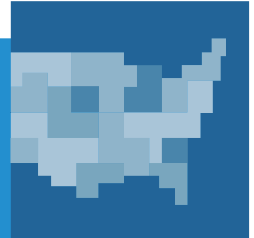
THE HENRY J. KAISER FAMILY FOUNDATION

THE KAISER COMMISSION ON
Medicaid and the Uninsured

REPORT



January 2016

Medicaid and CHIP Eligibility, Enrollment, Renewal, and Cost-Sharing Policies as of January 2016: Findings from a 50-State Survey

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Executive Summary

January 2016 marks the end of the second full year of implementation of the Affordable Care Act's (ACA) key coverage provisions. This 14th annual 50-state survey of Medicaid and CHIP eligibility, enrollment, renewal, and cost-sharing policies provides a point-in-time snapshot of policies as of January 2016 and identifies changes in policies that occurred during 2015. Coverage is driven by two key elements—eligibility levels determine who may qualify for coverage, and enrollment and renewal processes influence the extent to which eligible individuals are enrolled and remain enrolled over time. This report provides a detailed overview of current state policies in these areas, which have undergone significant change as a result of the ACA.

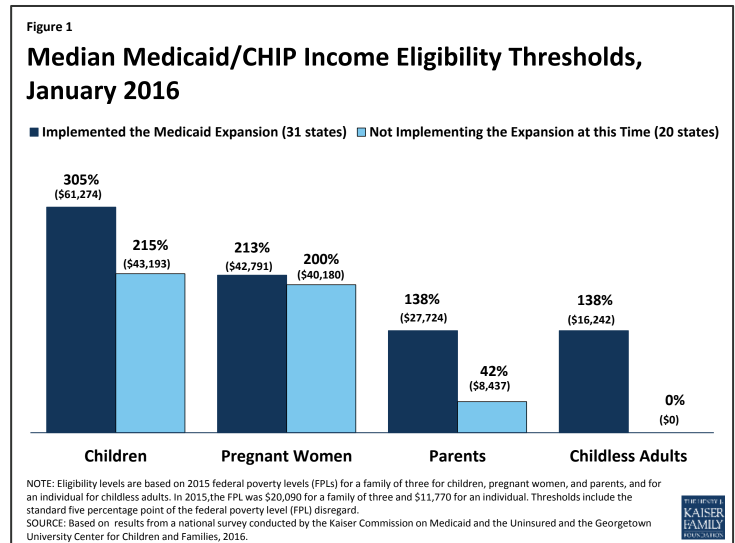
Together, the findings show that, during 2015, states continued to implement the major technological upgrades and streamlined enrollment and renewal processes triggered by the ACA. These changes are helping to connect eligible individuals to Medicaid coverage more quickly and easily and to keep eligible people enrolled as well as contributing to increased administrative efficiencies. However, implementation varies across states, and lingering challenges remain. The findings illustrate that the program continues to be a central source of coverage for low-income children and pregnant women nationwide and show the growth in Medicaid's role for low-income adults through the ACA Medicaid expansion.

Eligibility for Children, Pregnant Women, and Non-Disabled Adults

Medicaid and CHIP remained the central sources of coverage for low-income children and pregnant women nationwide during 2015. As of January 2016, 48 states cover children with incomes at or above 200% FPL, with 19 states extending eligibility to at least 300% FPL, while 33 states cover pregnant women with incomes at or above 200% FPL. Eligibility levels for children and pregnant women remained stable during 2015. This stability, in part, reflects the ACA's maintenance of effort provisions, which prevent states from making any reductions in children's eligibility through 2019. Some states made incremental changes that expanded access to coverage for children and pregnant women in 2015, such as eliminating waiting periods that required children to be uninsured for a period of time before enrolling in CHIP (Michigan and Wisconsin), eliminating the five-year waiting period for lawfully residing immigrant children and pregnant women (Colorado), expanding federally-funded CHIP coverage to dependents of state employees (Nevada and Virginia), and offering coverage to former foster youth from other states (New Mexico).

Medicaid's role for low-income adults continued to grow through the ACA Medicaid expansion. As of January 2016, 31 states have expanded Medicaid eligibility to parents and other non-disabled adults with incomes up to at least 138% FPL. This count reflects the adoption of the Medicaid expansion in three states—Alaska, Indiana, and Montana—during 2015. However, in the 20 states that have not expanded, median eligibility levels are 42% FPL for parents and 0% FPL for other adults, leaving many poor adults in a coverage gap since they earn too much to qualify for Medicaid but not enough for tax credit subsidies to purchase Marketplace coverage, which begin at 100% FPL. Aside from adoption of the Medicaid expansion in three states, there were few changes in eligibility for parents and other adults during 2015. Connecticut reduced eligibility for parents, but eligibility remains above the expansion limit and many of those who became ineligible likely qualify for subsidies to purchase Marketplace coverage. In addition, New York implemented a Basic Health Program (BHP) to offer more affordable coverage to adults with incomes up to 200% FPL, joining Minnesota as the second state with a BHP.

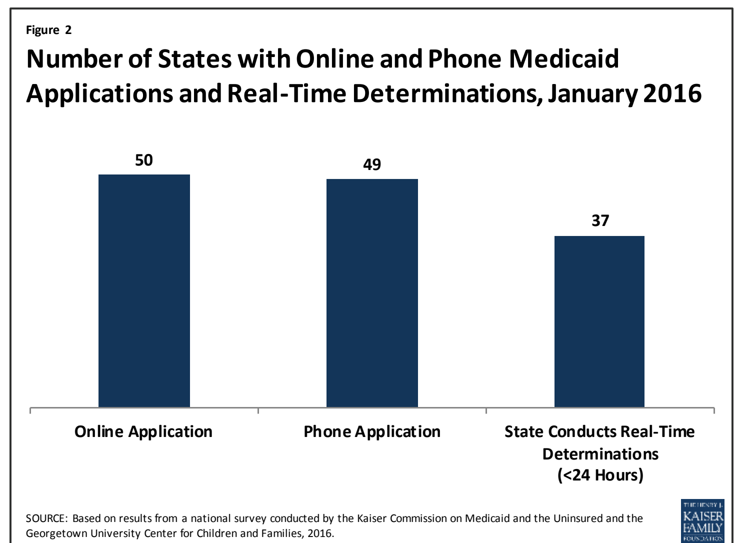
Eligibility levels vary across groups and states, and state Medicaid expansion decisions have increased these differences. Median eligibility levels for children and pregnant women remain well above those for parents and other adults in both Medicaid expansion and non-expansion states. Within each eligibility group, median eligibility levels are higher in expansion states than non-expansion states (Figure 1). As expected, these differences between expansion and non-expansion states are largest for parents and other adults. Underlying these medians, there also is significant variation in eligibility levels across states. Eligibility levels range from 152% to 405% FPL for children, from 138% to 380% FPL for pregnant women, from 18% to 221% FPL for parents, and from 0% to 215% for other adults.



System Enhancements and Streamlined Enrollment and Renewal

Regardless of whether states have implemented the ACA Medicaid expansion to adults, the law ushered in major changes to Medicaid systems and processes in all states. The changes are designed to harness technology to provide a modernized enrollment experience for consumers and may lead to increased administrative efficiencies for states. As documented in last year's survey, many states faced significant challenges implementing new systems and processes when they were launched in 2014. These difficulties resulted in backlogs and delays in enrollments and renewals, which were a major focus during 2014. This year's findings show that, in 2015, states resolved many of these challenges and built on successes to refine and enhance their upgraded systems. However, experiences vary across states and lingering challenges remain.

As of January 2016, individuals can apply for Medicaid online or by phone in nearly all states as envisioned by the ACA (Figure 2). All states, except Tennessee, have an online Medicaid application available either through the state Medicaid agency or an integrated portal that provides access to Medicaid and the State-Based Marketplace (SBM). Two states (Arkansas and Florida) began accepting telephone applications for Medicaid in 2015, bringing the total count of states doing so to 49 as of January 2016.

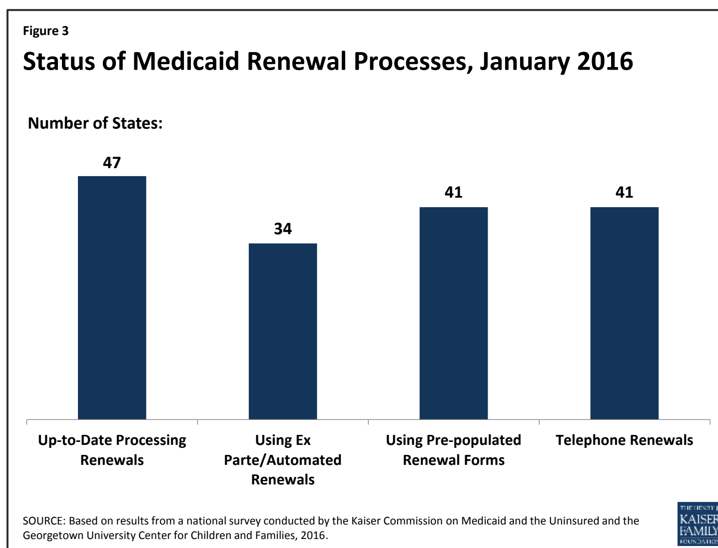


As of January 2016, 37 states report they can make real-time Medicaid eligibility determinations (defined as less than 24 hours) for children, pregnant women, and non-disabled adults. Among the 27 states that were able to report the share of applications for these groups that receive a real-time determination, 11 indicated that more than 50% of applications receive a determination in real time.

States expanded functionalities of online applications and accounts during 2015. Reflecting this work, all but one of the 50 online Medicaid applications allow applicants to start, stop, and return to the application, and 33 allow applicants to upload documents as of January 2016. In addition, 39 states allow consumers to create an online account to manage their Medicaid coverage. During 2015, a number of states expanded account functionalities, enabling consumers to report changes, view notices, upload documentation, renew coverage, and more.

Coordination between state Medicaid agencies and the Marketplaces improved during 2015, but challenges remain. Among the 17 states operating a SBM, 13 have a single integrated system that makes eligibility determinations for both Medicaid and Marketplace coverage, which eliminates the need for account transfers between programs. However, the 38 states that rely on the Federally Facilitated Marketplace (FFM), Healthcare.gov, for Marketplace eligibility and enrollment must electronically transfer accounts between Medicaid and the FFM to provide access to all insurance affordability programs. As of January 2016, all 38 states that rely on the FFM report they can receive electronic account transfers from the FFM, and 36 states report they can send electronic account transfers to the FFM. Twenty states report they are having problems or delays with transfers, although the scope of these problems varies across states. Although challenges remain, there has been marked improvement in coordination since the Marketplaces were launched in 2014, when states faced major technical difficulties with transfers that contributed to enrollment delays.

As implementation continues, a number of states eliminated delays in processing renewals and put streamlined renewal procedures in place as established by the ACA. When the ACA was first implemented, there was significant focus on implementing streamlined enrollment processes and establishing coordination between Medicaid and the new Marketplaces. As a result, most states delayed implementing new renewal procedures, and 36 states took up a temporary option to postpone renewals for existing Medicaid or CHIP enrollees during 2014. In 2015, most states caught up on renewals and many made gains in implementing streamlined renewal procedures. As of January 2016, 47 states are up to date in processing renewals for Medicaid (Figure 3). A total of 34 states report they can complete automatic or ex parte renewals by using information from electronic data sources, as outlined in the ACA. Among the 26 states that can report the share of renewals completed using automated processes, 10 indicate that over 50% of enrollees are automatically renewed, including 3 that report automatic renewal rates above 75%. In addition, 41 states can send pre-populated renewal forms, which states must use when they are unable to complete an automated renewal under ACA policies; 41 states offer telephone renewals as outlined by the ACA.



Premiums and Cost-Sharing

Premiums and cost-sharing in Medicaid and CHIP remain limited, although under waiver authority a few states are charging higher levels than otherwise allowed under federal law. The number of states charging premiums or enrollment fees (30 states) or copayments (26 states) for children

remained the same during 2015. While most states charge nominal copayments for parents (40 states) and expansion adults (23 of 31 expansion states), states generally do not charge these groups premiums given that most of these individuals have incomes below poverty. However, as of January 2016, five states (Arkansas, Indiana, Iowa, Michigan, and Montana) charge adults monthly contributions or premiums under Section 1115 waiver authority. Indiana also received approval to charge parents monthly contributions and, under separate Section 1916 waiver authority, to charge parents and adults higher cost-sharing for non-emergency use of the emergency room than otherwise allowed under federal law.

Looking Ahead

States' Medicaid and CHIP eligibility policies and enrollment and renewal processes will play a key role in reaching the remaining low-income uninsured population and keeping eligible individuals enrolled over time. Together, these survey findings show that:

Medicaid and CHIP continue to be central sources of coverage for the low-income population, but access to coverage varies widely across groups and states. Medicaid and CHIP offer a base of coverage to low-income children and pregnant women nationwide. Eligibility for adults has grown under the Medicaid expansion, but remains low in states that have not expanded. Overall, eligibility continues to vary significantly by group and across states, resulting in substantial differences in individuals' access to coverage based on their eligibility group and where they live.

Upgraded state Medicaid systems help eligible individuals connect to and retain coverage over time, provide gains in administrative efficiencies, and offer new options to support program management. One key outcome of the ACA has been the significant modernization of states' Medicaid eligibility and enrollment systems. These higher-functioning systems help eligible individuals connect to coverage more quickly and easily, keep individuals enrolled over time, reduce paperwork burdens, and lead to increased administrative efficiencies. Moreover, the modernized systems offer new options to support program management. For example, states may have increased data reporting capabilities and expanded options to connect Medicaid with other systems. Further, as systems and processes become more refined over time, states may be able to manage enrollment more efficiently, which may allow them to refocus resources on other activities.

There remain key questions about how recent changes in eligibility and enrollment may be affected by a range of factors moving forward. Funding for CHIP is set to expire in 2017, raising key questions about the future of the program and what might happen in its absence. In addition, the ACA maintenance of effort provisions for children's coverage end in 2019. State Medicaid expansion decisions will likely continue to evolve over time, and it remains to be seen how they might be affected by the gradual reduction in federal funding for newly eligible expansion adults, which begins to phase down in 2017 when it reduces to 95%. Pending proposals in current budget reconciliation legislation would roll back the Medicaid expansion to adults and eliminate the maintenance of effort requirements in 2017. Outside of these potential changes, it also will be important to examine how the Section 1115 waivers that allow states to charge adults premiums and monthly contributions are affecting coverage and program administration, particularly given that waiver authority is provided for research and demonstration purposes.

Introduction

January 2016 marks the second anniversary of the effective date of the Affordable Care Act's (ACA's) key coverage provisions. During 2015, Medicaid and CHIP continued to be central sources of coverage for low-income children and pregnant women nationwide, and Medicaid's role for low-income adults grew as a result of the ACA Medicaid expansion. At the end of the second full year of implementation of the ACA's coverage expansions, states have continued to implement and enhance new and upgraded eligibility and enrollment systems that underpin the ACA's vision for a modernized data-driven enrollment experience. States also worked to implement automated renewal processes and improve coordination between Medicaid and the Marketplaces, resolving many problems and delays faced during the initial year of ACA implementation.

This annual report presents Medicaid and CHIP eligibility, enrollment, renewal and cost-sharing policies based on a survey of state program officials. It provides a point-in-time snapshot of policies in place as of January 2016 and identifies changes in state policies that occurred between January 2015 and 2016. These changes provide insight into how state policies are evolving from the new baseline that was established at the end of 2014, after the first full year of ACA implementation. State-specific information is available in Tables 1 to 21 at the end of the report.

Medicaid and CHIP Eligibility

The ACA established a new minimum Medicaid eligibility level of 138% of the federal poverty level (FPL) for children, pregnant women, parents and non-disabled adults as of January 2014. This new minimum increased eligibility for parents in many states and provided a new eligibility pathway for other non-disabled adults who were largely excluded from Medicaid prior to the ACA. Although the expansion to adults with incomes up to 138% FPL was effectively made a state option by the Supreme Court's 2012 ruling on the constitutionality of the ACA, the Court's decision did not impact other eligibility changes in the law. As a result of the new 138% FPL minimum for children in Medicaid, some states moved certain children from CHIP to Medicaid. Moreover, all states implemented the ACA change to determine financial eligibility for Medicaid for children, pregnant women, parents, and non-disabled adults and CHIP based on Modified Adjusted Gross Income (MAGI). This change created alignment with the method used for determining eligibility for subsidies to purchase Marketplace coverage. States continue to determine eligibility for other groups, such as individuals with disabilities and elderly individuals, based on previous non-MAGI-based rules.

The findings below show Medicaid and CHIP eligibility levels for children, pregnant women, parents, and other non-disabled adults as of January 2016 and identify changes in eligibility that occurred between January 2015 and January 2016. These data show that Medicaid and CHIP continue to be central sources of coverage for the nation's low-income children and pregnant women, with some states adopting optional policies in 2015 that expand access to coverage for certain children and pregnant women. They also highlight the continued growth of Medicaid's role for low-income adults through the ACA Medicaid expansion.

Children and Pregnant Women

Coverage for children in Medicaid and CHIP remains strong and steady with median eligibility at 255% FPL. Under the ACA's maintenance of effort protections, states cannot make reductions in children's eligibility through 2019. Reflecting this protection, there were no policy changes to children's eligibility in 2015. However, in Kansas, the state's CHIP eligibility level is tied to the 2008 FPL; thus, CHIP eligibility declined from 247% to 244% FPL and will continue to erode over time. As of January 2016, 48 states cover children with incomes up to at least 200% FPL through Medicaid and CHIP, including 19 states that cover children at or above 300% FPL (Figure 4). Across states, the upper Medicaid/CHIP eligibility limit for children ranges from 152% FPL in Arizona to 405% FPL in New York.

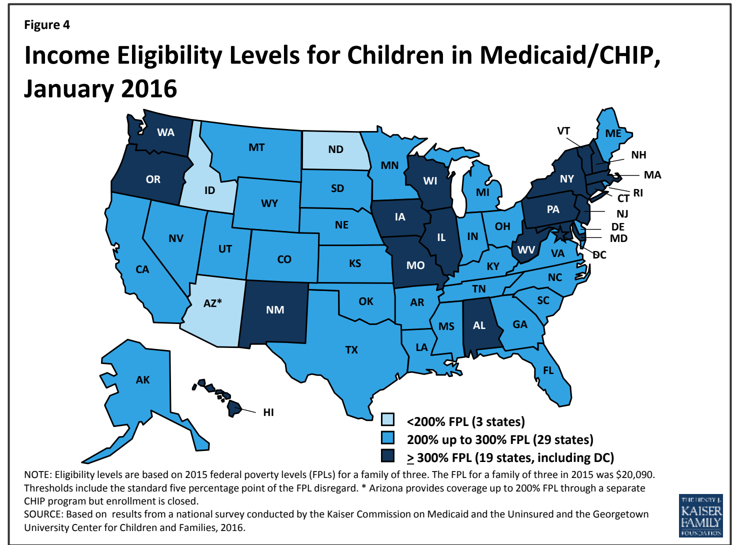


Figure 4

Income Eligibility Levels for Children in Medicaid/CHIP, January 2016

NOTE: Eligibility levels are based on 2015 federal poverty levels (FPLs) for a family of three. The FPL for a family of three in 2015 was $20,090. Thresholds include the standard five percentage point of the FPL disregard. * Arizona provides coverage up to 200% FPL through a separate CHIP program but enrollment is closed.

SOURCE: Based on results from a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2016.

Mirroring previous action taken by California and New Hampshire in 2014, Michigan transitioned all children from its separate CHIP program into Medicaid as of January 2016. In contrast, Arkansas established a new separate CHIP program and moved children with family incomes from 147% to 216% FPL from its CHIP-funded Medicaid expansion to the new separate CHIP program. Enrollment remains open in all states with separate CHIP programs except in Arizona. Arizona froze enrollment in its separate CHIP program at the end of 2009, prior to enactment of the ACA eligibility protections.

States continued to take up options to enhance children's access to coverage during 2015.

- ***Eliminating waiting periods for CHIP coverage.*** During 2015, Wisconsin eliminated its waiting period for its separate CHIP program. In addition, Michigan's CHIP waiting period was eliminated when it transitioned all children from its separate CHIP program to Medicaid. With these changes, 24 states have eliminated waiting periods for CHIP since the ACA was enacted in 2010. As of January 2016, 34 states do not have a waiting period for CHIP coverage (Figure 5). However, 16 of the 36 states with separate CHIP programs have a waiting period that requires a child to be uninsured for a period of time prior to enrolling. These waiting periods may not exceed 90 days.
- ***Expanding coverage to recent lawfully residing immigrant children.*** With the addition of Colorado during 2015, 29 states have taken up the option to eliminate the five-year waiting period for lawfully present immigrant children in Medicaid and/or CHIP as of January 2016. In addition, six states (California, District of Columbia, Illinois, Massachusetts, New York, and Washington) use state-only funds to cover some income-eligible children regardless of immigration status.[1] This count includes California, which has some local programs that

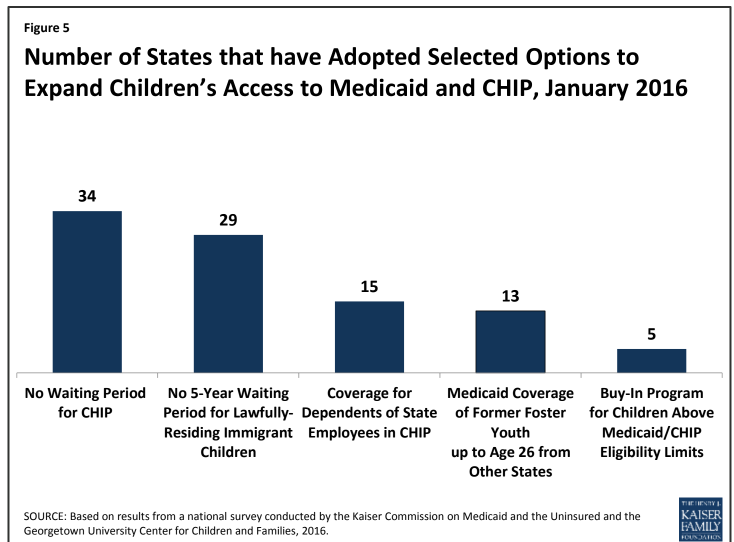


Figure 5

Number of States that have Adopted Selected Options to Expand Children's Access to Medicaid and CHIP, January 2016

SOURCE: Based on results from a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2016.

cover children regardless of immigration status and recently passed legislation to cover children regardless of immigration status on a statewide basis starting in 2016.

- ***Expanding federally-funded CHIP coverage to dependents of state employees.*** As of January 2016, 2 additional states (Nevada and Virginia) took up the option to cover otherwise eligible children of state employees in a separate CHIP program, bringing the total number of states that have taken up this option to 15.
- ***Expanding coverage for former foster youth.*** Under the ACA, all states must provide Medicaid coverage to youth who were in foster care in the state up to age 26, but it is a state option to extend this coverage to former foster youth from other states. During 2015, New Mexico took up this option, raising the total number of states covering former foster youth from other states to 13 as of January 2016.

Following a trend since enactment of the ACA, the number of states offering buy-in programs for children in families above Medicaid or CHIP income limits continued to decline. States may offer buy-in programs to allow families with incomes above the upper limit for children's coverage to buy-in to Medicaid or CHIP for their children. In 2015, North Carolina lifted the income limit on its buy-in program, while Connecticut eliminated its buy-in program. The number of states offering buy-in programs has declined from a peak of 15 in 2011 to 5 as of January 2016, reflecting that families above Medicaid and CHIP income thresholds may have new coverage options available through the Marketplaces.

Coverage for pregnant women remained stable in 2015. The median eligibility level for pregnant women in Medicaid or CHIP held steady at 205% FPL, with eligibility ranging from 138% FPL in Idaho and South Dakota to 380% FPL in Iowa. Overall, 33 states cover pregnant women with incomes up to at least 200% FPL (Figure 6). The number of states that have eliminated the five-year waiting period for lawfully residing immigrant pregnant women in Medicaid and/or CHIP remained constant at 23. However, Colorado, which had previously covered recent lawfully-residing pregnant women in Medicaid, expanded this option to pregnant women in CHIP during 2015. The number of states covering income-eligible pregnant women regardless of immigration status through the CHIP unborn child option (15 states) or with state-only funds (3 states) remained unchanged.

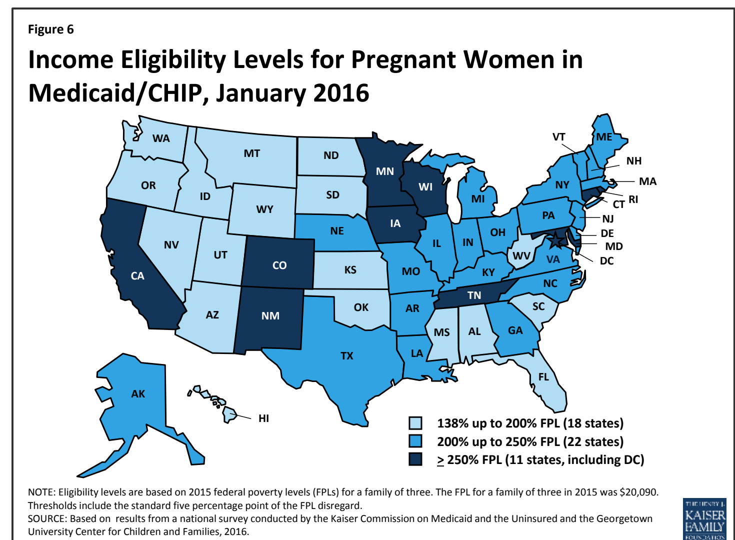


Figure 6

Income Eligibility Levels for Pregnant Women in Medicaid/CHIP, January 2016

NOTE: Eligibility levels are based on 2015 federal poverty levels (FPLs) for a family of three. The FPL for a family of three in 2015 was $20,090. Thresholds include the standard five percentage point of the FPL disregard.
SOURCE: Based on results from a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2016.

Parents and Adults

As of January 2016, 31 states, including the District of Columbia, have expanded Medicaid eligibility to parents and other non-disabled adults[2] with incomes up to at least 138% FPL. This finding reflects adoption of the ACA Medicaid expansion to low-income adults in three states during 2015– Indiana, Alaska, and, most recently, Montana, where the expansion went into effect on January 1, 2016. Indiana and Montana joined four other states (Arkansas, Iowa, Michigan, and New Hampshire) that expanded Medicaid for adults under Section 1115 waiver authority, allowing them to implement the expansion in ways that extend beyond the flexibility provided by the law.[3] During 2015, Pennsylvania moved from implementing its expansion through a waiver to regular expansion coverage, while New Hampshire moved from a regular expansion to a waiver as of January 2016. There is no deadline for states to adopt the Medicaid expansion, and additional states may expand in the future. Medicaid eligibility extends to parents and other adults with incomes up to at least 138% FPL in all 31 expansion states (Figures 7 and 8). Additionally, the District of Columbia covers parents up to 221% FPL and other adults up to 215% FPL. Connecticut reduced parent eligibility during 2015, lowering eligibility from 201% to 155% FPL. However, parent eligibility remains above the 138% FPL minimum, and many parents who lost Medicaid eligibility are likely eligible for subsidies to purchase Marketplace coverage.

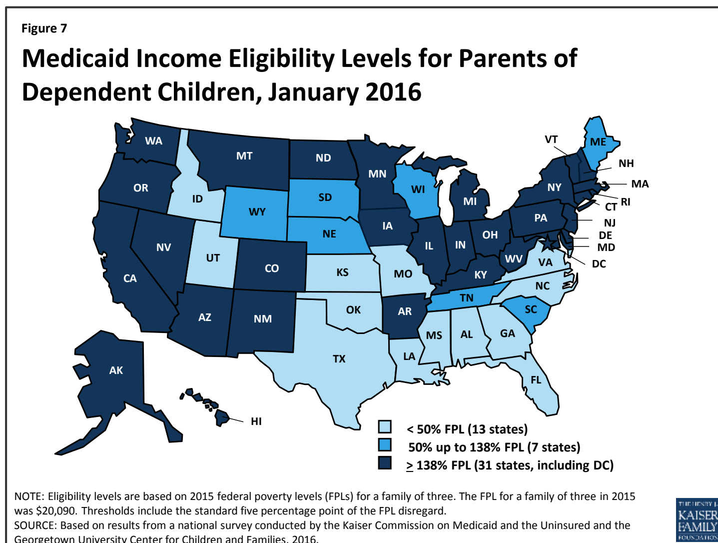


Figure 7
Medicaid Income Eligibility Levels for Parents of Dependent Children, January 2016

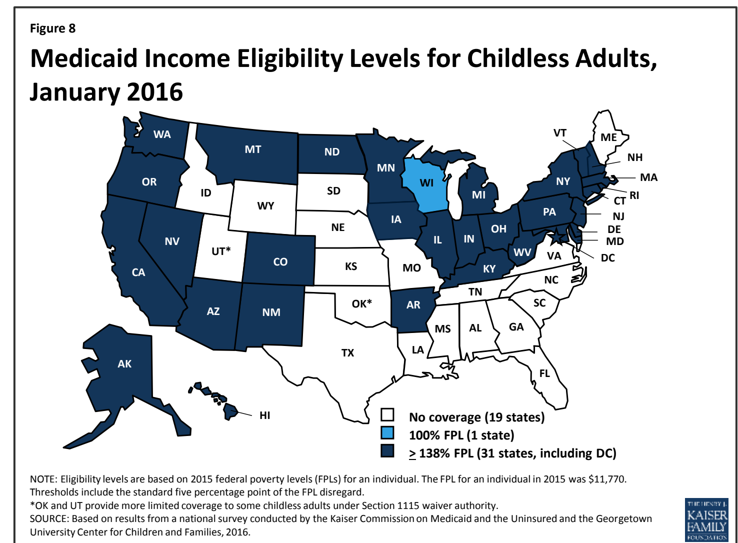
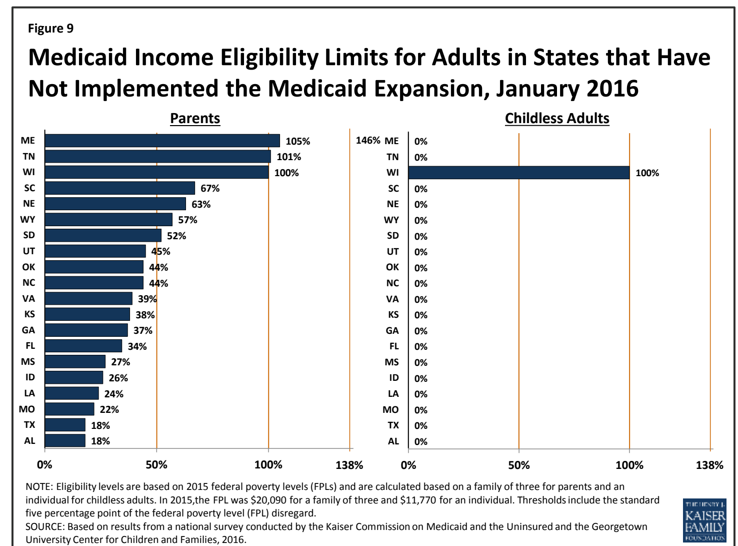


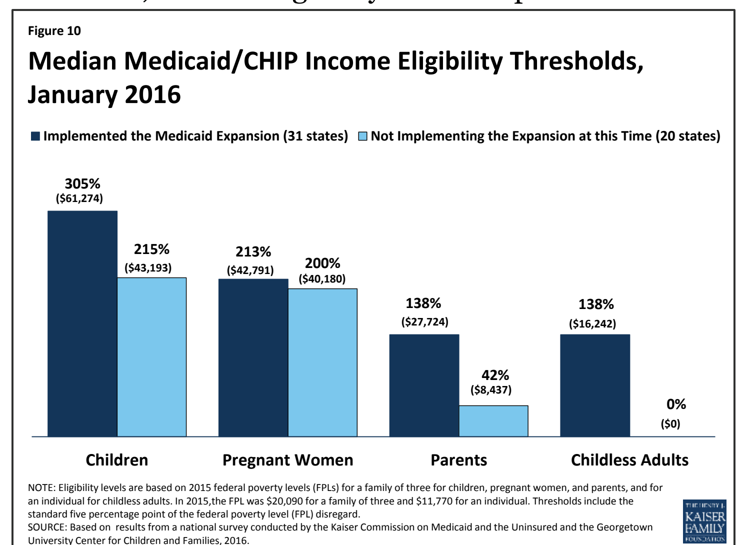
Figure 8
Medicaid Income Eligibility Levels for Childless Adults, January 2016

As of January 2016, two states—Minnesota and New York—have implemented Basic Health Programs. The ACA provides an option for states to create a Basic Health Program (BHP) for low-income residents with incomes between 138% and 200% FPL, who would otherwise be eligible to purchase Marketplace coverage. Through this option, states provide alternative coverage that may cover more services or be more affordable than what is offered through the Marketplaces, which may reduce movement between plans and coverage types for people whose incomes fluctuate above and below Medicaid levels.[4] New York's BHP will be fully phased in as of January 2016, joining Minnesota as the second state with a BHP. When New York implemented its BHP, it stopped providing some additional Medicaid-funded subsidies to parents with incomes between 138% and 150% FPL who can now receive coverage through the BHP.

In the 20 states that have not expanded Medicaid, the median eligibility level for parents is 42% FPL; other adults remain ineligible regardless of income in all of these states except Wisconsin. Among the 20 non-expansion states, parent eligibility levels range from 18% FPL in Alabama and Texas to 105% FPL in Maine (Figure 9). Only 3 of these states—Maine, Tennessee, and Wisconsin—cover parents at or above 100% FPL, while 13 states limit parent eligibility to less than half the poverty level ($10,045 for a family of three as of 2015). Wisconsin is the only non-expansion state that provides full Medicaid coverage to other non-disabled adults, although its 100% FPL eligibility limit is lower than the ACA expansion level. While this study reports eligibility based on a percentage of the FPL, it also is important to note that 13 non-expansion states base eligibility for parents on dollar thresholds (which have been converted to an FPL equivalent in this report). Of those states, 12 do not routinely update the standards, resulting in eligibility levels that erode over time relative to the cost of living. Other analysis shows that three million poor adults fall into a coverage gap as a result of these low Medicaid eligibility levels in non-expansion states.[5] These adults earn too much to qualify for Medicaid, but not enough to qualify for subsidies for Marketplace coverage, which are available only to those with incomes at or above 100% of FPL.



Eligibility levels for parents and other adults remain lower than those for children and pregnant women. Among expansion and non-expansion states, median eligibility levels for parents and other adults remain lower than those for pregnant women and children (Figure 10). In expansion states, median Medicaid and CHIP eligibility levels are 305% FPL for children and 213% FPL for pregnant women compared to 138% FPL for parents and other adults. However, these differences are more pronounced in states that have not implemented the Medicaid expansion. In the non-expansion states, the median Medicaid and CHIP eligibility level is 215% for children and 200% for pregnant women compared to 42% FPL for parents and 0% for other adults.



Medicaid and CHIP Enrollment and Renewal Processes

During 2015, states continued to implement system enhancements and adopt processes to implement the ACA's vision of a modernized data-driven enrollment experience and a largely automated renewal process. Adoption of these procedures represents significant transformation and streamlining in many states that previously relied on paper-based enrollment and renewal processes for Medicaid and CHIP. As states continued work developing the information technology systems that underpin enrollment and renewal, their functionality increased as demonstrated by the growing number of states that are able to make real-time eligibility determinations and automatically renew coverage. Coordination between Medicaid and the Marketplaces also improved considerably in 2015, but there are lingering challenges to ensure smooth transitions between coverage programs for individuals.

Eligibility and Enrollment Systems

In order to implement the new enrollment and renewal processes outlined in the ACA, most states needed to make major improvements to or build new Medicaid and CHIP eligibility and enrollment systems and coordinate enrollment with the Marketplaces. To support system development, the federal government provided 90% federal funding for system design and development. This increased funding level was initially set to expire at the end of 2015, but CMS finalized a rule in December 2015 to extend the higher federal match permanently.[6] The extension of this funding will support continued work in states that have not implemented enhanced system functionality to fully meet ACA requirements. It also will support continued state work to phase in additional capabilities and consumer features and keep systems current as technology evolves in the future. Higher functioning systems facilitate the ability to enroll and keep eligible individuals in coverage by reducing paperwork burdens and allowing individuals to manage more activities through an online environment. They also may contribute to increased administrative efficiencies. Moreover, as these systems and processes become more refined, they may enable states to manage larger enrollments more efficiently, allowing them to refocus resources on other services such as helping individuals understand how to use their health care services. They may also provide new tools and options to support program management, such as increased data reporting and data connections with other systems or programs.

As of January 2016, 37 states can complete MAGI-based eligibility determinations in real-time (defined as less than 24 hours), and 11 states indicate that at least 50% of MAGI-based applications receive a real-time determination. Among the 27 states that were able to report the percentage of MAGI-based applications that receive a real-time determination, 11 states report a success rate that exceeds 50%, including 9 that report a rate over 75%. In the remaining 16 states, less than half of MAGI-based applications receive a determination in real-time (Figure 11). Looking ahead, many states will continue to work to increase the share of applications that receive a real-time determination.

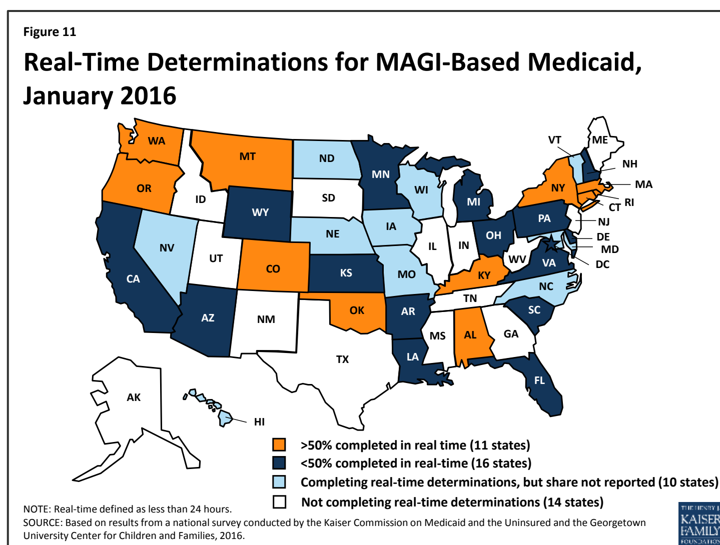
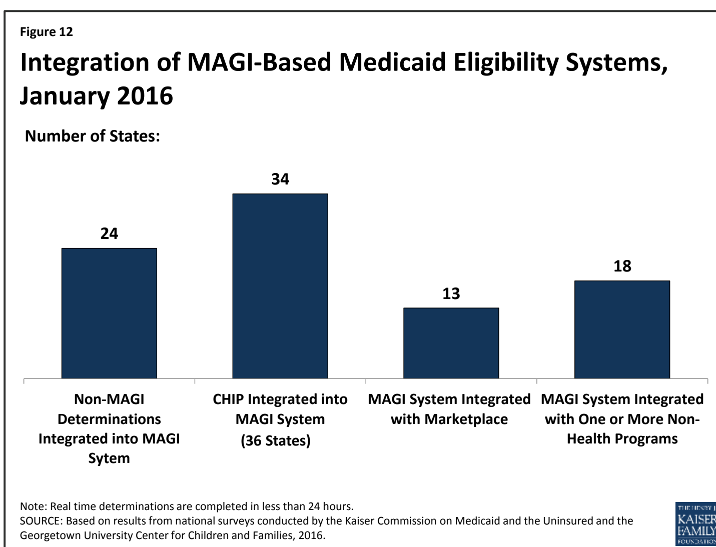


Figure 11

Real-Time Determinations for MAGI-Based Medicaid, January 2016

NOTE: Real-time defined as less than 24 hours.
SOURCE: Based on results from a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2016.

As of January 2016, states vary in the integration of other health programs in their MAGI-based Medicaid systems (Figure 12). During 2015, three states (Florida, Nebraska, and Virginia) integrated eligibility determinations for non-MAGI groups, which include elderly individuals and individuals with disabilities, into their MAGI-based systems. With these additions, 24 states process MAGI and non-MAGI groups through the same system as of January 2016. Most states with a separate CHIP program (34 of 36 states) have CHIP integrated into the MAGI-based system. Among the 17 states operating a State Based Marketplace (SBM), 13 have a single, integrated system that makes eligibility determinations for both MAGI-based Medicaid and Marketplace coverage. With Hawaii transitioning eligibility determinations from its SBM to the Federally Facilitated Marketplace (FFM) in 2015, 4 SBM states and the 34 FFM and Partnership states are using Healthcare.gov for Marketplace eligibility and enrollment functions as of January 2016. These 38 states all must maintain a separate Medicaid eligibility and enrollment system at the state level.



In 18 states, the MAGI-based Medicaid system is integrated with at least one non-health program, and a number of states are planning further integration in the future. Prior to the implementation of the ACA, 45 states had integrated systems to determine eligibility for Medicaid and other non-health programs such as the Supplemental Nutrition Assistance Program (SNAP or food stamps), Temporary Assistance for Needy Families (TANF), and childcare assistance. As states upgraded or built new Medicaid eligibility systems, many delinked these programs from the Medicaid system due to the large scale of the changes. However, as of January 2016, 18 states had integrated at least one non-health program into their MAGI-based Medicaid system. Colorado delinked non-health programs from its Medicaid system when it integrated its Medicaid system with its Marketplace system in 2015. However, a number of states plan to phase in additional non-health programs into their Medicaid system in 2016 or beyond. The continuation of enhanced funding for system development, as well as flexibility provided by CMS that requires other programs to pay only the incremental integration costs, support these efforts. Although this flexibility was slated to end at the close of 2015, CMS extended it for three more years.[7]

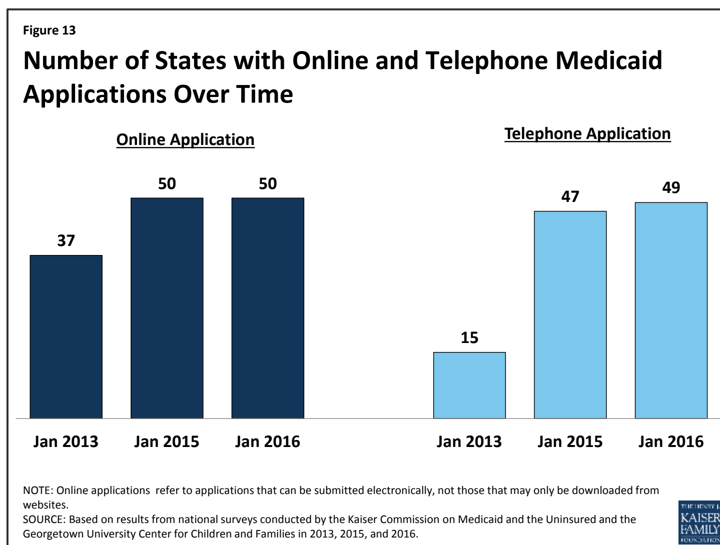
Coordination between Medicaid and Marketplace systems improved considerably in 2015, but there are lingering challenges. In the 38 states relying on the FFM for Marketplace eligibility and enrollment functions, electronic accounts must be transferred between the federal and state systems to provide a coordinated, seamless enrollment experience for individuals as envisioned by the ACA. Such transfers are not necessary in the 13 SBM states with an integrated Medicaid and Marketplace eligibility system although, in some cases, data transfers must occur after the eligibility determination to complete enrollment. Among the 38 states relying on the FFM for eligibility and enrollment, 8 states have authorized the federal system to make final Medicaid eligibility determinations, which can expedite the enrollment process. However in these states, the FFM still must transfer accounts to the Medicaid agency to complete enrollment. The remaining 30 states allow the FFM to assess rather than determine Medicaid eligibility. These counts reflect three states (Louisiana, North Dakota, and Oregon) choosing to rely on the FFM for assessments rather than final determinations, and

one state (Alaska) adopting the option for the FFM to make final determinations rather than assessments during 2015. States relying on the FFM for assessments must use the information received in the account transfer to determine eligibility based on the same verification requirements in place for individuals who apply directly through the state Medicaid agency. This process may require checking other data sources or requesting documentation for information that cannot be confirmed electronically. During 2014, there were significant difficulties with account transfers that contributed to delays in Medicaid enrollment. However, there have since been improvements in transfer functionality with all 38 states that rely on the FFM for Marketplace eligibility and enrollment functions reporting that they are receiving electronic account transfers from the FFM, and 36 states reporting that they are sending electronic account transfers to the FFM as of January 2016. A little more than half of these states (20 states) report they are still experiencing some delays or difficulties with transfers, although the scope of these challenges varies across these states.

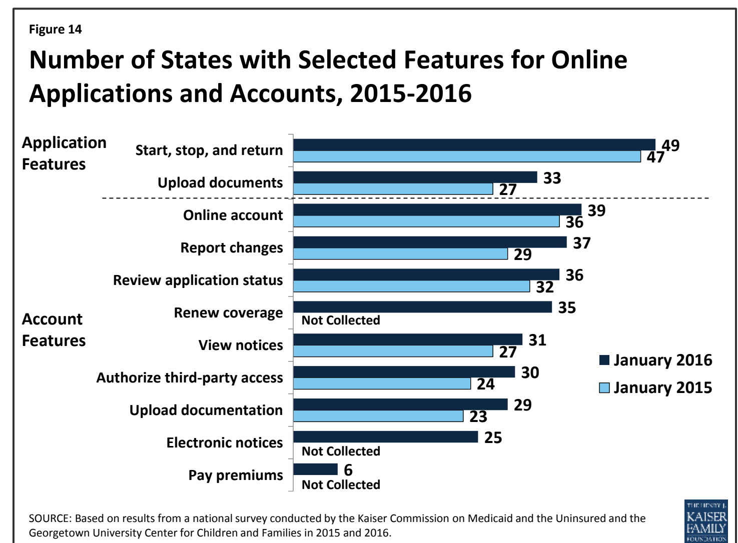
Applications

Under the ACA, states must provide multiple methods for individuals to apply for health coverage, including online, by phone, by mail, and in person, using a single streamlined application for Medicaid, CHIP, and Marketplace coverage. The use of online applications, as well as online accounts, gives states new opportunities to offer features and functions that enhance individuals' enrollment experience and expand their ability to manage their ongoing Medicaid coverage, which may help eligible individuals enroll and retain coverage over time. The increased use of technology may also provide administrative efficiencies to states by reducing paperwork and manual input of information that enrollees can report online, such as an address change. This growth in the use of technology has been supported by the 90% federal match for systems development and 75% federal match for ongoing operations that are now permanently available to states.

As of January 2016, individuals can apply online or by phone for Medicaid in nearly all states. In all states, except Tennessee, there is an online Medicaid application available through the state Medicaid agency or, in SBM states, an integrated portal that provides access to Medicaid and the SBM. In addition, 24 states offer an integrated online application that allows individuals to apply for Medicaid and non-health programs, such as SNAP or TANF. These states largely align with those states that have Medicaid and non-health programs integrated into a single eligibility system, although a few states are using separate eligibility systems to process multi-benefit applications. With the addition of Arkansas and Florida during 2015, 49 states are accepting Medicaid applications by phone as of January 2016. The number of states providing online and telephone Medicaid applications has significantly increased since initial implementation of the ACA changes in 2014 (Figure 13).



A number of states expanded the functionality of online applications and accounts during 2015. Between January 2015 and 2016, the number of states that provide applicants the option to start, stop, and return to complete their application at a later time increased from 47 to 49, while the number of states that allow applicants to upload electronic copies of documentation through the online application increased from 27 to 33 (Figure 14). In addition, the number of states that provide individuals the opportunity to create an online account for ongoing management of their Medicaid coverage rose from 36 to 39, with the addition of North Dakota, South Carolina, and South Dakota. A larger number of states added features to existing online accounts. Specifically, there were increases in the number of states that allow individuals to use their online account to report changes (29 to 37 states), review the status of their application (32 to 36 states), view notices (27 to 31 states), authorize third-party access (24 to 30 states), and upload documentation (23 to 29 states). This year's survey also asked about additional account functionalities and found that individuals can use their account to renew coverage in 35 states, go paperless and receive electronic notices in 25 states, and pay premiums in 6 of the 32 states that charge premiums in Medicaid or CHIP. Additional states plan to add online accounts in 2016 or beyond, while states with online accounts plan to continue to add features. These online functions provide timely and convenient access to account information that is commonplace in today's digital age, and may lead to administrative efficiencies by reducing mailing costs, call volume, and manual processing of updates. The ability for consumers to see and manage their application and information online also may contribute to increased enrollment and retention levels over time.



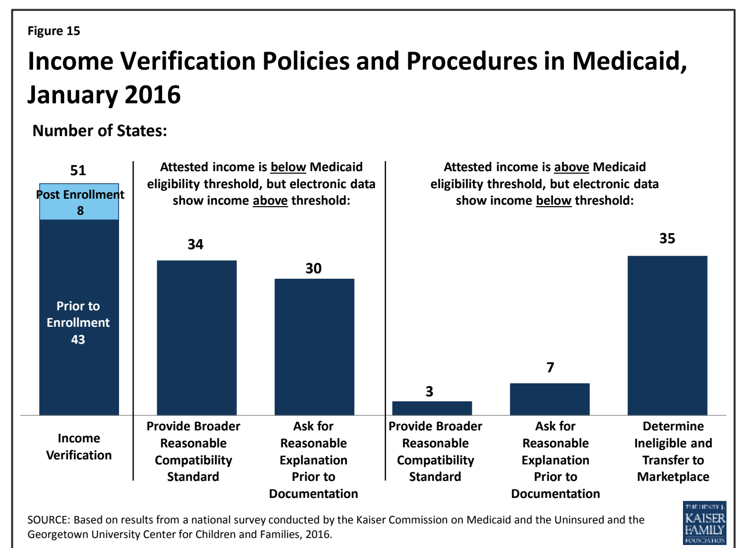
Nearly half of the states (24 states) provide a web portal or secure login for authorized consumer assisters to submit applications they have facilitated on behalf of consumers. In some cases, these portals provide additional administrative features that support the work of assisters, such as the ability to check a renewal date or update an address. Providing better tools for assisters may reduce state administrative workloads and free resources for other consumer services. This functionality may also allow the agency to track, monitor and report application activity by assister more thoroughly, accurately, and efficiently.

Verification of Eligibility Criteria

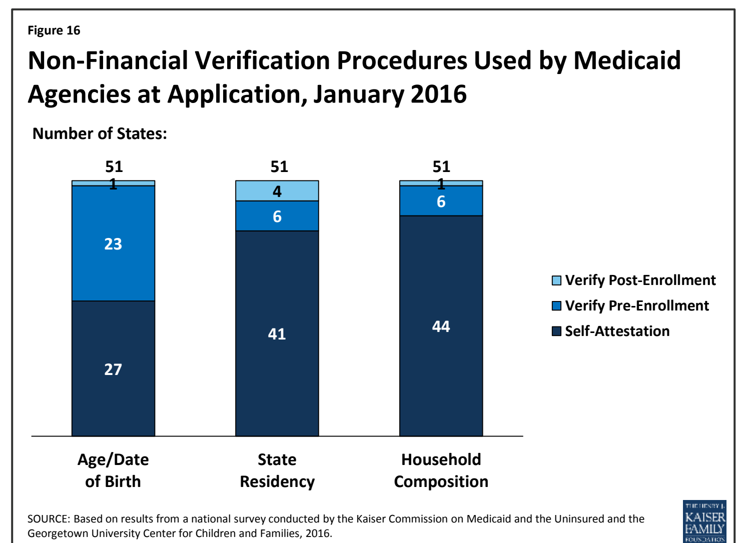
Under the ACA, all states must verify income eligibility and citizenship or immigrant status but they have flexibility to accept self-attestation for other criteria such as age/date of birth, state residency, and household composition. If verification is required, states are expected to use electronic data sources to the extent possible. Verifying eligibility criteria electronically is not only technically complicated, but requires the establishment of data sharing agreements between agencies to ensure that the privacy and security of personally identifiable information is protected. These challenges in accessing electronic data sources can slow state progress in implementing or maximizing real-time eligibility determinations and automated renewals without the intervention of an eligibility worker. However, as of 2016, a number of states are reporting success completing real-time eligibility determinations and automatic renewals that are facilitated through electronic data matches.

States are relying on a mix of data sources to electronically verify eligibility criteria. To facilitate electronic verification, a federal data hub was established that allows states to access information from multiple federal agencies, including the Internal Revenue Service, the Social Security Administration (SSA), and the Department of Homeland Security (DHS), which is used by almost three quarters of states. States not using the federal hub rely on pre-ACA linkages to SSA and DHS databases. Nearly all states also use state databases that collect quarterly state wage information or unemployment compensation, which may contain more current income information. About half of the states also use information from their state vital records while a smaller number of states access information from other state databases, such as the Department of Motor Vehicles or State Tax Department.

As of January 2016, 43 states use electronic data sources to verify income prior to enrollment, while 8 states verify after enrollment (Figure 15). States are required to verify income electronically either prior to or after enrollment and may apply "reasonable compatibility standards" to account for differences in self-reported income and data from electronic sources. If self-reported income and the data from the electronic source are both above or below the Medicaid or CHIP eligibility threshold, states must disregard the discrepancy since it does not impact eligibility. States have the option to establish broader reasonable compatibility standards, which 34 states have adopted for cases in which self-attested income is below but electronic data sources show income above the Medicaid or CHIP eligibility limit. If the difference is within this reasonable compatibility standard, which is most often 10%, states accept the self-reported income. In contrast, only three states (Colorado, Florida and New Jersey) have adopted a reasonable compatibility standard for when self-reported income is above the income standard but the electronic data source is below. In these circumstances, 35 states deny Medicaid or CHIP eligibility and transfer the account for an assessment of Marketplace eligibility. Regardless of whether they have set broader reasonable compatibility standards, states may accept a reasonable explanation of the difference (e.g., the individual lost a job) in lieu of requiring paper documentation.



States' procedures to verify non-financial eligibility criteria continue to evolve as their systems and electronic verification capacity develop. For non-financial eligibility criteria, including age/date of birth, state residency, and household composition, states may accept self-attestation or verify either before or after enrollment. Accepting self-attestation expedites the process for states and applicants, particularly when the state lacks access to trusted data sources that can be used for verification purposes. For states that rely

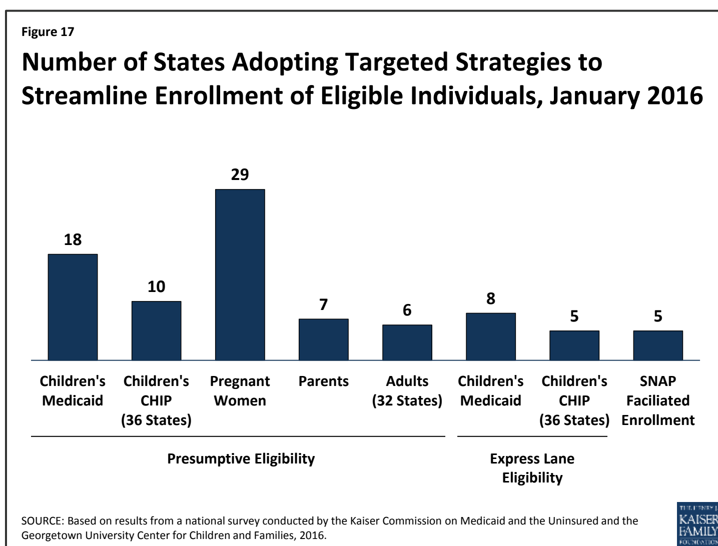


on self-attestation, verification is required if a state has any information on file that conflicts with the self-attestation. As of January 2016, just over half of the states accept self–attestation of age/date of birth (27 states), while a majority of states do so for state residency (41 states) and household size (44 states) (Figure 16). The remaining states verify these eligibility criteria either prior to enrollment or post-enrollment, and about half of those states re-verify the information at renewal.

Facilitated Enrollment Options

States vary in their use of policy options to streamline enrollment. As states achieve high rates of real time eligibility determinations, the reliance on facilitated enrollment options may decline. However, there will always be some individuals who may benefit from expedited paths to enrollment since not all individuals will be able to have eligibility verified in real time. As of January 2016, states continue to rely on a range of these policy options to provide facilitated access to coverage as discussed below.

- ***Presumptive eligibility.*** Presumptive eligibility is a longstanding option in Medicaid and CHIP, which allows states to authorize qualified entities—such as community health centers or schools—to make a temporary eligibility determination to expedite access to care for children and pregnant women while the regular application is being processed. The ACA broadened the use of presumptive eligibility in two ways. First, the law allows states that use qualified entities to presumptively enroll children or pregnant women to extend the policy to parents, adults, and other groups. As of January 2016, 18 states use presumptive eligibility for children in Medicaid, 10 for children in CHIP, 29 for pregnant women, 7 for parents, and 6 for other adults (Figure 17). This count reflects expansion of the use of presumptive eligibility to parents and adults in Colorado and Montana; to children in Medicaid and CHIP, parents, and adults in Indiana; and to pregnant women in Kansas during 2015. Second, the ACA gives hospitals nationwide the authority to determine eligibility presumptively for Medicaid for all non-elderly, non-disabled individuals. Hospital-based presumptive eligibility has been implemented in 45 states as of January 2016.



- ***Express Lane Eligibility.*** Express Lane Eligibility (ELE) is another pre-ACA option that allows states to enroll children in Medicaid or CHIP based on findings from other programs, like SNAP. During 2015, Oregon discontinued the use of ELE, while Iowa began using ELE to enroll CHIP eligible children. Following this state action, eight states (Alabama, Colorado, Georgia, Iowa, Louisiana, New Jersey, New York, and South Carolina) use ELE to enroll children in Medicaid, and five states (Colorado, Georgia, Iowa, New Jersey, and Pennsylvania) use ELE to enroll CHIP eligible children as of January 2016.

- ***Facilitated enrollment using SNAP data.*** In 2013, CMS offered states new temporary facilitated enrollment options, including using SNAP data to identify and enroll eligible individuals and using child enrollment data to expedite parent enrollment. In 2015, CMS made the SNAP facilitated enrollment option permanent.[8] As of January 2016, five states (Arkansas, California, New Jersey, Oregon, and South Dakota)

are using the facilitated SNAP enrollment strategy. Given that analysis has shown that facilitated enrollment strategies contribute to success enrolling newly eligible adults and children and reducing administrative costs,[9] other states may consider adopting the SNAP enrollment practice now that it is a permanent state option.

Renewal Processes

Many states eliminated delays in renewals during 2015. When the ACA was initially implemented, states and the federal government focused heavily on implementing streamlined enrollment processes and establishing coordination between Medicaid and Marketplace coverage. As a result, most states were delayed in implementing the new renewal procedures and 36 states took up a temporary option to postpone renewals for existing Medicaid or CHIP enrollees during 2014.[10] During 2015, most states caught up on renewals. As of January 2015, 47 states reported that they are up to date in processing Medicaid renewals.

States continued to implement streamlined renewal processes, with 34 states using automated renewal processes as of January 2016, including 10 states that automatically verify ongoing eligibility for more than half of MAGI-based renewals. Similar to data-driven enrollment processes, the ACA requires states to first use available data to determine if ongoing eligibility can be established without requiring the individual to fill out a renewal form or provide paper documentation. As of January 1, 2016, 34 states are using this automated renewal process—known as ex parte. Not all of these states were able to report the share of renewals that are automatically renewed through this process. However, among the 26 states that did report this data, 10 states reported that they are successfully renewing more than 50% of enrollees automatically, with 3 achieving automatic renewals rates above 75% (Figure 18). Under ACA policies, if a renewal cannot be completed automatically based on data, states must send the enrollee a pre-populated notice or renewal form. As of January 2016, 41 states report they are able to send forms or notices that are pre-populated with information (beyond demographics), and 14 states use updated sources of data to populate the form. As is the case with enrollment, the ACA also requires states to provide individuals the option to renew their coverage by telephone. As of January 2016, 41 states provide this renewal option.

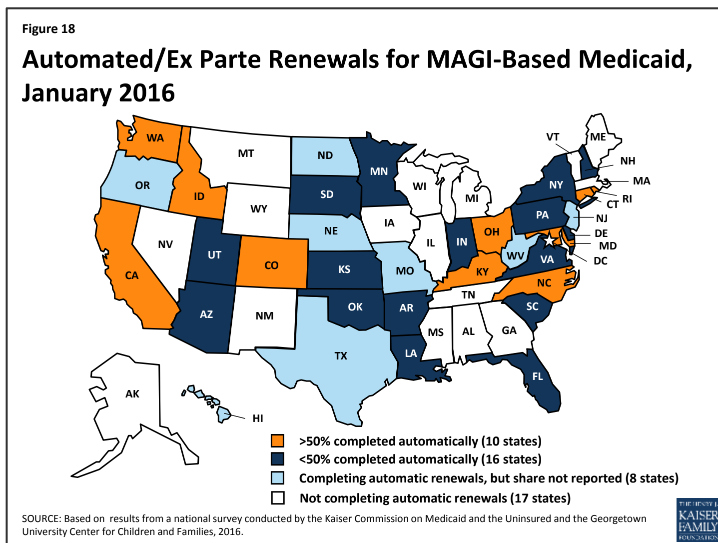


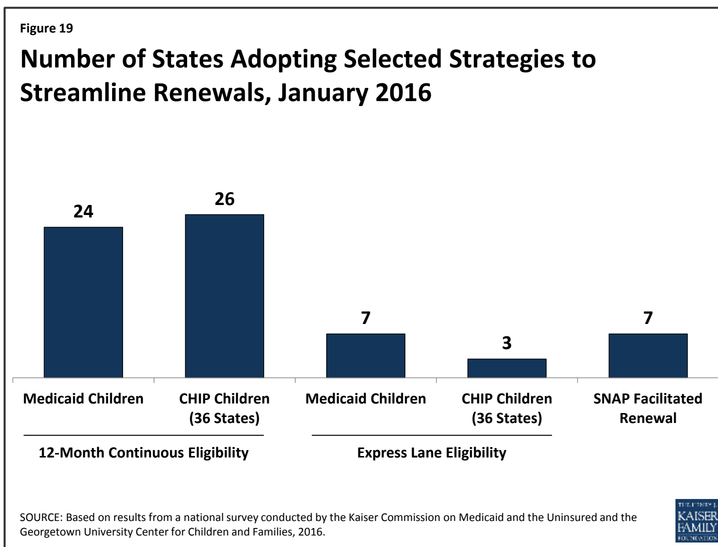
Figure 18
Automated/Ex Parte Renewals for MAGI-Based Medicaid, January 2016

States continue to use other policy tools to boost retention.

- ***12-month continuous eligibility.*** The ACA established a new policy that requires states to renew coverage no more frequently than once every 12 months. However, enrollees still are required to report changes and will lose coverage if these changes make them ineligible. One way states can provide more stable coverage over time is to provide 12-month continuous eligibility, which provides a full year of coverage regardless of changes in income or household size. This policy promotes retention and improves the ability of states to measure quality. It also reduces the number of people moving on and off of coverage due to small changes in income and lowers state administrative costs that result from processing small

changes in income. States have an option to adopt 12-month continuous eligibility for children, but must obtain a waiver to provide it to other groups. As of January 2016, 24 states provide 12-month continuous eligibility to children in Medicaid, while 26 of 36 states with a separate CHIP program have adopted the policy, including Arkansas for its newly established separate CHIP program (Figure 19). In addition, as of January 2016, New York and Montana provide 12-month continuous eligibility to parents and other adults under Section 1115 waiver authority.

- ***Express Lane Eligibility and Facilitated Renewal Using SNAP data.*** As is the case at enrollment, states can use ELE to streamline renewals. With the addition of Colorado, as of January 2016, 7 states (Alabama, Colorado, Iowa, Louisiana, Massachusetts, New York, and South Carolina) use ELE at renewal for children in Medicaid, and 3 of the 36 states with separate CHIP programs (Colorado, Massachusetts, and Pennsylvania) use ELE for CHIP renewals. In addition, Massachusetts uses ELE to renew parents and other adults in Medicaid under Section 1115 waiver authority. The new option or waiver to use SNAP data to expedite enrollment of eligible individuals also applies to using SNAP data to renew coverage for enrollees. As of January 2016, seven states (Alaska, Arkansas, New Jersey, Oregon, South Dakota, Tennessee, and Virginia) are using SNAP data to renew Medicaid coverage under the waiver or option.



Premiums and Cost-Sharing

Given that additional expenses can strain the budgets of low-income individuals and families, federal rules in Medicaid and CHIP set limits on the amounts that states can charge for premiums and cost-sharing, including copayments, coinsurance, and deductibles (see Box 1). In light of this, premiums and cost-sharing generally remain low in Medicaid and CHIP as of January 1, 2016, with few changes in 2015. However, under Section 1115 waiver authority, several states have implemented monthly contributions or premiums for adults that would not otherwise be allowed under federal rules.

Box 1: Premium and Cost-sharing Rules for Medicaid and CHIP

States have flexibility to impose premiums and cost-sharing in Medicaid. The maximum allowable charges vary by income and coverage group within federal rules:

Premiums in Medicaid. Medicaid enrollees, including children, pregnant women, parents and the adult expansion group, with incomes below 150% FPL may not be charged premiums. Premiums are allowed for Medicaid enrollees (both children and adults) with incomes above 150% FPL.

Cost-sharing in Medicaid. Children with incomes below 133% FPL generally cannot be charged cost-sharing. Cost-sharing is allowed for adults enrolled in Medicaid, but charges for those with incomes below 100% FPL are limited to nominal amounts. Cost-sharing cannot be charged for preventive services for children or emergency, family planning, or pregnancy-related services in Medicaid. Under the ACA, preventive services defined as essential health benefits in Alternative Benefit Plans (ABP) in Medicaid also are exempt from cost-sharing for any individual enrolled in an ABP.

Out-of-pocket limit in Medicaid. Overall premium and cost-sharing amounts for family members enrolled in Medicaid may not exceed five percent of household income.

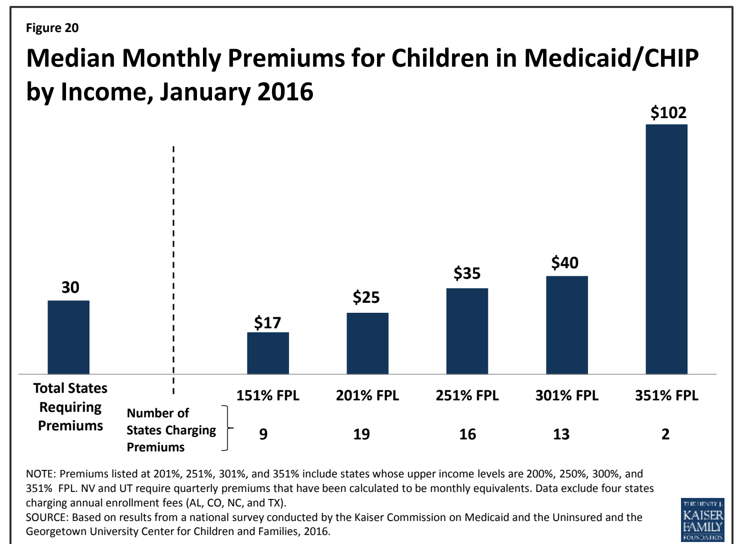
Premiums and Cost-sharing in CHIP. States have somewhat greater flexibility to charge premiums and cost-sharing for children covered by CHIP, although there remain federal limits on the amounts that can be charged, including an overall cap of five percent of household income.

See: Premiums, Copayments, and other Cost-Sharing at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/cost-sharing/cost-sharing.html

Premiums and Cost-Sharing For Children

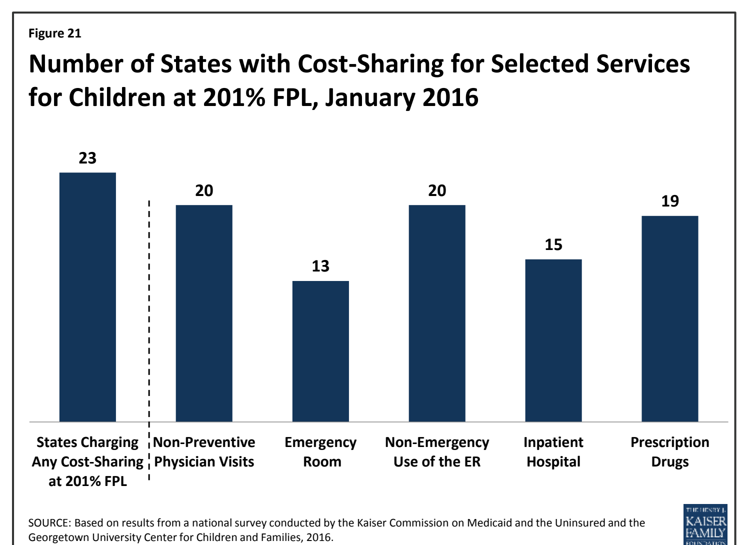
As of January 2016, 30 states charge premiums or enrollment fees for children in Medicaid or CHIP. Reflecting the ACA eligibility protections for children that extend through 2019, this count remained steady during 2015 as did most premium amounts. Under the ACA protections, states generally cannot increase premium amounts. One exception to this protection is if a state had a routine premium adjustment approved in its state Medicaid or CHIP plan prior to the enactment of the ACA on March 23, 2010. During 2015, two states (Maryland and Pennsylvania) increased premiums under such routine annual adjustments. Other changes included Michigan joining the three other states (California, Maryland and Vermont) that charge monthly premiums to children in Medicaid when it shifted all children from its separate CHIP program to Medicaid. Premiums and enrollment fees are more prevalent in CHIP than Medicaid due to the relatively higher incomes of families with children covered under CHIP and the program's more flexible premium rules.[11] Overall, 26

states charge monthly or quarterly premiums and 4 charge annual enrollment fees for children in Medicaid or CHIP. In the 26 states charging monthly or quarterly premiums, charges begin for families above 150% FPL in 19 states, including 8 states in which charges begin above 200% FPL. Median monthly premium amounts range from $17 at 151% FPL to $102 at 351% FPL, although only two states extend eligibility up to this level (Figure 20).



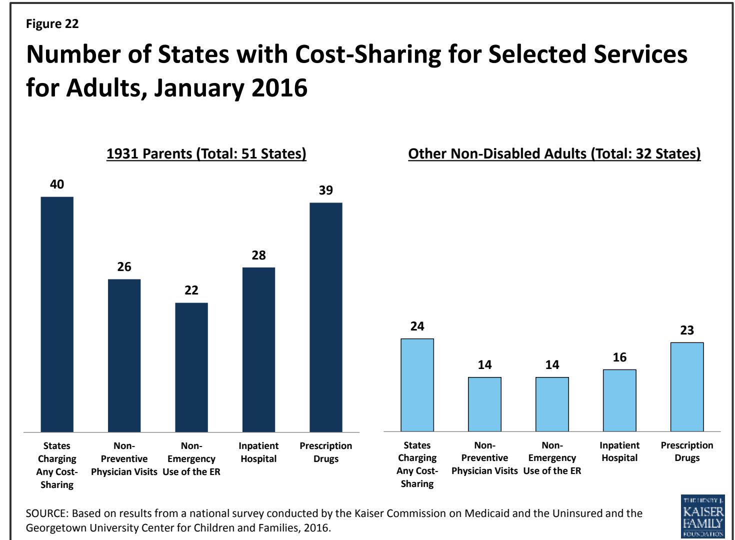
States vary in their policies for nonpayment of premiums. States must provide a minimum 60-day grace period in Medicaid before cancelling coverage for nonpayment of premiums and cannot require enrollees to repay outstanding premiums as a condition of reenrollment, nor can they delay reenrollment. In contrast, CHIP programs are required to provide only a minimum 30-day grace period and may impose up to a 90-day lockout period during which time a child is not allowed to reenroll. Among the 22 states that charge monthly or quarterly premiums or enrollment fees in CHIP, only 4 states limit the grace period to the minimum 30 days, while 17 states provide a 60-day or longer grace period. With the addition of New Jersey in 2015, 14 CHIP programs have a lock-out period after a child is disenrolled for nonpayment of premiums, which range from 1 month to the maximum 90 days. Sixteen states that charge monthly or quarterly payments in Medicaid or CHIP require children who have been disenrolled due to nonpayment of premiums to reapply for coverage. However, seven states reinstate coverage retroactively if outstanding premiums are repaid.

The number of states (26 states) charging cost-sharing for children in Medicaid or CHIP, as well as the amounts of copayments remained largely constant in 2015. As of January 2016, only three states charge cost-sharing for children in Medicaid, while 25 of the 36 states with separate CHIP programs charge cost-sharing. The number of states charging cost-sharing for children did not change in 2015; however, the data reflect Arkansas' transition of children who were subject to cost-sharing in Medicaid to its new separate CHIP program. Only Tennessee charges cost-sharing for children in families with incomes below 133% FPL; under Section 1115 waiver authority, cost-sharing for children starts at the poverty level in the state. Copayments vary by service type. For example, for a child with family income at 201% FPL, 20 states charge cost-sharing for a physician visit, 13 charge for an emergency room visit, 20 charge for non-emergency use of the emergency room, 15 charge for an inpatient hospital visit, and 19 have charges for prescription drugs, although, in some cases, charges only apply to brand name or non-preferred brand name drugs (Figure 21).



PREMIUMS AND COST-SHARING FOR PARENTS AND OTHER ADULTS

As of January 2016, states generally do not charge premiums for low-income parents in Medicaid, but many do have cost-sharing for these parents. Because most parents covered through the Section 1931 eligibility pathway that existed pre-ACA have incomes below poverty, states generally do not charge them monthly premiums. However, during 2015, Indiana implemented monthly contributions for Section 1931 parents under waiver authority, although enrollees cannot be disenrolled due to nonpayment. Forty states charge nominal cost-sharing for Section 1931 parents in Medicaid which varies by service. As of January 2016, 26 states charge parents cost-sharing for a physician visit, 22 charge for non-emergency use of the emergency room, 28 charge for an inpatient hospital visit, and 39 charge for prescription drugs, which may be limited to brand name drugs in some cases (Figure 22). Indiana is the only state to obtain Section 1916(f) waiver authority to charge parents higher cost-sharing than otherwise allowed, which applies to non-emergency use of the emergency room. Cost-sharing for parents remained stable in 2015 with a few exceptions: Florida and Oklahoma increased and Montana decreased cost-sharing for some services, and New York raised the income level at which cost-sharing begins from 0% to 100% FPL.



There are no premiums for expansion adults in 26 of the 31 states that have implemented the ACA Medicaid expansion, but 5 states charge premiums or monthly contributions under Section 1115 waiver authority as of January 2016. Specifically, Arkansas, Indiana, Iowa, Michigan, and Montana charge premiums and/or monthly contributions for adults with incomes above poverty. The consequences of nonpayment of these charges vary across these states. Indiana and Montana can disenroll adults above poverty due to unpaid amounts and impose a lock-out period for those disenrolled. Iowa can also disenroll adults with incomes above poverty; however, it must waive the charges for individuals who self-attest to financial hardship and individuals can reenroll at any time. In Arkansas, monthly contributions are in lieu of point-of-service copayments; adults who do not make monthly contributions are responsible for point-of-service cost-sharing charges. The waivers in Arkansas, Iowa, Indiana, and Montana also allow the states to collect monthly contributions from individuals with incomes below poverty, although Arkansas has not implemented monthly contributions at this income level as of January 2016. Individuals with incomes below poverty cannot be disenrolled due to nonpayment. (See Box 2 for more details).

As of January 2016, 23 of the 31 states that have expanded Medicaid charge expansion adults cost-sharing. In addition, Wisconsin charges the adults it covers up to 100% FPL cost-sharing. Most states have aligned cost-sharing policies for adults and Section 1931 parents, although there are differences in some states. Cost-sharing amounts are generally nominal reflecting the low incomes of adults. Overall, 14 states charge cost-sharing for a physician visit, 14 charge for non-emergency use of the emergency room, 16 charge for an inpatient hospital visit, and 23 charge for prescription drugs as of January 2016. There were few changes in cost-sharing in the past year. These changes included some increases in copayments in New Hampshire and New York raising the income at which cost-sharing begins from 0% to 100% FPL.

Box 2: Premiums/Monthly Contributions for Adults Under Section 1115 Waiver Authority

Arkansas received waiver approval to require certain enrollees to make monthly income-based contributions to health savings accounts (HSAs) to be used in lieu of paying point-of-service copayments and co-insurance. Medically-frail individuals, including those with disabilities or complex health conditions, are exempt from these payments. Monthly contributions are $10 for expansion adults with incomes between 101% - 115%, and $15 for individuals with incomes between 116% - 138%. Under the waiver, Arkansas can charge monthly HSA contributions for expansion adults with incomes down to 50% FPL, but the state is not currently charging those with incomes below poverty. Adults with incomes above poverty who fail to make monthly HSA contributions are responsible for copayments and co-insurance at the point of service, and providers can deny services for failure to pay cost-sharing. Cost-sharing charges are at amounts otherwise allowed under federal law.

In **Iowa**, the waiver allows the state to impose monthly contributions of $5 per month for non-medically frail beneficiaries with incomes between 50% and 100% FPL and $10 per month for non-medically frail beneficiaries with incomes above poverty beginning as of the second year of enrollment. The state cannot disenroll individuals below poverty due to unpaid premiums. Individuals above poverty have a 90-day grace period to pay past-due premiums before they are disenrolled, and the state must waive premiums for enrollees who self-attest to financial hardship. Individuals who are disenrolled for nonpayment can reenroll at any time.

The waiver in **Indiana** imposes monthly contributions at 2% of income for most newly eligible adults and Section 1931 parents. Those with incomes between 0% and 5% FPL must pay $1.00 per month. Individuals with incomes below poverty cannot be disenrolled due to nonpayment but receive a more limited benefit package and are subject to copayments at the point of service. (Medically frail individuals are not placed in the more limited benefit package.) Individuals above poverty are not enrolled in coverage until they make their first monthly payment. In addition, non-medically frail individuals above poverty can be disenrolled due to nonpayment after a 60-day grace period and are subject to a 6-month lock-out period.

Michigan's waiver provides for monthly premiums of 2% of income for enrollees with incomes above poverty, as well as monthly payments into HSAs based on their prior six months of copayments for services used. The copayments are at the same level as what would have been collected without the waiver. Enrollees cannot lose or be denied Medicaid eligibility, be denied health plan enrollment, or be denied access to services, and providers may not deny services for failure to pay copayments or premiums.[12]

In **Montana**, non-medically frail expansion adults with incomes above 50% FPL are subject to monthly premiums of 2% of income. Enrollees receive a credit in the amount of their premiums toward copayments incurred, so that they effectively only have to pay copayments that exceed 2% of income. Those with incomes above poverty can be disenrolled for nonpayment after notice and a 90-day grace period and can reenroll upon payment of arrears or after the debt is assessed against their state income taxes, no later than the end of the calendar quarter. Reenrollment does not require a new application, and the state must establish a process to exempt beneficiaries from disenrollment for good cause. Individuals below poverty cannot be disenrolled for nonpayment of premiums.

Source: M. Musumeci and R. Rudowitz, "The ACA and Medicaid Expansion Waivers," The Kaiser Commission on Medicaid and the Uninsured, November 2015, available at http://files.kff.org/attachment/issue-brief-the-aca-and-medicaid-expansion-waivers

Looking Ahead

States' Medicaid and CHIP eligibility policies and enrollment and renewal processes will play a key role in reaching the remaining low-income uninsured population and keeping eligible individuals enrolled over time. Together, these survey findings show that:

Medicaid and CHIP continue to be central sources of coverage for the low-income population, but access to coverage varies widely across groups and states. Medicaid and CHIP offer a base of coverage to low-income children and pregnant women nationwide. Eligibility for adults has grown under the Medicaid expansion, but remains low in states that have not expanded. Overall, eligibility continues to vary significantly by group, with coverage available to children and pregnant women at higher income levels relative to parents and other adults. Eligibility also varies across states, and these differences have increased as a result of state Medicaid expansion decisions. Given this variation, there are substantial differences in individuals' access to coverage based on their eligibility group and where they live.

Upgraded state Medicaid systems help eligible individuals connect to and retain coverage over time, provide gains in administrative efficiencies, and offer new options to support program management. One key outcome of the ACA has been the significant modernization of states' Medicaid eligibility and enrollment systems. Although state implementation of new eligibility systems got off to a rocky start in 2014, as of 2016, states have implemented system enhancements and processes to increasingly support real-time, data driven eligibility determinations and automatic, paperless renewals of coverage as envisioned by the ACA. The higher-functioning systems in states help eligible individuals connect to coverage more quickly and easily, keep eligible individuals enrolled over time, reduce paperwork burdens, and lead to increased administrative efficiencies as paper-based processes move to an electronic, automated environment. Moreover, the modernized systems offer new options to support program management. For example, states may have increased data reporting capabilities and expanded options to connect Medicaid with other systems and programs. Further, as systems and processes become more refined over time, states may be able to manage enrollment more efficiently, allowing for resources to be refocused on other activities. Looking ahead, states will continue to fully operationalize the streamlined enrollment and renewal processes outlined in the ACA and build on their developments to date to increase the use of technology, expand functionality, smooth out coordination across coverage programs, and integrate non-health programs into their new systems.

There remain key questions about how recent changes in eligibility and enrollment may be affected by a range of factors moving forward. Funding for CHIP is set to expire in 2017, raising key questions about the future of the program and what might happen in its absence. In addition, the ACA maintenance of effort provisions for children's coverage end in 2019. State Medicaid expansion decisions will likely continue to evolve over time, and it remains to be seen how they might be affected by the gradual reduction in federal funding for newly eligible expansion adults, which begins to phase down in 2017 when it reduces to 95%. Pending proposals in current budget reconciliation legislation would roll back the Medicaid expansion to adults and eliminate the maintenance of effort requirements in 2017. Outside of these potential changes, it also will be important to examine how the Section 1115 waivers that allow states to charge adults premiums and monthly contributions are affecting coverage and program administration, particularly given that waiver authority is provided for research and demonstration purposes.

Endnotes

[1] Iowa also used state funds to cover immigrant children in foster care.

[2] This group of adults may include some adults with disabilities who are not eligible for Medicare.

[3] MaryBeth Musumeci and Robin Rudowitz, *The ACA and Medicaid Expansion Waivers* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, November 2015), http://kff.org/medicaid/issue-brief/the-aca-and-medicaid-expansion-waivers/.

[4] Stan Dorn and Jennifer Tolbert, *The ACA's Basic Health Program Option: Federal Requirements and State Trade-Offs* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, November 2014), http://kff.org/health-reform/report/the-acas-basic-health-program-option-federal-requirements-and-state-trade-offs/.

[5] Rachel Garfield and Anthony Damico*, The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid – An Update* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, October 2015), http://kff.org/health-reform/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid-an-update/.

[6] 80 *Fed. Reg*. 75817-75843 (December 4, 2015). Available at https://www.federalregister.gov/articles/2015/12/04/2015-30591/medicaid-program-mechanized-claims-processing-and-information-retrieval-systems-9010.

[7] Kevin Concannon, Kevin Counihan, Mark Greenberg and Victoria Wachino, Tri-Agency Letter on *Additional Guidance to States on the OMB Circular A-87 Cost Allocation Exception*, July 20, 2015. Available at http://www.medicaid.gov/federal-policy-guidance/downloads/SMD072015.pdf.

[8] Vikki Wachino, CMS Letter to State Medicaid Directors and State Health Officials, SHO # 15-001; ACA #34 *Re: Policy Options for Using SNAP to Determine Medicaid Eligibility and an Update on Targeted Enrollment Strategies*, August 31, 2015. Available at https://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-15-001.pdf.

[9] Jocelyn Guyer, Tanya Schwartz, and Samantha Artiga, *Fast Track to Coverage: Facilitating Enrollment of Eligible People into the Medicaid Expansion* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, November 2013), http://kff.org/medicaid/issue-brief/fast-track-to-coverage-facilitating-enrollment-of-eligible-people-into-the-medicaid-expansion/.

[10] "Targeted Enrollment Strategies," CMS, accessed December 2015, http://www.medicaid.gov/medicaid-chip-program-information/program-information/targeted-enrollment-strategies/targeted-enrollment-strategies.html.

[11] The Medicaid and CHIP Payment and Access Commission (MACPAC) has indicated that the prevalent use of premiums in CHIP leads to the problem of 'premium stacking' for families, in which families have to pay both premiums for children enrolled in CHIP and for adults enrolled in Marketplace coverage. MACPAC notes that these combined premiums could constitute a percentage of a family's income that is higher than the limits established by the ACA. For more information see Medicaid and CHIP Payment and Access Commission, "Chapter 5: Children's Coverage under CHIP and Exchange Plans," in *Report to the Congress on Medicaid and CHIP* (Washington, DC: March 2014), 150-182, https://www.macpac.gov/wp-content/uploads/2015/01/2014-03-14_Macpac_Report.pdf.

[12] On December 17, 2015, Michigan received approval for a waiver amendment. Under the approved waiver amendment, beneficiaries between 100% and 138% FPL who are not medically frail could choose between two coverage options as of April 2018: continued coverage through Medicaid managed care or the Healthy Michigan Plan or Marketplace coverage through a Qualified Health Plan (QHP) or the Marketplace Option. If beneficiaries choose Medicaid managed care, they will be required to meet a healthy behavior requirement or they could be transitioned to a QHP plan. Beneficiaries above 100% FPL would face monthly premiums of up to 2% of income in both Healthy Michigan and QHPs, but failure to pay would not result in termination of eligibility. See, Kaiser Commission on Medicaid and the Uninsured, *Medicaid Expansion in Michigan* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, January 2016), http://kff.org/medicaid/fact-sheet/medicaid-expansion-in-michigan/.

Trend and State-by-State Tables

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Table A

Trends in State Medicaid and CHIP Eligibility, Enrollment, and Renewal Policies[1]

July 2000 to January 2016

	Program	July 2000	January 2002	April 2003	July 2004	July 2005	July 2006	January 2008	January 2009	December 2009	January 2011	January 2012	January 2013	January 2015	January 2016
ELIGIBILITY															
Cover children ≥200% FPL	**N/A**	36	40	39	39	41	41	45	44	47	47	47	47	48	48
Cover children ≥300% FPL	**N/A**	5	6	6	6	6	8	9	10	16	16	17	17	19	19
Cover lawfully-residing immigrant children without five-year wait	**Medicaid**	Option Not Available								17	21	24	25	28	29
	CHIP														19
Cover pregnant women ≥200% FPL	**N/A**	Not Collected		17	16	17	17	20	21	24	25	25	25	33	33
Cover lawfully-residing immigrant pregnant women without five-year wait	**Medicaid**	Option Not Available								14	17	18	20	23	23
	CHIP														4
Cover parents ≥100% FPL[2]	**N/A**	Not Collected	20	16	17	17	16	18	18	17	18	18	18	31	34
Cover childless adults[2]	**N/A**	Not Collected									7	8	25	29	32
Asset test not required	**Medicaid**	42	45	45	46	47	47	47	47	48	48	48	48	51*	51*
	CHIP	31	34	34	33	33	34	35	36	37	36	37	36		
	Parents	Not Collected	19	21	22	22	21	22	23	24	24	24	24		
STREAMLINED ENROLLMENT PROCESSES															
Online Medicaid application[3]	**Medicaid**	Not Collected									32	34	36	50	50
Telephone Medicaid application[3]	**Medicaid**	Not Collected											17	47	49
Presumptive eligiblity for children	**Medicaid**	8	9	7	8	9	9	14	14	14	16	16	17	15	18
	CHIP	4	5	4	6	6	6	9	9	9	10	11	12	9	10
Presumptive eligibility for pregnant women	**Medicaid**	Not Collected		29	29	30	31	30	30	30	31	31	32	27	29
	CHIP														2
No face-to-face interview at enrollment[3]	**Medicaid**	40	47	46	45	45	46	46	48	48	49	49	49	51*	51*
	CHIP	31	34	33	33	33	33	34	38	38	37	38	37		
	Parents	Not Collected	35	36	36	36	39	40	41	41	44	45	45		
STREAMLINED RENEWAL PROCESSES															
Ex parte renewals	**N/A**	Not Collected													34
Telephone Medicaid renewal	**N/A**	Not Collected													41
No face-to-face interview at renewal[3]	**Medicaid**	43	48	49	48	48	48	48	49	50	50	50	50	51*	51*
	CHIP	32	34	35	35	35	35	36	38	38	37	38	37		
	Parents		35	42	42	43	45	46	46	46	46	48	48		
12-month eligibility period[3]	**Medicaid**	39	42	42	41	42	44	45	44	47	49	49	49	51*	51*
	CHIP	23	33	33	32	34	34	37	39	39	38	28	38		
	Parents		38	38	36	36	39	40	40	43	45	46	46		
12-month continuous eligibility	**Medicaid**	14	18	15	15	17	16	16	18	22	23	23	23	21	24
	CHIP	22	23	21	21	24	25	27	30	30	28	28	27	25	26

SOURCES: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Center on Budget and Policy Priorities, 2000-2009; and with the Georgetown University Center for Children and Families, 2011-2015.

*See S. Artiga, M. Musumeci, and R. Rudowitz, "Medicaid Eligibility, Enrollment Simplification, and Coordination Under the Affordable Care Act: A Summary of CMS's March 23, 2012 Final Rule," December 2012

1. 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.

2. These counts do not include states that may have provided coverage above the levels shown using state-only funding or provide a more limited benefit package.

3. Required across all states under the Affordable Care Act (ACA). States are in varied stages of implementing the new streamlined enrollment and renewal processes under the ACA, and mitigation strategies are in place in cases in which requirements have not been met.

Table 1
Upper Income Eligibility Limits for Children's Health Coverage as a Percent of the Federal Poverty Level (FPL)[1]
January 2016

State	Upper Income Limit	Medicaid for Infants Ages 0-1[2]		Medicaid for Children Ages 1-5[2]		Medicaid for Children Ages 6-18[2]		Separate CHIP for Uninsured Children Ages 0-18[3]
		Medicaid Funded	CHIP-Funded	Medicaid Funded	CHIP-Funded	Medicaid Funded	CHIP-Funded	
Alabama	317%	146%		146%		146%	146%	317%
Alaska	208%	177%	208%	177%	208%	177%	208%	
Arizona[4]	152%	152%		146%		138%	138%	200% (closed)
Arkansas[5]	216%	147%		147%		147%	147%	216%
California[6]	266%	208%	266%	142%	266%	133%	266%	
Colorado	265%	147%		147%		147%	147%	265%
Connecticut	323%	201%		201%		201%		323%
Delaware	217%	194%	217%	147%		138%	138%	217%
District of Columbia	324%	324%	324%	324%	324%	324%	324%	
Florida[7,8]	215%	211%	211%	145%		138%	138%	215%
Georgia	252%	210%		154%		138%	138%	252%
Hawaii	313%	191%	313%	139%	313%	133%	313%	
Idaho	190%	147%		147%		138%	138%	190%
Illinois[9]	318%	147%		147%		147%	147%	318%
Indiana[10]	263%	218%		165%	165%	165%	165%	262%
Iowa	380%	380%	380%	172%		172%	172%	307%
Kansas[11]	244%	171%		154%		138%	138%	244%
Kentucky	218%	200%		142%	164%	142%	164%	218%
Louisiana	255%	142%	217%	142%	217%	142%	217%	255%
Maine[8,12]	213%	196%		162%	162%	162%	162%	213%
Maryland	322%	194%	322%	138%	322%	133%	322%	
Massachusetts[13]	305%	205%	205%	155%	155%	155%	155%	305%
Michigan[14]	217%	195%	217%	160%	217%	160%	217%	
Minnesota[15]	288%	275%	288%	280%		280%		
Mississippi	214%	199%		148%		138%	138%	214%
Missouri	305%	201%		155%	155%	155%	155%	305%
Montana	266%	148%		148%		148%		266%
Nebraska	218%	162%	218%	145%	218%	133%	218%	
Nevada	205%	165%		165%		138%	138%	205%
New Hampshire	323%	196%	323%	196%	323%	196%	323%	
New Jersey	355%	199%		147%		147%	147%	355%
New Mexico	305%	240%	305%	240%	305%	190%	245%	
New York[8]	405%	223%		154%		154%	154%	405%
North Carolina[8]	216%	215%	215%	215%	215%	138%	138%	216%
North Dakota	175%	152%		152%		138%	138%	175%
Ohio	211%	156%	211%	156%	211%	156%	211%	
Oklahoma[16]	210%	210%	210%	210%	210%	210%	210%	
Oregon	305%	190%	190%	138%		138%	138%	305%
Pennsylvania[8]	319%	220%		162%		138%	138%	319%
Rhode Island	266%	190%	266%	142%	266%	133%	266%	
South Carolina	213%	194%	213%	143%	213%	133%	213%	
South Dakota	209%	187%	187%	187%	187%	187%	187%	209%
Tennessee[17]	255%	195%	216%	142%	216%	133%	216%	255%
Texas	206%	203%		149%		138%	138%	206%
Utah	205%	144%		144%		138%	138%	205%
Vermont	317%	317%	317%	317%	317%	317%	317%	
Virginia	205%	148%		148%		148%	148%	205%
Washington	317%	215%		215%		215%		317%
West Virginia	305%	163%		146%		138%	138%	305%
Wisconsin[18]	306%	306%		191%		133%	156%	306%
Wyoming	205%	159%		159%		138%	138%	205%

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, 2016.
Table presents rules in effect as of January 1, 2016.

Table 1 Notes

1. January 2016 income limits reflect MAGI-converted income standards and include a disregard equal to five percentage points of the federal poverty level (FPL) applied at the highest income level for Medicaid and separate CHIP coverage. Eligibility levels are reported as percentage of the FPL. The 2015 FPL for a family of three was $20,090.
2. States may use Title XXI CHIP funds to cover children through CHIP-funded Medicaid expansion programs and/or separate child health insurance programs for children not eligible for Medicaid. Use of Title XXI CHIP funds is limited to uninsured children. The Medicaid income eligibility levels listed indicate thresholds for children covered with Title XIX Medicaid funds and uninsured children covered with Title XXI funds through CHIP-funded Medicaid expansion programs. 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 6-18 category, the child is age six or older, but has not yet reached his or her 19th birthday.
3. The states noted use federal CHIP funds to operate separate child health insurance programs for children not eligible for Medicaid. Such programs may either provide benefits similar to Medicaid or a somewhat more 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 for uninsured children until the child's 19th birthday.
4. Arizona instituted an enrollment freeze in its CHIP program, KidsCare, on December 21, 2009, prior to the ACA's maintenance of effort requirement. A temporary successor program, KidsCare II, was eliminated on January 31, 2014. As of April 2015, less than 1,300 children remain enrolled in the original KidsCare program.
5. Arkansas converted its CHIP-funded Medicaid expansion program to a separate CHIP program in 2015.
6. In California, children with higher incomes may be eligible for separate CHIP coverage in certain counties.
7. 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.
8. Florida, Maine, New York, North Carolina, and Pennsylvania allow families with incomes above the levels shown to buy into Medicaid/CHIP. For details, see Table 3.
9. In Illinois, infants born to non-Medicaid covered mothers are covered up to 147% FPL in Medicaid, and up to 318% FPL under CHIP. Infants born to mothers enrolled in Medicaid coverage are deemed eligible for Medicaid until age 1.
10. Indiana uses a state-specific income disregard that is equal to five percent of the highest income eligibility threshold for the group.
11. Kansas covers children in a separate CHIP program at an income level equal to 238% FPL in 2008. In 2016, the equivalent eligibility level adjusted for the conversion to Modified Adjusted Gross Income and reflecting the five percentage point of income disregard is 244% FPL.
12. In Maine, children ages 0-1 not born to mothers covered under Medicaid are eligible up to 196% FPL.
13. Massachusetts also covers insured children up to its separate CHIP program income limit under a Section 1115 waiver.
14. Michigan converted its separate CHIP program to a CHIP-funded Medicaid expansion program as of January 2016.
15. In Minnesota, the infant category under Title XIX-funded Medicaid includes insured and uninsured children up to age two with incomes up to 275% FPL. Under Title XXI-funded coverage for uninsured children, eligibility for infants is up to 288% FPL.
16. Oklahoma offers a premium assistance program to children ages 0 - 18 with income up to 222% FPL with access to employer sponsored insurance through its Insure Oklahoma program.

17. 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 216% FPL or are medically eligible.
18. In Wisconsin, a child is not eligible for CHIP if they have access to health insurance coverage through a job where the employer covers at least 80% of the cost.

Table 2
Waiting Period for CHIP Enrollment
January 2016

State	Waiting Period[1]	Income-Related Groups Exempt from Waiting Period (Percent of the FPL)
Total No Waiting Period	**34**	
Alabama	None	
Alaska	None	
Arizona[2]	Enrollment closed	
Arkansas	90 days	
California	None	
Colorado	None	
Connecticut	None	
Delaware	None	
District of Columbia	None	
Florida	2 months	
Georgia	2 months	
Hawaii	None	
Idaho	None	
Illinois	90 days	Below 209%
Indiana	90 days	
Iowa	1 month	Below 200%
Kansas	90 days	Below 200%
Kentucky	None	
Louisiana	90 days	Below 212%
Maine	90 days	
Maryland	None	
Massachusetts	None	
Michigan[3]	None	
Minnesota	None	
Mississippi	None	
Missouri	None	
Montana	None	
Nebraska	None	
Nevada	None	
New Hampshire	None	
New Jersey	90 days	Below 200%
New Mexico	None	
New York	90 days	Below 250%
North Carolina	None	
North Dakota	90 days	
Ohio	None	
Oklahoma	None	
Oregon	None	
Pennsylvania	None	
Rhode Island	None	
South Carolina	None	
South Dakota	90 days	
Tennessee	None	
Texas	90 days	
Utah	90 days	
Vermont	None	
Virginia	None	
Washington	None	
West Virginia	None	
Wisconsin[4]	None	
Wyoming	1 month	

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, 2016.
Table presents rules in effect as of January 1, 2016.

Table 2 Notes

1. "Waiting period" refers to the length of time a child is required to be without group coverage prior to enrolling in CHIP coverage. Waiting periods generally apply to separate CHIP programs only, as they are not permitted in Medicaid without a waiver. The ACA limits waiting periods to no more than 90 days, and states must waive the waiting period for specific good causes established in federal regulations. States may adopt additional exceptions to the waiting period, which vary by state. In addition to the income exemptions shown, specific categories of children such as newborns may be exempt from the waiting periods.
2. Arizona instituted an enrollment freeze in its CHIP program, KidsCare, on December 21, 2009, prior to the ACA's maintenance of effort requirement.
3. In Michigan, the waiting period was eliminated effective January 1, 2016, as children transitioned from separate CHIP to Medicaid expansion coverage.
4. Wisconsin eliminated its income-based exemption from the CHIP waiting period in July 2015.

Table 3
Optional Medicaid and CHIP Coverage for Children
January 2016

State	Buy-In Program (Income Eligibility as a Percent of the FPL)[1]	Coverage for Dependents of State Employees in CHIP (Total =36)[2]	Lawfully-Residing Immigrants Covered without 5-Year Wait (ICHIA Option)[3]		Medicaid Coverage of Former Foster Youth up to Age 26 Extends to Youth from Other States[4]
			Medicaid	CHIP (Total = 36)	
Total	**5**	**15**	**29**	**19**	**13**
Alabama		Y			
Alaska		N/A (M-CHIP)		N/A (M-CHIP)	
Arizona					
Arkansas		Y			
California[7]		N/A (M-CHIP)	Y	N/A (M-CHIP)	Y
Colorado[5]		Y	Y	Y	
Connecticut[6]		Y	Y	Y	
Delaware			Y	Y	
District of Columbia[7]		N/A (M-CHIP)	Y	N/A (M-CHIP)	
Florida[8]	>215%	Y			
Georgia		Y			Y
Hawaii		N/A (M-CHIP)	Y	N/A (M-CHIP)	
Idaho					
Illinois[7]			Y	Y	
Indiana					
Iowa[7]			Y	Y	
Kansas					
Kentucky		Y	Y	Y	Y
Louisiana					Y
Maine[9]	>213%		Y	Y	
Maryland		N/A (M-CHIP)	Y	N/A (M-CHIP)	
Massachusetts[7,10]			Y	Y	Y
Michigan		N/A (M-CHIP)		N/A (M-CHIP)	Y
Minnesota		N/A (M-CHIP)	Y	N/A (M-CHIP)	
Mississippi		Y			
Missouri					
Montana		Y	Y	Y	Y
Nebraska		N/A (M-CHIP)	Y	N/A (M-CHIP)	
Nevada[11]		Y			
New Hampshire		N/A (M-CHIP)		N/A (M-CHIP)	
New Jersey			Y	Y	
New Mexico[12]		N/A (M-CHIP)	Y	N/A (M-CHIP)	Y
New York[7]	>405%		Y	Y	Y
North Carolina[13]	>216%	Y	Y	Y	
North Dakota					
Ohio		N/A (M-CHIP)	Y	N/A (M-CHIP)	
Oklahoma		N/A (M-CHIP)		N/A (M-CHIP)	
Oregon			Y	Y	
Pennsylvania[14]	>319%	Y	Y	Y	Y
Rhode Island		N/A (M-CHIP)	Y	N/A (M-CHIP)	
South Carolina		N/A (M-CHIP)		N/A (M-CHIP)	
South Dakota					Y
Tennessee					
Texas		Y	Y	Y	
Utah					
Vermont		N/A (M-CHIP)	Y	N/A (M-CHIP)	
Virginia[11]		Y	Y	Y	Y
Washington[7]			Y	Y	
West Virginia		Y	Y	Y	
Wisconsin			Y	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, 2016.
Table presents rules in effect as of January 1, 2016.

Table 3 Notes

1. States with a buy-in program allow families with incomes over the upper income eligibility limit for children's coverage (including the 5 percentage point disregard), to buy into Medicaid or CHIP for their children.
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.
3. This column indicates whether the state has received approval through a State Plan Amendment and implemented coverage for immigrant children who have been lawfully residing in the U.S. for less than five years, otherwise known as the Immigrant Children's Health Improvement Act (ICHIA) option.
4. Under the ACA, all states must provide Medicaid coverage to youth up to age 26 who were in foster care in the state as of their 18th birthday and enrolled in Medicaid. This column indicates whether the state has elected the option to also provide Medicaid coverage to former foster youth up to age 26 who were enrolled in Medicaid in another state as of their 18th birthday.
5. Colorado passed legislation authorizing coverage of lawfully residing immigrant children in 2012; it implemented this coverage in July 2015.
6. Connecticut eliminated its buy-in program as of August 1, 2015.
7. The District of Columbia, Illinois, Massachusetts, New York, and Washington cover income-eligible children regardless of immigration status using state-only funds. In California, some local programs cover immigrant children regardless of immigration status. Legislation was approved in 2015 to cover all income-eligible children regardless of immigration status statewide; implementation is planned for 2016. Iowa also uses state-only funds to cover immigrant children in foster care.
8. In Florida, families can buy into Healthy Kids coverage for children ages 5 to 19 and into MediKids coverage for children ages 1 to 4.
9. Maine has a buy-in program called the Health Insurance Purchase Option. The program is limited to those who had been previously enrolled in CHIP. A child can participate for up to 18 months.
10. Massachusetts offers more limited state-subsidized coverage to children at any income through its Children's Medical Security Plan program; premiums vary based on income. Massachusetts also has buy-in coverage limited to children with disabilities with no income limit.
11. Nevada and Virginia began using CHIP funds to cover some dependents of state employees as January 2016.
12. New Mexico began covering former foster children from other states as of October 2015.
13. In North Carolina, eligibility for the buy-in program is limited to those who had been previously enrolled in CHIP. A child can participate for up to 12 months. The upper limit for the buy-in program was eliminated during 2015.
14. In Pennsylvania, CHIP coverage for dependents of state employees is limited to part-time and seasonal employees who meet a hardship exemption.

Table 4
Medicaid and CHIP Coverage for Pregnant Women
January 2016

State	Income Eligibility Limits (Percent of the FPL)[1]			Lawfully-Residing Immigrants Covered without 5-Year Wait (ICHIA Option)[3]		Full Medicaid/CHIP Benefit Package for Pregnant Women[4]	
	Medicaid (Title XIX)	CHIP (Title XXI)	Unborn Child Option (Title XXI)[2]	Medicaid	CHIP (Total = 5)	Medicaid	CHIP (Total = 5)
Total	**51**	**5**	**15**	**23**	**4**	**45**	**5**
Alabama[5]	146%				N/A	Y	N/A
Alaska[5]	205%				N/A	Y	N/A
Arizona	161%				N/A	Y	N/A
Arkansas[6]	214%		214%		N/A		N/A
California	213%		322%	Y	N/A		N/A
Colorado[7]	200%	265%		Y	Y	Y	Y
Connecticut	263%			Y	N/A	Y	N/A
Delaware	217%			Y	N/A	Y	N/A
District of Columbia[8]	211%	324%		Y	Y	Y	Y
Florida	196%				N/A	Y	N/A
Georgia	225%				N/A	Y	N/A
Hawaii	196%			Y	N/A	Y	N/A
Idaho	138%				N/A		N/A
Illinois	213%		213%		N/A	Y	N/A
Indiana[9]	218%				N/A	Y	N/A
Iowa	380%				N/A	Y	N/A
Kansas	171%				N/A	Y	N/A
Kentucky	200%				N/A		N/A
Louisiana	138%		214%		N/A	Y	N/A
Maine	214%			Y	N/A	Y	N/A
Maryland	264%			Y	N/A	Y	N/A
Massachusetts	205%		205%	Y	N/A	Y	N/A
Michigan	200%		200%		N/A	Y	N/A
Minnesota	283%		283%	Y	N/A	Y	N/A
Mississippi	199%				N/A	Y	N/A
Missouri	201%				N/A	Y	N/A
Montana	162%				N/A	Y	N/A
Nebraska	199%		202%	Y	N/A	Y	N/A
Nevada	165%				N/A	Y	N/A
New Hampshire	201%				N/A	Y	N/A
New Jersey[8]	199%	205%		Y	Y	Y	Y
New Mexico	255%			Y	N/A		N/A
New York[5,8]	223%			Y	N/A	Y	N/A
North Carolina	201%			Y	N/A	Y	N/A
North Dakota	152%				N/A	Y	N/A
Ohio	205%			Y	N/A	Y	N/A
Oklahoma[10]	138%		190%		N/A	Y	N/A
Oregon	190%		190%		N/A	Y	N/A
Pennsylvania	220%			Y	N/A	Y	N/A
Rhode Island	195%	258%	258%			Y	Y
South Carolina	199%				N/A	Y	N/A
South Dakota[11]	138%				N/A		N/A
Tennessee	200%		255%		N/A	Y	N/A
Texas	203%		207%		N/A	Y	N/A
Utah	144%				N/A	Y	N/A
Vermont	213%			Y	N/A	Y	N/A
Virginia	148%	205%		Y	Y	Y	Y
Washington	198%		198%	Y	N/A	Y	N/A
West Virginia	163%			Y	N/A	Y	N/A
Wisconsin	306%		306%	Y	N/A	Y	N/A
Wyoming	159%			Y	N/A	Y	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, 2016.
Table presents rules in effect as of January 1, 2016.

Table 4 Notes

1. January 2016 income limits reflect MAGI converted income standards, and include a disregard equal to five percentage points of the federal poverty level (FPL). As of 2015, the FPL for a family of three in 2015 was $20,090.
2. The unborn child option permits states to consider the fetus a "targeted low-income child" for purposes of CHIP coverage.
3. These columns indicate whether the state received approval through a State Plan Amendment to adopt and has implemented 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.
4. These columns indicate whether pregnant beneficiaries in the state receive the full Medicaid or CHIP benefit package. During a presumptive eligibility period, pregnant women receive only prenatal and pregnancy-related benefits. Pregnant women who are covered through the unborn child option may receive more limited pregnancy-related benefits. N/A responses indicate that the state does not provide CHIP coverage to pregnant women.
5. In 2015, Alabama, Alaska and New York implemented full Medicaid benefits for pregnant women.
6. Arkansas provides the full Medicaid benefits to pregnant women with incomes up to levels established for the old Aid to Families with Dependent Children (AFDC) program, which is $124 per month. Above those levels, more limited pregnancy-related benefits are provided to pregnant women covered under Medicaid and the unborn child option in CHIP with incomes up to 209% FPL.
7. Colorado passed legislation authorizing coverage of lawfully residing immigrant pregnant women in CHIP during 2012; it implemented this coverage in July 2015.
8. The District of Columbia, New Jersey, and New York provide pregnancy-related services not covered through emergency Medicaid for some income-eligible pregnant women regardless of immigration status using state-only funds.
9. Indiana uses a state-specific income disregard that is equal to five percent of the highest income eligibility threshold for the group.
10. Oklahoma offers a premium assistance program to pregnant women with incomes up to 205% FPL who have access to employer sponsored insurance through its Insure Oklahoma program.
11. South Dakota provides full Medicaid benefits to pregnant women with incomes up to $591 per month (for a family of three). Above those levels, more limited pregnancy-related benefits are provided to pregnant women covered under Medicaid.

Table 5
Medicaid Income Eligibility Limits for Adults as a Percent of the Federal Poverty Level[1]
January 2016

State	Parents (in a family of three)		Childless Adults (for an individual)
	Section 1931 Limit	Upper Limit	
Alabama	18%	18%	0%
Alaska[2]	143%	143%	138%
Arizona	106%	138%	138%
Arkansas	16%	138%	138%
California	109%	138%	138%
Colorado	68%	138%	138%
Connecticut[3]	155%	155%	138%
Delaware	87%	138%	138%
District of Columbia[4]	221%	221%	215%
Florida	34%	34%	0%
Georgia	37%	37%	0%
Hawaii[4]	100%	138%	138%
Idaho	26%	26%	0%
Illinois	25%	138%	138%
Indiana[5]	18%	139%	139%
Iowa	52%	138%	138%
Kansas	38%	38%	0%
Kentucky	20%	138%	138%
Louisiana	24%	24%	0%
Maine	105%	105%	0%
Maryland	123%	138%	138%
Massachusetts[4,6]	138%	138%	138%
Michigan	54%	138%	138%
Minnesota[7]	138%	138%	138%
Mississippi	27%	27%	0%
Missouri	22%	22%	0%
Montana[8]	45%	138%	138%
Nebraska[9]	63%	63%	0%
Nevada	29%	138%	138%
New Hampshire[10]	57%	138%	138%
New Jersey	30%	138%	138%
New Mexico	45%	138%	138%
New York[4,7]	90%	138%	138%
North Carolina	44%	44%	0%
North Dakota	52%	138%	138%
Ohio	90%	138%	138%
Oklahoma[11]	44%	44%	0%
Oregon	36%	138%	138%
Pennsylvania[4,12]	33%	138%	138%
Rhode Island	116%	138%	138%
South Carolina	67%	67%	0%
South Dakota	52%	52%	0%
Tennessee	101%	101%	0%
Texas[13]	18%	18%	0%
Utah[14]	45%	45%	0%
Vermont[15]	45%	138%	138%
Virginia[16]	39%	39%	0%
Washington	48%	138%	138%
West Virginia	18%	138%	138%
Wisconsin[17]	100%	100%	100%
Wyoming	57%	57%	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, 2016.

Table presents rules in effect as of January 1, 2016.

Table 5 Notes

1. January 2016 income limits reflect MAGI-converted income standards, and include a disregard equal to five percentage points of the federal poverty level (FPL) applied to the highest income limit for the group. In some states, eligibility limits for Section 1931 parents are based on a dollar threshold. The values listed represent the truncated FPL equivalents calculated from these dollar limits. Eligibility levels for parents are presented as a percentage of the 2015 FPL for a family of three, which is $20,090. Eligibility limits for other adults are presented as a percentage of the 2015 FPL for an individual, which is $11,770.
2. Alaska expanded Medicaid to adults as a state plan option during 2015.
3. Connecticut reduced parent eligibility from 201% to 155% FPL during 2015.
4. The District of Columbia, Hawaii, Massachusetts, New York, and Pennsylvania cover some income-eligible adults, regardless of immigration status using state-only funds.
5. Indiana expanded Medicaid to adults in February 2015 under Section 1115 waiver authority. Indiana uses a state-specific income disregard that is equal to five percent of the highest income eligibility threshold for the group.
6. Massachusetts also provides subsidies for Marketplace coverage for parents and childless adults with incomes up to 300% through its Connector Care program. The state's Section 1115 waiver also authorizes MassHealth coverage for HIV-positive individuals with incomes up to 200% FPL, uninsured individuals with breast or cervical cancer with incomes up to 250% FPL, and individuals who work for a small employer and purchase ESI with incomes up to 300% FPL, as well as coverage through MassHealth CommonHealth for adults with disabilities with no income limit.
7. Minnesota and New York received approval to implement a Basic Health Program (BHP) established by the ACA. Minnesota received approval in December 2014, and transferred coverage for Medicaid enrollees with incomes between 138% - 200% FPL to the BHP as of January 1, 2015. New York began phasing in its BHP during 2015 and will complete the phased-in implementation as of January 1, 2016.
8. Montana expanded Medicaid to adults under Section 1115 waiver authority as of January 1, 2016. When the state implemented the expansion, it reduced Section 1931 eligibility for parents to the minimum level allowed under federal rules.
9. Nebraska converted the basis of 1931 parent eligibility from a dollar threshold to a percent of the FPL during 2015, which resulted in a small increase in the income eligibility limit.
10. New Hampshire converted its Medicaid expansion to low-income adults from state option to under Section 1115 waiver authority effective January 1, 2016.
11. In Oklahoma, individuals without a qualifying employer with incomes up to 100% FPL are eligible for more limited subsidized insurance though the Insure Oklahoma Section 1115 waiver program. Individuals working for certain qualified employers with incomes at or below 200% FPL are eligible for premium assistance for employer-sponsored insurance.
12. Pennsylvania converted its Medicaid expansion to low-income adults from under Section 1115 waiver authority to the state option during 2015.
13. In Texas, the income limit for parents and other caretaker relatives is based on monthly dollar amounts which vary based on whether it is a one-parent family or a two-parent family and the family size. The eligibility level shown is for a single parent household and a family size of three.
14. In Utah, adults with incomes up to 100% FPL are eligible for coverage of primary care services under the Primary Care Network Section 1115 waiver program. Enrollment is opened periodically when there is capacity to accept new enrollees.

15. Vermont also provides a 1.5% reduction in the federal applicable percentage of the share of premium costs for individuals who qualify for advance premium tax credits to purchase Marketplace coverage with income up to 300% FPL.
16. In Virginia, eligibility levels for 1931 parents vary by region. The value shown is the eligibility level for Region 2, the most populous region.
17. Wisconsin covers adults up to 100% FPL in Medicaid but did not adopt the ACA Medicaid expansion.

Table 6
MAGI Eligibility Systems
January 2016

State	Able to Make Real-Time Determinations (<24 Hours)[1]	Share of MAGI-Based Applications With a Determination Completed in Real-Time[1]				Integrated with CHIP (Total = 36)[2]	Integrated with Non-MAGI Medicaid[2]	Integrated with:[2]		
		<25%	25%-50%	50%-75%	75%+			SNAP	TANF	Child Care Subsidy
Total	**37**	**12**	**4**	**2**	**9**	**34**	**24**	**17**	**17**	**7**
Alabama	Y				Y	Y				
Alaska						N/A (M-CHIP)				
Arizona	Y	Y				Y	Y			
Arkansas	Y	Y				Y				
California[3]	Y		Y			N/A (M-CHIP)				
Colorado[4]	Y				Y	Y	Y			
Connecticut	Y				Y	Y				
Delaware	Y	Y				Y	Y	Y	Y	Y
District of Columbia	Y	Y				N/A (M-CHIP)				
Florida[5]	Y		Y			Y	Y			
Georgia							Y	Y	Y	
Hawaii	Y		Not Reported			N/A (M-CHIP)	Y			
Idaho						Y	Y	Y	Y	
Illinois						Y	Y	Y	Y	
Indiana						Y	Y	Y	Y	
Iowa	Y		Not Reported			Y				
Kansas	Y	Y				Y	Y			
Kentucky	Y			Y		Y				
Louisiana	Y	Y				Y	Y			
Maine						Y	Y	Y	Y	Y
Maryland	Y		Not reported			N/A (M-CHIP)				
Massachusetts[6]	Y				Y	Y				
Michigan	Y		Y			N/A (M-CHIP)				
Minnesota	Y		Y			N/A (M-CHIP)				
Mississippi						Y				
Missouri	Y		Not Reported			Y				
Montana	Y				Y	Y	Y	Y	Y	
Nebraska[5]	Y		Not Reported			N/A (M-CHIP)	Y	Y	Y	Y
Nevada	Y		Not Reported			Y	Y	Y	Y	
New Hampshire	Y	Y				N/A (M-CHIP)	Y	Y	Y	Y
New Jersey						Y				
New Mexico						N/A (M-CHIP)	Y	Y	Y	
New York	Y				Y	Y				
North Carolina	Y		Not Reported			Y	Y	Y	Y	
North Dakota	Y		Not Reported			Y				
Ohio	Y	Y				N/A (M-CHIP)				
Oklahoma	Y				Y	N/A (M-CHIP)				
Oregon	Y			Y		Y				
Pennsylvania	Y	Y				Y	Y	Y	Y	
Rhode Island	Y				Y	N/A (M-CHIP)				
South Carolina	Y	Y				N/A (M-CHIP)				
South Dakota						Y				
Tennessee										
Texas						Y	Y	Y	Y	
Utah						Y	Y	Y	Y	Y
Vermont	Y		Not Reported			N/A (M-CHIP)				
Virginia[5]	Y	Y				Y	Y			Y
Washington	Y				Y	Y				
West Virginia						Y	Y	Y	Y	
Wisconsin	Y		Not Reported			Y	Y	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, 2016.

Table presents rules in effect as of January 1, 2016.

Table 6 Notes

1. Under the ACA, states must seek to verify eligibility criteria based on electronic data matches with reliable sources of data. These columns reflect whether the state system is able to make real-time eligibility determinations, defined as within 24 hours, and the share of MAGI-based applications that are determined eligible in real-time.
2. These columns indicate whether the state MAGI-based Medicaid eligibility system is integrated with CHIP, non-MAGI Medicaid, and certain non-health programs.
3. California's statewide-integrated Marketplace and Medicaid system, CALHEERs, is not integrated with other programs. However, counties in California use different Medicaid eligibility systems that are integrated with non-health programs.
4. Colorado integrated its Medicaid eligibility with its SBM system and delinked the Medicaid eligibility system from other non-health programs during 2015.
5. Florida, Nebraska and Virginia integrated non-MAGI Medicaid eligibility into their MAGI–based system during 2015.
6. In Massachusetts, the share of applications completed in real-time is among online applications.

Table 7
Coordination between Medicaid and Marketplace Systems
January 2016

State	Marketplace Structure[1]	FFM Conducts Assessment or Final Determination for Medicaid Eligibility[2]	State is Receiving Electronic Account Transfers from FFM[3] (Total = 38)	State is Sending Electronic Account Transfers to FFM[3]	State is Experiencing Delays or Problems with Transfers[3]
Total	**FFM: 28 Partnership: 6 SBM: 17**	**Assessment: 30 Determination: 8**	**38**	**36**	**20**
Alabama	FFM	Determination	Y	Y	Y
Alaska[5]	FFM	Determination	Y	Y	Y
Arizona	FFM	Assessment	Y	Y	Y
Arkansas	Partnership	Determination	Y	Y	Y
California	SBM	N/A (SBM)	N/A (SBM)	N/A (SBM)	N/A (SBM)
Colorado	SBM	N/A (SBM)	N/A (SBM)	N/A (SBM)	N/A (SBM)
Connecticut	SBM	N/A (SBM)	N/A (SBM)	N/A (SBM)	N/A (SBM)
Delaware	Partnership	Assessment	Y	Y	
District of Columbia	SBM	N/A (SBM)	N/A (SBM)	N/A (SBM)	N/A (SBM)
Florida	FFM	Assessment	Y	Y	Y
Georgia	FFM	Assessment	Y	Y	
Hawaii[4]	Federally-supported SBM	Assessment	Y	Y	Not reported
Idaho	SBM	N/A (SBM)	N/A (SBM)	N/A (SBM)	N/A (SBM)
Illinois	Partnership	Assessment	Y	Y	Y
Indiana	FFM	Assessment	Y	Y	
Iowa	FFM	Assessment	Y	Y	Y
Kansas	FFM	Assessment	Y	Y	Y
Kentucky	SBM	N/A (SBM)	N/A (SBM)	N/A (SBM)	N/A (SBM)
Louisiana[5]	FFM	Assessment	Y	Y	
Maine	FFM	Assessment	Y	Y	Y
Maryland	SBM	N/A (SBM)	N/A (SBM)	N/A (SBM)	N/A (SBM)
Massachusetts	SBM	N/A (SBM)	N/A (SBM)	N/A (SBM)	N/A (SBM)
Michigan	Partnership	Assessment	Y	Y	
Minnesota	SBM	N/A (SBM)	N/A (SBM)	N/A (SBM)	N/A (SBM)
Mississippi	FFM	Assessment	Y	Y	
Missouri	FFM	Assessment	Y	Y	Y
Montana	FFM	Determination	Y	Y	
Nebraska	FFM	Assessment	Y	Y	
Nevada	Federally-supported SBM	Assessment	Y	Y	Y
New Hampshire	Partnership	Assessment	Y	Y	Y
New Jersey	FFM	Determination	Y		
New Mexico	Federally-supported SBM	Assessment	Y	Y	
New York	SBM	N/A (SBM)	N/A (SBM)	N/A (SBM)	N/A (SBM)
North Carolina	FFM	Assessment	Y	Y	Y
North Dakota[5]	FFM	Assessment	Y	Y	Y
Ohio	FFM	Assessment	Y	Y	Y
Oklahoma	FFM	Assessment	Y	Y	
Oregon[5]	Federally-supported SBM	Assessment	Y	Y	Y
Pennsylvania	FFM	Assessment	Y	Y	Y
Rhode Island	SBM	N/A (SBM)	N/A (SBM)	N/A (SBM)	N/A (SBM)
South Carolina	FFM	Assessment	Y	Y	Y
South Dakota	FFM	Assessment	Y	Y	
Tennessee	FFM	Determination	Y		
Texas	FFM	Assessment	Y	Y	
Utah	FFM	Assessment	Y	Y	
Vermont	SBM	N/A (SBM)	N/A (SBM)	N/A (SBM)	N/A (SBM)
Virginia	FFM	Assessment	Y	Y	
Washington	SBM	N/A (SBM)	N/A (SBM)	N/A (SBM)	N/A (SBM)
West Virginia	Partnership	Determination	Y	Y	Y
Wisconsin	FFM	Assessment	Y	Y	Y
Wyoming	FFM	Determination	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, 2016.
Table presents rules in effect as of January 1, 2016.

Table 7 Notes

1. This column indicates whether a state has elected to establish and operate its own State-based Marketplace (SBM), establish a State-based Marketplace with federal support, use the Federally-facilitated Marketplace (FFM), or establish a Marketplace in partnership with the federal government (Partnership). States running a SBM are responsible for performing all Marketplace functions, except for four SBM states (Hawaii, Nevada, New Mexico, and Oregon) that rely on the FFM information technology (IT) platform for application processing and certain eligibility and enrollment activities. In a Federally-facilitated Marketplace (FFM), the US Department of Health and Human Services (HHS) conducts all Marketplace functions. States with a Partnership Marketplace may administer plan management functions, in-person consumer assistance functions, or both, and HHS is responsible for the remaining Marketplace functions.
2. This column indicates whether states using the FFM IT platform for eligibility activities (including FFM, Partnership, and Federally-supported SBM states) have elected to allow the FFM to make assessments or final determinations of Medicaid/CHIP eligibility for MAGI-based groups. In assessment states, applicants' accounts must be transferred to the state Medicaid/CHIP agency for a final determination. In determination states, the FFM makes a final Medicaid/CHIP eligibility determination and transfers the account to the state Medicaid/CHIP agency for enrollment. States marked as N/A do not rely on the FFM for eligibility functions.
3. These columns indicate whether states are receiving and sending electronic accounts transfers from and to the FFM, and whether they are experiencing delays or problems with the account transfer process.
4. Hawaii transitioned from a SBM to a Federally-Supported SBM during 2015. Hawaii did not report whether it is experiencing problems or delays with transfers to and from the FFM because it had not begun transfers at the time of the survey interview.
5. During 2015, Louisiana, North Dakota, and Oregon transitioned to rely on the FFM to make assessments rather than final determinations for Medicaid eligibility, while Alaska transitioned to rely on the FFM to make final determinations rather than assessments.

Table 8
Online and Telephone Medicaid Applications
January 2016

State	Applications Can be Submitted Online at the State Level[1]	Online Application for Medicaid Allows Individuals to:		Separate Online Portal for Application Assisters[2]	Online Multi-Benefit Application for MAGI-Based Medicaid and Non-Health Programs[3]	Telephone Applications at the State Level[4]
		Start, Stop, and Return to an Application	Scan and Upload Documentation			
Total	**50**	**49**	**33**	**24**	**24**	**49**
Alabama	Y	Y				Y
Alaska	Y	Y				Y
Arizona	Y	Y	Y	Y	Y	Y
Arkansas[5]	Y	Y				Y
California	Y	Y	Y	Y	Y	Y
Colorado	Y	Y	Y		Y	Y
Connecticut	Y	Y	Y			Y
Delaware[6]	Y	Y		Y	Y	Y
District of Columbia	Y	Y	Y	Y		Y
Florida[5]	Y	Y	Y	Y	Y	Y
Georgia[7]	Y	Y	Y		Y	Y
Hawaii[7]	Y	Y	Y	Y		Y
Idaho[7]	Y	Y	Y	Y		Y
Illinois	Y	Y	Y	Y	Y	Y
Indiana	Y	Y				Y
Iowa	Y	Y				Y
Kansas[7]	Y	Y	Y			Y
Kentucky	Y	Y	Y	Y		Y
Louisiana	Y	Y		Y		Y
Maine	Y	Y			Y	Y
Maryland	Y	Y	Y		Y	Y
Massachusetts	Y	Y				Y
Michigan	Y	Y	Y		Y	Y
Minnesota	Y	Y		Y		
Mississippi	Y		Y			Y
Missouri	Y	Y				Y
Montana	Y	Y	Y		Y	Y
Nebraska[8]	Y	Y	Y			Y
Nevada	Y	Y	Y		Y	Y
New Hampshire	Y	Y	Y		Y	Y
New Jersey[9]	Y	Y				Y
New Mexico	Y	Y	Y	Y	Y	Y
New York	Y	Y	Y	Y		Y
North Carolina	Y	Y			Y	Y
North Dakota	Y	Y	Y	Y	Y	Y
Ohio	Y	Y	Y	Y		Y
Oklahoma	Y	Y	Y	Y		Y
Oregon[7,9]	Y	Y	Y	Y		Y
Pennsylvania	Y	Y	Y	Y	Y	Y
Rhode Island	Y	Y	Y	Y	Y	Y
South Carolina	Y	Y				Y
South Dakota	Y	Y	Y		Y	Y
Tennessee						
Texas	Y	Y	Y	Y	Y	Y
Utah	Y	Y			Y	Y
Vermont	Y	Y		Y		Y
Virginia	Y	Y	Y		Y	Y
Washington	Y	Y	Y	Y		Y
West Virginia	Y	Y		Y	Y	Y
Wisconsin	Y	Y	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, 2016.

Table presents rules in effect as of January 1, 2016.

Table 8 Notes

1. This column indicates whether individuals can complete and submit an online application for Medicaid through a state-level portal. For State-based Marketplace (SBM) states, such a portal may be either exclusive to Medicaid or integrated with the Marketplace. For Federally-facilitated Marketplace (FFM) and Partnership Marketplace states, state Medicaid agency portals are indicated.
2. This column indicates whether the MAGI-based Medicaid eligibility system provides either a separate online portal for application assisters or a secure log-in for assisters to submit facilitated applications. Some states are able to identify and collect information about assister-facilitated applications although they do not have a separate portal or secure log-in for assisters to submit facilitated applications.
3. In these states, a combined online multi-benefit application is available that allows applicants to apply for MAGI-based Medicaid and one or more non-health programs, such as SNAP (food stamps) or cash assistance.
4. This column indicates whether individuals can complete MAGI-based Medicaid applications over the telephone at the state level, either through the Medicaid agency or the State-based Marketplace.
5. Arkansas and Florida began accepting telephone applications in 2015.
6. In Delaware, families can call an eligibility worker to complete a Medicaid application; the application is then mailed to the applicant for signature.
7. Georgia, Hawaii, Idaho, Kansas, and Oregon added functionality to allow scan and upload of documentation through the online application during 2015.
8. In Nebraska, applicants can return to and restart an application for 30 days only.
9. New Jersey and Oregon added the ability to start, stop, and return to an application during 2015.

Table 9
Online Account Capabilities for Medicaid
January 2016

State	Online Medicaid Account[1]	Online Account Allows Individuals to: Report Changes	Review Application Status	Renew Coverage	View Notices	Authorize Third-Party Access	Upload Verification Documentation	Go Paperless and Receive Notices Electronically	Pay Premiums
Total	**39**	**37**	**36**	**35**	**31**	**30**	**29**	**25**	**6**
Alabama	Y	Y	Y	Y		Y			
Alaska									N/A
Arizona	Y	Y	Y	Y	Y	Y	Y	Y	Y
Arkansas									
California	Y	Y	Y	Y	Y	Y	Y		
Colorado	Y	Y	Y	Y	Y	Y	Y	Y	Y
Connecticut	Y	Y	Y	Y	Y	Y	Y	Y	
Delaware[2]	Y	Y	Y	Y	Y	Y			
District of Columbia	Y	Y	Y		Y	Y	Y	Y	N/A
Florida	Y	Y	Y	Y	Y		Y	Y	N/A
Georgia[3]	Y	Y	Y	Y	Y	Y	Y		Y
Hawaii[2,3,4,5,6]	Y	Y	Y	Y	Y	Y	Y	Y	N/A
Idaho[3,4,5]	Y	Y	Y	Y	Y	Y	Y		
Illinois									
Indiana[7]	Y	Y	Y			Y			
Iowa									
Kansas									
Kentucky	Y	Y	Y	Y	Y	Y	Y	Y	N/A
Louisiana[4]	Y	Y		Y					
Maine	Y	Y	Y	Y	Y			Y	
Maryland	Y	Y	Y	Y	Y	Y	Y	Y	
Massachusetts[4]	Y	Y	Y	Y	Y				
Michigan	Y	Y	Y	Y	Y	Y	Y		
Minnesota									N/A
Mississippi									N/A
Missouri									
Montana	Y	Y	Y	Y	Y	Y	Y	Y	
Nebraska	Y	Y	Y	Y	Y	Y	Y	Y	N/A
Nevada									
New Hampshire	Y	Y	Y	Y	Y	Y	Y	Y	N/A
New Jersey									
New Mexico	Y	Y	Y	Y			Y		N/A
New York	Y	Y	Y	Y	Y	Y	Y	Y	
North Carolina									
North Dakota[2,3,4,5,6,8]	Y	Y	Y	Y	Y	Y	Y	Y	N/A
Ohio	Y	Y	Y	Y	Y	Y	Y	Y	N/A
Oklahoma	Y	Y	Y	Y	Y	Y	Y	Y	N/A
Oregon	Y	Y	Y	Y	Y	Y	Y	Y	N/A
Pennsylvania	Y	Y	Y	Y	Y		Y	Y	
Rhode Island	Y	Y	Y	Y	Y	Y	Y	Y	N/A
South Carolina[6,8]	Y		Y						N/A
South Dakota[3,4,8]	Y	Y		Y			Y		N/A
Tennessee									N/A
Texas[9]	Y	Y	Y	Y		Y	Y	Y	Y
Utah	Y	Y	Y	Y	Y	Y		Y	Y
Vermont[4]	Y	Y	Y		Y	Y			Y
Virginia	Y	Y	Y	Y		Y	Y		N/A
Washington[2,3,4]	Y	Y	Y	Y	Y	Y	Y	Y	
West Virginia	Y		Y	Y	Y			Y	
Wisconsin[2,5]	Y	Y	Y	Y	Y	Y	Y	Y	
Wyoming	Y	Y		Y	Y	Y	Y	Y	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, 2016.

Table presents rules in effect as of January 1, 2016.

Table 9 Notes

1. This column indicates whether individuals can create an online account for ongoing management of their MAGI-based Medicaid coverage at the state level, either through the Medicaid agency or a case management system that is integrated with the SBM.
2. Delaware, Hawaii, North Dakota, Washington, and Wisconsin added functionality to allow enrollees to authorize third party access to their account during 2015.
3. Georgia, Hawaii, Idaho, North Dakota, South Dakota, and Washington added functionality to allow enrollees to upload verification documents if needed during 2015.
4. Hawaii, Idaho, Louisiana, Massachusetts, North Dakota, South Dakota, Vermont, and Washington added functionality to allow enrollees to report changes through their online account during 2015.
5. Hawaii, Idaho, North Dakota, and Wisconsin added functionality to allow enrollees to view notices during 2015.
6. Hawaii, North Dakota, and South Carolina added functionality to allow applicants to review their application status during 2015.
7. In Indiana, individuals can manage their case online, but there is no account to set up.
8. North Dakota, South Carolina, and South Dakota implemented online accounts during 2015 or as of January 1, 2016.
9. In Texas, only certain notices can be viewed from a client's online account if the client does not elect to receive electronic notices.

Table 10
Income Verification Procedures Used by Medicaid Agencies at Application
January 2016

State	Pre-Enrollment Verification[1]	Post-Enrollment Verification[1]	If attestation is below and data are above the income standard[2]			If attestation is above and data are below the income standard[2]			
			Reasonable Compatibility Standard	*If not reasonably compatible, state first:*		Reasonable Compatibility Standard	*If not reasonably compatible, state first:*		
				Asks for a Reasonable Explanation	Requires Paper Documentation		Asks for a Reasonable Explanation	Requires Paper Documentation	Transfers to Marketplace
Total	**43**	**8**	**34**	**30**	**21**	**3**	**7**	**9**	**35**
Alabama	Y		10%	Y		None			Y
Alaska	Y		10%	Y		None			Y
Arizona	Y		None		Y	None			Y
Arkansas	Y		10%		Y	None			Y
California	Y		None		Y	None		Y	
Colorado[3]		Y	10%	Y		10%			Y
Connecticut[4,5]	Y		10%	Y		None			Y
Delaware		Y	10%	Y		None			Y
District of Columbia	Y		10%		Y	None		Y	
Florida[3,6]	Y		10%	Y		10%	Y		
Georgia	Y		None		Y	None			Y
Hawaii		Y	10%	Y		None			Y
Idaho	Y		None		Y	None		Y	
Illinois	Y		5%	Y		None			Y
Indiana	Y		None		Y	None			Y
Iowa	Y		10%	Y		None			Y
Kansas	Y		20%	Y		None			Y
Kentucky	Y		10%	Y		None			Y
Louisiana	Y		25%	Y		None			Y
Maine	Y		None	Y		None			Y
Maryland	Y		10%		Y	None			Y
Massachusetts[4]	Y		10%		Y	None			Y
Michigan	Y		10%	Y		None			Y
Minnesota	Y		10%	Y		None			Y
Mississippi	Y		$50	Y		None	Y		
Missouri[7]	Y		10%		Y	None	Y		
Montana		Y	10%	Y		None			Y
Nebraska	Y		10%		Y	None			Y
Nevada	Y		None	Y		None			Y
New Hampshire		Y	10%	Y		None			Y
New Jersey[6]	Y		10%	Y		10%	Y		
New Mexico	Y		None		Y	None		Y	
New York	Y		10%		Y	None			Y
North Carolina	Y		None	Y		None	Y		
North Dakota	Y		None	Y		None	Y		
Ohio	Y		5%		Y	None			Y
Oklahoma		Y	5%		Y	None			Y
Oregon[5,8]	Y		10%	Y		None			Y
Pennsylvania	Y		5%	Y		None		Y	
Rhode Island	Y		10%	Y		None			Y
South Carolina	Y		10%	Y		None			Y
South Dakota[6]	Y		None	Y		None	Y		
Tennessee	Y		10%		Y	None			Y
Texas	Y		None		Y	None		Y	
Utah[9]	Y		None		Y	None		Y	
Vermont		Y	None		Y	None		Y	
Virginia	Y		10%	Y		None			Y
Washington		Y	None	Y		None			Y
West Virginia	Y		10%	Y		None			Y
Wisconsin	Y		None		Y	None			Y
Wyoming	Y		None		Y	None		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, 2016. Table presents rules in effect as of January 1, 2016.

TABLE 10 NOTES

1. States are expected to attempt to verify income through an electronic source; they can verify information prior to enrollment or enroll based on an individual's self-attestation and conduct a post-enrollment verification. Only in cases where there is no electronic data source for a type of income are states able to accept self-attestation of income without verification.
2. If the information obtained from electronic data sources and the information provided by or on behalf of the individual are both above, at, or below the applicable income standard, the state must determine the applicant eligible or ineligible for Medicaid/CHIP. In these cases, any difference does not impact eligibility. If the data are not consistent, states have the option to apply a reasonable compatibility standard by establishing a threshold (e.g., a percentage or dollar figure) in which they will still consider the data to be reasonably compatible. States have the option to set different standards based on whether the applicant's attestation is above or below the eligibility threshold. In both cases, if the difference between the attested income and the electronic data source are within the reasonable compatibility standard, the state will process eligibility based on the individual's attestation. If the applicant reports income below the standard and the electronic source indicates income above the standard, and the difference is not reasonably compatible, the state may accept a reasonable explanation and/or request paper documentation. If the applicant reports income above the Medicaid or CHIP limit but the electronic source reflects income below, and the data are not reasonably compatible, the state may accept a reasonable explanation, request paper documentation, or determine the individual ineligible and transfer the application to the Marketplace.
3. Colorado and Florida implemented a reasonable compatibility standard of 10% when the applicant's income attestation is above but the data source reflects income below the Medicaid standard during 2015.
4. In Connecticut and Massachusetts, if the state is not able to verify income with electronic data, an individual will be enrolled based on self-attestation and income will be verified post-enrollment.
5. Connecticut and Oregon transitioned to verifying income prior to enrollment rather than relying on post-enrollment verification during 2015.
6. Florida, New Jersey, and South Dakota transitioned to rely on a reasonable explanation rather than transferring the account to the Marketplace when self-attested income is above the Medicaid standard but electronic data show income below the standard and the data are not reasonably compatible.
7. Missouri changed to request paper documentation when an individual's self-attestation is below the Medicaid income standard but electronic data show income above the standard during 2015.
8. Oregon added a reasonable compatibility standard of 10% when the applicant's income attestation is below but the data source reflects income above the Medicaid standard during 2015. Oregon also transitioned to rely on a reasonable explanation rather than paper documentation when data are not reasonably compatible.
9. In Utah, if an individual reports income above the Medicaid cutoff but a reliable data source qualifies the individual, Utah will approve the application.

Table 11
Non-Financial Eligibility Criteria Verification Procedures Used by Medicaid Agencies[1,2]
January 2016

State	Age/Date of Birth			State Residency				Household Composition			
				At Application			If Do Not Use Self-Attestation, Verify at Renewal	At Application			If Do Not Use Self-Attestation, Verify at Renewal
	Self-Attestation	Pre-Enrollment Verification	Post-Enrollment Verification	Self-Attestation	Pre-Enrollment Verification	Post-Enrollment Verification		Self-Attestation	Pre-Enrollment Verification	Post-Enrollment Verification	
Total	**27**	**23**	**1**	**41**	**6**	**4**	**4**	**44**	**6**	**1**	**4**
Alabama	Y			Y				Y			
Alaska	Y			Y				Y			
Arizona	Y				Y			Y			
Arkansas		Y		Y				Y			
California		Y		Y				Y			
Colorado	Y			Y				Y			
Connecticut	Y			Y				Y			
Delaware	Y			Y				Y			
District of Columbia	Y			Y				Y			
Florida	Y			Y				Y			
Georgia	Y			Y				Y			
Hawaii	Y			Y				Y			
Idaho	Y				Y				Y		
Illinois		Y			Y		Y	Y			
Indiana		Y			Y		Y		Y		Y
Iowa		Y		Y					Y		Y
Kansas	Y			Y				Y			
Kentucky		Y			Y				Y		
Louisiana	Y			Y				Y			
Maine	Y			Y				Y			
Maryland		Y		Y				Y			
Massachusetts	Y					Y		Y			
Michigan	Y			Y				Y			
Minnesota		Y		Y				Y			
Mississippi		Y		Y				Y			
Missouri	Y			Y				Y			
Montana	Y			Y				Y			
Nebraska		Y		Y				Y			
Nevada		Y		Y				Y			
New Hampshire			Y	Y				Y			
New Jersey	Y			Y				Y			
New Mexico		Y		Y				Y			
New York	Y			Y				Y			
North Carolina	Y				Y			Y			
North Dakota		Y		Y				Y			
Ohio	Y			Y				Y			
Oklahoma		Y		Y				Y			
Oregon	Y			Y				Y			
Pennsylvania		Y		Y				Y			
Rhode Island		Y		Y					Y		
South Carolina		Y		Y				Y			
South Dakota	Y			Y				Y			
Tennessee		Y				Y		Y			
Texas[3]		Y		Y				Y			
Utah	Y			Y				Y			
Vermont	Y			Y				Y			
Virginia	Y			Y				Y			
Washington		Y		Y				Y			
West Virginia		Y		Y				Y			
Wisconsin		Y				Y	Y			Y	Y
Wyoming		Y				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, 2016. Table presents rules in effect as of January 1, 2016.

TABLE 11 NOTES

1. In addition to the eligibility criteria shown in the table, all states must verify citizenship and immigration status through electronic data matches with the Social Security Administration (SSA) or the Department of Homeland Security (DHS).
2. States have the option to accept self-attestation for the non-financial eligibility criteria listed. If states verify non-financial eligibility criteria at application or renewal, they are expected to use electronic data and eliminate or minimize requirements for paper documentation. In states accepting self-attestation without further verification, the state may have access to electronic data for some applicants (for example, if the consumer is also enrolled in SNAP), which may be used to confirm eligibility. Verification is required if a state has any information on file that conflicts with the self-attestation. In states noted as conducting pre-enrollment verification, the state will confirm eligibility prior to enrolling an individual into coverage. States conducting post-enrollment verification enroll an individual based on their self-attested information and confirm the criteria after enrollment.
3. Texas accepts self-attestation for children, but verifies state residency for parents.

Table 12
Use of Selected Options to Facilitate Enrollment in Medicaid and CHIP
January 2016

	Hospital-based Presumptive Eligibility[1]	Broader Presumptive Eligibility Using Qualified Entities[2]						Express Lane Eligibility[3]		Use of SNAP Data to Facilitate Enrollment[4]
		Children		Pregnant Women						
		Medicaid	CHIP (Total =36)	Medicaid	CHIP (Total = 5)	Parents	Adults (Total = 32)	Medicaid Children	CHIP Children (Total = 36)	
Total	**45**	**18**	**10**	**29**	**2**	**7**	**6**	**8**	**5**	**5**
Alabama	Y				N/A		N/A	Y		
Alaska	Y		N/A (M-CHIP)		N/A				N/A (M-CHIP)	
Arizona[5]	Y				N/A					
Arkansas					N/A					Y
California[6]	Y	Y	N/A (M-CHIP)	Y	N/A				N/A (M-CHIP)	Y
Colorado[7]	Y	Y	Y	Y	Y	Y	Y	Y	Y	
Connecticut	Y	Y	Y	Y	N/A					
Delaware[5]	Y				N/A					
District of Columbia	Y		N/A (M-CHIP)	Y					N/A (M-CHIP)	
Florida	Y			Y	N/A		N/A			
Georgia	Y			Y	N/A		N/A	Y	Y	
Hawaii			N/A (M-CHIP)		N/A				N/A (M-CHIP)	
Idaho	Y	Y	Y	Y	N/A	Y	N/A			
Illinois[8]		Y	Y	Y	N/A					
Indiana[9]	Y	Y	Y	Y	N/A	Y	Y			
Iowa[10]	Y	Y	Y	Y	N/A			Y	Y	
Kansas[11]	Y	Y	Y	Y	N/A		N/A			
Kentucky	Y			Y	N/A					
Louisiana	Y				N/A		N/A	Y		
Maine	Y			Y	N/A		N/A			
Maryland	Y		N/A (M-CHIP)		N/A				N/A (M-CHIP)	
Massachusetts	Y				N/A					
Michigan	Y	Y	N/A (M-CHIP)	Y	N/A				N/A (M-CHIP)	
Minnesota	Y		N/A (M-CHIP)		N/A				N/A (M-CHIP)	
Mississippi	Y				N/A		N/A			
Missouri	Y	Y		Y	N/A		N/A			
Montana[12]	Y	Y	Y	Y	N/A	Y	Y			
Nebraska	Y		N/A (M-CHIP)	Y	N/A		N/A		N/A (M-CHIP)	
Nevada	Y				N/A					
New Hampshire	Y	Y	N/A (M-CHIP)	Y	N/A	Y	Y		N/A (M-CHIP)	
New Jersey[5]	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
New Mexico[13]	Y	Y	N/A (M-CHIP)	Y	N/A				N/A (M-CHIP)	
New York[14]		Y	Y	Y	N/A			Y		
North Carolina	Y			Y	N/A		N/A			
North Dakota	Y				N/A					
Ohio	Y	Y	N/A (M-CHIP)	Y	N/A	Y	Y		N/A (M-CHIP)	
Oklahoma	Y		N/A (M-CHIP)		N/A		N/A		N/A (M-CHIP)	
Oregon[15]	Y				N/A					Y
Pennsylvania[16]	Y			Y	N/A				Y	
Rhode Island	Y		N/A (M-CHIP)						N/A (M-CHIP)	
South Carolina	Y		N/A (M-CHIP)		N/A		N/A	Y	N/A (M-CHIP)	
South Dakota[5]	Y				N/A		N/A			Y
Tennessee		Y		Y	N/A		N/A			
Texas	Y			Y	N/A		N/A			
Utah	Y			Y	N/A		N/A			
Vermont			N/A (M-CHIP)		N/A				N/A (M-CHIP)	
Virginia	Y						N/A			
Washington	Y				N/A					
West Virginia[8]	Y				N/A					
Wisconsin	Y	Y		Y	N/A					
Wyoming	Y			Y	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, 2016.

Table presents rules in effect as of January 1, 2016.

TABLE 12 NOTES

1. This column indicates whether a state has implemented the hospital-based presumptive eligibility process required by the ACA. This process allows hospitals to conduct presumptive eligibility determinations to expedite access to Medicaid coverage, regardless of whether a state has otherwise adopted presumptive eligibility.
2. These columns indicate whether a state has elected to implement the broader presumptive eligibility option, under which a state can authorize qualified entities such as hospitals, community health centers, and schools to make presumptive eligibility determinations for Medicaid and/or CHIP and extend coverage to individuals temporarily until a full eligibility determination is made.
3. The Express Lane Eligibility (ELE) option allows states to use data and eligibility findings from other public benefit programs to determine children eligible for Medicaid and CHIP at application or renewal. States are designated as having ELE if they have an approved and implemented State Plan Amendment from CMS.
4. In May 2013 guidance, CMS offered states several temporary targeted enrollment strategies, including the ability to use to SNAP data to facilitate enrollment of eligible individuals (see SHO #13-003, May 17, 2013). In August 2015, CMS issued new guidance allowing states to adopt the SNAP targeted strategy at enrollment and renewal as a state plan option, or to continue using the strategy under temporary waiver authority. For details, see V. Wachino, Director of Centers for Medicaid and CHIP Services, letter to State Health Officials and State Medicaid Directors (SHO #15-001/ACA #34, August 31, 2015). States are designated as adopting a strategy if they have a CMS-approved waiver or are in the process of applying for a SPA to use this the strategy.
5. In Arizona, Delaware, New Jersey, and South Dakota, the SPA for hospital presumptive eligibility is approved but no hospitals have implemented.
6. California is evaluating whether to seek a temporary waiver or submit a state plan amendment to continue using SNAP as a targeted enrollment strategy.
7. Colorado implemented presumptive eligibility for parents and adults in 2015.
8. Illinois and West Virginia will no longer use the SNAP facilitated enrollment strategy in Medicaid as of January 2016.
9. Indiana implemented presumptive eligibility for children, parents, and expansion adults in 2015.
10. Iowa implemented Express Lane Eligibility for CHIP children in 2015.
11. Kansas implemented presumptive eligibility for pregnant women in 2015.
12. Montana implemented presumptive eligibility for expansion adults effective January 2016.
13. New Mexico has presumptive eligibility for parents and other adults in Medicaid, but it is limited to those in correctional facilities (state prisons/county jails) and health facilities operated by the Indian Health Service, a Tribe or Tribal organization, or an Urban Indian Organization.
14. New York uses Express Lane Eligibility to enroll parents in Medicaid (based on enrollment in TANF).
15. Oregon has temporarily discontinued use of Express Lane Eligibility for children in Medicaid and CHIP, but intends to reinstate in the future.
16. Pennsylvania uses Express Lane Eligibility to transition children between Medicaid and CHIP.

Table 13
Renewal Processes for MAGI-Based Medicaid Groups
January 2016

State	Processing Ex Parte Renewals[1]	Percentage of Renewals Completed via Ex Parte[1]				Prepopulated Renewal Form[2]	Populate Form with Updated Data[2]	Telephone Renewals at State Level[3]	Up-to-Date on Renewals[4]	
		<25%	25%-50%	50%-75%	75%+				Medicaid	CHIP (Total = 36)
Total	**34**	**5**	**11**	**7**	**3**	**41**	**14**	**41**	**47**	**34**
Alabama						Y		Y	Y	Y
Alaska[5]						Y			Y	N/A (M-CHIP)
Arizona	Y		Y			Y	Y	Y	Y	Y
Arkansas	Y	Y							Y	Y
California	Y			Y		Y	Y	Y	Y	N/A (M-CHIP)
Colorado	Y				Y	Y	Y	Y	Y	Y
Connecticut	Y			Y		Y		Y	Y	Y
Delaware	Y	Y				Y	Y	Y	Y	Y
District of Columbia						Y	Y	Y	Y	N/A (M-CHIP)
Florida[6]	Y		Y					Y	Y	Y
Georgia[7]						Y		Y	Y	Y
Hawaii	Y		Not Reported			Y	Y	Y	Y	N/A (M-CHIP)
Idaho	Y			Y		Y	Y	Y	Y	Y
Illinois						Y			Y	Y
Indiana	Y		Y			Y		Y	Y	Y
Iowa						Y	Y	Y	Y	Y
Kansas[8]	Y		Y			Y	Y		Y	Y
Kentucky	Y			Y				Y	Y	Y
Louisiana[9]	Y		Y					Y	Y	Y
Maine						Y		Y	Y	Y
Maryland	Y			Y		Y		Y	Y	N/A (M-CHIP)
Massachusetts								Y	Y	Y
Michigan[10]									Y	N/A (M-CHIP)
Minnesota	Y		Y			Y	Y		Y	N/A (M-CHIP)
Mississippi						Y		Y	Y	Y
Missouri	Y		Not Reported			Y	Y	Y	Y	Y
Montana						Y		Y	Y	Y
Nebraska	Y		Not Reported			Y		Y	Y	N/A (M-CHIP)
Nevada						Y		Y	Y	Y
New Hampshire	Y	Y				Y	Y	Y	Y	N/A (M-CHIP)
New Jersey	Y		Not Reported			Y		Y	Y	Y
New Mexico						Y		Y	Y	N/A (M-CHIP)
New York	Y		Y			Y		Y	Y	Y
North Carolina	Y				Y				Y	Y
North Dakota	Y		Not Reported			Y		Y	Y	Y
Ohio	Y				Y	Y		Y	Y	N/A (M-CHIP)
Oklahoma	Y		Y					Y	Y	N/A (M-CHIP)
Oregon	Y		Not Reported			Y		Y	Y	Y
Pennsylvania	Y	Y				Y		Y	Y	Y
Rhode Island	Y			Y		Y	Y	Y	Y	N/A (M-CHIP)
South Carolina	Y		Y			Y				N/A (M-CHIP)
South Dakota	Y		Y			Y		Y	Y	Y
Tennessee										
Texas	Y		Not Reported			Y	Y		Y	Y
Utah[8]	Y		Y			Y		Y	Y	Y
Vermont[11]								Y		N/A (M-CHIP)
Virginia	Y	Y				Y		Y		
Washington	Y			Y		Y		Y	Y	Y
West Virginia	Y		Not Reported			Y		Y	Y	Y
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, 2016.

Table presents rules in effect as of January 1, 2016.

Table 13 Notes

1. Under the ACA, states must seek to re-determine eligibility at renewal using electronic data matches with reliable sources of data, a process known as ex parte, prior to requiring enrollees to complete a renewal form. These columns reflect whether the state system is able to make ex parte re-determinations and reports the share of MAGI-based renewals that are successfully completed via ex parte.
2. Under the ACA, when a state is unable to determine ongoing eligibility at renewal via ex parte, it is expected to send the enrollee a renewal notice or form pre-populated with data on file. These columns indicate if a state is able to produce prepopulated renewal forms and whether the pre-populated information is updated with information accessed from electronic sources of data.
3. This column indicates whether enrollees are able to complete a MAGI-based Medicaid renewal over the phone at the state level, either through the Medicaid agency or a SBM call center.
4. These columns indicate whether states report any delays in processing 2015 renewals.
5. In Alaska, the state conducts ex parte review before closing a case after a non-response to renewal.
6. Florida's online renewal application is prepopulated when the enrollee completes an online renewal, but the state does not mail prepopulated forms.
7. Georgia has not implemented its new MAGI-based eligibility system but is sending pre-populated renewal forms through its older system.
8. In Kansas and Utah, families may report changes by phone but still need to sign and return the pre-populated renewal form.
9. Louisiana is procuring a new MAGI-based system, but conducts ex parte renewals through its existing system, which has been modified to be MAGI-enabled.
10. In Michigan, there may be some delays in renewals for children transitioning from separate CHIP to Medicaid expansion coverage as of January 2016.
11. Vermont has an approved renewal plan that allows delays of renewals until November 2016. Vermont began using a pre-populated renewal form as of January 2016 that includes name, address, phone number, and active Medicaid members due for renewal.

Table 14
Targeted Strategies to Streamline Renewals
January 2016

State	12-Month Continuous Eligibility for Children[1]		Express Lane Eligibility for Children at Renewal[2]		SNAP Data Used at Renewal[3]
	Medicaid	CHIP (Total = 36)	Medicaid	CHIP (Total = 36)	
Total	**24**	**26**	**7**	**3**	**7**
Alabama	Y	Y	Y		
Alaska	Y	N/A (M-CHIP)		N/A (M-CHIP)	Y
Arizona					
Arkansas[4]		Y			Y
California	Y	N/A (M-CHIP)		N/A (M-CHIP)	
Colorado[5]	Y	Y	Y	Y	
Connecticut					
Delaware		Y			
District of Columbia		N/A (M-CHIP)		N/A (M-CHIP)	
Florida[6]		Y			
Georgia					
Hawaii		N/A (M-CHIP)		N/A (M-CHIP)	
Idaho	Y	Y			
Illinois	Y	Y			
Indiana[7]					
Iowa	Y	Y	Y		
Kansas	Y	Y			
Kentucky					
Louisiana	Y	Y	Y		
Maine	Y	Y			
Maryland[8]		N/A (M-CHIP)		N/A (M-CHIP)	
Massachusetts[9]			Y	Y	
Michigan	Y	N/A (M-CHIP)		N/A (M-CHIP)	
Minnesota		N/A (M-CHIP)		N/A (M-CHIP)	
Mississippi	Y	Y			
Missouri					
Montana[10]	Y	Y			
Nebraska		N/A (M-CHIP)		N/A (M-CHIP)	
Nevada		Y			
New Hampshire		N/A (M-CHIP)		N/A (M-CHIP)	
New Jersey	Y	Y			Y
New Mexico	Y	N/A (M-CHIP)		N/A (M-CHIP)	
New York[11]	Y	Y	Y		
North Carolina	Y	Y			
North Dakota	Y	Y			
Ohio	Y	N/A (M-CHIP)		N/A (M-CHIP)	
Oklahoma		N/A (M-CHIP)		N/A (M-CHIP)	
Oregon	Y	Y			Y
Pennsylvania		Y		Y	
Rhode Island		N/A (M-CHIP)		N/A (M-CHIP)	
South Carolina	Y	N/A (M-CHIP)	Y	N/A (M-CHIP)	
South Dakota					Y
Tennessee		Y			Y
Texas[12]		Y			
Utah		Y			
Vermont		N/A (M-CHIP)		N/A (M-CHIP)	
Virginia					Y
Washington	Y	Y			
West Virginia	Y	Y			
Wisconsin					
Wyoming	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, 2016.

Table presents rules in effect as of January 1, 2016.

Table 14 Notes

1. Under state option, states may provide 12-month continuous eligibility for children, allowing them to remain enrolled regardless of changes in income or household size. States must obtain a waiver to provide 12-month continuous eligibility to adults.
2. The Express Lane Eligibility (ELE) option allows states to use data and eligibility findings from other public benefit programs to determine children eligible for Medicaid and CHIP at enrollment or renewal. States are designated as having ELE at renewal if they have an approved and implemented State Plan Amendment from CMS.
3. In August 2015, CMS issued new guidance allowing states to adopt the SNAP targeted strategy at enrollment and renewal as a state plan option or under temporary waiver authority. For details, see V. Wachino, Director of Centers for Medicaid and CHIP Services, letter to State Health Officials and State Medicaid Directors (SHO #15-001/ACA #34, August 31, 2015). States are designated as adopting a strategy if they have a CMS-approved waiver or are in the process of applying for a SPA to use this the strategy.
4. Arkansas adopted 12-month continuous eligibility in CHIP when it transitioned its CHIP-funded Medicaid expansion to a separate CHIP program in 2015.
5. Colorado implemented Express Lane Eligibility for renewals in CHIP in 2015.
6. In Florida, children younger than age five receive 12-month continuous eligibility and children ages five and older receive 6 months of continuous eligibility.
7. In Indiana, continuous eligibility is only provided to children under age 3.
8. In Maryland, newborns are provided 12-month continuous eligibility.
9. Massachusetts extends ELE to pregnant women, childless adults, and parents through a Section 1115 waiver.
10. Montana adopted 12-month continuous eligibility for parents and other adults as of January 2016.
11. New York implemented 12-month continuous eligibility for adults in 2015.
12. In Texas, a child in CHIP with income at or above 185% FPL receives 12 months of continuous eligibility unless there is an indication of a change at a six-month income check that would make the child ineligible for CHIP.

Table 15
Premium, Enrollment Fee, and Cost-Sharing Requirements for Children
January 2016

State	Premiums/Enrollment Fees			Cost-Sharing		
	Required in Medicaid	Required in CHIP (Total = 36)	Lowest Income at Which Premiums Begin (Percent of the FPL)[1]	Required in Medicaid	Required in CHIP (Total = 36)	Lowest Income at Which Cost-Sharing Begins (Percent of the FPL)[1]
Total	**4**	**26**		**3**	**25**	
Alabama		Y	>141%		Y	>141%
Alaska		N/A (M-CHIP)			N/A (M-CHIP)	
Arizona		Y	>133%			
Arkansas					Y	>142%
California	Y	N/A (M-CHIP)	>160%		N/A (M-CHIP)	
Colorado		Y	>157%		Y	>142%
Connecticut		Y	>249%		Y	>196%
Delaware[2]		Y	>142%		Y	>142%
District of Columbia		N/A (M-CHIP)			N/A (M-CHIP)	
Florida		Y	>133%		Y	>133%
Georgia		Y	>133%		Y	>133%
Hawaii		N/A (M-CHIP)			N/A (M-CHIP)	
Idaho		Y	>142%		Y	>142%
Illinois		Y	>157%		Y	>142%
Indiana		Y	>158%		Y	>158%
Iowa		Y	>182%		Y	>182%
Kansas		Y	>166%			
Kentucky					Y	>139%
Louisiana		Y	>212%			
Maine		Y	>157%			
Maryland	Y	N/A (M-CHIP)	>211%		N/A (M-CHIP)	
Massachusetts		Y	>150%			
Michigan[3]	Y	N/A (M-CHIP)	>160%		N/A (M-CHIP)	
Minnesota		N/A (M-CHIP)			N/A (M-CHIP)	
Mississippi					Y	>150%
Missouri		Y	>150%			
Montana					Y	>142%
Nebraska		N/A (M-CHIP)			N/A (M-CHIP)	
Nevada		Y	>133%			
New Hampshire		N/A (M-CHIP)			N/A (M-CHIP)	
New Jersey		Y	>200%		Y	>150%
New Mexico[4]		N/A (M-CHIP)		Y	N/A (M-CHIP)	>190%
New York		Y	>160%			
North Carolina		Y	>159%		Y	>133%
North Dakota					Y	>133%
Ohio		N/A (M-CHIP)			N/A (M-CHIP)	
Oklahoma		N/A (M-CHIP)			N/A (M-CHIP)	
Oregon						
Pennsylvania		Y	>208%		Y	>208%
Rhode Island		N/A (M-CHIP)			N/A (M-CHIP)	
South Carolina		N/A (M-CHIP)			N/A (M-CHIP)	
South Dakota						
Tennessee[5]				Y	Y	>100%
Texas		Y	>150%		Y	>133%
Utah		Y	>133%		Y	>133%
Vermont	Y	N/A (M-CHIP)	>195%		N/A (M-CHIP)	
Virginia					Y	>143%
Washington		Y	>210%			
West Virginia		Y	>211%		Y	>133%
Wisconsin		Y	>200%	Y	Y	>133%
Wyoming					Y	>133%

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, 2016.

Table presents rules in effect as of January 1, 2016.

TABLE 15 NOTES

1. In a number of states, the income at which premiums or cost-sharing begin may vary by the child's age since Medicaid and CHIP eligibility levels vary by age and some states exempt younger children from cost-sharing. The reported income eligibility limits at which premiums and cost-sharing begin do not reflect the five percentage points of FPL disregard that applies to eligibility determinations, although this disregard may apply when the income level at which premiums or cost-sharing applies aligns with the eligibility cutoff between Medicaid and separate CHIP programs.
2. Delaware increased the income level at which premiums and cost-sharing begin from 133% FPL to 143% FPL effective January 2016.
3. Michigan implemented premiums for children in Medicaid when it transitioned all children from its separate CHIP program to a CHIP-funded Medicaid expansion program effective January 2016.
4. In New Mexico, most cost-sharing applies to children covered through the CHIP-funded Medicaid expansion, which begins at 190% FPL. For children with income below this income limit, the only cost-sharing that applies is the $3 per brand name drug when there is a less expensive drug available and the $8 for non-emergent use of the emergency room.
5. Tennessee has waiver authority to charge cost-sharing for children between 100% and 133% FPL.

Table 16
Premiums and Enrollment Fees for Children at Selected Income Levels
January 2016

State	Premiums/Enrollment Fees at:[1,2]				
	151% FPL (or 150% if upper limit)	201% (or 200% if upper limit)	251% FPL (or 251% if upper limit)	301% FPL (or 300% if upper limit)	351% FPL (or 350% if upper limit)
MONTHLY PAYMENTS (24 states)					
Arizona[3]	$40|$60	$50|$70	N/A	N/A	N/A
California[3]	$0	$13|$26|$39	$13|$26|$39	N/A	N/A
Connecticut[3]	$0	$0	$30|$50	$30|$50	N/A
Delaware[4,5]	$15	$25	N/A	N/A	N/A
Florida	$15	$20	N/A	N/A	N/A
Georgia	$20	$29	N/A	N/A	N/A
Idaho	$15	N/A	N/A	N/A	N/A
Illinois[3,6]	$0	$15|$25	$40|$80	$40|$80	N/A
Indiana[3]	$0	$33|$50	$53|$70	N/A	N/A
Iowa[3]	$0	$10|$20	$20|$40	$20|$40	N/A
Kansas	$0	$30	N/A	N/A	N/A
Louisiana[4]	$0	$0	$50	N/A	N/A
Maine	$0	$32	N/A	N/A	N/A
Maryland[4]	$0	$0	$66	$66	N/A
Massachusetts	$12	$20	$28	$28	N/A
Michigan[4]	$0	$10	N/A	N/A	N/A
Missouri[3,7]	$19|$23|$28	$61|$77|$93	$148|$186|$224	$148|$186|$224	N/A
New Jersey	$0	$43	$86	$144.50	$144.50
New York	$0	$9	$30	$45	$60
Pennsylvania[8]	$0	$0	$70	$80	N/A
Vermont[4,9]	$0	$15	$20/$60	$20/$60	N/A
Washington	$0	$0	$20	$30	N/A
West Virginia[3]	$0	$0	$35|$71	$35|$71	N/A
Wisconsin	$0	$10	$34	$97	N/A
QUARTERLY PAYMENTS (2 states)					
Nevada	$50	$80	N/A	N/A	N/A
Utah[4]	$75	$75	N/A	N/A	N/A
ANNUAL PAYMENTS (4 states)					
Alabama[10]	$104	$104	$104	$104	N/A
Colorado[3]	$0	$25|$35	$75|$105	N/A	N/A
North Carolina[3]	$0	$50|$100	N/A	N/A	N/A
Texas	$35	$50	N/A	N/A	N/A
NO PREMIUMS OR ENROLLMENT FEES (21 states)					
Alaska	--	--	--	--	--
Arkansas	--	--	--	--	--
District of Columbia	--	--	--	--	--
Hawaii	--	--	--	--	--
Kentucky	--	--	--	--	--
Minnesota	--	--	--	--	--
Mississippi	--	--	--	--	--
Montana	--	--	--	--	--
Nebraska	--	--	--	--	--
New Hampshire	--	--	--	--	--
New Mexico	--	--	--	--	--
North Dakota	--	--	--	--	--
Ohio	--	--	--	--	--
Oklahoma	--	--	--	--	--
Oregon	--	--	--	--	--
Rhode Island	--	--	--	--	--
South Carolina	--	--	--	--	--
South Dakota	--	--	--	--	--
Tennessee	--	--	--	--	--
Virginia	--	--	--	--	--
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, 2016.

Table presents rules in effect as of January 1, 2016.

Table 16 notes

1. N/A indicates that coverage is not available at the specified income level. If a state does not charge premiums at all, it is noted as "- -".
2. Enrollment fees are charged annually and families are typically not allowed to enroll in coverage without paying the fee.
3. In Arizona, California, Connecticut, Illinois, Indiana, Iowa, Missouri, West Virginia, Colorado, and North Carolina the values before the vertical line represent premiums or enrollment fees for one child. Those after the line represent premiums for two or more children.
4. In Delaware, Louisiana, Maryland, Michigan, Vermont, and Utah, premiums are family-based and not based on costs per child.
5. Delaware has an incentive system for premiums where families can pay three months and get one premium-free month, pay six months and get two premium-free months, and pay nine months and get three premium-free months.
6. In Illinois, CHIP premiums are $15 per child, $25 for two children, and $5 for each additional child up to a $40 maximum for families with incomes below 208% FPL. Above 208% FPL, families pay $40 per child or $80 for two or more children.
7. In Missouri premiums vary by family size. Amounts shown are for 2-person, 3-person, and 4-person family. Rates increase based on family size with no cap.
8. In Pennsylvania, premiums vary by contractor. The average amount is shown.
9. In Vermont, for those above 238% 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 annual fee is not required before a child enrolls in coverage, nor is a child disenrolled for nonpayment in the first year. Following the annual renewal, families have 30 days to pay the annual enrollment fee to avoid disenrollment.

Table 17
Disenrollment Policies for Non-Payment of Premiums in Children's Coverage
January 2016

State	Grace Period (amount of time) Before a Child Loses Coverage for Nonpayment of Premiums[1]	After Disenrollment for Failure to Pay Premiums:		
		Lock-Out Period in Separate CHIP Program[2]	Families Must Reapply for Coverage to Reenroll	Retroactive Reinstatement of Coverage if Family Pays Outstanding Premiums
Total		**14**	**16**	**7**
MONTHLY PAYMENTS (24 states)				
Arizona	60 days	Enrollment Closed	Enrollment Closed	Enrollment Closed
California	60 days	N/A (M-CHIP)	Y	N/A (M-CHIP)
Connecticut[3,4]	Until Renewal	None		N/A
Delaware	60 days	None		Y
Florida[5]	30 days	1 month		
Georgia[6]	60 days	1 month		Y
Idaho[3]	Until Renewal	None	Y	N/A
Illinois	60 days	None		Y
Indiana	60 days	90 days		
Iowa	44 days	None	Y	
Kansas	60 days	90 days	Y	
Louisiana[7]	60 days	90 days	Y	
Maine[8]	12 months	up to 90 days	Y	
Maryland	60 days	N/A (M-CHIP)	Y	N/A (M-CHIP)
Massachusetts[9]	60 days	90 days		
Michigan[10]	60 days	N/A (M-CHIP)	Y	N/A (M-CHIP)
Missouri[11]	30 days	90 days	Y	
New Jersey[12]	60 days	90 days		
New York[13]	30 days	None	Y	
Pennsylvania[14]	90 days	90 days	Y	Y
Vermont[15]	60 days	N/A (M-CHIP)	Y	N/A (M-CHIP)
Washington[16]	90 days	90 days	Y	Y
West Virginia[3,17]	Until Renewal	None		N/A
Wisconsin[18]	60 days	90 days	Y	Y
QUARTERLY PAYMENTS (2 states)				
Nevada[19]	60 days	90 days	Y	
Utah	30 days	90 days	Y	Y
ANNUAL PAYMENTS (4 states)				
Alabama[20]	- -	- -	- -	- -
Colorado	- -	- -	- -	- -
North Carolina	- -	- -	- -	- -
Texas	- -	- -	- -	- -
NO PREMIUMS OR ENROLLMENT FEES (21 states)				
Alaska	- -	- -	- -	- -
Arkansas	- -	- -	- -	- -
District of Columbia	- -	- -	- -	- -
Hawaii	- -	- -	- -	- -
Kentucky	- -	- -	- -	- -
Minnesota	- -	- -	- -	- -
Mississippi	- -	- -	- -	- -
Montana	- -	- -	- -	- -
Nebraska	- -	- -	- -	- -
New Hampshire	- -	- -	- -	- -
New Mexico	- -	- -	- -	- -
North Dakota	- -	- -	- -	- -
Ohio	- -	- -	- -	- -
Oklahoma	- -	- -	- -	- -
Oregon	- -	- -	- -	- -
Rhode Island	- -	- -	- -	- -
South Carolina	- -	- -	- -	- -
South Dakota	- -	- -	- -	- -
Tennessee	- -	- -	- -	- -
Virginia	- -	- -	- -	- -
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, 2016.
Table presents rules in effect as of January 1, 2016.

TABLE 17 NOTES

1. This column indicates the grace period for payment of Medicaid or CHIP premiums before a child is disenrolled from coverage. If premiums are charged in Medicaid, a state must provide a 60-day grace period. CHIPRA required states to provide a minimum 30-day premium payment grace period under CHIP before cancelling a child's coverage.
2. A lock-out period is a period of time during which the disenrolled person is prohibited from returning to the CHIP program. Lock-outs are not permitted in Medicaid and the ACA limited such lock-out periods in CHIP to no more than 90 days.
3. Connecticut, Idaho and West Virginia do not disenroll children for unpaid premiums in CHIP. Renewal is considered a new application, and families need to pay the initial month to continue coverage at renewal. Retroactive coverage does not apply because there are no gaps in coverage since a child is not disenrolled until renewal.
4. Connecticut stopped disenrolling children for unpaid premiums in CHIP during 2015.
5. In Florida, children are locked out for one month for nonpayment of the premium but they do not need to reapply if the child is within the 12-month continuous eligibility period.
6. In Georgia, if a child who is disenrolled for nonpayment of premium re-enrolls within 90 days, eligibility must be re-verified but no new application is needed.
7. In Louisiana, children in the 12-month continuous eligibility period do 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. For example, if a family does not pay the last 2 months of premiums, they will have a 2-month penalty. If they do not pay 3 or more months, they will have a 3-month lock-out period. Families can re-enroll if they pay back-owed premiums.
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. After the 90-day lock-out period children may re-enroll for prospective coverage without paying the past due premiums. Children may re-enroll for prospective coverage during the 90-day lock-out period if the past due premiums are paid, if a payment plan is set up, or if the family is determined eligible for a premium waiver.
10. In Michigan, the grace period increased from 30 days to 60 days as a result of the transition from a separate CHIP program to a CHIP-funded Medicaid expansion program effective January 2016.
11. In Missouri, only children in families with incomes above 225% FPL are subject to the lock-out period.
12. New Jersey implemented a 90-day lock out period in its CHIP program in 2015.
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 past due premiums prior to the end of the renewal period, they do not have to re-apply for coverage.
15. In Vermont, if the premium is paid in the calendar month after the child lost coverage, the family does not have to reapply.
16. In Washington, the family must reapply only if they do not pay the past due premium. If they pay the premium then coverage is automatically reinstated back to the month coverage ended for non-payment of premiums.
17. In West Virginia, children are not disenrolled for non-payment of premiums, but past due amounts are subject to third-party collections after 120 days.
18. In Wisconsin, only families that reapply within 3 months after losing coverage are required to repay past due premiums.
19. In Nevada, if a family pays during the lockout period, they are enrolled effective the next month. If they do not during the lockout period, they must reapply.

20. Alabama's annual enrollment fee is not required before a child enrolls in coverage, nor is a child disenrolled for nonpayment in the first year. Following the annual renewal, families have 30 days to pay the annual enrollment fee to avoid disenrollment.

Table 18

Cost-Sharing Amounts for Selected Services for Children at Selected Income Levels[1]

January 2016

State	Family Income at 151% FPL (or 150% if upper eligibility limit)				Family Income at 201% FPL (or 200% if upper eligibility limit)			
	Non-Preventive Physician Visit	ER Visit	Non-Emergency Use of ER	Inpatient Hospital Visit	Non-Preventive Physician Visit	ER Visit	Non-Emergency Use of ER	Inpatient Hospital Visit
Total	**19**	**13**	**20**	**15**	**20**	**13**	**20**	**15**
Alabama	$13	$60	$60	$200	$13	$60	$60	$200
Alaska	--	--	--	--	--	--	--	--
Arizona	--	--	--	--	--	--	--	--
Arkansas	$10	$10	$10	20% of reimbursement rate for first day	$10	$10	$10	20% of reimbursement rate for first day
California	--	--	--	--	--	--	--	--
Colorado	$5	$30	$30	$20	$10	$50	$50	$50
Connecticut	$0	$0	$0	$0	$10	$0	$0	$0
Delaware	$0	$0	$10	$0	$0	$0	$10	$0
District of Columbia	--	--	--	--	--	--	--	--
Florida[2]	$5	$10	$10	$0	$5	$10	$10	$0
Georgia	$0.50-$3	$0	$10	$12.50	$0.50-$3	$0	$10	$12.50
Hawaii	--	--	--	--	--	--	--	--
Idaho	$4	$0	$4	$0	N/A	N/A	N/A	N/A
Illinois	$3.90	$0	$0	$3.90/day	$5	$5	$25	$5/day
Indiana	$0	$0	$0	$0	$0	$0	$0	$0
Iowa	$0	$0	$0	$0	$0	$0	$25	$0
Kansas	--	--	--	--	--	--	--	--
Kentucky[3]	$3	$0	$8	$50	$3	$0	$8	$50
Louisiana	--	--	--	--	--	--	--	--
Maine	--	--	--	--	--	--	--	--
Maryland	--	--	--	--	--	--	--	--
Massachusetts	--	--	--	--	--	--	--	--
Michigan	--	--	--	--	--	--	--	--
Minnesota	--	--	--	--	--	--	--	--
Mississippi	$5	$15	$15	$0	$5	$15	$15	$0
Missouri	--	--	--	--	--	--	--	--
Montana[4]	$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	$8	$0	$5	$0	$8	$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	--	--	--	--	--	--	--	--
Pennsylvania[2, 6]	$0	$0	$0	$0	$0	$0	$0	$0
Rhode Island	--	--	--	--	--	--	--	--
South Carolina	--	--	--	--	--	--	--	--
South Dakota	--	--	--	--	--	--	--	--
Tennessee[2,7]	$5 | $15/$20	$5 | $50	$10 | $50	$5 | $100	$15/$20	$50	$50	$100
Texas	$20	$0	$75	$75	$25	$0	$75	$125
Utah[8]	$25/$40	$300	$100-$200	20% daily reimbursement rate	$25/$40	$300	$100-$200	20% daily reimbursement rate
Vermont	--	--	--	--	--	--	--	--
Virginia	$5	$5	$25	$25	$5	$5	$25	$25
Washington	--	--	--	--	--	--	--	--
West Virginia[2,9]	$15	$35	$35	$25	$20	$35	$35	$25
Wisconsin	$0.50-$3	$0	$0	$3	$0.50-$3	$0	$0	$3
Wyoming[2]	$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, 2016.

Table presents rules in effect as of January 1, 2016.

TABLE 18 NOTES

1. If a state charges cost-sharing for selected services or drugs shown in Tables 18 and 19, 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 copayments at all, it is noted as "- -". Some states require 18-year-olds to meet the copayments of adults in Medicaid. These data are not shown.
2. In Florida, Pennsylvania, Tennessee, West Virginia, and Wyoming, the emergency room copayment is waived if the child is admitted.
3. In Kentucky, enrollees are charged 5% coinsurance for non-emergency use of the emergency room, which is capped at $8.
4. In Montana, cost-sharing is limited to $215 per family.
5. In New Mexico, most cost-sharing applies to children covered through the CHIP-funded Medicaid expansion, which begins at 190% FPL. For children with incomes below this income limit, the only cost-sharing that applies is the $3 for unnecessary use of a brand name drug and $8 for non-emergent use of the emergency room.
6. Pennsylvania charges cost-sharing but it does not begin charging until >208% FPL, so no charges are reported in the table.
7. Tennessee covers children in its regular Medicaid program, called TennCare, with incomes up to 195% FPL for infants, 142% for children ages 1 – 5, and 133% FPL for children 6 – 18. Children who lose eligibility in TennCare qualify for coverage under a Medicaid expansion program, called TennCare Standard, if they are uninsured, have no access to insurance, and have family incomes below 211% FPL. Tennessee also operates a separate CHIP program, called Cover Kids, which covers uninsured children of all ages who do not qualify for TennCare or TennCare Standard and have incomes below 250% FPL. Children enrolled in TennCare have no copayments. The values shown before the "|" represent copayments for children enrolled in TennCare Standard, whereas the values after the "|" represent copayments for children enrolled in Cover Kids. The values shown before a "/" represent copayments for a primary care provider, whereas the values after the "/" represent copayments for a provider that is a specialist.
8. Utah has a $300 deductible in CHIP. In Utah, for a non-preventive physician visit, the value before the "/" is the copayment amount for a visit with a primary care doctor, the value after the "/" is the copayment for a visit with a specialist.
9. In West Virginia, the copayment for a non-preventive physician visit is waived if the child goes to his or her medical home.

Table 19
Cost-Sharing Amounts for Prescription Drugs for Children at Selected Income Levels[1]
January 2016

State	Family Income at 151% FPL (or 150% if upper limit)			Family Income at 201% FPL (or 200% if upper limit)		
	Generic	Preferred Brand Name	Non-Preferred Brand Name	Generic	Preferred Brand Name	Non-Preferred Brand Name
Total	**16**	**17**	**15**	**18**	**19**	**16**
Alabama	$5	$25	$28	$5	$25	$28
Alaska	--	--	--	--	--	--
Arizona	--	--	--	--	--	--
Arkansas	$5	$5	$5	$5	$5	$5
California	--	--	--	--	--	--
Colorado	$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	$5	$5	$5	$5	$5	$5
Georgia	$0.50	$0.50-$3	$0.50-$3	$0.50	$0.50-$3	$0.50-$3
Hawaii	--	--	--	--	--	--
Idaho	$0	$0	$0	N/A	N/A	N/A
Illinois	$2	$3.90	$3.90	$3	$5	$5
Indiana	$0	$0	$0	$3	$10	$10
Iowa	$0	$0	$0	$0	$0	$0
Kansas	--	--	--	--	--	--
Kentucky	$1	$4	$8	$1	$4	$8
Louisiana	--	--	--	--	--	--
Maine	--	--	--	--	--	--
Maryland	--	--	--	--	--	--
Massachusetts	--	--	--	--	--	--
Michigan	--	--	--	--	--	--
Minnesota	--	--	--	--	--	--
Mississippi	$0	$0	$0	$0	$0	$0
Missouri	--	--	--	--	--	--
Montana[2]	$0	$0	$0	$0	$0	$0
Nebraska	--	--	--	--	--	--
Nevada	--	--	--	--	--	--
New Hampshire	--	--	--	--	--	--
New Jersey	$1	$5	$5	$5	$5	$5
New Mexico[3]	$0	$0	$3	$2	$3	$3
New York	--	--	--	--	--	--
North Carolina[4]	$1	$1	$3	$1	$1	$10
North Dakota	$2	$2	$2	N/A	N/A	N/A
Ohio	--	--	--	--	--	--
Oklahoma	--	--	--	--	--	--
Oregon	--	--	--	--	--	--
Pennsylvania[5]	$0	$0	N/C	$0	$0	N/C
Rhode Island	--	--	--	--	--	--
South Carolina	--	--	--	--	--	--
South Dakota	--	--	--	--	--	--
Tennessee[6]	$1.50 | $5	$3 | $20	$3 | $40	$1.50 | $5	$3 | $20	$3 | $40
Texas	$10	$35	N/C	$10	$35	N/C
Utah[7]	$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	$1	$3	$3	$1	$3	$3
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, 2016.

Table presents rules in effect as of January 1, 2016.

Table 19 Notes

1. If a state charges cost-sharing for selected services or drugs shown in Tables 18 and 19, 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 copayments 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 copayments of adults in Medicaid. These data are not shown.
2. In Montana, if families order prescriptions through the mail, they pay $6 for a 3-month supply of a generic drug and $10 for a 3-month supply of a brand-name drug.
3. In New Mexico, most cost-sharing applies to children covered through the CHIP-funded Medicaid expansion, which begins at 190% FPL. For children with incomes below this income limit, the only cost-sharing that applies is the $3 for unnecessary use of a brand name drug and $8 for non-emergent use of the emergency room.
4. In North Carolina, the copayment for brand-name drugs only applies if a generic version is available.
5. Pennsylvania charges cost-sharing but it does not begin charging until >208% FPL, so no charges are reported in the table.
6. Tennessee covers children in its regular Medicaid program, called TennCare, with incomes up to 195% FPL for infants, 142% for children ages 1 – 5, and 133% FPL for children 6 – 18. Children who lose eligibility in TennCare qualify for coverage under a Medicaid expansion program, called TennCare Standard, if they are uninsured, have no access to insurance, and have family incomes below 211% FPL. Tennessee also operates a separate CHIP program, called Cover Kids, which covers uninsured children of all ages who do not qualify for TennCare or TennCare Standard and have incomes below 250% FPL. Children enrolled in TennCare have no copayments. The values shown before the "|" represent copayments for children enrolled in TennCare Standard, whereas the values after the "|" represent copayments for children enrolled in Cover Kids. The values shown before a "/" represent copayments for a primary care provider, whereas the values after the "/" represent copayments for a provider that is a specialist.
7. Utah charges a $300 deductible.

Table 20
Premium and Cost-Sharing Requirements for Section 1931 Parents[1]
January 2016

State	Monthly Contribution/ Premiums	Cost-Sharing	Income at Which Cost-Sharing Begins (%FPL)	Cost-Sharing Amounts for Selected Services					
				Non-Preventive Physician Visit	Non-Emergency Use of ER	Inpatient Hospital Visit	Generic Drug	Preferred Brand Name Drug	Non-Preferred Brand Name Drug
Total	**1**	**40**		**26**	**22**	**28**	**37**	**39**	**38**
Alabama		Y	0%	$1.30-$3.90	$3.90	$50	$0.65-$3.90	$0.65-$3.90	$0.65-$3.90
Alaska		Y	0%	$10	$0	$50/day	$3	$3	$3
Arizona		Y	0%	$3.40	$0	$0	$2.30	$2.30	$2.30
Arkansas		Y	0%	$0	$0	10% cost of first day	$0.50-$3.90	$0.50-$3.90	$0.50-$3.90
California		Y	0%	$1	$5	$0	$1	$1	$1
Colorado		Y	0%	$2	$3	$10/day	$1	$3	$3
Connecticut			--	--	--	--	--	--	--
Delaware		Y	0%	$0	$0	$0	$0.50-$3	$0.50-$3	$0.50-$3
District of Columbia			--	--	--	--	--	--	--
Florida[2]		Y	0%	$2	5% of first $300	$3	$0	$0	$0
Georgia		Y	0%	$0	$0	$12.50	$0.50-$3	$0.50-$3	$0.50-$3
Hawaii			--	--	--	--	--	--	--
Idaho			--	--	--	--	--	--	--
Illinois		Y	0%	$3.90	$3.90	$3.90/day	$2	$3.90	$3.90
Indiana[3]	Y, >0%	Y	0%	$4	$8/$25 subsequent visits	$75	$4	$4	$8
Iowa[4]		Y	0%	$3	$3	$0	$1	$1	$2-$3
Kansas			--	--	--	--	--	--	--
Kentucky[5]		Y	0%	$3	$8	$50	$1	$4	$8
Louisiana		Y	0%	$0	$0	$0	$0.50-$3	$0.50-$3	$0.50-$3
Maine[6]		Y	0%	$0	$3	up to $3/day	$3	$3	$3
Maryland		Y	0%	$0	$0	$3	$1-$3	$1-$5	$1-$5
Massachusetts[7]		Y	0%	$0	$0	$3	$3.65	$3.65	$3.65
Michigan		Y	0%	$0	$0	$0	$1	$1	$1
Minnesota		Y	0%	$3	$3.50	$0	$1	$3	$3
Mississippi		Y	0%	$3	$0	$10	$3	$3	$3
Missouri		Y	0%	$1	$3	$10	$0.50-$2	$0.50-$2	$0.50-$2
Montana[8]		Y	0%	$4	$4	$75	$1-$4	$1-$4	$1-$4
Nebraska		Y	0%	$2	$0	$15	$2	$2	$3
Nevada			--	--	--	--	--	--	--
New Hampshire		Y	0%	$0	$0	$0	$1	$2	$2
New Jersey			--	--	--	--	--	--	--
New Mexico			--	--	--	--	--	--	--
New York[9]		Y	100%	$0	$3	$25/discharge	$1	$3	$3
North Carolina		Y	0%	$3	$0	$3/day	$3	$3	$3
North Dakota		Y	0%	$2	$3	$75	$0	$3	$3
Ohio		Y	0%	$0	$3	$0	$0	$2	$3
Oklahoma[10]		Y	0%	$4	$4	$10/day; $90 max	$4	$4	$4
Oregon[11]		Y	0%	$0	$3	$0	$2	$3	$3
Pennsylvania[12]		Y	0%	$0.65-$3.80	$0.50-$3	$3/day	$1	$3	$3
Rhode Island			--	--	--	--	--	--	--
South Carolina		Y	0%	$2.30	$0	$25	$3.40	$3.40	$3.40
South Dakota		Y	0%	$3	full amount	$50	$1	$3.30	N/C
Tennessee		Y	0%	$0	$0	$0	$1.50	$3	$3
Texas			--	--	--	--	--	--	--
Utah[13]		Y	>40%	$3	$6	$220	$3	$3	$3
Vermont		Y	0%	$0	$0	$75	$1-$3	$1-$3	$1-$3
Virginia		Y	0%	$1	$0	$100	$1	$3	$3
Washington			--	--	--	--	--	--	--
West Virginia[14]		Y	0%	$0-$4	$8	$0-$75	$0-$3	$0-$3	$0-$3
Wisconsin[15]		Y	0%	$0.50-$3	$0	$3	$1	$3	$3
Wyoming		Y	0%	$2.45	$3.65	$0	$0.65	$3.65	$3.65

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, 2016.
Table presents rules in effect as of January 1, 2016.

TABLE 20 NOTES

1. Data in the table present premiums or other monthly contributions and cost-sharing requirements for Section 1931 parents. If a state charges cost-sharing, but does not charge for the specific service, it is recorded as $0; if a state does not charge cost-sharing at all, it is noted as "- -"; if a state does not cover a type of drug, it is noted as "N/C". In some states, copayments vary based on the cost of the drug.
2. Florida increased copayments for some services during 2015.
3. Indiana implemented monthly contributions in 2015. In Indiana, Section 1931 parents who fail to pay monthly contributions will not be disenrolled but will receive HIP Basic, a more limited benefit package with state plan level copayments. In Indiana, copayments are only required if enrolled in HIP Basic. In the Plus plan, there are no copayments except for $8 for first time use and $25 for second time use of emergency room for a non-emergency.
4. In Iowa, charges are $2 for non-preferred name brand drugs that cost between $25.01 and $50; and $3 for non-preferred brand name drugs that cost >$50.
5. In Kentucky, enrollees are charged 5% coinsurance for non-preferred brand-name drugs, capped at $20.
6. In Maine, there are separate $30 monthly maximums for inpatient hospital and drug copayments.
7. In Massachusetts, generic drugs for diabetes, high blood pressure and high cholesterol have a $1 copayment. There is a cap of $36 per year for non-pharmacy copayments and a cap of $250 per year for pharmacy copayments.
8. Montana decreased copayments for some services during 2015.
9. New York eliminated copayments for parents and adults with incomes below 100% FPL in 2015.
10. Oklahoma increased copayments for prescription drugs during 2015.
11. In Oregon, there are no copayments for drugs ordered through home-delivery pharmacy programs.
12. In Pennsylvania, copayments vary based on the cost of service. The inpatient hospital copayment is subject to a maximum of $21 per stay.
13. In Utah, enrollees under the TANF payment limit are exempt from paying copayments.
14. In West Virginia, drug copayments range from $.50 to $3 depending on the cost of the drug, while other copayment amounts vary by income. Enrollees have a quarterly out-of-pocket maximum of $8 up to 50% FPL; $71 between 50% and 100%; and $143 above 100%.
15. In Wisconsin, emergency room copayments are waived if admitted.

Table 21

Premium and Cost-Sharing Requirements for Medicaid Adults[1]

January 2016

State	Monthly Contributions/ Premiums	Cost-Sharing	Income at Which Cost-Sharing Begins (%FPL)	Cost-Sharing Amounts for Selected Services					
				Non-Preventive Physician Visit	Non-Emergency Use of ER	Inpatient Hospital Visit	Generic Drug	Preferred Brand Name Drug	Non-Preferred Brand Name Drug
ADOPTED MEDICAID EXPANSION (31 States)									
Total	**5**	**23**		**13**	**14**	**15**	**18**	**21**	**22**
Alaska		Y	0%	$10	$0	$50/day	$3	$3	$3
Arizona			--	--	--	--	--	--	--
Arkansas[2]	Y, >100% FPL	Y	100%	$10	$0	$140/day	$4	$4	$8
California[3]		Y	0%	$1	$5	$0	$1	$1	$1
Colorado		Y	0%	$2	$3	$10/day	$1	$3	$3
Connecticut			--	--	--	--	--	--	--
Delaware[4]		Y	0%	$0	$0	$0	$0.50-$3	$0.50-$3	$0.50-$3
District of Columbia			--	--	--	--	--	--	--
Hawaii			--	--	--	--	--	--	--
Illinois		Y	0%	$3.90	$3.90	$3.90/day	$2	$3.90	$3.90
Indiana[5]	Y, >0%	Y	0%	$4	$8/ $25 subsequent visits	$75	$4	$4	$8
Iowa[6]	Y, >50% FPL	Y	50%	$0	$8	$0	$0	$0	$0
Kentucky		Y	0%	$3	$8	$50	$1	$4	$8
Maryland		Y	0%	$0	$0	$3	$1-$3	$1-$5	$1-$5
Massachusetts[7]		Y	0%	$0	$0	$3	$3.65	$3.65	$3.65
Michigan[8]	Y, >100% FPL	Y	0%	$0	$0	$0	$1	$1	$1
Minnesota		Y	0%	$3	$4	$0	$1	$3	$3
Montana[9]	Y, >50% FPL	Y	0%	$4/10% of state payment	$8	$75/10% of state peyment	$0	$4	$8
Nevada			--	--	--	--	--	--	--
New Hampshire[10]		Y	>100%	$3	$0	$125	$4	$8	$8
New Jersey			--	--	--	--	--	--	--
New Mexico		Y	0%	$0	$8	$0	$0	$3	$3
New York		Y	100%	$0	$3	$25/discharge	$1	$3	$3
North Dakota		Y	0%	$2	$3	$75	$0	$3	$3
Ohio		Y	0%	$0	$0	$0	$0	$0	$3
Oregon		Y	0%	$0	$3	$0	$2	$3	$3
Pennsylvania		Y	0%	$0.65-$3.80	$0.50-$3	$3/day	$1	$3	$3
Rhode Island			--	--	--	--	--	--	--
Vermont		Y	0%	$0	$0	$75	$1-$3	$1-$3	$1-$3
Washington			--	--	--	--	--	--	--
West Virginia[11]		Y	0%	$0-$4	$8	$0-$75	$0-$3	$0-$3	$0-$3
NOT ADOPTING THE MEDICAID EXPANSION AT THIS TIME (20 States)									
Total		**1**		**1**	**0**	**1**	**1**	**1**	**1**
Alabama									
Florida									
Georgia									
Idaho									
Kansas									
Louisiana									
Maine									
Mississippi									
Missouri									
Nebraska									
North Carolina									
Oklahoma									
South Carolina									
South Dakota									
Tennessee									
Texas									
Utah									
Virginia									
Wisconsin[12]		Y	0%	$0.50-$3	$0	$3	$1	$3	$3
Wyoming									

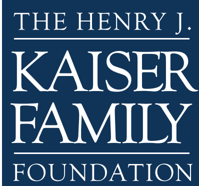
SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2016.

Table presents rules in effect as of January 1, 2016.

TABLE 21 NOTES

1. Data in the table represent premium or other monthly contributions and cost-sharing requirements for non-disabled adults. This group also includes parents above Section 1931 limits. If a state charges cost-sharing, but does not charge for the specific service or drug, it is recorded as $0; if a state does not charge cost-sharing at all, it is noted as "- -."
2. Arkansas received waiver approval to require certain non-medically frail enrollees to make monthly income-based contributions to health savings accounts (HSAs) to be used in lieu of paying point-of-service copayments and coinsurance. Arkansas can charge monthly HSA contributions for expansion adults with incomes down to 50% FPL, but the state is not currently charging individuals with incomes below poverty. Adults with incomes above poverty who fail to make monthly HSA contributions are responsible for copayments and coinsurance at the point of service, and providers can deny services for failure to pay cost-sharing. Cost-sharing is not a condition of Medicaid eligibility and is limited to 5% of monthly or quarterly income.
3. In California, inpatient visits are $100 per day, $200 max.
4. In Delaware, copayments vary based on cost of drug.
5. In Indiana, under Section 1115 waiver authority, adults with incomes above poverty who fail to pay monthly contributions will be disenrolled from coverage after a 60-day grace period and barred from re-enrolling for 6 months. Beneficiaries with incomes at or below 100% FPL who fail to pay monthly contributions will receive HIP Basic, a more limited benefit package with state plan level copayments. In Indiana, copayments are only required if enrolled in HIP Basic. In the Plus plan, there are no copayments except for $8 for first time use and $25 for second time use of emergency room for a non-emergency.
6. In Iowa, under Section 1115 waiver authority, Medicaid expansion beneficiaries above 100% FPL pay contributions of $10 per month. Beneficiaries from 50-100% FPL pay $5 per month and cannot be disenrolled for non-payment. Contributions are waived for the first year of enrollment. In subsequent years, contributions are waived if beneficiaries complete specified healthy behaviors. The state must grant waivers of payment to beneficiaries who self-attest to a financial hardship. Beneficiaries have the opportunity to self-attest to hardship on each monthly invoice.
7. In Massachusetts, generic drugs for diabetes, high blood pressure, and high cholesterol have a $1 copayment. There is a $36 annual cap for non-pharmacy copayments and a $250 annual cap for pharmacy copayments.
8. In Michigan, under Section 1115 waiver authority, expansion adults with incomes above 100% FPL are charged monthly premiums that are equal to 2% of income. Expansion adults have cost-sharing contributions based on their prior 6 months of copayments incurred, billed at the end of each quarter. There is no cost-sharing for the first six months of enrollment in the plan. Beneficiaries cannot lose or be denied Medicaid eligibility, be denied health plan enrollment or be denied access to services, and providers may not deny services for failure to pay copayments or premiums. Cost-sharing can be reduced through compliance with healthy behaviors. Cost-sharing and premiums cannot exceed 5% of household income.
9. In Montana, individuals with incomes at or below 100% FPL will not be disenrolled due to unpaid premiums. Individuals with incomes above 100% FPL will be disenrolled for unpaid premiums after notice and a 90-day grace period. Disenrollment lasts until arrears are paid or until the state assesses debt against income taxes, which must happen by the end of the calendar quarter (maximum disenrollment period is 3 months). The state must establish a process to exempt beneficiaries from disenrollment for good cause. Reenrollment does not require a new application. Combined premiums and copayment charges may not exceed 5% of household income. Enrollees will receive a credit toward their copayment obligations in the amount of their premiums. For copayments, amounts before the slash are for adults with incomes at or below 100% FPL; amounts after the slash are for adults with incomes above 100% FPL.
10. New Hampshire increased copayments for some services during 2015.

11. In West Virginia, drug copayments range from $.50 to $3 depending on the cost of the drug, while other copayment amounts vary by income. Enrollees have a quarterly out-of-pocket maximum of $8 up to 50% FPL; $71 between 50% and 100%; and $143 above 100%.
12. Wisconsin offers Medicaid coverage to childless adults up to 100% FPL, but has not adopted the ACA Medicaid expansion. Enrollees pay cost-sharing equal to those reported for parents in Table 20.



THE KAISER COMMISSION ON

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