0	0
Race												
White	924,303	111,258	152,463	212,345	447,763	474	8,672,474	923,208	1,663,191	1,751,163	4,330,882	4,030
African American	783,356	38,025	138,392	161,901	444,890	148	7,616,991	315,006	1,531,354	1,416,137	4,353,447	1,047
Other/unknown	638,217	35,439	42,067	119,032	441,587	92	6,011,380	351,731	467,812	944,247	4,246,956	634
Use of Nursing Facilities[c]												
Entire year	40,126	23,133	16,970	15	7	1	433,076	239,090	193,863	54	68	1
Part year	33,696	20,222	13,224	219	29	2	336,048	191,804	141,824	2,115	289	16
None	2,272,054	141,367	302,728	493,044	1,334,204	711	21,531,721	1,159,051	3,326,670	4,109,378	12,930,928	5,694
Maintenance Assistance Status												
Cash	277,947	23,524	151,953	18,167	84,303	0	2,941,334	268,601	1,750,529	168,945	753,259	0
Medically needy	409,345	62,223	76,422	260,686	10,014	0	3,544,061	561,490	734,941	2,196,142	51,488	0
Poverty-related	1,280,294	29,376	63,044	33,496	1,153,664	714	12,501,778	319,527	703,045	205,276	11,268,219	5,711
Other/unknown	378,290	69,599	41,503	180,929	86,259	0	3,313,672	440,327	473,842	1,541,184	858,319	0
Dual Medicare Status[d]												
Full dual, all year	310,797	156,962	146,454	7,041	307	33	3,023,313	1,329,250	1,634,017	57,353	2,488	205
Full dual, part year	23,738	10,310	13,033	387	8	0	264,022	112,382	147,955	3,607	78	0
Non-dual, all year	2,011,341	17,450	173,435	485,850	1,333,925	681	19,013,510	148,313	1,880,385	4,050,587	12,928,719	5,506
Managed Care (MC) Status												
Fee-for-service (FFS) all year	2,184,104	184,600	332,360	456,082	1,210,348	714	21,097,108	1,588,974	3,658,267	3,845,897	11,998,259	5,711
FFS part year, with Rx claims	74,670	25	398	20,033	54,214	0	441,571	132	2,809	117,206	321,424	0
FFS part year, no Rx claims	37,236	42	121	5,716	31,357	0	199,816	191	777	28,305	170,543	0

Source: Data for this table are from the MAX 2006 file for Illinois, released by CMS in 6/2009. This table was produced on 02/12/2010.

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]

ILLINOIS, 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	**58.0**	**6.6**	**$400**	**$61**	**$3,696**	**10.8**	**2,345,876**
Age							
5 and younger	64.8	3.4	162	48	1,930	8.4	527,433
6-14	54.0	3.3	237	71	1,090	21.7	580,314
15-20	56.6	4.3	302	70	1,985	15.2	284,874
21-44	65.0	8.8	530	60	4,281	12.4	508,581
45-64	65.5	23.4	1,485	63	12,044	12.3	211,043
65-74	36.1	7.2	336	46	6,048	5.5	95,228
75-84	28.3	3.5	122	35	6,861	1.8	85,979
85 and older	30.8	2.9	75	26	10,877	0.7	52,378
Unknown	45.7	1.8	91	51	1,446	6.3	46
Basis of Eligibility[e]							
Aged	26.9	3.3	122	37	6,469	1.9	184,722
Disabled	62.6	20.2	1,444	72	13,831	10.4	332,922
Adults	65.5	7.4	340	46	1,903	17.9	493,278
Children	58.3	3.4	199	59	1,442	13.8	1,334,240
Unknown	79.6	25.0	2,808	112	11,623	24.2	714
Gender							
Female	59.6	7.0	378	54	3,445	11.0	1,391,395
Male	55.6	6.0	433	72	4,062	10.7	954,481
Unknown	0.0	0.0	0	0	0	0.0	0
Race							
White	58.1	7.9	483	61	4,715	10.2	924,303
African American	57.7	6.5	413	64	3,842	10.8	783,356
Other/unknown	58.2	4.8	264	55	2,042	12.9	638,217
Use of Nursing Facilities[f]							
Entire year	61.6	20.9	1,316	63	32,648	4.0	40,126
Part year	64.4	15.5	927	60	26,160	3.5	33,696
None	57.8	6.2	376	60	2,852	13.2	2,272,054
Maintenance Assistance Status							
Cash	65.7	15.1	1,036	68	5,894	17.6	277,947
Medically needy	59.7	9.0	497	55	7,660	6.5	409,345
Poverty related	57.8	3.6	192	54	1,629	11.8	1,280,294
Other/unknown	51.1	8.1	531	65	4,789	11.1	378,290

Source: Data for this table are from the MAX 2006 file for Illinois, released by CMS in 6/2009. This table was produced on 02/12/2010.
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]

ILLINOIS, 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	**0.7**	**$42**	**10.8**	**42.0**	**46.9**	**4.7**	**4.2**	**1.7**	**0.4**	**$389**	**2,345,876**	**22,300,845**
Age												
5 and younger	0.4	17	8.4	35.2	60.6	2.9	1.1	0.2	0.0	207	527,433	4,920,786
6-14	0.3	23	21.7	46.0	49.1	2.9	1.8	0.2	0.0	108	580,314	5,874,272
15-20	0.5	32	15.2	43.4	49.6	4.0	2.4	0.5	0.1	209	284,874	2,709,395
21-44	1.0	60	12.4	35.0	47.3	8.0	6.9	2.2	0.5	482	508,581	4,515,309
45-64	2.3	147	12.3	34.5	27.4	8.9	15.7	10.3	3.1	1,191	211,043	2,133,976
65-74	0.8	35	5.5	63.9	24.1	4.2	4.8	2.4	0.6	627	95,228	918,349
75-84	0.4	14	1.8	71.7	22.5	2.8	2.1	0.8	0.1	761	85,979	775,618
85 and older	0.3	9	0.7	69.2	25.9	2.8	1.6	0.4	0.1	1,258	52,378	452,812
Unknown	0.3	13	6.3	54.3	45.7	0.0	0.0	0.0	0.0	203	46	328
Basis of Eligibility[e]												
Aged	0.4	14	1.9	73.1	21.2	2.7	2.1	0.7	0.1	752	184,722	1,589,945
Disabled	1.8	131	10.4	37.4	31.1	8.1	12.9	8.2	2.4	1,257	332,922	3,662,357
Adults	0.9	41	17.9	34.5	49.2	7.9	6.3	1.7	0.3	228	493,278	4,111,547
Children	0.4	21	13.8	41.7	53.6	3.0	1.5	0.2	0.0	149	1,334,240	12,931,285
Unknown	3.1	351	24.2	20.4	23.1	15.3	26.5	13.2	1.5	1,453	714	5,711
Gender												
Female	0.8	40	11.0	40.4	47.7	5.1	4.4	1.8	0.5	367	1,391,395	13,046,078
Male	0.6	45	10.7	44.4	45.7	4.2	3.9	1.5	0.4	419	954,481	9,254,767
Unknown	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0	0	0
Race												
White	0.8	52	10.2	41.9	44.6	5.6	5.2	2.2	0.6	503	924,303	8,672,474
African American	0.7	43	10.8	42.3	46.6	4.6	4.3	1.8	0.5	395	783,356	7,616,991
Other/unknown	0.5	28	12.9	41.8	50.7	3.7	2.7	0.9	0.2	217	638,217	6,011,380
Use of Nursing Facilities[f]												
Entire year	1.9	122	4.0	38.4	35.5	6.5	7.0	8.1	4.6	3,025	40,126	433,076
Part year	1.6	93	3.5	35.6	41.1	6.3	8.1	6.4	2.4	2,623	33,696	336,048
None	0.7	40	13.2	42.2	47.2	4.7	4.1	1.5	0.3	301	2,272,054	21,531,721
Maintenance Assistance Status												
Cash	1.4	98	17.6	34.3	41.3	7.1	10.0	5.7	1.5	557	277,947	2,941,334
Medically needy	1.0	57	6.5	40.3	41.5	7.5	7.2	2.8	0.7	885	409,345	3,544,061
Poverty related	0.4	20	11.8	42.2	52.8	3.0	1.6	0.3	0.1	167	1,280,294	12,501,778
Other/unknown	0.9	61	11.1	48.9	36.8	5.7	5.6	2.3	0.7	547	378,290	3,313,672

Source: Data for this table are from the MAX 2006 file for Illinois, released by CMS in 6/2009. This table was produced on 02/12/2010.

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]

ILLINOIS, 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	**0.7**	**$42**	**$61**	**0.2**	**$31**	**$156**	**0.0**	**$3**	**$98**	**0.5**	**$9**	**$18**
Age												
5 and younger	0.4	17	48	0.1	12	156	0.0	1	55	0.3	4	15
6-14	0.3	23	71	0.1	19	142	0.0	1	71	0.2	4	20
15-20	0.5	32	70	0.2	25	162	0.0	1	86	0.3	6	20
21-44	1.0	60	60	0.3	43	166	0.0	4	104	0.7	12	18
45-64	2.3	147	63	0.6	105	163	0.1	12	125	1.6	30	19
65-74	0.8	35	46	0.2	23	118	0.0	3	105	0.5	8	16
75-84	0.4	14	35	0.1	9	101	0.0	1	90	0.3	4	13
85 and older	0.3	9	26	0.1	5	93	0.0	1	67	0.3	3	10
Unknown	0.3	13	51	0.1	10	151	0.0	1	22	0.2	2	15
Basis of Eligibility[d]												
Aged	0.4	14	37	0.1	9	105	0.0	1	95	0.3	4	14
Disabled	1.8	131	72	0.5	99	185	0.1	9	118	1.2	24	19
Adults	0.9	41	46	0.2	26	123	0.0	4	105	0.6	11	17
Children	0.4	21	59	0.1	16	141	0.0	1	65	0.2	4	18
Unknown	3.1	351	112	0.9	272	305	0.2	29	165	2.1	51	25
Gender												
Female	0.8	40	54	0.2	28	142	0.0	3	99	0.5	9	18
Male	0.6	45	72	0.2	35	177	0.0	2	97	0.4	8	19
Unknown	0.0	0	0	0.0	0	0	0.0	0	0	0.0	0	0
Race												
White	0.8	52	61	0.3	38	148	0.0	4	98	0.6	10	18
African American	0.7	43	64	0.2	31	176	0.0	3	104	0.5	9	19
Other/unknown	0.5	28	55	0.1	20	147	0.0	2	90	0.4	6	17
Use of Nursing Facilities[e]												
Entire year	1.9	122	63	0.6	94	170	0.1	6	105	1.3	22	16
Part year	1.6	93	60	0.4	69	175	0.1	6	112	1.1	18	17
None	0.7	40	60	0.2	29	155	0.0	3	98	0.4	8	18
Maintenance Assistance Status												
Cash	1.4	98	68	0.4	73	181	0.1	7	115	1.0	18	19
Medically needy	1.0	57	55	0.3	40	150	0.0	4	112	0.7	13	18
Poverty related	0.4	20	54	0.1	15	137	0.0	1	71	0.2	4	17
Other/unknown	0.9	61	65	0.3	45	157	0.0	4	102	0.6	11	19

Source: Data for this table are from the MAX 2006 file for Illinois, released by CMS in 6/2009. This table was produced on 02/12/2010.

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 Illinois, 0.5 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]

ILLINOIS, 2006

	Number of Rx per Benefit Month Among Users				$ per Benefit Month Among Users				$ per Rx						Users[e]		
Therapeutic Category	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	0.2	0.0	0.0	0.2	$14	$9	$1	$4	$59	$247	$71	$21	2,084,011	$123,073,729	838,392	35.7	9,011,982
Biologicals	0.3	0.3	0.0	0.0	313	309	2	2	1144	1,197	3,261	129	22,166	25,362,643	7,917	0.3	81,106
Antineoplastic Agents	0.5	0.2	0.0	0.3	205	176	3	26	405	1,051	395	79	44,060	17,863,182	8,241	0.4	87,253
Endocrine/Metabolic Drugs	0.4	0.2	0.0	0.3	23	16	1	6	54	108	81	21	1,511,133	81,393,821	332,492	14.2	3,527,463
Cardiovascular Agents	1.1	0.3	0.1	0.7	48	28	8	11	43	81	118	16	2,071,511	88,844,044	171,880	7.3	1,852,885
Respiratory Agents	0.4	0.1	0.0	0.2	21	17	1	3	59	116	76	16	1,821,580	107,435,122	479,689	20.4	5,201,669
Gastrointestinal Agents	0.3	0.1	0.0	0.3	20	13	3	4	57	150	246	17	590,264	33,582,503	156,275	6.7	1,690,988
Genitourinary Agents	0.2	0.1	0.0	0.1	11	6	3	2	51	81	79	22	190,414	9,635,648	86,801	3.7	917,246
CNS Drugs	0.8	0.3	0.1	0.5	61	49	4	7	78	196	79	16	2,242,383	175,080,645	263,420	11.2	2,861,615
Stimulants/Anti-obesity/Anorexia	0.7	0.6	0.0	0.1	67	64	0	3	94	108	177	23	420,545	39,700,168	53,208	2.3	593,357
Miscellaneous Psychological/ Neurological Agents	0.3	0.2	0.0	0.1	87	75	0	12	299	376	135	134	43,517	13,018,741	13,458	0.6	148,943
Analgesics and Anesthetics	0.3	0.0	0.0	0.3	9	4	1	4	29	193	285	14	1,755,020	50,540,336	512,361	21.8	5,480,664
Neuromuscular Agents	0.6	0.2	0.0	0.4	44	33	1	10	72	162	80	26	931,678	67,162,027	137,778	5.9	1,511,614
Nutritional Products	0.3	0.0	0.0	0.3	7	2	0	4	21	39	34	17	334,507	6,977,384	102,526	4.4	1,044,236
Hematological Agents	0.6	0.1	0.0	0.4	83	76	0	7	146	593	30	16	360,013	52,418,989	57,415	2.4	629,223
Topical Products	0.2	0.0	0.0	0.2	6	3	0	3	29	86	47	16	976,949	28,751,149	461,986	19.7	5,001,899
Miscellaneous Products	0.2	0.1	0.0	0.0	28	26	1	2	178	210	286	53	93,458	16,619,622	53,866	2.3	585,384
Unknown Therapeutic Category	0.2	0.0	0.0	0.0	8	0	0	0	56	0	0	0	17,742	985,748	10,585	0.5	116,282
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.	15,510,951	938,445,501	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2006 file for Illinois, released by CMS in 6/2009. This table was produced on 02/12/2010.

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 Illinois, 0.5 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]

ILLINOIS, 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	$126,675,149	101,005	4.3	1,138,908	0.6	$197	$111
ANTIASTHMATIC	86,277,204	436,539	18.6	4,775,109	0.3	69	18
ANTICONVULSANT	61,986,328	98,962	4.2	1,103,579	0.6	92	56
ANTIVIRAL	59,426,991	30,412	1.3	330,570	0.4	455	180
ANTIDEPRESSANTS	40,899,200	182,857	7.8	1,978,572	0.4	48	21
STIMULANTS/ANTI-OBESITY/ANOREXIANTS	39,700,168	61,698	2.6	691,677	0.6	94	57
ANTIHYPERLIPIDEMIC	38,712,743	76,741	3.3	848,517	0.5	94	46
ANTIDIABETIC	35,169,014	95,952	4.1	1,041,713	0.6	61	34
MISC. HEMATOLOGICAL	27,962,586	13,771	0.6	152,324	0.5	379	184
PASSIVE IMMUNIZING AGENTS	24,537,133	4,885	0.2	46,032	0.4	1,312	533
Total	541,346,516	1,102,822	n.a.	12,107,001	n.a.	n.a.	n.a.

Source: Data for this table are from the MAX 2006 file for Illinois, released by CMS in 6/2009. This table was produced on 02/12/2010.

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.