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THE HENRY J. KAISER FAMILY FOUNDATION

HOLDING STEADY, LOOKING AHEAD: ANNUAL FINDINGS OF A 50-STATE SURVEY OF ELIGIBILITY RULES, ENROLLMENT AND RENEWAL PROCEDURES, AND COST SHARING PRACTICES IN MEDICAID AND CHIP, 2010-2011

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The Henry J. Kaiser Family Foundation

January 2011

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kaiser commission medicaid and the uninsured

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

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ACKNOWLEDGEMENTS

The authors extend our deep appreciation to the state officials who so generously shared their expertise and time with us by participating in this survey and helping us to understand the nuances and details of their programs. This work simply would not be possible without them and we greatly appreciate their important contributions, especially in a time of strained resources. The authors also would like to thank Donna Cohen Ross for her work on the nine earlier iterations of this annual survey, which established the strong foundation on which this year's survey builds. We also extend thanks to Qursum Qasim, intern with the Georgetown University Center for Children and Families, for her assistance in data collection.

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Executive Summary

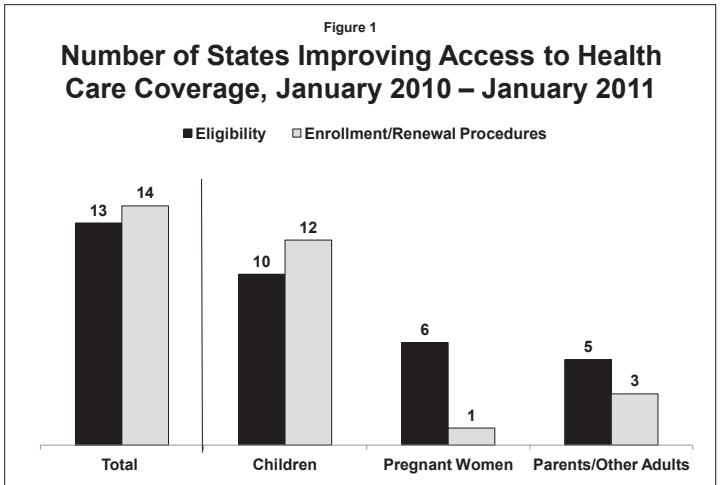
Introduction

Over the past year, as the nation's attention was focused on the country's continuing economic problems and the debate over the passage of broader health care reform, Medicaid and the Children's Health Insurance Program (CHIP) continued to play their central role of providing coverage to millions of people who otherwise lack affordable coverage options. In 2010, this role was more pronounced than ever as families losing their jobs and access to employer-based coverage turned to public programs in growing numbers. Without Medicaid and CHIP, many more individuals would have become uninsured, adding to the 50 million currently without coverage. Based on a survey of state officials in all 50 states and the District of Columbia conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, this tenth annual report provides an overview of state actions on eligibility rules, enrollment and renewal procedures, and cost sharing practices in Medicaid and CHIP during 2010, as well as the status of coverage as of January 1, 2011, for children, parents, pregnant women, and other non-disabled adults.

As the survey findings illustrate, families could turn to Medicaid and CHIP because nearly all states "held steady" or made targeted improvements in their eligibility and enrollment rules in 2010, with a total of 13 states expanding eligibility and 14 states making improvements in enrollment and renewal procedures (Figure 1). This striking stability in public programs can be directly attributed to the federal government's decision both to provide temporary Medicaid fiscal relief to states through June 2011, and to require states to maintain their Medicaid and CHIP eligibility rules and enrollment procedures until broader health reform goes into effect.

Figure 1

Number of States Improving Access to Health Care Coverage, January 2010 – January 2011



SOURCE: Based on the results of a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2011.

During 2010, states also were starting to look ahead to implementation of the Affordable Care Act (ACA) and, in some instances, to take advantage of early options to improve Medicaid coverage. Health reform provides a broad expansion in coverage that will take effect in 2014, including extending Medicaid to a new national eligibility floor of 133 percent of the federal poverty level ($24,352 for a family of three and $14,404 for an individual in 2010). However, it is important for states to begin taking steps now to address the technological changes necessary to develop the online, consumer-friendly enrollment process envisioned under the ACA. Although there has been some progress in 2010, the survey highlights that states still have a significant amount of work to be prepared in 2014. Looking ahead, it will be important for state policymakers to continue moving forward on implementation while sustaining the gains and progress made in coverage to date.

Key Findings on Eligibility and Enrollment Procedures

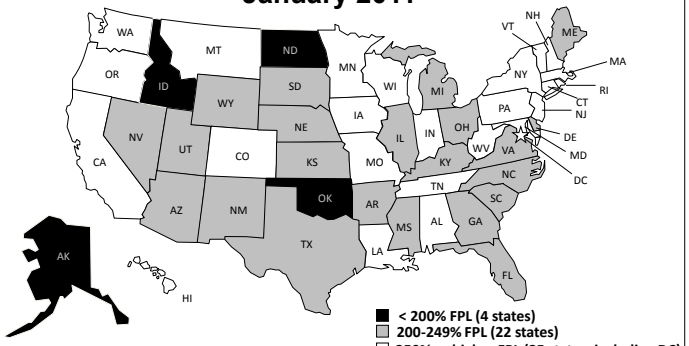
Nearly all states (49, including DC) held steady or made targeted improvements in their Medicaid and CHIP eligibility rules and enrollment procedures in 2010. By doing so, they maintained the central role of Medicaid and CHIP in providing affordable coverage to children and, to a lesser extent, their parents and other adults, many of whom lost jobs and their access to employer-based coverage in the ongoing economic downturn. This stability can be directly attributed to provisions in the American Recovery and Reinvestment Act (ARRA) adopted in February 2009, that required states to maintain their Medicaid eligibility rules and enrollment procedures as a condition of receiving a significant, temporary increase in the federal Medicaid matching rate. The ACA also included a maintenance-of-effort (MOE) requirement designed to keep Medicaid coverage steady for adults until broader reform goes into effect in 2014 and for children until 2019, as well as to extend these protections to children covered by CHIP. Without the MOE requirements and enhanced federal funding, many states almost certainly would have needed to turn to cutbacks in coverage in 2010 as a result of continuing budget pressures. Two states (AZ and NJ) did make coverage reductions that were not subject to the MOE. States also made other changes such as cuts to provider reimbursement rates and benefits to reduce Medicaid spending growth in 2010.

Despite significant budget challenges, 13 states went beyond maintaining coverage to implement targeted eligibility expansions for children, pregnant women, and adults in 2010. These expansions varied in size and scope. Most of the expansions focused on providing increased coverage to uninsured children, and in a many cases, also produced some state savings by allowing the state to draw down federal matching funds for previously fully state-funded coverage.

Building on progress made over the past decade, 3 states (CO, KS, and OR) increased income eligibility in Medicaid/CHIP for children in 2010. As such, as of January 1, 2011, 25 states, including DC, cover children in families with income at least up to 250 percent of the federal poverty level ($45,775 for a family of three in 2010), although enrollment remains heavily concentrated among the lowest-income children (Figure 2). Oregon also added a buy-in program in 2010 that enables families with incomes above Medicaid and CHIP thresholds to buy into coverage.

Figure 2

Children's Eligibility for Medicaid/CHIP by Income, January 2011



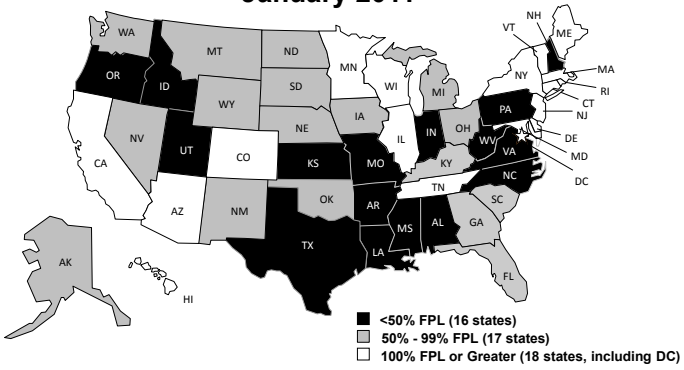
Notes: The federal poverty line (FPL) for a family of three in 2010 is $18,310 per year. IL uses state funds to cover children up to 300% of the FPL; OK has a premium assistance program for select children up to 200% of the FPL. AZ's CHIP program is currently closed to new enrollment.
SOURCE: Based on the results of a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2011.

In 2010, states continued to take advantage of the option to cover lawfully-residing immigrant children and pregnant women during their first five years residing in the country. The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) allowed states to draw down federal funding to cover these populations without imposing a 5-year waiting period. Six (6) states (DE, MN, MT, NE, NC, and WI) adopted the option for lawfully-residing immigrant children in 2010, resulting in a total of 21 states having eliminated this barrier for children as of January 1, 2011. In 15 of these states, coverage had previously been provided to these children with state-only dollars. In addition, in 2010, 5 states (DE, MN, NE, NC, and WI) adopted this option for lawfully-residing pregnant women, bringing the total number eliminating the "five-year bar" for pregnant women to 17. In 9 of these states, coverage had previously been provided with state-only dollars.

While states have made significant progress in expanding coverage for children, eligibility for their parents continues to lag far behind. In 2010, only one state (CO) expanded Medicaid coverage for parents. As of January 1, 2011, 33 states do not cover parents up to 100 percent of the federal poverty level ($18,310 for a family of three in 2010). The median eligibility threshold for parents remains at 64 percent of the federal poverty level and 16 states limit eligibility to below 50 percent of the federal poverty level ($9,155 for a family of three in 2010). In the absence of further expansions, these restrictive eligibility levels will leave most uninsured, low-income parents without an affordable coverage option until the health reform expansion goes into effect in 2014 (Figure 3).

Figure 3

Medicaid Eligibility for Working Parents by Income, January 2011



Notes: The federal poverty line (FPL) for a family of three in 2010 is $18,310 per year. Several states also offer coverage with a benefit package that is more limited than Medicaid at higher income levels.
SOURCE: Based on the results of a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2011.

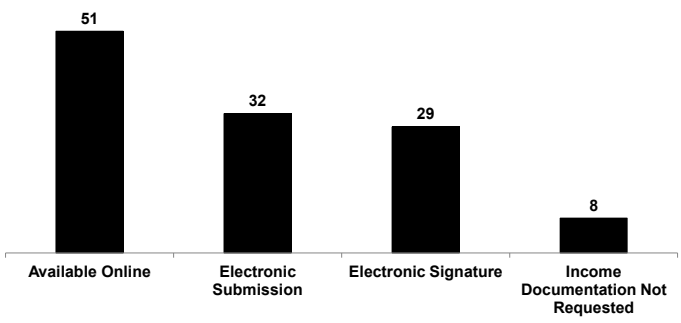
Low-income adults without dependent children remain ineligible for Medicaid in the vast majority of states. Under the ACA, Medicaid eligibility will be expanded to a minimum of 133 percent of the federal poverty level, ending the historic exclusion of non-disabled, non-pregnant adults without dependent children from the program. While this change is not required to be in effect until January 1, 2014, states have the option of moving early to cover these adults. In 2010, Connecticut and the District of Columbia took advantage of this option and moved low-income adults they had previously served through state-funded programs to Medicaid. Further, California received approval in 2010 for a waiver to continue and expand county coverage initiatives serving low-income adults. However, even with these expansions, as of January 1, 2011, only seven states (AZ, CT, DE, DC, HI, NY, and VT) provide Medicaid or Medicaid-equivalent benefits to adults without dependent children. Additional states offer more limited coverage to these adults, but in most states, low-income adults without children do not have access to public coverage regardless of their income.

States adopted improvements in their enrollment and renewal procedures in 2010 that helped to reduce burdens on families, streamline administrative processes, and achieve program efficiencies. In making these improvements, states often turned to options provided by CHIPRA. Specifically, 29 states took advantage of the CHIPRA option to more efficiently and accurately verify citizenship status by relying on an electronic data match with the Social Security Administration (SSA). A smaller, but still notable number of states, moved ahead with other simplification measures including the CHIPRA "Express Lane Eligibility" option, as well as long-standing strategies such as presumptive eligibility and continuous eligibility for children. Many appear to have done so at least in part to qualify for the Medicaid performance bonuses included in CHIPRA. These bonuses provide a financial reward and recognition to states that have implemented at least 5 of 8 simplification policies and that have reached specific enrollment targets for children in Medicaid. The Administration encouraged states in their efforts by launching the *Connecting Kids to Coverage Challenge*, a partnership of national and state organizations committed to enrolling all five million uninsured but eligible children in public programs.

States continued work to modernize their programs and begin preparing for health reform implementation by focusing on technological improvements. A number of states made program improvements such as offering applications that can be submitted online. Despite this early work, the survey findings highlight that states have a long way to go to develop the integrated, technology-driven, web-based eligibility systems for Medicaid, CHIP, and subsidized Exchange coverage that are envisioned and required under reform. For example, all states, including DC, post their Medicaid applications online, but only 32 accept the electronic submission of those applications. Among the 32 that accept electronic submission, 29 allow for the use of an electronic signature, but only 8 do not routinely ask families to submit paper documentation of information via mail or fax before checking other data sources to verify eligibility (Figure 4). In light of a rule proposed by the Administration at the end of 2010 to provide states with a 90 percent matching rate to prepare their Medicaid eligibility systems for health reform and the likelihood of additional guidance and funding opportunities in the months ahead, it can be expected that next year's survey will show more developments in this area.

Figure 4

Status of Online Applications for State Medicaid Programs, January 2011



Notes: In some states the online application is only available for children applying for coverage.
SOURCE: Based on the results of a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2011.

Conclusion

As implementation of broader health reform moves forward, the findings of this survey describe the foundation for coverage of low-income families and individuals through Medicaid and CHIP. These programs will play an even more substantial role in the years to come, particularly with the expansion in coverage for low-income adults. Valuable lessons can be learned from how states have streamlined and simplified their enrollment and renewal procedures in these programs, and while additional improvements will be necessary to further transform Medicaid and CHIP in order to fulfill the promise of reform, they provide a sound platform on which to begin.

Looking ahead, states face the challenge of implementing reform while at the same time dealing with significant budget pressures due to the nation's continuing economic problems and the corresponding increased need for Medicaid and CHIP. To continue forward progress on reform and keep the foundation solid, it will be important to focus on sustaining the coverage gains and progress made to date even in the face of these challenges. Health reform has the potential to markedly reduce the number of uninsured and provides states new opportunities to modernize, streamline, and continue to improve their Medicaid programs. While some of the most significant changes in health reform do not go into effect until 2014, it is important for states to lay the groundwork now. In 2010, there were initial signs of state Medicaid agencies preparing for health reform implementation, but more activity can be expected in 2011.

I. Introduction

The past year marked the passage of broad health reform, which will expand coverage to millions of uninsured individuals beginning in 2014. However, ongoing economic problems persisted throughout 2010, continuing to place pressures on families and state budgets and leading to continued growth in the number of uninsured adults. This tenth annual report provides an overview of changes made to state eligibility rules, enrollment and renewal procedures, and cost sharing practices in Medicaid and CHIP in 2010, as well as a snapshot of policies in place as of January 1, 2011. It is based on a survey of state officials conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families in all 50 states and the District of Columbia.

The survey findings highlight that Medicaid and CHIP eligibility rules were remarkably stable in 2010, allowing these programs to continue to play their central role of offering coverage to many low- and moderate-income families. This role was more pronounced than ever in the last year, as families increasingly turned to Medicaid and CHIP as they lost jobs and access to employer-sponsored insurance. Without these programs, many more individuals would have become uninsured. The striking stability in public programs can be directly attributed to the federal government's decision to both provide temporary Medicaid fiscal relief to states through June 2011, and to require states to maintain their Medicaid and CHIP eligibility rules and enrollment procedures until broader health reform goes into effect. Moreover, in 2010, a number of states went beyond maintaining coverage to implement targeted expansions and improvements in their programs designed to increase coverage, draw down additional federal matching funds, and/or achieve program efficiencies.

The report begins with a review of the fiscal and policy environment in which states made decisions about Medicaid and CHIP coverage in 2010. It then presents the major survey findings on eligibility rules, enrollment and renewal procedures, and cost sharing practices, providing data on state policies as of January 1, 2011, and identifying changes that occurred throughout 2010. The report concludes with a discussion of the policy implications of the findings, focusing on the challenges and opportunities facing states as they continue to cope with budget pressures and the increased demand for Medicaid and CHIP and begin to implement reform.

II. Policy and Fiscal Context in 2010

Over the years, states have made significant progress in both expanding coverage and streamlining eligibility and enrollment processes in Medicaid and CHIP, with most gains benefiting children. As they have achieved this progress, the programs have also adapted to changes in health care, such as the increased use of managed care, and varying economic and political environments. In 2010, state decisions about Medicaid and CHIP eligibility rules and enrollment procedures occurred in the context of multiple factors, as discussed below.

Despite the return of weak economic growth in 2010, the impact of the deepest recession since the Great Depression presented an ongoing challenge to families and states.[1] State Medicaid and CHIP programs continued to experience increased demand for coverage as families losing their jobs and access to employer-based coverage turned to public programs in growing numbers. The resulting growth in Medicaid and CHIP enrollment provided much needed coverage to low-income families, slowing the growth in the uninsured rate, particularly for children, for whom the uninsured rate actually declined.[2] Without these programs, many more individuals would be uninsured than the 50 million today. However, the enrollment growth also added pressure to already-stressed state budgets.[3]

Enhanced federal matching funds for Medicaid were provided throughout 2010, with the requirement that states maintain their eligibility and enrollment procedures as a condition of receiving these funds. Recognizing the increased demands on Medicaid and CHIP at a time when states were still dealing with substantially diminished revenues and unprecedented budget shortfalls, Congress provided significant fiscal relief to states under the American Recovery and Reinvestment Act (ARRA) of 2009. The legislation provided states with a temporary increase in the federal share of Medicaid payments (i.e., the "Federal Medical Assistance Percentage" or "FMAP") from October 1, 2008 through December 31, 2010. In August 2010, Congress passed an extension of the enhanced FMAP through June 2011, although at a lower level. As a condition of receiving the enhanced federal funds, states may not adopt more restrictive Medicaid eligibility rules and enrollment procedures than were in effect on July 1, 2008.[4] For example, they cannot eliminate eligibility for Medicaid beneficiaries covered at state option, lower the income threshold for Medicaid coverage, or adopt procedures that make it harder for eligible people to enroll in coverage (e.g., by imposing a face-to-face interview requirement or requiring people to renew their coverage more frequently.)[5] However, states are not barred by this "maintenance-of-effort" (MOE) requirement from cutting back on benefits, reimbursement rates or other aspects of Medicaid and, as documented elsewhere, many did so in 2010 in an effort to address budget problems.[6]

Broad health care reform was adopted through the Affordable Care Act (ACA) in March 2010, and is designed to address the growing uninsured problem by expanding coverage through the creation of a new continuum of affordable options. Under the ACA, Medicaid eligibility will be extended to a national floor of 133 percent of the federal poverty level, ending the historic exclusion of non-disabled, non-pregnant adults without dependent children from the program. While this change is not required to be in effect until January 1, 2014, under reform, states have the option of moving early to cover these adults. Individuals with income above Medicaid thresholds without access to other coverage will be eligible for coverage through new Health Benefit Exchanges, and those with income up to 400 percent of the federal poverty level will be eligible for subsidies in the form of advance tax credits to purchase coverage through these Exchanges.

Beyond expanding coverage options, the ACA sets out a strong vision for consumer-friendly, web-based eligibility and enrollment systems that will enable families to apply for Medicaid, CHIP, and Exchange subsidies through one simplified process. The goal is to create a "no wrong door" approach to coverage that offers multiple ways to apply (online, over the phone, via mail, or in-person) and ensures that no matter how a family chooses to apply for or renew coverage, they are screened for and enrolled in the appropriate program without having to take any additional steps. As part of creating a seamless enrollment system, the ACA makes significant changes in Medicaid rules for many beneficiaries, including eliminating the asset test and evaluating eligibility using an IRS-based definition of income (i.e., "Modified Adjusted Gross Income" or "MAGI"), which will also be used to determine eligibility for Exchange subsidies.

With passage of the ACA, Congress also adopted another MOE requirement aimed at ensuring Medicaid and CHIP coverage remain stable until implementation of the major coverage expansions. Under this MOE, as a condition of receiving federal Medicaid funding, states are required to maintain eligibility and enrollment policies in place as of March 23, 2010 (when the ACA was enacted) until January 1, 2014 for adults and until September 30, 2019 for children in both Medicaid and CHIP. There is one exception in the law that allows the handful of states that cover adults above 133 percent of the federal poverty level to reduce eligibility if they are facing a documented budget deficit.

In 2010, efforts also remained focused on covering uninsured children and taking advantage of the options and incentives provided through the passage of the Children's Health Insurance Program Reauthorization Act in 2009 (CHIPRA). The Administration launched the *Connecting Kids to Coverage Challenge*, a major initiative to engage stakeholders in efforts to enroll the five million uninsured children who are eligible but not covered by Medicaid and CHIP.[7] The effort has pulled together a broad coalition of partners, ranging from governors to national advocacy organizations. As part of the national outreach effort, HHS also initiated *Get in the Game, Get Covered*, a campaign that brings coaches, schools, families, and communities together in seven pilot states to get eligible children enrolled.[8]

III. About this Survey

This report presents the major findings of the Kaiser Commission on Medicaid and the Uninsured's tenth annual survey of eligibility rules, enrollment and renewal procedures, and cost sharing practices in Medicaid and CHIP. The findings address the policies implemented in states as of January 1, 2011 and the changes adopted by states throughout 2010. The survey was conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families through in-depth telephone interviews with state Medicaid and CHIP officials; the data were verified through follow-up communications via email and phone. (Prior surveys were conducted by the Kaiser Commission on Medicaid and the Uninsured with the Center on Budget and Policy Priorities.)

In light of the broad expansion in Medicaid through health reform, additional questions were added to this year's survey to include more information on policies for adults. Moreover, recognizing the important upgrades and improvements states will need to make to their eligibility and enrollment systems to prepare for reform, this year's survey also added questions designed to obtain more information about where state systems are today and progress being made as states begin to look forward to implementing reform. In addition, this year's survey continues to track state adoption of new options provided by CHIPRA. In some instances, the data are more extensive and specific for children, primarily because states have targeted their expansions and streamlining efforts to this population. For state-specific information, see the tables at the end of the report.

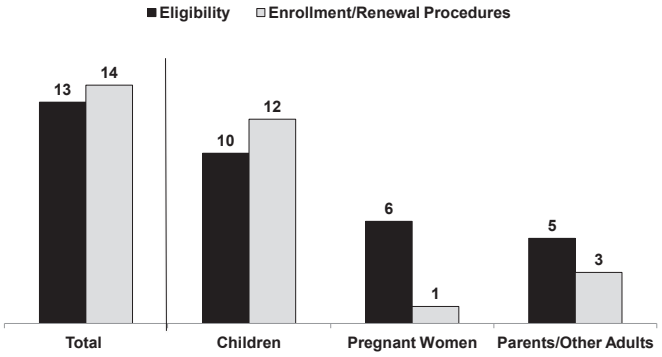
IV. Survey Findings

As the economic downturn continued to strain health coverage in 2010, Medicaid and CHIP maintained their central role of offering affordable coverage options to low- and moderate-income families. Nearly all states (49, including DC) held steady or made targeted improvements in their Medicaid and CHIP eligibility and enrollment rules in 2010. A total of 13 states moved forward with eligibility expansions and 14 states made improvements in enrollment and renewal procedures (Figure 5). Further, more than half of states (29 states) adopted new efficiencies in their application processes by using an electronic data match with the Social Security Administration (SSA) to verify the citizenship status of applicants.

This striking stability in Medicaid and CHIP eligibility and enrollment policies in 2010 can be directly attributed to the MOE requirements and the enhanced federal matching rate provided to states throughout 2010 and extended through June 2011 (see Maintenance of Effort box). Without these provisions, many states almost certainly would have needed to turn to cutbacks in coverage in 2010 as a result of continuing budget pressures. Over the past year, only 2 states made eligibility-related reductions and no state made adverse changes to enrollment and renewal procedures.

Figure 5

Number of States Improving Access to Health Care Coverage, January 2010 – January 2011



SOURCE: Based on the results of a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2011.

Changes in premium and cost sharing policies in 2010 occurred in both directions, with 4 states reducing or eliminating charges for enrollees and 8 states increasing or adding charges. Overall, the premium and cost sharing changes were modest.

Maintenance of Effort Requirements in the ARRA and ACA

ARRA provided states with a temporary increase in the federal share of Medicaid payments (i.e., the FMAP) from October 1, 2008 through December 31, 2010. In August 2010, Congress passed an extension of the enhanced FMAP through June 2011, although at a lower level. As a condition of receiving the enhanced federal funds, states may not adopt more restrictive Medicaid eligibility rules and enrollment procedures than were in effect on July 1, 2008.

Under the **ACA,** as a condition of receiving federal Medicaid funding, states must maintain eligibility and enrollment policies in place as of March 23, 2010 (when the ACA was enacted) until January 1, 2014 for adults and until September 30, 2019 for children in both Medicaid and CHIP. There is one exception in the law that would allow the handful of states that cover adults above 133 percent of the federal poverty level to reduce eligibility for these adults if they are facing a documented budget deficit.

A. Medicaid and CHIP Eligibility

Thirteen (13) (CA, CO, CT, DC, DE, KS, MN, MT, NE, NC, OR, TN, and WI) states went beyond maintaining coverage to implement targeted eligibility expansions in 2010. These expansions varied in size and scope, with a few states implementing broader expansions and improvements (see Spotlight box). Most of the expansions affected children, although, notably, three states moved ahead to cover low-income adults through Medicaid. Further, building on initial steps taken in 2009, states continued to adopt the CHIPRA option to cover immigrant children and pregnant women who have been lawfully residing in the U.S. for less than five years. Prior to CHIPRA, states were barred from using federal Medicaid or CHIP funds to cover lawfully-residing immigrant children and pregnant women during their first five years in the country.

Only 2 states implemented eligibility restrictions in 2010. Arizona capped enrollment in its CHIP program and New Jersey stopped enrolling parents covered through a CHIP waiver. These actions were not subject to the ARRA MOE and were implemented before the ACA MOE (which extended the protections to CHIP) became effective.

Spotlight on State Expansions and Simplifications in 2010

While many states focused their efforts on targeted changes, a few states took broader actions in 2010:

Colorado implemented a wide-ranging expansion, reaching many low- and moderate-income children and families. As part of the state's Healthcare Affordability Act of 2009, Colorado expanded eligibility for children (from 205 to 250 percent of the federal poverty level), pregnant women (from 200 to 250 percent of the federal poverty level), and parents (from 60 to 100 percent of the federal poverty level) in May 2010. In addition, to ease enrollment burdens placed on families, the state moved to paperless verification of income for children and parents. Next in line will be an expansion to adults without dependent children and adoption of 12-month continuous eligibility for children in Medicaid.

In joining the *Connecting Kids to Coverage Challenge,* Ohio fast-tracked simplification measures and earned a performance bonus. When accepting the Secretary's challenge to enroll all eligible children in coverage, in March 2010, the Governor announced that the state would implement presumptive eligibility, 12-month continuous eligibility, and Express Lane Eligibility. By April 1, presumptive eligibility and 12-month continuous eligibility were up and running. As a result of this quick work, as well as having increased enrollment in Medicaid, the state secured a performance bonus of more than $12 million in 2010.

Oklahoma used technology to streamline the application and renewal processes and help the state "go green" by significantly reducing paperwork. In September 2010, the state launched a new online enrollment system, allowing individuals to apply for coverage over the internet. Eligibility is determined in "real-time" and those found eligible are enrolled automatically and without delay (contingent on the receipt of any verification not available electronically). Enrollees can also use the system to review, update, and renew their coverage at any time, effectively creating a rolling renewal opportunity that allows enrollees to extend their coverage forward an additional 12 months whenever they update their information. The state has also created an easy-to-use web-based tool for hospitals to directly enroll infants born to mothers covered by Medicaid.

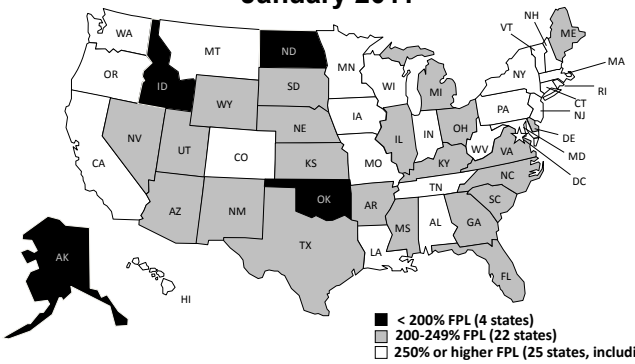
With a focus on children, Oregon made a number of advancements to expand coverage. In February 2010, the state expanded children's eligibility from 200 to 300 percent of the federal poverty level and gave families above 300 percent of the federal poverty level the ability to buy into the program at full cost. Oregon also created a new office dedicated to rolling out an aggressive outreach and marketing campaign and implemented some targeted simplification measures designed to reduce administrative barriers to enrollment, such as the SSA match and Express Lane Eligibility.

Eligibility for Children and Pregnant Women

For more than a decade, states have made significant advances in covering low- and moderate-income children through Medicaid and CHIP. As a result of these efforts, the number of uninsured children reached the lowest level on record in 2008 and 2009.[9] Due to continuing improvements in 2010, as of January 1, 2011, half of the states (25, including DC) provide affordable coverage options through Medicaid or CHIP to children in families with income at or above 250 percent of the federal poverty level ($45,775 for a family of three in 2010). (Illinois also provides state-funded coverage to children up to 300 percent of the federal poverty level.) Only 4 states (AK, ID, ND, and OK) now have eligibility levels of less than 200 percent of the federal poverty level (Figure 6). (Oklahoma has a premium assistance program for select children up to 200 percent of the federal poverty level.[10]) As states sought ways to build on previous success during 2010, even in the face of severe budget pressures, they often relied on the options and incentives established in CHIPRA, including the opportunity to receive performance bonuses for adopting specified simplifications and meeting enrollment targets (See CHIPRA box, next page).

Figure 6

Children's Eligibility for Medicaid/CHIP by Income, January 2011



Notes: The federal poverty line (FPL) for a family of three in 2010 is $18,310 per year. IL uses state funds to cover children up to 300% of the FPL; OK has a premium assistance program for select children up to 200% of the FPL. AZ's CHIP program is currently closed to new enrollment.
SOURCE: Based on the results of a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2011.

During 2010, 10 states expanded eligibility for children, although the expansions varied in size and scope.

- *Three (3) states (CO, KS, and OR) increased income eligibility in their Medicaid/CHIP programs.* Kansas expanded from 200 to 241 percent of the federal poverty level, Colorado from 205 to 250 percent of the federal poverty level, and Oregon from 200 to 300 percent of the federal poverty level. Oklahoma also expanded eligibility in its premium assistance program to certain children with incomes between 185 and 200 percent of the federal poverty level. Further, as of March 1, 2010, Tennessee reopened enrollment in its CHIP program, which had been closed since December 2009.
- *Six (6) states (DE, MN, MT, NE, NC, and WI) adopted the CHIPRA option to provide coverage of lawfully-residing immigrant children without imposing a five-year waiting period.* Following these additions, as of January 1, 2011, a total of 21 states, including DC, have taken up the option to cover these children. Fifteen (15) of these states previously provided this coverage with state-only dollars.
- *Oregon added a buy-in program in 2010, resulting in 15 states allowing families with incomes above Medicaid and CHIP thresholds to buy into coverage as of January 1, 2011.* Buy-in programs allow states to leverage the purchasing power of their Medicaid and CHIP programs to enable parents who otherwise cannot secure insurance for their children (for example, because of a child's pre-existing condition) to enroll their children at the full cost of coverage. While the ACA banned insurers in the small group and individual insurance market from denying coverage to children with pre-existing conditions as of September 23, 2010, insurers have responded in many states by ceasing to offer any new child-only plans. As a result, buy-in programs will be an even more important option for children with pre-existing conditions until the broader insurance reforms go into effect in 2014.

CHIPRA Helped Shape State Activity in 2010

A number of options and incentives established when CHIPRA was enacted in February 2009 helped shape state actions on eligibility and enrollment procedures in 2010.[11]

In 2010, 15 states were awarded a total of $206 million in performance bonuses, more than double the total award of $75 million in 2009. Ten (10) of the states (AL, AK, IL, KS, LA, MI, NJ, NM, OR, and WA) had previously received bonuses in 2009, and 5 states (CO, IA, MD, OH, and WI) were first-time recipients. CHIPRA encourages and rewards states for enrolling and retaining the lowest-income uninsured children who were already eligible for Medicaid through a performance bonus incentive. To earn a bonus, states must implement at least 5 of 8 simplification measures and meet specific enrollment targets. The bonus is designed to ease the fiscal impact on states of the increased enrollment in Medicaid and recognize successful enrollment and retention efforts.[12]

CHIPRA PERFORMANCE BONUS AWARDS

	2009	2010
Number of States Awarded Bonus	10	15
Median Individual State Award ($ in millions)	$3.9	$10.5
Total Amount Awarded ($ in millions)	$75.4	$206.2

By far, the most prevalent streamlining and efficiency measure implemented by states in 2010 was the electronic data match with the Social Security Administration (SSA) to verify citizenship. More than half of the states (29) adopted the option in Medicaid for children, 27 adopted it in Medicaid for parents, and 21 adopted it in CHIP. CHIPRA extended citizenship verification requirements to CHIP, but also gave states the new option to use an electronic data match with SSA to confirm the citizenship status of those applying for Medicaid and CHIP instead of relying on a paperwork-intensive process.[13]

In 2010, 6 states implemented Express Lane Eligibility (ELE). In an effort to avoid requiring families to provide the same information to multiple programs and to achieve administrative efficiencies, ELE allows states to use income and other eligibility findings from another assistance program as evidence of eligibility for Medicaid and CHIP. (Citizenship and immigration status must be separately verified.) Among the approved ELE initiatives, Alabama, Iowa, and Louisiana are partnering with SNAP (Supplemental Nutrition Assistance Program, formerly food stamps) while New Jersey and Maryland are using data from their state revenue agencies, and Oregon is working with the free and reduced-price school lunch program.

Building on activity from 2009, states continued to take up the new CHIPRA option to cover lawfully-residing immigrant children and pregnant women. Prior to CHIPRA, states were barred from using federal Medicaid or CHIP funds to cover lawfully-residing immigrant children and pregnant women during their first five years in the country. CHIPRA gave states the option to eliminate this "five-year bar." In 2010, 6 states (DE, MN, MT, NE, NC, and WI) adopted the option to eliminate the bar for children and 5 states (DE, MN, NE, NC, and WI) did so for pregnant women. In a number of instances, these populations were previously covered with state-only funds.

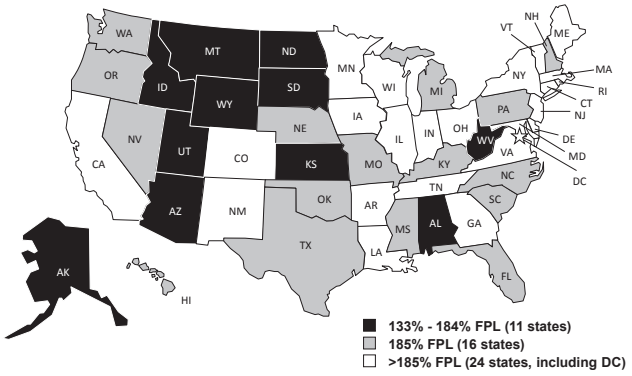
Reflecting the MOE requirements, enrollment remained open for children in nearly all states throughout 2010. As of January 1, 2011, 50 states, including DC, enroll uninsured children who meet the state's eligibility criteria for Medicaid and CHIP. The sole exception is Arizona, which has not enrolled any new children into its CHIP program since establishing an enrollment freeze in December 2009. Despite the strong MOE protections in the ACA, Arizona was allowed to retain its CHIP enrollment freeze throughout 2010 because it already was in effect and operational when the bill was signed into law on March 23, 2010.[14] (The MOE protection did, however, block the state from moving forward with plans to eliminate its CHIP program.) As noted, Tennessee had an enrollment freeze in place during the first few months of 2010, but began accepting new enrollees again on March 1, 2010, and has since kept enrollment open.

Most states have a waiting period for CHIP for at least some children, but it often is 3 months or less. Federal law requires states to adopt provisions to ensure that CHIP does not substitute for or "crowd-out" private insurance. To meet this requirement, states often require children to be uninsured for a period of time before they can enroll in separate CHIP programs.[15] As of January 1, 2011, 41 states have waiting periods for some of their children, with 20 of these states using waiting periods of 3 months or less. States frequently exclude the lowest income children from CHIP waiting periods and typically include "good cause" exemptions that allow a child to enroll in coverage right away (for example, for the death of a parent or loss of a job). In 2010, 2 states (SC and WV) shortened the amount of time during which children are required to be uninsured before enrolling in coverage. Two (2) other states (IA and KS) implemented waiting periods for new expansion groups.

Coverage for pregnant women remained largely stable in 2010, with some improvements. Overall, as of January 1, 2011, 40 states, including DC, cover pregnant women in families with income at or above 185 percent of the federal poverty level through Medicaid or CHIP ($33,874 for a family of three in 2010) (Figure 7). In addition, 14 states have adopted the option to cover unborn children using CHIP funds, which allows them to provide care to pregnant women. With regard to changes in 2010, Colorado expanded coverage for pregnant women from 200 to 250 percent of the federal poverty level. Moreover, 5 states (DE, MN, NE, NC, and WI) adopted the option to cover lawfully-residing immigrant pregnant women without a five-year waiting period, bringing the total number of states covering these pregnant women to 17 as of January 1, 2011. Nine (9) of these states previously provided this coverage with state-only funds.

Figure 7

Eligibility for Pregnant Women in Medicaid/CHIP by Income, January 2011



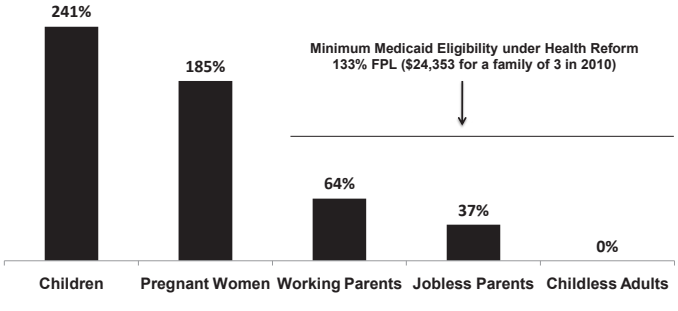
Notes: The federal poverty line (FPL) for a family of three in 2010 is $18,310 per year.
SOURCE: Based on the results of a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2011.

Eligibility for Parents and Other Adults

While states have made significant progress in expanding and improving coverage for children, coverage for parents and other adults lags far behind (Figure 8). This dynamic continued in 2010, as states made very few expansions in coverage for low-income parents and other adults. These modest improvements did not change the reality that most uninsured, low-income adults remain ineligible for Medicaid in most states.

Figure 8

Median Medicaid/CHIP Eligibility Threshold for Children, Pregnant Women, Parents, and Non-Disabled Adults, January 2011

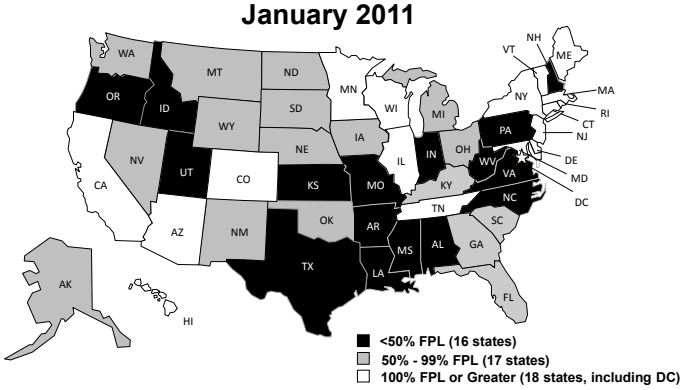


SOURCE: Based on the results of a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2011.

In most states, parent eligibility remains limited to below the federal poverty level. During 2010, Colorado increased Medicaid eligibility for parents from 60 to 100 percent of the federal poverty level. On the other hand, New Jersey closed new enrollment to certain parents eligible for its FamilyCare waiver program. As of January 1, 2011, 33 states still do not offer Medicaid coverage to parents up to 100 percent of the federal poverty level ($18,310 for a family of three in 2010) with 16 states limiting eligibility to below 50 percent of the federal poverty level (Figure 9). Separate from full Medicaid coverage, 15 states have a waiver or state-funded expansion program for parents that has fewer benefits, higher cost sharing, and/or enrollment caps. Further, an additional 6 states offer premium assistance to certain parents who meet employment-related eligibility requirements. Given the current limitations in Medicaid eligibility for parents, in the absence of further expansions over the next couple of years, most uninsured, low-income parents will remain unable to qualify for Medicaid until the broad expansion under health reform goes into effect in 2014.

Figure 9

Medicaid Eligibility for Working Parents by Income, January 2011



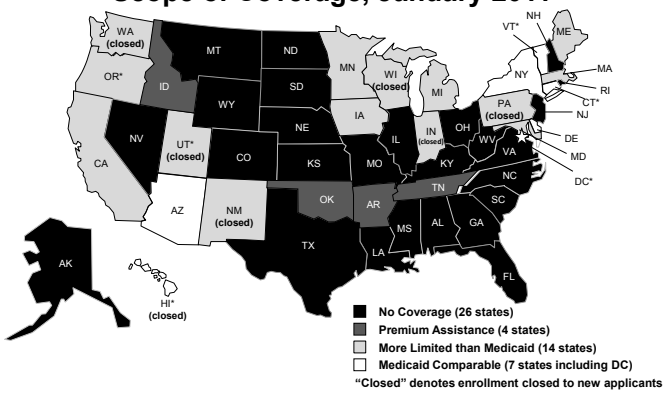
Notes: The federal poverty line (FPL) for a family of three in 2010 is $18,310 per year. Several states also offer coverage with a benefit package that is more limited than Medicaid at higher income levels.
SOURCE: Based on the results of a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2011.

Other non-disabled adults remain ineligible for Medicaid in the vast majority of states, regardless of their income level. As noted, until the passage of health reform, non-disabled adults without dependent children were excluded from Medicaid; under the previous federal rules, states could not receive federal matching funds to cover these adults unless they obtained a waiver. The Medicaid eligibility expansion to 133 percent of the federal poverty level under reform will, for the first time, allow states to cover these adults through Medicaid with the help of federal matching funds. While the expansion is not required to be in effect until January 1, 2014, reform also gave states the option to move early to cover adults. In 2010, Connecticut and DC took advantage of this option, and moved adults they have previously served through state- and locally-funded programs to Medicaid (see States Moving Early box, next page). Additionally, California received approval for a waiver to continue and expand county coverage initiatives serving low-income adults. Also in 2010, Oregon increased eligibility in its existing waiver premium assistance program from 185 to 201 percent of the federal poverty level.

Even with these advancements, as of January 1, 2011, only 7 states provide Medicaid or Medicaid-comparable coverage to childless adults (AZ, CT, DE, DC, HI, NY, VT) (Figure 10). Fourteen (14) states only provide these adults more limited coverage with fewer benefits, higher cost sharing, and/or enrollment caps. An additional 4 states solely cover childless adults through a premium assistance program that is limited to individuals who meet employment-related eligibility requirements.

Figure 10

Coverage of Childless Adults by Scope of Coverage, January 2011



* CT, DC, HI, & VT also offer coverage "more limited than Medicaid;" OR & UT also offer "premium assistance" with open enrollment.
SOURCE: Based on the preliminary results of a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2011.

Three States Moved Early to Extend Medicaid to Low-Income Adults in 2010

Under health reform Medicaid eligibility will expand to a national floor of 133 percent of the federal poverty level, providing coverage to millions of low-income adults who had previously been excluded from the program. The Medicaid expansion will go into effect as of January 1, 2014, and will be predominantly financed with federal funds through a higher federal matching rate for those made newly eligible for coverage under reform.[16] As of April 2010, states have the option to extend Medicaid coverage to low-income adults early, but they will receive their regular federal matching rate for the coverage until the higher rate becomes available in 2014.

In 2010, three states extended Medicaid coverage to low-income adults. In all of these cases, the states had previously provided coverage to adults through fully state- or locally-funded programs. By expanding Medicaid coverage, the states were able to bolster the coverage while at the same time achieving state savings by drawing down federal dollars.

- **Connecticut took up the new option under reform to extend Medicaid to adults with incomes up to 56 percent of the federal poverty level.** The state moved adults it had previously been covering through a state general assistance program to the new Medicaid adult option effective April 1, 2010.
- **The District of Columbia also took up the new Medicaid option, combined with a waiver, to cover adults with incomes up to 200 percent of the federal poverty level.** DC phased-in the expansion, first extending Medicaid to 133 percent of the federal poverty level as of July 1, 2010, and beginning to transfer adults from its locally-funded HealthCare Alliance program to Medicaid. Subsequently, the District obtained a waiver to extend coverage to 200 percent of the federal poverty level, and beginning December 1, 2010, transferred most of the remaining HealthCare Alliance enrollees to Medicaid.
- **California obtained a waiver that enabled it to continue and strengthen existing county adult coverage initiatives, as well as to potentially phase-in additional initiatives in more counties.** This coverage will be provided through two programs, the Medicaid Coverage Expansion for adults with family income at or below 133 percent of the federal poverty level and the Health Care Coverage Initiative for adults with family income between 134 to 200 percent of the federal poverty level.

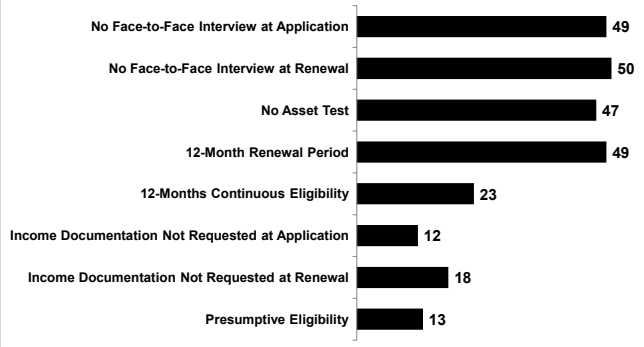
A few other states, including Minnesota, also have pending plans to take advantage of the new option to provide Medicaid coverage to adults. However, in the absence of significant expansions over the next few years, in most states, low-income adults will remain ineligible for Medicaid and without access to any affordable coverage options until the broad expansion goes into effect in 2014.

B. Enrollment and Renewal Policies and Procedures

States continued to adopt improvements in their enrollment and renewal procedures in 2010, reducing burdens on families and streamlining administrative processes. Experience over time in expanding coverage to children highlights that eligibility expansions alone are not enough to get individuals covered. To get and keep eligible individuals enrolled, it is important for coverage options to be promoted through outreach and accompanied by improvements and simplifications to the application, enrollment, and renewal processes. Building on these early lessons, in 2010, 14 states (AL, CO, CT, IA, LA, MD, MT, NE, NJ, NY, OH, OR, SC, and WV) continued to make gains in streamlining procedures, particularly for children. These encompassed a variety of different actions across states, such as moving to administrative verification of information rather than asking families to submit paper documentation, utilizing Express Lane Eligibility, adopting presumptive eligibility and continuous eligibility, as well as eliminating asset test and face-to-face interview requirements. Overall, states have made significant strides forward in simplification for children (Figure 11). However, the progress made for adults has been more limited (Figure 12). As states move forward on reform, it will be important to align these policies and procedures.

Figure 11

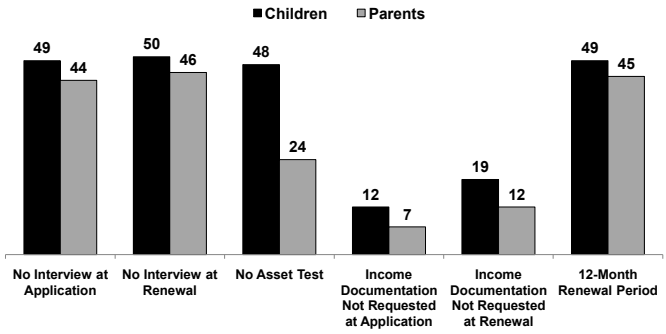
Simplified Enrollment and Renewal Procedures for Children in Medicaid and CHIP, January 2011



Notes: Totals reflect adoption in both Medicaid and CHIP, if the state has a separate CHIP program.
SOURCE: Based on the results of a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2011.

Figure 12

Coordination Between Child and Parent Simplification Measures in Medicaid, January 2011



SOURCE: Based on the results of a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2011.

States are beginning to use technology in innovative and cost-effective ways to improve application, enrollment, and renewal procedures (see Technology box, next page). In 2010, an increasing number of states began using electronic data matches to obtain or verify information at enrollment and/or renewal. Further, some states are beginning to utilize more robust online systems with application and account management capabilities. These types of streamlining measures increase administrative efficiency and accuracy, important benefits for states currently dealing with reduced staff and financial resources to manage their programs. They also help begin to build the base that will be necessary for states to successfully implement the integrated, web-based eligibility and enrollment systems they will need to provide under reform. However, states still have a significant amount of work to do to prepare for reform.

The Role of Technology in Medicaid and CHIP Eligibility Systems: Improvements and Challenges Ahead

States increasingly are using technology in helpful ways to streamline and simplify eligibility and enrollment in Medicaid and CHIP, with several states leading the way with significant innovations. However, there still are many opportunities for improvement and, looking forward, states have much work to prepare their systems for health reform.

Online application forms are evolving into true electronic applications. Going into 2011, more than half of states (32) offer an online application that can be submitted electronically, while 14 states offer online renewals. In a few states, such as Wisconsin and Oklahoma, more robust web-based systems that are reflective of what will be required under health reform have emerged. These systems allow individuals to assess their eligibility for benefits, apply for and renew coverage, update pertinent information, and pay premiums.

Increasingly, states are using data from state and private wage databases, state tax agencies, and federal agencies to verify aspects of eligibility rather than requiring families to submit paper documentation. As of January 1, 2011, for children applying for or renewing Medicaid, 12 states do not routinely ask families to submit paper documentation at application and 19 states do not do so at renewal. These states first seek to verify information through other data sources and only require a family to submit paper documentation if they are unable to administratively verify the information. Some states still have yet to implement administrative verification processes and a number of states continue to request paperwork from families at application and renewal despite having the capability to verify income administratively. Continued progress in adopting administrative verification procedures will be key as states look toward 2014, when enrollment and renewal processes are expected to become paperless under health reform.

While the momentum is growing to incorporate more technology into Medicaid and CHIP eligibility processes, it will be important for states to increase the pace of improvements to be ready for health reform in 2014. Given the current status of state eligibility systems and processes, many states will need to make large-scale upgrades and improvements to fulfill the promise of coverage and meet requirements under reform. In preparation for 2014, states have an opportunity to more fully align enrollment policies and renewal practices to streamline the rules on which enhanced eligibility and enrollment systems will be built. This will help lay the groundwork for and facilitate the creation of the seamless, integrated enrollment process across Medicaid, CHIP, and the Exchange that is required under reform. States also face opportunities and challenges of potentially integrating enrollment with other public assistance programs.

Federal funding for Exchange IT systems and Medicaid/CHIP eligibility systems will boost state efforts. In early 2011, HHS will award Innovator grants to up to 5 projects for the design and implementation of Exchange eligibility and enrollment systems. Additionally, a proposed rule to provide 90 percent federal funding for improvements or upgrades to Medicaid eligibility systems will help states invest in the enhanced functionality that will be required by health reform. Both funding opportunities emphasize the importance of states sharing technology as it is developed and adopted.

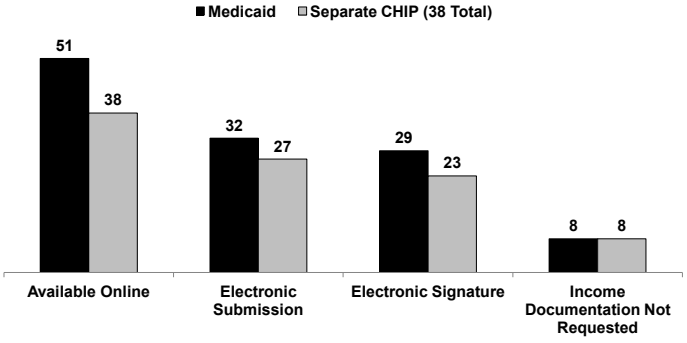
Application Procedures

Most states offer joint Medicaid and CHIP applications and simplified family-based applications. As of January 1, 2011, 36 of the 38 states with separate CHIP programs use a joint application form that allows them to simultaneously evaluate children for eligibility in Medicaid and the separate CHIP program, and 31 states use a joint Medicaid and CHIP renewal form. Further, 29 states, including DC, offer a simplified family application that enables parents to apply for coverage with their children without completing additional forms or steps. Under health reform, all states will need to offer a single application that can be used for Medicaid, CHIP, and Exchange coverage.

While all states make their application available online, fewer allow for the application and enrollment process to be completed electronically. About two-thirds of the states allow for the electronic submission of applications with most of these accepting electronic signatures rather than requiring families to mail or fax in a signed form (Figure 13). However, only 8 states do not ask families to submit paper documentation of income via mail or fax. Further, in 3 states (AK, MI, and WV) the electronic applications are only available for children's coverage.

Figure 13

Status of Online Applications for State Medicaid and CHIP Programs, January 2011

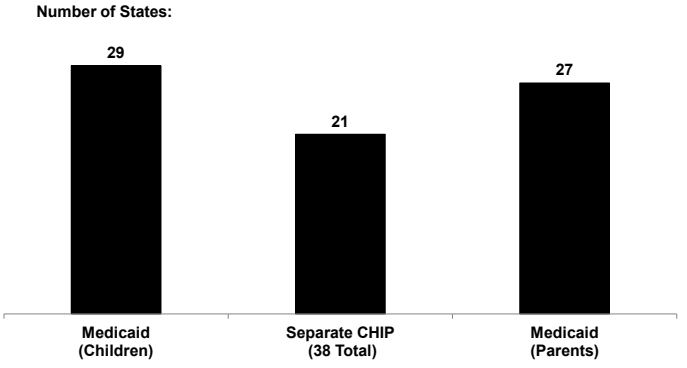


Notes: In some states the online application is only available for children applying for coverage. There are 38 separate CHIP programs.
SOURCE: Based on the results of a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2011.

In 2010, more than half of states adopted the new CHIPRA option to more efficiently and accurately verify citizenship status by relying on an electronic data match with the SSA. Twenty-nine (29) states, including DC, adopted this option for children in Medicaid, 21 adopted it in CHIP, and 27 adopted it for parents in Medicaid (Figure 14). Further, an additional 15 states reported that they plan to begin using the option in Medicaid and/or CHIP in 2011. Other analysis of state experience with the new option finds that it is highly effective in verifying citizenship in 94 percent of cases, while significantly easing the administrative workload of eligibility offices and eliminating unnecessary paperwork for families without sacrificing accuracy.[17]

Figure 14

Adoption of the Social Security Administration (SSA) Data Match to Verify Citizenship, January 2011



SOURCE: Based on the results of a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2011.

Over the years, a small but growing number of states have begun to electronically verify application data using state and private wage databases. In 2010, Colorado stopped asking families to submit

paperwork to verify income at both application and renewal. As a result, as of January 1, 2011, 12 states do not routinely request paper documentation of family income for children applying for Medicaid, 10 have adopted this policy for children in CHIP, and 7 do so for parents in Medicaid. These states instead first seek to verify the information through other available data sources. Even more states have adopted a paperless verification policy at renewal—19 for children in Medicaid, 14 for children in CHIP, and 12 for parents in Medicaid.

Six (6) states (AL, IA, LA, MD, NJ, and OR) took up the new CHIPRA option to implement Express Lane Eligibility (ELE) in 2010. Further, additional states expressed an interest in adopting ELE but are awaiting further guidance from CMS. ELE allows states to use a "finding" of income and other eligibility criteria for another public assistance program as evidence of eligibility for Medicaid or CHIP. To date, the 6 states are using data provided by SNAP (Supplemental Nutrition Assistance Program, formerly food stamps), free and reduced-price school lunch programs, and/or state revenue agencies to determine income and other components of eligibility for Medicaid and CHIP.

There is variation in who conducts eligibility determinations across states. In most states, Medicaid and CHIP eligibility determinations are conducted by a state worker. However, in 13 Medicaid programs and 7 CHIP programs determinations are made by county workers in a county-run office. Where determinations currently are made will have important implications for states as they consider how to design integrated enrollment processes and systems under reform.

In most states (44, including DC), the Medicaid eligibility system is the same system used for other assistance programs such as SNAP (formerly food stamps) and TANF. Connecting families applying for Medicaid and CHIP to other public programs is important to ensure that they receive all needed benefits, as well as to reduce duplication of effort by families and state agencies. However, application requirements differ across programs and, as such, combining application and enrollment processes across programs can impact the extent to which the process is simplified. As states look forward to reform, it will be important for them to consider the opportunities and challenges of connecting to other assistance programs while also creating an integrated system with Medicaid, CHIP, and Exchange coverage.

Enrollment Requirements and Procedures

With the addition of Iowa, Montana, and Ohio in 2010, as of January 1, 2011, 13 states use presumptive eligibility to enroll children in both Medicaid and CHIP and 3 additional states apply the policy to Medicaid only. Further, 31 states use presumptive eligibility to enroll pregnant women in coverage following Connecticut's adoption of the option in 2010. Presumptive eligibility empowers certain qualified entities, such as hospitals or community health centers, to make preliminary eligibility decisions so children and pregnant women can get care while they complete the regular Medicaid and CHIP application process. The ACA extended the option to use presumptive eligibility to enroll adults (previously the policy option was only available for children and pregnant women) and will authorize hospitals that are Medicaid providers to make presumptive eligibility determinations in 2014.

Nearly all states have eliminated the asset test for children in Medicaid and CHIP. As of January 1, 2011, only 3 Medicaid programs (SC, TX, and UT) and 2 separate CHIP programs (MO and TX) continue to examine a family's assets when determining children's eligibility for coverage. The number of states with no asset test for pregnant women remained steady at 44 states, including DC, in 2010. For parents, New York became the 24th state, including DC, to eliminate its asset test requirement. This lags well behind

the number of states that have eliminated the asset test for children, and shows that there is much progress to be made between now and 2014 when states must drop the asset test for most populations in Medicaid.

Similarly, nearly all states have eliminated the face-to-face interview requirement for children at application and renewal. With New York's elimination of the interview at enrollment and renewal for children and parents applying for Medicaid in 2010, as of January 1, 2011, only Mississippi and Tennessee continue to require face-to-face interviews for children at application, and only Mississippi requires one at renewal. In 2010, Nebraska also eliminated its interview requirement at enrollment and renewal for parents (the state already had eliminated the requirement for children). Following the changes in New York and Nebraska, only 7 states require a face-to-face interview when parents apply for or renew coverage.

Renewal Requirements and Procedures

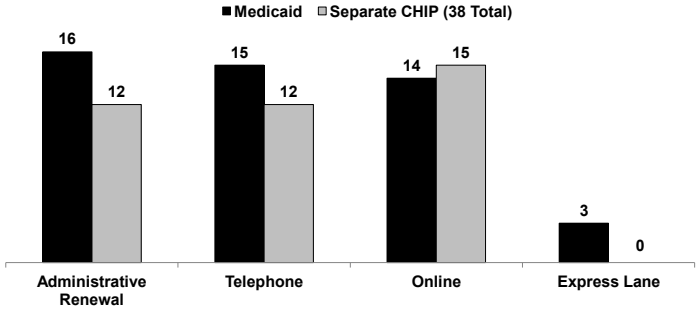
As of January 1, 2011, all but 2 states (GA and TX) have a 12-month renewal period for children, the maximum period allowed under federal law. During a 12-month renewal period, families are expected to report changes in their circumstances to the state, but they otherwise do not need to complete additional paperwork to continue coverage until the end of the renewal period. Forty-five (45) states, including DC, also provide parents with a 12-month renewal period. However, a few of these states require parents to submit a form periodically within the renewal period to confirm their income. While not as comprehensive as a full review of their ongoing eligibility, the requirement to submit forms in the midst of a 12-month renewal period increases the paperwork burden for parents.

Almost half of states go a step further than an annual renewal period by providing 12-month continuous eligibility for children. Through 12-month continuous eligibility a state can guarantee that a child's coverage will continue for 12 months even if his or her family circumstances change. With the addition of Ohio in 2010, a total of 23 states provide 12-month continuous eligibility in their Medicaid programs and 28 states provide it in their CHIP programs as of January 1, 2011. Providing this stability in health insurance coverage helps to ensure continuous preventive, primary, and condition-based care, which ultimately can improve health outcomes. It can also reduce administrative burdens by limiting the number of enrollments and reenrollments a state has to process. States currently do not have a readily available option to provide continuous eligibility to parents and other adults in Medicaid.[18]

States are increasingly offering more methods for families to renew coverage. In 2010, 3 states (AL, LA, and NJ) began using Express Lane Eligibility processes to renew coverage for children in Medicaid. For example, Louisiana is using enrollment in SNAP (formerly food stamps) to determine ongoing eligibility at renewal of children enrolled in Medicaid. Moreover, as of January 1, 2011, 16 states seek to administratively renew children's Medicaid coverage by relying on income information available from other sources rather than asking

Figure 15

Renewal Methods for Children in State Medicaid and CHIP Programs, January 2011



Notes: States that allow for administrative renewal seek to renew coverage by relying on income information available from other sources rather than asking families to resubmit information. In these states, families are generally sent a pre-populated form with the data the state has available and either take no action or sign and return the form to renew coverage.

SOURCE: Based on the results of a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2011.

families to resubmit information, and 12 allow for administrative renewals in CHIP. In these states, families are generally sent a pre-populated form with the data the state has available and either take no action or sign and return the form to renew coverage. Further, 15 Medicaid programs and 12 CHIP programs allow families to renew by phone, while 14 Medicaid programs and 15 CHIP programs offer online renewals (Figure 15).

C. Premium and Cost Sharing Requirements

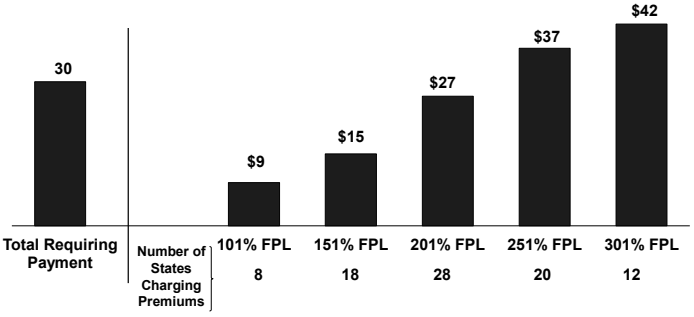
Overall changes in premiums and cost sharing were relatively limited in 2010. A total of 4 states (CT, DE, IA, and KY) made positive changes in premium and cost sharing policies either by reducing or eliminating charges or exempting additional enrollees from the charges. On the other hand, 8 states (AZ, CT, IN, MA, NC, NH, NJ, and PA) increased or added premium and cost sharing charges in their programs. Most of the changes in both directions were modest.

Premiums and Cost Sharing for Children

During 2010, only 3 states (CT, KY, and OR) made changes in their premium policies for children. Kentucky eliminated premiums in its CHIP program, while Connecticut moved in the opposite direction in 2010 by increasing CHIP premiums, the only state to do so. (The dearth of states increasing premiums may reflect that CMS could determine that such increases violate ACA's MOE requirements.[19]) Further, when Oregon implemented its expansion in CHIP coverage from 200 to 300 percent of the federal poverty level, it required premium payments for the new expansion group. In light of these changes, as of January 1, 2011, 30 states charge premiums and 4 states charge annual enrollment fees in their child health programs. However, few states require payments by families living at or very near the federal poverty line, with only 8 states requiring relatively limited premiums for children at 101 percent of the federal poverty level (Figure 16).

Figure 16

Median Monthly Premiums at Specified Income Levels Among States with Premiums in Children's Health Coverage Programs, January 2011



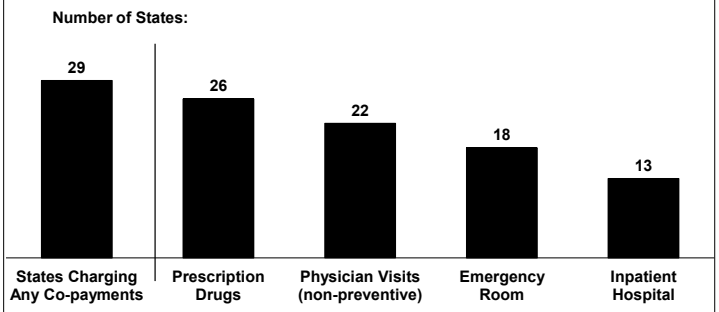
Notes: Premiums listed at 201%, 251%, and 301%, include states whose upper income levels are 200%, 250%, and 300% respectively. Does not include states that charge annual enrollment fees.
SOURCE: Based on the results of a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2011.

More than half of states charging premiums for children (17 of 30 states) give families more than the required 30-day grace period before they lose coverage for non-payment of premiums. CHIPRA requires states to provide a minimum 30-day grace period prior to cancelling a child's coverage under a separate CHIP program for missing a premium payment. Fifteen (15) states impose a "lock-out" period following disenrollment for non-payment of premiums, during which time the child is barred from re-enrolling in the program. Twenty-seven (27) states require families to reapply and 22 require re-payment of outstanding premiums before a child can re-enroll in coverage.

During 2010, 3 states (CT, NH, and NC) increased or added copayments to their child health programs. As of January 1, 2011, 26 states now require copayments for prescription drugs, 22 require copayments for non-preventive doctor visits, 18 require co-payments for emergency room care, and 13 require co-payments for inpatient hospital care in their children's health programs (Figure 17).

Figure 17

States with Co-payments for Selected Services for Children at 200% FPL, January 2011



Note: Based on the number of states charging co-payments for children in families with income at 200% of the federal poverty level.
SOURCE: Based on the results of a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2011.

Premiums and Cost Sharing for Adults

Four (4) states (CT, IA, NJ, and PA) made changes in premium policies for adults in 2010. In general, few states charge premiums to adults in Medicaid since eligibility for adults is often limited to low income levels and states are only allowed to charge premiums for adults in Medicaid beginning at 150 percent of the federal poverty level.[20] As of January 1, 2011, 3 states (IL, RI, and WI) charge premiums to parents enrolled in Medicaid with incomes above 150 percent of the federal poverty level. However, premiums and enrollment fees are commonly included in waiver or state-funded coverage for adults—21 of the 29 states that have waiver or state-funded coverage for parents and/or other adults charge premiums. During 2010, Iowa raised the income level at which premiums begin to be charged in its "IowaCare" waiver program from 100 to 150 percent of the federal poverty level, protecting more adults from charges.[21] On the other hand, Connecticut stopped subsidizing premium costs for new enrollees in its state-funded Charter Oak program and New Jersey and Pennsylvania increased premiums in their adult waiver and state-funded coverage programs in 2010.

Delaware eliminated a copayment for transportation services while 4 states (AZ, IN, MA, and PA) increased copayments in their adult coverage in 2010. Overall, 40 states require copayments for selected services from parents enrolled in Medicaid. Further, all but one of the 29 states that have expanded waiver or state-funded coverage for parents and/or other adults charge copayments for selected services.

V. Discussion

This tenth annual survey of eligibility rules and enrollment procedures shows striking stability in Medicaid and CHIP coverage in 2010. Nearly all states (49, including DC) held steady or made targeted improvements in their Medicaid and CHIP eligibility rules and enrollment procedures in 2010. By doing so, they maintained the important role of public programs in providing affordable coverage options to children and, to a lesser extent, their parents and other adults, many of whom lost jobs and their access to employer-based coverage in the ongoing downturn. This stability can be directly attributed to the MOE requirements and the enhanced federal Medicaid matching rate provided to states throughout 2010 and now extended through June of 2011. Without them, states almost certainly would have made more cutbacks in coverage in 2010 due to budget pressures.

Despite the difficult economic situation, states continued to make targeted expansions and improvements to not only increase coverage but also draw down additional federal funds and achieve program efficiencies. Thirteen (13) states continued efforts to expand eligibility, particularly for children. A number of these expansions focused on providing coverage to more uninsured individuals, but many also had the added benefit of producing some state savings by allowing the state to draw down federal matching funds for previously fully state-funded coverage. States also continued to simplify and improve enrollment and renewal procedures, benefiting families by reducing burdens and creating administrative efficiencies by eliminating unnecessary paperwork and increasing the use of technology.

Although states have achieved significant progress covering low-income children, there is still a large coverage gap for low-income adults. While almost all states now cover children above 200 percent of the federal poverty level, in most states, parent Medicaid eligibility levels remain well below poverty and most other non-disabled adults remain ineligible for Medicaid regardless of their income. Under reform, Medicaid will expand to a national eligibility floor of 133 percent of the federal poverty level, helping to fill the gap in coverage for adults and providing millions of currently uninsured adults an important new coverage option. However, until the expansion is implemented, many low-income adults will continue to lack access to any affordable coverage options.

Continued simplification of enrollment and renewal procedures and increased use of technology will be important for preparing for reform. With passage of the ACA, state efforts to simplify and streamline enrollment procedures take on added importance. Not only will the law expand coverage to millions of people, necessitating a large enrollment effort in many states, it also envisions an integrated, web-based, technology-driven enrollment process for Medicaid, CHIP, and Exchange coverage. State experience to date has established the importance of simple application, enrollment, and renewal procedures for getting and keeping eligible individuals enrolled. As such, to successfully enroll newly-eligible individuals under the expansion in a timely manner, it will be important for procedures to be as simple as possible. Further, increased use of technology will be key for enabling states to streamline processes and coordinate enrollment across coverage programs. Early state adopters of technology are showing that it can increase efficiency and cost-effectiveness while simplifying the application and renewal process for families, and improving the accuracy of eligibility decisions. Moreover, the popularity and success of the electronic data exchange with the SSA to verify citizenship illustrates the powerful impact that technology can have on the administration of Medicaid and CHIP.

Despite recent improvements, states have a substantial amount of work to do to prepare for reform. As significant as incremental efforts to increase eligibility and improve enrollment and renewal processes have been in Medicaid and CHIP, the changes now required to expand coverage and make enrollment systems work as envisioned under reform will be far more sweeping and transformative. Most states will need to make large-scale upgrades and improvements to their eligibility systems and processes to fulfill the promise of reform and they have limited time in which to do so. With the issuance of its proposed rule to provide a 90 percent federal matching rate for modernizing Medicaid eligibility systems and early Innovator grants in up to five states, the federal government has offered some important financial help and taken steps to foster the sharing of information and technology across states.

VI. Conclusion

As implementation of broader health reform moves forward, the findings of this survey describe the foundation for coverage of low-income families and individuals through Medicaid and CHIP. These programs will play an even more substantial role in the years to come, particularly with the expansion in coverage for low-income adults included in ACA. Valuable lessons can be learned from how states have streamlined and simplified their enrollment and renewal procedures in these programs, and while additional improvements are necessary to further transform Medicaid and CHIP in order to fulfill the promise of reform, they provide a sound platform on which to begin.

Looking ahead, states face the challenge of implementing reform while at the same time dealing with significant budget pressures due to the nation's continuing economic problems and the corresponding increased need for coverage. To continue progress forward on reform and keep the foundation solid, it will be important to focus on sustaining the coverage gains made to date even in the face of these challenges. Health reform has the potential to markedly reduce the number of uninsured and provides states new opportunities to modernize, streamline, and continue to improve Medicaid and CHIP. While some of the most significant changes in health reform do not go into effect until 2014, it is important for states to lay the groundwork now. In 2010, there were initial signs of state Medicaid agencies preparing for health reform implementation, but more activity can be expected in 2011.

Endnotes

[1] E. McNichol, P. Oliff, & N. Johnson, "States Continue to Feel Recession's Impact," Center on Budget and Policy Priorities (Updated December 16, 2010).
[2] J. Holahan, "The 2007-09 Recession And Health Insurance Coverage," *Health Affairs* (December 6, 2010).
[3] Kaiser Commission on Medicaid and the Uninsured, "Medicaid Enrollment: December 2009 Data Snapshot" (September 30, 2010).
[4] Originally available to states from December 2008 through December 2010, the temporary increase in the Medicaid matching rate was extended at a reduced level through June 30, 2011 by Public Law 111-226, signed by President Obama on August 10, 2010. Under the original ARRA provisions, states receive an extra 6.2 percentage points in the federal matching rate for their Medicaid programs, plus an additional increase based on the state's unemployment rate. Under the extension, the size of the enhancement declines to 3.2 percentage points in January 2011 and 1.2 percentage points in April, again with an additional increase based on the state's unemployment rate. The same maintenance-of-effort requirements that applied to states under ARRA were continued by the extension. Center for Medicaid, CHIP, and Survey & Certification, Centers for Medicare and Medicaid Services, "CMCS Informational Bulletin: FMAP Extension Guidance" (August 18, 2010).
[5] Letter from Cindy Mann, Director of Center for Medicaid and State Operations, Centers for Medicare and Medicaid Services, to State Medicaid Directors (SMD# 09-003) (June 17, 2009).
[6] V. Smith, *et al.*, "Hoping for Economic Recovery, Preparing for Health Reform: A Look at Medicaid Spending, Coverage, and Policy Trends," Kaiser Commission on Medicaid and the Uninsured (September 30, 2010).
[7] G. Kenny, *et al.,* "Who and Where Are the Children Yet to Enroll in Medicaid and the Children's Health Insurance Program?," *Health Affairs* (September 3, 2010).
[8] For more on these efforts, visit http://www.insurekidsnow.gov/professionals/campaigns/index.html.
[9] C. DeNavas-Walt, B. Proctor, & J. Smith, "Income, Poverty, and Health Insurance Coverage in the United States: 2009," U.S. Census Bureau (September 16, 2010).
[10] Children with family income between 185 and 200 percent of the federal poverty level can qualify for premium assistance, but only if their parents qualify for "Insure Oklahoma," a program that provides help buying coverage to individuals who work for small businesses (under 99 workers) offering a qualified health plan and direct coverage for others who are unemployed, self-employed or cannot access coverage through their employer.
[11] D. Horner, *et al.,* "The Children's Health Insurance Program Reauthorization Act of 2009," Georgetown Center for Children and Families (March 2009).
[12] For a detailed description of the performance bonus provision, see Georgetown University Center for Children and Families and the Kaiser Commission on Medicaid and the Uninsured, "CHIP Tips: Performance Bonus" and "CHIP Tips: Performance Bonus "5 of 8" Requirements " (June 4, 2009)
[13] For a detailed description of the citizenship documentation requirement and the SSA verification option, see Georgetown University Center for Children and Families and the Kaiser Commission on Medicaid and the Uninsured, "CHIP Tips: Citizenship Documentation Changes" (May 8, 2009).
[14] CMS has not yet issued guidance on the maintenance-of-effort requirements in the ACA. It seems clear that states will not be able to establish new CHIP enrollment caps or freezes not previously contemplated unless they run out of federal CHIP matching funds. It, however, is less certain how CMS will treat states that have approved language in their CHIP state plans authorizing such enrollment restrictions, but, on the date of enactment of the ACA did not actually have them in effect.
[15] In the absence of a waiver, states cannot make uninsured children wait for coverage in Medicaid, including in CHIP-financed Medicaid expansions.
[16] Most states will receive full-federal financing for 2014-2016 and then 90 percent federal financing by 2020; a limited number of specified expansion states will receive an enhanced match rate for coverage of certain childless adults that is phased-in to equal 90 percent in 2020. Overall, it is estimated that the federal government will pay for 95 percent of the new Medicaid coverage costs for adults.
[17] D. Cohen Ross, "New Citizenship Documentation Option for Medicaid and CHIP Is Up and Running," Center on Budget and Policy Priorities (April 20, 2010).
[18] While the statutory option to provide 12-month continuous eligibility in Medicaid applies only to children, it is possible that states could achieve a similar result for adults through a waiver from CMS or possibly through use of less restrictive income methodologies (e.g., a state could disregard changes in income that occur during the course of a 12-month renewal period).
[19] CMS has issued guidance indicating that it considers premium increases to be a violation of the Medicaid MOE included in ARRA, which remains in effect until June 2011. To date, CMS has not issued guidance on whether a state can increase its CHIP premiums without violating the CHIP MOE included in the Affordable Care Act.
[20] J. Guyer and J. Paradise, "Explaining Health Reform: Benefits and Cost-Sharing for Adult Medicaid Beneficiaries," Kaiser Family Foundation (August 2010).
[21] IowaCare is a limited health care program that covers adults ages 19-64 who would not normally be covered by Medicaid up to 200 percent of the federal poverty level.

VII. Trend and State-by-State Tables

Table A
Expanding Eligibility and Simplifying Enrollment:
Trends in Children's Health Coverage Programs
July 1997 to January 2011

	July 1997	Nov. 1998	July 2000	Jan. 2002	April 2003	July 2004	July 2005	July 2006	Jan. 2008	Jan. 2009	Dec. 2009	Jan. 2011
Number of children's health coverage programs	**51 MCD**	**51 MCD 19 CHIP**	**51 MCD 32 CHIP**	**51 MCD 35 CHIP**	**51 MCD 35 CHIP**	**51 MCD 36 CHIP**	**51 MCD 36 CHIP**	**51 MCD 36 CHIP**	**51 MCD 37 CHIP[4]**	**51 MCD 39 CHIP**	**51 MCD 39 CHIP**	**51 MCD 38 CHIP[5]**
Covered children at or above 200% FPL	6[1]	22	36	40	39	39	41	41	45	44	47	47
Lawfully-residing immigrant children covered without 5-year wait (ICHIA)	option not available	option not available	option not available	option not available	option not available	option not available	option not available	option not available	option not available	option not available	17	21
Joint Medicaid/ CHIP application	N/A	not collected	28	33	34	34	34	33	33	35	36	36
Application can be submitted online	not collected	not collected	not collected	not collected	not collected	not collected	not collected	not collected	not collected	not collected	not collected	32 (M) 27 (C)
Eliminated asset test	36	40 (M) 17 (C)	42 (M) 31 (C)	45 (M) 34 (C)	45 (M) 34 (C)	46 (M) 33 (C)	47 (M) 33 (C)	47 (M) 34 (C)	47 (M) 35 (C)	47 (M) 36 (C)	48 (M) 37 (C)	48 (M) 36 (C)
Adopted presumptive eligibility for children	option not available	6 (M)	8 (M) 4 (C)	9 (M) 5 (C)	7 (M) 4 (C)	8 (M) 6 (C)	9 (M) 6 (C)	9 (M) 6 (C)	14 (M) 9 (C)	14 (M) 9 (C)	14 (M) 9 (C)	16 (M) 10 (C)
Eliminated face-to-face interview at enrollment	22[2]	33[3] (M) not collected (C)	40 (M) 31 (C)	47 (M) 34 (C)	46 (M) 33 (C)	45 (M) 33 (C)	45 (M) 33 (C)	46 (M) 33 (C)	46 (M) 34 (C)	48 (M) 38 (C)	48 (M) 38 (C)	49 (M) 37 (C)
Income documentation not requested at enrollment[6]	not collected	not collected	10 (M) 7 (C)	13 (M) 11 (C)	12 (M) 11 (C)	10 (M) 10 (C)	9 (M) 9 (C)	9 (M) 9 (C)	10 (M) 8 (C)	11 (M) 10 (C)	12 (M) 10 (C)	12 (M) 10 (C)
Adopted SSA match for citizenship verification	option not available	option not available	option not available	option not available	option not available	option not available	option not available	option not available	option not available	option not available	option not available	29 (M) 21 (C)

	July 1997	Nov. 1998	July 2000	Jan. 2002	April 2003	July 2004	July 2005	July 2006	Jan. 2008	Jan. 2009	Dec. 2009	Jan. 2011
Eliminated face-to-face interview at renewal	not collected	not collected	43 (M) 32 (C)	48 (M) 34 (C)	49 (M) 35 (C)	48 (M) 35 (C)	48 (M) 35 (C)	48 (M) 35 (C)	48 (M) 36 (C)	49 (M) 38 (C)	50 (M) 38 (C)	50 (M) 37 (C)
Income documentation not requested at renewal[6]	not collected	not collected	not collected	not collected	not collected	not collected	not collected	9 (M) 10 (C)	11(M) 9 (C)	12 (M) 11 (C)	16 (M) 15 (C)	19 (M) 14 (C)
Adopted 12-month continuous eligibility for children	option not available	10 (M) not collected (C)	14 (M) 22 (C)	18 (M) 23 (C)	15 (M) 21 (C)	15 (M) 21 (C)	17 (M) 24 (C)	16 (M) 25 (C)	16 (M) 27 (C)	18 (M) 30 (C)	22 (M) 30 (C)	23 (M) 28 (C)
Implemented enrollment freeze	not collected	not collected	not collected	3 (C)	1 (M) 2 (C)	1 (M) 7 (C)	1 (M) 3 (C)	1 (M) 1 (C)	1 (M) 2 (C)	1(M) 0 (C)	1 (M) 2 (C)	1 (C)

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Center on Budget and Policy Priorities, 1997-2009; and with the Georgetown University Center for Children and Families, 2011.

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.
(M) indicates Medicaid; (C) indicates separate CHIP program.
1. In addition, two 2 states, Massachusetts and New York, financed children's health coverage to this income level using state funds only.
2. In 1997, 7 states still required telephone interviews; face-to-face interviews were left to county discretion in one state.
3. By November 1998, 33 states had eliminated the face-to-face interview for children applying for Medicaid. Six (6) states eliminated the face-to-face interview only for families using the joint Medicaid/CHIP application to apply for coverage. No data were collected specifically about separate CHIP programs.
4. In 2008, Tennessee and Missouri created separate CHIP-funded programs and Maryland replaced its separate CHIP program with a CHIP-funded Medicaid expansion.
5. In 2010, South Carolina replaced its separate CHIP program with a CHIP-funded Medicaid expansion.
6. In 2011, the definition was altered to determine whether states were requesting that families provide income documentation. States that verify income administratively, but continue to ask for income documentation on their applications are not counted as streamlining their procedures.

Table B
Expanding Eligibility and Simplifying Enrollment:
Trends in Health Coverage for Parents
January 2002 to January 2011

	Jan 2002	April 2003	July 2004	July 2005	July 2006	Jan 2008	Jan 2009	Dec 2009	Jan 2011
Total number of health coverage programs for parents	**51**	**51**	**51**	**51**	**51**	**51**	**51**	**51**	**51**
Covered working parents with income at or above 100%	20	16	17	17	16	18	18	17	18
Family application	23	25	27	27	27	28	31	27	29
Eliminated asset test	19	21	22	22	21	22	23	24	24
Eliminated face-to-face interview at enrollment	35	36	36	36	39	40	41	41	44
12-month eligibility period	38	38	36	36	39	40	40	43	45
Eliminated face-to-face interview at renewal	35	42	42	43	45	46	46	46	46
Implemented enrollment freeze[1]	not collected	1 (W) 2 (SF)	3 (W) 2 (SF)	2 (W) 2 (SF)	2 (W) 2 (SF)	2 (W) 2 (SF)	4 (W) 2 (SF)	3 (W) 2 (SF)	1 (W)

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

The numbers in the table reflect the net change in actions taken by states from year to year. Specific strategies may be adopted and retracted by several states during a given year.
1. "W" denotes a freeze in a waiver program; "SF" denotes a freeze in a state-funded program.

Table 1
Upper Income Eligibility Limit for Children's Coverage and Program Type
January 2011

State	Program Type[1]	Upper Income Limit[2] (Percent of the FPL)
Total Medicaid Expansion	**13**	
Total Separate CHIP	**17**	
Total Combination	**21**	
Alabama	S-CHIP	300
Alaska	M-CHIP	175
Arizona[3] ▼	S-CHIP	200 ***(closed)***
Arkansas[4]	M-CHIP	200
California[5]	COMBO	250
Colorado[6] ▲	S-CHIP	250
Connecticut[7]	S-CHIP	300
Delaware	COMBO	200
District of Columbia	M-CHIP	300
Florida[7]	COMBO	200
Georgia	S-CHIP	235
Hawaii	M-CHIP	300
Idaho	COMBO	185
Illinois[7, 8]	COMBO	200 (300)
Indiana	COMBO	250
Iowa	COMBO	300
Kansas[9] ▲	S-CHIP	241
Kentucky	COMBO	200
Louisiana	COMBO	250
Maine[7]	COMBO	200
Maryland	M-CHIP	300
Massachusetts[10]	COMBO	300
Michigan[11]	COMBO	200
Minnesota[4, 7, 12]	M-CHIP	275
Mississippi	S-CHIP	200
Missouri	COMBO	300
Montana	COMBO	250
Nebraska	M-CHIP	200
Nevada	S-CHIP	200
New Hampshire[7]	COMBO	300
New Jersey[7]	COMBO	350
New Mexico	M-CHIP	235
New York[7]	S-CHIP	400
North Carolina[7]	COMBO	200
North Dakota[5]	COMBO	160
Ohio[7]	M-CHIP	200
Oklahoma[4, 13]	M-CHIP	185
Oregon[7, 14] ▲	S-CHIP	300
Pennsylvania[7]	S-CHIP	300
Rhode Island[4]	M-CHIP	250
South Carolina[15]	M-CHIP	200
South Dakota	COMBO	200
Tennessee[7, 16] ▲	COMBO	250
Texas	S-CHIP	200
Utah	S-CHIP	200
Vermont	S-CHIP	300
Virginia	COMBO	200
Washington	S-CHIP	300
West Virginia	S-CHIP	250
Wisconsin[4, 7]	M-CHIP	300
Wyoming	S-CHIP	200

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2011.
▲ Indicates that a state has expanded eligibility in at least one of its children's health insurance programs between January 1, 2010 and January 1, 2011, unless noted otherwise.
▼Indicates that a state has reduced eligibility in at least one of its children's health insurance programs between January 1, 2010 and January 1, 2011, unless noted otherwise.
Table presents rules in effect as of January 1, 2011, unless noted otherwise.

Table 1 Notes

1. States can use their Title XXI (CHIP) funds to expand Medicaid (M-CHIP), cover children through a separate program (S-CHIP), or combine the two approaches (COMBO).

2. The income eligibility levels noted may refer to gross or net income depending on the state and reflect the highest income eligibility level in the state using Medicaid/CHIP funds.

3. Arizona instituted an enrollment freeze in its CHIP program, KidsCare, on December 21, 2009. The program is closed to new applicants.

4. Arkansas,, Minnesota, Oklahoma, Rhode Island, and Wisconsin have separate CHIP programs solely for their coverage of pregnant women using the unborn child option.

5. In California and North Dakota, Title XXI funding was used to eliminate the asset test.

6. Colorado increased eligibility from 205% to 250% of the FPL on May 1, 2010.

7. Connecticut, Florida, Illinois, Maine, Minnesota, New Hampshire, New Jersey, New York, North Carolina, Ohio, Oregon, Pennsylvania, Tennessee, and Wisconsin allow families with incomes above the levels shown buy into Medicaid/CHIP. For details, see Table 2.

8. Illinois provides state-financed coverage to children with incomes above CHIP levels. Eligibility is shown in parentheses.

9. Kansas increased eligibility from 200% to 250% of the 2008 FPL (approximately 241% of the 2009 FPL) on January 1, 2010.

10. In Massachusetts, children at any income are eligible for more limited state-subsidized coverage under the state's Children's Medical Security Plan; premiums are charged on a sliding scale based on income.

11. In Michigan, coverage for children ages 16 to 18, between 100% and 150% of the FPL is funded through Title XXI.

12. Minnesota covers infants in Medicaid with family income up to 280% of the FPL.

13. Oklahoma expanded Insure Oklahoma, a stand-alone premium assistance program, to children whose parents qualify for Insure Oklahoma with incomes between 186% and 200% of the FPL with Title XXI funding.

14. Oregon increased eligibility from 200% to 300% of the FPL on February 1, 2010. The state also implemented a new buy-in program.

15. South Carolina converted its separate CHIP program to a Medicaid expansion in October 2010.

16. In Tennessee, Title XXI funds are used for two programs, TennCare Standard and CoverKids (a separate CHIP program). TennCare Standard provides Medicaid coverage to uninsured children who lose eligibility under TennCare (Medicaid), have no access to insurance, and have family income below 200% of the FPL or are medically eligible. Tennessee reopened its separate CHIP program (CoverKids) to new applicants on March 1, 2010.

Table 1A
Income Eligibility Limits and Other Eligibility Features of Children's Health Coverage
January 2011

State	Medicaid for Infants Ages 0-1[1] (Percent of the FPL)		Medicaid for Children Ages 1-5[1] (Percent of the FPL)		Medicaid for Children Ages 6-19[1] (Percent of the FPL)		Separate CHIP Ages 0-19[2] (Percent of the FPL)	Lawfully-Residing Immigrants Covered without 5-Year Wait (ICHIA Option)[3]	Foster Children 18+[4]
	Medicaid (Title XIX) Funding	CHIP (Title XXI) Funding	Medicaid (Title XIX) Funding	CHIP (Title XXI) Funding	Medicaid (Title XIX) Funding	CHIP (Title XXI) Funding			
Total							**38**	**21**	**33**
Alabama	133		133		100		300		
Alaska	150	175	150	175	150	175			
Arizona[5] ▼	140		133		100		200 ***(closed)***		Y
Arkansas	133	200	133	200	100	200			
California[6, 7]	200		133		100		250	Y	Y
Colorado[8] ▲	133		133		100		250		Y
Connecticut[9]	185		185		185		300	Y	Y
Delaware[10] ▲	185	200	133		100		200	Y	
District of Columbia[11]	185	300	133	300	100	300		Y	
Florida[9, 12]	185	200	133		100		200		Y
Georgia[13]	200		133		100		235		Y
Hawaii	185	300	133	300	100	300		Y	
Idaho	133		133		100	133	185		
Illinois[9, 10, 11, 13, 14]	133	200	133		100	133	200 (300)		
Indiana	200		133	150	100	150	250		Y
Iowa	133	300	133		100	133	300	Y	Y
Kansas[15] ▲	150		133		100		241		Y
Kentucky	185		133	150	100	150	200		
Louisiana	133	200	133	200	100	200	250		Y
Maine[9, 13]	133	200	133	150	125	150	200	Y	
Maryland	185	300	133	300	100	300		Y	Y
Massachusetts[16]	185	200	133	150	114	150	300	Y	Y
Michigan[17]	185		150		150		200		Y
Minnesota[9, 10, 18] ▲	275	280	275		275			Y	
Mississippi	185		133		100		200		Y
Missouri	185		133	150	100	150	300		Y
Montana[10] ▲	133		133		100	133	250	Y	
Nebraska[10] ▲	150	200	133	200	100	200		Y	Y
Nevada	133		133		100		200		Y
New Hampshire[9]	185	300	185		185		300		
New Jersey[9, 13]	200		133		100	133	350	Y	Y
New Mexico	185	235	185	235	185	235		Y	Y
New York[9, 11]	200		133		100		400	Y	Y
North Carolina[9, 10, 19] ▲	185	200	133	200	100		200	Y	Y
North Dakota	133		133		100		160		
Ohio[9]	150	200	150	200	150	200			Y
Oklahoma[20]	133	185	133	185	100	185			Y
Oregon[9, 21] ▲	133		133		100		300	Y	Y
Pennsylvania[9, 10]	185		133		100		300		
Rhode Island[22]	185	250	133	250	100	250		Y	Y
South Carolina[23]	150	200	150	200	150	200			Y
South Dakota	133	140	133	140	100	140	200		Y
Tennessee[9, 24] ▲	185		133		100		250		
Texas[10]	185		133		100		200		Y
Utah	133		133		100		200		Y
Vermont[25]	225		225		225		300		
Virginia[19]	133		133		100	133	200	Y	
Washington[11]	200		200		200		300	Y	Y
West Virginia	150		133		100		250		Y
Wisconsin[9, 10] ▲	300		185	300	100	300		Y	Y
Wyoming	133		133		100		200		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, 2011.
▲ Indicates that a state has expanded eligibility in at least one of its children's health insurance programs between January 1, 2010 and January 1, 2011, unless noted otherwise.
▼Indicates that a state has reduced eligibility in at least one of its children's health insurance programs between January 1, 2010 and January 1, 2011, unless noted otherwise.
Table presents rules in effect as of January 1, 2011, unless noted otherwise.

Table 1A Notes

1. The income eligibility levels noted may refer to gross or net income depending on the state. Income eligibility levels listed are either for "regular" Medicaid (Title XIX) where states receive "regular" Medicaid matching payments or show eligibility levels for the state's CHIP-funded Medicaid expansion program (Title XXI) where the state receives the enhanced CHIP matching payments for these children. To be eligible in the infant category, a child has not yet reached his or her first birthday; to be eligible in the 1-5 category, the child is age one or older, but has not yet reached his or her sixth birthday; and to be eligible in the 6-19 category, the child is age six or older, but has not yet reached his or her 19th birthday.

2. The states noted use federal CHIP funds to operate separate child health insurance programs for children not eligible for Medicaid. Such programs may provide benefits similar to Medicaid or they may provide a limited benefit package. They also may impose premiums or other cost-sharing obligations on some or all families with eligible children. These programs typically provide coverage through the child's 19th birthday.

3. This column indicates whether the state received approval through a State Plan Amendment to adopt the option to cover immigrant children who have been lawfully residing in the U.S. for less than five years, otherwise known as the ICHIA option.

4. This column indicates whether the state has adopted the Medicaid option to cover children aging out of foster care, referred to as the Chafee option.

5. Arizona instituted an enrollment freeze in its CHIP program, KidsCare, on December 21, 2009. The program remains closed to new applicants.

6. Infants born to mothers in California's Access for Infants and Mothers (AIM) program are automatically enrolled in CHIP. The income guideline for these infants, through their second birthday, is 300% of the FPL.

7. In California, some undocumented immigrant children are covered through local programs.

8. Colorado increased eligibility from 205% to 250% of the FPL on May 1, 2010. The state has also passed legislation authorizing coverage of lawfully residing immigrant children, but has not provided funding for the expansion.

9. Connecticut, Florida, Illinois, Maine, Minnesota, New Hampshire, New Jersey, New York, North Carolina, Ohio, Oregon, Pennsylvania, Tennessee, and Wisconsin allow families with incomes above the levels shown buy into Medicaid/CHIP. For details, see Table 2.

10. Delaware, Minnesota, Montana, Nebraska, North Carolina, and Wisconsin received approval for state plan amendments to cover lawfully-residing immigrant children in 2010. Illinois, Pennsylvania, and Texas are waiting for CMS approval, but all three states currently cover these children with state-only funds.

11. DC, Illinois, New York, and Washington cover all children, regardless of immigration status.

12. 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. The Children's Medical Service Network serves children with special health care needs from birth through age 18.

13. Infants born to mothers enrolled in Medicaid in Georgia, Illinois, Maine, and New Jersey are covered up to 200% of the FPL in Medicaid. In Georgia, Maine, and New Jersey, infants born to non-Medicaid covered mothers are covered to 185% of the FPL, and 133% of the FPL in Illinois.

14. Illinois provides state-financed coverage to children with incomes above CHIP levels. Eligibility is shown in parentheses.

15. Kansas increased eligibility from 200% to 250% of the 2008 FPL (approximately 241% of the 2009 FPL) on January 1, 2010.

16. In Massachusetts, children at any income are eligible for more limited state-subsidized coverage under the state's Children's Medical Security Plan; premiums are charged on a sliding scale based on income.

17. In Michigan, coverage for children ages 16 to 18 between 100% and 150% of the FPL is funded through Title XXI.

18. In Minnesota, the infant category under "regular" Medicaid (Title XIX) includes children up to age 2, with income eligibility up to 275% of the FPL. Under CHIP, eligibility for infants is up to 280% of the FPL. Under "regular" Medicaid, income eligibility for children ages 2-19 is up to 150% of the FPL, and under the Section 1115 waiver, income eligibility for children in this age group is up to 275% of the FPL.

19. In North Carolina and Virginia, lawfully-residing immigrant children are covered only in Medicaid.

20. Oklahoma expanded Insure Oklahoma, a stand-alone premium assistance program, to children in families with incomes between 186% and 200% of the FPL.

Table 1A Notes (continued)

21. Oregon increased eligibility from 200% to 300% of the FPL on February 1, 2010.

22. Rhode Island covers children ages 1 to 7 with family incomes up to 133% of the FPL with Title XIX funding, and covers children ages 8 through their 19th birthday with incomes up to 100% of the FPL with Title XIX funding.

23. South Carolina converted its separate CHIP program to a Medicaid expansion in October 2010.

24. In Tennessee, Title XXI funds are used for two programs, TennCare Standard and CoverKids (a separate CHIP program). TennCare Standard provides Medicaid coverage to uninsured children who lose eligibility under TennCare (Medicaid), have no access to insurance, and have family income below 200% of the FPL or are medically eligible. Tennessee reopened its separate CHIP program (CoverKids) to new applicants on March 1, 2010.

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

Table 2
Key Features of Buy-In Programs for Children
January 2011

State	Buy-In Program for Children	Income Eligibility (Percent of the FPL)	Waiting Period[1] (in Months)	Monthly Premium (per Child)	Benefit Package Provided
Total	**15**				
Alabama					
Alaska					
Arizona					
Arkansas					
California					
Colorado					
Connecticut	Y	>300	2	$195	CHIP
Delaware					
District of Columbia					
Florida[2]	Y	>200	None	$133/$159	CHIP/Medicaid
Georgia					
Hawaii					
Idaho					
Illinois[3]	Y	>300	12	$70 - $300	CHIP
Indiana					
Iowa					
Kansas					
Kentucky					
Louisiana					
Maine[4]	Y	>200	None	$250	CHIP
Maryland					
Massachusetts[5]	Y	No limit	None	$0 - $64	More Limited
Michigan					
Minnesota[6] ▼	Y	>275	None	$480	Medicaid
Mississippi					
Missouri					
Montana					
Nebraska					
Nevada					
New Hampshire[7] ▲	Y	301-400	3	$205	CHIP
New Jersey	Y	>350	6	$144	CHIP
New Mexico					
New York[8]	Y	>400	None	$115 - $238	CHIP
North Carolina[9]	Y	201-225	None	$177	CHIP
North Dakota					
Ohio[3, 10] ▲	Y	>300	3	$290.58 - $581.15	Medicaid
Oklahoma					
Oregon[8, 11] ▲	Y	>300	2	$371/$230	More limited
Pennsylvania[8]	Y	>300	6	$190	CHIP
Rhode Island					
South Carolina					
South Dakota					
Tennessee	Y	>250	3	$239	CHIP
Texas					
Utah					
Vermont					
Virginia					
Washington					
West Virginia					
Wisconsin	Y	>300	3	$90	More limited
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, 2011.
▲ Indicates that a state has expanded eligibility in at least one of its children's health insurance programs between January 1, 2010 and January 1, 2011, unless noted otherwise.
▼Indicates that a state has reduced eligibility in at least one of its children's health insurance programs between January 1, 2010 and January 1, 2011, unless noted otherwise.
Table presents rules in effect as of January 1, 2011, unless noted otherwise.

Table 2 Notes

1. "Waiting period" refers to the length of time a child is required to be uninsured prior to enrolling in health coverage. Exceptions to the waiting period vary by state.

2. In Florida, families can buy-in to Healthy Kids coverage for children ages 5 to 19 and for MediKids coverage for children ages 1 to 4. The first amount listed is for Healthy Kids; the second is for MediKids.

3. In Illinois and Ohio, premiums in the buy-in program vary based on income.

4. In Maine, eligibility in the buy-in program is limited to those who had been previously enrolled in Medicaid or CHIP. A child can participate for up to 18 months.

5. Massachusetts has buy-in coverage limited to children with disabilities with no income limit. The state also offers more limited state subsidized coverage to children at any income through its Children's Medical Security Plan program; premiums vary based on income.

6. Minnesota is waiting for CMS approval to eliminate the requirement that the child must have been previously enrolled in Medicaid. In addition to other eligibility criteria, 10% of family income must be less than the cost of a premium under the state's high-risk pool coverage in order to qualify. Premiums increased in 2010.

7. New Hampshire expanded the benefit package from a more limited package to CHIP in 2010.

8. In New York, Oregon, and Pennsylvania, the monthly premium varies by health plan. The range of premiums is displayed for New York and the average amount is shown in Oregon and Pennsylvania. In Oregon, the first premium is for a child 0-24 months; the second is for a child 2-18.

9. In North Carolina, eligibility in the buy-in program is limited to those who had been previously enrolled in CHIP. A child can participate for up to 12 months.

10. In Ohio, the buy-in program is limited to families that are unable to obtain coverage due to a pre-existing condition, have lost coverage due to exhaustion of lifetime benefits, have coverage in which the premiums for available insurance coverage are more than twice those in the state's buy-in program, or have a child with medical disabilities. In 2010, the benefit package was changed from a more limited one to Medicaid.

11. Oregon implemented a full-cost buy-in program in February 2010.

Table 3

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

January 2011

State	Waiting Period (in Months)	Income-Related Groups Exempt from Waiting Period (Percent of the FPL)
Total with Waiting Period	**41**	
Alabama	3	
Alaska	None	
Arizona	3	
Arkansas[2]	6	Below 133% <6 years old Below 100% > 6 years old
California	3	
Colorado	3	
Connecticut	2	
Delaware	6	
District of Columbia	None	
Florida	2	
Georgia	6	
Hawaii	None	
Idaho	6	
Illinois	12	Below 200%
Indiana	3	
Iowa[3]	1	Below 200%
Kansas[3]	8	Below 200%
Kentucky	6	
Louisiana	12	Below 200%
Maine	3	
Maryland	6	
Massachusetts	6	Below 200%
Michigan	6	
Minnesota[2]	4	At or Below 150%
Mississippi	None	
Missouri	6	Below 150%
Montana	3	
Nebraska	None	
Nevada	6	
New Hampshire	6	
New Jersey	3	
New Mexico	6	Below 185%
New York	6	Below 250%
North Carolina	None	
North Dakota	6	
Ohio	None	
Oklahoma[4]	None	
Oregon	2	
Pennsylvania	6	Below 200%
Rhode Island	None	
South Carolina[5] ▲	None	
South Dakota	3	
Tennessee	3	
Texas	3	
Utah	3	
Vermont	1	
Virginia	4	
Washington	4	
West Virginia[6] ▲	3	
Wisconsin	3	Below 150%
Wyoming	1	

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2011.
▲ Indicates that a state has expanded eligibility in at least one of its children's health insurance programs between January 1, 2010 and January 1, 2011, unless noted otherwise.
▼Indicates that a state has reduced eligibility in at least one of its children's health insurance programs between January 1, 2010 and January 1, 2011, unless noted otherwise.
Table presents rules in effect as of January 1, 2011, unless noted otherwise.

Table 3 Notes

1. "Waiting period" refers to the length of time a child is required to be uninsured prior to enrolling in health coverage. They generally apply to separate CHIP programs only, unless otherwise noted, as waiting periods are not permitted in Medicaid without a waiver. Exceptions to the waiting period vary by state. In addition to the income exemptions shown, specific categories of children (for example, newborns or children with special health care needs) and those with job loss or "unaffordable" coverage may also be exempt from the waiting periods.

2. The waiting period only applies to those covered under the 1115 waiver in Arkansas and Minnesota.

3. Iowa and Kansas adopted waiting periods in their CHIP programs that apply to new expansion groups and, therefore, are not indicated as moving backward.

4. Oklahoma has a 6-month waiting period in its Insure Oklahoma premium assistance program.

5. South Carolina eliminated its waiting period when the state replaced its separate CHIP program with a CHIP-funded Medicaid expansion.

6. West Virginia decreased its waiting period from 12 months for those over 200% and 6 months for those under 200% to 3 months for all applicants.

Table 4
Adult Income Eligibility Limits at Application as a Percent of the FPL by Coverage Authority
(Limits for Working Adults are Calculated Based on a Family of Three for Parents and Based on an Individual for Other Adults)[1]
January 2011

State		Parents of Dependent Children						Other Adults (Non-Disabled)					
		Jobless			Working			Jobless			Working		
		1931 Eligibility	1115 Waiver	State-Funded	1931 Eligibility	1115 Waiver	State-Funded	ACA Option	1115 Waiver	State-Funded	ACA Option	1115 Waiver	State-Funded
Alabama		11%			24%								
Alaska		77%			81%								
Arizona		100%			106%				100%			110%	
Arkansas[2]		13%			17%	200%						200%	
California[3]	▲	100%	200%		106%	200%			200%			200%	
Colorado[4]	▲	100%			106%								
Connecticut[5, 6]	▲	185%		300%	191%		306%	56%		300%	73%		310%
Delaware		75%	100%		120%	106%			100%			110%	
District of Columbia[7]	▲	200%			207%			133%	200%	200%	144%	211%	211%
Florida		20%			59%								
Georgia		28%			50%								
Hawaii[8]		100%	200%		100%	200%			200%			200%	
Idaho[9]		21%			39%	185%						185%	
Illinois[10]		185%			191%		200%						
Indiana[11]		19%	200%		36%	200%			200% ***(closed)***			200% ***(closed)***	
Iowa[12]		28%	200%		83%	250%			200%			250%	
Kansas		26%			32%								
Kentucky		36%			62%								
Louisiana		11%			25%								
Maine[13]		200%		300%	200%		300%		100% ***(closed)***	300%		100% ***(closed)***	300%
Maryland[14]		116%			116%				116%			128%	
Massachusetts[15]		133%	300%		133%	300%			300%			300%	
Michigan[16]		37%			64%				35% ***(closed)***			45% ***(closed)***	
Minnesota[17]		100%	275%		121%	275%				250%			250%
Mississippi		24%			44%								
Missouri		19%			37%								
Montana		32%			56%								
Nebraska		47%			58%								
Nevada[18]		25%			88%	200%							
New Hampshire		39%			49%								
New Jersey[19]	▼	29%	200% ***(closed)***		133%	200% ***(closed)***							
New Mexico[20]		29%	200% ***(closed)***		67%	408% ***(closed)***			200% ***(closed)***			414% ***(closed)***	
New York[21]		69%	150%		75%	150%			100%			100%	
North Carolina		36%			49%								
North Dakota		34%			59%								
Ohio		90%			90%								
Oklahoma[22]		37%	200%		53%	200%			200%			200%	
Oregon[23]	▲	32%	201%		40%	201%			201%			201%	
Pennsylvania[24]		26%		200% ***(closed)***	46%		208% ***(closed)***			200% ***(closed)***			213% ***(closed)***
Rhode Island[25]		110%	175%		116%	181%							
South Carolina		50%			93%								
South Dakota		52%			52%								
Tennessee[26]		70%			127%		$55,000/yr ***(closed)***						$55,000/yr ***(closed)***
Texas		12%			26%								
Utah[27]		38%	150% ***(closed)***		44%	150%			150% ***(closed)***			150%	
Vermont[28]		77%	300%		83%	300%			300%			300%	
Virginia		25%			31%								
Washington[29]		37%		200% ***(closed)***	74%		200% ***(closed)***			200% ***(closed)***			200% ***(closed)***
West Virginia		17%			33%								
Wisconsin[30]		200%			200%				200% ***(closed)***			200% ***(closed)***	
Wyoming		39%			52%								

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, 2011.
▲ Indicates that a state has expanded eligibility in at least one of its children's health insurance programs between January 1, 2010 and January 1, 2011, unless noted otherwise.
▼Indicates that a state has reduced eligibility in at least one of its children's health insurance programs between January 1, 2010 and January 1, 2011, unless noted otherwise.
Table presents rules in effect as of January 1, 2011, unless noted otherwise.

Table 4 Notes

1. The table takes earning disregards, when applicable, into account when determining income thresholds for working adults. For parents, computations are based on a family of three with one earner; for other adults, computations are based on an individual. In some cases, earnings disregards may be time limited and only applied for the first few months of coverage; in these cases, eligibility limits for most enrollees would be lower than the levels that appear in this table. States may use additional disregards in determining eligibility. In some states, the income eligibility guidelines vary by region; in this situation, the income guideline in the most populous region is used. "Closed" indicates that the state was not enrolling new adults eligible for coverage into a program at any point between January 1, 2010 and January 1, 2011.

2. In Arkansas, adults up to 200% FPL are eligible for more limited subsidized coverage under the ARHealthNetworks waiver program; individuals must have income below the eligibility threshold and work for a qualifying, participating employer.

3. California received approval for a waiver in 2010 that allows the state continue and potential expand county-based initiatives serving low-income adults.

4. Colorado expanded coverage from 60% to 100% of the FPL to parents through a 1931 expansion on May 1, 2010.

5. Connecticut took up the new ACA option to cover adults in 2010 and transferred adults from a previously state-funded program to Medicaid.

6. As of June 1, 2010, Connecticut stopped subsidizing premiums for new enrollees in its state-funded Charter Oak program, which provides more limited coverage; it continues to subsidize cost sharing on a sliding scale based on income as well as premiums for existing (grandfathered) enrollees with incomes up to 300% FPL. Adults at any income can buy into the program at the full cost of $307 per month.

7. DC took up the new ACA option and obtained a waiver to cover adults up to 200% FPL in 2010, transferring adults from a previously locally-funded program to Medicaid. Adults up to 200% FPL who cannot qualify for Medicaid remain eligible for more limited coverage under the fully district-funded DC Health Care Alliance program.

8. Hawaii covers adults up to 100% FPL under its QUEST Medicaid managed care waiver program; enrollment in QUEST is closed except for certain groups including individuals receiving Section 1931 Medicaid coverage or General Assistance or those below the old AFDC standards. Adults up to 200% FPL are eligible for more limited coverage under the QUEST-ACE waiver program. Further, adults previously enrolled in Medicaid with incomes between 200-300% FPL can purchase more limited QUEST-NET waiver coverage by paying a monthly premium.

9. Idaho provides premium assistance to adults up to 185% FPL under a waiver; individuals must have income below the eligibility threshold and work for a qualified small employer.

10. Illinois also provides premium assistance for parents and children between 133% and 200% FPL through its Family Care Rebate program.

11. In Indiana, adults up to 200% FPL are eligible for limited coverage that resembles a Health Savings Account under the Healthy Indiana waiver program. Enrollment is closed for childless adults.

12. In Iowa, adults up to 250% FPL are eligible for more limited coverage under the IowaCare waiver program.

13. In Maine, childless adults up to 100% FPL are eligible for more limited coverage under the MaineCare waiver program; enrollment is closed. Adults up to 300% FPL are eligible for more limited subsidized coverage under the fully state-funded Dirigo Health program.

14. In Maryland, childless adults are eligible for primary care services under the Primary Adult Care waiver program.

15. In Massachusetts, childless adults who are long-term unemployed or a client of the Department of Mental Health with income below 100% FPL can receive more limited benefits under the MassHealth waiver program through MassHealth Basic or Essential. Additionally, adults up to 300% FPL are eligible for more limited subsidized coverage under the Commonwealth Care waiver program.

16. In Michigan, childless adults are eligible for more limited coverage under the Adult Benefit Waiver program; enrollment is closed.

17. In Minnesota, parents up to 275% FPL are eligible for coverage under the MinnesotaCare waiver program and childless adults up to 250% FPL are eligible under the fully state-funded portion of MinnesotaCare. Parents above 215% FPL and childless adults receive more limited coverage.

18. Nevada provides premium assistance to parents up to 200% FPL under its Check Up Plus waiver program; parents must have income below the eligibility threshold and work for a qualified small business.

Table 4 Notes (continued)

19. In New Jersey, parents up to 200% FPL are covered under the FamilyCare waiver program. Waiver enrollment closed in 2010 for parents who do not qualify for Medicaid using an enhanced income disregard.

20. In New Mexico, adults up to 200% FPL are eligible for more limited subsidized coverage under the State Coverage Insurance waiver program. Individuals must have income below the eligibility threshold and work for a participating employer; if they do not work for a participating employer, they can obtain coverage by paying both the employer and employee share of premium costs. Enrollment is closed.

21. In New York, childless adults up to 78% FPL are eligible for the Medicaid (Home Relief) waiver program and parents up to 150% FPL and childless adults up to 100% FPL are eligible for the Family Health Plus waiver program.

22. In Oklahoma, adults up to 200% FPL are eligible for more limited subsidized coverage under the Insure Oklahoma waiver program. Individuals must have income below eligibility threshold and also work for a small employer, be self-employed, be unemployed and seeking work, be working disabled, be a full-time college student, or be the spouse of a qualified worker.

23. In Oregon, adults up to 100% FPL are eligible for more limited coverage under the OHP Standard waiver program; enrollment in OHP Standard is closed. The state provides premium assistance to adults up to 201% FPL under its Family Health Insurance Assistance Program waiver program. Income eligibility increased from 185% to 201% effective January 1, 2010. FHIAP is open to open for both individual and employer sponsored insurance, however, the state is only enrolling individuals from the reservation list.

24. In Pennsylvania, adults up to 200% FPL are eligible for more limited coverage under the fully state-funded adultBasic program; enrollment in the program is closed.

25. In Rhode Island, parents up to 175% FPL are covered under the RIteCare and RIteShare waiver programs.

26. In Tennessee, adults earning up to $55,000 per year are eligible for more limited subsidized coverage under the CoverTN program. Individuals must have income below the eligibility threshold and be a worker of a qualified business, self-employed, or recently unemployed. To qualify as a business, at least 50% of employees must earn $55,000 or less per year. Once a business qualifies all eligible employees, regardless of income may enroll. Enrollment is closed.

27. In Utah, adults up to 150% FPL are eligible for coverage of primary care services under the Primary Care Network waiver program; enrollment is closed. The state also provides premium assistance for employer-sponsored coverage to working adults up to 150% FPL under the Utah Premium Partnership Health Insurance waiver program.

28. In Vermont, 1931 coverage is available up to 77% FPL in urban areas and 73% FPL in rural areas; parents up to 185% FPL and childless adults up to 150% FPL are eligible for the Vermont Health Access Plan waiver program. Additionally, the state offers more limited subsidized coverage to adults up to 300% FPL under its Catamount Health waiver program.

29. In Washington, adults up to 200% FPL are eligible for more limited coverage under the fully state-funded Basic Health program; enrollment is closed.

30. In Wisconsin, parents up to 200% FPL are eligible for the BadgerCare Plus waiver program. Childless adults up to 200% FPL are eligible for more limited coverage under the BadgerCare Plus Core Plan waiver program. Enrollment for childless adults is closed.

Table 5
Income Eligibility Limits for Working Adults at Application as a Percent of the FPL by Scope of Benefit Package
(Limits are Calculated Based on a Family of Three for Parents and Based on an Individual for Other Adults)[1]
January 2011

State	Medicaid or Medicaid-Equivalent Benefit Package		Benefit Package More Limited Than Medicaid		Premium Assistance With Work-Related Eligibility Requirements	
	Parents	Other Adults	Parents	Other Adults	Parents	Other Adults
Alabama	24%					
Alaska	81%					
Arizona	106%	110%				
Arkansas[2]	17%				200%	200%
California[3] ▲	106%		200%	200%		
Colorado[4] ▲	106%					
Connecticut[5, 6] ▲	191%	56%	306%	310%		
Delaware	120%	110%				
District of Columbia[7] ▲	207%	211%		211%		
Florida	59%					
Georgia	50%					
Hawaii[8]	100%	100% ***(closed)***	200%	200%		
Idaho[9]	39%				185%	185%
Illinois[10]	191%				200%	
Indiana[11]	36%		200%	200% ***(closed)***		
Iowa[12]	83%		250%	250%		
Kansas	32%					
Kentucky	62%					
Louisiana	25%					
Maine[13]	200%		300%	300%		
Maryland[14]	116%			128%		
Massachusetts[15]	133%		300%	300%		
Michigan[16]	64%			45% ***(closed)***		
Minnesota[17]	215%		275%	250%		
Mississippi	44%					
Missouri	25%					
Montana	56%					
Nebraska	58%					
Nevada[18]	88%				200%	
New Hampshire	49%					
New Jersey[19] ▼	200% ***(closed > 133%)***					
New Mexico[20]	67%		408% ***(closed)***	414% ***(closed)***	408% ***(closed)***	414% ***(closed)***
New York[21]	150%	100%				
North Carolina	49%					
North Dakota	59%					
Ohio	90%					
Oklahoma[22]	53%				200%	200%
Oregon[23] ▲	40%		201%	201%	201%	201%
Pennsylvania[24]	46%		208% ***(closed)***	213% ***(closed)***		
Rhode Island[25]	181%					
South Carolina	93%					
South Dakota	52%					
Tennessee[26]	127%				$55,000/yr ***(closed)***	$55,000/yr ***(closed)***
Texas	26%					
Utah[27]	44%		150% ***(closed)***	150% ***(closed)***	150%	150%
Vermont[28]	191%	160%	300%	300%		
Virginia	31%					
Washington[29]	74%		200% ***(closed)***	200%***(closed)***		
West Virginia	33%					
Wisconsin[30]	200%			200%***(closed)***		
Wyoming	52%					

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, 2011.
▲ Indicates that a state has expanded eligibility in at least one of its children's health insurance programs between January 1, 2010 and January 1, 2011, unless noted otherwise.
▼Indicates that a state has reduced eligibility in at least one of its children's health insurance programs between January 1, 2010 and January 1, 2011, unless noted otherwise.
Table presents rules in effect as of January 1, 2011, unless noted otherwise.

Table 5 Notes

1. The table takes earning disregards, when applicable, into account when determining income thresholds for working adults. For parents, computations are based on a family of three with one earner; for other adults, computations are based on an individual. In some cases, earnings disregards may be time limited and only applied for the first few months of coverage; in these cases, eligibility limits for most enrollees would be lower than the levels that appear in this table. States may use additional disregards in determining eligibility. In some states, the income eligibility guidelines vary by region; in this situation, the income guideline in the most populous region is used. "Closed" indicates that the state was not enrolling new adults eligible for coverage into a program at any point between January 1, 2010 and January 1, 2011.

2. In Arkansas, adults up to 200% FPL are eligible for more limited subsidized coverage under the ARHealthNetworks waiver program; individuals must have income below the eligibility threshold and work for a qualifying, participating employer.

3. California received approval for a waiver in 2010 that allows the state continue and potentially expand county-based initiatives serving low-income adults.

4. Colorado expanded coverage from 60% to 100% of the FPL to parents through a 1931 expansion on May 1, 2010.

5. Connecticut took up the new ACA option to cover adults in 2010 and transferred adults from a previously state-funded program to Medicaid.

6. As of June 1, 2010, Connecticut stopped subsidizing premiums for new enrollees in its state-funded Charter Oak program, which provides more limited coverage; it continues to subsidize cost sharing on a sliding scale based on income as well as premiums for existing (grandfathered) enrollees with incomes up to 300% FPL. Adults at any income can buy into the program at the full cost of $307 per month.

7. DC took up the new ACA option and obtained a waiver to cover adults up to 200% FPL in 2010, and transferring adults from a previously locally-funded program to Medicaid. Adults up to 200% FPL who cannot qualify for Medicaid remain eligible for more limited coverage under the fully district-funded DC Health Care Alliance program.

8. Hawaii covers adults up to 100% FPL under its QUEST Medicaid managed care waiver program; enrollment in QUEST is closed except for certain groups including individuals receiving Section 1931 Medicaid coverage or General Assistance or those below the old AFDC standards. Adults up to 200% FPL are eligible for more limited coverage under the QUEST-ACE waiver program. Further, adults previously enrolled in Medicaid with incomes between 200-300% FPL can purchase more limited QUEST-NET waiver coverage by paying a monthly premium.

9. Idaho provides premium assistance to adults up to 185% FPL under a waiver; individuals must have income below the eligibility threshold and work for a qualified small employer.

10. Illinois also provides premium assistance for parents and children between 133% and 200% FPL through its Family Care Rebate program.

11. In Indiana, adults up to 200% FPL are eligible for limited coverage that resembles a Health Savings Account under the Healthy Indiana waiver program. Enrollment is closed for childless adults.

12. In Iowa, adults up to 250% FPL are eligible for more limited coverage under the IowaCare waiver program.

13. In Maine, childless adults up to 100% FPL are eligible for more limited coverage under the MaineCare waiver program; enrollment is closed. Adults up to 300% FPL are eligible for more limited subsidized coverage under the fully state-funded Dirigo Health program.

14. In Maryland, childless adults are eligible for primary care services under the Primary Adult Care waiver program.

15. In Massachusetts, childless adults who are long-term unemployed or a client of the Department of Mental Health with income below 100% FPL can receive more limited benefits under the MassHealth waiver program through MassHealth Basic or Essential. Additionally, adults up to 300% FPL are eligible for more limited subsidized coverage under the Commonwealth Care waiver program.

16. In Michigan, childless adults are eligible for more limited coverage under the Adult Benefit Waiver program; enrollment is closed.

17. In Minnesota, parents up to 275% FPL are eligible for coverage under the MinnesotaCare waiver program and childless adults up to 250% FPL are eligible under the fully state-funded portion of MinnesotaCare. Parents above 215% FPL and childless adults receive more limited coverage.

18. Nevada provides premium assistance to parents up to 200% FPL under its Check Up Plus waiver program; parents must have income below the eligibility threshold and work for a qualified small business.

Table 5 Notes (continued)

19. In New Jersey, parents up to 200% FPL are covered under the FamilyCare waiver program. Waiver enrollment closed in 2010 for parents who do not qualify for Medicaid using an enhanced income disregard.

20. In New Mexico, adults up to 200% FPL are eligible for more limited subsidized coverage under the State Coverage Insurance waiver program. Individuals must have income below the eligibility threshold and work for a participating employer; if they do not work for a participating employer, they can obtain coverage by paying both the employer and employee share of premium costs. Enrollment is closed.

21. In New York, childless adults up to 78% FPL are eligible for the Medicaid (Home Relief) waiver program and parents up to 150% FPL and childless adults up to 100% FPL are eligible for the Family Health Plus waiver program.

22. In Oklahoma, adults up to 200% FPL are eligible for more limited subsidized coverage under the Insure Oklahoma waiver program. Individuals must have income below eligibility threshold and also work for a small employer, be self-employed, be unemployed and seeking work, be working disabled, be a full-time college student, or be the spouse of a qualified worker.

23. In Oregon, adults up to 100% FPL are eligible for more limited coverage under the OHP Standard waiver program; enrollment in OHP Standard is closed. The state provides premium assistance to adults up to 201% FPL under its Family Health Insurance Assistance Program waiver program. Income eligibility increased from 185% to 201% effective January 1, 2010. FHIAP is open to open for both individual and employer sponsored insurance, however, the state is only enrolling individuals from the reservation list.

24. In Pennsylvania, adults up to 200% FPL are eligible for more limited coverage under the fully state-funded adultBasic program; enrollment in the program is closed.

25. In Rhode Island, parents up to 175% FPL are covered under the RIteCare and RIteShare waiver programs.

26. In Tennessee, adults earning up to $55,000 per year are eligible for more limited subsidized coverage under the CoverTN program. Individuals must have income below the eligibility threshold and be a worker of a qualified business, self-employed, or recently unemployed. To qualify as a business, at least 50% of employees must earn $55,000 or less per year. Once a business qualifies all eligible employees, regardless of income may enroll. Enrollment is closed.

27. In Utah, adults up to 150% FPL are eligible for coverage of primary care services under the Primary Care Network waiver program; enrollment is closed. The state also provides premium assistance for employer-sponsored coverage to working adults up to 150% FPL under the Utah Premium Partnership Health Insurance waiver program.

28. In Vermont, 1931 coverage is available up to 77% FPL in Urban areas and 73% FPL in rural areas; parents up to 185% FPL and childless adults up to 150% FPL are eligible for the Vermont Health Access Plan waiver program. Additionally, the state offers more limited subsidized coverage to adults up to 300% FPL under its Catamount Health waiver program.

29. In Washington, adults up to 200% FPL are eligible for more limited coverage under the fully state-funded Basic Health program; enrollment is closed.

30. In Wisconsin, parents up to 200% FPL are eligible for the BadgerCare Plus waiver program. Childless adults up to 200% FPL are eligible for more limited coverage under the BadgerCare Plus Core Plan waiver program. Enrollment for childless adults is closed.

Table 6
Income Eligibility Limits and Other Features of Health Coverage for Pregnant Women
January 2011

State	Income Eligibility (Percent of the FPL)			Lawfully-Residing Immigrants Covered without 5-Year Wait (ICHIA Option)[2]	Asset Test Not Required[3] (Or Asset Test Limit)	Presumptive Eligibility
	Medicaid (Title XIX)	CHIP (Title XXI)	Unborn Child Option[1] (Title XXI)			
Total		**6**	**14**	**17**	**44**	**31**
Alabama	133				Y	
Alaska	175				Y	
Arizona	150				Y	
Arkansas	162	200	200		$3,100	Y
California[4]	200		300	Y	Y	Y
Colorado[5] ▲	133	250		Y	Y	Y
Connecticut[6] ▲	250			Y	Y	Y
Delaware[7] ▲	200			Y	Y	Y
District of Columbia[8]	300			Y	Y	Y
Florida	185				Y	Y
Georgia	200				Y	Y
Hawaii[9]	185			Y	Y	
Idaho	133				$5,000	Y
Illinois[7, 8]	200		200		Y	Y
Indiana	200				Y	Y
Iowa	300				$10,000	Y
Kansas	150				Y	
Kentucky	185				Y	Y
Louisiana[10]	200		200		Y	
Maine	200			Y	Y	Y
Maryland[10]	250			Y	Y	
Massachusetts	200		200	Y	Y	Y
Michigan	185		185		Y	Y
Minnesota[7] ▲	275		275	Y	Y	
Mississippi	185				Y	
Missouri	185				Y	Y
Montana	150				$3,000	Y
Nebraska[7] ▲	185			Y	Y	Y
Nevada[11]	133	185			Y	
New Hampshire	185				Y	Y
New Jersey[8]	185	200		Y	Y	Y
New Mexico	235			Y	Y	Y
New York[8, 12]	200			Y	Y	Y
North Carolina[7] ▲	185			Y	Y	Y
North Dakota	133				Y	
Ohio[10]	200				Y	
Oklahoma	185		185		Y	Y
Oregon	185		185		Y	
Pennsylvania[7]	185				Y	Y
Rhode Island[13]	185	250 (350)	250		Y	
South Carolina[10]	185				$30,000	
South Dakota	133				$7,500	
Tennessee	185		250		Y	Y
Texas	185		200		Y	Y
Utah[14]	133				$5,000	Y
Vermont	200				Y	
Virginia	133	200			Y	
Washington	185		185	Y	Y	
West Virginia	150				Y	
Wisconsin[7] ▲	300		300	Y	Y	Y
Wyoming	133				Y	Y

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2011.
▲ Indicates that a state has expanded eligibility in at least one of its children's health insurance programs between January 1, 2010 and January 1, 2011, unless noted otherwise.
▼Indicates that a state has reduced eligibility in at least one of its children's health insurance programs between January 1, 2010 and January 1, 2011, unless noted otherwise.
Table presents rules in effect as of January 1, 2011, unless noted otherwise.

Table 6 Notes

1. The unborn child option permits states to consider the fetus a "targeted low-income child" for CHIP coverage.

2. This column indicates whether the state received approval through a State Plan Amendment to adopt the option to cover immigrant pregnant women who have been lawfully residing in the U.S. for less than five years, otherwise known as the ICHIA option.

3. With the exception of Arkansas, all states with an asset test for pregnancy coverage rely on a standard limit regardless of family size. In Arkansas, the asset limit shown is for a family of three.

4. In California, the unborn child option is called Access for Infants and Mothers (AIM). Presumptive eligibility is available only to women through Medicaid.

5. Colorado increased eligibility from 200% to 250% FPL in 2010. Lawfully residing immigrant pregnant women are covered in Medicaid only.

6. Connecticut adopted presumptive eligibility in March 2010; prior to adopting presumptive eligibility the state had a presumptive eligibility-like process.

7. Delaware, Minnesota, Nebraska, North Carolina, and Wisconsin had state plan amendments approved in 2010 to provide coverage to lawfully-residing pregnant women without the five-year wait (ICHIA option). Illinois and Pennsylvania have submitted state plan amendments, but are awaiting CMS approval.

8. DC, Illinois, New Jersey, and New York cover all immigrant pregnant women regardless of immigration status.

9. In Hawaii, pregnant women whose income exceeds 185% of the FPL can enroll in Quest-ACE by paying premiums. Coverage goes up to 200% of the FPL, but provides limited benefits.

10. Louisiana, Maryland, Ohio, and South Carolina have a presumptive eligibility like process.

11. In Nevada, there is a spending cap in the CHIP coverage for pregnant women.

12. In New York, women with income between 100% and 200% of the FPL receive less comprehensive benefits.

13. In Rhode Island, coverage for pregnant women with income between 250% and 350% of the FPL is partially state funded and requires premium payments.

14. Women who exceed the asset limit in Utah may still qualify if they pay a one-time fee of 4% of their assets.

Table 7
Streamlined Application Requirements for Children's Health Coverage
January 2011

State	Joint Medicaid/ CHIP Application	Face-to-Face Interview NOT Required		Asset Test NOT Required (or Asset Test Limit)[1]		Paper Documentation of Income NOT Requested[2]	
		Medicaid	CHIP	Medicaid	CHIP	Medicaid	CHIP
Total	**36**	**49**	**37**	**48**	**36**	**12**	**10**
Aligned Medicaid and CHIP[3]	**49**	**49**		**47**		**12**	
Alabama	Y	Y	Y	Y	Y		Y
Alaska	N/A	Y	N/A	Y	N/A		N/A
Arizona	Y	Y	Y	Y	Y		
Arkansas	N/A	Y	N/A	Y	N/A	Y	N/A
California[4]	Y	Y	Y	Y	Y		
Colorado[5] ▲	Y	Y	Y	Y	Y	Y	Y
Connecticut	Y	Y	Y	Y	Y	Y	Y
Delaware	Y	Y	Y	Y	Y		
District of Columbia	N/A	Y	N/A	Y	N/A		N/A
Florida	Y	Y	Y	Y	Y	Y	Y
Georgia[4]	Y	Y	Y	Y	Y		
Hawaii	N/A	Y	N/A	Y	N/A	Y	N/A
Idaho	Y	Y	Y	Y	Y	Y	Y
Illinois	Y	Y	Y	Y	Y		
Indiana[6]	Y	Y	Y	Y	Y		
Iowa[4]	Y	Y	Y	Y	Y		
Kansas	Y	Y	Y	Y	Y		
Kentucky	Y	Y	Y	Y	Y		
Louisiana	Y	Y	Y	Y	Y		
Maine	Y	Y	Y	Y	Y		
Maryland	N/A	Y	N/A	Y	N/A	Y	N/A
Massachusetts[7]	Y	Y	Y	Y	Y		
Michigan	Y	Y	Y	Y	Y	Y	Y
Minnesota	N/A	Y	N/A	Y	N/A		N/A
Mississippi	Y			Y	Y		
Missouri[8]	Y	Y	Y	Y	$250,000		
Montana	Y	Y	Y	Y	Y		
Nebraska	N/A	Y	N/A	Y	N/A		N/A
Nevada		Y	Y	Y	Y		
New Hampshire	Y	Y	Y	Y	Y		
New Jersey	Y	Y	Y	Y	Y		
New Mexico	N/A	Y	N/A	Y	N/A		N/A
New York[9] ▲	Y	Y	Y	Y	Y		
North Carolina	Y	Y	Y	Y	Y		
North Dakota	Y	Y	Y	Y	Y		
Ohio	N/A	Y	N/A	Y	N/A		N/A
Oklahoma[10]	N/A	Y	N/A	Y	N/A	Y	N/A
Oregon	Y	Y	Y	Y	Y		
Pennsylvania	Y	Y	Y	Y	Y		
Rhode Island	N/A	Y	N/A	Y	N/A		N/A
South Carolina[11]	N/A	Y	N/A	$30,000	N/A		N/A
South Dakota	Y	Y	Y	Y	Y		
Tennessee			Y	Y	Y		Y
Texas[12]	Y	Y	Y	$2,000	$10,000		
Utah[13]	Y	Y	Y	$3,025	Y		
Vermont	Y	Y	Y	Y	Y	Y	Y
Virginia	Y	Y	Y	Y	Y		
Washington	Y	Y	Y	Y	Y	Y	Y
West Virginia	Y	Y	Y	Y	Y		
Wisconsin	N/A	Y	N/A	Y	N/A		N/A
Wyoming	Y	Y	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, 2011.
▲ Indicates that a state has expanded eligibility in at least one of its children's health insurance programs between January 1, 2010 and January 1, 2011, unless noted otherwise.
▼Indicates that a state has reduced eligibility in at least one of its children's health insurance programs between January 1, 2010 and January 1, 2011, unless noted otherwise.
Table presents rules in effect as of January 1, 2011, unless noted otherwise.

Table 7 Notes

1. In states with asset limits, the limit noted is for a family of three.

2. In states that do not require families to provide documentation of income at application, states generally verify this information through data matches with other government agencies, such as the Social Security Administration and state departments of labor, and/or private employment databases. Often, families in states with administrative verification have to provide documentation of income if self-employed, if income is questionable, or if the state is unable to administratively verify the information. Some states request paper documentation of income at application, but if the family does not submit the documentation with the application, the state will attempt to administratively verify the information before following up with the family. States that verify income administratively, but continue to ask for income documentation on their applications are not counted as streamlining their procedures. This is a change from prior year reports.

3. Aligned Medicaid and CHIP indicates the number of states that have simplified the given procedure and have applied the simplification to both their children's Medicaid program and their CHIP-funded separate program. States that have used CHIP funds to expand Medicaid exclusively are considered "aligned" if the simplified procedure applies to children in the "regular" Medicaid program and the CHIP-funded expansion program. There are 38 states with separate CHIP programs.

4. In California, Georgia, and Iowa although separate applications are used to apply for Medicaid and CHIP, the programs will accept the other's application. In California, the family must consent to the application transfer.

5. Colorado implemented administrative verification of income in October 2010.

6. Indiana requires telephone interviews at application and renewal (although some families use a mail-in paper form at renewal).

7. In Massachusetts, paper documentation is required for all except those applications approved for a presumptive eligibility period.

8. In Missouri, families with income above 150% of the FPL are subject to a "net worth" test.

9. In New York, the face-to-face interview requirement in Medicaid was eliminated April 1, 2010.

10. In Oklahoma, children who qualify for Title XXI funded coverage through Oklahoma's premium assistance program "Insure Oklahoma" must complete a separate application.

11. In South Carolina, families do not need to provide proof of assets.

12. In Texas, the limit is $3,000 if a family contains a disabled or elderly member. The $10,000 limit applies to those with income over 150% of the FPL.

13. In Utah, the asset limits are $2,000 for an individual, $3,000 for a couple, plus $25 for each additional person. The limit shown is for a two-parent family with one child. The state counts assets when determining eligibility for a child over than the age of 6.

Table 8
Streamlined Enrollment Processes for Children's Health Coverage
January 2011

State		Presumptive Eligibility		Express Lane Eligibility[1]		Social Security Administration (SSA) Data Match to Verify Citizenship[2]	
		Medicaid	CHIP	Medicaid	CHIP	Medicaid	CHIP
Total		**16**	**10**	**6**	**1**	**29**	**21**
Aligned Medicaid and CHIP[3]		**13**		**2**		**27**	
Alabama	▲			Y		Y	Y
Alaska	▲		N/A		N/A	Y	N/A
Arizona[4]							
Arkansas	▲		N/A		N/A	Y	N/A
California[5, 6]	▲	Y	Y			Y	
Colorado[5]		Y	Y				
Connecticut	▲	Y				Y	Y
Delaware	▲					Y	Y
District of Columbia	▲		N/A		N/A	Y	N/A
Florida[5]							
Georgia							
Hawaii[7]	▲		N/A		N/A	Y	N/A
Idaho	▲					Y	Y
Illinois[5, 8]		Y	Y				
Indiana							
Iowa[9]	▲	Y	Y	Y		Y	Y
Kansas[5, 10]		Y	Y				
Kentucky[5]							
Louisiana	▲			Y		Y	Y
Maine	▲					Y	Y
Maryland[11]	▲		N/A	Y	N/A	Y	N/A
Massachusetts[5]		Y	Y				
Michigan[12, 13]	▲	Y	Y			Y	
Minnesota[14]	▲		N/A		N/A	Y	N/A
Mississippi	▲					Y	Y
Missouri[15]		Y					
Montana[5, 16]	▲	Y	Y				Y
Nebraska[5]			N/A		N/A		N/A
Nevada[5]							Y
New Hampshire	▲	Y				Y	Y
New Jersey[17]	▲	Y	Y	Y		Y	Y
New Mexico[5]		Y	N/A		N/A		N/A
New York	▲	Y	Y			Y	Y
North Carolina	▲					Y	Y
North Dakota							
Ohio[18]	▲	Y	N/A		N/A	Y	N/A
Oklahoma	▲		N/A		N/A	Y	N/A
Oregon	▲			Y	Y	Y	Y
Pennsylvania[19]	▲					Y	Y
Rhode Island			N/A		N/A		N/A
South Carolina[5]			N/A		N/A		N/A
South Dakota	▲					Y	Y
Tennessee	▲						Y
Texas[5]							
Utah[5]							
Vermont[5]							
Virginia	▲					Y	Y
Washington	▲					Y	Y
West Virginia	▲					Y	Y
Wisconsin[20]	▲	Y	N/A		N/A	Y	N/A
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, 2011.
▲ Indicates that a state has expanded eligibility in at least one of its children's health insurance programs between January 1, 2010 and January 1, 2011, unless noted otherwise.
▼Indicates that a state has reduced eligibility in at least one of its children's health insurance programs between January 1, 2010 and January 1, 2011, unless noted otherwise.
Table presents rules in effect as of January 1, 2011, unless noted otherwise.

Table 8 Notes

1. The new Express Lane Eligibility option allows states to use data and eligibility findings from other public benefit programs when determining children's eligibility for Medicaid and CHIP at enrollment or renewal. States are designated as using Express Lane Eligibility if they have implemented an initiative and have an approved State Plan Amendment from CMS. States that have adopted the option are denoted as implementing a simplification in 2010 in the table.

2. This CHIPRA option became newly available in 2010 and allows states to conduct data matches with the Social Security Administration to verify citizenship. States that have adopted the option are denoted as implementing a simplification in 2010 the table.

3. Aligned Medicaid and CHIP indicates the number of states that have simplified the given procedure and have applied the simplification to both their children's Medicaid program and their CHIP-funded separate program. States that have used CHIP funds to expand Medicaid exclusively are considered "aligned" if the simplified procedure applies to children in the "regular" Medicaid program and the CHIP-funded expansion program. There are 38 states with separate CHIP programs.

4. Arizona has submitted a state plan amendment to implement Express Lane Eligibility in CHIP. The state is awaiting approval from CMS.

5. California, Colorado, Florida, Illinois, Kansas, Kentucky, Massachusetts, Montana, Nebraska, Nevada, New Mexico, South Carolina, Texas, Utah, and Vermont plan to implement the SSA match in the next twelve months.

6. In California, the CHIP program has a presumptive eligibility process available to families with income up to 200% of the FPL. This process is available through the Child Health and Disability Prevention program provider and the presumptive enrollment process, which provides temporary full scope no cost medical coverage.

7. Hawaii reports it has implemented ELE, however, it has not received approval from CMS for its State Plan Amendment.

8. In Illinois, presumptive eligibility is available in Medicaid and CHIP <200% FPL, but not the state-funded coverage between 200% and 300% FPL.

9. Iowa began doing presumptive eligibility in March 2010.

10. In Kansas, presumptive eligibility is processed in five locations.

11. In Maryland, there is an accelerated eligibility process that is available to children who already have an open case for other benefits at a local eligibility office.

12. In Michigan, presumptive eligibility is available only through the electronic application and applicants must be assisted by a trained or qualified entity.

13. In Michigan, the SSA match is only conducted in CHIP if the application is received via electronic transfer from the Medicaid agency.

14. In Minnesota, the SSA match has been adopted at the county-level only.

15. In Missouri, presumptive eligibility is available only to children with gross incomes of 150% FPL or less.

16. Montana implemented presumptive eligibility as of January 1, 2011.

17. New Jersey has submitted a state plan amendment to use Express Lane Eligibility in CHIP as well and is awaiting approval from CMS.

18. Ohio implemented presumptive eligibility in April 2010.

19. Pennsylvania has submitted a state plan amendment to implement ELE in its CHIP program; the state reports it deemed approved; CMS classifies it as pending.

20. In Wisconsin, presumptive eligibility is available only for children in families with incomes below 150% of the FPL.

Table 9

Use of Online Application Forms in Medicaid and CHIP[1]
January 2011

State	Application Form Available Online		Application Form Can be Submitted Electronically		Electronic Signature[2]		Paper Documentation NOT Requested with Electronic Submission[3]	
	Medicaid	CHIP	Medicaid	CHIP	Medicaid	CHIP	Medicaid	CHIP
Total	**51**	**38**	**32**	**27**	**29**	**23**	**8**	**8**
Aligned Medicaid and CHIP[4]	**51**		**32**		**29**		**8**	
Alabama	Y	Y	Y	Y	Y	Y		Y
Alaska	Y	N/A		N/A	N/A	N/A	N/A	N/A
Arizona	Y	Y	Y	Y	Y	Y		
Arkansas	Y	N/A	Y	N/A	Y	N/A	Y	N/A
California[5]	Y	Y	Y	Y	Y	Y		
Colorado	Y	Y			N/A	N/A	N/A	N/A
Connecticut	Y	Y			N/A	N/A	N/A	N/A
Delaware	Y	Y	Y	Y	Y	Y		
District of Columbia	Y	N/A		N/A	N/A	N/A	N/A	N/A
Florida	Y	Y	Y	Y	Y	Y	Y	Y
Georgia	Y	Y		Y	N/A		N/A	
Hawaii	Y	N/A		N/A	N/A	N/A	N/A	N/A
Idaho	Y	Y			N/A	N/A	N/A	N/A
Illinois	Y	Y	Y	Y				
Indiana[6]	Y	Y	Y	Y	Y	Y		
Iowa	Y	Y	Y	Y	Y	Y		
Kansas	Y	Y			N/A	N/A	N/A	N/A
Kentucky[7]	Y	Y			N/A	N/A	N/A	N/A
Louisiana	Y	Y	Y	Y	Y	Y		
Maine	Y	Y			N/A	N/A	N/A	N/A
Maryland	Y	N/A	Y	N/A	Y	N/A	Y	N/A
Massachusetts[8]	Y	Y			N/A	N/A	N/A	N/A
Michigan[7]	Y	Y	Y	Y	Y	Y	Y	Y
Minnesota	Y	N/A		N/A	N/A	N/A	N/A	N/A
Mississippi	Y	Y			N/A	N/A	N/A	N/A
Missouri	Y	Y	Y	Y	Y	Y		
Montana	Y	Y	Y	Y	Y	Y		Y
Nebraska	Y	N/A	Y	N/A	Y	N/A		N/A
Nevada	Y	Y	Y	Y	Y	Y		
New Hampshire[9]	Y	Y	Y	Y				
New Jersey	Y	Y	Y	Y	Y	Y		
New Mexico	Y	N/A		N/A	N/A	N/A	N/A	N/A
New York	Y	Y			N/A	N/A	N/A	N/A
North Carolina	Y	Y			N/A	N/A	N/A	N/A
North Dakota	Y	Y	Y	Y	Y	Y		
Ohio	Y	N/A	Y	N/A	Y	N/A		N/A
Oklahoma	Y	N/A	Y	N/A	Y	N/A	Y	N/A
Oregon	Y	Y	Y	Y	Y	Y		
Pennsylvania	Y	Y	Y	Y	Y	Y		
Rhode Island	Y	N/A		N/A	N/A	N/A	N/A	N/A
South Carolina	Y	N/A		N/A	N/A	N/A	N/A	N/A
South Dakota	Y	Y			N/A	N/A	N/A	N/A
Tennessee	Y	Y	Y	Y	Y	Y		Y
Texas	Y	Y	Y	Y	Y	Y		
Utah	Y	Y	Y	Y	Y	Y		
Vermont	Y	Y	Y	Y	Y	Y	Y	Y
Virginia	Y	Y	Y	Y	Y	Y		
Washington	Y	Y	Y	Y	Y	Y	Y	Y
West Virginia[7]	Y	Y	Y	Y				
Wisconsin	Y	N/A	Y	N/A	Y	N/A		N/A
Wyoming	Y	Y	Y	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, 2011. Data were not collected last year, so changes are not noted. Table presents rules in effect as of January 1, 2011, unless noted otherwise.

Table 9 Notes

1. Unless specified otherwise, the Medicaid online application and electronic submission, electronic signature, and documentation rules apply to both children and parents. Waiver or state-funded coverage for parents may have different policies.

2. The signature requirement for an application for medical assistance may be satisfied through an electronic signature, as defined in section 1710(1) of the Government Paperwork Elimination Act (44 U.S.C. 3504 note), which states, "the term 'electronic signature' means a method of signing an electronic message that—(A) identifies and authenticates a particular person as the source of the electronic message; and (B) indicates such person's approval of the information contained in the electronic message."

3. In states that do not require families to provide documentation of income at application, states generally verify this information through data matches with other government agencies, such as the Social Security Administration and state departments of labor, and/or private employment databases. Often, families in states with administrative verification have to provide documentation of income if self-employed, if income is questionable, or if the state is unable to administratively verify the information. Some states request paper documentation of income at application, but if the family does not submit the documentation with the application, the state will attempt to administratively verify the information before following up with the family. States that verify income administratively, but continue to ask for income documentation on their applications are not counted as streamlining their procedures. This is a change from prior year reports.

4. Aligned Medicaid and CHIP indicates the number of states that have simplified the given procedure and have applied the simplification to both their children's Medicaid program and their CHIP-funded separate program. States that have used CHIP funds to expand Medicaid exclusively are considered "aligned" if the simplified procedure applies to children in the "regular" Medicaid program and the CHIP-funded expansion program. There are 38 states with separate CHIP programs.

5. Electronic applications differ in California, depending on the county. Healthy Families (CHIP) applications could be submitted online through a Certified Application Assistant or Eligibility Worker, but are available to the general public as of December 2010.

6. In Indiana, a majority of counties allow online submission of applications.

7. The application that is available online in Kentucky, Michigan, and West Virginia can only be used to apply for coverage for children but not parents.

8. In Massachusetts, online applications may only be submitted by authorized users, who are usually providers.

9. In New Hampshire, online submission of Medicaid applications is done only through providers with access to NH Easy. The state plans to implement a pilot program in January 2011 that will allow the public to complete the online application and allow for electronic signature.

Table 10
Integration of Medicaid and CHIP Eligibility Systems
January 2011

State	Medicaid System Used for Other Assistance Programs (e.g., SNAP, TANF)	Same Eligibility System for Medicaid and CHIP
Total	**44**	**34**
Alabama		
Alaska	Y	Y
Arizona	Y	
Arkansas	Y	Y
California	Y	
Colorado	Y	Y
Connecticut	Y	
Delaware	Y	Y
District of Columbia	Y	Y
Florida	Y	
Georgia	Y	
Hawaii	Y	Y
Idaho	Y	Y
Illinois	Y	Y
Indiana	Y	Y
Iowa	Y	
Kansas	Y	Y
Kentucky	Y	Y
Louisiana		Y
Maine	Y	Y
Maryland	Y	Y
Massachusetts		Y
Michigan	Y	
Minnesota	Y	
Mississippi		Y
Missouri	Y	Y
Montana		
Nebraska	Y	Y
Nevada	Y	
New Hampshire	Y	Y
New Jersey	Y	Y
New Mexico	Y	Y
New York	Y	
North Carolina	Y	Y
North Dakota	Y	Y
Ohio	Y	Y
Oklahoma		Y
Oregon	Y	Y
Pennsylvania	Y	
Rhode Island	Y	Y
South Carolina		Y
South Dakota	Y	Y
Tennessee	Y	
Texas	Y	
Utah	Y	Y
Vermont	Y	Y
Virginia	Y	
Washington	Y	Y
West Virginia	Y	Y
Wisconsin	Y	Y
Wyoming	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, 2011. Data were not collected last year, so changes are not noted. Table presents rules in effect as of January 1, 2011, unless noted otherwise.

Table 10 Notes

No notes for Table 10.

Table 11
Renewal Periods and Streamlined Renewal Requirements for Children's Health Coverage
January 2011

State	Frequency of Renewal[1] (Months)		12-Month Continuous Eligibility		Face-to-Face Interview Not Required		Paper Documentation of Income NOT Requested[2]	
	Medicaid	CHIP	Medicaid	CHIP	Medicaid	CHIP	Medicaid	CHIP
Total Adopting Simplification	**49**	**38**	**23**	**28**	**50**	**37**	**19**	**14**
Aligned Medicaid and CHIP[3]	**49**		**23**		**50**		**18**	
Alabama	12	12	Y	Y	Y	Y	Y	Y
Alaska	12	N/A	Y	N/A	Y	N/A		N/A
Arizona[4]	12	12			Y	Y		
Arkansas[5]	12	N/A		N/A	Y	N/A	Y	N/A
California	12	12	Y	Y	Y	Y		
Colorado[6] ▲	12	12		Y	Y	Y	Y	Y
Connecticut	12	12			Y	Y	Y	Y
Delaware	12	12		Y	Y	Y		
District of Columbia	12	N/A		N/A	Y	N/A		N/A
Florida[7]	12	12		Y	Y	Y	Y	Y
Georgia	6	12			Y	Y		
Hawaii	12	N/A		N/A	Y	N/A	Y	N/A
Idaho	12	12	Y	Y	Y	Y	Y	Y
Illinois	12	12	Y	Y	Y	Y		
Indiana[8, 9]	12	12			Y	Y		
Iowa	12	12	Y	Y	Y	Y		
Kansas	12	12	Y	Y	Y	Y		
Kentucky	12	12			Y	Y		
Louisiana	12	12	Y	Y	Y	Y		
Maine	12	12	Y	Y	Y	Y		
Maryland[10]	12	N/A		N/A	Y	N/A	Y	N/A
Massachusetts	12	12			Y	Y		
Michigan	12	12	Y	Y	Y	Y	Y	Y
Minnesota[11]	12	N/A		N/A	Y	N/A		N/A
Mississippi	12	12	Y	Y				
Missouri	12	12			Y	Y		
Montana	12	12	Y	Y	Y	Y		
Nebraska	12	N/A		N/A	Y	N/A		N/A
Nevada[12]	12	12		Y	Y	Y	Y	
New Hampshire	12	12			Y	Y		
New Jersey	12	12	Y	Y	Y	Y		
New Mexico	12	N/A	Y	N/A	Y	N/A	Y	N/A
New York	12	12	Y	Y	Y	Y	Y	Y
North Carolina	12	12	Y	Y	Y	Y		
North Dakota	12	12	Y	Y	Y	Y		
Ohio[12, 13] ▲	12	N/A	Y	N/A	Y	N/A	Y	N/A
Oklahoma	12	N/A		N/A	Y	N/A	Y	N/A
Oregon	12	12	Y	Y	Y	Y		
Pennsylvania[14]	12	12		Y	Y	Y		
Rhode Island	12	N/A		N/A	Y	N/A		N/A
South Carolina	12	N/A	Y	N/A	Y	N/A		N/A
South Dakota	12	12			Y	Y		
Tennessee	12	12		Y	Y	Y		Y
Texas[15]	6	12		Y	Y	Y		
Utah	12	12		Y	Y	Y		Y
Vermont	12	12			Y	Y	Y	Y
Virginia[16]	12	12		Y	Y	Y	Y	Y
Washington	12	12	Y	Y	Y	Y	Y	Y
West Virginia[12]	12	12	Y	Y	Y	Y	Y	Y
Wisconsin	12	N/A		N/A	Y	N/A		N/A
Wyoming	12	12	Y	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, 2011.
▲ Indicates that a state has expanded eligibility in at least one of its children's health insurance programs between January 1, 2010 and January 1, 2011, unless noted otherwise.
▼Indicates that a state has reduced eligibility in at least one of its children's health insurance programs between January 1, 2010 and January 1, 2011, unless noted otherwise.
Table presents rules in effect as of January 1, 2011, unless noted otherwise.

Table 11

1. This column shows the frequency of renewals. Some states require monthly, quarterly, or semi-annual income reporting or reporting a change in income, which is not addressed in this table. If the frequency of renewal is every 12 months, as opposed to six months or more frequently, the procedure is considered "simplified" for the purposes of this table.

2. In states that do not require families to provide documentation of income at application, states generally verify this information through data matches with other government agencies, such as the Social Security Administration and state departments of labor, and/or private employment databases. Often, families in states with administrative verification have to provide documentation of income if self-employed, if income is questionable, or if the state is unable to administratively verify the information. Some states request paper documentation of income at application, but if the family does not submit the documentation with the application, the state will attempt to administratively verify the information before following up with the family. States that verify income administratively, but continue to ask for income documentation on their applications are not counted as streamlining their procedures. This is a change from prior year reports.

3. Aligned Medicaid and CHIP indicates the number of states that have simplified the given procedure and have applied the simplification to both their children's Medicaid program and their CHIP-funded separate program. States that have used CHIP funds to expand Medicaid exclusively are considered "aligned" if the simplified procedure applies to children in the "regular" Medicaid program and the CHIP-funded expansion program. There are 38 states with separate CHIP programs.

4. In Arizona, the 12-month continuous eligibility policy in CHIP is a guaranteed enrollment period that only applies to the first 12 months of coverage.

5. In Arkansas, children above 133% FPL and <6 years of age, and those above 100% FPL and >6 years of age, receive 12 months of continuous eligibility.

6. Colorado implemented administrative of income in October 2010.

7. In Florida's Medicaid program, children younger than age 5 receive 12 months of continuous eligibility and children ages 5 and older receive six months of continuous eligibility.

8. Indiana has 12-month continuous eligibility for children under age 3.

9. Indiana requires telephone interviews at application and renewal (although some families use mail-in paper forms at renewal instead).

10. Newborns in Maryland are given 12-month continuous eligibility.

11. In Minnesota, children and parents who qualify under the state's Section 1115 expansion program have eligibility reviewed every 12 months. In the "regular" Medicaid program, income reviews occur every 6 months and eligibility reviews every 12 months.

12. Families in Nevada (Medicaid only), Ohio, and West Virginia are not required to provide documentation if income has not changed.

13. Ohio implemented 12-month continuous eligibility in April 2010.

14. In Pennsylvania, in Medicaid, there is a 12 month renewal period, but income is reviewed at 6 months for some categories, excluding children in foster care, pregnant women, and families whose only enrollee is less than one year old.

15. In Texas, children covered under CHIP get 12 months of continuous coverage. However, the state will conduct administrative renewal for children in CHIP in families with income between 185% and 200% of the FPL at 6 months to determine whether income has exceeded 200% of the FPL.

16. In Virginia, children covered under CHIP get 12 months of continuous coverage unless the family's income exceeds the program's income eligibility guideline or the family leaves the state.

Table 12
Renewal Methods Available for Children's Health Coverage
January 2011

State	Joint Medicaid/CHIP Renewal Form	Administrative Renewal[1]		Telephone		Online		Express Lane	
		Medicaid	CHIP	Medicaid	CHIP	Medicaid	CHIP	Medicaid	CHIP
Total	**31**	**16**	**12**	**15**	**12**	**14**	**15**	**3**	**0**
Aligned Medicaid and CHIP[2]	**44**	**14**		**12**		**14**		**0**	
Alabama[3]	Y	Y		Y		Y	Y	Y	
Alaska	N/A	Y	N/A		N/A		N/A		N/A
Arizona	Y				Y	Y	Y		
Arkansas	N/A	Y	N/A		N/A		N/A		N/A
California[4, 5]	Y								
Colorado	Y			Y	Y				
Connecticut	Y	Y	Y						
Delaware	Y			Y	Y				
District of Columbia	N/A		N/A		N/A		N/A		N/A
Florida		Y	Y			Y	Y		
Georgia				Y					
Hawaii[6]	N/A	Y	N/A		N/A		N/A		N/A
Idaho	Y								
Illinois	Y	Y	Y	Y	Y				
Indiana	Y								
Iowa[7]							Y		
Kansas	Y	Y	Y						
Kentucky	Y	Y	Y						
Louisiana[3]	Y	Y	Y	Y	Y	Y	Y	Y	
Maine	Y	Y	Y						
Maryland	N/A	Y	N/A		N/A		N/A		N/A
Massachusetts	Y			Y	Y				
Michigan	Y	Y	Y			Y	Y		
Minnesota	N/A		N/A		N/A		N/A		N/A
Mississippi	Y								
Missouri	Y								
Montana				Y	Y				
Nebraska	N/A		N/A		N/A	Y	N/A		N/A
Nevada									
New Hampshire	Y								
New Jersey[3]	Y							Y	
New Mexico	N/A	Y	N/A	Y	N/A		N/A		N/A
New York		Y		Y					
North Carolina	Y								
North Dakota	Y						Y		
Ohio	N/A		N/A	Y	N/A	Y	N/A		N/A
Oklahoma	N/A	Y	N/A		N/A	Y	N/A		N/A
Oregon	Y			Y	Y				
Pennsylvania[8]	Y				Y	Y	Y		
Rhode Island	N/A		N/A		N/A		N/A		N/A
South Carolina	N/A		N/A		N/A		N/A		N/A
South Dakota	Y								
Tennessee			Y			Y	Y		
Texas	Y						Y		
Utah[9]	Y		Y	Y	Y				
Vermont	Y					Y	Y		
Virginia[10]	Y		Y				Y		
Washington	Y			Y	Y	Y	Y		
West Virginia[11]	Y					Y	Y		
Wisconsin[12]	N/A		N/A	Y	N/A	Y	N/A		N/A
Wyoming[5]	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, 2011.
Not all data were collected last year, so changes are not noted. Table presents rules in effect as of January 1, 2011, unless noted otherwise.

Table 12 Notes

1. A state is classified as providing administrative renewal if it sends a pre-populated form with all eligibility information available or a renewal letter to the family in advance of the renewal date. The family is required to either sign and return the form, signaling that they wish to continue coverage, or do nothing. States that send a pre-populated form, but require families to submit paper documentation to continue coverage do not qualify has having implemented administrative renewals.

2. Aligned Medicaid and CHIP indicates the number of states that have simplified the given procedure and have applied the simplification to both their children's Medicaid program and their CHIP-funded separate program. States that have used CHIP funds to expand Medicaid exclusively are considered "aligned" if the simplified procedure applies to children in the "regular" Medicaid program and the CHIP-funded expansion program. There are 38 states with separate CHIP programs.

3. Alabama, Louisiana, and New Jersey received approval for State Plan Amendments to conduct renewals through Express Lane Eligibility in 2010. New Jersey has submitted a state plan amendment to use Express Lane Eligibility in CHIP and is awaiting approval from CMS.

4. The use of pre-populated renewal forms and telephone and online renewals varies by county in California.

5. In California and Wyoming, although separate forms are used for Medicaid and CHIP, the programs will accept the other's application. In California the family must consent to the application transfer.

6. Hawaii reports it has implemented ELE, however, it has not received approval from CMS for its State Plan Amendment.

7. Although Iowa has not submitted a state plan amendment, the state believes that the administrative rules allowing the CHIP program to use the Medicaid income finding meets the definition of Express Lane Eligibility.

8. Pennsylvania has submitted a state plan amendment to implement ELE in its CHIP program; the state considers it deemed approved, but CMS continues to classify it as pending.

9. In Utah, CHIP enrollees with no changes during the year are sent a simplified form and do not have to take any further action. CHIP families with a change must complete, sign, and return a different form.

10. Virginia began administrative renewals in CHIP in October 2010.

11. A pre-populated renewal form is used for every other renewal in CHIP in West Virginia.

12. Children can renew coverage over the phone in Milwaukee. Statewide implementation is planned.

Table 13
Streamlined Application Processes for Parents in Medicaid[1]
January 2011

State		Simplified Family Application for Parents[2]	Face-to-Face Interview NOT Required	Asset Test NOT Required (or Asset Test Limit)[3]	Social Security Administration Data Match to Verify Citizenship[4]	Paper Documentation of Income NOT Requested[5]	Simplifications Consistent with Children's Programs[6]
Total		**29**	**44**	**24**	**27**	**7**	**2**
Alabama	▲	Y	Y	Y	Y		
Alaska[7]	▲		Y	$2,000	Y		
Arizona		Y	Y	Y			
Arkansas[8]	▲	Y		$1,000	Y		
California[9]	▲		Y	$3,150	Y		
Colorado[10, 11]	▲	Y	Y	Y		Y	
Connecticut	▲	Y	Y	Y	Y	Y	Y
Delaware	▲	Y	Y	Y	Y		
District of Columbia	▲	Y	Y	Y	Y		
Florida[11]			Y	$2,000			
Georgia		Y	Y	$1,000			
Hawaii	▲		Y	$3,250		Y	
Idaho	▲		Y	$1,000	Y	Y	
Illinois[11]		Y	Y	Y			
Indiana[9, 12]			Y	$1,000			
Iowa[9]	▲		Y	$2,000	Y		
Kansas[11]		Y	Y	Y			
Kentucky[11]				$2,000			
Louisiana[13]	▲		Y	Y	Y		
Maine[14]		Y	Y	$2,000			
Maryland	▲	Y	Y	Y	Y	Y	Y
Massachusetts[11]		Y	Y	Y			
Michigan[15]	▲		Y	$3,000	Y		
Minnesota[16, 17]	▲	Y	Y	$10,000	Y		
Mississippi	▲	Y		Y	Y		
Missouri		Y	Y	Y			
Montana			Y	$3,000			
Nebraska[11, 18]	▲		Y	$6,025			
Nevada[11]			Y	$2,000			
New Hampshire	▲			$1,000	Y		
New Jersey	▲	Y	Y	Y	Y		
New Mexico[11]		Y	Y	Y			
New York[19]	▲	Y	Y	Y	Y		
North Carolina[9]	▲		Y	$3,000	Y		
North Dakota		Y	Y	Y			
Ohio	▲	Y	Y	Y	Y		
Oklahoma	▲		Y	Y	Y		
Oregon		Y	Y	$2,500	Y		
Pennsylvania	▲	Y	Y	Y	Y		
Rhode Island		Y	Y	Y			
South Carolina[11, 20]			Y	$30,000			
South Dakota	▲	Y	Y	$2,000	Y		
Tennessee				$2,000			
Texas[11]				$2,000			
Utah[11]		Y	Y	$3,025			
Vermont[11]		Y	Y	$3,150		Y	
Virginia	▲		Y	Y	Y		
Washington	▲		Y	$1,000	Y		
West Virginia	▲			$1,000	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, 2011.
▲ Indicates that a state has expanded eligibility in at least one of its children's health insurance programs between January 1, 2010 and January 1, 2011, unless noted otherwise.
▼Indicates that a state has reduced eligibility in at least one of its children's health insurance programs between January 1, 2010 and January 1, 2011, unless noted otherwise.
Table presents rules in effect as of January 1, 2011, unless noted otherwise.

Table 13 Notes

1. This table presents policies for parents covered through 1931 Medicaid coverage; some states have differing policies for parents and other non-disabled adults covered through waiver or state-funded coverage programs.

2. States are classified as providing a simplified family application if parents can apply for coverage without having to complete a separate application or additional forms. In some states a longer form must be used to apply for family coverage while a shorter, simpler form is available for children's coverage; these states are not classified as offering a simplified family application.

3. In states with asset limits, the limit noted is for a family of three.

4. This CHIPRA option became newly available in 2010 and allows states to conduct data matches with the Social Security Administration to verify citizenship. States that have adopted the option are denoted as implementing a simplification in 2010 the table.

5. In states that do not require families to provide documentation of income at application, states generally verify this information through data matches with other government agencies, such as the Social Security Administration and state departments of labor, and/or private employment databases. Often, families in states with administrative verification have to provide documentation of income if self-employed, if income is questionable, or if the state is unable to administratively verify the information. Some states request paper documentation of income at application, but if the family does not submit the documentation with the application, the state will attempt to administratively verify the information before following up with the family. States that verify income administratively, but continue to ask for income documentation on their applications are not counted as streamlining their procedures. This is a change from prior year reports.

6. States are classified as having consistent policies for children and parents if they have adopted all of the simplification measures listed in both programs.

7. In Alaska, the asset test is $3,000 if the family includes a member age 60 or over.

8. In Arkansas, county offices have the option of requiring either a face-to-face or telephone interview for Medicaid. Applicants who have had an active Medicaid case within the past year are not required to do an interview.

9. In California, Indiana, Iowa, and North Carolina, the same simplified application can be used for children and parents but parents must complete additional forms or take additional steps.

10. Colorado implemented self-declaration of income in October 2010.

11. Colorado, Florida, Illinois, Kansas, Kentucky, Massachusetts, Nebraska, Nevada, New Mexico, South Carolina, Texas, Utah, and Vermont plan to implement the SSA match in the next twelve months.

12. A telephone interview will meet the interview requirement if the parent is applying for Medicaid only in Indiana.

13. In Louisiana, the Medicaid/CHIP application is not designed for use by parents but can be used in some circumstances to determine eligibility for a parent.

14. In Maine, asset rules exempt $8,000 for an individual and $12,000 for a household of 2 or more of certain savings, including retirement savings.

15. In Michigan, an SSA match is conducted secondary to vital records match.

16. In Minnesota, the asset limit is $10,000 for 1 parent and $20,000 for 2 parents.

17. In Minnesota, the SSA match has been adopted at the county-level only.

18. Nebraska eliminated its face-to-face interview requirement in 2010.

19. New York eliminated its face-to-face interview requirement and asset test in April 2010.

20. In South Carolina, families do not need to provide proof of assets.

Table 14
Renewal Periods and Streamlined Renewal Processes for Parents in Medicaid[1]
January 2011

State	Frequency of Renewal (Months)[2]	Face-to-Face Interview NOT Required	Paper Documentation of Income NOT Requested[3]	Simplifications Consistent with Children's Programs[4]
Total Adopting Simplifcation	**45**	**46**	**12**	**11**
Alabama	12	Y		
Alaska	12	Y		
Arizona	12	Y		
Arkansas	12	Y		
California[5]	12	Y		
Colorado[6] ▲	12	Y	Y	Y
Connecticut	12	Y	Y	Y
Delaware	12	Y		
District of Columbia	12	Y		
Florida[7]	12	Y		
Georgia	6	Y		
Hawaii	12	Y	Y	Y
Idaho	12	Y	Y	Y
Illinois	12	Y		
Indiana[8]	12	Y		
Iowa	12	Y		
Kansas	12	Y		
Kentucky	12			
Louisiana	12	Y		
Maine	12	Y		
Maryland	12	Y	Y	Y
Massachusetts	12	Y		
Michigan	12	Y		
Minnesota[9]	12	Y		
Mississippi	12			
Missouri	12	Y		
Montana	12	Y		
Nebraska[10] ▲	12	Y		
Nevada[11, 12]	12	Y	Y	
New Hampshire	6	Y		
New Jersey	12	Y		
New Mexico	12	Y	Y	Y
New York	12	Y	Y	Y
North Carolina	6	Y		
North Dakota[13]	12	Y		
Ohio[12]	12	Y	Y	Y
Oklahoma	12	Y	Y	Y
Oregon[14]	12	Y		
Pennsylvania	6	Y		
Rhode Island	12	Y		
South Carolina[15]	12	Y		
South Dakota	12	Y		
Tennessee	12	Y		
Texas	6			
Utah[16]	12	Y		
Vermont	12			
Virginia	12	Y	Y	Y
Washington[17]	6	Y		
West Virginia	12			
Wisconsin	12	Y		
Wyoming	12	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, 2011.
▲ Indicates that a state has expanded eligibility in at least one of its children's health insurance programs between January 1, 2010 and January 1, 2011, unless noted otherwise.
▼Indicates that a state has reduced eligibility in at least one of its children's health insurance programs between January 1, 2010 and January 1, 2011, unless noted otherwise.
Table presents rules in effect as of January 1, 2011, unless noted otherwise.

Table 14 Notes

1. This table presents policies for parents covered through 1931 Medicaid coverage; some states have differing policies for parents and other non-disabled adults covered through waiver or state-funded coverage programs.

2. This column shows the frequency of renewals. Some states require monthly, quarterly, or semi-annual income reporting or reporting a change in income, which is not addressed in this table. If the frequency of renewal is every 12 months, as opposed to six months or more frequently, the procedure is considered "simplified" for the purposes of this table. Total reflects number of states having adopted a 12-month renewal period.

3. In states that do not require families to provide documentation of income at application, states generally verify this information through data matches with other government agencies, such as the Social Security Administration and state departments of labor, and/or private employment databases. Often, families in states with administrative verification have to provide documentation of income if self-employed, if income is questionable, or if the state is unable to administratively verify the information. Some states request paper documentation of income at application, but if the family does not submit the documentation with the application, the state will attempt to administratively verify the information before following up with the family. States that verify income administratively, but continue to ask for income documentation on their applications are not counted as streamlining their procedures. This is a change from prior year reports.

4. States are classified as having consistent policies for children and parents if they have adopted all of the simplification measures listed in both programs.

5. California has a 12-month renewal period, but performs income reviews every 6 months.

6. Colorado implemented self-declaration of income in October 2010.

7. In Florida, parents who are enrolled in Medicaid and who do not receive other benefits, such as food stamps or TANF, have a 12-month renewal period. Parents who submit applications that do not appear to be prone to error or fraud, known as "green track" applications, are not required to complete an interview.

8. In Indiana, county offices may require telephone interviews, but not face-to-face interviews.

9. In Minnesota, children and parents who qualify under the state's Section 1115 expansion program have eligibility reviewed every 12 months. In the "regular" Medicaid program, income reviews occur every 6 months and eligibility reviews every 12 months.

10. Nebraska eliminated face-to-face interviews at renewal for Medicaid parents in 2010.

11. Nevada has a 12-month renewal period but performs income checks on a quarterly basis.

12. In Nevada and Ohio, paper documentation is required for changes in income only.

13. In North Dakota, there is a 12-month renewal period but income reported monthly.

14. In Oregon, the renewal period is up to 12 months, although most families not receiving other benefits have a 6-month eligibility period.

15. In South Carolina, renewals occur every 12 months, but every 6 months "if no income reported with no explanation for living expenses."

16. In Utah, the renewal period is 12 months, but can be more frequent if income fluctuates.

17. Washington has a 6-month renewal period but income reported monthly.

Table 15

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

January 2011

State	Premiums/Enrollment Fees				Co-payments			
	Change[2]	Required in Medicaid	Required in CHIP	Income at Which Premiums Begin (% FPL)	Change[2]	Required in Medicaid	Required in CHIP	Income at Which Copays Begin (% FPL)
Total		**5**	**30**			**3**	**25**	
Alabama			Y	101%			Y	101%
Alaska			N/A				N/A	
Arizona			Y	101%				
Arkansas			N/A			Y		200%
California			Y	101%			Y	101%
Colorado[3]			Y	151%			Y	101%
Connecticut[4]	Increased		Y	235%	Increased/ Decreased		Y	185%
Delaware[5]			Y	101%			Y	134%
District of Columbia			N/A				N/A	
Florida[6]			Y	101%			Y	101%
Georgia[7]			Y	101%				
Hawaii			N/A				N/A	
Idaho			Y	133%			Y	133%
Illinois			Y	151%			Y	134%
Indiana			Y	150%			Y	150%
Iowa			Y	151%			Y	151%
Kansas			Y	151%				
Kentucky[8]	Decreased						Y	101%
Louisiana			Y	201%			Y	201%
Maine			Y	151%				
Maryland[9]		Y	N/A	200%			N/A	
Massachusetts			Y	150%				
Michigan			Y	151%				
Minnesota[10]		Y	N/A	45%			N/A	
Mississippi							Y	150%
Missouri			Y	150%				
Montana							Y	133%
Nebraska			N/A				N/A	
Nevada[11]			Y	36%				
New Hampshire[12, 13]			Y	185%	Increased		Y	185%
New Jersey			Y	201%			Y	151%
New Mexico			N/A			Y	N/A	185%
New York			Y	160%				
North Carolina[14]			Y	151%	Increased		Y	100%
North Dakota							Y	100%
Ohio			N/A				N/A	
Oklahoma			N/A				N/A	
Oregon[15]			Y	201%			Y	201%
Pennsylvania			Y	201%			Y	201%
Rhode Island[13]		Y	N/A	150%			N/A	
South Carolina			N/A				N/A	
South Dakota								
Tennessee							Y	101%
Texas			Y	151%			Y	101%
Utah			Y	101%			Y	101%
Vermont		Y	Y	186%				
Virginia							Y	134%
Washington			Y	201%				
West Virginia			Y	201%			Y	101%
Wisconsin		Y	N/A	200%		Y	N/A	101%
Wyoming							Y	101%

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2011.

Table 15 Notes

1. Except for “mandatory children” (children under age six with family income below 133% of the FPL and children ages six to 17 with family income below 100% of the FPL), a state may impose premiums for children, with some limitations based on family income. Co-payments are also allowed, with some restrictions for children with family incomes up to 150% of the FPL. In general, states cannot adopt cost sharing or premium policies that impose costs that exceed 5% of family income or that favor higher-income families over lower-income families. They also are prohibited from imposing cost sharing for well-baby and well-child care, including immunizations. Some states require 18-year-olds to meet the co-payments of adults in Medicaid. These data are not shown.

2. "Increased" indicates that a state has increased premiums or co-payments or lowered the income level at which they are required in either Medicaid or CHIP. "Decreased" indicates that a state has decreased premiums or co-payments or raised the income level at which they are required in either Medicaid or CHIP. Changes occurred between January 1, 2010 and January 1, 2011, unless noted otherwise.

3. Co-payments increased in Colorado for those with income between 201% and 205% of the FPL when the state implemented its expansion from 205% to 250% of the FPL in May 2010.

4. Connecticut increased premiums and some copayments in CHIP in 2010; however, it also eliminated the copayment for emergency room services.

5. Delaware charges a copayment in CHIP for non-emergency use of the emergency room. For infants, the copayment charge begins at 186% FPL, and for children age 1-5 the copayment begins at 134% FPL.

6. Florida operates two CHIP-funded separate programs. Healthy Kids covers children ages 5 through 19, as well as younger siblings in some locations. MediKids covers children ages 1 through 4. Children in MediKids pay premiums, while children in Healthy Kids pay premiums and copayments.

7. Children under age 6 in Georgia are exempt from CHIP premiums.

8. Premiums in Kentucky were eliminated July 1, 2010.

9. In Maryland, most children are enrolled in MCOs and only have co-pays for mental health and HIV/AIDS drugs.

10. Premiums in MinnesotaCare begin at the old AFDC level. The state is awaiting approval of a waiver that would eliminate premiums for children at or below 200% of the FPL.

11. In Nevada, although Medicaid covers children in families with income up to 100% or 133% of the FPL, some children with lower incomes may qualify for CHIP depending on the source of income and family composition. Such families with incomes at or above 36% of the FPL are required to pay premiums.

12. New Hampshire increased the copayment for an emergency room visit for children above 200% FPL in 2010.

13. Premiums are not charged in New Hampshire or Rhode Island to children under age 1.

14. North Carolina increased the copayment for non-emergency use of the emergency room in 2010.

15. Premiums are charged in Oregon between 201% and 300% of the FPL, following the state's expansion to this income group in February 2010.

Table 16

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

January 2011

State	Effective Amount per Child at:[3] 101% FPL	151% FPL	201% FPL (200% if upper limit)	251% FPL (250% if upper limit)	301% FPL (300% if upper limit)	351% FPL (350% if upper limit)
NO PREMIUMS OR ENROLLMENT FEES						
Alaska	--	--	--	--	--	--
Arkansas	--	--	--	--	--	--
District of Columbia	--	--	--	--	--	--
Hawaii	--	--	--	--	--	--
Kentucky	--	--	--	--	--	--
Mississippi	--	--	--	--	--	--
Montana	--	--	--	--	--	--
Nebraska	--	--	--	--	--	--
New Mexico	--	--	--	--	--	--
North Dakota	--	--	--	--	--	--
Ohio	--	--	--	--	--	--
Oklahoma	--	--	--	--	--	--
South Carolina	--	--	--	--	--	--
South Dakota	--	--	--	--	--	--
Tennessee	--	--	--	--	--	--
Virginia	--	--	--	--	--	--
Wyoming	--	--	--	--	--	--
MONTHLY PAYMENTS						
Arizona	$10	$40	$50	N/A	N/A	N/A
California[4]	$4/$7	$13/$16	$21/$24	$21/$24	N/A	N/A
Connecticut	$0	$0	$0	$38	$38	N/A
Delaware[5]	$10	$15	$25	N/A	N/A	N/A
Florida	$15	$20	$20	N/A	N/A	N/A
Georgia	$10	$20	$29	N/A	N/A	N/A
Idaho	$0	$15	N/A	N/A	N/A	N/A
Illinois	$0	$15	$15	$40	$70	**N/A**
Indiana	$0	$22	$33	$53	N/A	N/A
Iowa	$0	$10	$10	$20	$20	N/A
Kansas	$0	$20	$30	N/A	N/A	N/A
Louisiana[6]	$0	$0	$50	$50	N/A	N/A
Maine	$0	$8	$32	N/A	N/A	N/A
Maryland[6]	$0	$0	$48	$60	$60	N/A
Massachusetts	$0	$12	$20	$28	$28	N/A
Michigan[6]	$0	$10	$10	N/A	N/A	N/A
Minnesota[7]	$4	$28	$57	$93	N/A	N/A
Missouri	$0	$13	$42	$102	N/A	N/A
New Hampshire	$0	$0	$32	$32	$54	N/A
New Jersey[6]	$0	$0	$40	$79	$133	$133
New York	$0	$0	$9	$30	$45	$60
Oregon[8]	$0	$0	$24	$36	$36	N/A
Pennsylvania[8]	$0	$0	$48	$76	N/A	N/A
Rhode Island[6]	$0	$61	$92	$92	N/A	N/A
Vermont[9]	$0	$0	$15	$20/$60	$20/$60	N/A
Washington	$0	$0	$20	$30	$30	N/A
West Virginia	$0	$0	$35	$35	N/A	N/A
Wisconsin	$0	$0	$10	$31	$76	N/A
QUARTERLY PAYMENTS						
Nevada[6]	$25	$50	$80	N/A	N/A	N/A
Utah[6]	$30	$75	$75	N/A	N/A	N/A
ANNUAL PAYMENTS						
Alabama	$50	$100	$100	$100	$100	N/A
Colorado	$0	$25	$25	$25	N/A	N/A
North Carolina	$0	$50	$50	N/A	N/A	N/A
Texas	$0	$35	$50	N/A	N/A	N/A

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2011. Table presents rules in effect as of January 1, 2011, unless noted otherwise.

Table 16 Notes

1. Except for “mandatory children” (children under age six with family income below 133% of the FPL and children ages six to 17 with family income below 100% of the FPL), a state may impose premiums for children, with some limitations based on family income.

2. Enrollment fees are charged annually and families are typically not allowed to enroll in coverage without paying the fee.

3. If a state does not charge premiums at all, it is noted as "- -". N/A indicates that coverage is not available at this income level.

4. Premiums in California depend on whether the child is enrolled in a community provider plan. The first figure applies to children enrolled in a community provider plan; the second applies to those who are not.

5. In Delaware, premiums are per family per month regardless of the number of eligible children. Delaware has an incentive system for premiums where families can pay 3 months and get 1 premium-free month, pay 6 months and get 2 premium-free months, and pay 9 months and get 3 premium-free months.

6. In Louisiana, Maryland, Michigan, Nevada, New Jersey, Rhode Island, and Utah, premiums are family-based, not costs per child.

7. In Minnesota, all children with family income below 150% of the FPL pay premiums of $4 per child, per month. Premiums reported are for a family of three, when only one child is enrolled in MinnesotaCare.

8. In Oregon and Pennsylvania, premiums vary by contractor. The average amount is shown.

9. In Vermont, premiums are for all children in the family, not costs per child. For those above 225% FPL, the monthly charge is $20 if the family has other health insurance and $60 if there is no other health insurance.

Table 17

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

January 2011

State	Grace Period for Non-Payment[2]	Lock-Out Period[3]	Requirements to Reenroll	
			Reapply for Coverage	Repay Outstanding Premiums
Total		**15**	**27**	**22**
Alabama	- -	- -	- -	- -
Alaska	- -	- -	- -	- -
Arizona	60 days	None	Y	Y
Arkansas	- -	- -	- -	- -
California	60 days	None	Y	Y
Colorado	- -	- -	- -	- -
Connecticut[4]	30 days	3 months	Y	Y
Delaware	60 days	None		
District of Columbia	- -	- -	- -	- -
Florida[5]	30 days	1 month	Y	
Georgia	30 days	1 month		Y
Hawaii	- -	- -	- -	- -
Idaho	60 days	None	Y	Y
Illinois	60 days	3 months	Y	Y
Indiana	60 days	None	Y	Y
Iowa	30 days	None	Y	Y
Kansas[6]	12 months	None	Y	Y
Kentucky	- -	- -	- -	- -
Louisiana[5]	60 days	None	Y	Y
Maine[7]	12 months	up to 3 months	Y	
Maryland	45 days	6 months	Y	Y
Massachusetts[8]	60 days	None		Y
Michigan[9]	30 days	None	Y	Y
Minnesota[10]	None	4 months	Y	Y
Mississippi	- -	- -	- -	- -
Missouri[11]	20 days	6 months	Y	Y
Montana	- -	- -	- -	- -
Nebraska	- -	- -	- -	- -
Nevada	60 days	None	Y	Y
New Hampshire	60 days	3 months	Y	
New Jersey	60 days	None	Y	Y
New Mexico	- -	- -	- -	- -
New York[12]	30 days	None	Y	
North Carolina	- -	- -	- -	- -
North Dakota	- -	- -	- -	- -
Ohio	- -	- -	- -	- -
Oklahoma	- -	- -	- -	- -
Oregon	31 days	2 months	Y	Y
Pennsylvania[13]	30 days	6 months	Y	Y
Rhode Island[14]	60 days	4 months	Y	
South Carolina	- -	- -	- -	- -
South Dakota	- -	- -	- -	- -
Tennessee	- -	- -	- -	- -
Texas	- -	- -	- -	- -
Utah[15]	30 days	- -	Y	Y
Vermont[16]	None	None	Y	
Virginia	- -	- -	- -	- -
Washington	90 days	3 months	Y	Y
West Virginia	30 days	6 months	Y	
Wisconsin	60 days	6 months	Y	Y
Wyoming	- -	- -	- -	- -

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2011. Table presents rules in effect as of January 1, 2011, unless noted otherwise.

Table 17 Notes

1. If a state does not charge premiums, it is noted as "- -".

2. CHIPRA required states to provide a 30-day premium payment grace period under CHIP before cancelling a child's coverage.

3. A lock-out period is a period of time during which the disenrolled person is prohibited from returning to the program.

4. In Connecticut, it depends on where the family is in their annual renewal process as to whether they have to submit a new application.

5. In Florida and Louisiana, if the child is in his/her 12-month continuous eligibility period, he/she does not need to reapply for coverage.

6. In Kansas, families are billed monthly, but only disenrolled for non-payment at renewal. A family does not need to reapply for coverage if termination is within 45 days of renewal date.

7. In 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.

8. 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.

9. In Michigan, families do not have to pay missed premiums over 6 months old.

10. MinnesotaCare currently cancels coverage when the premium has not been paid in advance of the month of coverage. However, there is currently a 20-day period in which people with good cause can have coverage restored if they pay the premium during that period. The state is awaiting approval for a 30-day grace period.

11. In Missouri, only children in families with incomes above 225% of the FPL are subject to the lock-out period and required to pay back missed premiums.

12. In New York, if the family pays the premium within 30 days of cancellation they do not need to reapply for coverage.

13. In Pennsylvania, if the family pays back-owed premiums prior to the end of the renewal period, they do not have to re-apply for coverage.

14. In Rhode Island, families do not have to pay back-owed premiums prior to reenrolling, but the balance will remain on their account.

15. In Utah, families don't have to pay back premiums that are over one year old.

16. In Vermont, premiums are paid on a prospective basis; payments must be received by the first business day following the month it was due for coverage to continue. If the premium is paid in the calendar month after the child lost coverage, the family does not have to reapply.

Table 18
Copayment Amounts for Selected Services for Children at Selected Income Levels[1]
January 2011

State	Family Income at 151% FPL			Family Income at 201% FPL[2] (200% if upper limit)		
	Non-Preventive Physician Visit	ER Visit	Inpatient Hospital Visit	Non-Preventive Physician Visit	ER Visit	Inpatient Hospital Visit
Total	**17**	**14**	**12**	**22**	**18**	**13**
Alabama[3]	$5	$15	$10	$5	$15	$10
Alaska	--	--	--	--	--	--
Arizona	--	--	--	--	--	--
Arkansas	$10	$10	20% of reimbursement rate for first day	$10	$10	20% of reimbursement rate for first day
California[4, 5]	$10	$15	$0	$10	$15	$0
Colorado	$5	$15	$0	$10	$20	$0
Connecticut	$0	$0	$0	$10	$0	$0
Delaware[3]	$0	$0	$0	$0	$0	$0
District of Columbia	--	--	--	--	--	--
Florida[3, 6]	$5	$0	$0	$5	$0	$0
Georgia	--	--	--	--	--	--
Hawaii	--	--	--	--	--	--
Idaho[3]	$0	$0	$0	N/A	N/A	N/A
Illinois[3]	$5	$5	$5	$10	$30	$100
Indiana	$0	$0	$0	$0	$0	$0
Iowa[3]	$0	$0	$0	$0	$0	$0
Kansas	--	--	--	--	--	--
Kentucky[3]	$0	$0	$0	$0	$0	$0
Louisiana[5]	$0	$0	$0	$0	$150	$0
Maine	--	--	--	--	--	--
Maryland	--	--	--	--	--	--
Massachusetts	--	--	--	--	--	--
Michigan	--	--	--	--	--	--
Minnesota	--	--	--	--	--	--
Mississippi	$5	$15	$0	$5	$15	$0
Missouri	--	--	--	--	--	--
Montana	$3	$5	$25	$3	$5	$25
Nebraska	--	--	--	--	--	--
Nevada	--	--	--	--	--	--
New Hampshire[5, 7]	$0	$0	$0	$10	$100	$0
New Jersey[3]	$5	$10	$0	$5	$35	$0
New Mexico[5]	$0	$0	$0	$5	$15	$25
New York	--	--	--	--	--	--
North Carolina[3]	$5	$0	$0	$5	$0	$0
North Dakota	$0	$5	$50	N/A	N/A	N/A
Ohio	--	--	--	--	--	--
Oklahoma	$0	$0	$0	N/A	N/A	N/A
Oregon[5]	--	--	--	$5	$100	$100
Pennsylvania[5]	$0	$0	$0	$5	$25	$0
Rhode Island	--	--	--	--	--	--
South Carolina	--	--	--	--	--	--
South Dakota	--	--	--	--	--	--
Tennessee[3, 5, 7]	$5/$15	$0/$15	$100/$100	$10/$15	$0/$15	$200/$100
Texas	$7	$50	$50	$10	$50	$100
Utah[8]	$20	$100/$200	20% of daily reimbursement rate	$20	$100/$200	20% of daily reimbursement rate
Vermont	--	--	--	--	--	--
Virginia[3]	$5	$0	$25	$5	$0	$25
Washington	--	--	--	--	--	--
West Virginia[5, 9]	$15	$35	$25	$20	$35	$25
Wisconsin[3]	$1-$3	$0	$3	$15	$0	$100
Wyoming[5]	$10	$25	$50	$10	$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, 2011. Data were not collected last year, so changes are not noted. Table presents rules in effect as of January 1, 2011, unless noted otherwise.

Table 18 Notes

1. Co-payments are allowed, with some restrictions for children with family incomes up to 150% of the FPL. In general, states cannot adopt cost sharing or premium policies that impose costs that exceed 5% of family income or that favor higher-income families over lower-income families. They also are prohibited from imposing cost sharing for well-baby and well-child care, including immunizations. If a state charges co-payments, but either does not charge them at the income level shown or for the specific service, it is recorded as $0; if a state does not provide coverage at a particular income level it is noted as "N/A;" if a state does not charge co-payments at all, it is noted as "- -". Some states require 18-year-olds to meet the co-payments of adults in Medicaid. These data are not shown.

2. If upper income eligibility level is 200% of the FPL, the co-payments shown reflect the cost at 200% of the FPL.

3. In Alabama, Delaware, Florida, Idaho, Illinois, Iowa, Kentucky, New Jersey, North Carolina, Tennessee, Virginia, and Wisconsin enrollees are charged a co-payment for non-emergency use of the ER that is higher than the amount shown in the table. In Alabama, enrollees are charged a $20 co-payment; in Delaware, enrollees are charged a $10 co-payment; in Florida, enrollees are charged a $10 co-payment; in Idaho, enrollees are charged a $3 co-payment; in Illinois, enrollees with income above 150% of the FPL are charged a $25 co-payment, enrollees with income above 200% of the FPL are charged a $30 co-payment; in Iowa enrollees with income above 150% of the FPL are charged a $25 co-payment; in Kentucky, enrollees are charged 5% co-insurance for non-emergency use of the ER, which is capped at $6; in New Jersey, enrollees with income above 150% of the FPL are charged a $10 co-payment, enrollees with income above 200% of the FPL are charged a $35 co-payment; in North Carolina, enrollees with incomes above 150% of the FPL are charged a $25 co-payment; in CoverKids in Tennessee, children are charged a $50 co-payment; in TennCare Standard, children at 151% of the FPL are charged a $25 co-payment, and children at 201% of the FPL are charged a $50 co-payment; in Virginia, enrollees with income above 150% of the FPL are charged a $25 co-payment;; and in Wisconsin, enrollees with income above 200% of the FPL are charged a $60 co-payment for non-emergency use of the ER.

4. In California, no coverage is provided if the services received in an emergency room are not for an emergency condition.

5. In California, Louisiana, New Hampshire, New Mexico, Oregon, Pennsylvania, Tennessee, West Virginia, and Wyoming the emergency room co-payment is waived if the child is admitted. In New Mexico, the inpatient co-payment is still applied.

6. In Florida, co-payments only apply to children over the age of five.

7. Tennessee has two CHIP programs. The first set of co-payments is for TennCare Standard and the second is for CoverKids.

8. In Utah, the co-payment for an emergency room visit is $100 for a participating hospital and $200 for a non-participating hospital.

9. In West Virginia, the co-payments for a non-preventive physician visit are waived if the child goes to his or her medical home.

Table 19
Copayment Amounts for Prescription Drugs for Children at Selected Income Levels[1]
January 2011

State	Family Income at 151% FPL			Family Income at 201% FPL[2] (200% if upper limit)		
	Generic	Preferred Brand Name	Non-Preferred Brand Name	Generic	Preferred Brand Name	Non-Preferred Brand Name
Total	**18**	**19**	**16**	**24**	**26**	**21**
Alabama	$2	$5	$10	$2	$5	$10
Alaska	--	--	--	--	--	--
Arizona	--	--	--	--	--	--
Arkansas	$5	$5	$5	$5	$5	$5
California[3]	$5	$15	$15	$10	$15	$15
Colorado	$3	$5	/	$5	$10	/
Connecticut	$0	$0	$0	$5	$10	$10
Delaware	$0	$0	$0	$0	$0	$0
District of Columbia	--	--	--	--	--	--
Florida[4]	$5	$5	$5	$5	$5	$5
Georgia	--	--	--	--	--	--
Hawaii	--	--	--	--	--	--
Idaho	$0	$0	$0	N/A	N/A	N/A
Illinois	$3	$5	$5	$3	$7	$7
Indiana	$3	$10	$10	$3	$10	$10
Iowa	$0	$0	$0	$0	$0	$0
Kansas	--	--	--	--	--	--
Kentucky	$1	$2	$3	$1	$2	$3
Louisiana[5]	$0	$0	$0	50% of cost	50% of cost	50% of cost
Maine	--	--	--	--	--	--
Maryland	--	--	--	--	--	--
Massachusetts	--	--	--	--	--	--
Michigan	--	--	--	--	--	--
Minnesota	--	--	--	--	--	--
Mississippi	$0	$0	$0	$0	$0	$0
Missouri	--	--	--	--	--	--
Montana[6]	$3	$5	$5	$3	$5	$5
Nebraska	--	--	--	--	--	--
Nevada	--	--	--	--	--	--
New Hampshire[3]	--	--	--	$5	$15	$25
New Jersey	$1	$5	$5	$5	$5	$5
New Mexico	$0	$0	$0	$2	$2	$2
New York	--	--	--	--	--	--
North Carolina[3]	$2	$10	$10	$2	$10	$10
North Dakota	$2	$2	$2	N/A	N/A	N/A
Ohio	--	--	--	--	--	--
Oklahoma						
Oregon	$0	$0	$0	$0	$10	/
Pennsylvania[7]	$0	$0	/	$6	$9	/
Rhode Island	--	--	--	--	--	--
South Carolina	--	--	--	--	--	--
South Dakota	--	--	--	--	--	--
Tennessee[8]	$0/$5	$3/$20	$3/$40	$0/$5	$3/$20	$3/$40
Texas	$5	$20	N/A	$5	$20	N/A
Utah	50% of cost	25% of cost	50% of cost	$10	25% of cost	50% of cost
Vermont	--	--	--	--	--	--
Virginia	$5	$5	$5	$5	$5	$5
Washington	--	--	--	--	--	--
West Virginia	$0	$10	$15	$0	$10	$15
Wisconsin[9]	$1	$3	/	$5	/	/
Wyoming	$5	$10	/	$5	$10	/

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2011. Table presents rules in effect as of January 1, 2011, unless noted otherwise.

Table 19 Notes

1. Co-payments are allowed, with some restrictions for children with family incomes up to 150% of the FPL. In general, states cannot adopt cost sharing or premium policies that impose costs that exceed 5% of family income or that favor higher-income families over lower-income families. They also are prohibited from imposing cost sharing for well-baby and well-child care, including immunizations. If a state charges co-payments, but either does not charge them at the income level shown or for the specific service, it is recorded as $0; if a state does not provide coverage at a particular income level it is noted as "N/A;" if a state does not charge co-payments at all, it is noted as "- -"; if a state does not cover a type of drug, it is noted as "/". Some states require 18-year-olds to meet the co-payments of adults in Medicaid. These data are not shown.

2. If upper income eligibility level is 200% of the FPL, the co-payments shown reflect the cost at 200% of the FPL.

3. In California, New Hampshire, and North Carolina, the co-payment for brand-name drugs only applies if a generic version is available. In California, brand name drugs cost $10 if there is no generic equivalent and the use of a brand name drug is medically necessary.

4. In Florida, co-payments only apply to children over the age of five.

5. In Louisiana, families pay 50% of the cost of the prescription, up to a maximum of $50 per 30-day supply. After $1,200 per person per plan year, the co-payment is $15 for brand named prescriptions and $0 for generic prescriptions.

6. If families order prescriptions through the mail in Montana, they pay $6 for a 3-month supply of a generic drug and $10 for a 3-month supply of a brand-named drug.

7. In Pennsylvania, if a drug is not included on the formulary of the managed care plan for a CHIP child, the family must pay for the drug out-of-pocket.

8. Tennessee has two CHIP programs. The first set of co-payments is for TennCare Standard and the second is for CoverKids.

9. Wisconsin doesn't cover brand name drugs, except for certain insulin brands and some asthma medications for enrollees above 200% of the FPL. When they do cover them, they have the same copayment as generic drugs.

Table 20

Premium, Enrollment Fee, and Copayment Requirements for Adults [1]

January 2011

State	Increase or Decrease in 2010 for:[2]		1931 Parent Medicaid Coverage				Expansion Coverage (Parents and Other Non-Disabled Adults)[3]			
	Premiums	Copays	Premiums/ Enrollment Fees	Income Premiums/ Fees Begin (% FPL)	Copays	Income Copays Begin (% FPL)	Premiums/ Enrollment Fees	Income Premiums/ Fees Begin (% FPL)	Copays	Income Copays Begin (% FPL)
Total			**3**		**40**		**21**		**26**	
Alabama			- -		Y	0%		N/A		
Alaska			- -		Y	0%		N/A		
Arizona[4]		Increased	- -		Y	0%	- -		Y	0%
Arkansas			- -		Y	0%	Y	0%	Y	0%
California[5]			- -		Y	0%	- -/Y	- -/150%	Y/Y	0%/0%
Colorado			- -		Y	0%		N/A		
Connecticut[6]	Increased		- -		- -		Y	0%	Y	0%
Delaware[7]		Decreased	- -		Y	0%	- -		Y	0%
District of Columbia[8]			- -		- -		- -		- -	
Florida			- -		Y	0%		N/A		
Georgia			- -		Y	0%		N/A		
Hawaii[9]			- -		- -		- -		- -	
Idaho[10]			- -		- -		Y	0%	Y	0%
Illinois[11]			Y	151%	Y	0%		Vary based on ESI Plan		
Indiana[12]		Increased	- -		Y	0%	Y	>0%	Y	0%
Iowa[13]	Decreased		- -		Y	0%	Y	150%	Y	133%
Kansas			- -		Y	0%		N/A		
Kentucky			- -		Y	0%		N/A		
Louisiana			- -		Y	0%		N/A		
Maine[14]			- -		Y	0%	- -/Y	--/0%	- -/Y	--/0%
Maryland[15]			- -		- -		- -		Y	0%
Massachusetts[16]		Increased	- -		Y	0%	- -/Y	--/150%	Y/Y	0%/0%
Michigan[17]			- -		Y	0%	- -		Y	0%
Minnesota[18]			- -		Y	100%	Y	0%	Y	0%
Mississippi			- -		Y	0%		N/A		
Missouri			- -		Y	0%		N/A		
Montana			- -		Y	0%		N/A		
Nebraska			- -		Y	0%		N/A		
Nevada[19]			- -		- -		Y	88%	Y	88%
New Hampshire			- -		Y	0%		N/A		
New Jersey[20]	Increased		- -		- -		Y	150%	Y	151%
New Mexico[21]			- -		- -		Y	101%	Y	101%
New York[22]			- -		Y	0%	- -		Y	0%
North Carolina			- -		Y	0%		N/A		
North Dakota			- -		Y	0%		N/A		
Ohio			- -		Y	0%		N/A		
Oklahoma[23]			- -		Y	0%	Y	0%	Y	0%
Oregon[24]			- -		Y	0%	Y/Y	10%/0%	- - /Y	- - / 0%
Pennsylvania[25]	Increased	Increased	- -		Y	0%	Y	0%	Y	0%
Rhode Island[26]			Y	150%	- -		Y	150%	- -	
South Carolina			- -		Y	0%		N/A		
South Dakota			- -		Y	0%		N/A		
Tennessee[27]			- -		Y	0%	Y	0%	Y	0%
Texas			- -		- -			N/A		
Utah[28]			- -		Y	0%	Y/Y	0%/varies	Y/Y	101%/varies
Vermont[29]			- -		Y	0%	Y/Y	50%/0%	Y/Y	0%/0%
Virginia			- -		Y	0%		N/A		
Washington[30]			- -		- -		Y	0%	Y	0%
West Virginia			- -		Y	0%		N/A		
Wisconsin[31]			Y	150%	Y	0%		- -	Y	0%
Wyoming			- -		Y	0%		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, 2011. Table presents rules in effect as of January 1, 2011, unless noted otherwise.

Table 20 Notes

1. A state may impose premiums for parents with some limitations based on family income. Co-payments are also allowed, with some restrictions. In general, states cannot adopt cost sharing or premium policies that impose costs that exceed 5% of family income or that favor higher-income families over lower-income families.

2. "Increased" indicates that a state has increased premiums or co-payments or lowered the income level at which they are required in either Medicaid or CHIP. "Decreased" indicates that a state has decreased premiums or co-payments or raised the income level at which they are required in either Medicaid or CHIP. Changes occurred between January 1, 2010 and January 1, 2011, unless noted otherwise.

3. Expansion coverage includes both waiver and state-funded programs for parents and/or other non-disabled adults.

4. In Arizona, parents and childless adults are charged nominal co-pays. Mandatory, higher copayments for childless adults were implemented October 1, 2010.

5. In California, premium policies in Health Care Coverage Initiative (HCCI) depend on the county. There are no premiums in the Medicaid Coverage Expansion (MCE).

6. Connecticut stopped subsidizing premiums for new enrollees in its state-funded Charter Oak program in 2010. There are no premium or cost sharing charges in the states ACA option coverage for adults.

7. Delaware eliminated a $1 copayment for non-emergency transportation in 2010.

8. In DC, expansion coverage is the ACA option coverage and DC HealthCare Alliance; there are no premiums or cost sharing charged in either program.

9. In Hawaii, expansion coverage is QUEST and QUEST-ACE coverage. Adults previously enrolled in Medicaid (QUEST Expanded Access (QExA) or QUEST) with incomes between 200%-300% FPL can buy into QUEST-NET coverage by paying a monthly premium.

10. In Idaho, expansion coverage is the Access to Health Insurance premium assistance program; as such, costs vary by plan.

11. In Illinois, expansion coverage is the Family Care Rebate premium assistance program; as such costs vary by plan.

12. In Indiana, expansion Coverage is the Healthy Indiana Plan; individuals with zero income are exempt from monthly contributions.

13. In Iowa, expansion coverage is IowaCare. Premiums for IowaCare used to begin at 100% FPL; effective 10/1/2010, they begin at 150% FPL.

14. In Maine, for expansion coverage, values before the slash are for MaineCare for Childless Adults and values after the slash are for Dirigo Health.

15. In Maryland, expansion coverage is Primary Adult Coverage. Maryland does not charge copayments for Section 1931 parents except for mental health and HIV/AIDS related drugs.

16. Massachusetts increased copayments for some generic prescription drugs for MassHealth parents in 2010. For Expansion Coverage, values before the slash are for MassHealth Basic and Essential and values after the slash are for Commonwealth Care.

17. In Michigan, expansion coverage is the Adult Benefits Waiver program.

18. In Minnesota, expansion coverage is MinnesotaCare.

19. In Nevada, expansion coverage is the Check Up Plus premium assistance program for parents above 1931 limits. Costs vary by plan.

20. In New Jersey, expansion coverage is its Family Care waiver program. Family Care premiums for parents increased effective July 1, 2010.

21. In New Mexico, expansion coverage is the SCI waiver program.

22. In New York, expansion coverage is the Family Health Plus waiver program.

23. In Oklahoma, expansion coverage is the Insure Oklahoma waiver program.

24. In Oregon, expansion coverage values before slash are for OHP Standard and values after slash are for FHIAP premium assistance.

Table 20 Notes (continued)

25. In Pennsylvania, expansion coverage is adultBasic. Premiums and cost sharing in adultBasic increased March 1, 2010.

26. In Rhode Island, expansion coverage is Rite Care and RIte Share.

27. In Tennessee, expansion coverage is CoverTN.

28. In Utah, for expansion coverage, values before slash are for Primary Care Network and values after slash are for Utah Premium Partnership premium assistance.

29. In Vermont, for Expansion Coverage, values before slash are for VHAP and values after slash are for Catamount Health.

30. In Washington, expansion coverage is Basic Health.

31. In Wisconsin, expansion coverage is BadgerCare Core Plan for childless adults.

Table 21

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

January 1, 2011

State	Effective Amount per Adult at:[3]					
	101% FPL (100% if upper limit)	151% FPL (150% if upper limit)	201% FPL (200% if upper limit)	251% FPL (250% if upper limit)	300% FPL (301% if upper limit)	351% FPL (350% if upper limit)
NO PREMIUMS OR ENROLLMENT FEES						
Alabama	- -	- -	- -	- -	- -	- -
Alaska	- -	- -	- -	- -	- -	- -
Arizona	- -	- -	- -	- -	- -	- -
Colorado	- -	- -	- -	- -	- -	- -
Delaware	- -	- -	- -	- -	- -	- -
District of Columbia	- -	- -	- -	- -	- -	- -
Florida	- -	- -	- -	- -	- -	- -
Georgia	- -	- -	- -	- -	- -	- -
Hawaii[4]	- -	- -	- -	- -	- -	- -
Kansas	- -	- -	- -	- -	- -	- -
Kentucky	- -	- -	- -	- -	- -	- -
Louisiana	- -	- -	- -	- -	- -	- -
Maryland	- -	- -	- -	- -	- -	- -
Michigan	- -	- -	- -	- -	- -	- -
Mississippi	- -	- -	- -	- -	- -	- -
Missouri	- -	- -	- -	- -	- -	- -
Montana	- -	- -	- -	- -	- -	- -
Nebraska	- -	- -	- -	- -	- -	- -
New Hampshire	- -	- -	- -	- -	- -	- -
New York	- -	- -	- -	- -	- -	- -
North Carolina	- -	- -	- -	- -	- -	- -
North Dakota	- -	- -	- -	- -	- -	- -
Ohio	- -	- -	- -	- -	- -	- -
South Carolina	- -	- -	- -	- -	- -	- -
South Dakota	- -	- -	- -	- -	- -	- -
Texas	- -	- -	- -	- -	- -	- -
Virginia	- -	- -	- -	- -	- -	- -
West Virginia	- -	- -	- -	- -	- -	- -
Wyoming	- -	- -	- -	- -	- -	- -
MONTHLY PAYMENTS						
Arkansas[5]	$25	$25	$25	N/A	N/A	N/A
California[6]	- -	Vary by County		N/A	N/A	N/A
Connecticut[7]	$307	$307	$307	$307	$307	N/A
Idaho[8]	Vary based on ESI Plan		N/A	N/A	N/A	N/A
Illinois[9]	$0	$15-$40	Vary based on ESI Plan	N/A	N/A	N/A
Indiana[10]	$27	$68	$90	N/A	N/A	N/A
Iowa	$0	$55	$75	$75	N/A	N/A
Maine[11]	20% cost	40% cost	60% cost	80% cost	80% cost	N/A
Massachusetts[12]	$0-$12	$39-$60	$77-$110	$116-$151	$116-$151	N/A
Minnesota[13]	$20	$49	$102	$162	N/A	N/A
New Jersey[14]	- -	$42.50	$42.50	N/A	N/A	N/A
Nevada[15]	Vary based on ESI Plan			N/A	N/A	N/A
New Mexico[16]	$25/$95	$35/$110	$35/$110	N/A	N/A	N/A
Oklahoma[17]	$36	$55	N/A	N/A	N/A	N/A
Oregon[18]	$20/vary	Vary based on Plan		N/A	N/A	N/A
Pennsylvania	$36	$36	$36	N/A	N/A	N/A
Rhode Island[19]	$0	$61	N/A	N/A	N/A	N/A
Tennessee[20]	$38-$220	$38-$220	$38-$220	$38-$220	$38-$220	$38-$220
Vermont[21]	$25/$60 or $96	$33/$60 or $96	$124 or $160	$180 or $216	$208 or $244	N/A
Washington[22]	$60	$89	$155	N/A	N/A	N/A
Wisconsin[23]	$0	$10	$268	N/A	N/A	N/A
ANNUAL PAYMENTS						
Utah[24]	$50/vary	$50/vary	N/A	N/A	N/A	N/A

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2011. Table presents rules in effect as of January 1, 2011, unless noted otherwise.

Table 21 Notes

1. A state may impose premiums for parents with some limitations based on family income. Co-payments are also allowed, with some restrictions. In general, states cannot adopt cost sharing or premium policies that impose costs that exceed 5% of family income or that favor higher-income families over lower-income families.

2. Enrollment fees are charged annually and families are typically not allowed to enroll in coverage without paying the fee.

3. If a state does not charge premiums at all, it is noted as "- -". N/A indicates that coverage is not available at this income level.

4. In Hawaii, adults previously enrolled in Medicaid (QUEST Expanded Access (QExA) or QUEST) with income between 200-300% FPL can buy into QUEST-NET for a monthly $60 premium.

5. In Arkansas, premium costs for ARHealthNet waiver program. Adults above 200% FPL can buy-in at full cost for $255/month.

6. In California, premium policies in Health Care Coverage Initiative (HCCI) depend on the county. There are no premiums in the Medicaid Coverage Expansion (MCE).

7. In Connecticut, premium costs are for state Charter Oak program. Effective June 1, 2010 the state stopped subsidizing premiums for new enrollees; adults at any income can buy in at full cost for $307 per month.

8. In Idaho, premiums are for the Access to Health Insurance premium assistance waiver program; actual costs vary based on ESI plan.

9. In Illinois, premium costs at 101% FPL and 151% FPL are for expanded Medicaid FamilyCare coverage for parents; costs vary based on the number of people covered. Parents up to 200% FPL are eligible for the FamilyCare Rebate premium assistance program; actual costs vary based on ESI plan.

10. In Indiana, costs represent monthly POWER Account contributions for the Healthy Indiana Plan waiver program; costs vary based on family composition and income; amounts shown are for a single adult with no children.

11. In Maine, costs are for the Dirigo Health plan. Individuals receive percentage discounts on costs based on income.

12. In Massachusetts, premium costs are for the Commonwealth Care waiver program; costs vary by income and plan type.

13. In Minnesota, premium costs are for the MinnesotaCare waiver program; costs vary based on income and family size; numbers shown are for an individual adult.

14. In New Jersey, premium costs are for the FamilyCare waiver program; they increased to $42.50 for the first parent and $21.25 for the second parent as of July 1, 2010.

15. In Nevada, those enrolled in CheckUp Plus premium assistance pay premiums, but costs vary by plan.

16. In New Mexico, premium costs are for the SCI waiver program; numbers before the slash represent the cost if an employer pays the employer share; numbers after the slash represent the cost if the individual pays both the employee and employer share.

17. In Insure Oklahoma, premiums range from $67.31 to $181.60, or 4% of income, whichever is less; amounts shown equal 4% of income.

18. In Oregon, OHP Standard waiver program premiums begin at 10% FPL and range from $9-$20 with eligibility ending at 100% FPL; premiums for FHIAP premium assistance waiver coverage vary by plan; individuals pay between 5-50% of premium costs depending on income; most FHIAP enrollees pay $25 per month.

19. In Rhode Island, premiums are family-based.

20. In Tennessee, premium costs are for the state-funded CoverTN program; costs vary based on age, weight, and tobacco use; they range from $37.53-$109.03 if the employer share is covered; without the employer share covered, cost doubles to $76-$220.

21. In Vermont, at 101% and 151% FPL, the values before the slash are for VHAP and the values after the slash are for Catamount Health. When only one number is shown, the costs are for Catamount Health for a single individual; these costs vary by plan. Individuals above 300% FPL can buy into Catamount Health at full cost for $416 per month.

22. In Washington, premium costs are for Basic Health; amounts shown are for a single adult 19-39 years old with no children in Adams County. Most but not all counties have the same premiums as Adams County.

23. In Wisconsin, premium costs are for parents in BadgerCare Plus Standard Plan. Childless adults in Core Plan pay a one-time application fee of $60.

24. In Utah, the value before the slash is the annual enrollment fee for Primary Care Network waiver coverage; the value after the slash is for the Utah Premium Partnership waiver premium assistance program; costs vary by plan.

Table 22
Cost Sharing Amounts for Selected Services for Adults at Selected Incomes[1, 2]
January 2011

State	1931 Medicaid for Parents			Waiver or State-Funded Expansion Coverage (Parents and Other Non-Disabled Adults)[3]					
				<100% FPL			100-200% FPL		
	Non-Preventive Physician Visit	Inpatient Hospital Visit	Emergency Room Visit[4]	Non-Preventive Physician Visit	Inpatient Hospital Visit	Emergency Room Visit[4]	Non-Preventive Physician Visit	Inpatient Hospital Visit	Emergency Room Visit[4]
Total	**23**	**24**	**17**	**22**	**15**	**17**	**18**	**16**	**19**
Alabama	$1	$50	$0/$3	N/A					
Alaska[5]	$3	$50/day	$0	N/A					
Arizona	$4	$0	$0	$5	$0	$0/$30		N/A	
Arkansas	$0	10% cost of first day	$0	15% coinsurance			15% coinsurance		
California	$1	$0	$5	$1	$0	$5	$1	$0	$5
Colorado	$0	$10	$0	N/A					
Connecticut[6]	- -	- -	- -	$25	10% after deductible	$100	$25	10% after deductible	$100
Delaware	$0	$0	$0	$0	$0	$0		N/A	
District of Columbia	- -	- -	- -	- -	- -	- -	- -	- -	- -
Florida	$0	$0	$0/$15	N/A					
Georgia	$0	$12.50	$0	N/A					
Hawaii	- -	- -	- -	- -	- -	- -	- -	- -	- -
Idaho[7]	- -	- -	- -	Vary based on ESI plan					
Illinois[7]	$2	up to $3	$0	Vary based on ESI plan				N/A	
Indiana[6, 8]	$0	$0	$0/<$3	$0	$0	Up to $25	$0	$0	Up to $25
Iowa	$3	$0	$0	$0	$0	$0	$0	$0	$0
Kansas	$2	$48	$0	N/A					
Kentucky[9]	$2	$50	$0/<$6	N/A					
Louisiana	$0	$0	$0	N/A					
Maine[10]	$0	$3	$0	$25	$250 deductible, then 30% coins.	$250 deductible, then 30% coins.	$25	$250 deductible, then 30% coins.	$250 deductible, then 30% coins.
Maryland[11]	- -	- -	- -	$0	not covered	not covered	$0	not covered	not covered
Massachusettss[6, 12]	$0	$3	$0	$0/$0	$0/$0	$0/$0	$10	$50	$50
Michigan	$0	$0	$0	$3	$0	$0		N/A	
Minnesota	$3	$0	$0/$6	$3	$0	$0/$6	$3	$0	$0/$6
Mississippi	$3	$10	$0	N/A					
Missouri	$1	$10	$0/$3	N/A					
Montana	$4	$100	$0/$5	N/A					
Nebraska	$2	$0	$0	N/A					
Nevada[7]	- -	- -	- -	Vary based on ESI plan					
New Hampshire	$0	$0	$0	N/A					
New Jersey	- -	- -	- -		N/A		$0	$0	$35
New Mexico[6, 13]	- -	- -	- -	$0	$0	$0	$5-$7	$25-$30	$15-$20
New York	$0	$25/discharge	$3	$0	$25/discharge	$3	$0	$25/discharge	$3
North Carolina	$3	$3/day	$0	N/A					
North Dakota	$2	$75	$0/$6	N/A					
Ohio	$0	$0	$0/$3	N/A					
Oklahoma[6]	$3	$10 day/$90 max	$0	$10	$50	$30	$10	$50	$30
Oregon[14]	$0	$0	$0/$3	- / vary based on plan			Vary based on plan		
Pennsylvania[6, 15]	$.50-$3	$3/day	0/$.50-$3	$10	10% coinsurance	$50	$10	10% coinsurance	$50
Rhode Island	- -	- -	- -	- -	- -	- -	- -	- -	- -
South Carolina	$2	$25	$0	N/A					
South Dakota[16]	$3	$50	$0/<$50	N/A					
Tennessee[17]	$0	$0	$0	$15-$20	$100	$0	$15-$20	$100	$0
Texas	- -	- -	- -	N/A					
Utah[18]	$3	$220	$0/$6	$15/vary	not covered/ vary	$30 if covered/ vary	$15/vary	not covered/ vary	$30 if covered/ vary
Vermont[19]	$0	$75	$0	$0/$10	$0/$500 deductible, then 20% coins.	$25/$500 deductible, then 20% coins.	$10	$500 deductible, then 20% coins.	$500 deductible, then 20% coins.
Virginia	$1	$100	$0	N/A					
Washington[6, 20]	- -	- -	- -	$15	$250 deductible, then 20% conins.	$100	$15	$250 deductible, then 20% conins.	$100
West Virginia	$0	$0	$0	N/A					
Wisconsin[6, 21]	$.50-$3	$.50-$3	$.50-$3	$.50-$3	$3 per day	$0	$.50-$3	$100 per stay	$60
Wyoming	$2	$0	$0/$6	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, 2011. Table presents rules in effect as of January 1, 2011, unless noted otherwise.

Table 22 Notes

1. A state may impose premiums for parents with some limitations based on family income. Co-payments are also allowed, with some restrictions. In general, states cannot adopt cost sharing or premium policies that impose costs that exceed 5% of family income or that favor higher-income families over lower-income families.

2. If a state charges co-payments, but either does not charge them at the income level shown or for the specific service, it is recorded as $0; if a state does not provide coverage at a particular income level it is noted as "N/A;" if a state does not charge co-payments at all, it is noted as "- -".

3. Expansion coverage includes both waiver and state-funded programs for parents and/or other non-disabled adults.

4. When two charges are presented for the emergency room visit, the charge before the slash is for ER use in a true emergency; the charge after the slash is for non-emergency use.

5. In Alaska, the inpatient hospital co-pay is for the first 4 days.

6. In Connecticut, Indiana, Massachusetts (Commonwealth Care), New Mexico, Oklahoma, Pennsylvania (adultBasic), Washington, and Wisconsin (BadgerCare Core enrollees between 100% and 200%) the emergency room visit co-pay is waived if admitted.

7. In Idaho, Illinois, and Nevada, expansion coverage is premium assistance, so cost sharing charges vary by ESI plan.

8. In the Healthy Indiana Plan, an emergency room visit has a sliding scale co-pay based on income and parental status.

9. In Kentucky, for non-emergency use of the emergency room, individuals are charged 5% coinsurance up to $6 per visit.

10. In Maine, for 1931 Medicaid parents there is a $30 monthly maximum for inpatient hospital and drug copayments. Expansion coverage costs are for Dirigo Health based on an individual; out-of-pocket costs are subject to a $800 annual limit.

11. In Maryland, expansion coverage is Primary Adult Coverage. There is no coverage for the enrollee for inpatient hospital and emergency room visits, however, effective January 1, 2010, there is coverage for the facility costs associated with these visits.

12. In Massachusetts expansion coverage for individuals below 100% FPL, the values before the slash are for MassHealth Basic and Essential and the values after the slash are for Commonwealth Care. Expansion coverage for individuals between 100-200% FPL shows costs for Commonwealth Care; out-of-pocket costs in Commonwealth Care are subject to annual maximums that vary by income.

13. In New Mexico, cost sharing varies based on income in SCI waiver coverage.

14. Under expansion coverage in Oregon, the value before slash is for OHP Standard and value after the slash is for Family Health Insurance Assistance Program (FHIAP). There are no co-pays in OHP Standard expansion coverage per court order. FHIAP is a premium assistance program; as such cost sharing varies by plan.

15. In Pennsylvania, copayments for 1931 parents vary based on cost of service; the inpatient hospital co-pay is subject to a maximum of $21. In adultBasic (expansion coverage), inpatient hospital coverage is limited to two stays per year.

16. In South Dakota, the non-emergency cost for using the emergency room is 5% of allowable Medicaid reimbursement, up to $50.

17. In CoverTennessee (expansion coverage), co-pays for physician visits vary based on plan.

18. For expansion coverage in Utah, the values before slash are for Primary Care Network (PCN) and values after the slash are for the Utah Premium Partnership (UPP) premium assistance program. For PCN, ER care is only covered for approved emergency diagnoses; UPP is a premium assistance program; as such, costs vary by plan.

19. In Vermont, for expansion coverage for individuals below 100% FPL, the values before the slash are for VHAP waiver coverage and the values after the slash are for Catamount Health. For VHAP coverage, the copayment for an emergency room visit is $60 if not medically necessary. Expansion coverage for individuals between 100-200% FPL shows costs for Catamount Health. Catamount Health has an annual in-network maximum on out of pocket costs of $1,050 for single coverage and $2,100 for a family plan. Out-of-pocket costs in Catamount Health are waived for patients who need clinically recommended treatment for a chronic condition or disease.

20. In Washington's Basic Health (expansion coverage) the maximum facility charge per admittance for inpatient care is $300.

21. For childless adults in Wisconsin's Core Plan, there is $30 out-of-pocket maximum per year for physician visits and a $75 out-of-pocket inpatient maximum per stay for those <100% FPL. There also is a $300 out-of-pocket maximum for inpatient and outpatient hospital services per year for Core Plan enrollees.

Table 23

Prescription Drug Copayments for Adults at Selected Incomes[1, 2]

January 2011

State	1931 Medicaid Parents			Expansion Coverage[3]					
				<100% FPL			100-200% FPL		
	Generic	Preferred Brand Name	Non-Preferred Brand Name	Generic	Preferred Brand Name	Non-Preferred Brand Name	Generic	Preferred Brand Name	Non-Preferred Brand Name
Alabama[4]	$.50-$3	$.50-$3	$.50-$3	N/A					
Alaska	$2	$2	$2	N/A					
Arizona	$2.30	$2.30	$2.30	$4	$10	$10		N/A	
Arkansas[4]	$.50-$3	$.50-$3	$.50-$3	$5	$15	$30	$5	$15	$30
California	- -	- -	- -	$0	$0	$0	$0	$0	$0
Colorado	$1	$3	$3	N/A					
Connecticut	$0	$0	$0	$10	$35	$35	$10	$35	$35
Delaware[4]	$.50-$3	$.50-$3	$.50-$3	$.50-$3	$.50-$3	$.50-$3		N/A	
District of Columbia	- -	- -	- -	- -	- -	- -	- -	- -	- -
Florida	$0	$0	$0	N/A					
Georgia[4]	$.50-$3	$.50-$3	$.50-$3	N/A					
Hawaii	- -	- -	- -	- -	- -	- -	- -	- -	- -
Idaho[5]	- -	- -	- -	Vary based on ESI plan			Vary based on ESI plan		
Illinois[5]	$0	$3	$3	Vary based on ESI plan			N/A		
Indiana[6]	$3	$3	$3	$3	$3	$3	$3	$3	$3
Iowa[7]	$1	$1	$2 or $3	Not covered					
Kansas	$3	$3	$3	N/A					
Kentucky	$1	$2	5% coinsurance up to $20	N/A					
Louisiana[4]	$.50-$3	$.50-$3	$.50-$3	N/A					
Maine[8]	$3	$3	$3	$10-$50			$10-$50		
Maryland[9]	- -	- -	- -	$2.50	$7.50	$7.50	$2.50	$7.50	$7.50
Massachusetts[10]	$3	$3	$3	$3	$3	$3	$10	$20	$40
Michigan	$1	$1	$1	$1	$1	$1		N/A	
Minnesota	$1	$3	$3	$3	$3	$3	$3	$3	$3
Mississippi	$3	$3	$3	N/A					
Missouri[4]	$.50-$2	$.50-$2	$.50-$2	N/A					
Montana[4]	$1-$5	$1-$5	$1-$5	N/A					
Nebraska	$2	$2	$2	N/A					
Nevada	$0	$0	$0						
New Hampshire	$1	$2	$2	N/A					
New Jersey	-	-	-	N/A			$5	$5	$5
New Mexico[11]	-	-	-	$0	$0	$0	$3	$3	$3
New York	$1	$3	$3	$3	$6	$6	$3	$6	$6
North Carolina	$1	$5	$5	N/A					
North Dakota	$0	$3	$3	N/A					
Ohio	$0	$2	$3	N/A					
Oklahoma[12]	$0 - $3.50	$0 - $3.50	$0 - $3.50	$5	$10	$10	$5	$10	$10
Oregon[13]	$2	$3	$3	- / vary based on plan			Vary based on plan		
Pennsylvania	$1	$3	$3	Not covered			Not covered		
Rhode Island	-	-	-	-	-	-	-	-	-
South Carolina	$3	$3	$3	N/A					
South Dakota	$0	$3	$3	N/A					
Tennessee[14]	$0	$3	$3	$8-$10	not covered	not covered	$8-$10	not covered	not covered
Texas	-	-	-	N/A					
Utah[15]	$3	$3	$3	$5/vary	25% cost/vary	25% cost/vary	$5/vary	25% cost/vary	25% cost/vary
Vermont[16]	$1-$3	$1-$3	$1-$3	$1-$2/$10	$1-$2/$35	$1-$2/$55	$10	$35	$55
Virginia	$1	$3	$3	N/A					
Washington	-	-	-	$10	50% cost	not covered	$10	50% cost	not covered
West Virginia[4]	$.50-$3	$.50-$3	$.50-$3	N/A					
Wisconsin[17]	$.50-$3	$.50-$3	$.50-$3	$.50-$3/<$4	$.50-$3/<$8	$.50-$3/<$8	$.50-$3/<$4	$.50-$3/<$8	$.50-$3/<$8
Wyoming	$1	$2	$3	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, 2011. Table presents rules in effect as of January 1, 2011, unless noted otherwise.

Table 23 Notes

1. A state may impose premiums for parents with some limitations based on family income. Co-payments are also allowed, with some restrictions. In general, states cannot adopt cost sharing or premium policies that impose costs that exceed 5% of family income or that favor higher-income families over lower-income families.

2. If a state charges co-payments, but either does not charge them at the income level shown or for the specific service, it is recorded as $0; if a state does not provide coverage at a particular income level it is noted as "N/A;" if a state does not charge co-payments at all, it is noted as "- -".

3. Expansion coverage includes both waiver and state-funded programs for parents and/or other non-disabled adults.

4. In Alabama, Arkansas, Delaware, Georgia, Louisiana, Missouri, Montana, and West Virginia costs vary based on cost of drug.

5. In Idaho and Illinois expansion coverage is a premium assistance program; as such costs vary by plan.

6. In Indiana, for 1931 parents, effective January 1, 2010, pharmacy services are carved out of managed care and co-pays apply for drugs; previously managed care enrollees were not charged co-pays.

7. In Iowa, charges are $2 for non-preferred brands between $25.01 and $50; and $3 when non-preferred brand >$50.

8. In Maine, for 1931 Medicaid parents there is a $30 monthly maximum for inpatient hospital and drug copayments. Expansion coverage costs are for Dirigo Health based on an individual; drug costs vary based on drug tier; out-of-pocket costs are subject to a $800 annual limit.

9. In Maryland, there are no copayments for 1931 parents except for mental health and HIV/AIDS drugs. Expansion coverage (Primary Adult Coverage), depending on which managed care plan an in individual is enrolled in, there may be drug copayments ranging from $2.50-$7.50 per drug.

10. In Massachusetts, generic drugs for diabetes, high blood pressure, and high cholesterol have a $1 co-pay in MassHealth and for Commonwealth Care enrollees below 100% FPL. Expansion coverage costs for those between 100-200% FPL are for Commonwealth Care; co-pays are lower for three-month supplies of prescription drugs obtained through mail order. Prescription drug co-pays in Commonwealth Care are subject to an annual out-of-pocket maximums that vary by income.

11. In New Mexico, under SCI waiver coverage, drug co-pays are subject to a $12 monthly maximum.

12. For 1931 Medicaid parents in Oklahoma, preferred generics are $0, brand name co-payments are $.65 for Medicaid allowable under $10; $1.20 for Medicaid allowable between $10.01 and $25; and $2.40 for Medicaid allowable between $25.01 and $50; and $3.50 for Medicaid allowable above $50.

13. In Oregon 1931 Medicaid coverage, drugs ordered through the home-delivery pharmacy program do not have co-pays. For expansion coverage, the value before the slash is for OHP Standard and value after the slash is for the Family Health Insurance Assistance Program (FHIAP). There are no copayments in OHP Standard per court order. FHIAP is a premium assistance program; as such, costs vary based on plan.

14. In Cover Tennessee expansion coverage, co-pays for generics vary based on plan and there is no coverage for brand name drugs except insulin and diabetic test strips.

15. For 1931 Medicaid parents in Utah, there is a monthly out-of-pocket maximum for prescription drug co-pays of $15. For expansion coverage, the values before slash are for the Primary Care Network (PCN) and values after the slash are for Utah Premium Partnership (UPP) coverage. PCN coverage has a limit of 4 drugs per month. UPP is a premium assistance program; as such costs vary by plan.

16. In Vermont, for expansion coverage for individuals below 100% FPL, the values before the slash are for VHAP waiver coverage and the values after the slash are for Catamount Health. Expansion coverage for individuals between 100-200% FPL shows costs for Catamount Health.

17. In expansion coverage under BadgerCare Core Plan for childless adults, there is a $24 per month, per provider limit for prescription drug co-pays.

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