Order Code RL31485

Prescription Drug Coverage for Medicare Beneficiaries: Medicaid and State Pharmaceutical Assistance Programs

June 27, 2002

Julie Stone
Analyst in Social Legislation
Domestic Social Policy Division

Heidi G. Yacker
Information Research Specialist
Information Research Division

Prescription Drug Coverage for Medicare Beneficiaries: Medicaid and State Pharmaceutical Assistance Programs

Summary

Medicare is the nation's health insurance program for 40 million elderly and disabled individuals. It provides beneficiaries with significant coverage for many health care services. However, it provides a very limited outpatient prescription drug benefit. Most beneficiaries (almost 90%) have private or public supplemental coverage to close the gaps in Medicare's coverage. However, in 1999, only 62.3% of beneficiaries had coverage for outpatient prescription drugs, primarily through employer-sponsored plans, Medicare managed care plans, and Medigap plans.

Approximately 13% of all beneficiaries are eligible for prescription drug coverage under programs run at the state level, through Medicaid and state pharmaceutical assistance programs. These are primarily individuals who are low-income or who have large medical expenses that deplete their income and assets.

Eligibility criteria for Medicaid and state pharmaceutical programs vary widely among the states. Medicaid has numerous pathways through which Medicare beneficiaries can qualify for coverage of their prescription drug costs. This report describes the standards used by each state in determining eligibility. In addition, 20 states currently operate pharmaceutical assistance programs that provide subsidies to qualified individuals, usually the low-income elderly or disabled. This report describes the eligibility criteria and benefits under each program. The report will be updated as new data become available.

Contents

List of Tables

Prescription Drug Coverage for Medicare Beneficiaries: Medicaid and State Pharmaceutical Assistance Programs

Introduction

Medicare is the nation's health insurance program for 40 million elderly and disabled individuals. It provides coverage for many health care services, including hospital, physician, home health, and skilled nursing facility services. It does not, however, provide coverage for all of the health-related services that beneficiaries need. Notably, Medicare provides only limited coverage of outpatient prescription drugs.[1]

Most beneficiaries (almost 90%) have supplemental private and public coverage for many expenses not paid by Medicare. However, in 1999, only 62.3% of beneficiaries had supplemental coverage that paid for outpatient prescription drugs.[2] Those who had supplemental coverage obtained it through employer sponsored plans (28.3%), Medicare HMOs (15.3%), Medicaid (10%), Medigap (6.8%), and public programs (1.9%) such as those through the Veterans Administration or the Department of Defense and through state pharmaceutical assistance programs.[3]

Drug coverage under Medicaid and states' pharmaceutical assistance programs is provided primarily to elderly and disabled persons who are low-income or who have large medical expenses that deplete their income and assets. Medicaid, the largest public payer of prescription drugs, offers outpatient drug coverage to certain groups of Medicare enrollees.[4] In 1999, the most recent year for which data are available, Medicaid paid for prescription drugs primarily on an outpatient basis for approximately 19.8 million individuals. Combined federal and state Medicaid spending for prescription drugs in that year totaled $16.6 billion.[5]

---

[1] See CRS Report RL30819, *Medicare Prescription Drug Coverage for Beneficiaries: Background and Issues*, by Jennifer O'Sullivan.

[2] Laschober, Mary A., et al. Trends in Medicare Supplemental Insurance and Prescription Drug Coverage, 1996-1999. *Health Affairs*, February 27, 2002. p. W127-W138.

[3] The questionnaire employed for the survey whose data are used in this report might not have fully captured beneficiary participation in state pharmaceutical programs.

[4] Medicaid covers prescription drugs for all inpatient stays, i.e., in hospitals or nursing homes. For more information on Medicaid coverage of prescription drugs, see CRS Report RL30726, *Prescription Drug Coverage under Medicaid*, by Jean Hearne.

[5] MSIS Statistical Report for Federal Fiscal Year 1999, Center for Medicare and Medicaid

(continued...)

Pharmaceutical assistance programs provide subsidies for prescription drug costs to about 1.25 million elderly and disabled individuals. As of April 2002, 20 states operated these programs. In general, these programs are targeted toward low-income elderly and disabled persons whose income exceeds the Medicaid standard used in the state but for whom paying for prescription drugs out-of-pocket is difficult.[6]

The growing cost of health care has sparked debate about whether and how to provide a Medicare prescription drug benefit. A number of bills have been introduced in Congress to provide such a benefit. It is generally agreed, however, that if Congress were to amend Medicare to create a drug benefit, it would take several years before the program could be implemented. As an interim measure, some proposals have been introduced to expand existing Medicaid drug coverage to a subset of the Medicare population that is low-income and not otherwise covered. The FY2003 budget proposed by President Bush, for example, would begin phasing in prescription drug coverage for low-income Medicare beneficiaries by allowing states to expand their current Medicaid programs to cover outpatient prescription drug costs of Medicare beneficiaries whose incomes are up to 100% of the poverty level. For this coverage, the federal government would pay states at the matching rates provided in current law.[7] Although some states already provide coverage to this group of individuals, most states do not. The President further proposed to allow states to expand their Medicaid programs to pay for prescription drug coverage for Medicare beneficiaries with incomes up to 150% of the poverty level at an enhanced federal match. The federal government would pay 90% of the states' costs for those beneficiaries with incomes between 100% and 150% of poverty. State participation under both of these Medicaid expansion proposals would be voluntary.

This report presents a broad brush picture of who among low-income Medicare beneficiaries are eligible for some level of prescription drug coverage under Medicaid and state-funded pharmaceutical assistance programs. Three tables are presented. **Table 1** shows income eligibility requirements for Medicaid prescription drug coverage by state in 2000, the most recent year in which data are available.[8] **Table 2** shows eligibility requirements and other information for state funded prescription drug coverage under state pharmaceutical assistance programs in 2002. **Table 3** shows each of the program's highest income eligibility requirements as a percent of the federal poverty level.

---

[5] (...continued)
Services, Washington, D.C. [http://www.hcfa.gov/medicaid/msis/msis99sr.htm]

[6] Some states also have programs that provide certain elderly and disabled individuals with discount cards or other bulk purchasing opportunities for the purchase of prescription drugs. See [www.ncsl.org/program/health/drugaid.htm for more information].

[7] The federal government shares in a state's Medicaid costs by means of a statutory formula designed to provide a higher federal matching rate, Federal Medical Assistance Percentage (FMAP), to states with lower per capita income.

[8] For more information on Medicaid eligibility requirements for the elderly and disabled, see CRS Report RL31413, *Medicaid: Eligibility for the Aged and Disabled*, by Julie Stone.

Eligibility for Prescription Drug Coverage Under Medicaid

Medicaid is a federal-state matching entitlement program, established under Title XIX of the Social Security Act, that provides medical assistance for certain groups of low-income individuals, primarily children, adult members of families with children, pregnant women, and individuals who are aged, blind, or disabled. It is the third largest social program in the federal budget, surpassed only by Social Security and Medicare, and is typically the second largest spending item in state budgets (surpassed often only by education). In FY1999, the federal share of spending on Medicaid was $107.7 billion; the states spent approximately $72 billion.

Medicaid is a means-tested program. To qualify, enrollees' income and other resources must be within the program's financial standards. Within broad federal guidelines, states have flexibility to set these standards. Financial standards used by states are based, in large part, on estimates of anticipated spending that will occur with these standards.

Although the Medicaid statute requires states to pay for certain services for Medicaid beneficiaries, it does not require them to pay for outpatient prescription drugs. For states that choose to provide coverage of these drugs, the statute grants them flexibility to select which groups they want to cover. Although there is a wide variety in the level of coverage across state Medicaid programs, all states cover outpatient prescription drugs for at least some beneficiaries; more than half of the states cover outpatient drugs for all beneficiaries. Most of the $16.6 billion spent on prescription drugs in 1999 was spent on medications for the program's elderly and disabled enrollees.

The following sections describe the eligibility categories that states use when determining which elderly and disabled individuals may qualify for Medicaid coverage. **Table 1** provides a summary of these eligibility pathways and provides information on the income eligibility standards for each of the categories. It is important to note that there are additional groups of low-income Medicare beneficiaries, not described below, that are eligible to have some of their Medicare cost-sharing expenses paid for by Medicaid. These groups are referred to as qualified Medicare beneficiaries (QMB), specified low-income Medicare beneficiaries (SLMB), and qualifying individuals (QI-1 and QI-2).[9] These individuals only qualify

---

[9] Qualified Medicare Beneficiaries (QMBs) are entitled to Medicare Part A, have income of 100% FPL or less and resources that do not exceed twice the limit for SSI eligibility ($4,000), and are not otherwise eligible for full Medicaid. Medicaid pays their Medicare Part A premiums, if any, Medicare Part B premiums, and Medicare deductibles and coinsurance for Medicare services provided by Medicare providers. Specified Low-Income Medicare Beneficiaries (SLMBs) are entitled to Medicare Part A, have income of greater than 100% FPL, but less than 120% FPL and resources that do not exceed twice the limit for SSI eligibility, and are not otherwise eligible for Medicaid. Medicaid pays their Medicare Part B premiums only. QI-1 and QI-2 categories are effective until December 31, 2002. There is an annual cap on money available for these categories, which may limit the

(continued...)

for Medicaid prescription drug coverage if they fall into the eligibility categories described below.

Welfare-Related Eligibility

Traditionally, Medicaid eligibility for aged and disabled individuals has been linked to the federal welfare program, Supplemental Security Income (SSI), under Title XVI of the Social Security Act. SSI is a means-tested cash assistance program for aged, blind, and disabled individuals who have low incomes and limited resources. The SSI program is administered at the federal level. While most states and the District of Columbia extend automatic Medicaid eligibility to persons receiving SSI, some states do not. These states are so-called "209(b) states." 209(b) states may elect to enroll all SSI recipients in their Medicaid programs or they may choose to set standards that are more restrictive.

Medicaid eligibility is also often linked to a state-funded cash payment assistance program for the aged, blind, and disabled, referred to as the State Supplemental Payment (SSP) program. Many states, recognizing that the SSI benefit standard may provide too little income to meet an individual's living expenses, supplement SSI with additional cash assistance payments. SSP is a voluntary program, and states decide whether they will make such payments, to whom, and in what amount.

Coverage of SSI Recipients. In general, states are required to provide automatic Medicaid coverage to recipients of SSI, and they rely on SSI eligibility rules, established at the national level, as the basis for Medicaid eligibility. In order to qualify for SSI, a person must satisfy the program criteria for age or disability. Aged persons are 65 and older and disabled persons are defined, in general, as those unable to do any kind of work that exists in the national economy, taking into account age, education, and work experience.

To qualify for SSI, persons must also meet income and resources requirements. An individual's income is used to determine eligibility for SSI and to calculate the benefit payment. If an SSI recipient has no income, he receives the full SSI benefit payment. If the recipient has income, a dollar-for-dollar reduction is made against the maximum federal SSI benefit. In addition to income criteria, SSI limits the resources, or assets, persons may have in order to qualify for benefits. Eligibility for SSI is restricted to otherwise qualified individuals whose resources do not exceed $2,000 for an individual and $3,000 for a couple, although certain resources, such as a person's home, are exempt. Applicants must also meet certain citizenship or United States residency requirements.

---

[9] (...continued)
number of people in the category. These beneficiaries are entitled to Medicare Part A , have resources that do not exceed twice the limit for SSI eligibility and are not otherwise eligible for Medicaid. QI-1s have incomes between 120%-135% FPL; Medicaid pays their Part B premiums only. QI-2s have incomes between 135%-175% FPL; Medicaid pays a portion of their Part B premiums.

Coverage of Persons in 209(b) States. Section 209(b) of the Social Security Amendments of 1972 (Public Law 92-603) gave states the option to elect to use income, resources and disability standards that are more restrictive or more generous than SSI standards. Each of the 209(b) states has at least one eligibility standard (income, resources, or definition of disability) that is more restrictive than SSI standards. The 11 Section 209(b) states are Connecticut, Illinois, Hawaii, Indiana, Minnesota, Missouri, New Hampshire, North Dakota, Ohio, Oklahoma and Virginia.

States that use more restrictive eligibility rules under Section 209(b) must also allow applicants to deduct medical expenses from their income when determining eligibility. This process is sometimes referred to as the "209(b) spend-down." An example of 209(b) spend-down is as follows: if an applicant has a monthly income of $700 (not including any SSI or SSP payments – described below) and the states' maximum allowable income standard for spend-down eligibility is $600, the applicant would qualify for Medicaid after incurring $100 in medical expenses in that month. As will be discussed later, the spend-down process is also used in establishing eligibility for the medically needy.

State Supplemental Payment (SSP) benefits. Like SSI payments, SSP benefits, paid on a regular monthly basis, are intended to cover such items as food, shelter, clothing, utilities, and other daily necessities determined by the individual states. Some states provide supplemental payments to all persons who receive SSI. Other states may decide to make payments to elderly persons living independently in the community without special needs, while still others may require that the elderly have special needs, such as requiring in-home personal care assistance or home-delivered meals. In all of these cases, states may decide whether to extend Medicaid coverage to persons receiving SSP on the same basis as they do to persons receiving only SSI. They may also decide to extend Medicaid eligibility to only some groups of SSP recipients or decide not to extend it to all.

Maximum Income Eligibility Standard. When a state provides automatic Medicaid eligibility to persons receiving SSI and that state does not provide SSP benefits, then the maximum income eligibility standard is the SSI level ($545 in 2002).[10] When a state provides automatic Medicaid eligibility to persons receiving SSI *and* SSP, then the maximum income eligibility standard for Medicaid is the combined federal SSI plus the SSP benefit. For 209(b) states, however, the effective maximum eligibility standard is the 209(b) categorical eligibility standard plus the SSP payment.

Table 1 provides data on income eligibility standards in January 2000. At that time, the maximum SSI benefit was $512. The table shows SSP levels only for persons who live in states that supplement aged, disabled, and blind individuals living independently and provide them with automatic Medicaid eligibility. States that only provide supplements to aged and disabled individuals living in group homes, for example, are not represented.

---

[10] The federal SSI benefit for a couple with both members qualifying for SSI is $817 in 2002.

Medically Needy

In addition to welfare-related pathways, Medicaid also provides states the option of covering elderly and disabled persons whose incomes are higher than SSI or SSP benefits, but who need assistance with medical care expenses. Individuals who live in states that exercise the medically needy option can qualify for Medicaid if they have income and sometimes resources that exceed the standards established by the states for the welfare-related eligibility pathways, but only if they incur medical expenses that "spend-down" or deplete their income and resources to specified levels. The process is the same as that described above under 209(b) spend-down.

The income and resource standards that states elect to use for their medically needy programs are restricted by certain federal guidelines. Often the monthly income levels that states choose are lower than the income standard for SSI benefits. The medically needy income standard represents income that individuals are left with for living expenses after incurring medical expenses, and not necessarily total income. State monthly income standards for their medically needy programs are shown in **Table 1, Columns 5** and **6**. Although there is some variation across states, most states use the SSI resource limit of $2,000 for an individual as the medically needy resource standard.

Poverty-Related Group

The enactment of Omnibus Budget Reconciliation Act of 1986 (OBRA 86) offered states another option for covering persons whose income exceeds SSI or 209(b) levels. This option allows states to cover aged and disabled individuals with incomes *up to* 100% of the federal poverty level (FPL).[11] States that have elected to extend Medicaid to persons who qualify under this eligibility pathway are shown in **Table 1**, **Column 7**.

Section 1115 Waiver Authority

Section 1115 of the Social Security Act authorizes the Secretary of Health and Human Services (HHS) to waive certain statutory requirements that would otherwise apply to services a state is required to cover under Medicaid. Under Section 1115, the Secretary may waive Medicaid requirements contained in Section 1902 (usually, freedom of choice of provider, comparability, and that the benefit be offered on a statewide basis). Under this authority, states have the flexibility to experiment with different approaches for the delivery of health care services, or to adapt their programs to the special needs of particular geographic areas or groups of recipients. Some states have used this authority to extend prescription drug coverage and other services to a select group of beneficiaries in a state. Illinois for example, has used 1115 waiver authority to provide a comprehensive pharmacy benefit to low-income

---

[11] The poverty guidelines, sometimes referred to as the FPL, are used to determine eligibility for federal programs. In 2002, the Department of Health and Human Services (HHS) reports the FPL to be $8,860 for individuals ($8,350 in 2000) and $11,940 for two people ($11,250 in 2000). For more information, see [http://aspe.hhs.gov/poverty/00poverty.htm].

seniors at or below 200% of the FPL. Tennessee has used this authority to provide prescription drug coverage only to persons who can show proof that they have been denied access to Medigap coverage. **Table 1** shows those states with 1115 programs that extend prescription drug coverage to a select group of beneficiaries.

1915(c) Waivers

States have the option of covering persons needing home and community-based long-term care services, if these persons would otherwise require institutional care that would be paid for by Medicaid.[12] Section 1915(c) of the Medicaid statue allows the Center for Medicare and Medicaid Services (CMS) to waive certain federal requirements in order to allow states to cover a wide range of home and community-based services. Rather than cover services for all qualifying individuals throughout a state, for example, this waiver authority can be used by states to provide a select bundle of services to a special population of persons that a state identifies.[13]

Recipients of 1915(c) waiver services must meet both financial and functional eligibility requirements set by state and federal law. Under 1915(c) waivers, states may limit coverage to those persons receiving SSI and/or SSP (209(b) states may limit coverage to persons meeting more restrictive standards), or allow persons to qualify under their medically needy standards. States also have the option of setting financial eligibility limits for income up to 300% of SSI benefits, or 221% of the federal poverty level. Those states that use the 300% rule, often referred to as the "special income rule," may also allow individuals to deposit income in excess of the 300% of SSI level in trusts, known as "Miller Trusts," and qualify for Medicaid, so long as the state becomes the beneficiary of the trust after the person's death. Federal functional requirements limit access to 1915(c) waivers to persons who would otherwise require institutional care. States may add additional functional restrictions.

As of 1999, 688,152 persons participated in 1915(c) waiver programs across the nation. Medicaid regulations require that services be limited to categories of individuals in specific target groups. These groups are aged, persons with disabilities, persons with mental retardation or developmental disabilities, and persons with mental illness. States must apply for separate waivers to serve each of these different groups. Enrollment numbers are capped for each waiver. **Table 1** does not include 1915(c) waiver eligibility pathways because of variations in eligibility used by states under this option.

---

[12] Long-term care consists of supportive and health services for persons who have lost some or all capacity for self-care.

[13] For more information on HCBS waivers, see CRS Report RL31163, *Long-term care: a profile of Medicaid 1915(c) home and community-based services waivers*, by Carol O'Shaughnessy and Rachel Kelly.

Table 1. Medicaid Income Eligibility for Outpatient Prescription Drug Coverage for Elderly and Disabled Individuals by State

State	Welfare-related income eligibility standards (as of 2000)				Medically needy (as of 2000)		Poverty-related group (as of 2001) (7)	Maximum eligibility standard for 1115 Waiver Authority as a % of FPL (as of March 2002) (8)	Highest income eligibility standard as a % of FPL (9)
	SSI or 209(b) standard[a] (1)	SSP[b] (2)	Maximum income standard[c] (3)	Income standard as a % of FPL (4)	Income standard (5)	Income standard as a % of FPL (6)			
Alabama	$512	$60	$572	82%	-	-	-	-	82%
Alaska	$512	$362	$874	100.5%	-	-	-	-	100.5%
Arizona	$512	$70	$582	83.6%	-	-	-	-	83.6%
Arkansas	$512	$0	$512	73.6%	$108.33	15.5%	-	-	73.6%
California	$512	$180	$692	99.4%	$600	86.1%	100%	-	100%
Colorado	$512	$36	$548	78.8%	-	-	-	-	78.8%
Connecticut	$564.10	$235	$799.10	114.8%	$476	68.3%	-	-	114.8%
Delaware	$512	$0	$512	73.6%	-	-	-	-	73.6%
District of Columbia	$512	$0	$512	73.6%	$377	54.1%	100%	-	100%
Florida	$512	$0	$512	73.6%	$180	25.8%	90%	-	90%
Georgia	$512	$0	$512	73.6%	medically needy does not cover Rx	-	100%	-	100%
Hawaii	$512	$4.90	$516.90	65%	$418	52.3%	100%	-	100%
Idaho	$512	$53	$565	81.2%	-	-	-	-	81.2%

State	Welfare-related income eligibility standards (as of 2000)				Medically needy (as of 2000)		Poverty-related group (as of 2001) (7)	Maximum eligibility standard for 1115 Waiver Authority as a % of FPL (as of March 2002) (8)	Highest income eligibility standard as a % of FPL (9)
	SSI or 209(b) standard[a] (1)	SSP[b] (2)	Maximum income standard[c] (3)	Income standard as a % of FPL (4)	Income standard (5)	Income standard as a % of FPL (6)			
Illinois	$487	$351	$718[d]	103.2%	$283	40.6%	85%	200% (as of 1/28/02)[e]	200%
Indiana	$512	$0	$512	73.6%	-	-	-	-	73.6%
Idaho	$512	$22	$534	76.7%	$483	69.3%	-	-	76.7%
Kansas	$512	$0	$512	73.6%	$475	68.2%	-	-	73.6%
Kentucky	$512	$0	$512	73.6%	$217	31.1%	-	-	73.6%
Louisiana	$512	$0	$512	73.6%	$100 urban/ $92 rural	14.3%/13.2%	-	-	73.6%
Maine	$512	$10	$522	75%	$315	45.2%	100%	300% (as of 6/1/01)[f]	300%
Maryland	$512	$0	$512	73.6%	$350	50.2%	-	-	73.6%
Massachusetts	$512	$128.82	$640.82	92.1%	$522	74.9%	100% A/ 133% DB	over 133% non-working disabled[g]	100% A/ over 133% DB
Michigan	$512	$14	$526	75.6%	$408[h]	37%	100%	-	100%
Minnesota	$482	$81	$563	80.9%	$482	69.2%	95%	-	95%
Mississippi	$512	$0	$512	73.6%	-	-	100%	-	100%

State	Welfare-related income eligibility standards (as of 2000)				Medically needy (as of 2000)		Poverty-related group (as of 2001) (7)	Maximum eligibility standard for 1115 Waiver Authority as a % of FPL (as of March 2002) (8)	Highest income eligibility standard as a % of FPL (9)
	SSI or 209(b) standard[a] (1)	SSP[b] (2)	Maximum income standard[c] (3)	Income standard as a % of FPL (4)	Income standard (5)	Income standard as a % of FPL (6)			
Missouri	$512	$0 AD/ $391B	$903 B	73.6% AD/ 129.8% B only	-	-	-	-	73.6% AD/ 129.8% B
Montana	$512	$0	$512	73.6	$508	72.9%	-	-	73.6%
Nebraska	$512	$7	$519	74.6%	$392	56.3%	100%	-	100%
Nevada	$512	$36.40 AD/ $213.96 B	$548.40 AD/ $725.96 B	78.8%	-	-	-	-	78.8%
New Hampshire	$526	$27	$553	79.5%	$526	75.5%	-	-	79.5%
New Jersey	$512	$31.25	$543.25	78.1%	medically needy does not cover Rx for AD	-	100%	-	100%
New Mexico	$512	$0	$512	73.6%	-	-	-	-	73.6%
New York	$512	$87	$599	86.1%	$600	86.1%	-	-	86.1%
North Carolina	$512	$0	$512	73.6%	$242	34.7%	100%	-	100%
North Dakota	$455	$0 (an option of individual counties)	$455	65.4%	$455	65.3%	-	-	65.4% (could be higher for these counties with SSP)

State	Welfare-related income eligibility standards (as of 2000)				Medically needy (as of 2000)		Poverty-related group (as of 2001) (7)	Maximum eligibility standard for 1115 Waiver Authority as a % of FPL (as of March 2002) (8)	Highest income eligibility standard as a % of FPL (9)
	SSI or 209(b) standard[a] (1)	SSP[b] (2)	Maximum income standard[c] (3)	Income standard as a % of FPL (4)	Income standard (5)	Income standard as a % of FPL (6)			
Ohio	$444	$0	$444	63.8%	-	-	-	-	63.8%
Oklahoma	$512	$53	$565	81.2%	$259	37%	100%	-	100%
Oregon	$512	$1.70 ($25.70 for blind)	$513.70 ($537.70 for blind)	73.8%	$413	59.3%	-	100% (Oregon Health Plan)	100%
Pennsylvania	$512	$27.40	$539.40	77.5%	MN does not cover Rx for ABD	-	100%	-	100%
Rhode Island	$512	$64.35	$576.35	82.8%	$600	86.1%	100%	-	100%
South Carolina	$512	$0	$512	73.6%	-	-	100%	-	100%
South Dakota	$512	$15[i]	$527	75.7%	-	-	-	-	75.7%
Tennessee	$512	$0	$512	73.6%	$241	34.6%	-	Medicare recipients who are denied Medigap policies[j]	73.6%/ Medicare recipients who are denied Medigap
Texas	$512	$0	$512	73.6%	-	-	-	-	73.6%
Utah	$512	$0	$512	73.6%	$382	54.8%	100%	-	100%
Vermont	$512	$57.66	$569.66	81.9%	$708	101.6%	100%	175%[k]	175%
Virginia	$512	$0	$512	73.6%	$250	35.9%	80%	-	80%

State	Welfare-related income eligibility standards (as of 2000)				Medically needy (as of 2000)		Poverty-related group (as of 2001) (7)	Maximum eligibility standard for 1115 Waiver Authority as a % of FPL (as of March 2002) (8)	Highest income eligibility standard as a % of FPL (9)
	SSI or 209(b) standard[a] (1)	SSP[b] (2)	Maximum income standard[c] (3)	Income standard as a % of FPL (4)	Income standard (5)	Income standard as a % of FPL (6)			
Washington	$512	$27	$539	77.4%	$539	77.4%	-	-	77.4%
West Virginia	$512	$0	$512	73.6%	$200	28.7%	-	-	73.6%
Wisconsin	$512	$83.78	$595.78	85.6%	$591.67	84.9%	-	-	85.6%
Wyoming	$512	$9.90	$521.90	75%	-	-	-	-	75%

Sources: (1) Congressional Research Service survey of selected Medicaid eligibility and post-eligibility for aged and disabled groups, November 2000; (2) Centers for Medicare and Medicaid Services, Center for Medicaid and State Operations.

Key: A = Aged; D = Disabled; and B = Blind

Notes: Table 1 shows only how elderly and disabled individuals could qualify for outpatient Medicaid prescription drug coverage in each state. Although Medicaid eligibility criteria includes income and resources standards (as described above), for simplification purposes the table depicts only income eligibility criteria. There are numerous ways in which elderly and disabled persons may qualify for Medicaid, however, prescription drug coverage is not extended to all Medicaid beneficiaries. **Table 1** shows only the income eligibility criteria that would qualify an individual to receive prescription drug coverage in that state. This table does not include 1915(c) waiver eligibility.

[a] Column 1 indicates the maximum amount of income an individual may retain and remain eligible for Medicaid through the welfare-related pathway. The federal SSI benefit rates in January 2000 are included in the combined federal SSI/state SSP data column (Column 3). In 2000, the federal SSI benefit for an individual living independently was $512.00.
[b] Column 2 shows only those SSP levels that are made to persons living independently and for whom Medicaid eligibility is guaranteed. The SSP benefit levels are included in the combined federal SSI/state SSP data column (Column 3).
[c] Column 3 shows the maximum amount of income an individual may retain and remain eligible for Medicaid through the welfare-related pathway. This amount is determined by adding the maximum SSI payment in 2000 ($512), or categorical limit for 209(b) states, to the maximum SSP payment, which varies by state as described above. Because specified amounts of income are disregarded in determining eligibility for SSI and most state SSP programs, a person with income exceeding the maximum benefit may still be eligible for cash assistance and Medicaid.
[d] Combined SSI plus SSP may not exceed this amount.
[e] On January 28, 2002, CMS approved Illinois' application to provide comprehensive pharmacy benefits to low-income seniors at or below 200% of the FPL. The demonstration program, approved under a Medicaid 1115 waiver, will be implemented by moving the majority of enrollees in Illinois' state-only pharmacy benefit program into the waiver program. Moving the state-funded program into the 1115waiver program would expand the scope of the pharmacy coverage. Participants will be required to pay an annual enrollment fee as well as contribute to the cost of care through cost-sharing.

[f] Healthy Maine Prescriptions is currently in operation. The elderly and disabled have been able to use services as of June 1, 2001, and other eligible individuals continue to sign up. There are currently approximately 180,000 individuals enrolled in the program and eligible to receive services. Maine anticipates that approximately 200,000 to 225,000 individuals will be eligible to participate in this demonstration program. Of this total, the state anticipates that approximately 20% will participate in the first program year.

[g] MassHealth Common Health has no cap and is statewide.

[h] Spend-down levels for Michigan vary by region (Shelter Area).

[i] Limited to SSI recipients with no other source of income.

[j] TennCare extends prescription drug coverage to uninsurable persons receiving Medicare who can prove that they cannot obtain Medigap insurance. There is no income limit for this program and coverage is statewide. Benefits are limited to services not covered by Medicare (no assistance with Medicare co-pays), and include drugs.

[k] Vermont Health Access Plan is statewide and has no enrollment cap. For Medicare and Social Security Disability beneficiaries with incomes up to 150% of FPL, Vermont Health Access Plan provides prescription drug coverage for all medications; copayments of $1-$3, depending on cost of drug, are required. For Medicare and Social Security Disability beneficiaries whose incomes are between 150% and 175% of FPL, Vermont Health Access Plan provides pharmacy-only coverage for maintenance medications only; copayments of $2-$4, depending on cost of drug, are required.

State Pharmaceutical Assistance Programs

Although Medicaid provides coverage of prescription drugs to some low-income elderly and disabled individuals, many more do not qualify for the program. Many states have established their own programs to assist low-income elderly and disabled individuals with purchasing prescription drugs. As of April 2002, 19 states operated programs that provide subsidies to approximately 1.25 million qualified individuals. **Table 2** describes these programs. In addition, five states (Arizona, Arkansas, Missouri, Texas, and Wisconsin) plan to be start new programs within the year, and four states (Illinois, North Carolina, Oregon, and Wyoming) plan expansions of their current programs.

Table 2 describes only those state programs that provide a subsidy to qualified individuals for purchasing pharmaceuticals. Although not listed in the table, there are currently 11 states which operate discount pharmaceutical purchasing programs through which qualified individuals can purchase prescription drugs at local pharmacies at discounted prices. These states are California, Florida, Iowa, Maryland, Maine, Massachusetts, New Hampshire, New Mexico, Oregon, Texas, and West Virginia.

Most of the subsidy programs are run with state dollars. Many use general revenue funds, while others use monies from state lotteries or tobacco settlements. Most plans cover those aged 65 and over, although the minimum age under the Kansas plan is 67, Nevada covers those over 62, and the Wyoming and one Maryland plan cover all ages. The disabled are included in many plans.

Massachusetts sets no income eligibility standard for the elderly, although the disabled must have incomes at or below 188% of the federal poverty level. All other state plans set income eligibility standards, ranging from 100% of the federal poverty level in some states to over 400% of poverty in others. All plans require some level of beneficiary financial participation in the form of premiums, deductibles, copayments, or a combination of these. Some use flat fees, such as a $5 copayment per prescription for cost-sharing, and others use sliding scales based on beneficiary income level.

The level of coverage offered also varies among the states. Some states set maximum payment limits on their spending per beneficiary. Others provide coverage only once persons have incurred certain out-of-pocket expenses (often called a "catastrophic cap"); e.g., the state assumes the full cost for any additional drugs purchased by the beneficiary in that year. While some states cover all prescription drugs, some cover only those on specific formularies or those used to treat specific conditions.

The majority of states impose no limits on enrollment. Some states, however, have faced budgetary problems and have confined enrollment to current levels or will restrict new enrollees as funds are exhausted.

Table 2. State Pharmaceutical Assistance Programs in Operation as of April, 2002

State	Age	Income/other eligibility requirements		Deductibles copayments	Catastrophic cap	Enrollment cap	Additional information when available
		Program	% FPL				
Connecticut	65+or on SSDI	Single $20,000; Couple $27,100. Cannot have other prescription coverage; CT resident for 6 months.	225%	Beneficiary pays $12 per prescription; state pays the rest.	no	no	
Delaware	65+ or on SSDI or medical costs = 40% of income	200% FPL	200%	Beneficiary pays the greater of 25% of cost of prescription or $5.	no	no	State pays a maximum of $2,500 per person per year.
Florida	65+	90%-120% FPL. Eligible for Medicare and Medicaid; not enrolled in Medicare HMO.	90%-120%	10% copayment	no	yes, capped at present level.	State pays maximum of $80 per person per month.

State	Age	Income/other eligibility requirements		Deductibles copayments	Catastrophic cap	Enrollment cap	Additional information when available
		Program	% FPL				
Illinois Pharmaceutical Assistance Program	65+ or disabled	Single $21,218; Couple $28,480; 3 or more $35,740.	240%	Annual fee of $5 for people below FPL, no copayments. Annual fee of $25 for those above FPL, $3 copayment. When state has paid $2,000 for a beneficiary, then beneficiary pays 20% of cost of drug. Those above FPL continue to pay $3 copayment; others have no copayments.	no	no	Drugs covered are for treatment of heart disease, diabetes (including supplies), arthritis, Alzheimer's, Parkinson's, lung disease, smoking-related illness, glaucoma, cancer, and osteoporosis.
Indiana	65+	135% FPL. State resident for 3 months; cannot have other prescription drug coverage.	135%	None (see Comments)	no	no	Beneficiary pays for drugs and gets quarterly refunds from state. State pays 50% of cost of drugs up to an annual limit on sliding scale: Income limits: $8,352 (single), $11,256 (couple): refund up to $1,000; $10,020 (single), $13,500 (couple): refund up to $750; $11,280 (single), $15,192 (couple): refund up to $500.

State	Age	Income/other eligibility requirements		Deductibles copayments	Catastrophic cap	Enrollment cap	Additional information when available
		Program	% FPL				
Kansas	67+	135% FPL; resource limit of $4,000 (single), $6,000 (couple). Must be enrolled in Medicare QMB or SLMB program; cannot have other prescription drug coverage.	135%	30% copayment	no	no	State pays maximum of $1,200 per person per year. Covers maintenance drugs only.
Maryland							
Maryland Pharmacy Assistance Program	All ages	Single: income $10,300, resources $3,750; Couple: income $11,150, resources $4,500.	116% (single); 93% (couple)	$5 copayment	no	no	
Maryland Care First	65+	300% FPL	300%	$10 monthly premium. Copayments: $10 for generics, $20 for preferred brand name, $30 for non-preferred brand name.	no	30,000	Temporary program for seniors to replace Medicare+Choice pullouts. Preferred drugs are those on Medicare+Choice formulary.

State	Age	Income/other eligibility requirements		Deductibles copayments	Catastrophic cap	Enrollment cap	Additional information when available
		Program	% FPL				
Massachusetts	65+ and disabled	No income eligibility for elderly; 188% FPL for disabled. MA resident; not enrolled in Medicaid	For disabled only: 188% (no limit for elderly)	Premium, copayments, and deductible computed on sliding scale based on income.	Single= $2,000 Couple= $3,000 or 10% of gross annual household income.	no	
Michigan	65+	Gross household income of 200% FPL – no deductions. Not enrolled in Medicaid; cannot have other prescription drug coverage	200%	$15 copayment for brand name drugs if generic is available. Copayment cannot be more than 20% of cost of drug. Maximum monthly copay amount computed on sliding scale based on income.	no	Limited by funding availability	
Minnesota	65+ Starting July 1, 2002: under 65 on Medicare	100%-200% FPL. Enrolled in Medicare QMB or SLMB program; MN resident; cannot have had prescription drug coverage in prior 9 months.	100%-120%	$35 monthly premium. No copayments.	no	Limited by funding availability	Drugs covered are those on Medicaid formulary plus antacids, insulin, vitamins, smoking cessation, and lice medication.
Nevada	62+	Family income $21,500. Nevada resident for 12 months; not eligible for Medicaid.	180% of FPL for two people	Copayments: $10 for generic, $25 for insurer's formulary[a] drugs, more for nonformulary based on cost of drug.	no	7,500	Maximum benefit $5,000. State contracts with insurer and pays seniors' premium.

State	Age	Income/other eligibility requirements		Deductibles copayments	Catastrophic cap	Enrollment cap	Additional information when available
		Program	% FPL				
New Jersey							
Pharmaceutical Assistance for the Aged and Disabled (PAAD)	65+ or 18+ on SSDI	Single $19,739; Couple $24,203. NJ resident.	222% (single); 202% (couple)	$5 copayment	no	no	
Senior Gold Program	65+ or 18+ on SSDI	Single $29,739; Couple $34,203	335% (single); 286% (couple)	$15 copayment plus 50% of cost of drug. (See Catastrophic cap)	When beneficiary has reached out of pocket cap in a year ($2,000 single, $3,000 couple), copayment is only $15.	no	

State	Age	Income/other eligibility requirements		Deductibles copayments	Catastrophic cap	Enrollment cap	Additional information when available
		Program	% FPL				
New York	65+	PLAN I: Single $20,000; Couple $26,000	225% (single); 218% (couple)	Annual fee based on income ranging from $8-$230 (single) and $8-$300 (couple). No deductible.	Total out of pocket expenses limited to 6% (single) and 8% (couple) of income.	no	
		PLAN II: Single $20,000-$35,000; Couple $26,000-$50,000	225%-395% (single); 218%-418% (couple)	Deductible based on income ranging from $530 (single at $20,000) to $1,715 (couple at $50,000).			
		For both plans: NY resident; not enrolled in Medicaid; have no other better prescription coverage.		For both plans: copays on sliding scale based on cost of drug, ranging from $3 to $20.			
North Carolina	65+	150% FPL. Not enrolled in Medicaid	150%	$6 copayment	no	Limited to funding availability	Coverage limited to drugs to treat cardiovascular disease and diabetes.

State	Age	Income/other eligibility requirements		Deductibles copayments	Catastrophic cap	Enrollment cap	Additional information when available
		Program	% FPL				
Pennsylvania							
Pharmaceutical Assistance Contract for the Elderly (PACE)	65+	Single $14,000; Couple $17,200	158% (single); 144% (couple)	$6 copayment	no	no	Does not cover experimental drugs, cosmetic drugs, or over-the-counter drugs.
Needs Enhancement Tier (PACENET)	65+	Single $17,000; Couple $20,200 For both programs: PA resident 90 days; Not enrolled in Medicaid.	192% (single); 169% (couple)	$500 deductible Copayments: $8 generic, $15 brand name.	no	no	

State	Age	Income/other eligibility requirements		Deductibles copayments	Catastrophic cap	Enrollment cap	Additional information when available
		Program	% FPL				
Rhode Island	65+	Single $16,400-$36,225 Couple $20,613-$41,400. RI resident.	185% to 409% (single); 168% to 346% (couple)	Copayments: Single up to $16,490 and couple up to $20,613 = 40% of program's price for drugs. Single up to $20,700 and couple up to $25,875 = 70% of program's price. Single up to $36,225 and couple up to $41,400 = 85% of program's price.	Cap of $1,500 for people with incomes at or below $16,400 (single) and $20,613 (couple).	no	Covers medications for high blood pressure, heart disease, circulatory insufficiency, asthma or chronic respiratory disease, diabetes, cancer, Parkinson's, Alzheimer's, glaucoma, urinary incontinence, depression, arthritis, anti-effectives, influenza A and B, and osteoporosis. Does not cover anti-pain (narcotics), gastrointestimal, anti-anxiety, psychotic, thyroid, or ERT medications.
South Carolina	65+	Single $8,351-$15,032; Couple $11,000-$20,000. SC resident for 6 months.	94% to 170% (single); 92% to 167% (couple)	Deductible $500 After deductible is met, copayments = $10 generic, $21 brand name.	no	no	Program cardholders receive 10% discount on drugs. Does not cover experimental, cosmetic, or OTC drugs.
Vermont	65+ or disabled receiving OASDI or Medicare.	175%-225% FPL	175% to 225%	Copayment 50%.	no	no	

State	Age	Income/other eligibility requirements		Deductibles copayments	Catastrophic cap	Enrollment cap	Additional information when available
		Program	% FPL				
Wyoming	All ages	100% FPL $1,000 resource limit (excluding home, one vehicle). Not categorically eligible for Medicaid.	100%	$25 copayment per prescription; limit three prescriptions per month.	no	no	

Sources: Congressional Research Service interviews conducted with program administration offices, April 2002. Data from the National Governors' Association and the National Council of State Legislatures.

[a] A formulary is a list of drugs which are preferred for use by a health plan.

Table 3 presents a broad brush picture of who among low-income Medicare beneficiaries are eligible for some level of prescription drug coverage through either Medicaid or state-funded pharmaceutical assistance programs. Eligibility is presented as a percent of the federal poverty level. **Columns 1** and **2** are extracted from **Tables 1** and **2**.

Table 3. Highest Income Eligibility Standards under Medicaid and State Pharmaceutical Assistance Programs as a Percent of the Federal Poverty Level

State	Medicaid (1)	Pharmacy assistance programs (2)
Alabama	82%	no subsidy program
Alaska	100.5%	no subsidy program
Arizona	83.6%	no subsidy program
Arkansas	73.6%	no subsidy program
California	99.4%	no subsidy program
Colorado	78.8%	no subsidy program
Connecticut	114.8%	225%
Delaware	73.6%	200%
District of Columbia	100%	no subsidy program
Florida	90%	90%-120%
Georgia	100%	no subsidy program
Hawaii	100%	no subsidy program
Idaho	81.2%	no subsidy program
Illinois	200%	240%
Indiana	73.6%	135%
Iowa	76.7%	no subsidy program
Kansas	73.6%	135%
Kentucky	73.6%	no subsidy program
Louisiana	73.6%	no subsidy program
Maine	300%	no subsidy program

State	Medicaid (1)	Pharmacy assistance programs (2)
Maryland	73.6%	116% (single) 93% (couple) and 300%
Massachusetts	100% for aged; over 133% for disabled and blind	no limit for elderly 188% for disabled
Michigan	100%	200%
Minnesota	95%	100%-120%
Mississippi	100%	no subsidy program
Missouri	73.6% for aged and disabled; 129.8% for blind	no subsidy program
Montana	73.6%	no subsidy program
Nebraska	100%	no subsidy program
Nevada	78.8%	180% for family
New Hampshire	79.5%	no subsidy program
New Jersey	100%	222% (single) 202% (couple) and 335% (single) 286% (couple)
New Mexico	73.6%	no subsidy program
New York	86.1%	225% (single) 218% (couple) and 225%-395% (single) 218%-418% (couple)
North Carolina	100%	150%
North Dakota	65.4% (could be higher for those counties with State Supplemental Payments)	no subsidy program
Ohio	63.8%	no subsidy program
Oklahoma	100%	no subsidy program

State	Medicaid (1)	Pharmacy assistance programs (2)
Oregon	100%	no subsidy program
Pennsylvania	100%	158% (single) 144% (couple) and 192% (single) 169% (couple)
Rhode Island	100%	185%-409% (single) 168%-346% (couple)
South Carolina	100%	94%-170% (single) 92%-167% (couple)
South Dakota	75.7%	no subsidy program
Tennessee	73.6% Medicare recipients who are denied Medigap	no subsidy program
Texas	73.6%	no subsidy program
Utah	100%	no subsidy program
Vermont	175%	175%-225%
Virginia	80%	no subsidy program
Washington	77.4%	no subsidy program
West Virginia	73.6%	no subsidy program
Wisconsin	85.6%	no subsidy program
Wyoming	75%	100%