V. OTHER WOMEN'S HEALTH-RELATED SERVICES

Ensuring that state policies allow women to access the full range of needed health services requires attention to a wide range of policy areas and issues. Many important public health services do not fall into a distinct funding stream or program area, yet these services are crucial for developing the infrastructure needed to meet women's total health care needs.

Beyond administering Medicaid and regulating private insurance, states can create programs that support healthy lifestyles for women. Some states have laid the groundwork for coordinating and overseeing some of these services through offices of women's health. Some states have done this through a more formalized structure where others have set up offices or commissions within health agencies. States can facilitate access to health-related services that address specific threats to women's health, such as violence, HIV/AIDS, or help with costs of prescription drugs for seniors. These programs are often critical for women and help fill the gaps left by programs such as Medicaid, Medicare, and private insurance.

The following chapter looks at state offices of women's health, and examines state policies on violence against women, women and HIV, and prescription drug access.

OFFICES OF WOMEN'S HEALTH

A state office of women's health can assist states in addressing women's health access issues. These offices can develop a state's agenda on women's health issues; provide policy guidance to the governor's office, state legislature, and the state department of health; serve as a clearinghouse and resource for information on women's health for the public; and fund direct health care services.

The effectiveness and scope of responsibility of women's health offices varies considerably. Most offices provide policy analysis to officials in the department of health, provide referrals for services and public education, and coordinate research and data collection on women's health issues. Some offices provide direct services, including breast and cervical cancer screenings and bone density screenings. Some offices exclude reproductive health services, because these services are often provided through Title X program offices or other state health offices. Some women's health offices report directly to the state health department, while others report to lower level officials.

TABLE V-1 STATE OFFICES OF WOMEN'S HEALTH

- 13 states have offices of women's health created by the legislature, executive order or administrative action.
  - The offices have budgets ranging from $70,000 to more than $5 million; 6 of the 13 receive direct funding that must be used for these offices.
  - Staffing ranges from no full-time employees to 15 employees.

TABLE V-1
State Offices of Women's Health

State	Office of Women's Health	How Established	Receives Direct Funding	FY 2002 Budget ($)	Staffing (Full-Time Employees)	Scope of Responsibility
United States Total	**13**		**6**			
Alabama						
Alaska						
Arizona						
Arkansas						
California	●	executive order	yes	940,000	10	Policy analysis and advocacy, service referrals, public education, research and data collection.
Colorado						
Connecticut						
Delaware	●	legislation	no	--	1	Service referrals, research and data collection; office also houses Title X Family Planning grant program.
District of Columbia						
Florida						
Georgia	●	legislation	yes	500,000	--	Develops state plan to address women's health issues, conducts education and awareness activities, serves as clearinghouse for information, provides referrals, collects data; excludes reproductive health issues.
Hawaii						
Idaho						
Illinois	●	administrative action	yes	5,600,000	15	Serves as clearinghouse, conducts research and data collection, provides grants to local health departments and community organizations; excludes reproductive & maternal health and domestic violence.
Indiana	●	legislation	yes	175,000	5	Screenings, service referrals, research and data collection; excludes reproductive health services.
Iowa						
Kansas						
Kentucky	●	legislation	no	--	3	Resource center for all aspects of women's physical and mental health.
Louisiana						
Maine						
Maryland	●	executive order	yes	300,000*	3 *	Service referrals, research and data collection; includes reproductive health.
Massachusetts						
Michigan						
Minnesota						
Mississippi						
Missouri	●	administrative action	no	--	2	Office advises director of state Health Department on women's health issues; also provides referrals, facilitates coordination of services, and provides consultation on research and data collection.
Montana						
Nebraska	●	legislation	no	--	2	Serves as clearinghouse, conducts strategic planning and policy analysis, coordinates pilot projects, provides referrals and technical assistance on women's health issues.
Nevada						
New Hampshire						
New Jersey						
New Mexico						
New York						
North Carolina	●	legislation	no	--	0	Office provides advocacy on women's health issues.
North Dakota						
Ohio	●	legislation	no	361,000	4	Service referrals, research and data collection.
Oklahoma						
Oregon						
Pennsylvania						
Rhode Island						
South Carolina						
South Dakota						
Tennessee	●	legislation	no	--	0	Provides direct services and referrals; statute also authorizes office to make policy recommendations to the Commissioner of Health, conduct education and outreach activities, and perform data collection and analysis; houses Title X Family Planning grant program.
Texas						
Utah						
Vermont						
Virginia						
Washington						
West Virginia						
Wisconsin	●	legislation	yes	68,500	1.5	Office provides leadership and consultation for state Health Department on women's health issues.
Wyoming						

Notes: ● State has an Office of Women's Health
* Due to a budget shortfall and hiring freeze, funds allocated by the governor have not been distributed and staff positions not filled.
-- Data not available from the state

Source: National Conference of State Legislatures Health Policy Tracking Service, "Offices of Women's Health Requirements," unpublished data collected for this report.
Data current as of May 2002

VIOLENCE AGAINST WOMEN

Violence against women, including domestic violence and sexual assault, is a critical but often neglected women's health issue. Nearly one-third of American women (31%) report being physically or sexually abused by a husband or boyfriend at some point in their lives.[174] In addition, nearly one-fifth of women (18%) reported experiencing a completed or attempted rape at some time in their lives.[175] There are several ways that states can facilitate access to assistance for victims of violence and lessen the impact of violence. The three types of policies described below provide examples of how states can assist victims of domestic violence and sexual assault.

Domestic Violence Health Care Protocols, Screening, and Training

The medical care system can be an important venue for identifying and providing assistance to victims of domestic violence. Each year, more than 1 million women seek medical care for injuries related to battering.[176] Furthermore, about one-third of women who seek care in emergency rooms do so because of injuries inflicted by a violent partner.[177] Health care providers are in a unique position to identify women who are victims of violence and health care settings can provide safety and privacy for women who have been abused. However, women who have experienced violence are more likely to have unmet medical needs.[178] Some states require that providers screen for domestic violence and mandate the development of protocols to assist health care providers in identifying and treating domestic violence victims. States can also give training to providers in detecting abuse and providing health care to victims.

Sexual Assault Training for Health Care Providers, Police, and Prosecutors

Recognizing that survivors of sexual assault have unique needs when seeking health care and interacting with law enforcement, some states require that health care providers, police personnel, and prosecutors receive special training to assist sexual assault victims. This training improves evidence collection, increases sensitivity to survivors and reduces further trauma, and encourages survivors to seek legal redress.

TABLE V-2 VIOLENCE PROTOCOLS, TRAINING AND SCREENING FOR HEALTH CARE PROVIDERS AND LAW ENFORCEMENT PERSONNEL

- 9 states require domestic violence treatment protocols, 3 states require screening for domestic violence and 11 states require provider training.
  - 3 states, California, New York and Pennsylvania, require protocols, screening and provider training.
- 7 states require training of health care providers to assist survivors of sexual assault and 14 states require training of police and/or prosecutors to assist survivors of sexual assault.
  - 6 states require training for both health care providers and police/prosecutors.

TABLE V-2
Violence Protocols/Training/Screening and Insurance Anti-Discrimination Laws

	Domestic Violence Health Care Provider Protocols, Screening and Training			Insurance Anti-Discrimination Laws				Sexual Assault Health Care Provider, Police/Prosecutor Training	
State	Protocols	Screening	Training	Health	Life	Disability	Property/ Casualty	Health Care Provider	Police/ Prosecutor
United States Total	**9**	**3**	**11**	**40**	**34**	**26**	**26**	**7**	**14**
Alabama				●	●	●	●		
Alaska	●		●	●	●	●	●	●	●
Arizona				●	●	●	●		
Arkansas									
California	●	●	●	●	●	●	●	●	●
Colorado				●	●	●	●		
Connecticut				●				●	●
Delaware				●	●	●	●		
District of Columbia									
Florida			●	●	●	●	●		●
Georgia				●	●	●	●		
Hawaii				●	●	●	●		
Idaho									
Illinois				●	●	●		●	●
Indiana				●	●	●			
Iowa	●			●	●	●	●		
Kansas				●	●		●		
Kentucky			●	●			●	●	●
Louisiana				●					
Maine				●	●	●			
Maryland				●	●				●
Massachusetts				●	●	●	●		●
Michigan				●	●				
Minnesota				●	●				
Mississippi									
Missouri				●	●	●	●		
Montana				●	●	●	●		
Nebraska				●	●	●	●		
Nevada				●					
New Hampshire	●		●	●	●	●	●		
New Jersey				●					●
New Mexico				●	●	●	●		●
New York	●	●	●	●	●	●	●	●	●
North Carolina									
North Dakota							●		
Ohio	●		●	●	●				●
Oklahoma			●						
Oregon				●	●	●	●		
Pennsylvania	●	●	●	●	●	●	●	●	
Rhode Island				●	●				
South Carolina									
South Dakota									
Tennessee				●					
Texas	●			●	●				●
Utah				●	●	●			
Vermont									
Virginia				●	●	●	●		
Washington			●	●	●	●	●		●
West Virginia	●		●	●	●		●		
Wisconsin				●	●	●	●		
Wyoming									

Note: ● State has the policy

Sources:

Domestic Violence Health Care Provider Protocols, Screening and Training:
Family Violence Prevention Fund, State-by-State Report Card on Health Care Laws and Domestic Violence (San Francisco: Family Violence Prevention Fund, 2001), [Online] http://endabuse.org/statereport/list.php3. **Data current as of August 2001**

Insurance Anti-Discrimination Laws:
Terry Fromson and Nancy Durburow, Insurance Discrimination Against Victims of Domestic Violence (Harrisburg: Pennsylvania Coalition Against Domestic Violence Publications, 1998), updated with data from Terry Fromson, Women's Law Project (February 2002). **Data current as of February 2002**

Sexual Assault Health Care Provider, Police/ Prosecutor Training:

Neal Miller, Review of State Sexual Assault Laws, 1998 Legislative Codes (Alexandria: Institute for Law and Justice, 1999), [Online] http://www.ilj.org/sa/sexaltpr.htm.

Neal Miller, 1999 Domestic Violence, Stalking, and Sexual Assault Legislation: State by State Analysis of 1999 Legislation (Alexandria: Institute for Law and Justice, 2000), [Online] http://www.ilj.org/dv/99StateLawUpdate.htm.

Neal Miller, 1999 Violence Against Women Legislation (Alexandria: Institute for Law and Justice, 2000), [Online] http://www.ilj.org/dv/99SessionLaw.htm.

Neal Miller, A Review of State Domestic Violence Related Legislation: A Law Enforcement and Prosecution Perspective (Alexandria: Institute for Law and Justice, 2000), [Online] http://www.ilj.org/dv/vawa1.html.

Neal Miller, 2000 Legislative Session: Violence Against Women Legislation (Alexandria: Institute for Law and Justice, 1999), [Online] http://www.ilj.org/dv/2000SessionLaw.pdf. **Data current as of November 2000**

Insurance Anti-Discrimination Laws

States can also assist domestic violence victims through laws that prohibit insurance discrimination based on a history of domestic violence. Although federal law prohibits insurers' use of domestic violence as a pre-existing condition exclusion,[179] a 1994 U.S. House Judiciary subcommittee found that half of the nation's 16 largest insurers considered a history of domestic violence when issuing policies and setting rates.[180] These practices may discourage victims from seeking help for fear of losing their insurance coverage if the abuse is reported to a health provider or law enforcement official. States can offer greater protection with laws that prohibit insurers from using a history of domestic violence victimization when selling insurance. Various states have enacted such laws with regard to four types of insurance: health, life, disability and property/casualty.

TABLE V-2 DOMESTIC VIOLENCE INSURANCE ANTI-DISCRIMINATION LAWS

- 40 states prohibit discrimination in health insurance policies based on a history of domestic violence, 34 states prohibit discrimination in life insurance policies, 26 states prohibit discrimination in property/casualty insurance, and 26 states prohibit discrimination in disability insurance.
  - 22 states prohibit discrimination based on a history of domestic violence in all four types of insurance.

WOMEN AND HIV/AIDS

The AIDS epidemic has taken a growing toll on women, especially minority and low-income women, since the disease was identified in 1981. Women represent an estimated 30% of new HIV infections in the United States.[181] In just over a decade, the percentage of all new AIDS cases among adult and adolescent women has more than tripled, from 7% of all AIDS cases in 1986 to 26% of all AIDS cases in 2001.[182] The incidence of AIDS has increased most dramatically among women of color, with African-American and Latina women accounting for 81% of these new infections.[183] While HIV/AIDS affects women of all ages, it is most common among women in their childbearing years. In 1999, 86% of all new cases of AIDS reported in women were among those ages 20 to 49.[184]

HIV Testing of Pregnant Women

The finding that the anti-AIDS drug AZT can dramatically reduce the likelihood of perinatal transmission of HIV increased the drive to identify pregnant women who are HIV positive.[185] However, as of 2001, 44% of pregnant women did not receive an HIV test.[186] In 1995, the U.S. Public Health Service (PHS) issued guidelines recommending universal counseling and voluntary HIV testing of all pregnant women.[187] Since 1995, these guidelines have been revised, most recently in 2003, to state that HIV testing should be a routine part of prenatal care for all women regardless of risk and to encourage states to require automatic testing for pregnant women, unless a woman specifically refuses the test.[188] The issue of whether HIV testing for pregnant women should be voluntary or mandatory has remained controversial. All states and the District of Columbia have certified to the CDC that they have measures in place to implement the 1995 PHS guidelines, which state that testing must be voluntary and that informed consent must be obtained as per relevant state laws.[189] Some states have already gone beyond these guidelines and have passed laws that require automatic testing of pregnant women with provisions for women to specifically opt out and refuse the test. Other states require providers to offer the test to pregnant women.

TABLE V-3 HIV TESTING OF PREGNANT WOMEN

- 7 states automatically test pregnant women for HIV unless a woman specifically refuses the test.
- 11 states require providers to offer HIV tests to pregnant women.
- 32 states and the District of Columbia have voluntary testing as per the CDC's 1995 guidelines.

TABLE V-3
HIV Testing of Pregnant Women

State	Providers Required to Test Unless Woman Refuses	Providers Required to Offer Test	Voluntary Testing
United States Total	**7**	**11**	**32 + DC**
Alabama			●
Alaska			●
Arizona			●
Arkansas	●		
California		●	
Colorado			●
Connecticut	●		
Delaware			●
District of Columbia			●
Florida		●	
Georgia			●
Hawaii			●
Idaho			●
Illinois			●
Indiana		●	
Iowa		●	
Kansas			●
Kentucky		●	
Louisiana		●	
Maine			●
Maryland		●	
Massachusetts			●
Michigan	●		
Minnesota			●
Mississippi			●
Missouri			●
Montana			●
Nebraska			●
Nevada			●
New Hampshire			●
New Jersey		●	
New Mexico	●*		
New York	●		
North Carolina			●
North Dakota			●
Ohio			●
Oklahoma			●
Oregon			●
Pennsylvania			●
Rhode Island		●	
South Carolina			●
South Dakota			●
Tennessee	●		
Texas	●		
Utah			●
Vermont			●
Virginia		●	
Washington		●	
West Virginia			●
Wisconsin			●
Wyoming			●

Note: ● State has the policy
* Effective June 20, 2003

Source: The Henry J. Kaiser Family Foundation, "HIV Testing for Mothers and Newborns, 2000," State Health Facts Online, [Online] http://www.statehealthfacts.kff.org, citing National Conference of State Legislatures, Health Policy Tracking Service, updated per correspondence with Lillian MacEachern, National Conference of State Legislatures, May 2002. **Data current as of April 2003**

AIDS Drug Assistance Programs

Since 1987, the federal government has provided funds to every state and the District of Columbia to help the uninsured and underinsured with HIV/AIDS pay for medications. States administer these AIDS Drug Assistance Programs (ADAP) and establish income eligibility rules and guidelines for covered medications. Most states provide additional state funds for ADAPs, but are not required to do so in order to receive federal funds.[190] ADAPs grew in size and importance in the mid-1990s with the development of more effective medications to treat HIV/AIDS.

ADAPs are an important resource for women of modest resources who are living with HIV/AIDS. More than one-fifth (21%) of HIV-positive women age 18 and older are uninsured and nearly two-thirds earn less than $10,000 annually.[191] Women represented 21% of ADAP clients as of June 2001.[192] Women's representation in ADAP ranges from a low of 6% in New Mexico, to a high of 34% in New Jersey.[193]

TABLE V-4 ADAP INCOME ELIGIBILITY LEVELS

- 50 states and the District of Columbia have AIDS Drug Assistance Programs.
- Eligibility for ADAPs is based on income; requirements range from 125% to 500% of the FPL.

TABLE V-4
ADAP Income Eligibility Levels

State	Income Eligibility (% FPL)
United States Total	
Alabama	250
Alaska	300
Arizona	300
Arkansas	300*
California	400
Colorado	300
Connecticut	400
Delaware	500+
District of Columbia	300
Florida	350
Georgia	300**
Hawaii	400
Idaho	200***
Illinois	400
Indiana	300
Iowa	200
Kansas	300
Kentucky	300
Louisiana	200
Maine	300
Maryland	400
Massachusetts	<$50,000 per year
Michigan	450
Minnesota	300
Mississippi	400
Missouri	300
Montana	300
Nebraska	200
Nevada	400
New Hampshire	300
New Jersey	500
New Mexico	300
New York	<$44,000 per year
North Carolina	125
North Dakota	400
Ohio	300
Oklahoma	200
Oregon	200
Pennsylvania	<$30,000 per year
Rhode Island	400
South Carolina	300***
South Dakota	300
Tennessee	300
Texas	200
Utah	200
Vermont	200
Virginia	300/333~***
Washington	300
West Virginia	250
Wisconsin	300
Wyoming	200

Notes: FY 2002 Eligibility
- * To be medically eligible, the individual must have a CD4 cell count <350 or a viral load of >55,000.
- ** To be medically eligible, the individual must have a CD4 cell count <500 and a viral load of >55,000.
- *** To be medically eligible, the individual must have a CD4 cell count <500.
- \+ Delaware has a sliding scale up to 500% of the FPL.
- ~ 333% for Northern Virginia only
- FPL 100% of the federal poverty level was $8,860 for a family of one in 2002.

Source: National ADAP Monitoring Project, *Annual Report,* (Menlo Park: The Henry J. Kaiser Family Foundation, April 2003), [Online] http://www.kff.org/content/2003/20030430a/6071v2.pdf. **Data current as of June 2002**

PRESCRIPTION DRUG COVERAGE

In addition to Medicaid assistance with prescription drug coverage, states can develop separate programs to help alleviate some of the barriers to accessing prescription medications for women who are not covered by Medicaid. Women, particularly women over age 65, are disproportionately affected by the crisis in affordable medications, as women are more likely to use prescription drugs, make up a greater share of older Medicare beneficiaries, and are poorer.[194] Hence, women over age 65 spend 20% more for prescription drugs than men the same age.[195]

Non-Medicaid State Pharmacy Assistance Programs

To aid with the gaps in prescription drug coverage, many states have established their own drug assistance programs. (Information on state Medicaid programs' coverage of prescription drugs is contained in Chapter III and Table III-11.) Targeted to low-income Medicare beneficiaries and people with disabilities who do not qualify for Medicaid assistance, these programs vary significantly in their structure, eligibility requirements and benefits. Most offer direct subsidies for enrollees, but some are discount programs that allow enrollees to purchase prescriptions at a reduced rate at pharmacies participating in the program. Some programs require a one-time or annual membership fee and some require a copayment.

TABLE V-5 STATE PHARMACY ASSISTANCE PROGRAMS

- 32 states and the District of Columbia have state-sponsored pharmacy assistance programs for low-income seniors and people with disabilities who receive Medicare but do not qualify for Medicaid.
  - 8 of the pharmacy assistance programs are discount programs.
- 12 states have programs that are not yet operational.

✶ ✶ ✶

This chapter speaks to the struggle that states have in moving beyond federal mandates, and taking advantage of tremendous opportunities to proactively close some of the gaps in women's health care access. A state office on women's health can provide the infrastructure and leadership to coordinate a concerted effort to increase women's access to health care, but few states have created such offices, and many existing offices have limited resources and influence.

States have taken measures to address the widespread incidence of violence against women by recognizing the importance of training the medical and justice systems to better serve survivors of violence. The majority of states explicitly prohibit insurers from discriminating against victims of domestic violence in the provision of health, life, disability, or property/casualty insurance coverage.

States have played a role in addressing the epidemic of HIV/AIDS among women. Most states have implemented voluntary testing programs for pregnant women, which has helped dramatically reduce the incidence of mother-to-child transmission in the U.S. ADAPs and other state pharmacy assistance programs help low-income HIV/AIDS patients and seniors acquire costly medications, but the current state fiscal crises threaten such programs' long-term solvency.

TABLE V-5
Non-Medicaid State Pharmacy Assistance Programs

State	State-Funded Program[&]	Age/Disability Status Requirements	Annual Income Limit (Single/Married) ($)	Cost-Sharing	Notes
United States Total	**32 + DC**			**18**	
Alabama					
Alaska					
Arizona	○	Medicare eligible	17,180		Must reside in county w/o HMO prescription drug coverage.
Arkansas	○^	65	6,872		Waiver authorized by state; not yet approved by federal govt.
California	●	Medicare beneficiaries	none	discount program~	
Colorado					
Connecticut	●	65/disabled: >18 on SSI or SSDI	20,000/27,100		
Delaware (1)	●	65/disabled: SSDI-eligible	16,488/22,128		
Delaware (2)	●	65	12,500/17,125		
District of Columbia	●		17,180		Must be patient of DC Healthcare Alliance & ineligible for other drug ben. program.
Florida (1)	●	65: eligible for both Medicare and Medicaid	10,200		
Florida (2)	●	Medicare beneficiaries	none	discount program	
Georgia					
Hawaii					
Idaho					
Illinois (1)	●	65/disabled: 16	21,218/28,480		
Illinois (2)	○^	65	17,200/23,220		
Indiana	●	65	11,964/16,128		
Iowa	●^	Medicare beneficiaries	none	discount program; $20 enrollment fee	
Kansas	●	67	12,525/16,875	30% copayment	Excludes prescriptions for acute illness; max. reimb./individual is $1,200/yr.
Kentucky					
Louisiana					
Maine (1)	●^	Medicare beneficiaries	300% FPL		Court action on waiver is pending.
Maine (2)	○	none		discount program	Program delayed by legal challenge.
Maryland (1)	●	none	10,000/10,850		Assets limited to $4,500.
Maryland (2)	●	65 or Medicare eligible	25,770/34,830		Benefits limited to $1,000/yr.
Maryland (3)	●^	Medicare beneficiaries	15,033/20,318	65% copayment	Must not have other drug coverage; program contingent on federal waiver approval.
Massachusetts	●	65	16,142 for full coverage / Disabled: 15,698	sliding scale premium subsidy for incomes up to $42,950	
Michigan	●	65	17,720/23,880	$25 annual fee	
Minnesota	●	65	10,632/14,328		Limits liquid assets to <$10,000 per individual; $18,000 per couple.
Mississippi					
Missouri	○	none	17,000/23,000	40% copayment;$250-500 deductible	
Montana					
Nebraska					
Nevada	●	62	family: 21,500		
New Hampshire	●	65	none	discount program	Pilot program; no enrollment fee.
New Jersey (1)	●	65/disabled: 21	19,739/24,203	$5 copayment	
New Jersey (2)	●	65	19,740-29,739 / 23,204-34,203	50% copayment	
New Mexico	○	65	none	discount program	
New York	●	65	35,000/50,000		
North Carolina (1)	●	65	13,290		Lmt. to ind. with CVD or diabetes.
North Carolina (2)	○	65	17,180/23,220		Lmt. to ind. with CVD, COPD or diabetes.
North Dakota					
Ohio					
Oklahoma					
Oregon (1)	○	65	15,891/21,478	$50 annual fee; 50% copayment	Assets lmtd. to $2,000; no other drug ben. program in prior 6 months; other ben.cap of $2,000/yr.
Oregon (2)	○	65	not yet established	discount program	Discount not to exceed Medicaid rate for prescriptions.
Pennsylvania (1)	●	65	14,000/17,200		
Pennsylvania (2)	●	65	16,000/19,200		
Rhode Island	●	65	16,490-36,225 / 20,613-41,400		3 levels of coverage based on income.
South Carolina	●	65	15,505/20,895	$10-$21 copayment; $500 deductible/yr.	
South Dakota					
Tennessee					
Texas	○	Medicare eligible			
Utah					
Vermont (1)	●^	65/disabled: receives SSI or Medicare benefits	13,368/17,988		
Vermont (2)	●	65/disabled: receives SSI	15,600/20,988		Limited to maintenance drugs.
Vermont (3)	●^	65 or disabled	20,052/26,988		Limited to maintenance drugs.
Virginia					
Washington					
West Virginia	●	60	none	discount program	
Wisconsin	○	65	240% FPL	$20 enrollment fee	
Wyoming (1)	●	none	8,860		
Wyoming (2)	○	none	17,720		

Notes:
- ● State has program
- ○ Program not yet operational
- ^ Program receives federal funds
- ~ Discount programs provide a reduced retail price for participants, but do not provide state subsidy for purchase of prescription drugs.
- SSI Supplemental Security Income
- SSDI Social Security Disability Insurance
- CVD Cardiovascular Disease
- COPD Chronic Obstructive Pulmonary Disease
- FPL 100% of the federal poverty level (FPL) was $8,860 for a family of one in 2002.
- & Number of bullets exceeds 33 because some states have multiple programs

Source: National Conference of State Legislatures, "State Pharmaceutical Assistance Programs," May 9, 2002, [Online] http://www.ncsl.org/programs/health/drugaid.htm. **Data Current as of May 2002**