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THE HENRY J. KAISER FAMILY FOUNDATION

Getting into Gear for 2014: Findings from a 50-State Survey of Eligibility, Enrollment, Renewal, and Cost-Sharing Policies in Medicaid and CHIP, 2012–2013

Prepared by:

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January 2013

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kaiser commission medicaid and the uninsured

The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bi-partisan group of national leaders and experts in health care and public policy.

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Acknowledgements

The authors extend our deep appreciation to the state officials who so generously shared their expertise and time with us by participating in this survey and helping us to understand the nuances and details of their programs. This work simply would not be possible without them and we greatly appreciate their important contributions, especially in a time of strained resources. We also extend thanks to Tara Mancini, research assistant with the Georgetown University Center for Children and Families, for her support in data collection.

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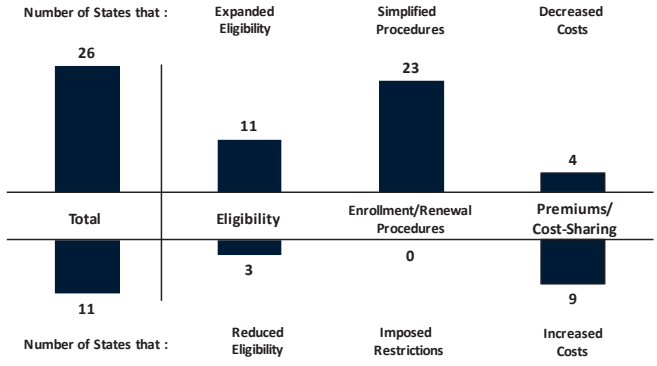
EXECUTIVE SUMMARY

As 2013 begins, implementation of the major provisions of the Affordable Care Act (ACA), including its coverage expansions, is less than a year away. Following the Supreme Court ruling to uphold the ACA and the 2012 elections, efforts to prepare for 2014 are moving into high gear in many states. During the past year, a number of states shifted focus to wide-ranging improvements in Medicaid enrollment processes and systems and a number continued to make more targeted eligibility or procedural improvements (Figure 1). Similar to recent years, Medicaid and the Children's Health Insurance Program (CHIP) continued to be bedrock sources of coverage for children and, to a lesser degree, their parents, as the ACA requirement for states to maintain eligibility levels and enrollment and renewal procedures remained in place. Modest improvement in the economy curbed Medicaid enrollment growth and its impact on state budgets. Yet, continuing fiscal constraints prompted a number of states to increase cost-sharing and a handful eliminated coverage for adults under limited exceptions to the requirement for states to maintain eligibility.

Figure 1

State Medicaid and CHIP Policy Actions for Low-Income Families, January 2012 – January 2013



Notes: Includes policy changes affecting children, pregnant women, parents, and childless adults. Does not include changes for elderly individuals or individuals with disabilities.
SOURCE: Based on the results of a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2013.

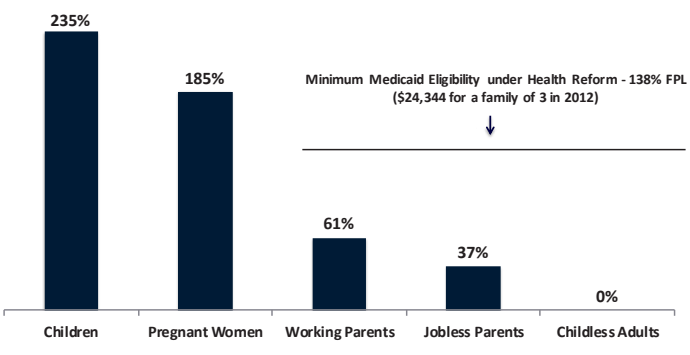
At this pivotal time, this twelfth annual report provides a snapshot of current Medicaid eligibility and enrollment policies and procedures and highlights changes states will need to make in the coming year to implement the Medicaid provisions of the ACA. Conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, it provides results from a 50-state survey of eligibility, enrollment, renewal, and cost-sharing policies in Medicaid and CHIP, documenting changes made during 2012 and policies in place as of January 1, 2013.

Medicaid and CHIP Eligibility

Targeted improvements strengthened the role of Medicaid and CHIP as primary sources of coverage for low-income children and pregnant women. In 2012, eligibility levels for children and pregnant women remained stable, as intended by the ACA requirement to maintain coverage. The median eligibility level is 235 percent of the federal poverty level (FPL) for children and 185 percent of the FPL for pregnant women as of January 1, 2013 (Figure 2). Small improvements for children and pregnant women occurred in ten (10) states largely through continued state take-up of new options in the ACA and the 2009 CHIP Reauthorization Act (CHIPRA) to cover dependents of state employees and lawfully-residing immigrant children and pregnant women without a five-year waiting period.

Figure 2

Median Medicaid/CHIP Eligibility Thresholds, January 2013



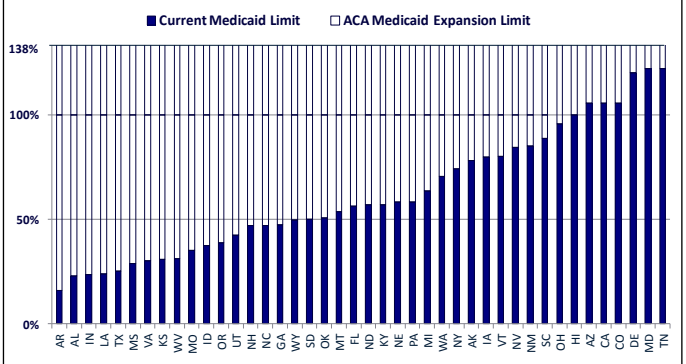
SOURCE: Based on the results of a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2013.

Adult eligibility continues to fall far short of that for children, and a few states scaled back coverage for parents and other adults during 2012. Parent eligibility levels remain very low, with the median level at just 61 percent of the FPL. Moreover, only nine (9) states provide full Medicaid coverage to other adults without dependent children. One state (CO) added coverage for adults to Medicaid through a limited expansion in 2012. In addition, Utah increased eligibility for its Section 1115 waiver premium assistance program for adults from 150 to 200 percent of the FPL. In contrast, three states (HI, IL, and MN) reduced eligibility for adults where it was not protected by the federal requirement to maintain eligibility.

The ACA Medicaid expansion would significantly increase eligibility for parents in many states, with even larger potential coverage gains for other adults. The ACA creates a new continuum of public and private coverage options, including extending Medicaid to a eligibility floor of 138 percent of the FPL in January 2014, with significant federal financing. This expansion would fill the substantial coverage gaps for low-income parents and other adults. Although the Supreme Court ruling upheld the Medicaid expansion, it limited the federal government's ability to enforce it, effectively making implementation a state choice. If a state does not expand Medicaid, poor uninsured adults in that state will not gain a new affordable coverage option and likely remain uninsured. Currently, 33 states limit parent eligibility to less than 100 percent of the FPL, with 16 limiting eligibility to less than 50 percent of poverty (Figure 3). Moreover, the majority of states do not provide Medicaid coverage to low-income childless adults, regardless of how low their income is (Figures 4).

Figure 3

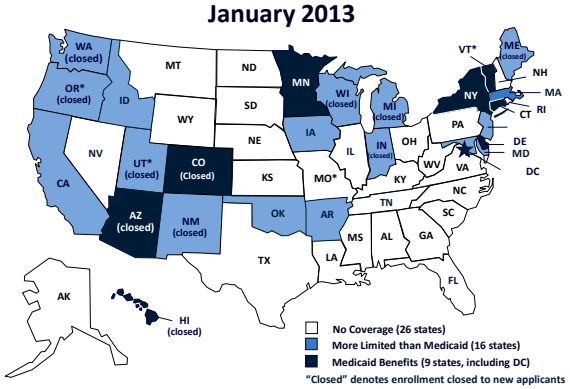
Changes in Parent Medicaid Eligibility Under the ACA Medicaid Expansion, as a Percent of the Federal Poverty Level



NOTE: Ten states (CT, IL, ME, MA, MN, NJ, NY, RI, VT, WI) and DC already offer coverage to parents at or above 133% FPL; under the ACA an income disregard of 5 percentage points will be applied to this limit increasing the effective income limit to 138% FPL.
SOURCE: Based on the results of a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2013.

Figure 4

Coverage of Low-Income Adults by Scope of Coverage, January 2013



NOTE: Map identifies the broadest scope of coverage in the state. MN and VT also offer waiver coverage that is more limited than Medicaid. OR and UT also offer "premium assistance" with open enrollment. IL, LA, and MO offer coverage limited to adults residing in a single county or area.
SOURCE: Based on the results of a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2013.

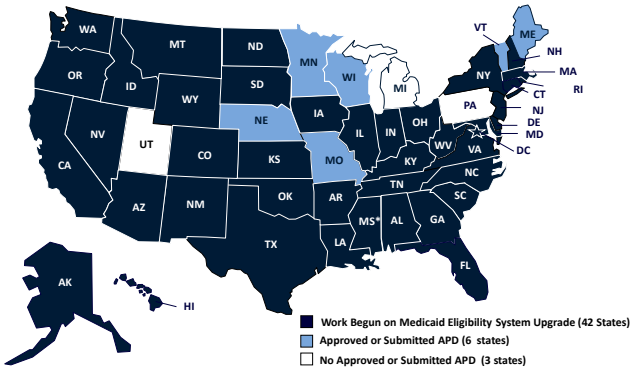
Use of Technology to Re-engineer Processes and Enhance Systems

States are pressing forward to develop high-performing eligibility and enrollment systems. During 2012, final regulations were released that outline new requirements for web-based, paperless, real-time eligibility and enrollment processes that will go into place in 2014. States also will need to coordinate closely with exchanges in implementing these processes to establish a "no wrong door" enrollment approach, so that, regardless of a person's point of entry (i.e., the individual exchange or Medicaid), eligibility is determined for all insurance affordability programs. States must meet these new requirements regardless of whether they expand Medicaid. Many states have already harnessed technology to facilitate families' access to coverage and gain administrative efficiencies. Moving forward, advanced use of technology holds the promise of further revolutionizing the Medicaid enrollment experience.

Taking advantage of a time-limited 90 percent federal matching rate available for systems development, almost all states are moving forward with major updates to their information technology (IT) infrastructure. As of January 1, 2013, 47 states have submitted or received approval for an advanced planning document (APD) to institute system upgrades, and 42 have already launched their system development work (Figure 5). In addition to this significant federal funding, CMS is providing technical assistance and has created a central repository for states to pool resources on IT development and reuse technology developed by leader states.

Figure 5

Status of Major Medicaid Eligibility System Upgrades, January 2013

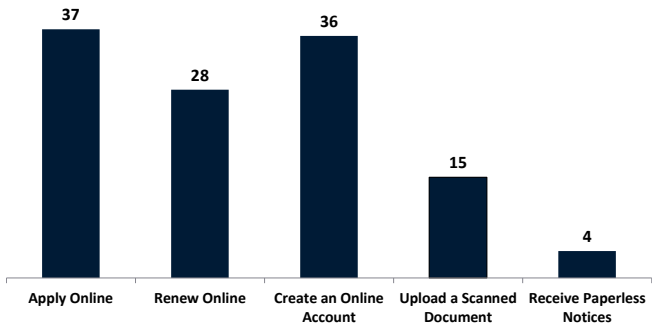


NOTE: "APD" refers to an Expedited Advanced Planning Document. MS has begun work on upgrading its Medicaid eligibility systems without submitting an APD.
SOURCE: Based on the results of a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2013.

The majority of states are capitalizing on web-based tools to facilitate individuals' access to coverage and ease administrative burdens. As of January 1, 2013, more than two-thirds (37) of states have an electronic online application in Medicaid or CHIP, an increase of four states over last year (Figure 6). Over half (28) of states allow families to renew online, including eight states that added this capability in 2012. Moreover, over two-thirds of states (36) provide online accounts. However, less than half of these accounts provide advanced features, such as the ability to receive paperless notices or upload electronic images of documents, which maximize the efficiency of online processes.

Figure 6

Number of States with Selected Online Application and Renewal Capabilities in Medicaid and/or CHIP, January 2013



SOURCE: Based on preliminary results from a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2013.

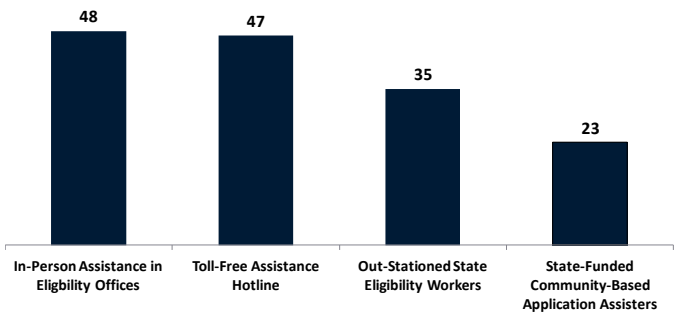
Illustrating the effectiveness of electronic verification, the large majority of states (45) have adopted a data match with the Social Security Administration (SSA) to verify citizenship in Medicaid or CHIP. States have quickly adopted the new option provided by CHIPRA to verify citizenship through an electronic data match with the SSA and have reported increased efficiency as well as highly successful match rates. This experience serves as a precursor to the new federal data hub established by the ACA to help states electronically confirm eligibility criteria as of 2014. State data sources can be tapped in a similar expedited fashion, and, as of January 1, 2013, 11 states report they have a state data hub that allows them to access multiple information sources at once. However, paper still remains the predominant method currently used by states to verify income. As such, movement to electronic verification under the ACA will represent a major procedural and cultural change for many states.

Outreach, Enrollment, and Renewal Policies

As the ACA is implemented, states will build on existing outreach and enrollment assistance resources to connect eligible people to coverage. As of January 1, 2013, a majority of states offers in-person assistance at eligibility offices, a toll-free assistance hotline, and/or provides assistance at the local level through out-stationed state eligibility workers or by funding community-based application assisters (Figure 7). Enrollment efforts under the ACA will extend this base through call centers, navigators, and other assistance programs.

Figure 7

Number of States with Selected Outreach and Enrollment Assistance Resources in Medicaid and/or CHIP, January 2013



SOURCE: Based on preliminary results from a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2013.

Building on previous progress in streamlining enrollment and renewal processes, the ACA will continue to transform how families connect to coverage. For example, while most states have already eliminated asset tests and face-to-face interview requirements for children, a number will need to remove these barriers for parents in the coming year. States must also continue to expand the avenues available to families to apply for and renew coverage to include online, telephone, in-person, and mail options. As of January 1, 2013, all states offer in-person and mail-in enrollment and renewal options. However, fewer states offer both online and telephone enrollment (16) and renewal (19). Moreover, beginning in 2014, states will be required to conduct annual renewals based on available information rather than requesting information and documentation from individuals. The vast majority of states (46) already have twelve-month renewal periods for both children and parents, but fewer states (22) seek to automatically renew coverage based on available information. As states move to these streamlined, data-driven procedures, they also will need to adjust eligibility worker roles and expectations to align with the new paradigm.

Cost-Sharing

During 2012, a majority of states did not impose additional cost-sharing requirements on families even though they continued to experience budget constraints. States generally cannot increase premiums under current federal requirements to maintain eligibility and enrollment policies. As such, premium changes were minimal and largely routine annual adjustments or modest increases to reflect inflation, as allowed under current requirements. States are not restricted from increasing co-payments within federal program limits, and nine (9) made such increases in 2012.

Conclusion

The ACA's Medicaid expansion and requirements for a modern, simplified enrollment experience build on states' accomplishments in covering children and accelerate the adoption of proven strategies. As states face a shrinking timeline to prepare for 2014, much work remains to be done and it will be important for states to leverage the experience of those leading the way. As they prepare for 2014, a key choice facing states is whether to expand Medicaid. If a state does not expand, poor uninsured adults in that state will not gain a new affordable coverage option and likely remain uninsured. Thus, 2013 will be a pivotal year as states weigh this decision and move into the final preparations for 2014.

I. Introduction

With major provisions of the ACA going into effect on January 1, 2014, efforts to prepare for implementation are moving into high gear. States are shifting their focus from making incremental program improvements to setting their sights on establishing new systems and executing the wide-ranging changes in the law. While states have many key decisions in front of them, including whether to extend Medicaid to low-income adults, new tools and resources are available to facilitate implementation. However, progress to date varies widely, reflecting divergent political will and ideology across the states and continuing fiscal pressures.

At this important time, this twelfth annual report provides a snapshot of current Medicaid eligibility and enrollment policies and procedures and highlights the changes states will need to make in the coming year to put into place the Medicaid and CHIP provisions of the ACA. Conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, it provides results from a 50-state survey of eligibility, enrollment, renewal and cost-sharing policies in Medicaid and the CHIP, documenting changes implemented during 2012 and policies in place as of January 1, 2013.

II. Background

The past year has been a key juncture for states, with a number of events that have important implications for state Medicaid and CHIP programs and preparations for the ACA:

Final regulations for the ACA's eligibility standards and enrollment simplification and coordination provisions were released in March 2012. The final rule establishes procedures for states to implement the Medicaid expansion to a new minimum eligibility floor of 138 percent of the FPL and the streamlined, integrated eligibility and enrollment processes. New procedures will build on proven strategies states have developed over the years to facilitate enrollment in Medicaid and CHIP. They also will harness technology and electronic data matches to the greatest extent possible to provide real-time eligibility determinations and minimize burdens on families and administrative staff. (See Text Box 1: Overview of Final Medicaid Eligibility and Enrollment Regulations.)

The Supreme Court upheld the ACA but limited the federal government's ability to enforce the Medicaid expansion to low-income adults. In its June ruling on *National Federation of Independent Business v. Sebelius,* the Supreme Court declared the ACA, including the Medicaid expansion to adults up to 138 percent of the FPL, constitutional. However, it limited the federal government's ability to enforce the expansion, effectively making implementation a state choice.[1] States continue to analyze the impact of adopting the expansion, both in terms of the financial implications for state budgets as well as the impact on coverage for low-income people, and a majority has yet to make a decision. As the year drew to a close, the Department of Health and Human Services clarified that partial expansions to the new adult eligibility group (e.g., up to 100 percent of the FPL) are not consistent with the intent of the law and will not qualify for the enhanced federal match available for the expansion, which may further shape state decisions. The Supreme Court ruling affirmed all other aspects of the law, including the requirement that states preserve Medicaid and CHIP eligibility levels and maintain enrollment and renewal policies. Moreover, states are required to implement the new Medicaid enrollment simplifications regardless of whether they expand Medicaid.

Text Box 1:
Overview of Final Medicaid Eligibility and Enrollment Regulations*

On March 23, 2012, the Centers for Medicare and Medicaid Services (CMS) issued a final rule to implement the ACA provisions relating to Medicaid eligibility, enrollment simplification, and coordination. The new approach will transform the Medicaid enrollment experience into a real-time, electronically driven process that minimizes burdens on individuals and eligibility workers. Key provisions of the rule include the following:

Beginning in 2014, the ACA will expand and simplify Medicaid eligibility categories, and financial eligibility for most enrollees will be based on Modified Adjusted Gross Income (MAGI), as defined in the Internal Revenue Code. Medicaid eligibility is expanded to a new "adult group" that includes all non-pregnant individuals ages 19 to 65 with incomes at or below 133 percent of the FPL. (The law includes a disregard of five percentage points of the FPL, which raises the effective limit to 138 percent of the FPL). Existing eligibility categories based on income or pregnancy are collapsed into three broad groups: parents, pregnant women, and children under age 19. Financial eligibility for these groups will be based on MAGI. The new MAGI rules differ from the way income is calculated in Medicaid and CHIP today. MAGI is a methodology or formula for counting income and household size based on tax filing definitions.

States will use a single streamlined application for all insurance affordability programs that is available for submission through multiple avenues. The Secretary will develop a single application that must be used by states, unless they receive approval for use of an alternative application. The application may be submitted online, by telephone, by mail, in-person, and by fax. Moreover, state Medicaid agencies must provide assistance with the application in-person, by telephone, and online. The application and assistance must be accessible to persons with limited English proficiency and people with disabilities.

States will streamline enrollment processes and rely on electronic data matches to verify eligibility criteria. Under the new rule, states will no longer be allowed to require an in-person interview as part of the application or renewal process. Moreover, states are expected to rely on electronic data matches to verify eligibility criteria to the greatest extent possible. They may only request paperwork when they are unable to obtain information electronically or when information obtained electronically is not "reasonably compatible' with information provided by the individual.

State agencies must renew eligibility no more frequently than once every 12 months by evaluating information available from the individual's account and other reliable data sources. If there is sufficient data to determine continued eligibility, the state will renew coverage without requiring further action from the individual. If not, the state must provide the individual with a pre-populated form containing data available to the agency and a reasonable period of time for the individual to provide needed information online, in-person, by telephone, or by mail. To avoid unnecessary reapplications, the rule also provides a reconsideration period for individuals who lose coverage because they did not return a renewal form in time, but do respond within a reasonable period after coverage terminates.

States will coordinate eligibility determinations with exchanges and other insurance affordability programs. State Medicaid agencies must ensure that any individual who is determined ineligible for Medicaid is screened for potential eligibility for advanced premium tax credits and promptly transfer the individual's electronic account to the exchange. (States also can enter into an agreement with an exchange to make final eligibility determinations for the advance tax credits.) With regard to exchange determinations of Medicaid eligibility, states can enter into agreements to have the exchange make *either* final Medicaid eligibility determinations or assess potential Medicaid eligibility and transfer accounts to the Medicaid agency for final Medicaid eligibility determinations.

*These rules apply to those whose eligibility is determined on the basis of MAGI. There are some variations in rules for groups who remain exempt from MAGI methodologies.

See "Medicaid Eligibility, Enrollment Simplification, and Coordination under the Affordable Care Act: A Summary of CMS's March 23, 2012 Final Rule" Kaiser Family Foundation, December 2012, available at http://www.kff.org/medicaid/8391.cfm for more details.

The outcome of the November 2012 elections affirmed implementation of the ACA. Following the Supreme Court ruling, some state policymakers continued to delay implementation of the ACA, awaiting the outcome of the elections. With no shift in the balance of political power at the federal level, implementation of the ACA continues, and states must accelerate efforts to be ready for 2014.

Additional IT-related resources became available, building on significant federal funding available for state investments in IT. In 2011, the federal government began providing a time-limited enhanced 90 percent federal match for states to upgrade or replace their aging Medicaid eligibility and enrollment systems in preparation for new data-driven enrollment processes under the ACA. Additionally, over the past year, there has been a growing inventory of products—software, system design specifications, and other resources, such as model contracting language—available for states to adopt and adapt to speed the development of new or enhanced systems. States are being encouraged to use these resources and to tap the growing body of knowledge developed by leader states.

After experiencing the impacts of the worst economic downturn since the Great Depression, states finally began to see signs of economic recovery. Throughout 2012, states experienced positive revenue growth and Medicaid enrollment and spending growth slowed. While states continued to face cost pressures, with small improvements in the economy, they had more latitude to consider positive program changes and were less likely to propose deep cuts.[2]

III. About this Survey

This twelfth annual report examines states' current Medicaid and CHIP eligibility and enrollment policies and highlights further progress states will need to make in the coming year to implement the provisions of the ACA. Conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, it provides detailed results from a 50-state survey of eligibility, enrollment, renewal, and cost-sharing policies in Medicaid and CHIP. The survey is based on in-depth telephone interviews with state Medicaid and CHIP officials, and the data were verified through follow-up communications via email and phone.

The report identifies changes implemented during 2012 and policies in place as of January 1, 2013. The survey examines eligibility for children, pregnant women, parents, and other non-disabled adults through Medicaid, CHIP, and Section 1115 waivers. Changes to buy-in programs are identified but are not incorporated in the overall counts of changes since they do not receive any federal Medicaid or CHIP financing; data on other state-funded programs are not included. The report also presents data pertaining to states' Medicaid and CHIP application, enrollment, and renewal procedures and cost-sharing requirements. In some instances, the data are more extensive for children, primarily because states have targeted their expansions and streamlining efforts to this population. For state-specific information, see the tables at the end of the report.

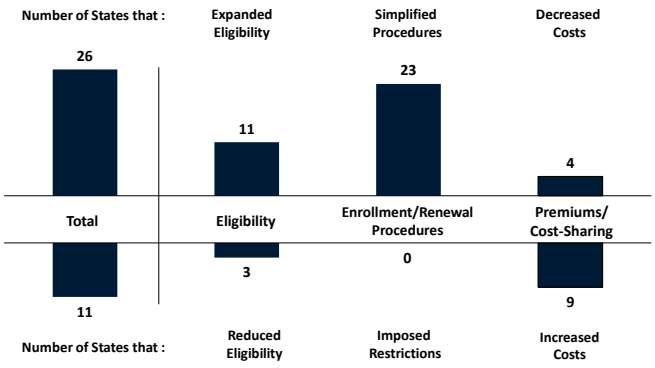
Each year, the survey instrument is updated to reflect emerging trends in states, as well as new coverage opportunities and federal policy options. Understanding the important role technology will play in streamlining the eligibility process, additional questions were included in this year's survey to examine IT system improvements in the states. Also, in recognition of the ongoing need for consumer assistance in securing coverage, data were collected on states' current consumer assistance resources. In addition, the survey continues to track the adoption of new coverage and enrollment streamlining options provided by the ACA and the 2009 Children's Health Insurance Program Reauthorization Act (CHIPRA).

IV. Key Findings

In 2012, state focus shifted to making wider-ranging reforms to prepare for the ACA, although a number of states continued to make targeted program improvements. As seen in earlier years, a number of states made incremental changes, often utilizing new options provided by CHIPRA and the ACA. States made more positive improvements than adverse changes, often capitalizing on technology to gain administrative efficiencies and reduce paperwork (Figure 8). However, 2012 was a key juncture for states, as a number shifted into high gear to prepare for implementation of the major provisions of the ACA. Many states moved beyond incremental changes to concentrate on more sweeping transformation of their IT infrastructure and procedures to prepare their systems and processes to meet new requirements under the ACA.

Figure 8

State Medicaid and CHIP Policy Actions for Low-Income Families, January 2012 – January 2013



Notes: Includes policy changes affecting children, pregnant women, parents, and childless adults. Does not include changes for elderly individuals or individuals with disabilities.
SOURCE: Based on the results of a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2013.

A. Medicaid and CHIP Eligibility for Families and Individuals

The ACA strengthens Medicaid and CHIP coverage for children and expands eligibility for their parents and other adults. As part of a continuum of affordable insurance options for those who are uninsured, the ACA extends Medicaid to a new minimum eligibility floor of 138 percent of the FPL, initially with 100 percent federal funding, phasing down to 90 percent over time. This expansion ends the historic exclusion of adults without dependent children from the program. However, as noted, the Supreme Court's ruling to limit the federal government's authority to enforce the expansion effectively makes its implementation a state choice. The ACA also includes "maintenance-of-effort" provisions that protect ongoing coverage of low- and moderate-income children and families by requiring states to maintain eligibility and enrollment policies until the coverage provisions of the ACA are implemented. In addition, the ACA and CHIPRA provided new coverage options to states.

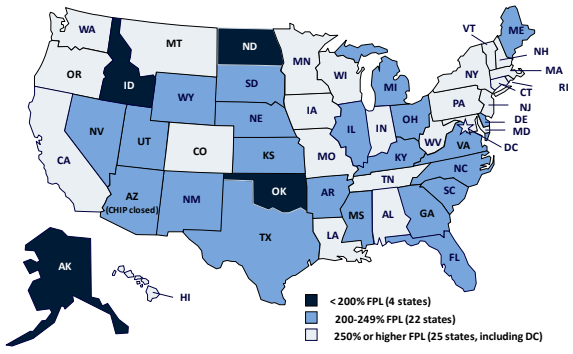
Amid this policy environment, during 2012, eligibility levels for children and pregnant women remained stable and strong, with some states making additional improvements. However, consistent with earlier years, coverage for adults continues to lag far behind, and a handful of states cut back eligibility in areas not protected by the federal requirement to maintain coverage.

Eligibility for Children and Pregnant Women

Medicaid and CHIP continued to serve as primary sources of coverage for children and pregnant women. In 2012, eligibility remained stable for children and pregnant women in all states—a reflection of the federal maintenance-of-effort requirement—and was strengthened in ten (10) states that made targeted coverage improvements. A majority of these advancements (9) extended coverage to more children, often through new options provided by CHIPRA and the ACA. As of January 1, 2013, half of the states (25, including DC) cover children in families with income at or above 250 percent of the FPL ($47,725 for a family of three in 2012) and 17, including DC, cover uninsured children in families with income at or above 300 percent of the FPL ($57,270 for a family of three) (Figure 9). Moreover, 39 states, including DC, cover pregnant women at or above 185 percent of the FPL ($35,317 for a family of three in 2012) (Figure 10). And, with the addition of Nebraska in 2012, 15 states have adopted the unborn child option to use CHIP funds to provide care to pregnant women not otherwise eligible for Medicaid.

Figure 9

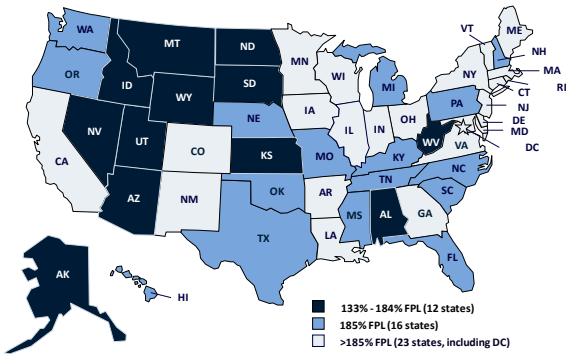
Children's Eligibility for Medicaid/CHIP by Income, January 2013



NOTE: The federal poverty line (FPL) for a family of three in 2012 is $19,090 per year. OK has a premium assistance program for select children up to 200% of the FPL. AZ's CHIP program is currently closed to new enrollment.
SOURCE: Based on the results of a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2013.

Figure 10

Eligibility for Pregnant Women in Medicaid/CHIP by Income, January 2013



NOTE: The federal poverty line (FPL) for a family of three in 2012 is $19,090 per year.
SOURCE: Based on the results of a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2013.

A few states have transitioned coverage for children from CHIP to Medicaid in advance of the ACA requirement to align minimum Medicaid eligibility thresholds. Under existing rules, states must, at a minimum, provide Medicaid to children under age six with family income up to 133 percent of the FPL and to children age six through eighteen with family income up to 100 percent of the FPL. In 2014, all children with family income up to 133 percent of the FPL will be covered in Medicaid regardless of age. Colorado made this transition early, on January 1, 2013. Moreover, while not required by the ACA, two (2) states (CA and NH) ended or are phasing out their separate CHIP programs and moving all children covered by CHIP into Medicaid.[3] An additional 19 states with separate CHIP programs will need to shift older children with family income between 100 to 133 percent of the FPL from their separate CHIP programs to Medicaid by 2014.

Twelve states have adopted the ACA option to cover dependents of state employees in CHIP. Prior to the ACA, dependents of state employees could not be covered through CHIP with federal funds. Under the new option, states can receive federal match to cover these children if they have maintained their contribution levels for health coverage for employees with dependent coverage or can demonstrate that state employees' out-of-pocket health care costs exceed five percent of family income.[4] With the addition of three (3) states (CO, FL, and VT) in 2012, a total of 12 states have now adopted this option, providing low- and moderate-income families a new source of affordable coverage for their children.

States continue to adopt the CHIPRA option to cover lawfully-residing immigrant children and pregnant women in Medicaid and CHIP without a five-year waiting period. Prior to the 2009 CHIP reauthorization, coverage of lawfully-residing immigrants during the first five years of legal residence generally did not qualify for federal Medicaid or CHIP matching funds. CHIPRA gave states the option to eliminate this waiting period for children and pregnant women, although not for other adults. In 2012, four (4) states (MA (CHIP), PA, VA (Medicaid), and VT (CHIP)) picked up the option for children and two (2) states (PA and VA) adopted the option for pregnant women. As a result, as of January 1, 2013, half of states (25) have taken up this option for children in Medicaid or CHIP and 20 have done so for pregnant women. Under the ACA, outside of states taking up this option for pregnant women and children, the five-year waiting period for Medicaid and CHIP will remain in place. Lawfully-residing immigrants will be eligible for subsidized coverage in the exchanges during this waiting period; however, the coverage will likely be less affordable and comprehensive than Medicaid and CHIP coverage.

There has been a decline in buy-in programs that enable parents to enroll children with family income above income eligibility limits into Medicaid or CHIP by paying the full cost of coverage. The buy-in program available in New Hampshire ended in 2012, joining programs in two other states that ended in 2011. As a result, as of January 1, 2013, in 12 states, families with incomes above Medicaid and CHIP thresholds can buy into coverage for their children. These remaining programs may be phased out once the ACA is implemented and subsidized coverage in the exchanges becomes available for many of those children in the income groups typically covered through buy-in programs.

While most states (38) continue to require that children be uninsured for a period of time prior to enrolling in CHIP, three (3) states (MN, NH, and VT) reduced their waiting periods during 2012. Vermont eliminated its waiting period as did New Hampshire, when it moved children covered through its separate CHIP program to Medicaid; Minnesota raised the income limit of children subject to its waiting period. States have often used waiting periods to meet the federal requirement that CHIP not substitute for private insurance. A majority of states offers "good cause" exemptions (such as loss of a job) to the waiting period and 20 allow a child to enroll in coverage right away if the cost of private coverage exceeds a specific affordability threshold (i.e., if costs exceed a particular share of income). However, it is unclear what will happen the remaining waiting periods under the ACA, when everyone is expected to secure coverage.

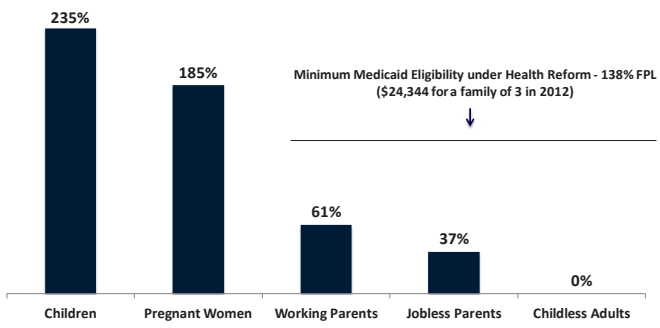
In 2012, Arizona enrolled a limited number of children through a new waiver coverage option, but its CHIP program remains closed to new enrollment. In December 2009, prior to the enactment of the ACA, Arizona implemented an enrollment freeze in its CHIP program, KidsCare, which covers children up to 200 percent of the FPL. It has not enrolled any new children in the program since that time and enrollment in the program fell from 46,886 in December 2009 to 10,792 as of April 2012.[5] In May 2012, the state implemented a new waiver program, KidsCare II, available to eligible children with family income between 100 and 175 percent of the FPL. Enrollment in this program is limited based on available funding and will extend through December 31, 2013, when these children will likely transition to coverage through the exchange.[6]

Eligibility for Parents and Adults

Medicaid eligibility for parents and adults continues to lag far behind that of children. Parent eligibility levels for Medicaid remain well below levels for children, with the median level at just 61 percent of the FPL compared to 235 percent of the FPL for children (Figure 11). Moreover, most states currently do not provide coverage to adults without dependent children who do not qualify on the basis of a disability, regardless of how low their income is.

Figure 11

Median Medicaid/CHIP Eligibility Thresholds, January 2013

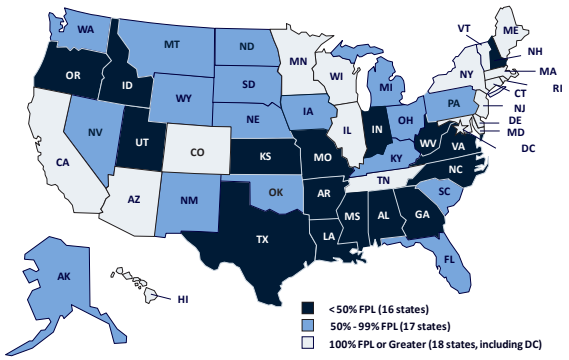


SOURCE: Based on the results of a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2013.

As of January 1, 2013, nearly two-thirds of states limit parent eligibility to less than the 100 percent of the FPL and most do not cover other low-income adults. A total of 33 states limit parent eligibility for Medicaid to less than the federal poverty level ($19,090 for a family of three in 2012), including 16 states that limit eligibility to parents earning less than 50 percent of the FPL ($9,545 for a family of three in 2012) (Figure 12). Coverage for other adults is even more limited. As of January 1, 2013, only nine (9) states (AZ, CO, CT, DE, DC, HI, MN, NY, and VT) provide benefits to low-income adults that are equivalent to Medicaid for parents (Figure 13). A number of states also provide more limited waiver coverage to parents at higher income levels (13 states) and childless adults (16 states), although enrollment is closed in many of these programs.

Figure 12

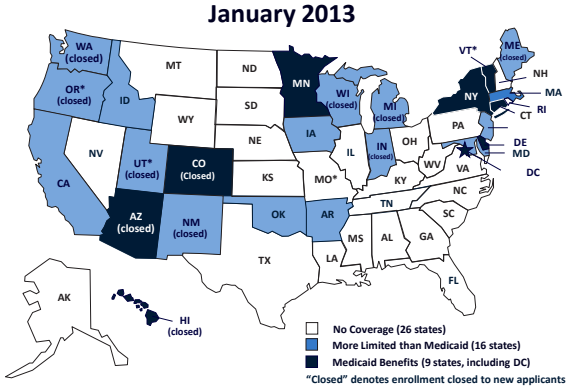
Medicaid Eligibility for Working Parents by Income, January 2013



NOTE: The federal poverty line (FPL) for a family of three in 2012 is $19,090 per year. Several states also offer coverage with a benefit package that is more limited than Medicaid to parents at higher income levels through waiver or state-funded coverage.
SOURCE: Based on the results of a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Ge orgetown University Center for Children and Families, 2013.

Figure 13

Coverage of Low-Income Adults by Scope of Coverage, January 2013



NOTE: Map identifies the broadest scope of coverage in the state. MN and VT also offer waiver coverage that is more limited than Medicaid. OR and UT also offer "premium assistance" with open enrollment. IL, LA, and MO offer coverage limited to adults residing in a single county or area.
SOURCE: Based on the results of a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2013.

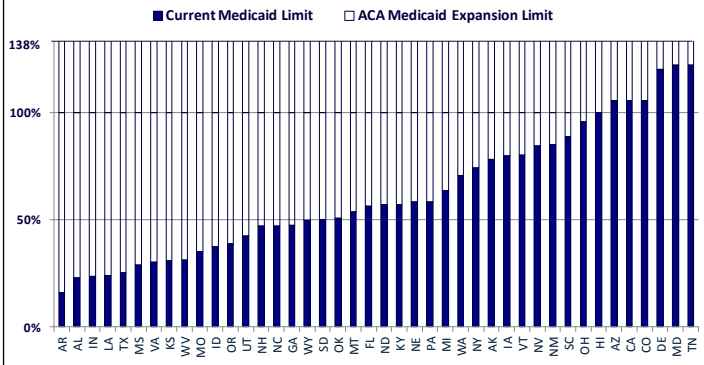
In 2012, three (3) states (HI, IL, and MN) reduced eligibility for parents or other adults. Hawaii rolled back coverage for parents and childless adults from 200 to 133 percent of the FPL, Illinois cut eligibility for parents from 185 to 133 percent of the FPL, and Minnesota reduced coverage for childless adults from 250 to 200 percent of the FPL.[7] These restrictions were made under an exemption to the maintenance-of-effort provision for coverage of adults above 133 percent of the FPL if a state has a documented budget deficit.[8] Despite these changes, coverage in these states remains above the median. In contrast to these reductions, Utah increased eligibility for its Section 1115 waiver premium assistance program for adults from 150 to 200 percent of the FPL.

Colorado expanded Medicaid to low-income adults in 2012, joining six other states that have implemented early expansions to adults since the enactment of the ACA. While the ACA Medicaid expansion, with its 100 percent federal funding, does not go into effect until January 2014, the ACA also provided states an option to get an early start on the expansion at their regular matching rate. Since the enactment of the ACA, seven (7) states (CA, CO, CT, DC, MN, NJ, and WA) began covering adults through the early expansion option or Section 1115 waiver authority, including Colorado, which began covering a limited number of childless adults in 2012. (Several additional states (MO, IL, and LA) implemented waiver expansions in a single county or area.) Nearly all of these states previously covered adults with state-only dollars, and transitioning this coverage to Medicaid enabled them to preserve and, in some cases, expand this coverage by securing federal matching funds.

A majority of states reported that they had not yet made a decision as to whether they will extend Medicaid to low-income adults in 2014. A number of states reported the decision will likely be addressed in the upcoming legislative session. Given the current limited eligibility levels, the Medicaid expansion would significantly increase eligibility for parents (Figure 14). Potential coverage gains are even larger for other adults. If a state does not implement the expansion, poor uninsured adults in that state would not gain a new affordable coverage option and likely remain uninsured. (See Text Box 2: The Medicaid Expansion to Low-Income Adults.)

Figure 14

Changes in Parent Medicaid Eligibility Under the ACA Medicaid Expansion, as a Percent of the Federal Poverty Level



NOTE: Ten states (CT, IL, ME, MA, MN, NJ, NY, RI, VT, WI) and DC already offer coverage to parents at or above 133% FPL; under the ACA an income disregard of 5 percentage points will be applied to this limit increasing the effective income limit to 138% FPL.
SOURCE: Based on the results of a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2013.

Text Box 2:
The Medicaid Expansion to Low-Income Adults

As part of a continuum of affordable insurance options, the ACA extends Medicaid eligibility to a new minimum eligibility floor of 138 percent of the FPL, with significant federal funding. This expansion would end the historic exclusion of low-income adults from Medicaid and fill their longstanding gap in coverage. In the absence of the Medicaid expansion, individuals with incomes at or above 100 percent of the FPL could be eligible for subsidies to purchase exchange coverage; however, those below poverty would not be eligible for subsidies. As such, they would not gain a new affordable coverage option and many would likely remain uninsured.

National analysis estimates that an additional 21.3 million people would enroll in Medicaid by 2022 if all states implement the Medicaid expansion and other coverage provisions of the ACA. With the Medicaid expansion and other coverage provisions in the ACA, the number of uninsured would be cut by 48 percent compared to what it would be without the ACA, and states with the highest uninsured rates would experience the steepest declines in the uninsured.

As states weigh the decision to expand, they will consider impacts on coverage as well as costs. With significant federal funding (initially at 100 percent, and phasing down to 90 percent over time) for those who are newly eligible, the federal government will fund the vast majority of increased Medicaid costs for the expansion. Some states are expected to see budget savings related to increased federal matching funds for populations that are currently covered under limited waiver programs, and some states will face costs associated with their share of the newly eligible, additional participation among currently eligible populations, and administrative costs. New state costs would be mitigated by savings from reductions in uncompensated care and other state spending for uninsured populations.

See "The Cost and Coverage Implications of the Medicaid Expansion: National and State-by-State Analysis," Kaiser Family Foundation, November 2012, available at http://www.kff.org/medicaid/8384.cfm for more details.

B. Harnessing Technology to Simplify Processes and Enhance Systems

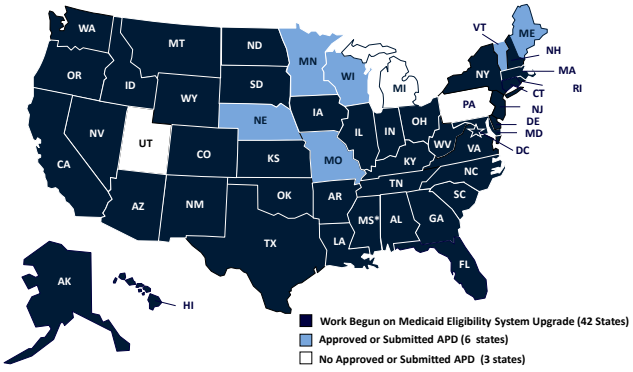
A primary goal of the ACA is to create a simple, real-time eligibility and enrollment process that uses electronic data to ease the paperwork burden on applicants and state agencies while expediting a determination. State government has been steadily adopting technology-based innovations to counterbalance diminishing administrative resources and staff by increasing efficiency. The ACA accelerates this evolution through the establishment of an electronic, "no-wrong-door" enrollment system for all insurance affordability programs, including Medicaid, CHIP, and the exchanges, which will become effective in 2014.

Implementation of this system requires substantial investments in IT infrastructure at a time when state fiscal situations remain constrained. Recognizing the need for financial support, the federal government provided a time-limited 90 percent federal match for development of Medicaid systems and 100 percent federal funding for exchange IT development. Moreover, to expedite system development, the federal government is encouraging states to take advantage of software and the growing body of resources and experience accumulated by those states that are leading the way in building new systems through early innovator or exchange establishment grants. To support reuse of knowledge and resources, states are posting information in a shared environment known as the Collaborative Application Lifecycle Management Tool (CALT) that is accessible to all exchange, Medicaid, and CHIP programs. Utilizing these federal resources and supports, states are working to replace outdated legacy-based mainframe computers and to enhance newer systems with additional consumer features and automated processes.

States are tapping the considerable federal funding available for IT development to build high-performing eligibility and enrollment systems. As of January 1, 2013, nearly all states have either submitted or received approval of an advanced planning document (APD) to institute a Medicaid system upgrade, and 42 have begun work on their projects (Figure 15). Independent of their decisions to build a state-based exchange or expand Medicaid, states will need to prepare their systems for new eligibility, verification, and renewal requirements. In 2014, the systems must not only have the capability to determine eligibility based on MAGI, they must also implement new data-driven verification processes intended to deliver real-time eligibility determinations and coordinate with exchanges.

Figure 15

Status of Major Medicaid Eligibility System Upgrades, January 2013

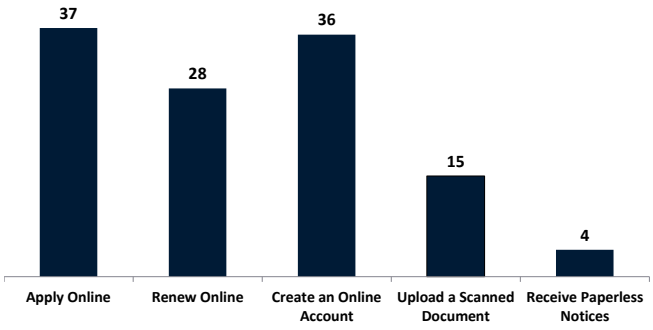


NOTE: "APD" refers to an Expedited Advanced Planning Document. MS has begun work on upgrading its Medicaid eligibility systems without submitting an APD.
SOURCE: Based on the results of a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2013.

During 2012, a number of states enhanced online tools and capabilities, facilitating families' access to coverage and creating administrative efficiencies. Four (4) states (KS, MI, MN, and VA) launched online applications for one or more groups in 2012, increasing the total number of states accepting electronically submitted Medicaid or CHIP applications to 37. All but one of these states (IL) accepts electronic signatures with the adoption of electronic signatures in West Virginia in 2012. Additionally, more than half of states (28) allow families to renew online with the addition of eight (8) that began offering online renewals in Medicaid or CHIP during 2012 (CA, DE, GA, ME, NH, ND, TX, and VA) (Figure 16). Under the ACA, all states will need to provide online enrollment and renewal options as of 2014.

Figure 16

Number of States with Selected Online Application and Renewal Capabilities in Medicaid and/or CHIP, January 2013



SOURCE: Based on preliminary results from a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2013.

Over two-thirds of states (36) provide individuals an option to create an online account in Medicaid or CHIP. While not all online applications or renewals are linked to a personal online account today, moving forward it is likely that these accounts will serve as access points to apply for and renew coverage as well as perform other tasks. Currently, almost all states have an online account that offers the functionality to start, stop, and return to an application, while less than half have advanced features, such as reviewing the status of an application or reporting changes. Although not required by the ACA, creating online accounts with robust functionality such as receiving electronic notices (currently available in four (4) states) and uploading scanned or electronic images of documents (currently available in 15 states) will help maximize the efficiency and cost savings offered by the web-based environment.

Illustrating the effectiveness of electronic verification, nearly all states have adopted a data match with the SSA to verify citizenship as of January 1, 2013. In 2012, two (2) states (GA (Medicaid) and IN) added the SSA data match, bringing the total to 45 states that have eliminated an extensive paper-based citizenship documentation process in favor of a real-time lookup or an automated "batch" process that confirms citizenship status on hundreds or thousands of individual records overnight utilizing SSA data. Under the ACA, the use of electronic data sources will speed up the verification process and reduce the paperwork burden on eligibility workers and families. Beginning in 2014, access to citizenship data will be handled through the new federal hub that will provide this and other data such as immigration status and income from federal tax returns. Although the federal hub will be a new resource, 11 states already have facilitated access to multiple sources of data through their own state hubs or alternative types of data brokering systems. Other states will likely look at these models as they implement links to electronic data sources, such as quarterly wage or unemployment databases. However, paper still remains the predominant method currently used by states to verify income information; thus, movement to electronic verification under the ACA will represent a major procedural and cultural change in many states. (See Text Box 3: Moving to Data-Driven, Real-Time Verification of Eligibility.)

Text Box 3:
Moving to Data-Driven, Real-Time Verification of Eligibility

One of the most significant aspects of the ACA is its transformation of the verification process. Beginning in 2014:

States must rely, to the maximum extent possible, on electronic data matches to verify information and minimize the need for paper documentation. States are expressly permitted to accept self-attestation of all Medicaid eligibility criteria, except for citizenship and immigration status. However, through electronic data matches, they are expected to request specific information related to financial eligibility from other state and federal agencies to the extent they determine such information is useful. The Secretary will establish a secure electronic verification system, or federal hub, through which Medicaid and other insurance affordability programs can verify information. States can no longer request paper documentation from individuals at application or renewal unless they are unable to verify criteria through electronic data matches.

If information provided by an individual is "reasonably compatible" with that obtained from other sources, the agency must determine or renew eligibility without requiring additional documentation. For Medicaid, data is considered reasonably compatible if information obtained through an electronic data match and provided by the individual are both above, at, or below the eligibility limit for coverage. States do, however, have flexibility in further defining reasonable compatibility, as well as determining if a particular data source is "useful." If the agency is unable to obtain information electronically, or if the information is not reasonably compatible, the agency may contact the individual and accept the individual's reasonable explanation of the discrepancy or require additional information, including documentation.

States must develop and maintain current verification plans. Each state must develop a verification plan describing its verification policies and procedures, including the standards applied by the state to determine the usefulness of information from possible electronic data sources. The verification plans must be available to the Secretary upon request, enabling oversight of state implementation of the new verification standards, and will be used for quality and audit purposes going forward.

Coordination between Medicaid and the individual exchange will be important to achieving the ACA's no wrong door approach and limiting duplicative verification. The ACA establishes a vision of a seamless application and renewal process regardless of where or how someone applies. However, states have flexibility to decide whether the exchange will determine eligibility for Medicaid or assess potential Medicaid eligibility and transfer the client's electronic account to the Medicaid agency for a final eligibility determination. In order to minimize requests of information from individuals in transferred cases, the Medicaid agency may not request any information or documentation that has already been provided to the exchange. States also are required to electronically track these transfers to ensure they are successfully processed, which will be particularly important for family members who receive coverage through different sources and when circumstances result in a change in coverage.

States are deploying document imaging systems to advance the transition to a paperless environment and allow for easier information sharing across the state and with other programs. While electronic verification may not eliminate paper documentation entirely, the use of document imaging systems will make managing paperwork more efficient. Even with the most current and reliable data sources, people will always have changes in circumstances that impact eligibility and cannot be immediately verified electronically. While states have the option to accept self-attestation, they may also choose to require documentation. To that end, electronic storage of documents is useful for facilitating access to information previously contained in a paper file in a single location. More than half of states (30) have a document imaging system statewide in either Medicaid or CHIP, while 22 states have it in both programs. The extent to which these systems currently are linked to online client accounts is not clear. In 2014, document imaging will need to be fully integrated into the client account to enable states to coordinate coverage by transferring electronic client accounts across insurance affordability programs, including all notices and verification documents.

C. Connecting Families to Coverage by Enhancing Consumer Assistance and Simplifying Enrollment and Renewal Processes

Achieving the ACA's goal of substantially reducing the number of uninsured will entail more than increasing affordable coverage options. With most uninsured people becoming eligible for coverage, the focus of the administrative process must shift from excluding ineligible people from programs to matching individuals to the appropriate coverage option. This new paradigm necessitates an approach that welcomes people into coverage and eliminates known barriers to enrollment and retention. Past state experience in Medicaid and CHIP points to the importance of outreach and enrollment assistance as well as simplified processes for translating eligibility into coverage gains.

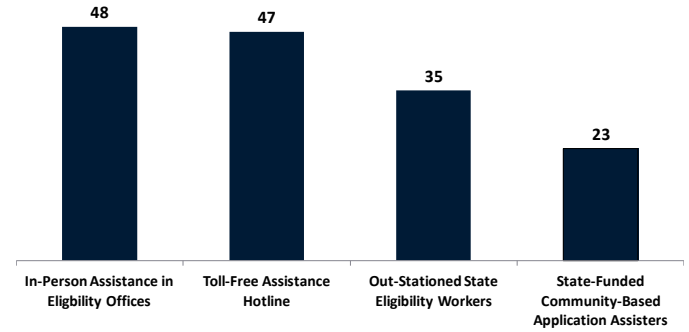
Consumer Assistance

States that have achieved success in covering children or implementing broader coverage expansions credit outreach and consumer assistance as key strategies contributing to their coverage gains. As expanded insurance options become available, the importance of outreach and consumer assistance to help eligible families and individuals enroll will grow. Even with consumer-friendly online applications, some consumers will want or need direct, one-on-one support. The ACA recognizes this by boosting requirements for consumer assistance accessible for all individuals, including people with disabilities or limited English proficiency.

States will build on their existing base of consumer assistance resources to connect families to coverage as millions become eligible for expanded insurance options. Currently, nearly all states offer in-person assistance in eligibility offices (48) and/or offer a toll-free hotline (47) to help consumers enroll in Medicaid or CHIP. A significant number also use out-stationed state eligibility workers or fund community-based application assisters to provide assistance in places other than government offices (Figure 17). Under the ACA, Medicaid agencies must provide assistance to any individual seeking help with the application or renewal process in-person, over the telephone, and online. Moreover, exchanges will be required to operate call centers and provide consumer assistance, including a navigator program to conduct outreach and assist vulnerable populations with enrollment in coverage.[9] It will be important for states to coordinate services across the different agencies to achieve the most effective consumer assistance.

Figure 17

Number of States with Selected Outreach and Enrollment Assistance Resources in Medicaid and/or CHIP, January 2013



SOURCE: Based on preliminary results from a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2013.

Simplified Enrollment and Renewal Processes

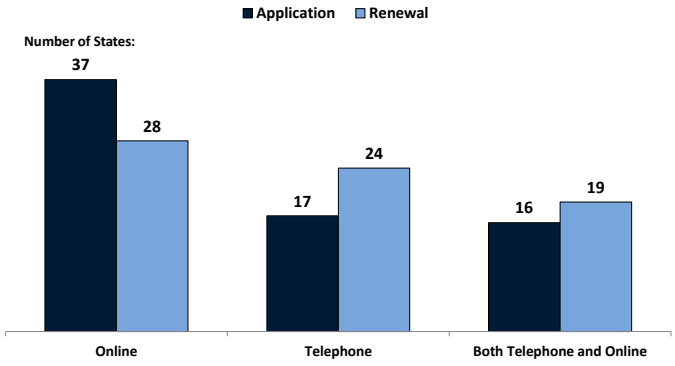
Past Medicaid and CHIP experience in connecting children to coverage demonstrates the importance of a welcoming approach that makes it easy to get and stay enrolled. States have been moving in this direction incrementally, and the ACA employs lessons learned from state successes to further transform how families will gain and retain coverage. In addition, applying lessons learned from state advances in coordinating children's coverage between Medicaid and separate CHIP programs, the ACA establishes "no wrong door" access so that regardless of where or how someone applies, all family members requesting coverage will be screened for and enrolled in or referred to the applicable insurance affordability program. To this end, states will be required to automatically transfer electronic client accounts as needed between the agencies that manage the different coverage options at application and renewal and as circumstances change.

In 2012, 23 states adopted proven simplifications and moved closer to the new ACA requirements by making positive changes to their enrollment or renewal policies or procedures. Moreover, CHIPRA established performance bonuses for states that adopt specified enrollment and renewal simplifications and increase enrollment of uninsured children. In 2012, nearly half of states (23) qualified for these CHIPRA performance bonuses, which totaled almost $306 million.

States are increasingly offering families multiple pathways to enrollment and renewal, as will be required under the ACA. Currently, all states allow for in-person or mail-in applications and renewals. In addition, 37 provide online applications in Medicaid or CHIP and 17 states accept telephone applications, with 16 offering both options. Moreover, following the adoption of telephone or online renewal options in nine (9) states during 2012, a total of 28 states provide online renewals in Medicaid or CHIP and 24 offer telephone renewals, with 19 offering both options (Figure 18). While there is significant emphasis on web-based enrollment under the ACA, the law recognizes that not everyone will have access to online resources and that some individuals may prefer to enroll through different avenues. As such, under the ACA, states must assure that families and individuals can access coverage using a variety of paths—including online, telephone, in-person, and mail—at application, renewal, or to report a change in circumstances.

Figure 18

Availability of Simplified Application and Renewal Methods in Medicaid and/or CHIP, January 2013



NOTE: SOURCE: Based on the results of a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2013.

While most states have already eliminated asset tests and face-to-face interview requirements for children, a number will need to remove these barriers for parents in the coming year. As of January 1, 2013, just four (4) states have asset tests and two (2) require face-to-face interviews for children. However, more states still have these requirements in place for parents, with 27 states imposing an asset test and six (6) requiring a face-to-face interview. Starting in 2014, the ACA no longer will allow either asset tests or face-to-face interviews to be applied to anyone eligible for coverage under the new MAGI-based categories.

State adoption of expedited enrollment strategies, including express lane eligibility (ELE) and presumptive eligibility (PE), continue to advance coverage. ELE allows states to rely on eligibility findings of other assistance programs to determine Medicaid and CHIP eligibility for children, providing administrative efficiencies and preventing families from having to provide the same information to multiple agencies. With one state (SC) taking up use of ELE at enrollment and four (4) states (CO, MA, NY, and UT) starting to use ELE at renewal during 2012, one-quarter of states (13) actively use ELE for children in Medicaid or CHIP as of January 1, 2013. In addition, through a Section 1115 waiver, Massachusetts began using ELE for parents and pregnant women during 2012, enabling the state to align its policies across family members. Going forward, the future of the ELE option is uncertain. Although it was scheduled to sunset in the third quarter of 2013, it was extended for one year through the "fiscal cliff" deal enacted at the beginning of 2013. PE is another tool that expedites connections to care by empowering qualified entities such as hospitals or community health centers to make preliminary eligibility decisions while the regular application process is being completed. With the addition of Utah in 2012, 17 states use PE for children as of January 1, 2013. Moreover, 32 states use PE to enroll pregnant women with the addition of Ohio in 2012. PE was broadened by the ACA to include adults, in addition to children and pregnant women and, as of 2014, all hospitals will have the option to use PE. As such, states will need to create a process to manage PE and may want to make it available through other community-based qualified entities.

To promote ongoing coverage, nearly all states have a 12-month renewal period for children in both Medicaid and CHIP (49) and their parents (46), which will be required for all states in 2014. Under the new eligibility and enrollment regulations, states will be required to review eligibility for groups determined eligible on a MAGI basis no more often than once every 12 months. This requirement already is met by most states, but several continue to require parents to report income at specific intervals within the 12-month period. While this routine reporting requirement is not as burdensome as completing a full renewal, it adds to the actions and paperwork currently required of both families and eligibility workers and will need to be eliminated by 2014.

Further strengthening the continuity of care, nearly two-thirds of states (32) provide 12-month continuous eligibility for children. Providing continuous coverage can promote more reliable access to needed health care services, which can result in better health outcomes. It also stretches administrative resources by reducing the number of enrollees that "churn" on and off coverage and the workload associated with repeated processing. States currently have the option to provide 12 months of continuous coverage to children, regardless of fluctuations in income, although not for adults in Medicaid—a disparity that is not changed by the ACA. As of January 1, 2013, 23 states provide 12-month continuous eligibility for children in Medicaid and 28 of the 38 states with separate CHIP programs have adopted this policy. New York also has Section 1115 waiver approval to provide 12-month continuous coverage to parents, pregnant women, and certain other adults, but has not yet implemented this policy.

A number of states facilitate continuous enrollment by using electronic data to support a more automated renewal process, as will be required in 2014. Over the years, there has been growing recognition that the traditional way of renewing coverage—requiring a new application and paper documentation of income—was cumbersome for families and inefficient for state agencies. The loss of Medicaid or CHIP coverage at renewal for administrative or paperwork reasons has been a persistent problem, resulting in churn that is costly for states. To help overcome these challenges, 20 Medicaid agencies and 16 CHIP programs currently conduct some type of administrative renewal process whereby families with no change in circumstances are not required to take action beyond confirming their desire to stay enrolled. With new eligibility and enrollment systems, states will have increased ability to verify

ongoing eligibility by capitalizing on access to electronic data sources. As such, beginning in 2014, states will be expected to review data and automatically renew enrollees who continue to qualify based on available information.

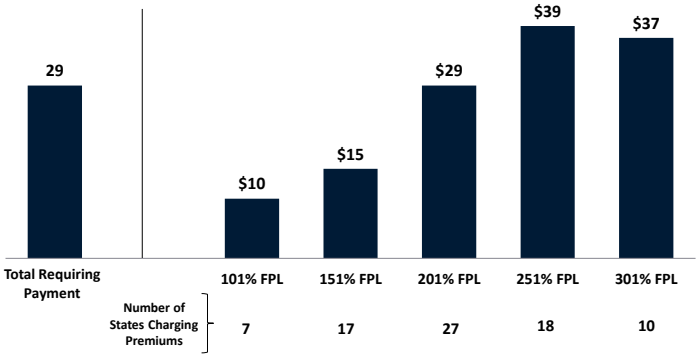
D. Keeping Coverage Affordable with Nominal Cost-Sharing Requirements

Medicaid and CHIP provide affordable coverage to families by limiting out-of-pocket costs, including premiums and other cost-sharing, to five percent of income. The ACA's maintenance-of-effort requirement also prevents states from raising premiums by more than modest increases tied to inflation, although it does not restrict states from increasing co-payments within existing federal guidelines.[10] As a result of these limitations, and the administrative cost of collecting nominal fees, only a small number of states increased premiums during 2012. However, states did impose higher co-payments to a greater extent than seen in years past, likely reflecting continuing fiscal strains.

Although more than half of states charge premiums for children's coverage, the amounts are often minimal and generally do not apply to those with the lowest incomes. As of January 1, 2013, 29 states charge premiums and four (4) states charge annual fees in their child health programs. However, few states require families living at or near the federal poverty line to pay premiums, with just seven (7) states requiring premiums for children at or below 101 percent of the FPL in their separate CHIP or Medicaid waiver programs (Figure 19).[11] In 2012, Minnesota raised the income level at which children in its waiver program must pay a premium to 200 percent of the FPL[12] and New Hampshire eliminated all premiums when moving children covered in its separate CHIP program into Medicaid. Alabama increased premiums by modest amounts tied to inflation as allowed under the ACA's premium protections. Twenty (20) of the 29 states charging premiums provide families with longer than the required 30-day grace period before their child loses coverage for non-payment. Following disenrollment for non-payment of premiums, 12 states impose a "lock-out" period during which time the child is barred from re-enrolling in the program. Twenty-three (23) states require families to reapply and 24 require families to repay outstanding premiums before a child can re-enroll in coverage.

Figure 19

Median Monthly Premiums, by Income, Among States with Premiums in Medicaid and CHIP, January 2013

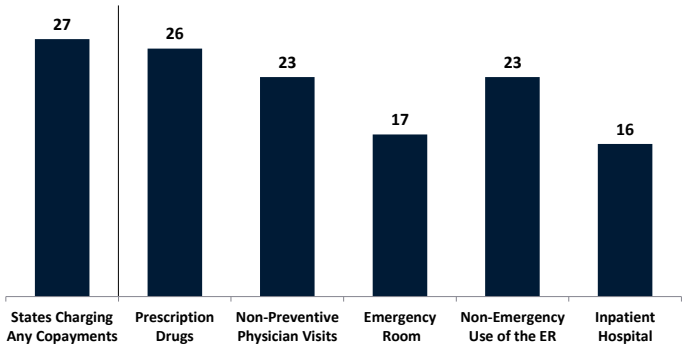


NOTE: Premiums listed at 201%, 251%, and 301% include states whose upper income levels are 200%, 250%, and 300% FPL. NV and UT require quarterly premiums. In NV, some children with income at or above 36% FPL may qualify for CHIP and are required to pay premiums.
SOURCE: Based on the results of a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2013.

Compared to prior years, a larger number of states ((5), AL, CO, GA, TX and UT) increased co-payments in their child health programs, while one (NH) decreased co-payments for children. As of January 1, 2013, three (3) states charge co-payments in their Medicaid expansions for children and 27 charge them in their separate CHIP programs. For children at 201% FPL, 26 states require co-payments for prescription drugs, 23 states require co-payments for non-preventive doctor visits, 17 require co-payments for emergency room care, 23 require co-payments for non-emergency use of the emergency room (which may be higher than those charged for an emergency), and 16 require co-payments for inpatient hospital care in their children's health programs (Figure 20).

Figure 20

States with Co-Payments for Selected Services for Children at 201% FPL, January 2013



NOTE: Includes states whose upper income level is 200% FPL. CA and CT do not provide coverage for non-emergency use of the ER.
SOURCE: Based on the results of a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2013.

Waiver coverage for parents and other adults often has premium requirements, which tend to be much higher than those charged for children. As states are not allowed to charge premiums in Medicaid below 150 percent of the FPL and eligibility for adults is often limited to lower income levels, only one state (WI) charges premiums to parents in Medicaid.[13] However, premiums and enrollment fees are more commonly charged in waiver coverage for adults, with 19 of 34 programs requiring premiums. During 2012, just one state, Wisconsin, increased premiums for adults above 133 percent of the FPL, which could otherwise have their coverage eliminated under the budget deficit exception to the maintenance of effort requirement. No state decreased premiums. Premiums tend to be much higher for adults compared to children at the same income levels.

Almost all states charge co-payments for parents and other adults, but few states increased the amounts in 2012. As of January 1, 2013, 39 states require co-payments from parents enrolled in Medicaid, while almost three-quarters of waiver coverage programs (26 of 34) for parents and/or other adults charge co-payments. Four (4) states (IL, PA, SD and VT) increased co-payments for parents or adults during 2012, while two (2) states decreased co-payments. Kansas eliminated all co-payments for parents and Vermont eliminated its co-payment for inpatient hospital visits for parents.

V. Conclusion

As states prepare for full implementation of the ACA, their focus is shifting to wide-ranging improvements in the administration of Medicaid and CHIP. As seen in earlier years, a number of states made incremental improvements and targeted eligibility expansions, often utilizing new options provided by CHIPRA and the ACA. On balance, states made more positive improvements than adverse changes, often capitalizing on technology to gain administrative efficiencies and reduce paperwork. However, 2012 was a key juncture for states, as implementation of the ACA was affirmed through the Supreme Court ruling and the 2012 elections, and many states shifted into high gear to prepare for implementation in 2014 through major IT system upgrades and procedural improvements.

Significant gaps in coverage persist for low-income parents and other adults that would be filled by the ACA Medicaid expansion. Continuing the trend of previous years, Medicaid and CHIP coverage for low-income children and pregnant women remains strong, while coverage for parents and other adults lags far behind. The stability of Medicaid and CHIP coverage for children and pregnant women largely reflects the ACA's maintenance-of-effort requirement that protects eligibility levels. In contrast, several states scaled back coverage for adults where it was not protected by the requirement. The ACA's Medicaid expansion to 138 percent of the FPL would significantly increase eligibility for parents and other adults in many states, filling their longstanding gap in coverage. However, if a state does not expand Medicaid, poor uninsured adults in that state will be left without a new affordable coverage option and likely remain uninsured.

States are moving closer to the ACA's goal of transforming the Medicaid enrollment experience into a real-time, electronically-based process that minimizes burdens on individuals and eligibility workers. The ACA establishes a streamlined "no wrong door" enrollment system for Medicaid, exchanges, and other insurance affordability programs by modernizing eligibility processes and shifting to reliance on electronic data rather than paper documentation. The approach aims to provide consumers with a straightforward enrollment experience that results in real-time determinations to the greatest extent possible. In preparation, states continue to streamline procedures and build new IT systems to automate procedures and create electronic data linkages. However, preparing for 2014 entails more than just upgrading Medicaid IT systems—many policy and procedural decisions will be embedded into these new systems and a variety of tasks previously performed manually will become automated. As such, the new paradigm will require states to reengineer their business practices, reassess staff roles, and realign expectations to the vision of a real-time, paperless process. In addition, even with sophisticated web-based enrollment systems in place, outreach and consumer assistance will remain important to successfully enrolling eligible individuals, and states will need to build on their existing resources.

Looking ahead, 2013 will be a pivotal year as states decide whether to expand Medicaid and move into final preparations for 2014. As states face a shrinking timeline to be ready for 2014, much work remains to be done and many key decisions still need to be made. The most significant decision facing many states in 2013 will be whether to close the gap in coverage for low-income adults by expanding Medicaid. In coming to a decision, they will weigh a variety of factors, including the coverage and fiscal impacts, which include potential net savings from reductions in uncompensated care and other spending on services for the uninsured.[14] Moreover, states face a number of outstanding questions as they finalize their systems and processes, including areas that require further federal information and clarification. In the coming months, states will be dealing with multiple issues such as deciding which sources of electronic data to tap, defining reasonable compatibility, developing their verification plans, and coordinating coverage with either their state-based exchange or the federally-facilitated exchange. As states continue to prepare for 2014, leveraging the experience of those leading the way and utilizing available federal resources and support will hasten their progress and heighten their readiness for 2014.

ENDNOTES

[1] The ruling removed the Department of Health and Human Services ability to withhold all Medicaid matching funds if a state does not expand Medicaid to adults up to 138 percent of the federal poverty level.
[2] Smith, V. et al. "Medicaid Today; Preparing for Tomorrow: A Look at State Medicaid Program Spending, Enrollment and Policy Trends." Kaiser Commission on Medicaid and the Uninsured (October 2012).
[3] California is in the process of moving children covered in the separate CHIP program (Healthy Families) into Medicaid (Medi-Cal). The transition will begin no sooner than on January 1, 2013. New Hampshire moved its children in August 2012.
[4] Mississippi and North Carolina do not provide any contribution for dependent coverage, therefore dependents of state employees have always been eligible for CHIP, assuming they meet the other eligibility criteria. Arkansas covers these children in its ARKids B waiver.
[5] M. Heberlein, J. Guyer, and C. Hope, "The Arizona KidsCare CHIP Enrollment Freeze: How Has it Impacted Enrollment and Families?" Kaiser Commission on Medicaid and the Uninsured (September 2011); and Arizona Health Care Cost Containment System (AHCCCS), "KidsCare Enrollment by Age, Gender and Ethnicity" (November 1, 2012).
[6] In reaching an agreement with CMS to establish additional funding streams for uncompensated care payments to certain hospitals and Indian health services, Arizona was required to use a portion of the funding to cover children waiting for the KidsCare program. The program is subject to intermittent enrollment freezes to keep enrollment within available funding levels. For more, see Arizona Health Care Cost Containment System, "AHCCCS Receives Approval of Two Important Waiver Amendments," available at: http://www.azahcccs.gov/applicants/Downloads/KidsCareII/WebSNCP_AIOverview%203_2.pdf
[7] In an August 1, 2012 State Plan Amendment, Maine requested to roll back eligibility for parents to 100 percent of the FPL. Under the exception to the maintenance-of-effort requirements, the state could reduce eligibility to 133 percent FPL because of its budget deficit; however, CMS has yet to make a final ruling on whether the state can further limit coverage below the 133 percent FPL threshold. The state is awaiting full approval prior to making any eligibility change.
[8] For details, see C. Mann, Director of Centers for Medicaid and CHIP Services letter to State Medicaid Directors, SMDL #11-001 (February 25, 2011).
[9] In states where a federally-facilitated exchange (FFE) will operate, the FFE will provide consumer assistance (unless a state opts for the FFE partnership model) and operate the call center.
[10] In general, premium increases are not allowable under the protections in the ACA; however, given the longer time frame of the requirements to maintain coverage, CMS permits them under certain conditions. For example, states that have explicit language in their approved state plan authorizing automatic increases would not be considered in violation of the provision for increasing their premiums. In addition, states may adopt premiums for new coverage groups as well as make adjustments based on inflation.
[11] States cannot impose any cost-sharing on children in Medicaid below 150 percent of the FPL except in a narrow range of circumstances. However, states have more flexibility to impose cost-sharing in separate CHIP programs. For more details, see Georgetown University Center for Children and Families, "Cost-Sharing for Children and Families in Medicaid and CHIP" (March 2009).
[12] Under its MinnesotaCare 1115 waiver, all children with family income below 150 percent of the FPL had been required to pay premiums of $4 per child, per month.
[13] J. Guyer and J. Paradise, "Explaining Health Reform: Benefits and Cost-Sharing for Adult Medicaid Beneficiaries," Kaiser Family Foundation (August 2010).
[14] J. Holahan, *et al.,* "The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis," Kaiser Commission on Medicaid and the Uninsured (November 2012).

VI. Trend and State-by-State Tables

Table A
Expanding Eligibility and Simplifying Enrollment:
Trends in Children's Health Coverage Programs
July 1997 to January 2013

	Program	July 1997	November 1998	July 2000	January 2002	April 2003	July 2004	July 2005	July 2006	January 2008	January 2009	December 2009	January 2011	January 2012	January 2013
Cover children ≥200% FPL[1]	**N/A**	6	22	36	40	39	39	41	41	45	44	47	47	47	47
Cover children ≥300% FPL[1]	**N/A**	2	4	5	6	6	6	6	8	9	10	16	16	17	17
Cover lawfully-residing immigrants without 5-year wait	**N/A**	option not available										17	21	24	25
Joint Medicaid/ CHIP application	**N/A**	N/A	not collected	28	33	34	34	34	33	33	35	36	36	36	36
Application can be submitted online	**Medicaid**	not collected											32	34	36
	CHIP												27	30	30
Asset test not required	**Medicaid**	36	40	42	45	45	46	47	47	47	47	48	48	48	48
	CHIP		17	31	34	34	33	33	34	35	36	37	36	37	36
Presumptive eligibility	**Medicaid**	option not available	6	8	9	7	8	9	9	14	14	14	16	16	17
	CHIP		0	4	5	4	6	6	6	9	9	9	10	11	12
SSA match for citizenship verification	**Medicaid**	option not available											29	41	42
	CHIP												21	31	30
No face-to-face interview at enrollment	**Medicaid**	22	33	40	47	46	45	45	46	46	48	48	49	49	49
	CHIP		not collected	31	34	33	33	33	33	34	38	38	37	38	37
No face-to-face interview at renewal	**Medicaid**	not collected		43	48	49	48	48	48	48	49	50	50	50	50
	CHIP			32	34	35	35	35	35	36	38	38	37	38	37
12-month continuous eligibility	**Medicaid**	option not available	10	14	18	15	15	17	16	16	18	22	23	23	23
	CHIP		not collected	22	23	21	21	24	25	27	30	30	28	28	27
Enrollment freeze[2]	**Medicaid**	not collected			0	1	1	1	1	1	1	1	0	0	0
	CHIP				3	2	7	3	1	2	0	2	1	1	1

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Center on Budget and Policy Priorities, 1997-2009; and with the Georgetown University Center for Children and Families, 2011-2013.
The numbers in this table reflect the net change in actions taken by states from year to year. Specific strategies may be adopted and retracted by several states during a given year.
1. These counts do not include states that may have provided cvoerage above the levels shown using state-only funding.
2. States are not allowed to impose enrollment limits or caps in their Medicaid programs, except under a waiver.

Table B
Expanding Eligibility and Simplifying Enrollment:
Trends in Health Coverage for Parents
January 2002 to January 2013

	January 2002	April 2003	July 2004	July 2005	July 2006	January 2008	January 2009	December 2009	January 2011	January 2012	January 2013
Cover working parents ≥ 100% FPL	20	16	17	17	16	18	18	17	18	18	18
Family application	23	25	27	27	27	28	31	27	29	31	31
Asset test not required	19	21	22	22	21	22	23	24	24	24	24
SSA match for citizenship verification	option not available								27	41	41
No face-to-face interview at enrollment	35	36	36	36	39	40	41	41	44	45	45
No face-to-face interview at renewal	35	42	42	43	45	46	46	46	46	48	48
12-month eligibility period	38	38	36	36	39	40	40	43	45	46	46

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Center on Budget and Policy Priorities, 1997-2009; and with the Georgetown University Center for Children and Families, 2010-2013.
Data reflect coverage under 1931 Medicaid and not waiver or state-funded coverage.

Table 1
Income Eligibility Limits for Children's Health Coverage as a Percent of the Federal Poverty Level (FPL)
January 2013

State	Upper Income Limit[2]	Medicaid for Infants Ages 0-1[1]		Medicaid for Children Ages 1-5[1]		Medicaid for Children Ages 6-19[1]		Separate CHIP Ages 0-19[2] (Percent of the FPL)
		Medicaid (Title XIX) Funding	CHIP (Title XXI) Funding	Medicaid (Title XIX) Funding	CHIP (Title XXI) Funding	Medicaid (Title XIX) Funding	CHIP (Title XXI) Funding	
Total								**38**
Alabama	300%	133%		133%		100%		300%
Alaska	175%	150%	175%	150%	175%	150%	175%	
Arizona[3] ▲	200% ***(closed)***	140%		133%		100%		200% ***(closed)***
Arkansas	200%	133%	200%	133%	200%	100%	200%	
California[4, 5, 6]	250%	200%		133%		100%		250%
Colorado[7]	250%	133%		133%		133%		250%
Connecticut[8]	300%	185%		185%		185%		300%
Delaware	200%	185%	200%	133%		100%		200%
District of Columbia	300%	185%	300%	133%	300%	100%	300%	
Florida[8, 9]	200%	185%	200%	133%		100%		200%
Georgia[10]	235%	185%		133%		100%		235%
Hawaii	300%	185%	300%	133%	300%	100%	300%	
Idaho	185%	133%		133%		100%	133%	185%
Illinois[10, 11]	200% (300%)	133%	200%	133%		100%	133%	200% (300%)
Indiana	250%	200%		133%	150%	100%	150%	250%
Iowa	300%	133%	300%	133%		100%	133%	300%
Kansas[12]	232%	150%		133%		100%		232%
Kentucky	200%	185%		133%	150%	100%	150%	200%
Louisiana	250%	133%	200%	133%	200%	100%	200%	250%
Maine[8, 13]	200%	185%		133%	150%	125%	150%	200%
Maryland	300%	185%	300%	133%	300%	100%	300%	
Massachusetts[8]	300%	185%	200%	133%	150%	114%	150%	300%
Michigan[14]	200%	185%		150%		150%		200%
Minnesota[8,15]	275%	275%	280%	275%		275%		
Mississippi	200%	185%		133%		100%		200%
Missouri	300%	185%		133%	150%	100%	150%	300%
Montana	250%	133%		133%		100%	133%	250%
Nebraska	200%	150%	200%	133%	200%	100%	200%	
Nevada	200%	133%		133%		100%		200%
New Hampshire[7, 16]	300%	185%	300%	185%	300%	185%	300%	
New Jersey[8]	350%	185%	200%	133%		100%	133%	350%
New Mexico	235%	185%	235%	185%	235%	185%	235%	
New York[8]	400%	200%		133%		100%	133%	400%
North Carolina[8]	200%	185%	200%	133%	200%	100%		200%
North Dakota[4]	160%	133%	100%	133%	100%	100%	100%	160%
Ohio	200%	150%	200%	150%	200%	150%	200%	
Oklahoma	185%	133%	185%	133%	185%	100%	185%	
Oregon[8, 17]	300%	133%		133%		100%		300%
Pennsylvania[8]	300%	185%		133%		100%		300%
Rhode Island[18]	250%	185%	250%	133%	250%	100%	250%	
South Carolina	200%	150%	200%	150%	200%	150%	200%	
South Dakota	200%	133%	140%	133%	140%	100%	140%	200%
Tennessee[8, 19]	250%	185%		133%		100%		250%
Texas	200%	185%		133%		100%		200%
Utah	200%	133%		133%		100%		200%
Vermont[20]	300%	225%		225%		225%		300%
Virginia[21]	200%	133%		133%		100%	133%	200%
Washington[10]	300%	200%		200%		200%		300%
West Virginia	300%	150%		133%		100%		300%
Wisconsin[8]	300%	300%		185%		100%	150%	300%
Wyoming	200%	133%		133%		100%		200%

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2013.

▲Indicates that a state has expanded eligibility in at least one of its children's health insurance programs between January 1, 2012 and January 1, 2013.

Table presents rules in effect as of January 1, 2013.

Table 1 Notes

1. The income eligibility levels noted may refer to gross or net income depending on the state. Income eligibility levels listed include "regular" Medicaid (Title XIX) where states receive "regular" Medicaid matching payments and any CHIP-funded Medicaid expansion program (Title XXI) where the state receives the enhanced CHIP matching payments for these children. To be eligible in the infant category, a child has not yet reached his or her first birthday; to be eligible in the 1-5 category, the child is age one or older, but has not yet reached his or her sixth birthday; and to be eligible in the 6-19 category, the child is age six or older, but has not yet reached his or her 19th birthday.
2. The states noted use federal CHIP funds to operate separate child health insurance programs for children not eligible for Medicaid. Such programs may provide benefits similar to Medicaid or they may provide a limited benefit package. They also may impose premiums or other cost-sharing obligations on some or all families with eligible children. These programs typically provide coverage through the child's 19th birthday.
3. Arizona instituted an enrollment freeze in its CHIP program, KidsCare, on December 21, 2009. The program remains closed to new applicants. The state opened a new program (KidsCare II) on May 1, 2012. In order to be eligible, a child must have family income between 100% and 175% FPL. Enrollment is limited subject to available funding. The program will end on December 31, 2013, and new children will be added until the funding limit is reached.
4. In California and North Dakota, Title XXI funding was used to eliminate the asset test.
5. Infants born to mothers in California's Access for Infants and Mothers (AIM) program are automatically enrolled in CHIP. The income guideline for these infants, through their second birthday, is 300% of the FPL.
6. California is in the process of moving children covered in the separate CHIP program (Healthy Families) into Medicaid (Medi-Cal). The transition began on January 1, 2013, and will continue over the course of 2013 in a phased approach.
7. Colorado converted its coverage for children ages 6-19 between 100% and 133% of the FPL from a separate CHIP program to a Medicaid expansion as of January 1, 2013.
8. Connecticut, Florida, Maine, Massachusetts, Minnesota, New Jersey, New York, North Carolina, Oregon, Pennsylvania, Tennessee, and Wisconsin allow families with incomes above the levels shown to buy into Medicaid/CHIP. New Hampshire eliminated its buy-in program in 2012. For details, see Table 2.
9. Florida operates three CHIP-funded separate programs. Healthy Kids covers children ages 5 through 19, as well as younger siblings in some locations; MediKids covers children ages 1 through 4; and the Children's Medical Service Network serves children with special health care needs from birth through age 18.
10. Infants born to mothers enrolled in Medicaid in Georgia and Illinois are covered up to 200% of the FPL in Medicaid. In Georgia, infants born to non-Medicaid covered mothers are covered to 185% of the FPL. In Illinois, infants born to non-Medicaid covered mothers are covered to 133% of the FPL.
11. Illinois is awaiting approval for federal funding of its state-funded coverage between 200% and 300% of the FPL.
12. Kansas covers children in a separate CHIP program up to 250% of the 2008 FPL or approximately 232% of the 2012 FPL.
13. In Maine, infants born to mothers enrolled in Medicaid are covered up to 200% of the FPL in Medicaid. Infants born to non-Medicaid covered mothers are covered up to 185% of the FPL.
14. In Michigan, coverage for children ages 16 to 18 between 100% and 150% of the FPL is funded through Title XXI.
15. In Minnesota, the infant category under "regular" Medicaid (Title XIX) includes children up to age 2, with income eligibility up to 275% of the FPL. Under CHIP, eligibility for infants is up to 280% of the FPL. Under "regular" Medicaid, income eligibility for children ages 2-19 is up to 150% of the FPL, and under the Section 1115 waiver, income eligibility for children in this age group is up to 275% of the FPL.
16. New Hampshire ended its separate CHIP program effective July 1, 2012. Children covered in the program are now covered in Medicaid.
17. Oregon covers children through 300% of the FPL.
18. Rhode Island covers children ages 1 to 7 with family incomes up to 133% of the FPL with Title XIX funding, and covers children ages 8 through their 19th birthday with incomes up to 100% of the FPL with Title XIX funding.
19. In Tennessee, Title XXI funds are used for two programs, TennCare Standard and CoverKids (a separate CHIP program). TennCare Standard provides Medicaid coverage to uninsured children who lose eligibility under TennCare (Medicaid), have no access to insurance, and have family income below 200% of the FPL or are medically eligible.

20. In Vermont, Title XIX funding covers uninsured children in families with income at or below 225% of the FPL; uninsured children in families with income between 226% and 300% of the FPL are covered via Title XXI funding under a separate CHIP program. Underinsured children are covered in Medicaid through Title XIX funding up to 300% of the FPL.

21. In Virginia, children age 6-19 with income between 100-133% who have another source of coverage are in regular Medicaid, receiving the regular Medicaid match.

Table 2
Optional Coverage for Children
January 2013

State	Income Eligibility for Buy-In Program (Percent of the FPL)	Lawfully-Residing Immigrants Covered without 5-Year Wait (ICHIA Option)[1]	Coverage for Dependents of State Employees in CHIP[2]
Total	**12**	**25**	**12**
Alabama			Y
Alaska			N/A
Arizona			
Arkansas			Y
California[3]		Y	
Colorado[4, 5] ▲			Y
Connecticut	>300%	Y	
Delaware		Y	
District of Columbia[6]		Y	N/A
Florida[7, 8] ▲	>200%		Y
Georgia			Y
Hawaii		Y	N/A
Idaho			
Illinois[9]		Y	
Indiana			
Iowa		Y	
Kansas			
Kentucky			Y
Louisiana			
Maine[10]	>200%	Y	
Maryland		Y	N/A
Massachusetts[11, 12] ▲	No limit	Y	
Michigan			
Minnesota[13]	>275%	Y	N/A
Mississippi			Y
Missouri			
Montana		Y	Y
Nebraska		Y	N/A
Nevada			
New Hampshire[14]			N/A
New Jersey	>350%	Y	
New Mexico		Y	N/A
New York[15]	>400%	Y	
North Carolina[16, 17]	201-225%	Y	Y
North Dakota			
Ohio			N/A
Oklahoma			N/A
Oregon	>301%	Y	
Pennsylvania[18] ▲	>300%	Y	Y
Rhode Island		Y	N/A
South Carolina			N/A
South Dakota			
Tennessee	>250%		
Texas		Y	Y
Utah			
Vermont[19] ▲		Y	Y
Virginia[20] ▲		Y	
Washington[21]		Y	
West Virginia			
Wisconsin	>300%	Y	
Wyoming			

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2013.

▲Indicates that a state has expanded eligibility for at least one coverage option between January 1, 2012 and January 1, 2013

Table presents rules in effect as of January 1, 2013.

Table 2 Notes

1. This column indicates whether the state has received approval through a State Plan Amendment to cover immigrant children who have been lawfully residing in the U.S. for less than five years, otherwise known as the ICHIA option.
2. This column indicates whether the state has adopted the option to cover otherwise eligible children of state employees in a separate CHIP program. Under the option, states may receive federal funding to extend CHIP eligibility where the state has maintained its contribution levels for health coverage for employees with dependent coverage or where it can demonstrate that the state employees' out-of-pocket health care costs pose a financial hardship for families. States that have adopted this option (and received CMS approval of their state plan amendment) in 2012 are denoted as expanding coverage. Arkansas covers these children under its ARKids B waiver. Mississippi and North Carolina have always covered dependents of state employees, as they are exempt from the provision because there is no employer contribution for dependent coverage.
3. In California, some local programs cover immigrant children regardless of legal status.
4. Colorado passed legislation authorizing coverage of lawfully residing immigrant children in 2012, but has not provided funding for the expansion.
5. Colorado adopted the option to cover children of state employees in CHIP as of January 1, 2013.
6. DC covers all children, regardless of immigration status.
7. In Florida, families can buy in to Healthy Kids coverage for children ages 5 to 19 and for MediKids coverage for children ages 1 to 4.
8. Florida received approval of a State Plan Amendment to adopt the option to cover children of state employees in its CHIP program in 2012.
9. Illinois is awaiting approval of a State Plan Amendment to cover lawfully-residing immigrant children in CHIP; the state already covers these children in Medicaid. Illinois covers all children, regardless of immigration status.
10. In Maine, eligibility in the buy-in program is limited to those who had been previously enrolled in Medicaid or CHIP. A child can participate for up to 18 months.
11. Massachusetts has buy-in coverage limited to children with disabilities with no income limit. The state also offers more limited state subsidized coverage to children at any income through its Children's Medical Security Plan program; premiums vary based on income.
12. Massachusetts received approval for a SPA to cover lawfully residing immigrant children in its CHIP program in 2012; they were already covering these children in Medicaid.
13. Minnesota eliminated the requirement that the child must have been previously enrolled in MinnesotaCare (the state's section 1115 waiver) in July 2012 in order to be eligible for the buy-in program.
14. In New Hampshire, a buy-in program previously offered by a state contractor was eliminated effective August 2012.
15. New York covers all children, regardless of immigration status.
16. In North Carolina, eligibility in the buy-in program is limited to those who had been previously enrolled in CHIP. A child can participate for up to 12 months.
17. In North Carolina, lawfully-residing immigrant children in the U.S. for less than five years are covered only in Medicaid.
18. Pennsylvania received CMS approval of its Medicaid and CHIP SPAs to cover lawfully-residing immigrant children in 2012.
19. Vermont received CMS approval to cover state employee dependent children in CHIP in 2012. The state also received approval for a CHIP SPA to cover lawfully-residing immigrant children without a five-year wait. Previously they were covered only in Medicaid.
20. Virginia received approval for a CHIP SPA to cover lawfully-residing immigrant children in 2012. Previously they were covered only in Medicaid.
21. Washington covers all children, regardless of immigration status.

Table 3

Length of Time a Child is Required to be Uninsured Prior to Enrollment in CHIP [1]

January 2013

State	Waiting Period[1] (in Months)	Income-Related Groups Exempt from Waiting Period (Percent of the FPL)
Total with Waiting Period	**38**	
Alabama	3	
Alaska	None	
Arizona	3	
Arkansas[2]	6	Below 133% <6 years old Below 100% > 6 years old
California	3	
Colorado	3	
Connecticut	2	
Delaware	6	
District of Columbia	None	
Florida	2	
Georgia	6	
Hawaii	None	
Idaho	6	
Illinois[3]	None	
Indiana	3	
Iowa	1	Below 200%
Kansas	8	Below 200%
Kentucky	6	
Louisiana	12	Below 200%
Maine	3	
Maryland	6	
Massachusetts	6	Below 200%
Michigan	6	
Minnesota[4] ▲	4	At or Below 200%
Mississippi	None	
Missouri	6	Below 150%
Montana	3	
Nebraska	None	
Nevada	6	
New Hampshire[5] ▲	None	
New Jersey	3	
New Mexico	6	Below 185%
New York	6	Below 250%
North Carolina	None	
North Dakota	6	
Ohio	None	
Oklahoma[6]	None	
Oregon	2	
Pennsylvania	6	Below 200%
Rhode Island	None	
South Carolina	None	
South Dakota	3	
Tennessee	3	
Texas	3	
Utah	3	
Vermont[7] ▲	None	
Virginia	4	
Washington	4	
West Virginia	3	
Wisconsin	3	Below 150%
Wyoming	1	

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2013.

▲Indicates that a state has shortened its waiting period or limited the populations subject to the waiting period between January 1, 2012 and January 1, 2013.

Table presents rules in effect as of January 1, 2013.

Table 3 Notes

1. "Waiting period" refers to the length of time a child is required to be uninsured prior to enrolling in health coverage. They generally apply to separate CHIP programs only, as waiting periods are not permitted in Medicaid without a waiver. Exceptions to the waiting period vary by state. In addition to the income exemptions shown, specific categories of children (for example, newborns or children with special health care needs) and those with job loss or "unaffordable" coverage may also be exempt from the waiting periods.
2. In Arkansas, the waiting period only applies to those covered under the 1115 waiver.
3. Under CHIP, Illinois imposes a 3-month waiting period for children between 133% and 200% FPL. However, the state funds coverage during this period. They also have a 12-month waiting period in their state-funded coverage between 200% and 300% FPL.
4. In July 2012, Minnesota eliminated its waiting period for kids covered under the MinnesotaCare waiver between 150% and 200% of the FPL. Those above 200% of the FPL are still subject to the 4-month waiting period.
5. New Hampshire eliminated its 6-month waiting period for CHIP when it converted its combination CHIP program to a Medicaid expansion in July 2012.
6. Oklahoma has a 6-month waiting period in its Insure Oklahoma premium assistance program.
7. Vermont received approval of a State Plan Amendment to eliminate its CHIP waiting period in 2012.

Table 4
Adult Income Eligibility Limits at Application as a Percent of the FPL
(Limits for Working Adults are Calculated Based on a Family of Three for Parents and Based on an Individual for Other Adults)[1]
January 2013

State	Parents of Dependent Children				Other Adults (Non-Disabled)			
	Medicaid Benefits[2]		More Limited Coverage		Medicaid Benefits[2]		More Limited Coverage	
	Jobless	Working	Jobless	Working	Jobless	Working	Jobless	Working
Alabama	10%	23%						
Alaska	74%	78%						
Arizona[3]	100%	106%			100% *(closed)*	100% *(closed)*		
Arkansas[4]	13%	16%		200%				200%
California[5]	100%	106%	200%	206%			200%	210%
Colorado[6] ▲	100%	106%			10% *(closed)*	20% *(closed)*		
Connecticut	185%	191%			55%	70%		
Delaware	100%	120%			100%	110%		
District of Columbia	200%	206%			200%	211%		
Florida	19%	56%						
Georgia	27%	48%						
Hawaii[7] ▼	133%	133%			133%	133%		
Idaho[8]	20%	37%		185%				185%
Illinois[9, 10] ▼	133%	139%						
Indiana[11]	18%	24%	200%	206%			200% *(closed)*	210% *(closed)*
Iowa[12]	27%	80%	200%	250%			200%	250%
Kansas	25%	31%						
Kentucky	33%	57%						
Louisiana[13]	11%	24%						
Maine[14]	200%	200%					100% *(closed)*	100% *(closed)*
Maryland[15]	116%	122%					116%	128%
Massachusetts[16]	133%	133%	300%	300%			300%	300%
Michigan[17]	37%	64%					35% *(closed)*	45% *(closed)*
Minnesota[18] ▼	215%	215%	275%	275%	75%	75%	200%	200%
Mississippi	23%	29%						
Missouri[19]	18%	35%						
Montana	31%	54%						
Nebraska	47%	58%						
Nevada	24%	84%						
New Hampshire	38%	47%						
New Jersey[20]	200% *(closed > 133%)*	200% *(closed > 133%)*					23%	23%
New Mexico[21]	28%	85%	200% *(closed)*	408% *(closed)*			200% *(closed)*	414% *(closed)*
New York[22]	150%	150%			100%	100%		
North Carolina	34%	47%						
North Dakota	33%	57%						
Ohio	90%	96%						
Oklahoma[23]	36%	51%		200%				200%
Oregon[24]	30%	39%	100% *(closed)*	201% *(closed)*			100% *(closed)*	201% *(closed)*
Pennsylvania	25%	58%						
Rhode Island[25]	175%	181%						
South Carolina	50%	89%						
South Dakota	50%	50%						
Tennessee	67%	122%						
Texas	12%	25%						
Utah[26] ▲	37%	42%	150% *(closed)*	200%			150% *(closed)*	200%
Vermont[27]	185%	191%	300%	331%	150%	160%	300%	353%
Virginia	25%	30%						
Washington[28]	35%	71%	133% *(closed)*	200% *(closed)*			133% *(closed)*	200% *(closed)*
West Virginia	16%	31%						
Wisconsin[29]	200%	200%					200% *(closed)*	200% *(closed)*
Wyoming	37%	50%						

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families,
▲Indicates that a state has expanded eligibility in at least one of its adult coverage programs between January 1, 2012 and January 1, 2013.
▼Indicates that a state has reduced eligibility in at least one of its adult coverage programs between January 1, 2012 and January 1, 2013.
Table presents rules in effect as of January 1, 2013.

Table 4 Notes

1. The table takes earning disregards, when applicable, into account when determining income thresholds for working adults. For parents, computations are based on a family of three with one earner; for other adults, computations are based on an individual. In some cases, earnings disregards may be time-limited and only applied for the first few months of coverage; in these cases, eligibility limits for most enrollees would be lower than the levels that appear in this table. States may use additional disregards in determining eligibility. In some states, the income eligibility guidelines vary by region; in this situation, the income guideline in the most populous region is used. "Closed" indicates that the state was not enrolling new adults eligible for coverage into a program at any point between January 1, 2012 and January 1, 2013.
2. This column does not differentiate by coverage authority, only by the scope of the benefit package. States may expand coverage to parents and other adults through Section 1115 waivers that provide full Medicaid benefits or more limited coverage.
3. Arizona froze enrollment in its waiver coverage for childless adults on July 8, 2011.
4. In Arkansas, adults up to 200% FPL are eligible for more limited subsidized coverage under the ARHealthNetworks waiver program; individuals must have income below the eligibility threshold and work for a qualifying, participating employer.
5. California extends coverage for adults through two programs: the Medicaid Coverage Expansion (MCE) up to 133% FPL and the Health Care Coverage Initiative (HCCI) between 133% and 200% FPL. While both coverage options offer more limited benefits than full Medicaid, the MCE benefit package is more comprehensive. Fifty out of 58 counties are participating in MCE; 5 counties are participating in HCCI.
6. Colorado extended Medicaid coverage to a limited number (10,000) of adults with income up to 10% FPL through a waiver as of May 2012.
7. Hawaii reduced coverage for parents and other adults to 133% FPL in 2012.
8. Idaho provides premium assistance to adults up to 185% FPL under a waiver; individuals must have income below the eligibility threshold and work for a qualified small employer.
9. Illinois reduced Medicaid eligibility for 1931 parents from 200% to 133% FPL in 2012.
10. In Illinois, adults with income up to 133% FPL who reside in Cook County are eligible for Medicaid, as of November 2012.
11. In Indiana, adults up to 200% FPL are eligib`le for limited coverage under the Healthy Indiana waiver program. Enrollment is closed for childless adults.
12. In Iowa, adults up to 200% FPL are eligible for more limited coverage under the IowaCare waiver program.
13. In Louisiana, adults with income up to 200% FPL who reside in Greater New Orleans area are eligible for more limited coverage through the Greater New Orleans Community Health Connection (GNOCHC) 1115 Waiver.
14. Maine received approval of a State Plan Amendment to reduce eligibility for 1931 parents from 200% to 133% FPL in January 2013. The state plans to implement the cuts on March 1, 2013. Childless adults up to 100% FPL are eligible for more limited coverage under the MaineCare waiver program; enrollment is closed.
15. In Maryland, childless adults are eligible for primary care services under the Primary Adult Care waiver program.
16. In Massachusetts, childless adults who are long-term unemployed or a client of the Department of Mental Health with income below 100% FPL can receive more limited benefits under the MassHealth waiver program through MassHealth Basic or Essential. Additionally, adults up to 300% FPL are eligible for more limited subsidized coverage under the Commonwealth Care waiver program.
17. In Michigan, childless adults are eligible for more limited coverage under the Adult Benefit Waiver program; enrollment is closed.
18. In Minnesota, parents up to 215% FPL receive full Medicaid benefits with the exception of some optional services (e.g., non-emergency transportation, private duty nursing, personal care, orthodontic services, targeted case management) and institutionally-based long-term care services. Parents above 215% FPL and childless adults receive a more limited benefit package that has a $10,000 annual limit on inpatient hospital care. Minnesota decreased eligibility for childless adults in its 1115 and state-funded coverage from 250% to 200% of the FPL in 2012.
19. In Missouri, adults with income up to 200% FPL who reside in the St. Louis area are eligible for more limited coverage through the Gateway to Better Health 1115 waiver.
20. In New Jersey, parents up to 200% FPL are covered under the FamilyCare waiver program. Waiver enrollment closed in 2010 for parents who do not qualify for Medicaid using an enhanced income disregard. In April 2011, New Jersey obtained

a waiver to expand coverage to childless adults who had previously been covered through the state's general assistance program. For those who are unemployable, the limit is $210 per individual; for those who are employable the limit is $140 per individual.

21. In New Mexico, adults up to 200% FPL are eligible for more limited subsidized coverage under the State Coverage Insurance waiver program. Individuals must have income below the eligibility threshold and work for a participating employer; if they do not work for a participating employer, they can obtain coverage by paying both the employer and employee share of premium costs. Enrollment is closed.
22. In New York, childless adults up to 78% FPL are eligible for the Medicaid (Home Relief) waiver program and parents up to 150% FPL and childless adults up to 100% FPL are eligible for the Family Health Plus waiver program.
23. In Oklahoma, adults up to 200% FPL are eligible for more limited subsidized coverage under the Insure Oklahoma waiver program. Individuals must have income below eligibility threshold and also work for a small employer, be self-employed, be unemployed and seeking work, be working disabled, be a full-time college student, or be the spouse of a qualified worker.
24. In Oregon, adults up to 100% FPL are eligible for more limited coverage under the OHP Standard waiver program; enrollment in OHP Standard is closed. The state provides premium assistance to adults up to 201% FPL under its Family Health Insurance Assistance Program waiver program. Enrollment in FHIAP is open to children only.
25. In Rhode Island, parents up to 175% FPL are covered under the RIteCare and RIteShare waiver programs.
26. In Utah, adults up to 150% FPL are eligible for coverage of primary care services under the Primary Care Network waiver program; enrollment is closed. The state also provides premium assistance for employer-sponsored coverage to working adults under the Utah Premium Partnership (UPP) Health Insurance waiver program. Eligibility in UPP increased from 150% to 200% in October 2012.
27. In Vermont, 1931 coverage is available up to 77% FPL in urban areas and 73% FPL in rural areas; parents up to 185% FPL and childless adults up to 150% FPL are eligible for the Vermont Health Access Plan waiver program. Additionally, the state offers more limited subsidized coverage to adults up to 300% FPL under its Catamount Health waiver program.
28. In Washington, adults up to 133% FPL are eligible for more limited coverage under the state's Basic Health waiver. Enrollment is closed.
29. In Wisconsin, childless adults up to 200% FPL are eligible for more limited coverage under the BadgerCare Plus Core Plan waiver program. Enrollment for childless adults is closed. In 2012, the state changed its crowd-out policy for parents and adults; if health insurance costs 9.5% or less of income, they are excluded from coverage.

Table 5
Income Eligibility Limits and Other Features of Health Coverage for Pregnant Women
January 2013

State	Income Eligibility (Percent of the FPL)			Lawfully-Residing Immigrants Covered without 5-Year Wait (ICHIA Option)[2]	Asset Test Not Required[3] (or Asset Test Limit)	Presumptive Eligibility
	Medicaid (Title XIX)	CHIP (Title XXI)	Unborn Child Option[1] (Title XXI)			
Total	**51**	**5**	**15**	**20**	**45**	**32**
Alabama[4]	133%				Y	
Alaska	175%				Y	
Arizona	150%				Y	
Arkansas[3]	162%	200%	200%		$3,100	Y
California[5]	200%		300%	Y	Y	Y
Colorado[6, 7]	185%	250%		Y	Y	Y
Connecticut	250%			Y	Y	Y
Delaware	200%			Y	Y	Y
District of Columbia[8]	185%	300%		Y	Y	Y
Florida	185%				Y	Y
Georgia	200%				Y	Y
Hawaii	185%			Y	Y	
Idaho[3]	133%				$5,000	Y
Illinois	200%		200%		Y	Y
Indiana	200%				Y	Y
Iowa[3]	300%				$10,000	Y
Kansas	150%				Y	
Kentucky	185%				Y	Y
Louisiana[4]	200%		200%		Y	
Maine	200%			Y	Y	Y
Maryland[4]	250%			Y	Y	
Massachusetts	200%		200%	Y	Y	Y
Michigan	185%		185%		Y	Y
Minnesota	275%		275%	Y	Y	
Mississippi	185%				Y	
Missouri	185%				Y	Y
Montana	150%				Y	Y
Nebraska[9] ▲	185%		185%	Y	Y	Y
Nevada	133%				Y	
New Hampshire	185%				Y	Y
New Jersey[10]	185%	200%		Y	Y	Y
New Mexico	235%			Y	Y	Y
New York[11]	200%			Y	Y	Y
North Carolina	185%			Y	Y	Y
North Dakota	133%				Y	
Ohio[12] ▲	200%				Y	Y
Oklahoma	185%		185%		Y	Y
Oregon	185%		185%		Y	
Pennsylvania[13] ▲	185%			Y	Y	Y
Rhode Island[14]	185%	250% (350%)	250%		Y	
South Carolina[3, 4]	185%				$30,000	
South Dakota[3]	133%				$7,500	
Tennessee	185%		250%		Y	Y
Texas	185%		200%		Y	Y
Utah[3, 15]	133%				$5,000	Y
Vermont	200%			Y	Y	
Virginia[16] ▲	133%	200%		Y	Y	
Washington	185%		185%	Y	Y	
West Virginia	150%				Y	
Wisconsin	300%		300%	Y	Y	Y
Wyoming	133%				Y	Y

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2013.

▲Indicates that a state expanded eligibility or adopted new coverage options for pregnant women between January 1, 2012 and January 1, 2013.

Table presents rules in effect as of January 1, 2013.

Table 5 Notes

1. The unborn child option permits states to consider the fetus a "targeted low-income child" for purposes of CHIP coverage.
2. This column indicates whether the state received approval through a State Plan Amendment to adopt the option to cover immigrant pregnant women who have been lawfully residing in the U.S. for less than five years, otherwise known as the ICHIA option.
3. With the exception of Arkansas and Utah, all states with an asset test for pregnancy coverage rely on a standard limit regardless of family size. In Arkansas and Utah, the asset limit shown is for a family of three. Documentation of assets is not required in Utah and South Carolina. In Idaho, pregnant women are not required to provide paper documentation unless their declared assets are within 10% of the asset limit threshold.
4. Alabama, Louisiana, Maryland, and South Carolina have a presumptive eligibility-like process.
5. In California, presumptive eligibility is available only to women through Medicaid.
6. In Colorado, lawfully-residing immigrant pregnant women are covered in Medicaid only.
7. Effective January 1, 2013, Colorado began covering pregnant women with income between 133% and 185% FPL in Medicaid. These women were previously covered in CHIP.
8. DC covers all immigrant pregnant women regardless of immigration status.
9. Nebraska adopted the unborn child option in July 2012.
10. New Jersey covers all immigrant pregnant women regardless of immigration status.
11. In New York, women with income between 100% and 200% of the FPL receive less comprehensive benefits.
12. Ohio added presumptive eligibility for pregnant women in April 2012. Prior to this, the state had a presumptive eligibility-like process.
13. Pennsylvania received CMS approval of a SPA to provide coverage to lawfully-residing pregnant women without the five-year waiting period in 2012.
14. In Rhode Island, coverage for pregnant women with income between 250% and 350% of the FPL is partially state funded and requires premium payments.
15. In Utah, women who exceed the asset limit may still qualify if they pay a one-time fee of 4% of their assets.
16. Virginia received SPA approval to cover lawfully-residing pregnant women in Medicaid and CHIP in 2012.

Table 6
Streamlined Application and Enrollment Processes for Children's Health Coverage
January 2013

State	Face-to-Face Interview NOT Required		Asset Test NOT Required (or Asset Test Limit)[1]		Presumptive Eligibility		Express Lane Eligibility[2]	
	Medicaid	CHIP	Medicaid	CHIP	Medicaid	CHIP	Medicaid	CHIP
Total in Medicaid and/or CHIP	**50**		**49**		**17**		**10**	
Aligned Medicaid and CHIP[3]	**49**		**47**		**15**		**7**	
Alabama	Y	Y	Y	Y			Y	
Alaska	Y	N/A	Y	N/A		N/A		N/A
Arizona	Y	Y	Y	Y				
Arkansas	Y	N/A	Y	N/A		N/A		N/A
California	Y	Y	Y	Y	Y	Y		
▲ Colorado[4]	Y	Y	Y	Y	Y	Y	Y	Y
Connecticut	Y	Y	Y	Y	Y	Y		
Delaware	Y	Y	Y	Y				
District of Columbia[5]	Y	N/A	Y	N/A		N/A		N/A
Florida	Y	Y	Y	Y				
Georgia	Y	Y	Y	Y			Y	Y
Hawaii	Y	N/A	Y	N/A		N/A		N/A
Idaho	Y	Y	Y	Y				
Illinois[6]	Y	Y	Y	Y	Y	Y		
Indiana	Y	Y	Y	Y				
Iowa	Y	Y	Y	Y	Y	Y	Y	Y
Kansas[7]	Y	Y	Y	Y	Y	Y		
Kentucky	Y	Y	Y	Y				
Louisiana	Y	Y	Y	Y			Y	
Maine	Y	Y	Y	Y				
Maryland[8]	Y	N/A	Y	N/A		N/A	Y	N/A
Massachusetts	Y	Y	Y	Y	Y	Y		
Michigan	Y	Y	Y	Y	Y	Y		
Minnesota	Y	N/A	Y	N/A		N/A		N/A
Mississippi			Y	Y				
Missouri[9, 10]	Y	Y	Y	$250,000	Y			
Montana	Y	Y	Y	Y	Y	Y		
Nebraska	Y	N/A	Y	N/A		N/A		N/A
Nevada	Y	Y	Y	Y				
New Hampshire	Y	N/A	Y	N/A	Y	N/A		N/A
New Jersey[11]	Y	Y	Y	Y	Y	Y	Y	Y
New Mexico	Y	N/A	Y	N/A	Y	N/A		N/A
New York	Y	Y	Y	Y	Y	Y		
North Carolina	Y	Y	Y	Y				
North Dakota	Y	Y	Y	Y				
Ohio	Y	N/A	Y	N/A	Y	N/A		N/A
Oklahoma	Y	N/A	Y	N/A		N/A		N/A
Oregon	Y	Y	Y	Y			Y	Y
Pennsylvania	Y	Y	Y	Y				Y
Rhode Island	Y	N/A	Y	N/A		N/A		N/A
▲ South Carolina[12]	Y	N/A	$30,000	N/A		N/A	Y	N/A
South Dakota	Y	Y	Y	Y				
Tennessee		Y	Y	Y				
Texas[13]	Y	Y	$2,000	$10,000				
▲ Utah[14, 15]	Y	Y	$3,025	Y	Y	Y		
Vermont	Y	Y	Y	Y				
Virginia	Y	Y	Y	Y				
Washington	Y	Y	Y	Y				
West Virginia	Y	Y	Y	Y				
Wisconsin[16]	Y	Y	Y	Y	Y			
Wyoming	Y	Y	Y	Y				
Total	**49**	**37**	**48**	**36**	**17**	**12**	**9**	**6**

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2013.

▲Indicates that a state simplified application and enrollment processes between January 1, 2012 and January 1, 2013.

Table presents rules in effect as of January 1, 2013.

Table 6 Notes

1. In states with asset limits, the limit noted is for a family of three, except for in South Carolina where the same asset limit applies regardless of family size. In Missouri, South Carolina, Texas and Utah, families do not need to provide proof of assets.
2. The express lane eligibility option allows states to use data and eligibility findings from other public benefit programs when determining children's eligibility for Medicaid and CHIP at enrollment or renewal. States are designated as having express lane eligibility if they have an approved State Plan Amendment from CMS.
3. Aligned Medicaid and CHIP indicates the number of states that have simplified the given procedure and have applied the simplification to both their children's Medicaid program and their CHIP-funded separate program. States that have used CHIP funds to expand Medicaid exclusively are considered "aligned" if the simplified procedure applies to children in the "regular" Medicaid program and the CHIP-funded expansion program. There are 38 states with separate CHIP programs.
4. Colorado received approval to conduct ELE at application in Medicaid and CHIP in 2012. The state plans to implement the process in 2013.
5. In DC, face-to-face or phone interviews are required for families using the joint application, even if they are just applying for Medicaid. Interviews are not required for individuals using the family medical application to apply for coverage.
6. In Illinois, presumptive eligibility is available in Medicaid and CHIP <200% FPL, but not the state-funded coverage between 200% and 300% FPL.
7. In Kansas, presumptive eligibility is processed in six locations.
8. Maryland is conducting a pilot for an accelerated eligibility process that is available to children who already have an open case for other benefits at a local eligibility office.
9. In Missouri, families with income above 150% of the FPL are subject to a "net worth" test."
10. In Missouri, presumptive eligibility is available only to children with gross incomes of 150% FPL or less.
11. New Jersey implemented express lane eligibility statewide in CHIP in September 2012. The state had piloted ELE through grants in some districts prior to full implementation.
12. South Carolina received approval to conduct ELE at application in 2012. Implementation began in September 2012.
13. In Texas, the limit is $3,000 if a family contains a disabled or elderly member. The $10,000 limit applies to those with income over 150% of the FPL.
14. In Utah, the asset limits are $2,000 for an individual, $3,000 for a couple, plus $25 for each additional person. The limit shown is for a two-parent family with one child. The state counts assets when determining eligibility for a child over the age of 6.
15. Utah adopted presumptive eligibility for children in 2012.
16. In Wisconsin, presumptive eligibility is available only for children in Medicaid.

Table 7
Streamlined Application Processes for Parents in Medicaid [1]
January 2013

State	Simplified Family Application for Parents[2]	Face-to-Face Interview NOT Required	Asset Test NOT Required (or Asset Test Limit)[3]	Simplifications Consistent with Children's Programs[4]
Total	**31**	**45**	**24**	**20**
Alabama	Y	Y	Y	Y
Alaska[5, 6]		Y	$2,000	
Arizona	Y	Y	Y	Y
Arkansas[7]	Y		$1,000	
California[8]		Y	$3,150	
Colorado	Y	Y	Y	Y
Connecticut	Y	Y	Y	Y
Delaware	Y	Y	Y	Y
District of Columbia[9]	Y	Y	Y	Y
Florida		Y	$2,000	
Georgia	Y	Y	$1,000	
Hawaii		Y	$3,250	
Idaho		Y	$1,000	
Illinois	Y	Y	Y	Y
Indiana[8]		Y	$1,000	
Iowa[8]		Y	$2,000	
Kansas	Y	Y	Y	Y
Kentucky			$2,000	
Louisiana[10]		Y	Y	
Maine[11]	Y	Y	$2,000	
Maryland	Y	Y	Y	Y
Massachusetts	Y	Y	Y	Y
Michigan		Y	$3,000	
Minnesota[12]	Y	Y	$20,000	
Mississippi	Y		Y	
Missouri	Y	Y	Y	Y
Montana[8]		Y	$3,000	
Nebraska[13]		Y	$6,000	
Nevada		Y	$2,000	
New Hampshire[14]			$1,000	
New Jersey	Y	Y	Y	Y
New Mexico	Y	Y	Y	Y
New York	Y	Y	Y	Y
North Carolina[8]		Y	$3,000	
North Dakota	Y	Y	Y	Y
Ohio	Y	Y	Y	Y
Oklahoma		Y	Y	
Oregon	Y	Y	$2,500	
Pennsylvania	Y	Y	Y	Y
Rhode Island	Y	Y	Y	Y
South Carolina	Y	Y	$30,000	
South Dakota	Y	Y	$2,000	
Tennessee			$2,000	
Texas			$2,000	
Utah	Y	Y	$3,025	
Vermont	Y	Y	$3,150	
Virginia		Y	Y	
Washington		Y	$1,000	
West Virginia	Y	Y	$1,000	
Wisconsin	Y	Y	Y	Y
Wyoming	Y	Y	Y	Y

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2013.

▲Indicates that a state simplified processes between January 1, 2012 and January 1, 2013.

Table presents rules in effect as of January 1, 2013.

Table 7 Notes

1. This table presents policies for parents covered through 1931 Medicaid coverage; some states have differing policies for parents and other non-disabled adults covered through waiver or state-funded coverage programs.
2. States are classified as providing a simplified family application if parents can apply for coverage without having to complete a separate application or additional forms. In some states a longer form must be used to apply for family coverage while a shorter, simpler form is available for children's coverage; these states are not classified as offering a simplified family application.
3. In states with asset limits, the limit noted is for a family of three. However, in Georgia, Iowa, Kentucky, Michigan, Nevada, North Carolina, South Carolina and South Dakota, the asset limits apply regardless of family size. Documentation of assets is not required by parents in Alaska, Florida, Georgia, Hawaii, Oregon, South Carolina, Tennessee, Utah, Vermont, and Washington. In Idaho, paper documentation of assets is not required unless declared assets are within 10% of the asset limit threshold.
4. States are classified as having consistent policies for children and parents if they have adopted all of the simplification measures listed in Medicaid for children and parents. At application, states must also have a simplified family application.
5. In Alaska, the asset test is $3,000 if the family includes a member age 60 or over.
6. Telephone interviews are required in Alaska.
7. In Arkansas, county offices have the option of requiring either a face-to-face or telephone interview for Medicaid. Applicants who have had an active Medicaid case within the past year are not required to do an interview.
8. In California, Indiana, Iowa, Montana, and North Carolina, the same simplified application can be used for children and parents but parents must complete additional forms or take additional steps.
9. In DC, face-to-face or telephone interviews are required for families using the joint application, even if just applying for Medicaid. Interviews are not required for families using the medical only application.
10. In Louisiana, the Medicaid/CHIP application is not designed for use by parents but can be used in some circumstances to determine eligibility for a parent.
11. In Maine, asset rules exempt $8,000 for an individual and $12,000 for a household of 2 or more of certain savings, including retirement savings.
12. In Minnesota, the asset limit is $10,000 for any single household. For those households of two or more, the asset limit is $20,000.
13. Telephone interviews are required for parents in Nebraska.
14. An interview is required in New Hampshire, but it can be conducted over the telephone.

Table 8
Outreach and Application Assistance
January 2013

State	In-Person Assistance at State/County Eligibility Offices		Toll-Free Hotline		Out-Stationed State Eligibility Workers[1]		State Funding for Community-Based Application Assisters
	Medicaid	CHIP	Medicaid	CHIP	Medicaid	CHIP	
Total in Medicaid and/or CHIP	**48**		**47**		**35**		**23**
Aligned Medicaid and CHIP[2]	**43**		**45**		**28**		
Alabama	Y	Y	Y	Y	Y		
Alaska	Y	N/A	Y	N/A	Y	N/A	Y
Arizona	Y	Y	Y	Y	Y		Y
Arkansas	Y	N/A	Y	N/A	Y	N/A	
California	Y			Y	Y		
Colorado[3]					Y		Y
Connecticut	Y	Y	Y	Y	Y	Y	Y
Delaware	Y	Y	Y	Y			Y
District of Columbia	Y	N/A	Y	N/A	Y	N/A	
Florida	Y		Y	Y	Y	Y	Y
Georgia	Y	Y	Y	Y	Y	Y	
Hawaii	Y	N/A	Y	N/A		N/A	Y
Idaho	Y	Y					
Illinois	Y	Y	Y	Y			
Indiana	Y	Y	Y	Y			
Iowa	Y		Y	Y	Y		Y
Kansas	Y	Y	Y	Y	Y	Y	
Kentucky	Y	Y	Y	Y			
Louisiana	Y	Y	Y	Y	Y	Y	Y
Maine	Y	Y	Y	Y			
Maryland	Y	N/A	Y	N/A	Y	N/A	
Massachusetts	Y	Y	Y	Y			Y
Michigan	Y	Y	Y	Y	Y	Y	
Minnesota	Y	N/A	Y	N/A	Y	N/A	Y
Mississippi	Y	Y			Y	Y	
Missouri	Y	Y	Y	Y	Y	Y	
Montana	Y	Y	Y	Y			
Nebraska[3] ▲	Y	N/A	Y	N/A	Y	N/A	Y
Nevada	Y		Y	Y			
New Hampshire	Y	N/A	Y	N/A		N/A	Y
New Jersey	Y	Y	Y	Y	Y	Y	
New Mexico	Y	N/A	Y	N/A	Y	N/A	Y
New York	Y	Y	Y	Y	Y	Y	Y
North Carolina	Y	Y	Y	Y	Y	Y	
North Dakota	Y	Y	Y	Y	Y	Y	
Ohio		N/A	Y	N/A	Y	N/A	Y
Oklahoma	Y	N/A	Y	N/A	Y	N/A	Y
Oregon	Y	Y	Y	Y			Y
Pennsylvania	Y	Y	Y	Y			
Rhode Island[4]	Y	N/A		N/A	Y	N/A	Y
South Carolina	Y	N/A	Y	N/A	Y	N/A	
South Dakota	Y	Y	Y	Y			Y
Tennessee	Y		Y	Y	Y		
Texas	Y	Y	Y	Y	Y	Y	Y
Utah	Y	Y	Y	Y	Y	Y	
Vermont			Y	Y			
Virginia	Y	Y	Y	Y	Y	Y	Y
Washington	Y	Y	Y	Y	Y	Y	Y
West Virginia	Y	Y	Y	Y	Y		
Wisconsin	Y	Y	Y	Y	Y	Y	
Wyoming	Y	Y		Y			
Total	**48**	**31**	**45**	**35**	**35**	**17**	**23**

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2013.

▲Indicates that a state enhanced outreach and assistance between January 1, 2012 and January 1, 2013.

Table presents rules in effect as of January 1, 2013.

Table 8 Notes

1. This column indicates whether the state has state employees conducting eligibility determinations for Medicaid or CHIP at locations other than eligibility offices. While states are required to establish out-stationed locations to process applications, they are not required to have state eligibility workers. States may choose instead to utilize volunteers or community-based organizations to serve this function. These alternative plans to provide application assistance at locations other than government offices may be equally effective in connecting eligible individuals to Medicaid and CHIP.
2. Aligned Medicaid and CHIP indicates the number of states that have the given feature in both Medicaid and separate CHIP programs. There are 38 states with separate CHIP programs.
3. Nebraska added out-stationed eligibility workers and state funding for community-based application assisters in 2012.
4. Rhode Island has a telephone line for applicants to call for assistance, but it is not toll-free.

Table 9
Telephone and Online Applications in Medicaid and CHIP[1]
January 2013

State	Application Can be Submitted Over the Telephone		Application Can be Submitted Electronically		Electronic Signature for Online Applications[2]		Data from Online Application Automatically Imports into Eligibility System	
	Medicaid	CHIP	Medicaid	CHIP	Medicaid	CHIP	Medicaid	CHIP
Total in Medicaid and/or	**17**		**37**		**36**		**30**	
Aligned Medicaid and CHIP[3]	**15**		**36**		**35**		**26**	
Alabama	Y	Y	Y	Y	Y	Y	Y	Y
Alaska		N/A		N/A	N/A	N/A	N/A	N/A
Arizona			Y	Y	Y	Y	Y	Y
Arkansas		N/A	Y	N/A	Y	N/A	Y	N/A
California		Y	Y	Y	Y	Y	Y	Y
Colorado			Y	Y	Y	Y	Y	Y
Connecticut	Y	Y			N/A	N/A	N/A	N/A
Delaware	Y	Y	Y	Y	Y	Y	Y	Y
District of Columbia		N/A		N/A	N/A	N/A	N/A	N/A
Florida			Y	Y	Y	Y	Y	Y
Georgia				Y	N/A	Y	N/A	Y
Hawaii		N/A		N/A	N/A	N/A	N/A	N/A
Idaho					N/A	N/A	N/A	N/A
Illinois	Y	Y	Y	Y			Y	Y
Indiana	Y	Y	Y	Y	Y	Y	Y	Y
Iowa			Y	Y	Y	Y		
Kansas[4] ▲			Y	Y	Y	Y		
Kentucky					N/A	N/A	N/A	N/A
Louisiana	Y	Y	Y	Y	Y	Y	Y	Y
Maine			Y	Y	Y	Y	Y	Y
Maryland	Y	N/A	Y	N/A	Y	N/A	Y	N/A
Massachusetts[5]					N/A	N/A	N/A	N/A
Michigan[6] ▲			Y	Y	Y	Y	Y	Y
Minnesota[7] ▲		N/A	Y	N/A	Y	N/A		
Mississippi					N/A	N/A	N/A	N/A
Missouri			Y	Y	Y	Y	Y	Y
Montana	Y	Y	Y	Y	Y	Y	Y	Y
Nebraska		N/A	Y	N/A	Y	N/A		N/A
Nevada			Y	Y	Y	Y	Y	
New Hampshire	Y	N/A	Y	N/A	Y	N/A	Y	N/A
New Jersey	Y	Y	Y	Y	Y	Y		
New Mexico				N/A	N/A	N/A	N/A	N/A
New York					N/A	N/A	N/A	N/A
North Carolina					N/A	N/A	N/A	N/A
North Dakota			Y	Y	Y	Y		
Ohio	Y	N/A	Y	N/A	Y	N/A	Y	N/A
Oklahoma		N/A	Y	N/A	Y	N/A	Y	N/A
Oregon			Y	Y	Y	Y		
Pennsylvania		Y	Y	Y	Y	Y	Y	Y
Rhode Island		N/A		N/A	N/A	N/A	N/A	N/A
South Carolina		N/A		N/A	N/A	N/A	N/A	N/A
South Dakota					N/A	N/A	N/A	N/A
Tennessee			Y	Y	Y	Y		Y
Texas	Y	Y	Y	Y	Y	Y	Y	Y
Utah	Y	Y	Y	Y	Y	Y	Y	Y
Vermont			Y	Y	Y	Y	Y	Y
Virginia[8, 9] ▲	Y	Y	Y	Y	Y	Y	Y	Y
Washington			Y	Y	Y	Y	Y	Y
West Virginia[10, 11] ▲			Y	Y	Y	Y	Y	Y
Wisconsin	Y	Y	Y	Y	Y	Y	Y	Y
Wyoming			Y	Y	Y	Y		Y
Total	**15**	**14**	**36**	**30**	**35**	**29**	**27**	**24**

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2013.

▲Indicates that a state expanded telephone and online application features between January 1, 2012 and January 1, 2013

Table presents rules in effect as of January 1, 2013.

Table 9 Notes

1. Unless specified otherwise, a telephone application, electronic submission of an online application, electronic signature, and data importation apply to both children and parents in Medicaid. Waiver coverage for parents may have different policies.
2. The signature requirement for an application for medical assistance may be satisfied through an electronic signature, as defined in section 1710(1) of the Government Paperwork Elimination Act (44 U.S.C. 3504 note), which states, "the term 'electronic signature' means a method of signing an electronic message that—(A) identifies and authenticates a particular person as the source of the electronic message; and (B) indicates such person's approval of the information contained in the electronic message."
3. Aligned Medicaid and CHIP indicates the number of states that have the given feature in both Medicaid and separate CHIP programs. There are 38 states with separate CHIP programs.
4. Kansas began allowing for the use of online applications in 2012.
5. In Massachusetts, online applications may only be submitted by authorized users, who are usually providers.
6. Michigan added a new online application system in 2012 that allows parents to apply online along with their children. Previously, families were only able to apply for coverage for their children online.
7. Minnesota began allowing for the use of online applications in April 2012.
8. In Virginia, telephone applications are limited to those filed at the Central Processing Unit, not at local social services offices.
9. Virginia extended the ability to apply online to parents in Medicaid in 2012.
10. West Virginia began allowing for electronic signatures In CHIP in 2012.
11. In West Virginia, the online application in Medicaid can only be used by children, and not by parents, to apply for coverage.

Table 10
Online Account Capabilities[1]
January 2013

State		Indivdidual Can Create an Online Account		Online Account Allows Individuals To:							
				Start, Stop, and Return to an Application		Review Application Status		Report Changes		View Notices	
		Medicaid	CHIP	Medicaid	CHIP	Medicaid	CHIP	Medicaid	CHIP	Medicaid	CHIP
Total in Medicaid and/or CHIP		**36**		**33**		**21**		**19**		**8**	
Aligned Medicaid and CHIP[2]		**34**		**31**		**15**		**17**		**6**	
Alabama[3]	▲	Y	Y	Y	Y	Y		Y	Y		
Alaska			N/A		N/A		N/A		N/A		N/A
Arizona		Y	Y	Y	Y	Y	Y	Y	Y		
Arkansas		Y	N/A	Y	N/A	Y	N/A		N/A		N/A
California[4]	▲	Y	Y	Y	Y						Y
Colorado		Y	Y	Y	Y	Y	Y	Y	Y		
Connecticut[5]	▲	Y				Y				Y	
Delaware		Y	Y	Y	Y						
District of Columbia			N/A		N/A		N/A		N/A		N/A
Florida[6]	▲	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Georgia		Y	Y		Y			Y	Y		
Hawaii			N/A		N/A		N/A		N/A		N/A
Idaho											
Illinois		Y	Y	Y	Y						
Indiana											
Iowa		Y	Y	Y	Y						
Kansas[7]	▲	Y	Y	Y	Y						
Kentucky											
Louisiana		Y	Y	Y	Y						
Maine		Y	Y	Y	Y						
Maryland			N/A		N/A		N/A		N/A		N/A
Massachusetts		Y	Y			Y	Y	Y	Y	Y	Y
Michigan[8]	▲	Y	Y	Y	Y						
Minnesota[9]	▲	Y	N/A	Y	N/A		N/A		N/A		N/A
Mississippi											
Missouri		Y	Y	Y	Y	Y	Y	Y	Y		
Montana		Y	Y	Y	Y						
Nebraska		Y	N/A	Y	N/A	Y	N/A	Y	N/A		N/A
Nevada[10]	▲	Y		Y		Y					
New Hampshire[11]	▲	Y	N/A	Y	N/A	Y	N/A	Y	N/A	Y	N/A
New Jersey											
New Mexico											
New York											
North Carolina											
North Dakota[12]	▲	Y	Y	Y	Y						
Ohio		Y	N/A	Y	N/A	Y	N/A	Y	N/A	Y	N/A
Oklahoma		Y	N/A	Y	N/A	Y	N/A	Y	N/A	Y	N/A
Oregon[13]	▲	Y	Y	Y	Y	Y	Y				
Pennsylvania		Y	Y					Y			
Rhode Island			N/A		N/A		N/A		N/A		N/A
South Carolina			N/A		N/A		N/A		N/A		N/A
South Dakota											
Tennessee		Y	Y	Y	Y		Y		Y		
Texas		Y	Y	Y	Y	Y	Y	Y	Y		
Utah		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Vermont		Y	Y	Y	Y						
Virginia[14, 15]	▲	Y	Y	Y	Y	Y		Y	Y		
Washington		Y	Y	Y	Y	Y	Y	Y	Y		
West Virginia[16]		Y	Y	Y	Y						
Wisconsin		Y	Y	Y	Y	Y	Y	Y	Y		
Wyoming		Y	Y	Y	Y	Y		Y	Y		
Total		**36**	**28**	**32**	**26**	**20**	**11**	**18**	**14**	**7**	**4**

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2013.

▲Indicates that a state expanded online account functions between January 1, 2012 and January 1, 2013.

Table presents rules in effect as of January 1, 2013.

Table 10 Notes

1. Unless otherwise noted, the online account functions listed in the table apply to both children and parents in Medicaid. Waiver coverage for parents may have different policies.
2. Aligned Medicaid and CHIP indicates the number of states that have simplified function in both their children's Medicaid program and their separate CHIP-funded program.
3. Alabama added the ability to report changes in its online CHIP account in 2012.
4. California added the ability to view notices in its online CHIP account in 2012. The functionality of online Medicaid accounts varies by county.
5. Connecticut added online accounts in Medicaid as of January 2013.
6. Florida added the ability to view notices in its online accounts in 2012.
7. Kansas added online accounts in 2012.
8. Michigan added online accounts for parents in 2012. Previously, only children in Medicaid and CHIP could create an account.
9. Minnesota added online accounts in 2012.
10. Nevada added the ability to review the status of applications in its online Medicaid accounts in 2012.
11. New Hampshire added the ability to report changes in its online accounts in 2012.
12. North Dakota added online accounts in 2012.
13. Oregon added online accounts in 2012.
14. In Virginia, the status of CHIP applications can be reviewed using an automated telephone system, but not through the online account.
15. Virginia added the ability to report changes in its online accounts in 2012.
16. In West Virginia, the ability to start, stop, and return to an online application is only available for children's coverage and not parents' coverage in Medicaid. However, there is a My Benefits Account that is available to anyone with an existing case, which allows them to view details of their case online.

Table 11
Enhanced Systems Capabilities
January 2013

State	Social Security Administration (SSA) Data Match to Verify Citizenship[1]		Document Imaging		State Data Hub		Paperless Notices		Upload a Scanned Document	
	Medicaid	CHIP	Medicaid	CHIP	Medicaid	CHIP	Medicaid	CHIP	Medicaid	CHIP
Total in Medicaid and/or	**45**		**30**		**11**		**4**		**15**	
Aligned Medicaid and CHIP[2]	**42**		**22**		**8**		**4**		**7**	
Alabama	Y	Y		Y						
Alaska	Y	N/A		N/A		N/A		N/A		N/A
Arizona			Y	Y					Y	Y
Arkansas	Y	N/A	Y	N/A	Y	N/A		N/A		N/A
California	Y	Y	Y	Y						Y
Colorado	Y	Y								Y
Connecticut[3]	Y	Y		Y						
Delaware	Y	Y	Y	Y						
District of Columbia	Y	N/A	Y	N/A		N/A		N/A		N/A
Florida			Y	Y			Y	Y	Y	
Georgia[4] ▲	Y	Y		Y						Y
Hawaii	Y	N/A		N/A		N/A		N/A		N/A
Idaho	Y	Y	Y	Y	Y	Y				
Illinois	Y	Y								
Indiana[5] ▲	Y	Y	Y	Y					Y	Y
Iowa	Y	Y	Y	Y	Y					Y
Kansas			Y	Y						
Kentucky	Y	Y								
Louisiana	Y	Y	Y	Y						
Maine	Y	Y								
Maryland	Y	N/A		N/A		N/A		N/A		N/A
Massachusetts	Y	Y	Y	Y						
Michigan[6]	Y									
Minnesota[7]	Y	N/A		N/A		N/A		N/A	Y	N/A
Mississippi	Y	Y								
Missouri										
Montana	Y	Y	Y	Y	Y	Y			Y	Y
Nebraska	Y	N/A	Y	N/A		N/A		N/A	Y	N/A
Nevada		Y							Y	
New Hampshire	Y	N/A	Y	N/A		N/A	Y	N/A		N/A
New Jersey[3]	Y	Y			Y	Y				
New Mexico	Y	N/A								
New York	Y	Y	Y							
North Carolina	Y	Y								
North Dakota	Y	Y							Y	Y
Ohio	Y	N/A		N/A		N/A		N/A		N/A
Oklahoma	Y	N/A	Y	N/A		N/A	Y	N/A		N/A
Oregon	Y	Y	Y	Y	Y	Y				
Pennsylvania	Y	Y	Y		Y	Y			Y	
Rhode Island	Y	N/A		N/A		N/A		N/A		N/A
South Carolina	Y	N/A		N/A		N/A		N/A		N/A
South Dakota	Y	Y	Y	Y						
Tennessee		Y		Y						
Texas	Y	Y	Y	Y	Y					
Utah	Y	Y	Y		Y	Y	Y	Y		
Vermont			Y	Y	Y	Y				
Virginia[8]	Y	Y		Y	Y					Y
Washington	Y	Y	Y	Y						
West Virginia	Y	Y								
Wisconsin	Y	Y	Y	Y					Y	Y
Wyoming										
Total	**43**	**31**	**25**	**22**	**11**	**7**	**4**	**2**	**10**	**10**

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families,
▲Indicates that a state added the SSA data match to verify citizenship between January 1, 2012 and January 1, 2013. Data on changes were not collected for other
Table presents rules in effect as of January 1, 2013.

Table 11 Notes

1. This CHIPRA option became available in 2010 and allows states to conduct data matches with the Social Security Administration to verify citizenship. States that have adopted the option in 2012 are denoted as implementing a simplification in the table and include Georgia (Medicaid) and Indiana.
2. Aligned Medicaid and CHIP indicates the number of states that have the given feature in both their children's Medicaid program and their separate CHIP-funded program. There are 38 states with separate CHIP programs.
3. Connecticut and New Jersey are in the process of implementing a statewide document imaging system in Medicaid.
4. Georgia implemented the SSA match in Medicaid in 2012. The state had previously been doing it in CHIP only.
5. Indiana implemented the SSA match in Medicaid and CHIP in 2012.
6. In Michigan, the SSA match is only conducted in CHIP if the application is received via electronic transfer from the Medicaid agency. Michigan began a pilot program to implement paperless notices and a document imaging system in 2012.
7. In Minnesota, the SSA match is done for Medical Assistance applications (traditional Medicaid), but not for applications for MinnesotaCare (1115 waiver). The state is working on implementing it for the waiver.
8. Virginia does not conduct the SSA match for 1931 parents.

Table 12
Integration and Upgrade of Medicaid Eligibility Systems
January 2013

State	Medicaid System Used for Other Assistance Programs (e.g., SNAP, TANF)	Same Eligibility System for Medicaid and CHIP	Approved or Submitted APD for Upgrading Medicaid Eligibility System[1]	Work Begun on Medicaid Eligibility System Upgrade
Total	**45**	**22**	**47**	**42**
Alabama			Y	Y
Alaska	Y	N/A	Y	Y
Arizona	Y		Y	Y
Arkansas	Y	N/A	Y	Y
California[2]	Y		Y	Y
Colorado	Y	Y	Y	Y
Connecticut	Y		Y	Y
Delaware	Y	Y	Y	Y
District of Columbia	Y	N/A	Y	Y
Florida	Y		Y	Y
Georgia	Y		Y	Y
Hawaii	Y	N/A	Y	Y
Idaho	Y	Y	Y	Y
Illinois	Y	Y	Y	Y
Indiana	Y	Y	Y	Y
Iowa	Y		Y	Y
Kansas	Y	Y	Y	Y
Kentucky	Y	Y	Y	Y
Louisiana		Y	Y	Y
Maine	Y	Y	Y	
Maryland	Y	N/A	Y	Y
Massachusetts[3]		Y	Y	Y
Michigan	Y			
Minnesota[4]	Y		Y	
Mississippi		Y		Y
Missouri	Y	Y	Y	
Montana[5]	Y	Y	Y	Y
Nebraska	Y	N/A	Y	
Nevada	Y		Y	Y
New Hampshire	Y	N/A	Y	Y
New Jersey	Y		Y	Y
New Mexico	Y	N/A	Y	Y
New York	Y		Y	Y
North Carolina	Y	Y	Y	Y
North Dakota	Y	Y	Y	Y
Ohio	Y	N/A	Y	Y
Oklahoma		N/A	Y	Y
Oregon	Y	Y	Y	Y
Pennsylvania	Y			
Rhode Island	Y	N/A	Y	Y
South Carolina		N/A	Y	Y
South Dakota	Y	Y	Y	Y
Tennessee	Y		Y	Y
Texas	Y		Y	Y
Utah	Y	Y		
Vermont	Y	Y	Y	
Virginia	Y		Y	Y
Washington	Y	Y	Y	Y
West Virginia	Y	Y	Y	Y
Wisconsin	Y	Y	Y	
Wyoming	Y		Y	Y

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2013.
Data were reported differently in 2012; as such changes are not noted. Table presents rules in effect as of January 1, 2013.

Table 12 Notes

1. The state has submitted and/or received approval of an Advanced Planning Document (APD) for the enhanced federal match (i.e., 90/10) to upgrade its Medicaid eligibility system.
2. California has three eligibility systems in use in its Medicaid program.
3. The Medicaid eligibility system in Massachusetts does eligibility for the state's health programs (Medicaid, CHIP, CommonwealthCare (subsidized coverage in the Exchange), and the health safety net) but does not do eligibility for other assistance programs such as SNAP or TANF.
4. In Minnesota separate systems are used for eligibility data for the state's Medicaid program (Medical Assistance) and its Section 1115 Waiver (MinnesotaCare).
5. Montana integrated its Medicaid and CHIP eligibility system with other assistance programs in November 2012.

Table 13
Renewal Periods and Streamlined Renewal Processes for Children's Health Coverage
January 2013

State	Frequency of Renewal[1] (Months)		12-Month Continuous Eligibility		Face-to-Face Interview Not Required		Express Lane Eligibility[1]	
	Medicaid	CHIP	Medicaid	CHIP	Medicaid	CHIP	Medicaid	CHIP
Total Adopting Simplification in Medicaid and/or CHIP	**51**		**32**		**50**		**8**	
Aligned Medicaid and CHIP[3]	**49**		**23**		**50**		**2**	
Alabama	12	12	Y	Y	Y	Y	Y	
Alaska	12	N/A	Y	N/A	Y	N/A		N/A
Arizona[4]	12	12			Y	Y		
Arkansas[5]	12	N/A		N/A	Y	N/A		N/A
California	12	12	Y	Y	Y	Y		
Colorado[6] ▲	12	12		Y	Y	Y	Y	
Connecticut	12	12			Y	Y		
Delaware	12	12		Y	Y	Y		
District of Columbia[7]	12	N/A		N/A	Y	N/A		N/A
Florida[8]	12	12		Y	Y	Y		
Georgia	6	12			Y	Y		
Hawaii	12	N/A		N/A	Y	N/A		N/A
Idaho	12	12	Y	Y	Y	Y		
Illinois	12	12	Y	Y	Y	Y		
Indiana[9]	12	12			Y	Y		
Iowa	12	12	Y	Y	Y	Y		
Kansas	12	12	Y	Y	Y	Y		
Kentucky[?]	12	12			Y	Y		
Louisiana	12	12	Y	Y	Y	Y	Y	
Maine	12	12	Y	Y	Y	Y		
Maryland[10]	12	N/A		N/A	Y	N/A		N/A
Massachusetts[11] ▲	12	12			Y	Y	Y	Y
Michigan	12	12	Y	Y	Y	Y		
Minnesota[12]	12	N/A		N/A	Y	N/A		N/A
Mississippi	12	12	Y	Y				
Missouri	12	12			Y	Y		
Montana	12	12	Y	Y	Y	Y		
Nebraska	12	N/A		N/A	Y	N/A		N/A
Nevada[13]	12	12		Y	Y	Y		
New Hampshire	12	N/A		N/A	Y	N/A		N/A
New Jersey	12	12	Y	Y	Y	Y		
New Mexico	12	N/A	Y	N/A	Y	N/A		N/A
New York[14] ▲	12	12	Y	Y	Y	Y	Y	
North Carolina	12	12	Y	Y	Y	Y		
North Dakota	12	12	Y	Y	Y	Y		
Ohio	12	N/A	Y	N/A	Y	N/A		N/A
Oklahoma[15]	12	N/A		N/A	Y	N/A		N/A
Oregon	12	12	Y	Y	Y	Y		
Pennsylvania[16]	12	12		Y	Y	Y		Y
Rhode Island	12	N/A		N/A	Y	N/A		N/A
South Carolina	12	N/A	Y	N/A	Y	N/A	Y	N/A
South Dakota	12	12			Y	Y		
Tennessee[17]	12	12		Y	Y	Y		
Texas[18]	6	12		Y	Y	Y		
Utah[19] ▲	12	12		Y	Y	Y		Y
Vermont	12	12			Y	Y		
Virginia	12	12		Y	Y	Y		
Washington	12	12	Y	Y	Y	Y		
West Virginia	12	12	Y	Y	Y	Y		
Wisconsin	12	12			Y	Y		
Wyoming	12	12	Y	Y	Y	Y		
Total Adopting Simplification	**49**	**38**	**23**	**28**	**50**	**37**	**6**	**3**

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2013.

▲Indicates that a state simplified renewal policies in its children's health programs between January 1, 2012 and January 1, 2013.

Table presents rules in effect as of January 1, 2013.

Table 13 Notes

1. This column shows the frequency of renewals. Some states require monthly, quarterly, or semi-annual income reporting or reporting a change in income, which is not addressed in this table. If the frequency of renewal is every 12 months, as opposed to six months or more frequently, the procedure is considered "simplified" for the purposes of this table.
2. The express lane eligibility (ELE) option allows states to use data and eligibility findings from other public benefit programs when determining children's eligibility for Medicaid and CHIP at enrollment or renewal. States are designated as using ELE have an approved State Plan Amendment from CMS. States that obtained approval for ELE in 2012 and include Colorado, New York (Medicaid), Utah (CHIP), and Massachusetts.
3. Aligned Medicaid and CHIP indicates the number of states that have simplified the given procedure and have applied the simplification to both their children's Medicaid program and their CHIP-funded separate program. There are 38 states with separate CHIP programs.
4. In Arizona, there is a 12-month continuous eligibility policy in CHIP that applies to the first 12 months of coverage.
5. In Arkansas, children above 133% FPL and <6 years of age, and those above 100% FPL and >6 years of age, receive 12 months of continuous eligibility.
6. Colorado obtained approval for the use of ELE in Medicaid and CHIP at renewal. The state has implemented ELE in Medicaid only and plans to extend to CHIP renewals in the next year.
7. In DC, face-to-face or phone interviews are required for families using the joint application, even if they are just applying for Medicaid. Interviews are not required for individuals using the family medical application to apply for coverage.
8. In Florida's Medicaid program, children younger than age 5 receive 12 months of continuous eligibility and children ages 5 and older receive six months of continuous eligibility.
9. Indiana has 12-month continuous eligibility for children under age 3.
10. Newborns in Maryland have 12-month continuous eligibility.
11. Massachusetts received approval for the use of ELE at renewal in Medicaid and CHIP in 2012. The state has implemented ELE for children, pregnant women, and parents with income up to 150% FPL.
12. In Minnesota, children and parents who qualify under the state's Section 1115 expansion program have eligibility reviewed every 12 months. In the "regular" Medicaid program, income reviews occur every 6 months and eligibility reviews every 12 months.
13. Nevada has a 12-month renewal period but performs income checks using state wage databases on a regular basis.
14. New York obtained approval for the use of ELE in Medicaid at renewal in 2012.
15. Oklahoma does rolling renewals, advancing forward the renewal date 12 months when a change is reported.
16. In Pennsylvania, in Medicaid, there is a 12 month renewal period, but income is reviewed at 6 months for some categories, excluding children in foster care, pregnant women, and families whose only enrollee is less than one year old.
17. Tennessee Medicaid requires a phone interview at renewal.
18. In Texas, children covered under CHIP have 12 months of continuous coverage. However, the state will conduct administrative renewal for children in CHIP in families with income between 185% and 200% of the FPL at 6 months to determine whether income has exceeded 200% of the FPL.
19. Utah obtained approval for the use of ELE in CHIP at renewal in 2012.

Table 14
Renewal Periods and Streamlined Renewal Processes for Parents in Medicaid[1]
January 2013

State	Frequency of Renewal (Months)[2]	Face-to-Face Interview NOT Required	Simplifications Consistent with Children's Programs[3]
Total Adopting Simplification	**46**	**48**	**44**
Alabama	12	Y	Y
Alaska	12	Y	Y
Arizona	12	Y	Y
Arkansas[4]	12	Y	Y
California[5]	12	Y	Y
Colorado	12	Y	Y
Connecticut	12	Y	Y
Delaware	12	Y	Y
District of Columbia	12	Y	Y
Florida[6]	12	Y	Y
Georgia	6	Y	
Hawaii	12	Y	Y
Idaho	12	Y	Y
Illinois	12	Y	Y
Indiana	12	Y	Y
Iowa	12	Y	Y
Kansas	12	Y	Y
Kentucky	12		
Louisiana	12	Y	Y
Maine	12	Y	Y
Maryland	12	Y	Y
Massachusetts	12	Y	Y
Michigan	12	Y	Y
Minnesota	12	Y	Y
Mississippi	12		
Missouri	12	Y	Y
Montana	12	Y	Y
Nebraska[8]	12	Y	Y
Nevada[9]	12	Y	Y
New Hampshire	6	Y	
New Jersey	12	Y	Y
New Mexico[10]	12	Y	Y
New York[11]	12	Y	Y
North Carolina	6	Y	
North Dakota	12	Y	Y
Ohio	12	Y	Y
Oklahoma	12	Y	Y
Oregon[12]	12	Y	Y
Pennsylvania[13]	12	Y	Y
Rhode Island	12	Y	Y
South Carolina[14]	12	Y	Y
South Dakota	12	Y	Y
Tennessee[15]	12	Y	Y
Texas	6		
Utah[16]	12	Y	Y
Vermont	12	Y	Y
Virginia	12	Y	Y
Washington	6	Y	
West Virginia	12	Y	Y
Wisconsin	12	Y	Y
Wyoming	12	Y	Y

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2013.
Table presents rules in effect as of January 1, 2013.

Table 14 Notes

1. This table presents policies for parents covered though 1931 Medicaid coverage. Some states have differing policies for parents and other non-disabled adults covered through waiver or state-funded coverage programs.
2. This column shows the frequency of renewals. Some states require monthly, quarterly, or semi-annual income reporting or reporting a change in income, which is not addressed in this table. If the frequency of renewal is every 12 months, as opposed to six months or more frequently, the procedure is considered "simplified" for the purposes of this table.
3. States are classified has having consistent policies for children and parents if they have adopted all of the simplification measures listed in Medicaid for children and parents.
4. In Arkansas, county offices have the option or requiring either a face-to-face or telephone interview for Medicaid. Applicants who have had an active Medicaid case within the past year are not required to do an interview.
5. California has a 12-month renewal period, but performs income reviews every 6 months for parents.
6. In Florida, parents who are enrolled in Medicaid and who do not receive other benefits, such as food stamps or TANF, have a 12-month renewal period. Parents who submit applications that do not appear to be prone to error or fraud, known as "green track" applications, are not required to complete an interview.
7. In Minnesota, children and parents who qualify under the state's Section 1115 expansion program have eligibility reviewed every 12 months. In the "regular" Medicaid program, income reviews occur every 6 months and eligibility reviews every 12 months.
8. Nebraska requires a telephone interview for parents at Medicaid renewal.
9. Nevada has a 12-month renewal period but performs income checks on a quarterly basis.
10. New Mexico submitted an 1115 waiver that includes a provision to conduct 12-month continuous eligibility for adults in 2012.
11. New York has a waiver approved to do 12-months continuous eligibility for parents. The state has not yet implemented the provision.
12. In Oregon, the renewal period is up to 12 months, although most families receiving other benefits have a 6-month eligibility period.
13. Pennsylvania has a 12-month renewal period, but performs income reviews every 6 months.
14. In South Carolina, renewals typically occur every 12 months, but are conducted every 6 months if families report no income with no explanation for living expenses.
15. Tennessee requires a telephone interview for parents at Medicaid renewal.
16. In Utah, the renewal period is 12 months, but can be more frequent if income fluctuates.

Table 15
Renewal Methods Available for Medicaid and CHIP
January 2013

State	Telephone[1]		Online		Administrative Renewal[2]	
	Medicaid	CHIP	Medicaid	CHIP	Medicaid	CHIP
Total in Medicaid and/or CHIP	**24**		**28**		**22**	
Aligned Medicaid and CHIP[3]	**16**		**26**		**20**	
Alabama	Y	Y	Y	Y		
Alaska[3]		N/A		N/A	Y	N/A
Arizona		Y	Y	Y		
Arkansas[3]		N/A		N/A	Y	N/A
California[4,5] ▲				Y		
Colorado	Y	Y	Y	Y	Y	Y
Connecticut					Y	Y
Delaware[5] ▲	Y	Y	Y	Y		
District of Columbia		N/A		N/A		N/A
Florida[6]	Y		Y	Y	Y	Y
Georgia[5] ▲	Y		Y	Y		
Hawaii		N/A		N/A	Y	N/A
Idaho					Y	Y
Illinois[3, 7]	Y	Y			--	--
Indiana						
Iowa				Y		
Kansas[8]					Y	Y
Kentucky					Y	Y
Louisiana[9]	Y	Y	Y	Y	Y	Y
Maine[5] ▲			Y	Y	Y	Y
Maryland		N/A		N/A		N/A
Massachusetts[10]						
Michigan[3, 11]			Y	Y	Y	Y
Minnesota		N/A		N/A		N/A
Mississippi						
Missouri						
Montana	Y	Y			Y	Y
Nebraska		N/A	Y	N/A		N/A
Nevada						
New Hampshire[5, 12] ▲	Y	N/A	Y	N/A		N/A
New Jersey			Y	Y	Y	Y
New Mexico	Y	N/A		N/A	Y	N/A
New York[13]	Y					
North Carolina[3, 14]	Y	Y			Y	Y
North Dakota[5] ▲			Y	Y		
Ohio[15]	Y	N/A	Y	N/A	Y	N/A
Oklahoma[16]	Y	N/A	Y	N/A	Y	N/A
Oregon	Y	Y	Y	Y		
Pennsylvania		Y	Y	Y		
Rhode Island		N/A		N/A		N/A
South Carolina		N/A		N/A		N/A
South Dakota						
Tennessee	Y		Y	Y		Y
Texas[3, 5] ▲	Y	Y	Y	Y		
Utah[17] ▲	Y	Y	Y	Y	Y	Y
Vermont			Y	Y		
Virginia[5] ▲	Y	Y	Y	Y		Y
Washington	Y	Y	Y	Y		
West Virginia[3, 18]			Y	Y	Y	Y
Wisconsin	Y	Y	Y	Y		
Wyoming		Y	Y	Y		
Total	**21**	**16**	**26**	**24**	**20**	**16**

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2013.

▲Indicates that a state expanded renewal methods between January 1, 2012 and January 1, 2013.

Table presents rules in effect as of January 1, 2013.

Table 15 Notes

1. A state is considered to allow telephone renewals if the practice is done on a routine basis and not on a case-by-case basis or for a subset of the caseload.
2. A state is classified as providing administrative renewal if it sends a pre-populated form with all eligibility information available or a renewal letter to the family in advance of the renewal date. The family is required to either sign and return the form, signaling that they wish to continue coverage, or take no action. States that send a pre-populated form, but require families to submit paper documentation to continue coverage are not counted has having implemented administrative renewals. Additionally, states that check available data sources and send a notice of ongoing eligibility are counted as providing administrative renewals.
3. In Alaska, Arkansas, Illinois, Michigan, North Carolina, Texas, and West Virginia, administrative renewals are done for children, but not for parents.
4. The use of telephone, online, and administrative renewals varies by county in California.
5. California (CHIP), Delaware, Georgia, Maine, New Hampshire, North Dakota, Texas (Medicaid), and Virginia added online renewals in 2012.
6. In Florida, the administrative renewal process is only available in KidCare (CHIP) when enrolled using the joint Medicaid/CHIP application and not the family Medicaid application.
7. In Illinois, data on administrative renewals were not verified.
8. Kansas sends out renewal letters confirming ongoing eligibility based on information available to the state. They do not use a pre-populated form.
9. Louisiana has an administrative renewal process that doesn't require sending a pre-populated form to the family. This process if available for all children and some parents.
10. Massachusetts is implementing a pilot phone renewal process.
11. In Michigan, online renewals are available to children, but not parents.
12. New Hampshire added phone renewals in 2012.
13. In New York, phone renewals are available, but only in some counties.
14. In North Carolina, the administrative and phone renewal options are available to children, but not parents in Medicaid.
15. Ohio has an administrative renewal process that doesn't require sending a pre-populated form to the family. This process is available for children's coverage, but not for parents.
16. Oklahoma conducts rolling renewals through its online account management system. If a beneficiary has not accessed their online account in twelve months, the state will send a paper notification directing them to update their information online.
17. Utah added administrative renewals (using a pre-populated form) for both children and parents in Medicaid in 2012. In Utah, CHIP enrollees with no changes during the year are sent a simplified form and do not have to take any further action. CHIP families with a change must complete, sign, and return a different form.
18. In West Virginia, the online and administrative renewal processes are available for children, but not for parents.

Table 16

Premium, Enrollment Fee, and Copayment Requirements for Children[1, 2]

January 2013

State	Premiums/Enrollment Fees				Co-payments			
	Change in 2012[2]	Required in Medicaid	Required in CHIP	Income at Which Premiums Begin (% FPL)	Change[2]	Required in Medicaid	Required in CHIP	Income at Which Copays Begin (% FPL)
Total		**5**	**30**			**3**	**27**	
Alabama[3]	Increased		Y	101%	Increased		Y	101%
Alaska			N/A				N/A	
Arizona			Y	101%				
Arkansas			N/A			Y	N/A	200%
California			Y	101%			Y	101%
Colorado[4]			Y	151%	Increased		Y	101%
Connecticut			Y	235%			Y	185%
Delaware[5]			Y	101%			Y	101%
District of Columbia			N/A				N/A	
Florida[6]			Y	101%			Y	101%
Georgia[7]			Y	101%	Increased		Y	101%
Hawaii			N/A				N/A	
Idaho			Y	133%			Y	133%
Illinois			Y	151%			Y	134%
Indiana			Y	150%			Y	150%
Iowa			Y	150%			Y	151%
Kansas			Y	151%				
Kentucky							Y	101%
Louisiana			Y	201%			Y	201%
Maine			Y	151%				
Maryland[8]		Y	N/A	200%			N/A	
Massachusetts			Y	150%				
Michigan			Y	151%				
Minnesota[9]	Decreased	Y	N/A	201%			N/A	
Mississippi							Y	150%
Missouri[10]			Y	150%				
Montana							Y	133%
Nebraska			N/A				N/A	
Nevada[11]			Y	36%				
New Hampshire[12]	Decreased		N/A		Decreased		N/A	
New Jersey[13]			Y	201%			Y	151%
New Mexico			N/A			Y	N/A	185%
New York			Y	160%				
North Carolina[?]			Y	151%			Y	100%
North Dakota							Y	100%
Ohio			N/A				N/A	
Oklahoma			N/A				N/A	
Oregon[14]			Y	201%			Y	201%
Pennsylvania[15]			Y	201%			Y	201%
Rhode Island		Y	N/A	150%			N/A	
South Carolina			N/A				N/A	
South Dakota								
Tennessee							Y	101%
Texas[16]			Y	151%	Increased		Y	101%
Utah[17]			Y	101%	Increased		Y	101%
Vermont		Y	Y	186%				
Virginia							Y	134%
Washington			Y	201%				
West Virginia			Y	201%			Y	101%
Wisconsin[18]		Y	Y	200%		Y	Y	101%
Wyoming							Y	101%

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2013.

Table presents rules in effect as of January 1, 2013.

Table 16 Notes

1. Except for “mandatory children” (children under age six with family income below 133% of the FPL and children ages six to 17 with family income below 100% of the FPL), a state may impose premiums for children, with some limitations based on family income. Co-payments are also allowed, with some restrictions for children with family incomes up to 150% of the FPL. In general, states cannot adopt cost sharing or premium policies that impose costs that exceed 5% of family income or that favor higher-income families over lower-income families. They also are prohibited from imposing cost sharing for well-baby and well-child care, including immunizations. Some states require 18-year-olds to meet the co-payments of adults in Medicaid. These data are not shown.
2. "Increased" indicates that a state has increased premiums or co-payments or lowered the income level at which they are required in either Medicaid or CHIP. "Decreased" indicates that a state has decreased premiums or co-payments or raised the income level at which they are required in either Medicaid or CHIP. Changes occurred between January 1, 2012 and January 1, 2013, unless noted otherwise. Some states have automatic or annual premium increases (for example, tied to changes in the Federal Poverty Level). These changes are not marked as increases/decreases; only those changes that are the result of a policy change are noted.
3. Alabama increased CHIP annual premiums and copayments for physician, ER, and hospital visits in June 2012.
4. Colorado increased CHIP copayments for emergency and non-emergency room visits, inpatient hospital room visits and brand-name drugs in July 2012.
5. Delaware charges a copayment in CHIP for non-emergency use of the emergency room. For infants, the copayment charge begins at 186% FPL, and for children age 1-5, the copayment begins at 134% FPL.
6. Florida operates two CHIP-funded separate programs. Healthy Kids covers children ages 5 through 19, as well as younger siblings in some locations. MediKids covers children ages 1 through 4. Children in MediKids pay premiums, while children in Healthy Kids pay premiums and copayments.
7. Children under age 6 in Georgia are exempt from CHIP premiums. The state implemented new copayments in CHIP for physicians, hospital visits, and drugs in 2012.
8. In Maryland, most children are enrolled in MCOs and only have co-pays for mental health and HIV/AIDS drugs. Premiums decreased in 2012, due to annual indexing.
9. In Minnesota, premiums only apply in MinnesotaCare (1115 waiver). The state received approval in June 2011 for an amendment to eliminate premiums for children at or below 200% FPL and implemented the change for applicants and enrollees in October 2012. Premiums for children between 201% FPL and 250% FPL increased automatically with an increase in federal poverty level.
10. In Missouri, CHIP premiums for children at 200% FPL and 250% FPL as part of a routine annual adjustment.
11. In Nevada, although Medicaid covers children in families with income up to 100% or 133% FPL, some children with lower incomes may qualify for CHIP depending on the source of income and family composition. Such families with incomes at or above 36% of the FPL are required to pay premiums.
12. New Hampshire eliminated premiums and cost sharing in CHIP when it converted its separate CHIP program into a Medicaid expansion in 2012.
13. In New Jersey, premiums increased as part of an annual adjustment in 2012.
14. In Oregon, premiums decreased based on an annual adjustment in 2012.
15. The average premium amount in Pennsylvania increased for children in families with income at 200% and 250% FPL in 2012 as part of a routine annual adjustment to reflect utilization and cost trends.
16. Texas increased copays for non-preventive physician visits, non-emergency use of the ER, inpatient hospital visits, and generic and preferred brand name drugs in 2012.
17. Utah increased copayments for physician and ER visits in 2012. The state also added a deductible ($500 per child; $1500 per family) for those with income between 151% and 200% of the FPL.
18. In Wisconsin, infants covered in Medicaid between 200% and 300% of the FPL would be subject to premiums; those between 150% and 300% would be subject to copayments.

Table 17

Premiums and Enrollment Fees for Children at Selected Income Levels[1, 2]

January 2013

State	Effective Amount per Child at:[3] 101% FPL	151% FPL	201% FPL (200% if upper limit)	251% FPL (250% if upper limit)	301% FPL (300% if upper limit)	351% FPL (350% if upper limit)
NO PREMIUMS OR ENROLLMENT FEES						
Alaska	--	--	--	--	--	--
Arkansas	--	--	--	--	--	--
District of Columbia	--	--	--	--	--	--
Hawaii	--	--	--	--	--	--
Kentucky	--	--	--	--	--	--
Mississippi	--	--	--	--	--	--
Montana	--	--	--	--	--	--
Nebraska	--	--	--	--	--	--
New Hampshire	--	--	--	--	--	--
New Mexico	--	--	--	--	--	--
North Dakota	--	--	--	--	--	--
Ohio	--	--	--	--	--	--
Oklahoma	--	--	--	--	--	--
South Carolina	--	--	--	--	--	--
South Dakota	--	--	--	--	--	--
Tennessee	--	--	--	--	--	--
Virginia	--	--	--	--	--	--
Wyoming	--	--	--	--	--	--
MONTHLY PAYMENTS						
Arizona	$10	$40	$50	N/A	N/A	N/A
California[4]	$4/$7	$13/$16	$21/$24	$21/$24	N/A	N/A
Connecticut	$0	$0	$0	$30	$30	N/A
Delaware[5]	$10	$15	$25	N/A	N/A	N/A
Florida	$15	$20	$20	N/A	N/A	N/A
Georgia	$10	$20	$29	N/A	N/A	N/A
Idaho	$0	$15	N/A	N/A	N/A	N/A
Illinois	$0	$15	$15	N/A	N/A	N/A
Indiana	$0	$22	$42	$53	N/A	N/A
Iowa	$0	$10	$20	$20	$20	N/A
Kansas	$0	$20	$50	N/A	N/A	N/A
Louisiana[6]	$0	$0	$50	$50	N/A	N/A
Maine	$0	$8	$32	N/A	N/A	N/A
Maryland[6]	$0	$0	$50	$63	$63	N/A
Massachusetts	$0	$12	$20	$28	$28	N/A
Michigan[6]	$0	$10	$10	N/A	N/A	N/A
Minnesota[7]	$0	$0	$60	$95	N/A	N/A
Missouri	$0	$13	$43	$105	N/A	N/A
New Jersey	$0	$0	$41.50	$83	$134.50	$134.50
New York	$0	$0	$9	$30	$45	$60
Oregon[8]	$0	$0	$28.50	$43.00	$43.00	N/A
Pennsylvania[8]	$0	$0	$48	$67	N/A	N/A
Rhode Island[6]	$0	$61	$92	$92	N/A	N/A
Vermont[9]	$0	$0	$15	$20/$60	$20/$60	N/A
Washington	$0	$0	$20	$30	$30	N/A
West Virginia	$0	$0	$35	$35	N/A	N/A
Wisconsin	$0	$0	$10	$34	$97	N/A
QUARTERLY PAYMENTS						
Nevada[6]	$25	$50	$80	N/A	N/A	N/A
Utah[6]	$30	$75	$75	N/A	N/A	N/A
ANNUAL PAYMENTS						
Alabama[10]	$52	$104	$104	$104	$104	N/A
Colorado	$0	$25	$25	$75	N/A	N/A
North Carolina	$0	$50	$50	N/A	N/A	N/A
Texas	$0	$35	$50	N/A	N/A	N/A

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2013.

Table presents rules in effect as of January 1, 2013.

Table 17 Notes

1. Except for “mandatory children” in Medicaid (children under age six with family income below 133% of the FPL and children ages six to 17 with family income below 100% of the FPL), a state may impose premiums for children, with some limitations based on family income.
2. Enrollment fees are charged annually and families are typically not allowed to enroll in coverage without paying the fee.
3. If a state does not charge premiums at all, it is noted as "- -". N/A indicates that coverage is not available at this income level.
4. Premiums in California depend on whether the child is enrolled in a community provider plan. The first figure applies to children enrolled in a community provider plan; the second applies to those who are not.
5. In Delaware, premiums are per family per month regardless of the number of eligible children. Delaware has an incentive system for premiums where families can pay 3 months and get 1 premium-free month, pay 6 months and get 2 premium-free months, and pay 9 months and get 3 premium-free months.
6. In Louisiana, Maryland, Michigan, Rhode Island, Nevada, and Utah premiums are family-based, not costs per child.
7. In MinnesotaCare premium amounts vary based on income and family size and number of members receiving coverage; premiums reported are for a family of three, when only one child is enrolled in MinnesotaCare.
8. In Oregon and Pennsylvania, premiums vary by contractor. The average amount is shown.
9. In Vermont, premiums are for all children in the family, not costs per child. For those above 225% FPL, the monthly charge is $20 if the family has other health insurance and $60 if there is no other health insurance.
10. Alabama’s premium is an annual fee and is not required before a child enrolls in coverage.

Table 18

Disenrollment Policies for Non-Payment of Premiums in Children's Coverage[1]

January 2013

State	Grace Period for Non-Payment[2]	Lock-Out Period[3]	Requirements to Reenroll	
			Reapply for Coverage	Repay Outstanding Premiums
Total		**12**	**23**	**24**
Alabama[4]	11 months	None	Y	Y
Alaska	- -	- -	- -	- -
Arizona	60 days	None	Y	Y
Arkansas	- -	- -	- -	- -
California	60 days	None	Y	Y
Colorado	- -	- -	- -	- -
Connecticut	30 days	3 months		Y
Delaware	60 days	None		
District of Columbia	- -	- -	- -	- -
Florida[5]	30 days	1 month		
Georgia	30 days	1 month		Y
Hawaii	- -	- -	- -	- -
Idaho	60 days	None	Y	Y
Illinois	60 days	3 months	Y	Y
Indiana	60 days	None	Y	Y
Iowa	44 days	None	Y	Y
Kansas[6]	12 months	None	Y	Y
Kentucky	- -	- -	- -	- -
Louisiana[7]	60 days	None		Y
Maine[8]	12 months	up to 3 months	Y	
Maryland	45 days	None	Y	Y
Massachusetts[9]	60 days	None		Y
Michigan[10]	30 days	None	Y	Y
Minnesota[11]	None	4 months	Y	Y
Mississippi	- -	- -	- -	- -
Missouri[12]	30 days	6 months	Y	Y
Montana	- -	- -	- -	- -
Nebraska	- -	- -	- -	- -
Nevada	60 days	None	Y	Y
New Hampshire	- -	- -	- -	- -
New Jersey	60 days	None	Y	Y
New Mexico	- -	- -	- -	- -
New York[13]	30 days	None	Y	
North Carolina	- -	- -	- -	- -
North Dakota	- -	- -	- -	- -
Ohio	- -	- -	- -	- -
Oklahoma	- -	- -	- -	- -
Oregon	31 days	2 months	Y	Y
Pennsylvania[14]	60 days	6 months	Y	Y
Rhode Island[15]	60 days	4 months	Y	
South Carolina	- -	- -	- -	- -
South Dakota	- -	- -	- -	- -
Tennessee	- -	- -	- -	- -
Texas	- -	- -	- -	- -
Utah[16]	30 days	None	Y	Y
Vermont[17]	30 days	None	Y	Y
Virginia	- -	- -	- -	- -
Washington[18]	90 days	None		Y
West Virginia	30 days	3 months	Y	
Wisconsin[19]	60 days	6 months	Y	Y
Wyoming	- -	- -	- -	- -

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2013.

Table presents rules in effect as of January 1, 2013

Table 18 Notes

1. If a state does not charge premiums, it is noted as "- -".
2. CHIPRA required states to provide a 30-day premium payment grace period under CHIP before cancelling a child's coverage.
3. A lock-out period is a period of time during which the disenrolled person is prohibited from returning to the program.
4. Alabama charges an annual premium in its CHIP program. If the premium is not paid, the child is not able to renew coverage.
5. In Florida, if the child is in his/her 12-month continuous eligibility period, he/she does not need to reapply for coverage.
6. In Kansas, families are billed monthly, but only disenrolled for non-payment at renewal. A family does not need to reapply for coverage if termination is within 45 days of renewal date.
7. In Louisiana, if the child is in his/her 12-month continuous eligibility period, he/she does not need to reapply for coverage.
8. In Maine, for each month there is an unpaid premium, there is a month of ineligibility up to a maximum of 3 months. The penalty period begins in the first month following the enrollment period in which the premium was overdue.
9. In Massachusetts, families must reapply for coverage if their application is more than 12 months old. Premiums that are more than 24 months overdue are waived.
10. In Michigan, families do not have to pay missed premiums over 6 months old.
11. MinnesotaCare currently cancels coverage when the premium has not been paid in advance of the month of coverage. However, there is currently a 20-day period in which people with good cause can have coverage restored if they pay the premium during that period.
12. In Missouri, only children in families with incomes above 225% of the FPL are subject to the lock-out period and required to pay back missed premiums.
13. In New York, if the family pays the premium within 30 days of cancellation they do not need to reapply for coverage.
14. In Pennsylvania, if the family pays back-owed premiums up to 60 days after the renewal period, they do not have to re-apply for coverage. The family has six months to pay any unpaid premiums; if the family pays the overdue premiums, coverage will be reinstated retroactively.
15. In Rhode Island, families do not have to pay back-owed premiums prior to reenrolling, but the balance will remain on their account. Children under age 1 are exempt from the lock-out period.
16. In Utah, families don't have to pay back premiums that are over one year old.
17. In Vermont, premiums are paid on a prospective basis; payments must be received by the first business day following the month it was due for coverage to continue. If the premium is paid in the calendar month after the child lost coverage, the family does not have to reapply.
18. In Washington, the child only needs to reapply for coverage if he/she is past the initial certification period.
19. In Wisconsin, only families that reapply within 6-12 months after losing coverage are required to repay outstanding premiums.

Table 19
Copayment Amounts for Selected Services for Children at Selected Income Levels[1]
January 2013

State	Family Income at 151% FPL				Family Income at 201% FPL[2] (200% if upper limit)			
	Non-Preventive Physician Visit	ER Visit	Non-Emergency Use of ER[3]	Inpatient Hospital Visit	Non-Preventive Physician Visit	ER Visit	Non-Emergency Use of ER[3]	Inpatient Hospital Visit
Total	**18**	**14**	**19**	**14**	**23**	**17**	**23**	**16**
Alabama[3]	$13	$60	$60	$200	$13	$60	$60	$200
Alaska	- -	- -	- -	- -	- -	- -	- -	- -
Arizona	- -	- -	- -	- -	- -	- -	- -	- -
Arkansas	$10	$10	$0	20% of reimbursement rate for first day	$10	$10	$10	20% of reimbursement rate for first day
California[4, 5]	$10	$15	N/C	$0	$10	$15	N/C	$0
Colorado[6]	$5	$30	$30	$20	$10	$50	$50	$50
Connecticut	$0	$0	N/C	$0	$10	$0	N/C	$0
Delaware	$0	$0	$10	$0	$0	$0	$10	$0
District of Columbia	- -	- -	- -	- -	- -	- -	- -	- -
Florida[7]	$5	$0	$10	$0	$5	$0	$10	$0
Georgia[8]	$.50-$3	$0	$0	$12.50	$.50-$3	$0	$0	$12.50
Hawaii	- -	- -	- -	- -	- -	- -	- -	- -
Idaho	$0	$0	$3	$0	N/A	N/A	N/A	N/A
Illinois	$5	$5	$25	$5	$10	$30	$30	$100
Indiana	$0	$0	$0	$0	$0	$0	$0	$0
Iowa[9]	$0	$0	$25	$0	$0	$0	$25	$0
Kansas	- -	- -	- -	- -	- -	- -	- -	- -
Kentucky[10]	$0	$0	$6	$0	$0	$0	$6	$0
Louisiana[5]	$0	$0	$0	$0	10% of cost	$150 + 10% of cost	$150 + 10% of cost	10% of cost
Maine	- -	- -	- -	- -	- -	- -	- -	- -
Maryland	- -	- -	- -	- -	- -	- -	- -	- -
Massachusetts	- -	- -	- -	- -	- -	- -	- -	- -
Michigan	- -	- -	- -	- -	- -	- -	- -	- -
Minnesota	- -	- -	- -	- -	- -	- -	- -	- -
Mississippi	$5	$15	$15	$0	$5	$15	$15	$0
Missouri	- -	- -	- -	- -	- -	- -	- -	- -
Montana	$3	$5	$5	$25	$3	$5	$5	$25
Nebraska	- -	- -	- -	- -	- -	- -	- -	- -
Nevada	- -	- -	- -	- -	- -	- -	- -	- -
New Hampshire	- -	- -	- -	- -	- -	- -	- -	- -
New Jersey	$5	$10	$10	$0	$5	$35	$35	$0
New Mexico[5]	$0	$0	$0	$0	$5	$15	$15	$25
New York	- -	- -	- -	- -	- -	- -	- -	- -
North Carolina	$5	$0	$10	$0	$5	$0	$25	$0
North Dakota	$0	$5	$5	$50	N/A	N/A	N/A	N/A
Ohio	- -	- -	- -	- -	- -	- -	- -	- -
Oklahoma	- -	- -	- -	- -	- -	- -	- -	- -
Oregon[5]	$0	$0	$0	$0	$5	$100	$100	$100
Pennsylvania[5]	$0	$0	$0	$0	$5	$25	$25	$0
Rhode Island	- -	- -	- -	- -	- -	- -	- -	- -
South Carolina	- -	- -	- -	- -	- -	- -	- -	- -
South Dakota	- -	- -	- -	- -	- -	- -	- -	- -
Tennessee[5, 11]	$10/$15	$0/$15	$50/$50	$200/$100	$10/$15	$0/$15	$50/$50	$200/$100
Texas[12]	$20	$0	$75	$75	$25	$0	$75	$125
Utah[13]	$25	$300	$300	20% of daily reimbursement rate	$25	$300	$300	20% of daily reimbursement rate
Vermont	- -	- -	- -	- -	- -	- -	- -	- -
Virginia	$5	$5	$25	$25	$5	$5	$25	$25
Washington	- -	- -	- -	- -	- -	- -	- -	- -
West Virginia[5, 14]	$15	$35	$35	$25	$20	$35	$35	$25
Wisconsin	$1-$3	$0	$0	$3	$15	$0	$60	$100
Wyoming[5]	$10	$25	$25	$50	$10	$25	$25	$50

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2013.

Table presents rules in effect as of January 1, 2013.

Table 19 Notes

1. Co-payments are allowed, with some restrictions for children with family incomes up to 150% of the FPL. In general, states cannot adopt cost sharing or premium policies that impose costs that exceed 5% of family income or that favor higher-income families over lower-income families. They also are prohibited from imposing cost sharing for well-baby and well-child care, including immunizations. If a state charges co-payments, but either does not charge them at the income level shown or for the specific service, it is recorded as $0; if a state does not provide coverage at a particular income level it is noted as "N/A;" if a state does not charge co-payments at all, it is noted as "- -". Some states require 18-year-olds to meet the co-payments of adults in Medicaid. These data are not shown.
2. If the upper income eligibility level is 200% of the FPL, the co-payments shown reflect the cost at 200% of the FPL.
3. Alabama increased copayments for non-preventive physician visits, ER visits, and inpatient hospital visits in 2012.
4. In California, no coverage is provided if the services received in an emergency room are not for an emergency condition.
5. In California, Louisiana, Oregon, Pennsylvania, Tennessee, West Virginia, and Wyoming, the emergency room co-payment is waived if the child is admitted. In New Mexico, the emergency room co-payment is waived if the child is admitted, but the inpatient co-payment is still applied.
6. Colorado increased CHP+ copayments for ER visits, and inpatient hospital visits in 2012.
7. In Florida, co-payments only apply to children over the age of five.
8. Georgia implemented new copayments in CHIP for non-preventive physician visits and inpatient hospital visits in 2012.
9. In Iowa, enrollees are charged a co-payment for non-emergency use of the ER that is higher than the amount charged for a visit for a true emergency. These charges only apply to those with income above 150% FPL in Iowa.
10. In Kentucky enrollees are charged a co-payment for non-emergency use of the ER that is higher than the amount charged for a visit for a true emergency. In Kentucky, enrollees are charged 5% co-insurance for non-emergency use of the ER, which is capped at $6.
11. Tennessee has two CHIP programs. The first set of co-payments is for TennCare Standard and the second is for CoverKids.
12. Texas increased copayments for non-preventive physician visits, non-emergency use of the ER, and inpatient hospital visits in 2012.
13. Utah increased copayments for physician and ER visits in 2012. The state also added a deductible ($500 per child; $1500 per family) for those with income between 151% and 200% of the FPL.
14. In West Virginia, the co-payments for a non-preventive physician visit are waived if the child goes to his or her medical home.

Table 20
Copayment Amounts for Prescription Drugs for Children at Selected Income Levels[1]
January 2013

State	Family Income at 151% FPL			Family Income at 201% FPL[2] (200% if upper limit)		
	Generic	Preferred Brand Name	Non-Preferred Brand Name	Generic	Preferred Brand Name	Non-Preferred Brand Name
Total	**19**	**20**	**16**	**24**	**26**	**20**
Alabama[3]	$5	$25	$28	$5	$25	$28
Alaska	- -	- -	- -	- -	- -	- -
Arizona	- -	- -	- -	- -	- -	- -
Arkansas	$5	$5	$5	$5	$5	$5
California[4]	$5	$15	$15	$10	$15	$15
Colorado[5]	$3	$10	N/C	$5	$15	N/C
Connecticut	$0	$0	$0	$5	$10	$10
Delaware	$0	$0	$0	$0	$0	$0
District of Columbia	- -	- -	- -	- -	- -	- -
Florida[6]	$5	$5	$5	$5	$5	$5
Georgia[7]	$0.50	$0.50	$.50- $3	$0.50	$0.50	$.50- $3
Hawaii	- -	- -	- -	- -	- -	- -
Idaho	$0	$0	$0	N/A	N/A	N/A
Illinois	$3	$5	$5	$3	$7	$7
Indiana	$3	$10	$10	$3	$10	$10
Iowa	$0	$0	$0	$0	$0	$0
Kansas	- -	- -	- -	- -	- -	- -
Kentucky	$1	$2	$3	$1	$2	$3
Louisiana[8]	$0	$0	$0	50% of cost	50% of cost	50% of cost
Maine	- -	- -	- -	- -	- -	- -
Maryland	- -	- -	- -	- -	- -	- -
Massachusetts	- -	- -	- -	- -	- -	- -
Michigan	- -	- -	- -	- -	- -	- -
Minnesota	- -	- -	- -	- -	- -	- -
Mississippi	$0	$0	$0	$0	$0	$0
Missouri	- -	- -	- -	- -	- -	- -
Montana[9]	$3	$5	$5	$3	$5	$5
Nebraska	- -	- -	- -	- -	- -	- -
Nevada	- -	- -	- -	- -	- -	- -
New Hampshire	- -	- -	- -	- -	- -	- -
New Jersey	$1	$5	$5	$5	$5	$5
New Mexico	$0	$0	$0	$2	$2	$2
New York	- -	- -	- -	- -	- -	- -
North Carolina[10]	$1	$1	$3	$1	$1	$10
North Dakota	$2	$2	$2	N/A	N/A	N/A
Ohio	- -	- -	- -	- -	- -	- -
Oklahoma	- -	- -	- -	- -	- -	- -
Oregon	$0	$0	$0	$0	$10	N/C
Pennsylvania[11]	$0	$0	N/C	$6	$9	N/C
Rhode Island	- -	- -	- -	- -	- -	- -
South Carolina	- -	- -	- -	- -	- -	- -
South Dakota	- -	- -	- -	- -	- -	- -
Tennessee[12]	$0/$5	$3/$20	$3/$40	$0/$5	$3/$20	$3/$40
Texas[13]	$10	$35	N/C	$10	$35	N/C
Utah	$15	25% of cost	50% of cost	$15	25% of cost	50% of cost
Vermont	- -	- -	- -	- -	- -	- -
Virginia	$5	$5	$5	$5	$5	$5
Washington	- -	- -	- -	- -	- -	- -
West Virginia	$0	$10	$15	$0	$10	$15
Wisconsin[14]	$1	$3	N/C	$5	N/C	N/C
Wyoming	$5	$10	N/C	$5	$10	N/C

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2013.

Table presents rules in effect as of January 2013.

Table 20 Notes

1. Co-payments are allowed, with some restrictions for children with family incomes up to 150% of the FPL. In general, states cannot adopt cost sharing or premium policies that impose costs that exceed 5% of family income or that favor higher-income families over lower-income families. They also are prohibited from imposing cost sharing for well-baby and well-child care, including immunizations. If a state charges co-payments, but either does not charge them at the income level shown or for the specific service, it is recorded as $0; if a state does not provide coverage at a particular income level it is noted as "N/A;" if a state does not charge co-payments at all, it is noted as "- -"; if a state does not cover a type of drug, it is noted as "N/C". Some states require 18-year-olds to meet the co-payments of adults in Medicaid. These data are not shown.
2. If the upper income eligibility level is 200% of the FPL, the co-payments shown reflect the cost at 200% of the FPL.
3. Alabama increased copayments for generic drugs, preferred brand name drugs, and non-preferred brand name drugs in 2012.
4. In California, the co-payment for brand-name drugs only applies if a generic version is available. In California, brand name drugs cost $10 if there is no generic equivalent and the use of a brand name drug is medically necessary.
5. Colorado increased copayments for preferred brand name drugs in 2012.
6. In Florida, co-payments only apply to children over the age of five.
7. Georgia implemented new CHIP copayments for generic and brand-name drugs in 2012.
8. In Louisiana, families pay 50% of the cost of the prescription, up to a maximum of $50 per 30-day supply. After $1,200 per person per plan year, the co-payment is $15 for brand named prescriptions and $0 for generic prescriptions.
9. If families order prescriptions through the mail in Montana, they pay $6 for a 3-month supply of a generic drug and $10 for a 3-month supply of a brand-named drug.
10. In North Carolina, the co-payment for brand-name drugs only applies if a generic version is available.
11. In Pennsylvania, if a drug is not included on the formulary of the managed care plan for a CHIP child, the family must pay for the drug out-of-pocket.
12. Tennessee has two CHIP programs. The first set of co-payments is for TennCare Standard and the second is for CoverKids.
13. Texas increased copayments for generic and preferred brand name drugs in 2012.
14. Wisconsin does not cover brand name drugs, except for certain insulin brands and some asthma medications for enrollees above 200% of the FPL. When they do cover them, they have the same copayment as generic drugs.

Table 21

Premium and Copayment Requirements for 1931 Parents[1]

January 2013

State	Change in 2012?[2]	Premiums/ Enrollment Fees?	Income Premiums/ Fees Begin (% FPL)	Change in 2012?[2]	Copays	Income Copays Begin (% FPL)
Total		**1**			**39**	
Alabama		- -			Y	0%
Alaska		- -			Y	0%
Arizona		- -			Y	0%
Arkansas		- -			Y	0%
California		- -			Y	0%
Colorado		- -			Y	0%
Connecticut		- -			- -	
Delaware		- -			Y	0%
District of Columbia		- -			- -	
Florida		- -			Y	0%
Georgia		- -			Y	0%
Hawaii		- -			- -	
Idaho		- -			- -	
Illinois[3]		- -		Increased	Y	0%
Indiana		- -			Y	0%
Iowa		- -			Y	0%
Kansas[4]		- -		Decreased	- -	
Kentucky		- -			Y	0%
Louisiana		- -			Y	0%
Maine		- -			Y	0%
Maryland[5]		- -			- -	
Massachusetts		- -			Y	0%
Michigan		- -			Y	0%
Minnesota		- -			Y	0%
Mississippi		- -			Y	0%
Missouri		- -			Y	0%
Montana		- -			Y	0%
Nebraska		- -			Y	0%
Nevada		- -			- -	
New Hampshire		- -			Y	0%
New Jersey		- -			- -	
New Mexico		- -			- -	
New York		- -			Y	0%
North Carolina		- -			Y	0%
North Dakota		- -			Y	0%
Ohio		- -			Y	0%
Oklahoma		- -			Y	0%
Oregon		- -			Y	0%
Pennsylvania[6]		- -		Increased	Y	0%
Rhode Island		- -			- -	
South Carolina		- -			Y	0%
South Dakota[7]		- -		Increased	Y	0%
Tennessee		- -			Y	0%
Texas		- -			- -	
Utah		- -			Y	0%
Vermont[8]		- -		Increased/ Decreased	Y	0%
Virginia		- -			Y	0%
Washington		- -			- -	
West Virginia		- -			Y	0%
Wisconsin[9]	Increased	Y	133%		Y	0%
Wyoming		- -			Y	0%

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2013.

Table presents rules in effect as of January 1, 2013.

Table 21 Notes

1. A state may impose premiums for parents with some limitations based on family income. Copayments are also allowed, with some restrictions. In general, states cannot adopt cost sharing or premium policies that impose costs that exceed 5% of family income or that favor higher-income families over lower-income families.
2. "Increased" indicates that a state has increased premiums or co-payments or lowered the income level at which they are required in Medicaid. "Decreased" indicates that a state has decreased premiums or co-payments or raised the income level at which they are required in Medicaid. Changes occurred between January 1, 2012 and January 1, 2013, unless noted otherwise. Some states have automatic or annual premium increases (for example, tied to changes in the Federal Poverty Level). These changes are not marked as increases/decreases; only those changes that are the result of a policy change are noted.
3. Illinois cut eligibility for parents from 200% to 133% FPL in 2012. Premiums, which previously applied to parents above 151% FPL no longer apply. Illinois also increased copayments for non-preventive physician visits, non-emergency use of the ER, and drugs in 2012.
4. Kansas eliminated copayments for section 1931 parents on January 1, 2013.
5. Maryland does not charge copayments for section 1931 parents except for mental health and HIV/AIDS related drugs.
6. Pennsylvania increased copayments for non-preventive physician visits for parents in 2012.
7. South Dakota increased copays for generic and preferred brand name drugs in 2012.
8. Vermont eliminated its $75 copayment for inpatient hospital visits for 1931 Medicaid parents and increased copays for other services in 2012.
9. In July 2012, Wisconsin began charging parents premiums at 133% of the FPL (previously premiums weren't imposed on parents with incomes below 150% of the FPL). They also increased premium amounts for 1931 parents.

Table 22

Premium and Copayment Amounts for Selected Services for Section 1931 Parents[1, 2]

January 2013

State	Premiums (per month)	Non-Preventive Physician Visit	Emergency Room Visit	Non-Emergency Use of ER	Inpatient Hospital Visit	Generic Drug	Preferred Brand Name Drug	Non-Preferred Brand Name Drug
Total Requiring Fees		**22**	**2**	**18**	**24**	**36**	**39**	**39**
Alabama	- -	$1	$0	$3	$50	$.50-$3	$.50-$3	$.50-$3
Alaska[3]	- -	$10	$0	$0	$50/day	$3	$3	$3
Arizona	- -	$3.40	$0	$0	$0	$2.30	$2.30	$2.30
Arkansas	- -	$0	$0	$0	10% cost of first day	$.50-$3	$.50-$3	$.50-$3
California	- -	$1	$0	$5	$0	$1	$1	$1
Colorado	- -	$0	$0	$0	$10	$1	$3	$3
Connecticut	- -	- -	- -	- -	- -	- -	- -	- -
Delaware	- -	$0	$0	$0	$0	$.50-$3	$.50-$3	$.50-$3
District of Columbia	- -	- -	- -	- -	- -	- -	- -	- -
Florida	- -	$0	$0	$15	$0	$0	$0	$0
Georgia	- -	$0	$0	$0	$12.50	$.50-$3	$.50-$3	$.50-$3
Hawaii	- -	- -	- -	- -	- -	- -	- -	- -
Idaho	- -	- -	- -	- -	- -	- -	- -	- -
Illinois[4]	- -	$3.65	$0	$3.65	up to $3 per day	$2	$3.65	$3.65
Indiana	- -	$0	$0	$3	$0	$3	$3	$3
Iowa[5]	- -	$3	$0	$0	$0	$1	$1	$2 or $3
Kansas[6]	- -	- -	- -	- -	- -	- -	- -	- -
Kentucky[7]	- -	$2	$0	$6	$50	$1	$2	5% coinsurance up to $20
Louisiana	- -	$0	$0	$0	$0	$.50-$3	$.50-$3	$.50-$3
Maine[8]	- -	$0	$0	$0	$3	$3	$3	$3
Maryland	- -	- -	- -	- -	- -	- -	- -	- -
Massachusetts	- -	$0	$0	$0	$3	$3.65	$3.65	$3.65
Michigan	- -	$0	$0	$0	$0	$1	$1	$1
Minnesota	- -	$3	$0	$3.50	$0	$1	$3	$3
Mississippi	- -	$3	$0	$0	$10	$3	$3	$3
Missouri	- -	$1	$0	$3	$10	$.50-$2	$.50-$2	$.50-$2
Montana	- -	$4	$0	$5	$100	$1-$5	$1-$5	$1-$5
Nebraska	- -	$2	$0	$0	$15	$2	$2	$3
Nevada	- -	- -	- -	- -	- -	- -	- -	- -
New Hampshire	- -	$0	$0	$0	$0	$1	$2	$2
New Jersey	- -	- -	- -	- -	- -	- -	- -	- -
New Mexico	- -	- -	- -	- -	- -	- -	- -	- -
New York	- -	$0	$3	$3	$25/discharge	$1	$3	$3
North Carolina	- -	$3	$0	$0	$3/day	$3	$3	$3
North Dakota	- -	$2	$0	$3	$75	$0	$3	$3
Ohio	- -	$0	$0	$3	$0	$0	$2	$3
Oklahoma[9]	- -	$3	$0	$0	$10 day/$90 max	$0 - $3.50	$0 - $3.50	$0 - $3.50
Oregon[10]	- -	$0	$0	$3	$0	$2	$3	$3
Pennsylvania[11]	- -	$.65-$3.80	$0	$.50-$3	$3/day	$1	$3	$3
Rhode Island	- -	- -	- -	- -	- -	- -	- -	- -
South Carolina	- -	$2.30	$0	$0	$25	$3.40	$3.40	$3.40
South Dakota[12]	- -	$3	$0	$50	$50	$1	$3.30	N/C
Tennessee	- -	$0	$0	$0	$0	$0	$3	$3
Texas	- -	- -	- -	- -	- -	- -	- -	- -
Utah[13]	- -	$3	$0	$6	$220	$3	$3	$3
Vermont	- -	$0	$0	$0	$75	$1-$3	$1-$3	$1-$3
Virginia	- -	$1	$0	$0	$100	$1	$3	$3
Washington	- -	- -	- -	- -	- -	- -	- -	- -
West Virginia	- -	$0	$0	$0	$0	$.50-$3	$.50-$3	$.50-$3
Wisconsin	$95-200	$.50-$3	$.50-$3	$.50-$3	$.50-$3	$.50-$3	$.50-$3	$.50-$3
Wyoming	- -	$2	$0	$6	$0	$1	$2	$3

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2013.

Table presents rules in effect as of January 1, 2013.

Table 22 Notes

1. A state may impose premiums for parents with some limitations based on family income. Co-payments are also allowed, with some restrictions. In general, states cannot adopt cost sharing or premium policies that impose costs that exceed 5% of family income or that favor higher-income families over lower-income families.
2. If a state charges co-payments, but either does not charge them for the specific service, it is recorded as $0; if a state does not charge co-payments at all, it is noted as "- -"; if a state does not cover a type of drug, it is noted as "/".
3. In Alaska, the inpatient hospital co-pay is for the first 4 days.
4. Illinois increased copayments for non-preventive physician visits, non-emergency use of the ER, and drugs in 2012.
5. In Iowa, charges are $2 for non-preferred brands between $25.01 and $50; and $3 when non-preferred brand >$50.
6. Kansas eliminated co-payments for section 1931 parents on January 1, 2013.
7. In Kentucky enrollees are charged a co-payment for non-emergency use of the ER that is higher than the amount charged for a visit for a true emergency. In Kentucky, enrollees are charged 5% co-insurance for non-emergency use of the ER, which is capped at $6.
8. In Maine, there is a $30 monthly maximum for inpatient hospital and drug copayments for 1931 Medicaid parents.
9. For 1931 Medicaid parents in Oklahoma, preferred generics are $0, brand name co-payments are $.65 for Medicaid allowable under $10; $1.20 for Medicaid allowable between $10.01 and $25; and $2.40 for Medicaid allowable between $25.01 and $50; and $3.50 for Medicaid allowable above $50.
10. In Oregon 1931 Medicaid coverage, drugs ordered through the home-delivery pharmacy program do not have co-pays.
11. In Pennsylvania, copayments for 1931 parents vary based on cost of service; the inpatient hospital co-pay is subject to a maximum of $21.
12. South Dakota increased copays for generic and preferred brand name drugs in 2012.
13. For 1931 Medicaid parents in Utah, there is a monthly out-of-pocket maximum for prescription drug co-pays of $15.

Table 23

Premium, Enrollment Fee, and Copayment Requirements for Expanded Adult Coverage[1]

January 2013

State	Expansion Program Name	Change in 2012?[2]	Premiums/ Enrollment Fees?	Income Premiums/ Fees Begin (% FPL)	Change in 2012?[2]	Copays	Income Copays Begin (% FPL)
Total			**19**			**26**	
Arizona[3]	AHCCCS (1115 Waiver)		- -			Y	0%
Arkansas	ARHealthNetworks (1115 Waiver)		Y	0%		Y	0%
California[4]	Medicaid Coverage Expansion (1115 Waiver)		- -			Y	0%
	Health Care Coverage Initiative (1115 Waiver)		Y	150%		Y	0%
Connecticut	Medicaid for Low-Income Adults (ACA Option)		- -			- -	
Colorado	Adults Without Dependent Children (1115 Waiver)		- -			Y	0%
Delaware	Diamond State Health Plan (1115 Waiver)		- -			Y	0%
District of Columbia	ACA Adult Expansion		- -			- -	
	ACA Expansion (1115 Waiver)		- -			- -	
Hawaii	QUEST (1115 Waiver)		- -			- -	
Idaho	Access to Health Insurance (1115 Waiver)		Y	0%		Y	0%
Indiana[5]	Healthy Indiana Plan (1115 Waiver)		Y	>0%		Y	0%
Iowa	IowaCare (1115 Waiver)		Y	150%		Y	133%
Maine	Maine Care (1115 Waiver)		- -			- -	--
Maryland	Primary Adult Coverage (1115 Waiver)		- -			Y	0%
Massachusetts	MassHealth Basic & Essential (1115 Waiver)		- -			Y	0%
	Commonwealth Care (1115 Waiver)		Y	150%		Y	0%
Michigan	Adult Benefits Waiver (1115 Waiver)		- -			Y	0%
Minnesota	ACA Adult Expansion		- -			Y	0%
	MinnesotaCare (1115 Waiver)		Y	0%		Y	0%
New Jersey	Family Care (1115 Waiver)		Y	150%		Y	151%
	New Jersey Childless Adults (1115 Waiver)		- -			- -	
New Mexico	SCI (1115 Waiver)		Y	101%		Y	101%
New York	Family Health Plus (1115 Waiver)		- -			Y	0%
Oklahoma	Insure Oklahoma (1115 Waiver)		Y	0%		Y	0%
Oregon	OHP Standard (1115 Waiver)		Y	10%		- -	
	FHIAP (1115 Waiver)		Y	0%		Y	0%
Rhode Island	RIte Care/Share (1115 Waiver)		Y	150%		- -	
Utah[6]	Primary Care Network (1115 Waiver)		Y	0%		Y	101%
	Utah Premium Partnership (1115 Waiver)		Y	101%		Y	101%
Vermont	VHAP (1115 Waiver)		Y	50%		Y	0%
	Catamount Care (1115 Waiver)		Y	0%		Y	0%
Washington	Basic Health (1115 Waiver)		Y	0%		Y	0%
Wisconsin[7]	BadgerCare Plus Core Plan (1115 Waiver)	Increased	Y	133%		Y	0%

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2013.

Table presents rules in effect as of January 1, 2013.

Table 23 Notes

1. Expansion coverage includes waiver programs for parents and/or other non-disabled adults.
2. "Increased" indicates that a state has increased premiums or co-payments or lowered the income level at which they are required. "Decreased" indicates that a state has decreased premiums or co-payments or raised the income level at which they are required. Changes occurred between January 1, 2012 and January 1, 2013, unless noted otherwise.
3. Arizona added $2 copays for medically necessary taxi rides in Maricopa and Pima counties, (effective 4/1/12.
4. In California, premium policies in Health Care Coverage Initiative (HCCI) depend on the county. There are no premiums in the Medicaid Coverage Expansion (MCE).
5. In Indiana, expansion coverage is the Healthy Indiana Plan; individuals with zero income are exempt from monthly contributions.
6. Utah now limits premiums and copayments in the Utah Premium Partnership to those with income above 100% of the FPL.
7. Wisconsin added premiums for adults enrolled in the BadgerCare Plus Core 1115 Waiver program in 2012.

Table 24
Premiums and Enrollment Fees for Expanded Adult Coverage at Selected Incomes [1, 2, 3]
January 2013

State	Expansion Program Name	101% FPL (100% if upper limit)	151% FPL (150% if upper limit)	201% FPL (200% if upper limit)	251% FPL (250% if upper limit)	300% FPL (301% if upper limit)	351% FPL (350% if upper limit)
MONTHLY PAYMENTS							
Arizona	AHCCCS (1115 Waiver)	--	--	--	--	--	--
Arkansas[4]	ARHealthNetworks (1115 Waiver)	$25	$25	$25	N/A	N/A	N/A
California[5]	Medicaid Coverage Expansion (1115 Waiver)	--	--	--	--	--	--
	Health Care Coverage Initiative (1115 Waiver)	--	vary by county		N/A	N/A	N/A
Colorado	Adults Without Dependent Children (1115 Waiver)	--	--	--	--	--	--
Connecticut	Medicaid for Low-Income Adults (ACA Option)	--	--	--	--	--	--
Delaware	Diamond State Health Plan (1115 Waiver)	--	--	--	--	--	--
District of Columbia	ACA Adult Expansion	--	--	--	--	--	--
	ACA Expansion (1115 Waiver)	--	--	--	--	--	--
Hawaii	QUEST (1115 Waiver)	--	--	--	--	--	--
Idaho[6]	Access to Health Insurance (1115 Waiver)	vary based on ESI plan		N/A	N/A	N/A	N/A
Indiana[7]	Healthy Indiana Plan (1115 Waiver)	$27	$68	$90	N/A	N/A	N/A
Iowa	IowaCare (1115 Waiver)	$0	$51	$65	$65	N/A	N/A
Maine	Maine Care (1115 Waiver)	--	--	--	--	--	--
Maryland	Primary Adult Coverage (1115 Waiver)	--	--	--	--	--	--
Massachusetts[8]	MassHealth Basic & Essential (1115 Waiver)	--	--	--	--	--	--
	Commonwealth Care (1115 Waiver)	$0-$28	$40-$81	$78-$138	$118-$182	$118-$182	N/A
Michigan	Adult Benefits Waiver (1115 Waiver)	--	--	--	--	--	--
Minnesota[9]	ACA Adult Expansion	N/A	N/A	N/A	N/A	N/A	N/A
	MinnesotaCare (1115 Waiver)	$20	$50	$105	$167	N/A	N/A
New Jersey	Family Care (1115 Waiver)	N/A	$44	$44	N/A	N/A	N/A
	New Jersey Childless Adults (1115 Waiver)	N/A	N/A	N/A	N/A	N/A	N/A
New Mexico[10]	SCI (1115 Waiver)	$25/$95	$35/$110	$35/$110	N/A	N/A	N/A
New York	Family Health Plus (1115 Waiver)	--	--	--	--	--	--
Oklahoma[11]	Insure Oklahoma (1115 Waiver)	$36.46	$54.51	N/A	N/A	N/A	N/A
Oregon[12]	OHP Standard (1115 Waiver)	$20	N/A	N/A	N/A	N/A	N/A
	FHIAP (1115 Waiver)		vary by plan		N/A	N/A	N/A
Rhode Island[13]	RIte Care/Share (1115 Waiver)	$0	$61	N/A	N/A	N/A	N/A
Vermont[14]	VHAP (1115 Waiver)	$25	$33	N/A	N/A	N/A	N/A
	Catamount Care (1115 Waiver)	$60 or $119	$60 or $119	$124 or $183	$152 or $211	$208 or $267	N/A
Washington[15]	Basic Health (1115 Waiver)	$60	$80.15	$140.27	N/A	N/A	N/A
Wisconsin[16]	BadgerCare Plus Core Plan (1115 Waiver)	--	$56	$117	N/A	N/A	N/A
ANNUAL PAYMENTS							
Utah	Primary Care Network (1115 Waiver)	$15-$50	$15-$50	N/A	N/A	N/A	N/A
	Utah Premium Partnership (1115 Waiver)	up to $150	up to $150	N/A	N/A	N/A	N/A

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2013. Table presents rules in effect as of January 1, 2013.

Table 24 Notes

1. Expansion coverage includes programs for parents and/or other non-disabled adults.
2. Enrollment fees are charged annually and families are typically not allowed to enroll in coverage without paying the fee.
3. If a state does not charge premiums at all, it is noted as "- -". N/A indicates that coverage is not available at this income level.
4. In Arkansas, adults above 200% FPL can buy-in to the ARHealthNet waiver program at full cost for $255/month.
5. In California, premium policies in Health Care Coverage Initiative (HCCI) depend on the county. There are no premiums in the Medicaid Coverage Expansion (MCE).
6. In Idaho, actual premium costs for the Access to Health Insurance premium assistance waiver program vary based on ESI plan.
7. In Indiana, costs represent monthly POWER Account contributions for the Healthy Indiana Plan waiver program; costs vary based on family composition and income; amounts shown are for a single adult with no children.
8. In Massachusetts, premium costs for the Commonwealth Care waiver program vary by income and plan type.
9. In MinnesotaCare premium amounts vary based on income and family size and number of members receiving coverage; premiums reported are for an individual adult.
10. In New Mexico, premium costs before the slash represent the cost if an employer pays the employer share; numbers after the slash represent the cost if the individual pays both the employee and employer share.
11. In Oklahoma, premiums range from $67.31 to $181.60, or 4% of income, whichever is less; amounts shown equal 4% of income.
12. In Oregon, OHP Standard waiver program premiums begin at 10% FPL and range from $9-$20 with eligibility ending at 100% FPL; premiums for FHIAP premium assistance waiver coverage vary by plan; individuals pay between 5-50% of premium costs depending on income; the average premium amount is $35.49 per month for indivdual plans and $21.36 per month for employer-sponsored plans.
13. In Rhode Island, premiums are family-based.
14. In Vermont, costs for Catamount Health are for a single individual; these costs vary by plan. Individuals above 300% FPL can buy into Catamount Health at full cost for $416 per month.
15. In Washington, premium costs for Basic Health are for a single adult 19-39 years old with no children in Adams County. Most but not all counties have the same premiums as Adams County.
16. In Wisconsin, childless adults in the BadgerCare Plus Core Plan also pay an annual fee of $60.

Table 25
Cost Sharing Amounts for Selected Services for Expanded Adult Coverage at Selected Incomes [1, 2]
January 2013

State	Expansion Program Name	<100% FPL				100-200% FPL			
		Non-Preventive Physician Visit	Emergency Room Visit	Non-Emergency Use of ER	Inpatient Hospital Visit	Non-Preventive Physician Visit	Emergency Room Visit	Non-Emergency Use of ER	Inpatient Hospital Visit
Arizona	AHCCCS (1115 Waiver)	$5	$0	$30	$0	N/A			
Arkansas	ARHealthNetworks (1115 Waiver)	15% coinsurance				15% coinsurance			
California	Medicaid Coverage Expansion (1115 Waiver)	$1	$5	N/C	$0	N/A			
	Health Care Coverage Initiative (1115 Waiver)	N/A				$1	$5	N/C	$0
Colorado	Adults Without Dependent Children (1115 Waiver)	$0	$0	$0	$10	N/A			
Connecticut	Medicaid for Low-Income Adults (ACA Option)	--	--	--	--	--	--	--	--
Delaware	Diamond State Health Plan (1115 Waiver)	$0	$0	$0	$0	N/A			
District of Columbia	ACA adult expansion	- -	- -	- -	- -	- -	- -	- -	- -
	ACA Expansion (1115 Waiver)	- -	- -	- -	- -	- -	- -	- -	- -
Hawaii	QUEST (1115 Waiver)	- -	- -	- -	- -	- -	- -	- -	- -
Idaho[3]	Access to Health Insurance (1115 Waiver)	Vary based on ESI plan				Vary based on ESI plan			
Indiana[4]	Healthy Indiana Plan (1115 Waiver)	$0	Up to $25	Up to $25	$0	$0	Up to $25	Up to $25	$0
Iowa	IowaCare (1115 Waiver)	$3	$0	$3	$0	$3	$0	$3	$0
Maine	Maine Care (1115 Waiver)	- -	- -	- -	- -	N/A			
Maryland[5]	Primary Adult Coverage (1115 Waiver)	$0	N/C	N/C	N/C	$0	N/C	N/C	N/C
Massachusetts[6, 7]	MassHealth Basic & Essential (1115 Waiver)	$0	$0	$0	$3	- -	- -	- -	- -
	Commonwealth Care (1115 Waiver)	$0	$0	$0	$0	$10	$50	$50	$50
Michigan	Adult Benefits Waiver (1115 Waiver)	$3	$0	$0	$0	N/A			
Minnesota	ACA adult expansion	$3	$0	$3.50	$0	N/A			
	MinnesotaCare (1115 Waiver)	$3	$0	$6	$0	$3	$0	$6	$0
New Jersey	Family Care (1115 Waiver)	N/A				$0	$35	$35	$0
	New Jersey Childless Adults (1115 Waiver)	- -	- -	- -	- -	- -	- -	- -	- -
New Mexico[8, 9]	SCI (1115 Waiver)	$0	$0	$0	$0	$5-$7	$15-$20	$15-$20	$25-$30
New York	Family Health Plus (1115 Waiver)	$0	$3	$3	$25/discharge	$0	$3	$3	$25/discharge
Oklahoma[10]	Insure Oklahoma (1115 Waiver)	$10	$30	$30	$50	$10	$30	$30	$50
Oregon[11]	OHP Standard (1115 Waiver)	- -	- -	- -	- -	N/A			
	FHIAP (1115 Waiver)	vary based on plan				vary based on plan			
Rhode Island	RIte Care/Share (1115 Waiver)	- -	- -	- -	- -	- -	- -	- -	- -
Utah[12]	Primary Care Network (1115 Waiver)	$15	$30 (if covered)		N/C	$15	$30 (if covered)		N/C
	Utah Premium Partnership (1115 Waiver)	vary based on plan				vary based on plan			
Vermont[13, 14]	VHAP (1115 Waiver)	$0	$25	$60	$0	$0	$25	$60	$0
	Catamount Care (1115 Waiver)	$10	$500 deductible, then 20% coins.			$10	$500 deductible, then 20% coins.		
Washington	Basic Health (1115 Waiver)	$15	$100	$100	$250 deductible, then 20% conins.	$15	$100	$100	$250 deductible, then 20% conins.
Wisconsin[15]	BadgerCare Plus Core Plan (1115 Waiver)	$.50-$3	$0	$0	$3 per day	$.50-$3	$60	$60	$100 per stay

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2013.
Table presents rules in effect as of January 1, 2013.

Table 25 Notes

1. Expansion coverage includes both waiver and state-funded programs for parents and/or other non-disabled adults.
2. If a state charges co-payments, but either does not charge them at the income level shown or for the specific service, it is recorded as $0; if a state does not provide coverage at a particular income level it is noted as "N/A;" if a state does not charge co-payments at all, it is noted as "- -"; if a state does not cover a type of service or drug, it is noted as "/".
3. In Idaho the expansion coverage is premium assistance, so cost sharing charges vary by ESI plan.
4. In Indiana, the emergency room visit co-pay is waived if admitted.
5. In Maryland, there is no coverage for the enrollee for inpatient hospital and emergency room visits; however, there is coverage for the facility costs associated with these visits.
6. In Massachusetts (Commonwealth Care), the emergency room visit co-pay is waived if admitted.
7. In Massachusetts, out-of-pocket costs in Commonwealth Care are subject to annual maximums that vary by income.
8. In New Mexico, the emergency room visit co-pay is waived if admitted.
9. In New Mexico, cost-sharing varies based on income in SCI waiver coverage.
10. In Oklahoma, the emergency room visit co-pay is waived if admitted.
11. There are no co-pays in OHP Standard expansion coverage per court order. FHIAP is a premium assistance program; as such cost sharing varies by plan.
12. For the Primary Care Network (PCN), ER care is only covered for approved emergency diagnoses; Utah Premium Partnership (UPP) is a premium assistance program; as such, costs vary by plan.
13. In Vermont (VHAP) enrollees are charged a co-payment for non-emergency use of the ER that is higher than the amount charged for a visit that is a true emergency.
14. Catamount Health has an annual in-network maximum on out of pocket costs of $1,050 for single coverage and $2,100 for a family plan. Out-of-pocket costs in Catamount Health are waived for patients who need clinically recommended treatment for a chronic condition or disease.
15. In Wisconsin (BadgerCare Core enrollees between 100% and 200%), the emergency room visit co-pay is waived if admitted.

Table 26

Prescription Drug Copayments for Expanded Adult Coverage at Selected Incomes[1, 2]

January 2013

State	Expansion Program Name	<100% FPL			100-200% FPL		
		Generic	Preferred Brand Name	Non-Preferred Brand Name	Generic	Preferred Brand Name	Non-Preferred Brand Name
Arizona	AHCCCS (1115 Waiver)	$4	$10	$10		N/A	
Arkansas	ARHealthNetworks (1115 Waiver)	$5	$15	$30	$5	$15	$30
California	Medicaid Coverage Expansion (1115 Waiver)	$0	$0	$0	$0	$0	$0
	Health Care Coverage Initiative (1115 Waiver)	$0	$0	$0	$0	$0	$0
Colorado	Adults Without Dependent Children (1115 Waiver)	$1	$1	$3	--	--	--
Connecticut	Medicaid for Low-Income Adults (ACA Option)	--	--	--	--	--	--
Delaware[3]	Diamond State Health Plan (1115 Waiver)	$.50-$3	$.50-$3	$.50-$3		N/A	
District of Columbia	ACA Adult Expansion	- -	- -	- -	- -	- -	- -
	ACA Expansion (1115 Waiver)	- -	- -	- -	- -	- -	- -
Hawaii	QUEST (1115 Waiver)	- -	- -	- -	- -	- -	- -
Idaho[4]	Access to Health Insurance (1115 Waiver)	Vary based on ESI plan			Vary based on ESI plan		
Indiana	Healthy Indiana Plan (1115 Waiver)	$3	$3	$3	$3	$3	$3
Iowa[5]	IowaCare (1115 Waiver)		N/C				
Maine	Maine Care (1115 Waiver)	- -	- -	- -	- -	- -	- -
Maryland[6]	Primary Adult Coverage (1115 Waiver)	$2.50	$7.50	$7.50	$2.50	$7.50	$7.50
Massachusetts[7]	MassHealth Basic & Essential (1115 Waiver)	$3.65	$3.65	$3.65		N/A	
	Commonwealth Care (1115 Waiver)	$3.65	$3.65	$3.65	$10	$20	$40
Michigan	Adult Benefits Waiver (1115 Waiver)	$1	$1	$1		N/A	
Minnesota	ACA Adult Expansion	$1	$3	$3		N/A	
	MinnesotaCare (1115 Waiver)	$3	$3	$3	$3	$3	$3
New Jersey	Family Care (1115 Waiver)		N/A		$5	$5	$5
	New Jersey Childless Adults (1115 Waiver)	- -	- -	- -	- -	- -	- -
New Mexico[8]	SCI (1115 Waiver)	$0	$0	$0	$3	$3	$3
New York	Family Health Plus (1115 Waiver)	$3	$6	$6	$3	$6	$6
Oklahoma	Insure Oklahoma (1115 Waiver)	$5	$10	$10	$5	$10	$10
Oregon[9]	OHP Standard (1115 Waiver)	- -	- -	- -	- -	- -	- -
	FHIAP (1115 Waiver)	Vary based on plan			Vary based on plan		
Rhode Island	RIte Care/Share (1115 Waiver)	- -	- -	- -	- -	- -	- -
Utah[10]	Primary Care Network (1115 Waiver)	$5	25% cost	25% cost	$5	25% cost	25% cost
	Utah Premium Partnership (1115 Waiver)	Vary based on plan			Vary based on plan		
Vermont	VHAP (1115 Waiver)		N/A		$1-$3	$1-$3	$1-$3
	Catamount Care (1115 Waiver)	$10	$35	$55	$10	$35	$55
Washington	Basic Health (1115 Waiver)	$10	50% cost	N/C	$10	50% cost	N/C
Wisconsin[11]	BadgerCare Plus Core Plan (1115 Waiver)	<$4	<$8	<$8	<$4	<$8	<$8

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2013.

Table presents rules in effect as of January 1, 2013.

Table 26 Notes

1. Expansion coverage includes both waiver and state-funded programs for parents and/or other non-disabled adults.
2. If a state charges co-payments, but either does not charge them at the income level shown or for the specific service, it is recorded as $0; if a state does not provide coverage at a particular income level it is noted as "N/A;" if a state does not charge co-payments at all, it is noted as "- -"; if a state does not cover a type of service or drug, it is noted as "/".
3. In Delaware, costs vary based on cost of drug.
4. In Idaho, expansion coverage is a premium assistance program; as such costs vary by plan.
5. Drugs for IowaCare are not covered unless part of an inpatient or outpatient stay.
6. In Maryland's Primary Adult Coverage, depending on which managed care plan an in individual is enrolled in, there may be drug copayments ranging from $2.50-$7.50 per drug.
7. In Massachusetts, generic drugs for diabetes, high blood pressure, and high cholesterol have a $1 co-pay in MassHealth and for Commonwealth Care enrollees below 100% FPL. In Commonwealth Care, co-pays are lower for three-month supplies of prescription drugs obtained through mail order. Prescription drug co-pays in Commonwealth Care are subject to an annual out-of-pocket maximums that vary by income.
8. In New Mexico, for SCI waiver coverage, drug co-pays are subject to a $12 monthly maximum.
9. In Oregon, there are no copayments in OHP Standard per court order. FHIAP is a premium assistance program; as such, costs vary based on plan.
10. The Primary Care Network (PCN) has a limit of 4 drugs per month. Utah Premium Partnership (UPP) is a premium assistance program; as such costs vary by plan.
11. In expansion coverage under BadgerCare Core Plan for childless adults, there is a $24 per month, per provider limit for prescription drug co-pays.

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