kaiser commission on medicaid and the uninsured

THE HENRY J. KAISER FAMILY FOUNDATION

ISSUE PAPER

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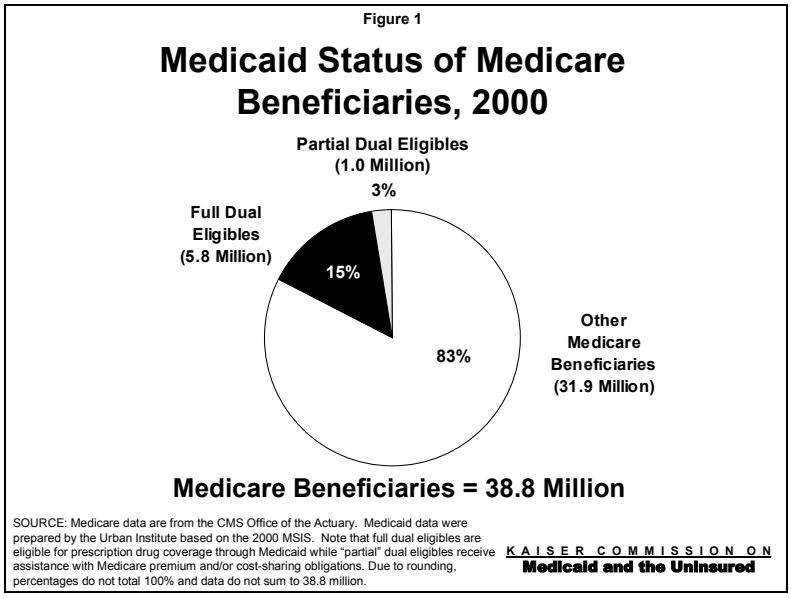
A Prescription Drug Benefit in Medicare: Implications for Medicaid and Low-Income Medicare Beneficiaries

A prescription drug benefit could be added to Medicare within the next several months. The Senate and House of Representatives each approved legislation in June of 2003 that would establish outpatient prescription drug coverage for Medicare beneficiaries as part of Medicare program reform and a conference committee is now working to reconcile differences.[1] President Bush has made a number of public statements urging Congress to finalize the legislation and send it to him for his signature. Among the key differences in the House and Senate bills that still must be addressed are the treatment of Medicaid beneficiaries and the structure of low-income subsidy programs. The way in which these issues are resolved will have major implications for Medicaid beneficiaries, other low-income individuals, and state budgets, as well as potential cost implications for the federal government. As with all other provisions in the bill, these issues will be debated in the context of congressional budget constraints that generally limit the amount of resources available for a Medicare prescription drug benefit to $400 billion over the next ten years. The major issues for low-income individuals and Medicaid in the bills are described below.

I. Treatment of Medicare and Medicaid Dual Eligibles

Currently, Medicaid plays a key role in filling in gaps in Medicare coverage for 6.8 million low-income Medicare beneficiaries who also are enrolled in Medicaid (these individuals often are known as "dual eligibles"). For 5.8 million seniors and people with disabilities, Medicaid provides prescription drugs, long-term care services, and other health care services not provided by Medicare ("full" dual eligibles). For one million other dual eligibles, Medicaid simply provides assistance with Medicare premium and cost-sharing obligations ("partial" dual eligibles). Overall, "full" dual eligibles account for one in seven (15 percent) of Medicare beneficiaries (Figure 1).

Figure 1



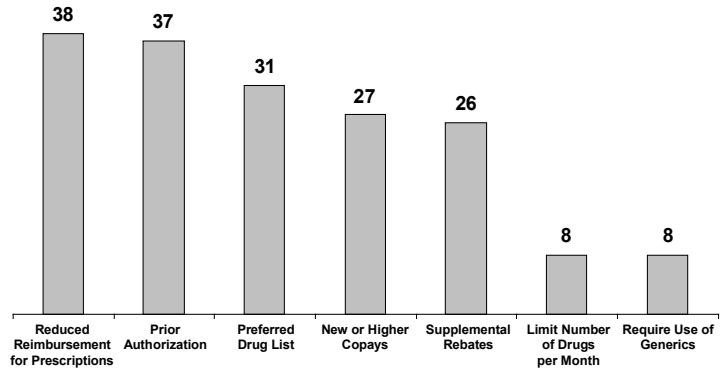
However, due to wide variation across states in the extent to which Medicare beneficiaries are impoverished and in the degree to which they have expanded coverage for dual eligibles beyond federal minimum standards, the percent of Medicare beneficiaries who also are covered by Medicaid ranges from six percent of all Medicare beneficiaries in Idaho to close to one-third (30 percent) of all Medicare beneficiaries in Mississippi (Table 1).

Since seniors and people with disabilities generally must have income well below the poverty line and minimal assets to qualify for Medicaid, dual eligibles are much poorer than other Medicare beneficiaries – more than 70 percent of dual eligibles have annual incomes below $10,000 compared to 13 percent of all other Medicare beneficiaries. Dual eligibles also tend to be much sicker and to need more care than other Medicare beneficiaries – dual eligibles are more than twice as likely to be in fair or poor health as other Medicare beneficiaries (52 percent versus 24 percent) and nearly a quarter of dual eligibles are in nursing homes compared to two percent of other Medicare beneficiaries.

The House and Senate Medicare bills contain substantial differences in their treatment of dual eligibles – the Senate bill specifically excludes dual eligibles with full Medicaid coverage from the Medicare prescription drug benefit, while the House bill includes them in coverage.[2] The Senate bill leaves Medicaid as the payor for prescription drugs for dual eligibles. If adopted, the Senate provision would represent the first time in Medicare's history that a benefit would not be provided on a universal basis to all individuals eligible for Medicare. Under the House bill, Medicare would become the primary payor of prescription drug coverage for dual eligibles and Medicaid would continue to function as a secondary payor, supplementing the Medicare prescription drug benefit for dual eligibles as needed to raise it to Medicaid standards.

Figure 2

Recent Action by States to Reduce Growth in Medicaid Prescription Drug Spending, 2003-2004



NOTE: Data reflect the number of states adopting new strategies (or expanding their use of existing strategies) to reduce prescription drug spending growth in their fiscal year 2003 or 2004 budgets. States that had these strategies in place prior to fiscal year 2003, but did not modify them in their 2003 or 2004 budgets, are not reflected in this figure.
SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, June and December 2002 and forthcoming September 2003.

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Historically, the prescription drug benefit in Medicaid has filled the gap in Medicare created by the lack of a prescription drug benefit by providing beneficiaries with necessary drugs with little or no co-payment, reflecting the poor health status and minimal income of Medicaid beneficiaries. In recent years, however, nearly all states have been compelled by fiscal problems and rising prescription drug costs to adopt cost containment strategies in their Medicaid prescription drug benefits. To varying degrees, states are increasing their use of formularies, prior authorization requirements, and co-payments (Figure 2). In some states, including Georgia, Louisiana, Mississippi, Missouri, North Carolina, Oklahoma, South Carolina, and Texas, Medicaid beneficiaries now face limits on the number of prescriptions

that they can fill each month. These growing restrictions on prescription drug coverage in Medicaid mean coverage for dual eligibles is at risk of deteriorating in many states. If they are left out of a Medicare prescription drug benefit, dual eligibles may find that in some cases they do not receive as much assistance with prescription drugs as those with Medicare coverage.

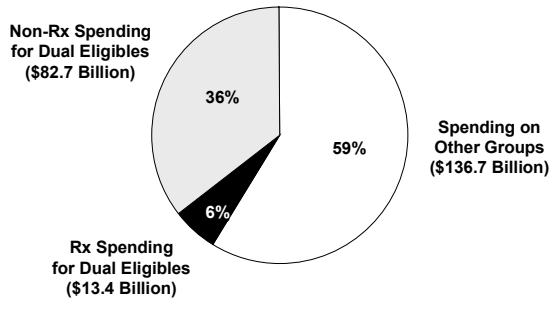
II. Implications of Medicare Drug Coverage for States and Their Medicaid Budgets

States have long maintained that it is inappropriate to rely on Medicaid to fill gaps in Medicare coverage, including the lack of prescription drug coverage. Governors and other state leaders have pressed for a prescription drug benefit in Medicare as a way to relieve states from their share of Medicaid spending on prescription drug coverage for dual eligibles. Since states pay for an average of 43 percent of the cost of financing the Medicaid program (but none of the cost of financing Medicare benefits), such a shift could provide significant fiscal relief to states.

The effort to persuade the federal government to take responsibility for prescription drug coverage for Medicare beneficiaries has grown stronger in recent years in response to the state fiscal crisis and the pressure from rapidly rising prescription drug costs on Medicaid budgets. In federal fiscal year 2002, more than 40 percent of Medicaid expenditures were for dual eligibles (Figure 3). Their prescription drug expenses accounted for six percent of all Medicaid expenditures, costing the federal government $7.6 billion and states $5.8 billion. In some states, the share of Medicaid expenditures attributable to the cost of providing prescription drugs to dual eligibles is even higher, reaching 10 percent or more in Florida, Kentucky, and Mississippi (Table 2). Over the next ten years, states are expected to spend in excess of $100 billion nationwide for their share of the cost of providing prescription drug coverage to dual eligibles.

Figure 3

Spending on Dual Eligibles as a Share of Medicaid Spending on Benefits, FFY2002



Total Spending on Benefits = $232.8 Billion

SOURCE: Urban Institute estimates prepared for KCMU based on an analysis of 2000 MSIS data applied to CMS-64 FY2002 data.
Note:Due to rounding, percentages do not total 100%.

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Under the Senate bill, states would continue to bear full responsibility for providing prescription drug coverage to dual eligibles with full Medicaid benefits. As a result, states would experience little fiscal relief from the Senate's Medicare prescription drug benefit (although the Senate bill includes other provisions designed to provide some fiscal relief to states through alternative means). The House bill includes dual eligibles in the Medicare prescription drug benefit, allowing state Medicaid programs to shift some of the responsibility for prescription drug costs for dual eligibles to the federal government. However, to offset the cost to the federal government of this shift, the House bill reduces federal Medicaid payments to the states over the next several years,

effectively "recapturing" some of the state fiscal relief that otherwise would be generated by the House bill. Overall, the Congressional Budget Office (CBO) has estimated that the Senate bill would generate a net of $20 billion in fiscal relief for states in Medicaid, while the House bill would generate a net of $44 billion.

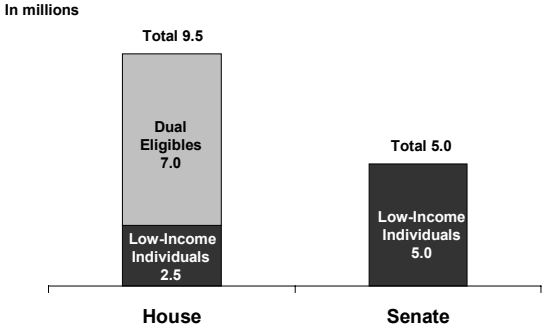
III. Treatment of Low-income Individuals Not Enrolled in Medicaid

Medicare beneficiaries with low incomes face particular challenges in securing prescription drugs. Many of them are not eligible for assistance with prescription drug costs through Medicaid, state-funded programs, or retiree health plans, yet have very limited resources with which to pay for prescription drugs out of pocket. As a result, they spend a significant share of their income on prescription drugs and often forgo needed medications.

Both the Senate and House prescription drug bills include subsidy programs that provide assistance with prescription drug premium and cost-sharing obligations to a significant number of low-income Medicare beneficiaries. In general, the Senate bill extends coverage to low-income individuals at higher income levels than the House bill and has more generous asset rules.[3] (For a detailed description of the Senate and House low-income subsidy programs, see Chart 2.) However, due to its exclusion of dual eligibles from the prescription drug benefit, CBO estimates the Senate's low-income subsidy program will cover fewer people than the House. Specifically, CBO estimates that about 5 million people would enroll in the Senate's low-income subsidy program, while 2.5 million low-income individuals not already on Medicaid would be covered under the House's low-income subsidy program. The House bill also would extend low-income subsidies to 7 million dual eligibles (Figure 4).

Figure 4

Estimated Enrollment of Medicare Beneficiaries in House v. Senate Low-Income Subsidy Program, 2013



SOURCE: CBO cost estimate of H.R. 1 and S. 1, July 22, 2003. All estimates are approximate.

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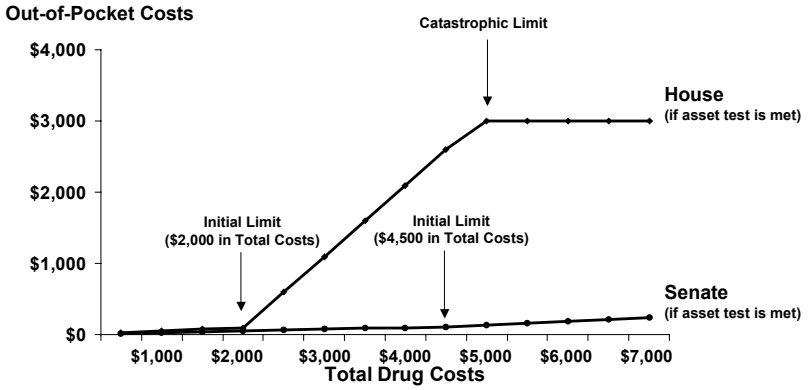
The Senate bill provides a significantly more extensive subsidy to the low-income individuals it covers, primarily because it pays for a share of all of an individual's drug expenses, regardless of the level of spending that they reach. In comparison, the House offers an extensive subsidy to low-income individuals until their drug expenses reach an initial limit of $2,000. If their expenses exceed $2,000, however, the House requires low-income individuals to pay for the full cost of all of their drugs on their own until their

out-of-pocket expenses reach $3,500. Once their out-of-pocket payments reach this "catastrophic" level, the House bill will pay for any additional drug expenses that they incur.

Figure 5

Out-of-Pocket Drug Costs for a Medicare Beneficiary Not on Medicaid with Income Below 100% of Poverty, House v. Senate Low-Income Subsidy Programs



SOURCE: KCMU calculations. For the House bill, out-of-pocket costs for co-payments are assumed to average 5 percent of drug costs up to $2,000. NOTES: In the House bill, Medicare low-income subsidy payments count as "out-of-pocket costs" applied toward the catastrophic limit of $3,500. In this example, the individual reaches the $3,500 catastrophic limit when out-of-pocket payments reach $3,000 because of a $500 low-income subsidy. To qualify for the low-income subsidies presented in this chart, beneficiaries also must meet an asset test.

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The effect of the House's decision not to provide assistance with drug expenses above $2,000 until low-income individuals reach a catastrophic limit has significant implications for the adequacy of its low-income subsidy program. As shown in Figure 5, under the House bill, low-income individuals' out-of-pocket expenses rise sharply after their drug costs reach $2,000 and continue to rise steeply until their out-of-pocket expenses reach a catastrophic limit. In comparison, the out-of-pocket expenses incurred by low-income individuals under the Senate bill increase only modestly as drug costs rise.

For example, under the Senate proposal, an elderly woman living just below the poverty line with $3,000 in prescription drug costs would have to spend $150 of her own money on drugs. In comparison, her out-of-pocket costs would be some $1,100 under the House bill, or more than ten percent of her income.

The Senate bill also includes more provisions than the House to make the application process for the low-income subsidy program easy for Medicare beneficiaries to navigate, as well as to coordinate the new Medicare low-income subsidy program with other Medicaid-based programs designed to help with their premium and cost-sharing obligations under Parts A and B of Medicare.

IV. Conclusion

In the weeks and months ahead as Congress debates the final shape of a prescription drug benefit in Medicare, a number of issues with major implications for dual eligibles, other low-income Medicare beneficiaries, and Medicaid budgets will be debated. The outcome of these debates is of critical importance to low-income Medicare beneficiaries,

particularly dual eligible individuals who typically are deeply impoverished and far more reliant than other Medicare beneficiaries on publicly-funded programs for prescription drugs and other health care services. States also have much at stake in the outcome of these debates, including potentially their ability to finance care for the more than 50 million children, parents, seniors, and people with disabilities who rely on Medicaid for health coverage. The key issues that will be debated include:

- **Treatment of Dual Eligibles.** Determining whether to include the 5.8 million full dual eligibles in the Part D prescription drug benefit or leave them reliant exclusively on Medicaid for their prescription drug coverage is a critical consideration. Depending on the fiscal fortunes and political priorities of the state in which they happen to reside, dual eligibles if excluded from the Medicare prescription drug benefit may end up with more restrictive prescription drug coverage in some instances than other Medicare beneficiaries – even though their need for assistance is far greater.

- **Treatment of States.** The decision on dual eligibles will also have significant fiscal implications for states. In the absence of a fundamental shift in the role of the federal government versus states in financing prescription drug coverage for dual eligibles, many states are expected to find that they cannot sustain current rates of growth in their Medicaid programs without cutting coverage for low-income people deeply.

- **Adequacy of Low-Income Subsidy Program.** Finally, Congress must determine the size and scope of its low-income subsidy program for low-income Medicare beneficiaries not on Medicaid. Most fundamentally, it must decide how many low-income Medicare beneficiaries it will cover; how easy it will be for beneficiaries to enroll in the subsidy program; and whether it will provide low-income individuals with a subsidy that is adequate enough to enable them to use needed prescription drugs.

Additional Resources from the Kaiser Family Foundation

This issue brief is based on a longer background paper on the implications of a Medicare prescription drug benefit for Medicaid and low-income people available at www.kff.org, publication #4135. The longer paper includes citations for all of the data used in this policy brief. This issue paper was prepared by Jocelyn Guyer of the Kaiser Commission on Medicaid and the Uninsured with assistance from colleagues on the Commission and others on the staff of the Kaiser Family Foundation. KCMU would like to acknowledge the invaluable contributions of Brian Bruen and John Holohan of the Urban Institute who provided the data in this issue paper on the number of dual enrollees and the cost of providing them with services.

For a detailed comparison of all provisions of the prescription drug proposals in the House and Senate bills, see the side-by-side prepared by Health Policy Alternatives for the Kaiser Family Foundation at www.kff.org.

CHART 1

Comparison of Key Medicaid and Low-Income Prescription Drug Provisions in S.1 and H.R. 1		
	Senate (S. 1)	**House (H.R. 1)**
Treatment of Medicaid Beneficiaries		
Eligibility for Part D	• "Full" dual enrollees (i.e., those with full Medicaid coverage that includes prescription drugs) are ineligible for Part D • Other Medicaid beneficiaries without full benefits are eligible for Medicare Part D, including individuals on Medicare Savings Programs and Pharmacy Plus enrollees	• All Medicaid beneficiaries are eligible for Part D • Medicare becomes the primary payor for prescription drug coverage for dual enrollees; Medicaid serves as the secondary payor, supplementing Part D coverage as needed to raise it to state Medicaid standards
Coordination between Medicare and Medicaid prescription drug benefit	• Not applicable since dual enrollees with full Medicaid coverage are ineligible for the Medicare prescription drug benefit	• The Medicare Administrator will implement a plan to coordinate Medicare and Medicaid drug coverage
Treatment of States		
State fiscal relief	• No Medicare coverage of prescription drug benefits for dual enrollees • Instead, 100% federal matching funds are provided for Part B premiums for dual enrollees with incomes between SSI level and 100% FPL	• Medicare pays for Part D prescription drug benefits for dual enrollees • Federal government "recaptures" some of the state fiscal relief, with the share declining each year until 2021 when states retain all fiscal relief
Incentives for States to Maintain Optional Expansions	• In states that maintain optional expansions for dual enrollees, 100% federal matching funds are provided for Medicare Part A deductible and coinsurance costs	• No provision
Treatment of State Pharmacy Assistance Programs	• Allows qualified state pharmaceutical assistance programs to receive Medicare drug subsidies (in a manner similar to qualified retiree plans)	• A commission is established to study coordination between Medicare Part D and state pharmacy assistance programs
Responsibility for Administering Low-Income Subsidy	• States must determine eligibility for the low-income subsidy program; enhanced matching funds provided	• States (along with SSA) must determine eligibility for the low-income subsidy program; enhanced matching funds provided
Low-Income Subsidy Program		
Eligibility Rules	• Cost-sharing and premium assistance provided to Part D beneficiaries with income below 160% of poverty • Do not need to meet an asset test to qualify for assistance, but more generous assistance is provided to those who can meet one	• Cost-sharing and premium assistance provided to Part D beneficiaries with income below 135% of poverty • Sliding-scale premium assistance for individuals with income between 135% and 160% of poverty • Must meet an asset test to qualify for any assistance
Level of cost-sharing assistance	• Substantial help is provided with all of low-income individuals' drug expenditures, including expenditures above the initial limit of $4,500 (i.e., there is no "donut hole" for low-income beneficiaries)	• Substantial help is provided until drug expenditures reach an initial limit of $2,000 • No help with cost-sharing is provided above the initial limit until out-of-pocket spending (including low-income subsidy payments) reaches $3,500
CBO Estimates of Medicaid and Low-Income Provisions		
State fiscal relief (04--13)	• Net of $20 billion	• Net of $44 billion
Cost of low-income subsidy program (2006 – 2013)	• $96 billion ($18 billion for Pharmacy Plus enrollees and $78 billion for other low-income Medicare beneficiaries)	• $69 billion ($49 billion for dual enrollees and $20 billion for other low-income Medicare beneficiaries)
Average payments under low-income subsidy program (2013)	• $3,400 for those below 135% of poverty who meet asset test / $2,800 for all others	• $600
Estimated enrollment in low-income subsidy program (2013)	• 5 million low-income individuals	• 2.5 million low-income individuals and 7 million dual enrollees (9.5 million total)

Source: Prepared by KCMU. For a more detailed comparison of the two bills, see the side-by-side prepared for the Kaiser Family Foundation by Health Policy Alternatives at www.kff.org.

CHART 2

The Low-Income Subsidy Programs Under the Senate and House Medicare Bills	
Senate Bill	**House Bill**
Income under 100% of Poverty	
• No premium (no asset test) • No deductible • Cost-sharing of 2.5% up to $4,500 in drug costs ("initial coverage limit") • Cost-sharing of 5% between initial coverage limit and the point an individual spends $3,700 out-of-pocket on drugs ("stop-loss threshold") • Above stop-loss threshold, 2.5% cost-sharing • Must meet asset test * (except for premium assistance)	• No deductible and no premium • Cost-sharing of up to $2 per generic and $5 per brand name drug up to $2,000 in drug costs ("initial coverage limit") • After initial limit, no assistance until the individual has spent $3,500 out-of-pocket on drugs ("stop-loss threshold") • Above stop-loss threshold, no cost-sharing required • Must meet asset test **
Income 100% - 135% of Poverty	
• No premium (no asset test) • No deductible • Cost-sharing of 5% up to $4,500 in drug costs ("initial coverage limit") • Cost-sharing of 10% between initial coverage limit and the point an individual spends $3,700 out-of-pocket on drugs, the stop-loss threshold • Above the stop-loss threshold, 2.5% cost-sharing • Must meet asset test * (except for premium assistance)	• No deductible and no premium • Cost-sharing of up to $2 per generic and $5 per brand name drug up to $2,000 in drug costs ("initial coverage limit") • After initial limit, no assistance until the individual has spent $3,500 out-of-pocket on drugs, when catastrophic coverage begins • Above stop-loss threshold, no cost-sharing required • Must meet asset test **
135% - 160% of Poverty and Individuals < 135% of Poverty Not Meeting the Asset Test	**135% - 150% of Poverty**
• $50 deductible • Sliding scale premium based on income (expected to average $420 in 2006, the first year of the program, for someone without a subsidy) • Cost-sharing of 10% up to $4,500 in drug costs ("initial coverage limit") • Cost-sharing of 20% between initial coverage limit and the point an individual spends $3,700 out-of-pocket on drugs, the stop-loss threshold • After catastrophic coverage, 10% cost-sharing • No asset test *Note: People with income below 135% of poverty who do not meet the asset test receive the cost-sharing subsidies described in this section except they are fully exempt from premium obligations.*	• $250 deductible • Sliding scale premium based on income (expected to average $420 in 2006, the first year of the program, for someone without a subsidy) • Cost-sharing of 20% up to $2,000 in drug costs ("initial coverage limit") • After initial limit, no assistance until the individual has spent $3,500 out-of-pocket on drugs, the stop-loss threshold • Above stop-loss threshold, no cost-sharing required • Must meet asset test

* In the Senate, the asset test for 2006 – 2008 is $4,000 for a single person / $6,000 for a couple. Beginning in 2009, the asset test is $10,000 for a single person / $20,000 for a couple, indexed over time. ** In the House, the asset test is set at $6,000 for a single person and $9,000 for a couple, indexed over time.

Under the Senate and House bills, the deductible, initial coverage limit, stop-loss threshold, and asset limits are indexed. In addition, premium costs are expected to rise over time under both bills. Under the House bill, co-payment requirements are indexed to increases in per capita Medicare prescription drug spending.

SOURCE: Prepared by KCMU.

[1] The Senate bill, S. 1, is known as the "Prescription Drug and Medicare Improvement Act of 2003" while the House bill, H.R. 1, is known as the "Medicare Prescription Drug and Modernization Act of 2003." For a detailed description of the two bills, see the side-by-side prepared by Health Policy Alternatives for the Kaiser Family Foundation at www.kff.org.

[2] The Senate bill extends eligibility for Medicare Part D to Medicaid beneficiaries receiving assistance only with their Medicare premiums and cost-sharing obligations (i.e., those enrolled in "Medicare Savings Programs") as well as those receiving drug-only coverage under Pharmacy Plus waivers.

[3] The Senate does not require income-eligible individuals to meet an asset test to qualify for assistance under its low-income program, although it offers a more generous level of assistance to individuals who do meet its asset test. The Senate asset test for 2006 – 2008 is $4,000 for a single person / $6,000 for a couple. Beginning in 2009, it is set at $10,000 for a single person / $20,000 for a couple, indexed over time. Under the House bill, low-income individuals must meet an asset test to qualify for any assistance under the low-income subsidy program. The House's asset test is set at $6,000 for a single person and $9,000 for a couple, indexed over time.

Table 1

"Full" Dual Eligibles as a Share of Medicare Beneficiaries by State , FFY 2000

	"Full" Dual Eligibles[1]	Medicare Beneficiaries[2]	"Full" Dual Eligibles as a Share of Medicare Beneficiaries
United States[3]	**5,840,000**	**38,762,000**	**15%**
Alabama	116,000	685,000	17%
Alaska	9,000	42,000	21%
Arizona	54,000	675,000	8%
Arkansas	93,000	439,000	21%
California	862,000	3,901,000	22%
Colorado	57,000	467,000	12%
Connecticut	73,000	515,000	14%
Delaware	9,000	112,000	8%
District of Columbia	16,000	75,000	21%
Florida	337,000	2,804,000	12%
Georgia	123,000	916,000	13%
Hawaii	25,000	165,000	15%
Idaho	9,000	165,000	6%
Illinois	163,000	1,635,000	10%
Indiana	98,000	852,000	12%
Iowa	52,000	477,000	11%
Kansas	37,000	390,000	10%
Kentucky	164,000	623,000	26%
Louisiana	104,000	602,000	17%
Maine	40,000	216,000	18%
Maryland	68,000	645,000	10%
Massachusetts	184,000	961,000	19%
Michigan	181,000	1,403,000	13%
Minnesota	88,000	654,000	13%
Mississippi	126,000	419,000	30%
Missouri	132,000	861,000	15%
Montana	14,000	137,000	10%
Nebraska	33,000	254,000	13%
Nevada	17,000	240,000	7%
New Hampshire	18,000	170,000	11%
New Jersey	134,000	1,203,000	11%
New Mexico	26,000	234,000	11%
New York	512,000	2,715,000	19%
North Carolina	215,000	1,133,000	19%
North Dakota	12,000	103,000	12%
Ohio	171,000	1,701,000	10%
Oklahoma	73,000	508,000	14%
Oregon	54,000	489,000	11%
Pennsylvania	293,000	2,095,000	14%
Rhode Island	26,000	172,000	15%
South Carolina	111,000	568,000	20%
South Dakota	13,000	119,000	11%
Tennessee	182,000	829,000	22%
Texas	346,000	2,265,000	15%
Utah	16,000	206,000	8%
Vermont	21,000	89,000	23%
Virginia	97,000	893,000	11%
Washington	88,000	736,000	12%
West Virginia	35,000	338,000	10%
Wisconsin	110,000	783,000	14%
Wyoming	6,000	65,000	9%

Source: Urban Institute estimates prepared for KCMU based on an analysis of data from CMS (MSIS and Medicare enrollment data).

1) "Full" dual eligibles are Medicare beneficiaries who also are enrolled in Medicaid and receive full Medicaid benefits.

2) "Medicare beneficiaries" defined as individuals enrolled in either Medicare Part A (HI), Part B (SMI), or both. Beneficiaries as of July 2000, as reported at http://cms.hhs.gov/statistics/enrollment/st00all.asp (Accessed August 25, 2003).

3) State figures will not sum to the national totals because of rounding. In addition, the United States' total for Medicare beneficiaries includes roughly 13,000 individuals that CMS listed as "residence unknown" who are not included in the state figures.

Table 2

Medicaid Expenditures for Dual Eligibles, FFY2000

	Total Expenditures on Services (federal and state combined, in millions)			State Expenditures on Services (state share only, in millions)			
	Expenditures for All Enrollees†	Expenditures for Dual Eligibles	Prescribed Drugs for Dual Eligibles	Expenditures for All Enrollees	Expenditures for Dual Eligibles	Prescribed Drugs for Dual Eligibles	Rx for Duals as a Share of Total Medicaid
United States	**$165,638**	**$68,396**	**$9,535**	**71,807**	**29,829**	**4,067**	6%
Alabama	2,330	1,012	139	689	299	41	6%
Alaska	460	108	17	196	46	7	4%
Arizona	2,112	577	66	740	202	23	3%
Arkansas	1,469	765	109	402	209	30	7%
California	16,498	5,822	1,196	8,018	2829	581	7%
Colorado	1,778	791	99	889	396	50	6%
Connecticut	2,790	1,788	145	1,395	894	73	5%
Delaware	515	183	17	257	91	9	3%
District of Columbia	783	220	21	235	66	6	3%
Florida	7,109	2,825	678	3,097	1231	295	10%
Georgia	3,531	1,202	216	1,448	493	88	6%
Hawaii *	528	179	23	231	78	10	4%
Idaho	580	121	20	168	35	6	3%
Illinois	7,657	2,304	306	3,828	1152	153	4%
Indiana	2,891	1,423	218	1,098	540	83	8%
Iowa	1,441	707	90	535	262	33	6%
Kansas	1,195	614	79	476	244	31	7%
Kentucky	2,827	1,493	302	850	449	91	11%
Louisiana	2,551	965	183	758	287	54	7%
Maine	1,276	501	77	427	168	26	6%
Maryland	3,510	1,046	132	1,755	523	66	4%
Massachusetts	5,262	2,785	295	2,631	1392	148	6%
Michigan	4,810	1,397	259	2,099	610	113	5%
Minnesota	3,236	1,721	167	1,618	860	84	5%
Mississippi	1,746	799	187	417	191	45	11%
Missouri	3,160	1,536	295	1,230	598	115	9%
Montana	423	158	24	115	43	6	6%
Nebraska	930	418	59	376	169	24	6%
Nevada	511	152	24	255	76	12	5%
New Hampshire	636	363	38	318	182	19	6%
New Jersey	4,604	2,066	275	2,302	1033	138	6%
New Mexico	1,238	307	34	334	83	9	3%
New York	25,710	12,142	868	12,855	6071	434	3%
North Carolina	4,693	2,112	381	1,809	814	147	8%
North Dakota	352	217	20	106	65	6	6%
Ohio	6,918	3,448	359	2,852	1421	148	5%
Oklahoma	1,563	653	89	462	193	26	6%
Oregon	1,678	579	113	685	236	46	7%
Pennsylvania **	6,259	2,516	402	2,838	1141	182	6%
Rhode Island	1,051	567	46	500	270	22	4%
South Carolina	2,695	902	139	826	276	43	5%
South Dakota	394	185	21	134	63	7	5%
Tennessee ***	4,509	1,550	142	1,640	563	52	3%
Texas	8,853	3,658	473	3,526	1457	189	5%
Utah	937	202	37	281	61	11	4%
Vermont	461	189	43	170	70	16	9%
Virginia	2,422	1,097	176	1,176	533	85	7%
Washington	2,364	720	173	1,173	357	86	7%
West Virginia	1,345	476	56	333	118	14	4%
Wisconsin	2,839	1,630	198	1,176	675	82	7%
Wyoming	209	100	11	80	38	4	5%

Source: Urban Institute estimates prepared for KCMU based on an analysis of data from CMS (MSIS and Medicaid Financial Management Reports).

† Total expenditures are as reported through MSIS. CMS-64 data for FFY 2000 indicate $182.6 billion in total spending on services.

* Estimates for Hawaii are based on MSIS data for FFY 1999, not FFY 2000 as in all other states.

** Pennsylvania did not report any dual eligibles in the FFY 2000 MSIS data. Estimates for dual eligible spending and enrollment in PA are based on the average distributions between dual enrollees and other groups of Medicaid enrollment and spending in 15 states that, like PA, use 100% of poverty (or higher) as the income eligibility standard for aged and disabled individuals. See Appendix C of the full report for more information on methodology.

*** Source data for Tennessee did not appear to include nursing facility expenditures. The Uban Institute estimated the amount of nursing home spending in the state using the FFY 2002 Medicaid FMR report for TN from CMS. The share of this total attributable to dual eligibles was estimated based on nationwide spending patterns.

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