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PERFORMING UNDER PRESSURE: ANNUAL FINDINGS OF A 50-STATE SURVEY OF ELIGIBILITY, ENROLLMENT, RENEWAL, AND COST-SHARING POLICIES IN MEDICAID AND CHIP, 2011-2012

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January 2012

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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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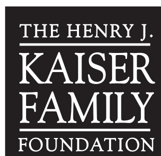

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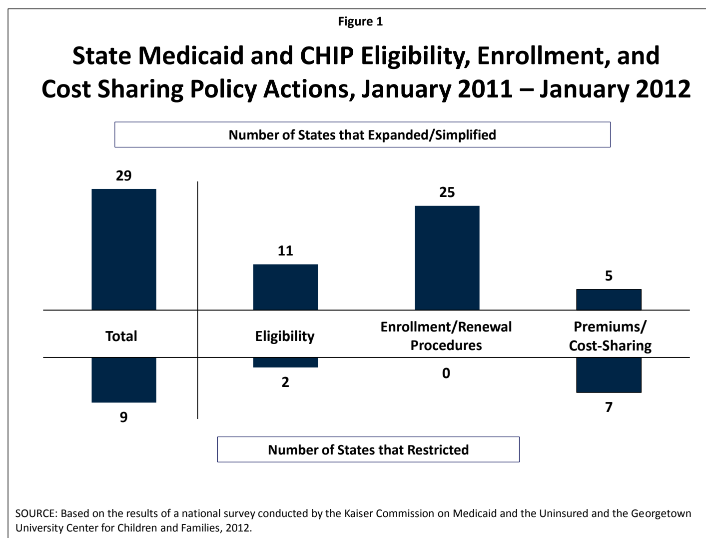
EXECUTIVE SUMMARY

In 2011, Medicaid and the Children's Health Insurance Program (CHIP) continued to be key sources of coverage for children, and, in some cases, for their parents, as the weak economic recovery was slow to add new jobs with access to employer-based insurance. At the same time, state budgets remained stressed due to dampened state revenue growth and the mid-year expiration of the temporary increase in the federal share of Medicaid provided through the American Recovery and Reinvestment Act of 2009 (ARRA).

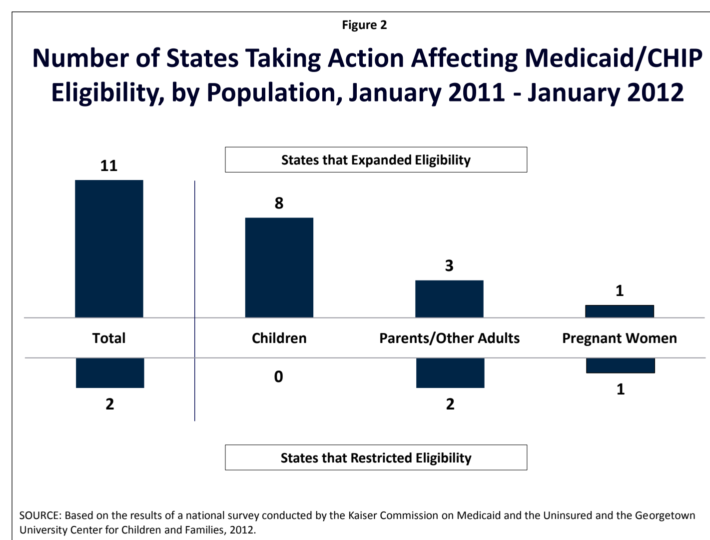
Amid state fiscal challenges, the requirement in the Affordable Care Act (ACA) that states maintain their eligibility levels and enrollment and renewal procedures was central in preserving coverage during 2011. In addition, some states made targeted eligibility expansions and many used technology to boost program efficiency and make it easier for families to enroll in coverage (Figure 1). Moreover, new enhanced federal funding spurred many states to launch major Medicaid systems improvements that will help states modernize their programs and prepare for the 2014 ACA coverage expansions.



In this eleventh annual report, the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families provide results from a 50-state survey of eligibility, enrollment, renewal, and cost-sharing policies in Medicaid and CHIP. The data identify changes implemented during 2011 and present policies in place for children, pregnant women, parents, and other non-disabled adults as of January 1, 2012.

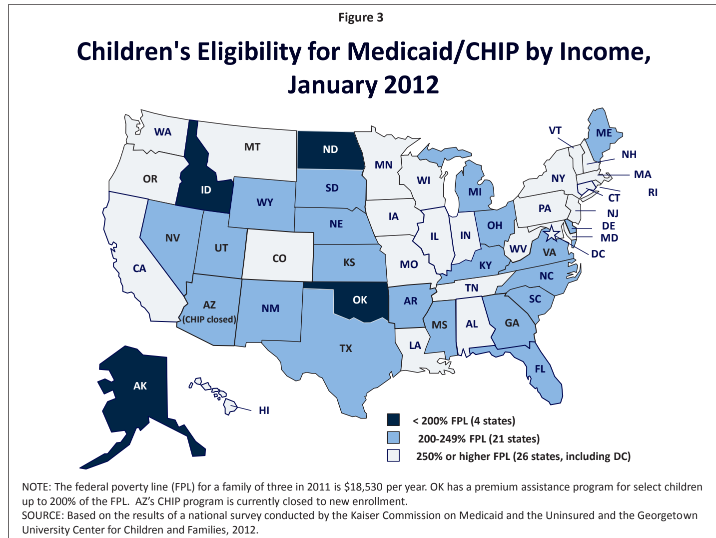
Eligibility: States Maintained Coverage, and Some Moved Forward with Expansions

Reflecting the ACA requirement for states to maintain coverage, Medicaid and CHIP eligibility remained largely stable in 2011, while 11 states made targeted expansions (Figure 2). A number of the expansions utilized new options available through the ACA and the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) and some enabled the states to draw down federal matching funds for previously solely state-funded coverage. Two (2) states made eligibility cutbacks that were not subject to the ACA requirement. It is likely that without the requirement more states would have made reductions due to budget pressures.

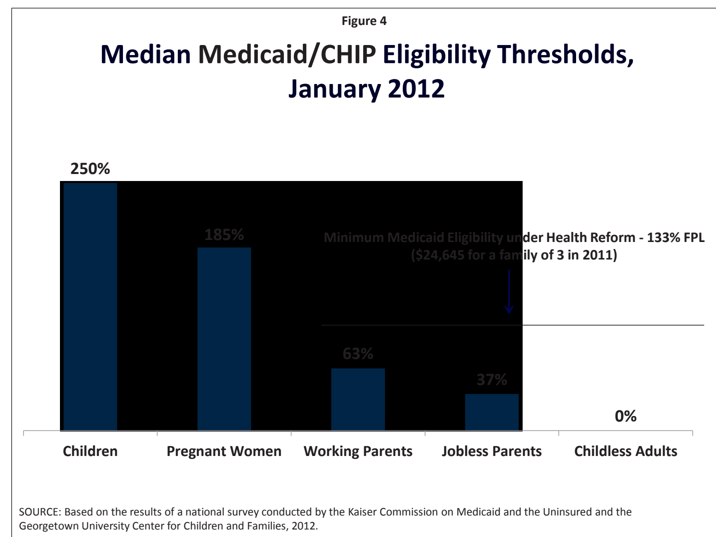


In keeping with the historic trend, most of the eligibility expansions (eight (8) of 11) focused on coverage for children. Specifically, West Virginia expanded CHIP eligibility for children from 250 to 300 percent of the federal poverty level (FPL). Moreover, Illinois, Texas, and Vermont took up the option provided by CHIPRA to cover lawfully-residing immigrant children without a five-year wait. Finally, five (5) states (AL, GA, KY, PA, and TX) took up the new ACA option to allow qualifying state employees to access affordable coverage for their children through CHIP.

Medicaid and CHIP remain key sources of coverage for low- and moderate-income children. As of January 1, 2012, half of the states (26, including DC) cover uninsured children in families with income at or above 250 percent of the FPL ($46,325 for a family of three in 2011) and 18 of these states cover uninsured children at or above 300 percent of the FPL ($55,590 for a family of three) (Figure 3). In addition, almost half of the states (24, including DC) cover lawfully-residing children in Medicaid or CHIP without a five-year waiting period, and nine (9) states make coverage available to children of state employees who are eligible for CHIP, in part, reflecting flexibility provided by the ACA to cover these children.



Coverage for parents, while remaining constant in 2011, continues to lag far behind that of their children (Figure 4). There were no changes to Medicaid coverage for parents in 2011, and, as of January 1, 2012, only 18 states cover parents with full Medicaid benefits at or above the poverty level ($18,530 for a family of three in 2011), while 17 states limit full Medicaid coverage to parents earning less than half of the poverty level ($9,265 for a family of three in 2011). A total of 19 states have expanded parent eligibility for more limited coverage through waivers or state-funded coverage, but enrollment was closed in three (3) of these programs at some point during 2011.

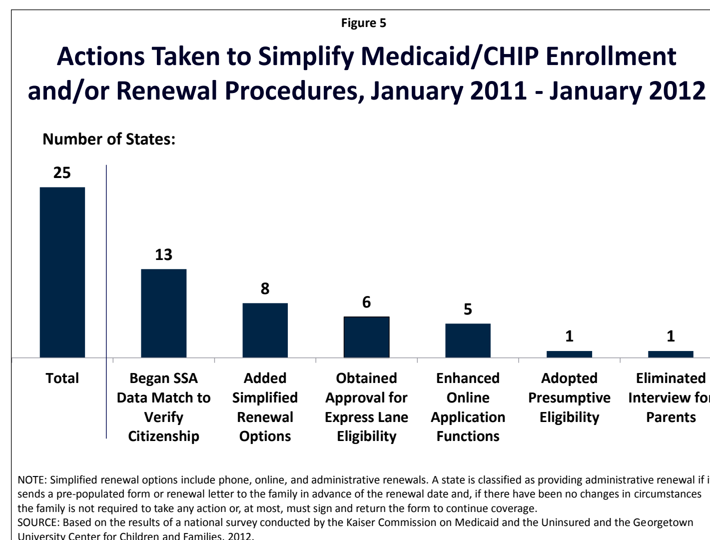


Three (3) states took steps to bolster Medicaid coverage for low-income adults in 2011, but these expansions were offset by reductions in two (2) states. New Jersey and Washington obtained Section 1115 waivers to draw down federal Medicaid matching funds to cover low-income adults who were previously covered by state-only funds. Minnesota also obtained federal matching funds for previously solely state-funded coverage of low-income adults through the new ACA early adult expansion option, in conjunction with a waiver. These actions helped the states preserve existing coverage by securing

federal financing and get an early start on the Medicaid expansion that will occur in 2014. However, two states made cutbacks in Medicaid waiver coverage that were exempt from the ACA requirement to maintain eligibility. Specifically, Arizona froze enrollment in its waiver coverage for adults without dependent children as part of its waiver renewal, and Nevada discontinued its limited coverage for some parents and pregnant women when its waiver expired in 2011. In addition, outside of Medicaid, Pennsylvania ended its state-funded program for low-income adults. Accordingly, coverage for low-income adults remains very limited as of January 1, 2012**.** Only eight (8) states (AZ, CT, DE, DC, HI, MN, NY, and VT) provide benefits to low-income adults that are equivalent to Medicaid. Eighteen (18) states provide more limited benefits to these adults, but five (5) of those programs were closed to new enrollment at some point during 2011.

Enrollment and Renewal: States are Using Technology to Achieve Efficiencies and Streamline Processes

Responding to budget pressures, half of the states (25) made strides in increasing the efficiency of their enrollment and renewal practices (Figure 5). These improvements have the dual benefit of reducing paperwork requirements for families and eligibility workers while streamlining program administration. Moreover, these actions assisted states in balancing the competing demands of increased caseloads and decreased staffing, while also helping them to prepare for the new eligibility changes that will take effect in 2014 under the ACA. The improvements also enabled seven (7) new states, for a total of 23 states, to earn between $1.3 and $28.3 million in CHIPRA performance bonuses, which reward states that are successful in enrolling eligible children in Medicaid.[1]



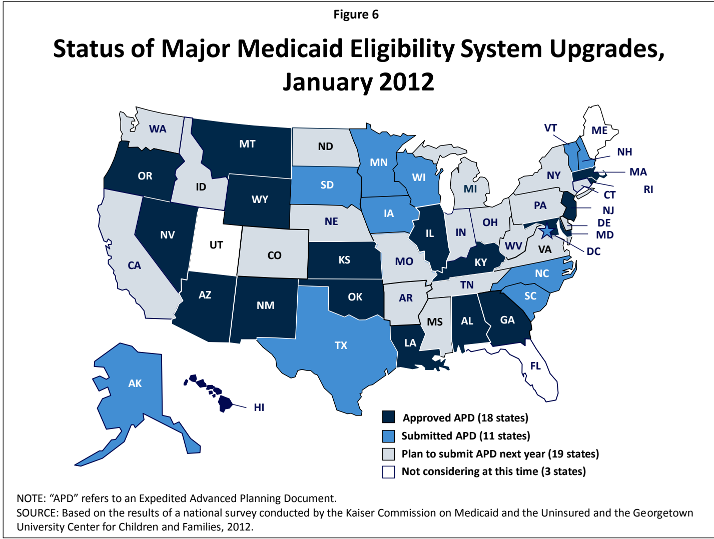
States increasingly used technology to modernize eligibility and enrollment processes, often adopting policy options provided by CHIPRA. During 2011, 13 states adopted the CHIPRA option to use an electronic data match with the Social Security Administration to more efficiently and accurately verify citizenship for children, bringing the total number of states using this option in Medicaid and/or CHIP to 44. Another CHIPRA option – Express Lane Eligibility (ELE) for children – was implemented or expanded in five (5) states in 2011, resulting in a total of 9 states taking up this option in Medicaid and/or CHIP as of January 2012. Also, under separate waiver authority, Massachusetts received approval to utilize ELE to renew coverage for parents. In addition, five (5) states enhanced their online application capabilities, for example, by enabling applications to be electronically submitted.

Many improvements focused on streamlining the renewal process to increase retention of eligible children and families. By concentrating on retention, states can reduce the inefficient administrative effort required to close and reopen cases, as well as eliminate gaps in coverage created when eligible individuals “churn” on and off of Medicaid and CHIP over short periods of time. Specifically, five (5) states implemented administrative renewals by sending out a form pre-populated with the family’s information and not requiring families to take any action beyond returning a signed copy of the form if circumstances have not changed. Also, eight (8) states added online or telephone renewal options.

Enhanced federal funding for technology investments spurred state action to upgrade their eligibility systems. Technology allows states to modernize their eligibility systems to achieve gains in efficiency and vastly streamline or automate enrollment processes. However, the high cost of these investments has long prevented many states from upgrading to new technology. Recognizing these opportunities and challenges, in April 2011, the Centers for Medicare and Medicaid Services (CMS) made enhanced federal funding available to states to upgrade or replace eligibility systems to help prepare for the ACA. Through 2015, states are able to secure a 90 percent federal match, as opposed to the typical 50 percent administrative matching rate, for the design and implementation of eligibility and enrollment systems. The enhanced federal funding has already made a difference in states' willingness to invest in technology. As of January 1, 2012, 18 states have received approval for their system upgrades, while an additional 11 have submitted plans to CMS (Figure 6).

Figure 6

Status of Major Medicaid Eligibility System Upgrades, January 2012



NOTE: "APD" refers to an Expedited Advanced Planning Document.
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, 2012.

Cost-Sharing: Few States Changed Premium and Copayment Requirements for Families

Even with the flexibility to do so, the majority of states did not impose additional cost-sharing requirements on beneficiaries. Outside of routine annual rate adjustments, only one state increased premiums or enrollment fees during 2011, reflecting the fact that premiums can be a barrier to enrollment and are, therefore, subject to the ACA requirement that states maintain enrollment processes. While copayments are not subject to this same requirement, only six (6) states increased copayments while four (4) states reduced copayments.

Conclusion

Despite ongoing state fiscal pressures, the requirement that states hold steady on their eligibility levels and enrollment and renewal procedures maintained coverage for children and their families during 2011 and preserved the foundation that Medicaid and CHIP coverage will provide under the ACA. While strained state budgets have taken a toll on administrative resources, states have sharpened their use of technology and streamlined their procedures to create more efficient programs, while also simplifying the steps for families to enroll in and renew coverage. Moreover, the CHIPRA tools to streamline program administration, some new options provided in the ACA, and the significant new federal financial incentive for eligibility system upgrades have all served as key catalysts for continued state improvement and modernization of Medicaid and CHIP programs. These actions have not only helped states deal with current pressures, but also lay the groundwork for the coverage expansions and new enrollment requirements that will take effect in 2014.

I. INTRODUCTION

Over the past year, families and states alike continued to face financial pressures. Medicaid and the Children's Health Insurance Program (CHIP) connected many families to health coverage as they struggled to get back on sound financial footing. Meanwhile, amid the weak economic recovery, the temporary enhanced federal funding match for Medicaid expired, putting additional pressure on state budgets. At the same time, as the 2014 implementation date for the coverage expansions under the Affordable Care Act (ACA) drew closer, states faced a tightening timeline to prepare for the expansion and transform many aspects of the health care system, including eligibility, enrollment, and delivery systems and quality initiatives.

In this eleventh annual report on state eligibility, enrollment, renewal, and cost-sharing policies in Medicaid and CHIP for children, pregnant women, parents and other non-disabled adults, the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families provide an overview of changes made in 2011 and policies in place as of January 1, 2012. The report is based on a survey of state officials in all 50 states and the District of Columbia.

In sum, the survey findings show that Medicaid and CHIP eligibility held steady during 2011, providing families hit hard by the recession and the lack of new job opportunities with access to health coverage. This stability is a predictable result of the ACA's requirement that states maintain eligibility and enrollment and renewal procedures in advance of the coverage expansion. This requirement was designed to preserve the foundation of coverage that Medicaid and CHIP provide for broader health reform. Moreover, a number of states found ways to improve coverage and streamline eligibility and enrollment procedures, often with a focus on using scarce state administrative funds as efficiently as possible and continuing to adopt options made available by the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) and the ACA. Further, spurred by enhanced federal matching funds made available to help states prepare for the ACA coverage expansions, the most notable new trend of 2011 was an acceleration of state efforts to modernize eligibility systems, moving closer toward a goal of creating real-time, consumer-friendly enrollment and renewal experiences for individuals.

II. BACKGROUND: POLICY AND FISCAL CONTEXT IN 2011

Over time, states have achieved significant progress in expanding Medicaid and CHIP coverage and streamlining enrollment and renewal procedures. During this time, state Medicaid and CHIP programs have adapted and evolved in response to changes in health care delivery, public policy priorities, resources, and the economic and political environments. Children's health coverage, bolstered by strong public support, has made the most gains and serves as an incubator for innovative strategies, helping states achieve coverage objectives and improve administrative efficiency. In 2011, state decisions about Medicaid and CHIP eligibility rules and procedures occurred in the context of many factors, as discussed below.

As the impact of the deepest recession since the Great Depression lingered in 2011, families and states continued to grapple with ongoing financial pressures. While the steep increases in the need for coverage over the past couple of years leveled off somewhat in 2011, families who became newly unemployed or who remained unable to secure new jobs with access to employer-sponsored coverage continued to rely on Medicaid and CHIP. Families were not alone in their financial struggles. The sluggish economy continued to inhibit state revenue growth, making it challenging for states to meet the ongoing need for Medicaid and CHIP coverage, particularly as the temporary enhanced federal matching

funds provided under the American Recovery and Reinvestment Act of 2009 (ARRA) expired at the end of June 2011. The enhanced federal match helped states fill the gap between decreased revenue and increased demand for Medicaid and CHIP during the worst of the recession. Although the expiration of the enhanced match was expected, states still found it difficult to return to the normal matching rate, especially as budget shortfalls persisted and revenues were slow to rebound.

The ACA requires states to preserve Medicaid and CHIP eligibility levels and enrollment and renewal policies. Medicaid and CHIP are the base on which the coverage expansions in health reform are built. The ACA preserves this foundation through a provision (similar to one under ARRA that expired) that states maintain eligibility as well as enrollment and renewal procedures (Box 1: *Maintaining Coverage Under the ACA*). Although the year began with political pressure to eliminate the requirement, especially in light of the mid-year expiration of the ARRA enhanced federal funding, it remains in place, ensuring the continued availability of coverage for children and their families, people with disabilities, and seniors still feeling the effects of the economic downturn and maintaining Medicaid and CHIP coverage in advance of reform.

Box 1:
Maintaining Coverage Under the ACA

As a condition of receiving federal Medicaid funding, the ACA requires states to maintain eligibility, enrollment, and renewal policies that were in place as of March 23, 2010 (when the ACA was enacted). The requirement, which was designed to preserve coverage until broader reform is in place, remains in effect until January 1, 2014 for adults and until September 30, 2019 for children in both Medicaid and CHIP.

There are some limited exceptions to the requirement. For example, there is an exception that permits states that cover adults above 133 percent of the FPL to reduce eligibility for these adults if they are facing a documented budget deficit. In addition, states are not required to renew expiring waivers or to continue coverage that is fully state-funded. States also are able to adjust cost-sharing provisions, within certain parameters.[2]

While the overwhelming majority of states held eligibility steady in 2011, two made scale backs in Medicaid coverage that were not subject to the ACA requirement. These eligibility changes targeted low-income adults, whose coverage already lags far behind that of children. Arizona froze enrollment in its waiver program for childless adults; and Nevada discontinued its limited coverage for some parents and pregnant women when the state chose not to renew its expiring waiver in 2011.[3]

Recognizing the pivotal role that technology will play in 2014, the Administration provided a significant new financial incentive to support investments in state-of-the-art eligibility and enrollment systems. In April 2011, the Centers for Medicare and Medicaid Services (CMS) approved an increase in the federal funding match, from 50 percent to 90 percent, for the design and development of Medicaid eligibility and enrollment systems, which will be available through the end of 2015. The maintenance and operation of such systems also is eligible for an increased 75 percent federal match, which will remain available indefinitely, provided the systems continue to meet specific requirements. This enhanced federal funding enables states that otherwise would have lacked the resources to improve or replace their aging eligibility and enrollment systems (some of which are decades old) and to invest in automated, data-driven processes to streamline eligibility and enrollment. Even as some states struggled to find consensus on health reform and await the outcome of two key events in 2012 – the Supreme Court's ruling on the ACA's constitutionality and the presidential elections – the new funding prompted them to take action to upgrade their Medicaid eligibility systems.

Proposed rules outlining implementation of the ACA's eligibility and enrollment provisions were released. In August 2011, the Department of Health and Human Services and the Internal Revenue Service released proposed rules describing the policies and procedures for eligibility and enrollment through the exchange, Medicaid, and CHIP under the ACA. Accompanied by other guidance released throughout the year, the proposed rules provide necessary direction for states on the coordinated policies envisioned across coverage options and the seamless, paperless eligibility and enrollment process expected for applicants in 2014. To a large extent, the proposed rules reflect many of the proven strategies that states have developed over the years to promote enrollment in Medicaid and CHIP, including providing consistent policies across coverage programs (such as the same renewal periods), eliminating paperwork, tapping trusted data sources to verify eligibility, and harnessing technology to expand access and drive administrative efficiency. While not yet final, the proposed rules spurred some states to begin more-detailed planning for implementation of eligibility and enrollment provisions of the ACA and are likely to be even more influential on state policies in 2012 and beyond.

States continued to respond to new options and incentives provided by the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). CHIPRA provided states several new options and tools to expand coverage and improve enrollment and renewal processes.[4] These included the ability to cover lawfully-residing immigrant children and pregnant women without a five-year waiting period, to verify citizenship through an electronic data match with the Social Security Administration (SSA), and to use Express Lane Eligibility (ELE) to enroll children in Medicaid and CHIP based on eligibility findings from other assistance programs. Moreover, under CHIPRA, states that implement at least five out of eight simplification measures and meet specific enrollment targets may qualify for performance bonuses.[5] These options and incentives helped shape state activity during 2010, and this action continued in 2011.

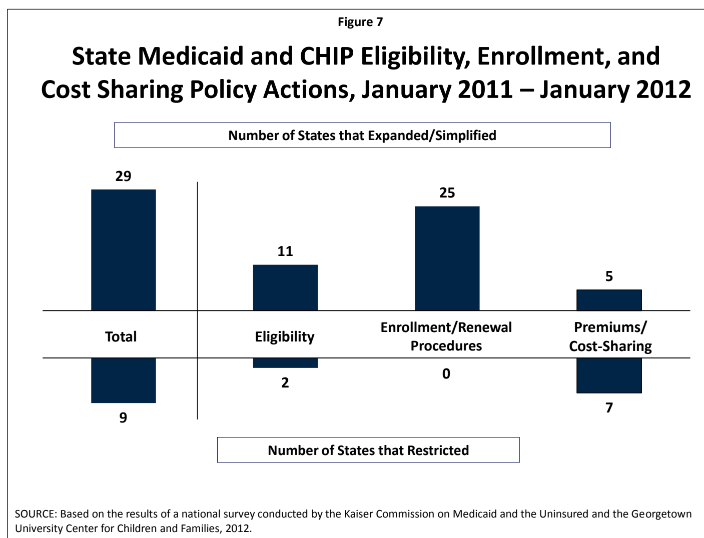
III. ABOUT THIS SURVEY

This report presents the major findings of an eleventh annual survey of eligibility, enrollment, renewal, and cost-sharing policies in Medicaid and CHIP. Conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, this year's survey provides data on state policies in place as of January 1, 2012 and the changes adopted in Medicaid and CHIP coverage during 2011. Changes in state-funded and buy-in programs are also identified, but are not included in the overall counts of changes since these programs do not receive any federal Medicaid or CHIP financing. The survey is based on in-depth telephone interviews with state Medicaid and CHIP officials; the data were verified through follow-up communications via email and phone.

The survey examines eligibility for children, pregnant women, parents, and other non-disabled adults, through Medicaid, CHIP, 1115 waivers, and state-funded programs. It also includes questions pertaining to states' Medicaid and CHIP application, enrollment, and renewal processes and cost-sharing requirements. Each year, the survey instrument is updated to reflect emerging trends in states, as well as new coverage opportunities and federal policy options. In recognition of the availability of enhanced federal matching funds for upgrades to eligibility and enrollment systems, this year's survey added several questions designed to obtain more information about where states are in their systems development. In addition, the 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.

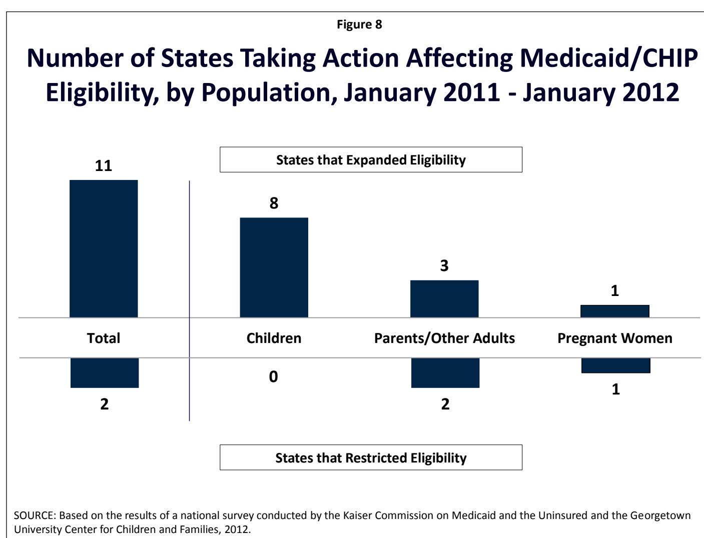
IV. SURVEY FINDINGS

The ACA requirement for states to maintain their eligibility levels and enrollment and renewal procedures preserved Medicaid and CHIP coverage in 2011, while 29 states made improvements in their programs. Medicaid and CHIP eligibility held steady in most states with 11 states making targeted expansions, mostly focused on children, and two (2) states restricting eligibility for low-income adults (Figure 7). Even with the flexibility to do so, few states imposed additional cost-sharing requirements on families. The challenging fiscal times combined with reduced administrative resources precipitated efforts in half of the states (25) to increase efficiency by reducing paperwork and simplifying the steps for families to enroll in or renew coverage, often through the increased use of technology. Moreover, the CHIPRA tools to streamline program administration, some new options in the ACA, and the significant new federal financial incentive for eligibility system upgrades served as key catalysts for continued state improvement and modernization of Medicaid and CHIP programs.



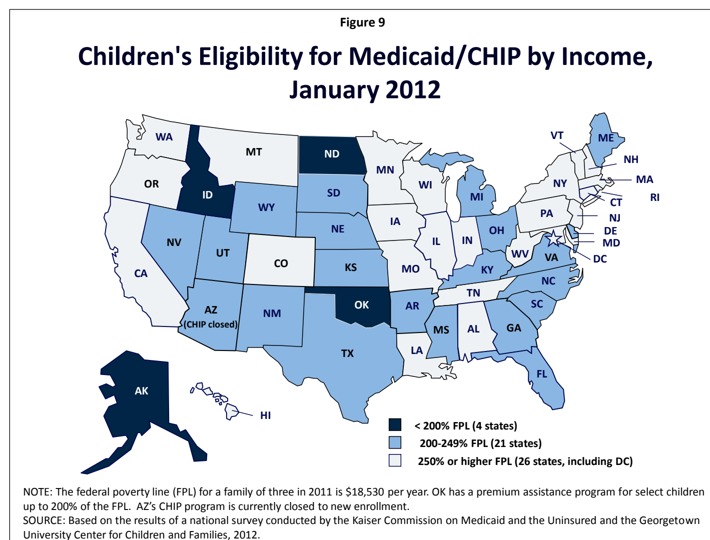
A. Eligibility: States Maintained Coverage, and Some Moved Forward with Expansions

Reflecting the ACA requirement to maintain coverage, during 2011, Medicaid and CHIP eligibility held steady in most states, with 11 states going beyond maintaining coverage to implement targeted eligibility expansions. In some cases, these expansions enabled the states to draw down federal matching funds for coverage that was previously solely state-funded. In keeping with the historic trend, most of the expansions (eight (8) of the 11) focused on covering more children (Figure 8). Two (2) states made eligibility cutbacks for low-income adults that were exempt from the ACA's maintenance requirement. It is likely that, in the absence of the requirement, more states would have limited eligibility or tightened enrollment procedures given ongoing budget pressures.



1. *Eligibility for Children and Pregnant Women*

Medicaid and CHIP remain key sources of coverage for low- and moderate-income children. During 2011, West Virginia expanded CHIP eligibility for children from 250 to 300 percent of the FPL.[6] As a result, as of January 1, 2012, half of the states (26, including DC) cover children in families with income up to at least 250 percent of the FPL ($46,325 for a family of three in 2011) and 18 cover uninsured children in families with income at or above 300 percent of the FPL ($55,590 for a family of three) (Figure 9).



New York shifted older children from its separate CHIP program into Medicaid in preparation for 2014. Currently, states must, at a minimum, provide Medicaid to children under age six with family income up to 133 percent of the FPL and to children ages six through eighteen with family income up to 100 percent of the FPL. In 2014, the mandatory minimum levels will increase, and all children with family income up to 133 percent of the FPL will be covered in Medicaid regardless of age.[7] A uniform eligibility standard across age groups will ensure that children within the same family are covered under the same program. To meet this new requirement, 19 of 39 states with separate CHIP programs will need to shift older children with family income between 100 to 133 percent of the FPL from their separate CHIP programs to Medicaid. In 2011, New York became the first state to make this transition. Colorado also passed legislation to move older children from CHIP to Medicaid, effective in 2012.

Three (3) states (IL, TX, and VT) adopted the CHIPRA option to cover lawfully-residing immigrant children without imposing a five-year waiting period. Prior to CHIPRA, lawfully-residing immigrants could not be covered with federal Medicaid or CHIP funds during the first five years of legal residence. As noted, CHIPRA gave states the option to eliminate this "five-year bar" for pregnant women and children, although not for other adults. During 2011, Illinois and Texas adopted this option for children previously covered with state-only dollars, while Vermont newly added coverage for these children. As a result of these actions, as of January 1, 2012, almost half of the states (24, including DC) cover lawfully-residing immigrant children without the five-year waiting period.

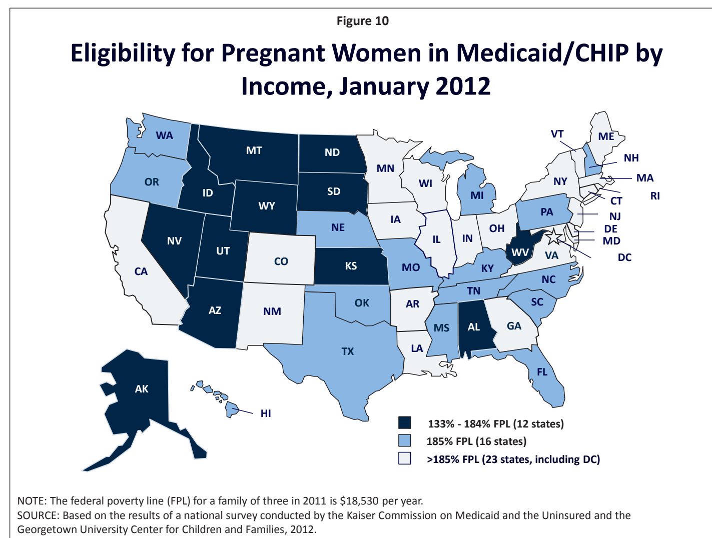
Five (5) states (AL, GA, KY, PA, and TX) adopted the ACA option to cover dependents of state employees in their separate CHIP programs. Under this option, states can receive federal funding to extend CHIP eligibility to the dependents of state employees, providing they meet the other eligibility criteria. States can adopt this option if they have maintained their contribution levels for health coverage for employees with dependent coverage or can demonstrate that state employees' out-of-pocket health care costs exceed five percent of family income. Along with the five (5) states adopting the option in 2011, four (4) additional states (AR, MS, MT, and NC) already provided coverage to these children, bringing the total number of states covering the dependents of state employees in their separate CHIP programs to nine (9) as of January 1, 2012.[8]

Two (2) states (IL and OH) eliminated the option for families to buy into Medicaid or CHIP programs. State buy-in programs enable parents who are over income eligibility limits to enroll their children in Medicaid or CHIP by paying the full cost of coverage. These programs do not receive any federal Medicaid or CHIP funds and are not subject to the ACA requirement to maintain coverage. Ohio, one of the two states to eliminate the option during 2011, operated a buy-in program that was limited to children with specific special health care needs who often are unable to purchase private insurance due to pre-existing conditions. Its high cost prohibited most eligible families from buying in, and, at its maximum enrollment, the program covered only seven children. With the changes in Illinois and Ohio, as of January 1, 2012, 13 states allow families with incomes above Medicaid and CHIP thresholds to buy into coverage. Additional states may consider eliminating this option once health reform is implemented and subsidized coverage in the exchanges becomes available (without regard to pre-existing conditions) for those in the income groups typically covered through buy-in programs.

Most states continue to require that children be uninsured for a period of time prior to enrolling in CHIP. Federal law requires states to adopt provisions to ensure that CHIP does not substitute for or "crowd-out" private insurance. To meet this requirement, most states require children to be uninsured for a period of time before they can enroll in CHIP.[9] As of January 1, 2012, 40 states have waiting periods for some of their children, with 20 of these states requiring waiting periods of three months or less. States sometimes exclude the lowest income children from CHIP waiting periods and typically include "good cause" exemptions (such as, the death of a parent or loss of a job) that allow a child to enroll in coverage right away. Eighteen (18) states have "affordability" exceptions to the waiting period, for example, allowing children to enroll if the cost of private coverage exceeds five percent of family income. It is unclear what will happen to waiting period requirements under health reform, as, under the ACA, individuals are intended to remain continuously covered without any gaps as they transition between coverage types.

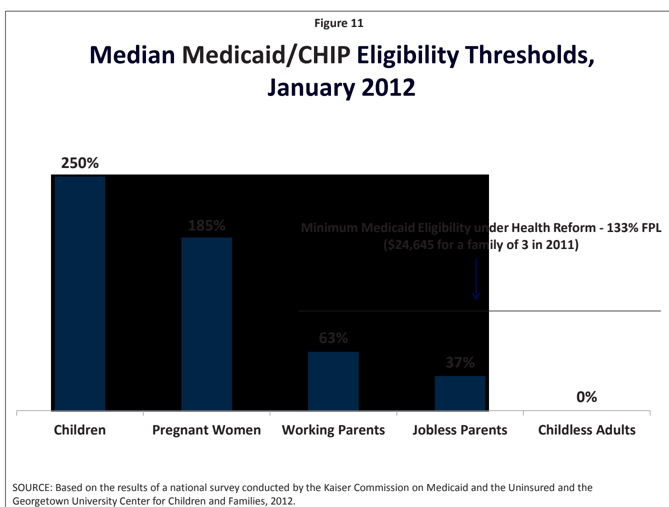
With the exception of Arizona, CHIP enrollment remained open for children in all states throughout 2011. As of January 1, 2012, 50 states, including DC, enroll all uninsured children who meet the state's eligibility criteria for Medicaid and CHIP. Arizona, however, has not enrolled any new children into its CHIP program since establishing an enrollment freeze in December 2009, prior to the enactment of the ACA when the requirement to maintain eligibility and enrollment policies was extended to CHIP.[10] Research indicates that the CHIP enrollment freeze saved the state $12.9 million in FY2011, but also resulted in over 100,000 children being placed on a waiting list for coverage and the loss of $41 million in federal matching funds.[11]

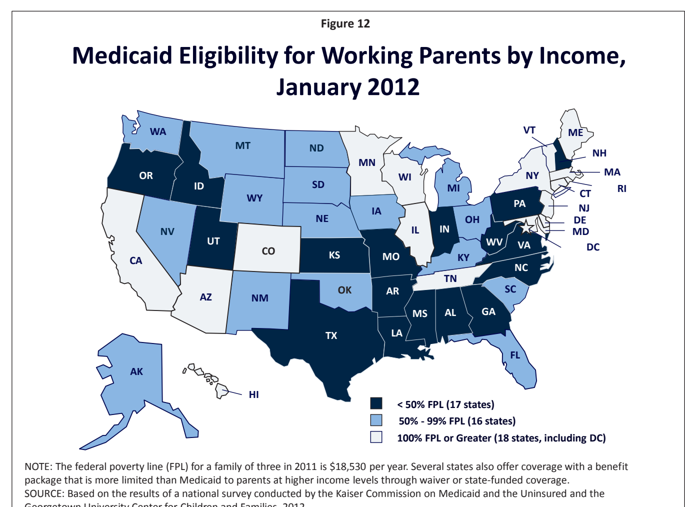
Eligibility for pregnant women remained stable in 2011, excluding the expiration of Nevada's waiver coverage. Under an exception to the ACA requirement to maintain coverage, Nevada allowed a waiver that covered pregnant women between 133 and 185 percent of the FPL to expire on November 30, 2011.[12] Following this change, as of January 1, 2012, 39 states, including DC, cover pregnant women in families with income at or above 185 percent of the FPL through Medicaid or CHIP ($34,281 for a family of three in 2011) (Figure 10). In addition, 14 states have adopted the unborn child option to use CHIP funds to provide care to pregnant women. Also, 18 states have adopted the CHIPRA option to provide coverage to lawfully-residing immigrant pregnant women without a five-year waiting period.



2. *Eligibility for Parents and Other Non-Disabled Adults*

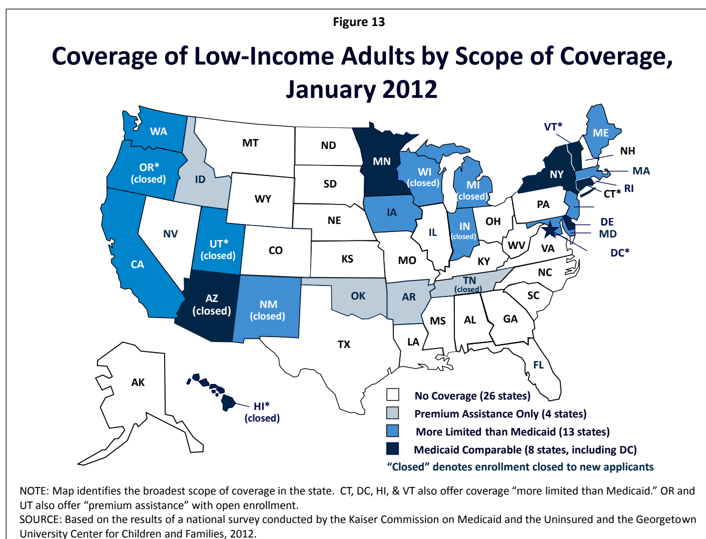
While remaining constant in 2011, coverage for parents continues to lag far behind that of their children (Figure 11). As of January 1, 2012, only 18 states, including DC, extend Medicaid eligibility to parents at or above the federal poverty level ($18,530 for a family of three in 2011) (Figure 12). The median Medicaid eligibility threshold for working parents is only 63 percent of the FPL and 17 states limit Medicaid coverage to parents earning less than 50 percent of the FPL ($9,265 for a family of three in 2011). A total of 19 states provide more limited coverage to parents through waivers or state-funded coverage, but enrollment was closed in three (3) of these programs at some point during 2011. Given state fiscal circumstances, and their historic reluctance to cover parents at the same level as their children, it is likely that many low-income parents will remain ineligible for Medicaid until the ACA expansion goes into effect in 2014.





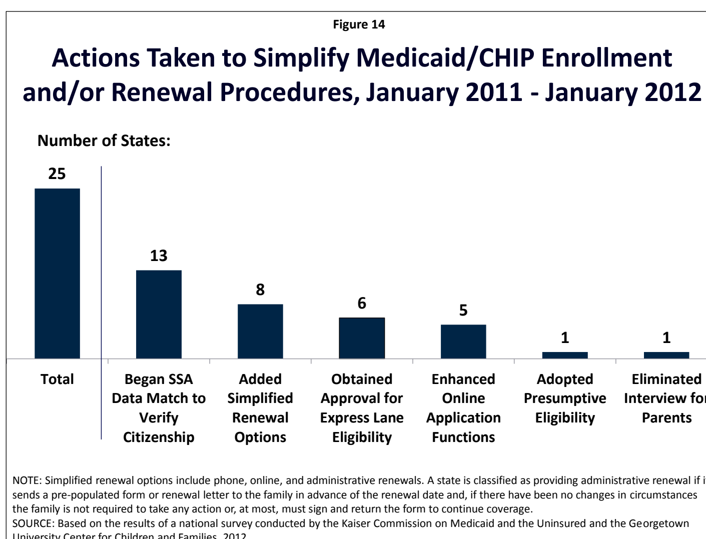
Three (3) states took steps to bolster Medicaid coverage for low-income adults during 2011. New Jersey and Washington obtained Section 1115 waivers that enabled them to draw down federal Medicaid matching funds to cover low-income adults who were previously covered solely with state funds. Minnesota also began receiving federal matching funds for previously solely state-funded adult coverage through the new adult coverage option provided by the ACA and a waiver.[13] These actions helped the states preserve coverage of low-income adults by securing federal financing and get an early start on the Medicaid expansion that will occur in 2014.

However, two (2) other states made Medicaid eligibility reductions for low-income adults during the year. Arizona froze enrollment in its waiver program for childless adults and Nevada discontinued its limited coverage for some parents and pregnant women when its waiver expired in 2011.[14] In addition, outside of Medicaid, Pennsylvania ended its state-funded coverage program for low-income adults. Each of these reductions fell under the limited exceptions to the ACA requirement that states maintain eligibility.[15] Following these changes, as of January 1, 2012, only eight (8) states (AZ, CT, DE, DC, HI, MN, NY, and VT) provide benefits to low-income adults that are equivalent to Medicaid (Figure 13). Seventeen (17) states provide more limited benefits to low-income adults, but six (6) of those programs were closed to new enrollment at some point during 2011.



B. Enrollment and Renewal Procedures: States are Using Technology to Achieve Efficiencies and Streamline Processes for Families

Building on the lessons learned in other states, in 2011, half of the states (25) adopted improvements in enrollment and renewal procedures, often streamlining administrative tasks through the use of technology. These changes ranged from adopting presumptive eligibility and eliminating the face-to-face interview requirement to instituting new options for renewing coverage and increasing the use of technology to automate processes (Figure 14).[16] A handful of states made a number of improvements simultaneously in their Medicaid and CHIP programs. (Box 2: *Spotlight on State Simplification Measures*, next page).



Box 2:
Spotlight on State Simplification Measures

In 2011, a few states made multiple changes to simplify how families apply for and renew coverage, generating broader improvements for families. Each of these states earned Medicaid performance bonuses in 2011, with Georgia and South Carolina becoming first-time recipients as a result of simplifications implemented during the year.

Building on its broad eligibility expansion in 2010, Colorado moved forward on several fronts to streamline enrollment and renewal during 2011. The state launched online applications and renewals and instituted the data match with the SSA to verify citizenship. The state also put a pre-populated renewal form in place that does not require families to take action to renew coverage unless there are relevant changes to report. In addition, it submitted a state plan amendment for ELE at application and renewal for both Medicaid and CHIP using the school lunch program.

Georgia adopted a variety of changes to improve and expand access in Medicaid and CHIP. The state implemented the SSA citizenship data match in CHIP, began accepting e-signatures for CHIP applications, added online renewals in Medicaid, and adopted ELE through a partnership with Special Supplemental Nutrition Program for Women, Infants and Children (WIC)—becoming the first state to establish this partnership. The state also was one of five to extend CHIP coverage to dependents of eligible state employees in 2011.

With a focus on retaining eligible children in Medicaid, South Carolina picked up the ELE option at renewal. Using data from its Supplemental Nutrition Assistance Program (SNAP, formerly food stamps) and Temporary Assistance for Needy Families (TANF) programs, the state approved 65,000 children for ongoing coverage in just eight months. In the year ahead, the state expects to take a number of additional steps to streamline the application process and minimize the amount of paperwork families have to complete. As a result, it expects to cover an additional 70,000 uninsured children who already are eligible for Medicaid or CHIP.

1. Using Technology to Gain Efficiency

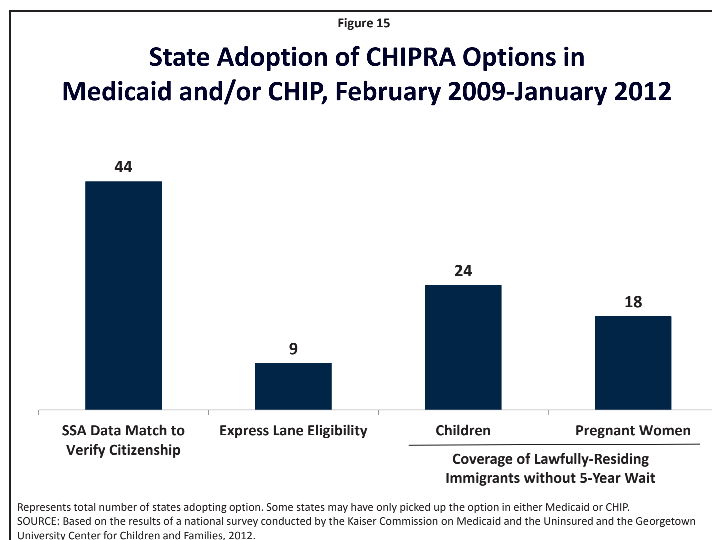
The majority of states making improvements in enrollment and renewal processes (20 of the 25) focused on increasing the use of technology to help gain efficiencies. These states made incremental improvements to their web-based services and behind-the-scenes electronic functions with an eye on managing growing caseloads with fewer staff, simplifying the steps for families to apply for and renew coverage, and reducing the time required to process determinations. As highlighted below, these changes included improving and expanding online enrollment and renewal services and increasing the use of existing data sources to verify eligibility criteria. Further, in many cases, these improvements implemented new options provided by CHIPRA (Box 3: *CHIPRA Advances Its Positive Impact on Children's Coverage*, next page).

Seven (7) states made improvements to their online enrollment and renewal services during 2011. As people increasingly turn to the web for many personal tasks such as banking, electronic applications and renewals provide a convenient and familiar way for many families to apply for or renew coverage. In 2011, five (5) states (CO, GA, ME, NH, and WV) improved their electronic applications by either allowing for electronic submission of applications and/or accepting e-signatures in lieu of requiring families to sign and return a form. A total of four (4) states (CO, GA (Medicaid), UT, and WY (Medicaid)) added renewal functions to their online services in 2011, raising the total number of states that allow Medicaid coverage for children to be renewed online to 20, while 19 CHIP programs allow online renewals.

Box 3:
CHIPRA Continues Its Positive Impact on Children's Coverage

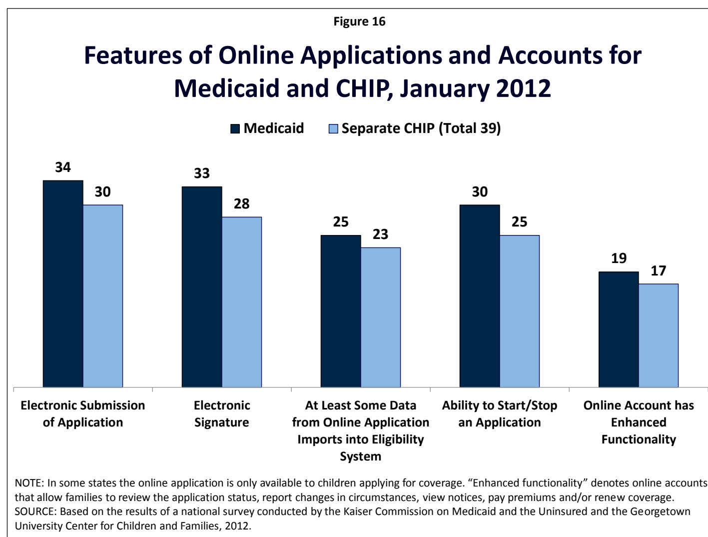
Many of the state actions to improve children's coverage over the past few years have been precipitated by new options and incentives established by CHIPRA in 2009. 2011 was no exception, as CHIPRA continued to shape state actions on eligibility and enrollment procedures. Specifically:

- Thirteen (13) states adopted the electronic data match with the SSA to verify citizenship for children in Medicaid and/or CHIP in 2011, bringing the total number of states using this match in Medicaid or CHIP to 44 as of January 1, 2012 (Figure 15).
- Five (5) states expanded or adopted ELE in 2011, bringing the total number of states who have adopted this option in Medicaid or CHIP to nine (9) as of January 1, 2012.
- Four (4) states adopted the option to cover lawfully-residing children or pregnant women without a five year wait in 2011, and, as of January 1, 2012, nearly half of the states (24, including DC) cover lawfully-residing immigrant children without a five-year wait, while 18 have eliminated the five-year wait for lawfully-residing pregnant women.



Reflecting continued state enrollment and retention improvements, 23 states, including seven (7) new states, earned Medicaid performance bonuses totaling over $296 million in 2011. 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 qualify for a bonus, states must implement at least five of eight simplification measures and meet specific enrollment targets. The bonus is designed to ease the budgetary impact on states from the increased enrollment in Medicaid and is especially welcome fiscal relief to states this year given the mid-year expiration of the ARRA enhanced federal matching funds.

As of January 1, 2012, 34 Medicaid programs and 30 separate CHIP programs allow for electronically submitted applications for children and, with only a couple of exceptions, their parents as well. In most cases, these applications allow for an electronic signature. Twenty-five (25) states maximize the use of their online Medicaid application to automatically populate at least some data elements into their eligibility system, and 23 states do so in CHIP. This data importation reduces errors and saves the time required for manual data entry. Thirty (30) Medicaid and 25 CHIP programs allow families to start, stop, and return to an online application. Nineteen (19) Medicaid programs and 17 CHIP programs have online accounts with enhanced functionality, allowing families to perform tasks such as checking benefits or reporting changes (Figure 16). However, to date, Oklahoma remains the only state with a fully-automated, real-time Medicaid enrollment management system (Box 4: *Oklahoma: The First Online, Fully-Automated, Real-Time Medicaid Enrollment System*).



Box 4:
Oklahoma: The First Online, Fully-Automated, Real-Time Medicaid Enrollment System

Oklahoma is the first state to maximize the use of technology through a web-based, fully-automated, real-time eligibility determination system that is available 24 hours a day, seven days a week. The system allows individuals to apply online and receive an immediate or "real-time" decision on their application after the system has queried various electronic data sources to verify eligibility. Thereafter, individuals can use their account to renew coverage and update information such as an address or a change in family status or employment. Using this system, the state processes more than a thousand applications per day, and 90 percent receive on-the-spot eligibility decisions, even when state offices are closed.

Five (5) states (GA, IA, NJ, PA, and SC) implemented or expanded the use of ELE to expedite enrollment or renewal of eligible children in 2011, and Massachusetts received waiver approval to use ELE for parents. As of January 1, 2012, a total of nine (9) states have adopted the ELE option provided by CHIPRA, enabling them to enroll or renew children eligible for Medicaid or CHIP by relying on eligibility information from other income-based public programs or the state tax or revenue department.[17] In addition, during 2011, Massachusetts became the first state to receive approval under waiver authority to use ELE to renew coverage for parents in Medicaid. Through ELE, states can use information already available from other programs (with the exception of citizenship and immigration status), eliminating the need for families to provide the same eligibility-related information to multiple agencies. In 2011, Georgia implemented the first ELE partnership with the WIC program. Other state ELE partner agencies include the SNAP, TANF, the Free and Reduced Cost School Lunch Program, as well as state tax agencies. States have the flexibility to use ELE for children in Medicaid and/or CHIP, at new application and/or at renewal. Not all states have fully automated ELE, particularly if they only recently have begun to take advantage of the option, but its greatest potential is achieved when data is exchanged electronically and the related administrative steps are automated.

In 2011, 13 states adopted the data match with the SSA to verify citizenship for children electronically and 11 did so for parents. One of the most popular CHIPRA provisions, this data exchange replaces cumbersome paper documentation requirements with a more cost-effective and accurate way to verify citizenship. In April 2011, the SSA further enhanced state access to citizenship data by adding a real-time, web-based look-up capability through its existing State Online Query System (SOLQ), providing states with the option to check citizenship status online as they handle individual applications. States also can continue to use a behind-the-scenes electronic data exchange with the SSA to verify citizenship for a group of beneficiaries at a time. As of January 1, 2012, 41 states have adopted the SSA data match option for children, parents, and pregnant women in Medicaid and 31 states have adopted it for children in CHIP. The widespread adoption of this option illustrates that federally-supported solutions to eligibility challenges can ease administrative burdens and help states move toward an online, fully-automated, real-time eligibility and enrollment system.

Five (5) states (CO, ID, MT (Medicaid), NC, and WV) adopted administrative renewals for children in 2011, sending a pre-populated renewal form to families that does not require the family to take any action beyond returning the form if no information has changed. Overall, as of January 1, 2012, 35 states use pre-populated renewal forms for children in Medicaid and/or CHIP, eliminating the need for families to complete blank forms to provide information the agency already has on file.[18] These forms reduce data-entry errors by eliminating the need for eligibility workers to decipher and manually enter information from handwritten forms. In 21 Medicaid programs and 17 CHIP programs, if the information on a pre-populated reform is accurate and current, families are not required to take any further action to renew coverage, or, at most, are asked to sign and return the form indicating they want to stay enrolled.

2. Enhanced Federal Funding to Support Eligibility System Modernization

Enhanced federal funding has many states on the fast track to upgrade or build new Medicaid eligibility systems. In April 2011, the Administration announced that the federal government will pay 90 percent of the cost for states to develop new or upgrade existing Medicaid eligibility systems (Box 5: *Enhanced Federal Funding Accelerates Technology Transformation*). Since this funding is designed to help states prepare for implementation of health reform, it is short-lived, expiring in 2015 (although an enhanced 75 percent federal match rate will remain available to support the ongoing maintenance of these systems). At a time when diminished state budgets severely inhibit capital expenditures for systems development, the enhanced federal funding already has made a difference in states' willingness to launch major systems improvement projects. As of January 1, 2012, 18 states have received CMS approval for overhauling or building new systems, while an additional 11 states have submitted plans (Figure 17).

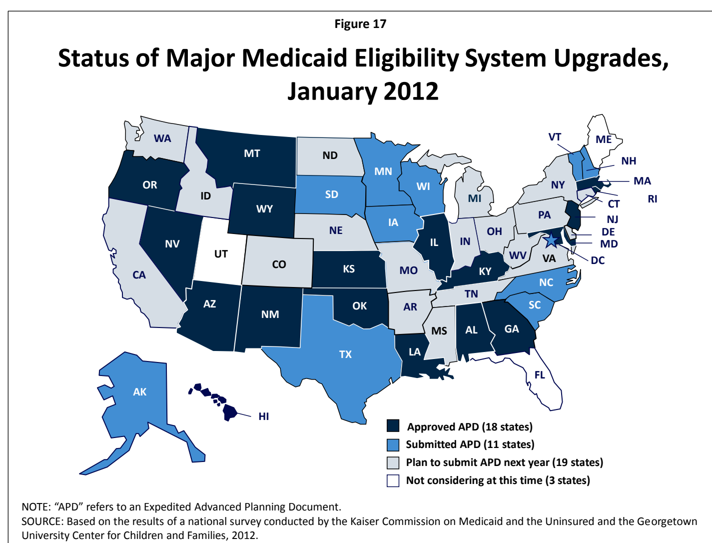


Figure 17

Status of Major Medicaid Eligibility System Upgrades, January 2012

NOTE: "APD" refers to an Expedited Advanced Planning Document.
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, 2012.

Box 5:
Enhanced Federal Funding Accelerates Technology Transformation

From online applications to verification of eligibility through electronic data exchanges to reaching more eligible children through ELE, the use of technology is transforming how Medicaid and CHIP agencies do business. Over the past few years, states have continued to make incremental enhancements, but only a few have made sweeping overhauls to their eligibility and enrollment systems. The high cost of technology, coupled with state fiscal challenges, has prevented states from making the capital budget investments needed to replace their outdated systems. By bringing state Medicaid and CHIP eligibility and enrollment technology into the 21st century, states will gain efficiencies and save administrative costs while making it easier for eligible individuals to enroll in and retain coverage.

Ninety percent federal match is key to state investment in technology. In April 2011, the federal government approved a significant but temporary funding opportunity, known as the 90/10 rule, to support state investment in eligibility systems. Effective immediately, states can receive a 90 percent federal funding match (up from the regular 50 percent match for administrative functions and systems) for the design, development, and implementation of major upgrades or new systems.[19] Maintenance and operating costs of these systems also may qualify for an ongoing 75 percent federal match. The intent is to help states prepare for the ACA requirement for data-driven, online, paperless systems that will deliver real-time eligibility decisions.

New process expedites federal approval of enhanced funding requests. Before the federal government will approve funding for major Medicaid eligibility system changes, states must submit their plans using an Advance Planning Document (APD). To further support the initiative to encourage state-of-the-art Medicaid eligibility systems, CMS also instituted a new expedited APD process that enables states to receive the green light for plans in as little as 45 days, in contrast to what has taken months, if not years, of planning in the past.

90/10 funding has already prompted many states to take action. Going into 2012, 18 states have received approval under the expedited APD process and an additional 11 states, including DC, have submitted plans. Given this valuable and time-limited funding opportunity, more states are likely to embark on major systems development during 2012, as 19 indicated in the survey.

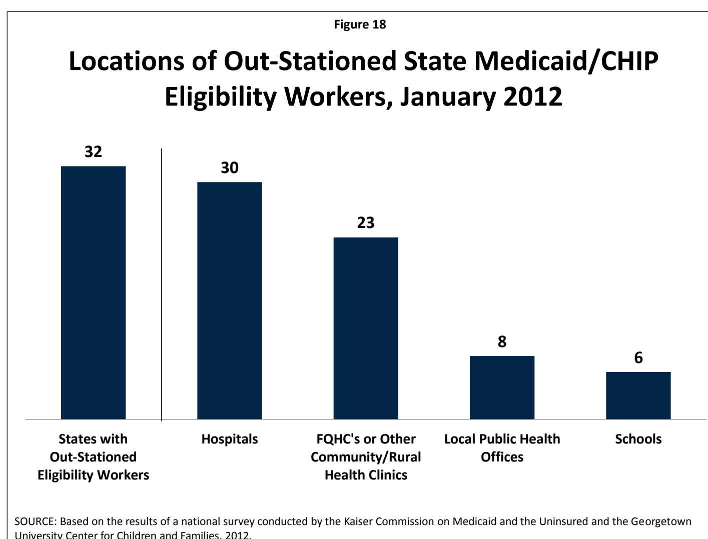
3. Applications and Eligibility Determinations

Almost all states offer a joint Medicaid and CHIP application and a majority offers a simplified family-based application. Under health reform, all states must use a single application for Medicaid, CHIP, and subsidized coverage in the exchange. Many states have already taken a step in that direction by offering a simplified family-based form. As of January 1, 2012, 36 of the 39 states with separate CHIP programs use a joint application form that enables them to evaluate a child's eligibility for both Medicaid and CHIP without requiring families to submit another application. Thirty-two (32) states use a joint Medicaid and CHIP form at renewal as well. In addition, following the adoption of a family application in West Virginia during 2011, 31 states, including DC, now offer a simplified family application that enables parents to apply for Medicaid coverage along with their children without completing additional forms or steps.

As of January 1, 2012, presumptive eligibility is used to enroll children in Medicaid in 16 states and in separate CHIP programs in 11 states. This reflects Connecticut's implementation of presumptive eligibility in CHIP in 2011, which aligned the state's CHIP and Medicaid policies. Moreover, 31 states use presumptive eligibility to enroll pregnant women in coverage. 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 or CHIP application process. As of enactment of the ACA, states also have the option to use presumptive eligibility to enroll adults, although no state has taken up this option to date.[20]

State workers conduct eligibility determinations in most states, but some states use county workers or a contractor. In most states, Medicaid and CHIP eligibility determinations are made by state workers. However, in 10 Medicaid programs and six (6) CHIP programs, eligibility determinations are made by county workers in a county-run office. In 14 of the 39 states with separate CHIP programs, eligibility is determined by a contractor. In a handful of states, there may be multiple points of eligibility determination. For example, in three (3) states (NJ, ND, and VA), eligibility determinations for Medicaid are made by both state and county workers; and, in four (4) states, (CO, KS, MI, and VA) CHIP eligibility determinations are made at the state or county level or through a contractor.

Thirty-two (32) states use out-stationed state eligibility workers to help connect Medicaid and/or CHIP applicants to coverage. While some states may contract with community-based organizations to serve as application assistors, another way for states to expand access to coverage is to place state eligibility workers in locations where families are seeking care, such as at hospitals and federally-qualified health centers (Figure 18).[21] Such an approach is beneficial both for families, whose services are covered if they are found eligible, and for providers, who receive payment for services that may have otherwise resulted in uncompensated care. As health reform implementation moves forward, the importance of out-stationed eligibility workers may become even greater as newly-eligible people seek help enrolling in coverage.

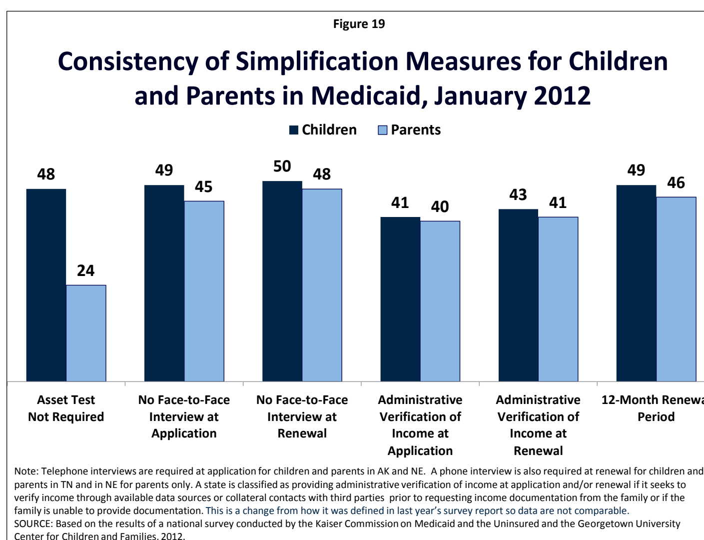


In most states (44, including DC), the Medicaid eligibility system is used for other human service programs, such as SNAP (formerly food stamps) and TANF. Twenty-four (24) of the 39 states with separate CHIP programs use the same system for both Medicaid and CHIP. Connecting families to other public programs is important to ensure that they receive all needed benefits, as well as to reduce duplication of effort by families and state agencies. 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 a sophisticated, online, real-time eligibility and enrollment system for Medicaid, CHIP, and exchange coverage.

4. Enrollment and Renewal Requirements

Requirements for families to enroll in and renew coverage remained largely stable in 2011, reflecting the ACA requirement for states to maintain these policies, while some states adopted new simplifications. In keeping with the historic trend, as of January 1, 2012, states have achieved greater progress in simplifying certain requirements for children, relative to their parents (Figure 19).

As of January 1, 2012, only three (3) Medicaid programs (SC, TX, and UT) and two (2) separate CHIP programs (MO and TX) consider a family's assets when determining children's eligibility for coverage. However, none of these states require families to provide documentation of assets, with the exception of Utah (where documentation is subject to caseworker discretion). In 2011, the number of states without an asset test for pregnant women also remained steady (44 states, including DC), as did the number of states without an asset test for parents (24 states, including DC). The disparity between asset test requirements for children and parents remains, highlighting that many states will need to eliminate asset tests for adults in preparation for 2014, when they will no longer be allowed.[22]



Note: Telephone interviews are required at application for children and parents in AK and NE. A phone interview is also required at renewal for children and parents in TN and in NE for parents only. A state is classified as providing administrative verification of income at application and/or renewal if it seeks to verify income through available data sources or collateral contacts with third parties prior to requesting income documentation from the family or if the family is unable to provide documentation. This is a change from how it was defined in last year's survey report so data are not comparable.
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, 2012.

Only two (2) states continue to require face-to-face interviews for children at application and/or renewal. In 2011, there were no changes in the use of face-to-face interviews for children, with only Mississippi and Tennessee continuing to require them for children at application, and only Mississippi requiring one at renewal. West Virginia, however, did eliminate the requirement for parents in 2011. As a result, only six (6) states (AR, KY, MS, NH, TN, and TX) continue to require parents to apply for or renew coverage in person. In 2014, requiring face-to-face interviews will no longer be permitted in Medicaid or CHIP.[23]

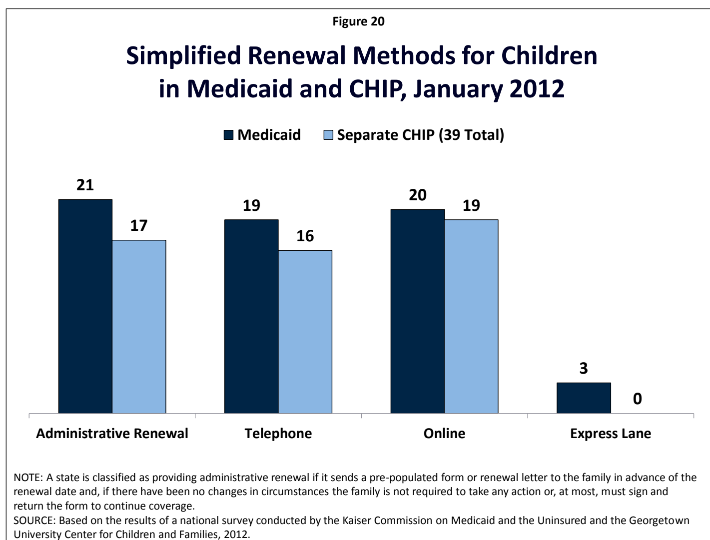
Most states attempt to verify income administratively through available data sources or contacts with third parties, such as employers, but even with these attempts, families often must submit paper documentation. A state may attempt to administratively verify income prior to asking the family for documentation, if the family is unable to provide the documentation, or conduct a behind-the-scenes verification of self-attested information. This approach can minimize the burden on families and save staff time in processing paperwork, especially if states avoid asking for documentation at application or renewal. As of January 1, 2012, 41 states attempt to verify income administratively at application for children in Medicaid and 43 do so at renewal. Thirty (30) of the 39 states with separate CHIP programs attempt to administratively verify income at application and 31 check other sources at renewal. For parents, 40 states attempt to verify income administratively at application and 41 do so at renewal. However, it is unclear to what extent these efforts have effectively reduced the incidence of families submitting paperwork to prove eligibility, particularly since a number of these states continue to routinely request documentation from families. The ACA envisions a process through which states use electronic data to the maximum extent feasible to verify eligibility and may request paper documentation only if they cannot secure reliable electronic information.

As January 1, 2012, 49 states, including DC, use the maximum 12-month renewal period for children in Medicaid, while 39 do so in CHIP. During the 12-month renewal period, families must report changes that may impact their children's eligibility. Slightly fewer, 46 states, including DC, also use a 12-month renewal period for parents, although several continue to require parents to report income at specific intervals within the 12-month period. This routine reporting requirement, although not as burdensome as completing a renewal application, adds to the paperwork required of both families and eligibility workers. Extending the maximum renewal period reduces a state's administrative workload by limiting the number of renewals and eligibility re-verifications a state must process.

Close to half the states provide 12-month continuous eligibility for children, facilitating continuity of care. States have the option to provide 12-months of continuous coverage to children, regardless of fluctuations in income. As of January 1, 2012, twenty-three (23) states provide 12-month continuous eligibility for children in Medicaid and 28 of the 39 states with separate CHIP programs have adopted this policy. Although there currently is no state option to provide 12-month continuous eligibility to adults in Medicaid, New York has received waiver approval to provide 12-months of continuous coverage to parents, pregnant women, and certain other adults. However, the state has not yet implemented this policy. Providing continuous coverage can promote more reliable access to preventive, primary, and other needed health care services, which, in turn, can result in better health outcomes. Additionally, researchers, providers, and health plans report that it is only with continuous periods of coverage that quality of care can be adequately measured and improved.[24] Providing a continuous year of coverage can also stretch administrative resources by reducing the number of children that "churn" on and off coverage and the workload associated with repeated enrollment and disenrollment.

States continue to add simplified renewal options for families. While states must review eligibility for individuals enrolled in Medicaid and CHIP at least once every 12 months, federal regulations do not require either a renewal form or signature at renewal. This allows states the flexibility to provide different paths to renewal including online, over the phone, and through administrative or ELE renewals that tap eligibility information available from other sources. In 2011, eight (8) states adopted telephone or online renewal options for children's coverage. In addition, as previously noted, one (1) state added ELE at renewal and five (5) added administrative renewals. As a result, as of January 1, 2012, a number of states provide simplified options for families to renew children's coverage (Figure 20).

Figure 20



NOTE: A state is classified as providing administrative renewal if it sends a pre-populated form or renewal letter to the family in advance of the renewal date and, if there have been no changes in circumstances the family is not required to take any action or, at most, must sign and return the form to continue 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, 2012.

C. Cost-Sharing Requirements: Few States Changed Premium and Copayment Requirements for Families

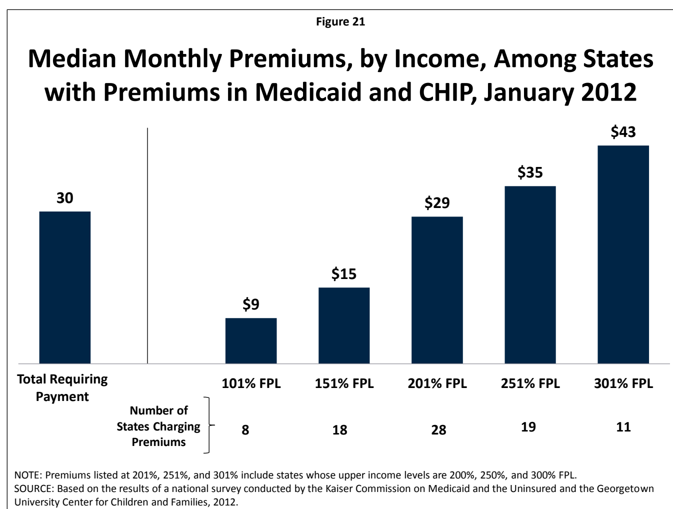
Despite having the flexibility to do so, the majority of states did not impose additional cost-sharing requirements on beneficiaries during 2011. Outside of routine annual rate adjustments, premium and enrollment fee changes were minimal during 2011. The limited scope of these changes likely reflects the fact that premiums can be a barrier to enrollment, and, therefore, the ACA requirement to maintain enrollment procedures largely precludes states from anything but modest premium increases tied to inflation or other automatic annual adjustments.[25] The ACA does not restrict states from increasing copayments within federal program limits, but only six (6) states made increases while four (4) reduced copayments.

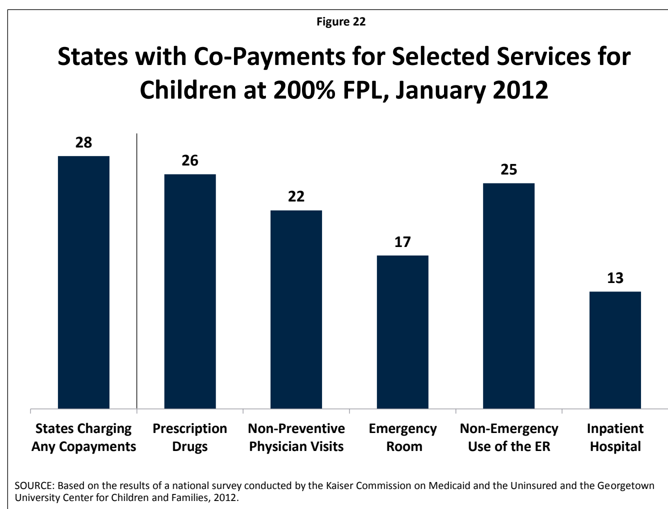
1. Premiums and Copayments for Children

In 2011, only Colorado made a change in its enrollment fee policy for children. While premiums increased in five (5) other states (MD, MN, NJ, OR, and PA), these changes were small, automatic annual adjustments (e.g., the increase is tied to changes in the federal poverty level).[26] The enrollment fee increase in Colorado applies only to children covered under the state's May 2010 expansion, which is not subject to ACA's requirement to maintain coverage. As of January 1, 2012, 30 states charge premiums and four (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 eight (8) states requiring relatively modest premiums for children at 101 percent of the FPL in their separate CHIP or Medicaid waiver programs (Figure 21).[27]

Nineteen (19) of the 30 states charging premiums provide families with more than the required 30-day grace period before their child loses coverage for non-payment of premiums. Following disenrollment for non-payment of premiums, 15 states impose a "lock-out" period during which time the child is barred from re-enrolling in the program. Twenty-four (24) states require families to reapply and 22 require families to repay outstanding premiums before a child can re-enroll in coverage.

In 2011, two (2) states (TX and UT) increased copayments in their child health programs. As of January 1, 2012, two (2) states charge co-payments in their Medicaid expansions and 26 charge them in their separate CHIP programs. In total, for children at 200% of FPL, 26 states require copayments for prescription drugs, 22 states require copayments for non-preventive doctor visits, 17 require co-payments for emergency room care, 25 require co-payments for non-emergency use of the emergency room (which may be higher than those charged for an emergency), and 13 require co-payments for inpatient hospital care (Figure 22).





2. *Premiums and Copayments for Parents and Other Adults*

Only one state made a policy change to premiums for adults in 2011. Specifically, Washington reduced premium amounts charged to adults in its waiver coverage with income below 101 percent of the FPL. As states are only allowed to charge premiums in Medicaid beginning at 150 percent of the FPL and eligibility for adults is often limited to lower income levels, only two (2) states (IL and WI) charge premiums to parents in Medicaid.[28] However, premiums and enrollment fees are commonly included in waiver or state-funded expansion coverage for adults, with 21 of these 37 programs charging premiums. During 2011, premiums in several waiver or state-funded coverage programs increased due to routine annual adjustments.

Four (4) states (AK, MA, MN, and NE) increased copayments for parents in Medicaid, and Massachusetts decreased some copayments but increased others in its waiver expansion coverage for adults. As of January 1, 2012, 40 states require copayments for selected services from parents enrolled in Medicaid, while 26 of the 37 waiver or state-funded expansion coverage programs for parents and/or other adults charge copayments for selected services.

V. CONCLUSION

Taken together, these survey findings show that Medicaid and CHIP played a central role in providing affordable coverage to low-income families during 2011. As expected, Medicaid and CHIP eligibility and enrollment and renewal policies remained steady in 2011, due to the requirement in the ACA that states maintain their programs. As such, Medicaid and CHIP continued to serve as key sources of coverage for low- and moderate-income children. However, while coverage for parents remained stable during 2011, it still lags far behind that of their children. Two states made Medicaid eligibility reductions for low-income adults under the limited exceptions to the ACA requirement suggesting that, without the requirement, it is likely that more states would have rolled back coverage as a result of ongoing budget pressures, which would limit coverage options for low-income families, increase the number of uninsured, and weaken the coverage base for broader health reform.

Despite state fiscal pressures, a number of states enhanced coverage through targeted expansions in eligibility, often focused on children. Some of the expansions helped preserve coverage by enabling states to draw down federal matching funds for individuals previously covered by state funds alone. Consistent with earlier years, the majority of expansions affected children, but several states took steps forward to bolster coverage for low-income adults and get an early start on the 2014 Medicaid expansion.

While the challenging fiscal times further diminished Medicaid and CHIP administrative resources, they also accelerated state efforts to increase efficiency. Half of states made improvements in how they process enrollments and renewals. Many of these improvements focused on enhancing the use of technology to expand and improve web-based and administrative functions, for example, by advancing the capabilities of online enrollment and renewal systems and increasing the use of available data sources to verify eligibility criteria. These actions not only helped states gain increased program efficiencies and streamline processes for families, but also began moving them closer to the real-time, consumer-friendly, paperless eligibility and enrollment systems that will be required in 2014.

More notably, this year saw a jump in the number of states embracing far-reaching changes to their Medicaid and CHIP technology systems in response to the availability of new enhanced federal funding. For years, state officials have cited antiquated computer systems as a major impediment to efforts to improve enrollment and retention. The significant availability of a 90 percent federal funding match for major system upgrades has spurred states to move forward with systems development, with over half of states having already begun or planning to implement major upgrades in the coming year. In some instances, these actions are part of broader efforts to implement the ACA; however, even states that are not actively moving forward on reform are taking up this valuable federal funding opportunity, reflecting the growing recognition among states that new technology makes better use of scarce administrative funding.

Despite ongoing state fiscal pressures, the requirement that states hold steady on their eligibility levels and enrollment and renewal procedures maintained coverage for children and their families during 2011 and preserved the foundation that Medicaid and CHIP coverage will provide under the ACA. While strained state budgets have taken a toll on administrative resources, states have sharpened their use of technology and streamlined their procedures to create more efficient programs, while also simplifying the steps for families to enroll in and renew coverage. Moreover, the CHIPRA tools to streamline program administration, some new options provided in the ACA, and the significant new federal financial incentive for eligibility system upgrades have all served as key catalysts for continued state improvement and modernization of Medicaid and CHIP programs. These actions have not only helped states deal with current pressures, but also lay the groundwork for the coverage expansions and new enrollment requirements that will take effect in 2014.

Endnotes

[1] Insure Kids Now, "FY 2011 Performance Bonus Awards," (2011).
[2] For details, see C. Mann, Director of Centers for Medicaid, CHIP and Survey & Certification letter to State Medicaid Directors, SMDL #11-001 (February 25, 2011).
[3] While not a focus of this research, Arizona also ended its medical spend-down program (Medical Expense Deduction) as of October 1, 2011. The state stopped taking applications for the program in May 2011.
[4] D. Horner, *et al.,* "The Children's Health Insurance Program Reauthorization Act of 2009," Georgetown University Center for Children and Families (March 2009).
[5] 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).
[6] Illinois is awaiting approval to use federal matching funds to refinance its state-funded coverage of children between 200 and 300 percent of the FPL, incorporating these children into its CHIP program.
[7] According to the preamble in the proposed regulations implementing the ACA, states will continue to draw down the enhanced federal matching rate for the children moving from separate CHIP programs into Medicaid. This is consistent with precedent, as in the past, coverage for children made newly eligible for Medicaid, including lawfully residing immigrant children covered at state option, has been matched at the enhanced CHIP matching rate. "Medicaid Program; Eligibility Changes under the Affordable Care Act of 2010," *Federal Register,* 76: 51148-51199 (August 17, 2011).
[8] Arkansas covers these children under its ARKids B waiver and Montana adopted the ACA option last year. The regulation that had restricted states from covering the dependents of state employees requires that the state make more than a "nominal" contribution to such coverage. As Mississippi and North Carolina do not provide any contribution for dependent coverage, dependents of state employees have always been eligible for CHIP, assuming they meet the other eligibility criteria. The regulations defining a qualified low-income child can be found here: 42 *CFR* 457.310(c)(1)(ii).
[9] States cannot make uninsured children wait for coverage in Medicaid, including in CHIP-financed Medicaid expansions unless approved under a federal waiver. Arkansas and Minnesota have waiting periods in their waiver coverage, which accounts for the 40 states – more than the 39 separate CHIP programs – with waiting periods.
[10] It appears that instituting an enrollment cap, unless already in place as in Arizona, may be considered a violation of the requirement in the ACA to maintain coverage. CMS, however, has not yet directly addressed this issue.
[11] M. Heberlein, J. Guyer, and C. Hope, "The Arizona KidsCare CHIP Enrollment Freeze: How Has it Impacted Enrollment and Families?," Kaiser Commission on Medicaid and the Uninsured (September 2011).
[12] The requirement that states maintain coverage does not require states to renew expiring waivers or continue coverage that is solely state-funded. *op. cit.* (2). In anticipation of the reduction, Nevada stopped taking applications for waiver coverage as of June 1, 2011, but continued coverage for women already enrolled in the program through the 60-day post-partum period.
[13] In Washington, the state-funded Basic Health program covered adults up to 200 percent FPL; the coverage under the section 1115 waiver covers adults up to 133 percent of the FPL.
[14] *op. cit.* (3).
[15] *op. cit.* (2).
[16] For more information on key lessons learned and factors contributing to success in covering children, see J. Guyer, T. Brooks, and S. Artiga, "Secrets to Success: An Analysis of Four States at the Forefront of the Nation's Gains in Children's Health Coverage," Kaiser Commission on Medicaid and the Uninsured (January 2012).
[17] Arizona, Colorado, and Massachusetts submitted state plan amendments in 2011 to utilize Express Lane eligibility for children and are awaiting approval from CMS.
[18] In addition, there are some states that conduct administrative renewals through other means that does not involve sending out a pre-populated form to families; these states are also counted.
[19] Certain requirements to allocate costs across other public programs also have been temporarily waived. States are routinely required to allocate systems costs across the programs that use them, but under the 90/10 match, costs incurred by and for Medicaid do not have to be cost-allocated regardless of whether other programs benefit. Only incremental costs for additional requirements to integrate the non-health programs must be charged to the specific program. Ongoing operational costs will be cost-allocated under the traditional rules.
[20] In 2014, the ACA also gives hospitals that provide Medicaid services the prerogative to make presumptive eligibility decisions regardless of whether the state otherwise has adopted the option. For more on presumptive eligibility, see T. Brooks, "Presumptive Eligibility: Providing Access to Health Care Without Delay and Connecting Children to Coverage," Georgetown University Center for Children and Families (May 2011).
[21] While states are required to establish out-station locations to process applications, they do not have to be state workers. States may choose instead to utilize volunteers or community-based organizations to serve this function. 42 *CFR* 435.904.
[22] States will still able to require an asset test for the elderly and those with disabilities.

[23] In the preamble to the proposed regulations implementing the ACA, CMS makes it clear that in-person interviews cannot be required from individuals whose eligibility is based on modified adjusted gross income (MAGI). Under the ACA, eligibility for Medicaid will be determined using MAGI for all populations except those whose eligibility is based on their elderly or disabled status. "Medicaid Program; Eligibility Changes under the Affordable Care Act of 2010," *Federal Register,* 76: 51148-51199 (August 17, 2011).

[24] Committee on Pediatric Health and Health Care Quality Measures, "Child and Adolescent Health and Health Care Quality," Institute of Medicine and National Research Council (2011).

[25] In general, premium increases are not allowable under the protections in the ACA; however, given the longer time frame of the requirements to maintain coverage, CMS permits them under certain conditions. For example, states that have explicit language in their approved state plan authorizing automatic increases would not be considered in violation of the provision for increasing their premiums. In addition, states may adopt premiums for new coverage groups as well as make adjustments based on inflation. *op. cit.* (2).

[26] States may include a provision for regularly-scheduled increases in premiums in their state plans or waiver documents. These automatic increases may be based on benchmarks such as the annual changes in federal poverty level or increases tied to capitation payments for health plans. These policies will be considered "in effect" as of the applicable MOE date and therefore not a violation of the MOE. *op. cit.* (2).

[27] States cannot impose any cost-sharing on children in Medicaid below 150 percent of the FPL except in a narrow range of circumstances. However, states have more flexibility to impose cost-sharing in separate CHIP programs. For more details, see Georgetown University Center for Children and Families, "Cost-Sharing for Children and Families in Medicaid and CHIP" (March 2009).

[28] J. Guyer and J. Paradise, "Explaining Health Reform: Benefits and Cost-Sharing for Adult Medicaid Beneficiaries," Kaiser Family Foundation (August 2010).

VI. Trend and State-by-State Tables

Table A:	Expanding Eligibility and Simplifying Enrollment: Trends in Children's Health Coverage Programs, July 1997 to January 2012
Table B:	Expanding Eligibility and Simplifying Enrollment: Trends in Health Coverage for Parents, January 2002 to January 2012
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Table A
Expanding Eligibility and Simplifying Enrollment:
Trends in Children's Health Coverage Programs
July 1997 to January 2012

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

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

The numbers in this table reflect the net change in actions taken by states from year to year. Specific strategies may be adopted and retracted by several states during a given year.
1. These counts do not include states that may have provided cvoerage above the levels shown using state-only funding.
2. States are not allowed to impose enrollment limits or caps in their Medicaid programs, except under a waiver.

Table B
Expanding Eligibility and Simplifying Enrollment:
Trends in Health Coverage for Parents
January 2002 to January 2012

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

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Center on Budget and Policy Priorities, 1997-2009; and with the Georgetown University Center for Children and Families, 2011-2012.

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. Note that these data reflect coverage under 1931 and not waiver or state-funded coverage.

Table 1
Upper Income Eligibility Limit for Children's Coverage and Program Type
January 2012

State	Program Type[1]	Upper Income Limit[2] (Percent of the FPL)
Total Medicaid Expansion	**12**	
Total Separate CHIP	**16**	
Total Combination	**23**	
Alabama	S-CHIP	300%
Alaska	M-CHIP	175%
Arizona[3]	S-CHIP	200% (closed)
Arkansas[4]	M-CHIP	200%
California[5]	COMBO	250%
Colorado	S-CHIP	250%
Connecticut[6]	S-CHIP	300%
Delaware	COMBO	200%
District of Columbia	M-CHIP	300%
Florida[6]	COMBO	200%
Georgia	S-CHIP	235%
Hawaii	M-CHIP	300%
Idaho	COMBO	185%
Illinois[6, 7]	COMBO	200% (300%)
Indiana	COMBO	250%
Iowa	COMBO	300%
Kansas[8]	S-CHIP	238%
Kentucky	COMBO	200%
Louisiana	COMBO	250%
Maine[6]	COMBO	200%
Maryland	M-CHIP	300%
Massachusetts[9]	COMBO	300%
Michigan[10]	COMBO	200%
Minnesota[4, 6, 11]	M-CHIP	275%
Mississippi	S-CHIP	200%
Missouri	COMBO	300%
Montana	COMBO	250%
Nebraska	M-CHIP	200%
Nevada	S-CHIP	200%
New Hampshire[6]	COMBO	300%
New Jersey[6]	COMBO	350%
New Mexico	M-CHIP	235%
New York[6, 11]	COMBO	400%
North Carolina[6]	COMBO	200%
North Dakota[5]	COMBO	160%
Ohio[6]	M-CHIP	200%
Oklahoma[4]	M-CHIP	185%
Oregon[6, 12]	S-CHIP	300%
Pennsylvania[6]	S-CHIP	300%
Rhode Island[4]	M-CHIP	250%
South Carolina	M-CHIP	200%
South Dakota	COMBO	200%
Tennessee[6, 13]	COMBO	250%
Texas	S-CHIP	200%
Utah	S-CHIP	200%
Vermont	S-CHIP	300%
Virginia	COMBO	200%
Washington	S-CHIP	300%
West Virginia[14] ▲	S-CHIP	300%
Wisconsin[6]	COMBO	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, 2012.
▲Indicates that a state has expanded eligibility in at least one of its children's health insurance programs between January 1, 2011 and January 1, 2012, unless noted otherwise.
▼Indicates that a state has reduced eligibility in at least one of its children's health insurance programs between January 1, 2011 and January 1, 2012, unless noted otherwise.
Table presents rules in effect as of January 1, 2012, 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, and Rhode Island 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. Connecticut, Florida, Maine, Minnesota, New Hampshire, New Jersey, New York, North Carolina, Oregon, Pennsylvania, Tennessee, and Wisconsin allow families with incomes above the levels shown buy into Medicaid/CHIP. Illinois and Ohio eliminated their buy-in programs in 2011. For details, see Table 2.

7. Illinois is awaiting approval for federal funding of its state-funded coverage between 200% and 300% of the FPL.

8. Kansas covers children in a separate CHIP program at 238% FPL in 2011, approximately 250% of the 2008 FPL.

9. 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.

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

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

12. Oregon covers children through 300% of the FPL.

13. 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.

14. West Virginia increased eligibility from 250% to 300% of the FPL as of July 1, 2011.

Table 1A
Income Eligibility Limits and Other Eligibility Features of Children's Health Coverage
January 2012

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]	Dependent Coverage of State Employees in CHIP[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**	**24**	**9**
Alabama[4] ▲	133%		133%		100%		300%		Y
Alaska	150%	175%	150%	175%	150%	175%			
Arizona[5]	140%		133%		100%		200% ***(closed)***		
Arkansas	133%	200%	133%	200%	100%	200%			Y
California[6, 7]	200%		133%		100%		250%	Y	
Colorado[8]	133%		133%		100%		250%		
Connecticut[9]	185%		185%		185%		300%	Y	
Delaware	185%	200%	133%		100%		200%	Y	
District of Columbia[10]	185%	300%	133%	300%	100%	300%		Y	
Florida[9, 11]	185%	200%	133%		100%		200%		
Georgia[4, 12] ▲	185%		133%		100%		235%		Y
Hawaii	185%	300%	133%	300%	100%	300%		Y	
Idaho	133%		133%		100%	133%	185%		
Illinois[3, 10, 12, 13, 14] ▲	133%	200%	133%		100%	133%	200% (300%)	Y	
Indiana	200%		133%	150%	100%	150%	250%		
Iowa	133%	300%	133%		100%	133%	300%	Y	
Kansas[15]	150%		133%		100%		238%		
Kentucky[4] ▲	185%		133%	150%	100%	150%	200%		Y
Louisiana	133%	200%	133%	200%	100%	200%	250%		
Maine[9, 12]	185%		133%	150%	125%	150%	200%	Y	
Maryland	185%	300%	133%	300%	100%	300%		Y	
Massachusetts[14, 16]	185%	200%	133%	150%	114%	150%	300%	Y	
Michigan[17]	185%		150%		150%		200%		
Minnesota[9, 18]	275%	280%	275%		275%			Y	
Mississippi	185%		133%		100%		200%		Y
Missouri	185%		133%	150%	100%	150%	300%		
Montana	133%		133%		100%	133%	250%	Y	Y
Nebraska	150%	200%	133%	200%	100%	200%		Y	
Nevada	133%		133%		100%		200%		
New Hampshire[9]	185%	300%	185%		185%		300%		
New Jersey[9]	185%	200%	133%		100%	133%	350%	Y	
New Mexico	185%	235%	185%	235%	185%	235%		Y	
New York[9, 10, 20]	200%		133%		100%	133%	400%	Y	
North Carolina[9, 14]	185%	200%	133%	200%	100%		200%	Y	Y
North Dakota[21]	133%	100%	133%	100%	100%	100%	160%		
Ohio	150%	200%	150%	200%	150%	200%			
Oklahoma	133%	185%	133%	185%	100%	185%			
Oregon[9, 19]	133%		133%		100%		300%	Y	
Pennsylvania[4, 9] ▲	185%		133%		100%		300%		Y
Rhode Island[22]	185%	250%	133%	250%	100%	250%		Y	
South Carolina	150%	200%	150%	200%	150%	200%			
South Dakota	133%	140%	133%	140%	100%	140%	200%		
Tennessee[9, 23]	185%		133%		100%		250%		
Texas[3, 4, 14] ▲	185%		133%		100%		200%	Y	Y
Utah	133%		133%		100%		200%		
Vermont[3, 14, 24] ▲	225%		225%		225%		300%	Y	
Virginia[14]	133%		133%		100%	133%	200%	Y	
Washington[10]	200%		200%		200%		300%	Y	
West Virginia[25] ▲	150%		133%		100%		300%		
Wisconsin[9]	300%		185%		100%	150%	300%	Y	
Wyoming	133%		133%		100%		200%		

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2012.
▲Indicates that a state has expanded eligibility in at least one of its children's health insurance programs between January 1, 2011 and January 1, 2012, unless noted otherwise.
▼Indicates that a state has reduced eligibility in at least one of its children's health insurance programs between January 1, 2011 and January 1, 2012, unless noted otherwise.
Table presents rules in effect as of January 1, 2012, 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. States that have adopted this option (and received CMS approval of their state plan amendment) in 2011 are denoted as expanding coverage and include Illinois (Medicaid), Texas, and Vermont (Medicaid). Illinois (CHIP), Massachusetts (CHIP), and Pennsylvania are waiting for CMS approval. Pennsylvania currently covers these children with state-only funds.

4. This column indicates whether the state has adopted the option to cover otherwise eligible children of state employees in a separate CHIP program. Under the option, states may receive federal funding to extend CHIP eligibility where the state has maintained its contribution levels for health coverage for employees with dependent coverage or where it can demonstrate that the state employees' out-of-pocket health care costs pose a financial hardship for families. States that have adopted this option (and received CMS approval of their state plan amendment) in 2011 are denoted as expanding coverage and include Alabama, Georgia, Kentucky, Pennsylvania, and Texas. Arkansas covers these children under its ARKids B waiver and Montana adopted the option last year. The regulation that had restricted states from covering the dependents of state employees requires that the state make more than a "nominal" contribution to such coverage. As Mississippi and North Carolina do not provide any contribution for dependent coverage, dependents of state employees have always been eligible for CHIP, assuming they meet the other eligibility criteria.

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 eligible for CHIP unless they are enrolled in Employer-Sponsored Insurance (ESI) or no-cost Medi-Cal. 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 has passed legislation authorizing coverage of lawfully residing immigrant children, but has not provided funding for the expansion.

9. Connecticut, Florida, Maine, Minnesota, New Hampshire, New Jersey, New York, North Carolina, Oregon, Pennsylvania, Tennessee, and Wisconsin allow families with incomes above the levels shown buy into Medicaid/CHIP. Illinois and Ohio eliminated their buy-in programs in 2011. For details, see Table 2.

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

11. 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.

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

13. Illinois is waiting for approval for federal funding of its state-funded coverage between 200% and 300% of the FPL.

14. In Illinois, Massachusetts, North Carolina, Vermont, and Virginia, lawfully-residing immigrant children are covered only in Medicaid.

15. Kansas covers children in a separate CHIP program at 238% FPL in 2011, approximately 250% of the 2008 FPL.

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, known as Medical Assistance or MA, 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. Oregon covers children through 300% of the FPL.

20. New York converted its coverage for children ages 6-19 between 100% and 133% of the FPL from a separate CHIP program to a Medicaid expansion as of November 1, 2011.

21. In North Dakota, if a child is within the applicable Medicaid income limit, coverage is funded through Title XIX. If the child is within the applicable income eligibility limit and family assets exceed the Medicaid asset limits, the child is funded through Title XXI. The state does not have an asset test limit, but families are asked whether their assets are within, or exceed, certain amounts.

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. 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.

24. 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.

25. West Virginia increased eligibility from 250% to 300% of the FPL as of July 1, 2011.

Table 2
Key Features of Buy-In Programs for Children
January 2012

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	**13**				
Alabama					
Alaska					
Arizona					
Arkansas					
California					
Colorado					
Connecticut[2] ▼	Y	>300%	2	$270.36	CHIP
Delaware					
District of Columbia					
Florida[3, 4]	Y	>200%	None	$133/$196	CHIP/Medicaid
Georgia					
Hawaii					
Idaho					
Illinois[5] ▼					
Indiana					
Iowa					
Kansas					
Kentucky					
Louisiana					
Maine[6]	Y	>200%	None	$250	Medicaid
Maryland					
Massachusetts[7]	Y	No limit	None	$0 - $64	More Limited
Michigan					
Minnesota[4, 8]	Y	>275%	None	$509	Medicaid
Mississippi					
Missouri					
Montana					
Nebraska					
Nevada					
New Hampshire[4]	Y	301-400%	3	$237	CHIP
New Jersey[4]	Y	>350%	6	$144	CHIP
New Mexico					
New York[4, 9]	Y	>400%	None	$175.86	CHIP
North Carolina[4, 10]	Y	201-225%	None	$198	CHIP
North Dakota					
Ohio[5] ▼					
Oklahoma					
Oregon[4, 9]	Y	>301%	2	$435/$233	More Limited
Pennsylvania[4, 9]	Y	>300%	6	$209	CHIP
Rhode Island					
South Carolina					
South Dakota					
Tennessee[4, 11]	Y	>250%	3	$268-341	CHIP
Texas					
Utah					
Vermont					
Virginia					
Washington					
West Virginia					
Wisconsin	Y	>300%	3	$97.53	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, 2012.

▲Indicates that a state has expanded eligibility or decreased premiums in its buy-in program between January 1, 2011 and January 1, 2012, unless noted otherwise.

▼Indicates that a state has reduced eligibility or increased premiums in its buy-in program between January 1, 2011 and January 1, 2012, unless noted otherwise.

Table presents rules in effect as of January 1, 2012, 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. Connecticut increased premiums for children in its buy-in program from $195 to $270.36 in 2011.

3. 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.

4. Premiums in the buy-in programs in Florida, Minnesota, New Hampshire, New York, North Carolina, Oregon, Pennsylvania, and Tennessee increased through annual adjustments in 2011. In New Jersey, the state sets the rate for what the carrier can charge; however, the carrier opted not to increase premiums this year.

5. Illinois and Ohio eliminated their buy-in programs in 2011.

6. In Maine, eligibility in the buy-in program is limited to those who had been previously enrolled in Medicaid or CHIP and lost eligibility due to an increase in income. A child can participate for up to 18 months.

7. 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.

8. In June 2011, Minnesota received approval to eliminate the requirement that in order to be eligible for the buy-in, the child must have been previously enrolled in Medicaid. This change, however, has yet to be implemented.

9. In New York, Oregon, and Pennsylvania, the monthly premium varies by health plan and the average amount is shown. In Oregon, the first premium is for a child 0-24 months; the second is for a child 2-18.

10. 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.

11. In Tennessee, premiums vary by income.

Table 3

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

January 2012

State	Waiting Period[1] (in Months)	Income-Related Groups Exempt from Waiting Period (Percent of the FPL)
Total with Waiting Period	**40**	
Alabama	3	
Alaska	None	
Arizona	3	
Arkansas[2]	6	Below 133% <6 years old Below 100% > 6 years old
California	3	
Colorado	3	
Connecticut	2	
Delaware	6	
District of Columbia	None	
Florida	2	
Georgia	6	
Hawaii	None	
Idaho	6	
Illinois[3]	None	
Indiana	3	
Iowa	1	Below 200%
Kansas	8	Below 200%
Kentucky	6	
Louisiana	12	Below 200%
Maine	3	
Maryland	6	
Massachusetts	6	Below 200%
Michigan	6	
Minnesota[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	None	
South Dakota	3	
Tennessee	3	
Texas	3	
Utah	3	
Vermont	1	
Virginia	4	
Washington	4	
West Virginia	3	
Wisconsin	3	Below 150%
Wyoming	1	

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2012.

▲Indicates that a state has shortened its waiting period between January 1, 2011 and January 1, 2012, unless noted otherwise.

▼Indicates that a state has lengthened its waiting period between January 1, 2011 and January 1, 2012, unless noted otherwise.

Table presents rules in effect as of January 1, 2012, 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. Minnesota received approval when it renewed its waiver to remove the waiting period for children with family income at or below 200% FPL, but has not yet implemented the change.

3. Under CHIP, Illinois imposes a 3-month waiting period for those between 133% and 200% FPL; however, the state funds coverage during this period. They also have a 12-month waiting period in their state-funded coverage between 200% and 300% FPL.

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

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 2012

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	76%			81%								
Arizona[2] ▼	100%			106%				100% *(closed)*			110% *(closed)*	
Arkansas[3]	13%			17%	200%						200%	
California[4]	100%	200%		106%	200%			200%			200%	
Colorado	100%			106%								
Connecticut[5]	185%		300%	191%		306%	56%		300%	72%		310%
Delaware	75%	100%		119%	106%			100%			110%	
District of Columbia	200%		200%	206%		206%	133%	200%	200%	144%	211%	211%
Florida	20%			58%								
Georgia	27%			49%								
Hawaii[6]	100%	200%		100%	200%			200%			200%	
Idaho[7]	21%			39%	185%						185%	
Illinois[8]	185%			191%		200%						
Indiana[9]	19%	200%		24%	206%			200% *(closed)*			210% *(closed)*	
Iowa[10]	28%	200%		82%	250%			200%			250%	
Kansas	26%			32%								
Kentucky	34%			59%								
Louisiana	11%			25%								
Maine[11]	200%		300%	200%		300%		100% *(closed)*	300%		100% *(closed)*	300%
Maryland[12]	116%			116%				116%			128%	
Massachusetts[13]	133%	300%		133%	300%			300%			300%	
Michigan[14]	37%			63%				35% *(closed)*			45% *(closed)*	
Minnesota[15] ▲	100%	275%	275%	120%	275%	275%	75%	250%	250%	75%	250%	250%
Mississippi	24%			44%								
Missouri	19%			36%								
Montana	32%			55%								
Nebraska	46%			57%								
Nevada[16] ▼	25%			87%								
New Hampshire	39%			49%								
New Jersey[17] ▲	29%	200% *(closed)*		133%	200% *(closed)*			23%			23%	
New Mexico[18]	29%	200% *(closed)*		85%	408% *(closed)*			200% *(closed)*			414% *(closed)*	
New York[19]	68%	150%		74%	150%			100%			100%	
North Carolina	35%			49%								
North Dakota	34%			59%								
Ohio	90%			90%								
Oklahoma[20]	37%	200%		53%	200%			200%			200%	
Oregon[21]	31%	201%		40%	201%			201%			201%	
Pennsylvania[22] ▼	26%			46%								
Rhode Island[23]	110%	175%		116%	181%							
South Carolina	50%			91%								
South Dakota	52%			52%								
Tennessee[24]	69%			126%		$55,000/yr *(closed)*						$55,000/yr *(closed)*
Texas	12%			26%								
Utah[25]	38%	150% *(closed)*		44%	150%			150% *(closed)*			150%	
Vermont[26]	77%	300%		82%	300%			300%			300%	
Virginia	25%			31%								
Washington[27] ▲	36%	133%		73%	133%			133%			133%	
West Virginia	16%			32%								
Wisconsin[28]	200%			200%				200% *(closed)*			200% *(closed)*	
Wyoming	38%			51%								

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, 2012.
▲Indicates that a state has expanded eligibility in at least one of its adult coverage programs between January 1, 2011 and January 1, 2012, unless noted otherwise.
▼Indicates that a state has reduced eligibility in at least one of its adult coverage programs between January 1, 2011 and January 1, 2012, unless noted otherwise.
Table presents rules in effect as of January 1, 2012, 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 (such as child care expenses) in determining eligibility that are not accounted for here. 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 some point between January 1, 2011 and January 1, 2012.

2. Arizona froze enrollment in its waiver coverage for childless adults on July 8, 2011.

3. 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. In 2011, the state opened up the program to those who are also self-employed.

4. California covers adults through two programs: the Medicaid Coverage Expansion (MCE) up to 133% FPL and the Health Care Coverage Initiative (HCCI) between 133% and 200% FPL. While both coverage options offer more limited benefits than full Medicaid, the MCE benefit package is more comprehensive.

5. In 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 and adults at any income can buy into the program at the full cost of $446 per month. Enrollment was limited to those applicants who do not qualify for the CT Pre-Existing Condition Insurance Plan effective September 1, 2011.

6. 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. Hawaii is awaiting CMS approval to reduce eligibility from 200% to 133% FPL in QUEST ACE and from 300% to 133% FPL in QUEST NET.

7. 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.

8. Illinois provides premium assistance for parents and children between 133% and 200% FPL through its state-funded Family Care Rebate program.

9. In Indiana, adults up to 200% FPL are eligible for more limited coverage under the Healthy Indiana waiver program. Enrollment is closed for childless adults. During 2011, the state opened the waiting in an effort to add members up to the cap.

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

11. 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 DirigoChoice program.

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

13. 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.

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

15. In March of 2011, Minnesota adopted the ACA option for adults up to 75% FPL and obtained a waiver to expand coverage to childless adults above 75% and up to 250% FPL effective August 1, 2011. Childless adults were previously covered in a fully state-funded program, which the state has continued. In Minnesota, parents up to 275% FPL and childless adults up to 250% FPL are eligible for coverage under the MinnesotaCare waiver program; parents above 215% FPL and childless adults in the waiver program receive more limited coverage.

16. Nevada eliminated its premium assistance program (Check Up Plus) when its waiver expired in November 2011. The state stopped taking new enrollees as of June 2011.

17. In New Jersey, parents up to 200% FPL are covered under the FamilyCare waiver program. Waiver enrollment closed in 2010 for parents who do not qualify for Medicaid using an enhanced income disregard. In April 2011, New Jersey obtained a waiver to expand coverage to childless adults who had previously been covered through the state's general assistance program. The eligibility levels shown apply to individuals who are "employable;" those considered "unemployable" have a lower threshold.

18. 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.

19. 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.

20. 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.

21. 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. FHIAP is open for both individual and employer sponsored insurance, however, the state is only enrolling individuals from the reservation list.

22. In February 2011, Pennsylvania eliminated its state-funded adultBasic program that covered adults up to 200% FPL.

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

24. 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.

25. 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.

26. 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.

27. Washington converted its state-funded program (Basic Health) to waiver coverage. The state-funded Basic Health program covered adults up to 200% FPL; coverage under the section 1115 waiver covers adults up to 133% FPL.

28. 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 2012

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[2] ▼	106%	110% *(closed)*				
Arkansas[3]	17%				200%	200%
California[4]	106%		200%	200%		
Colorado	106%					
Connecticut[5]	191%	72%	306%	310%		
Delaware	119%	110%				
District of Columbia	206%	211%	206%	211%		
Florida	58%					
Georgia	49%					
Hawaii[6]	100%	100% *(closed)*	200%	200%		
Idaho[7]	39%				185%	185%
Illinois[8]	191%				200%	
Indiana[9]	24%		206%	210% *(closed)*		
Iowa[10]	82%		250%	250%		
Kansas	32%					
Kentucky	59%					
Louisiana	25%					
Maine[11]	200%		300%	300%		
Maryland[12]	116%			128%		
Massachusetts[13]	133%		300%	300%		
Michigan[14]	63%			45% *(closed)*		
Minnesota[15] ▲	215%	75%	275%	250%		
Mississippi	44%					
Missouri	36%					
Montana	55%					
Nebraska	57%					
Nevada[16] ▼	87%					
New Hampshire	49%					
New Jersey[17] ▲	200% *(closed > 133%)*			23%		
New Mexico[18]	85%		408% *(closed)*	414% *(closed)*	408% *(closed)*	414% *(closed)*
New York[19]	150%	100%				
North Carolina	49%					
North Dakota	59%					
Ohio	90%					
Oklahoma[20]	53%				200%	200%
Oregon[21]	40%		201%	201%	201%	201%
Pennsylvania[22] ▼	46%					
Rhode Island[23]	181%					
South Carolina	91%					
South Dakota	52%					
Tennessee[24]	126%				$55,000/yr *(closed)*	$55,000/yr *(closed)*
Texas	26%					
Utah[25]	44%		150% *(closed)*	150% *(closed)*	150%	150%
Vermont[26]	185%	150%	300%	300%		
Virginia	31%					
Washington[27] ▲	73%		133%	133%		
West Virginia	32%					
Wisconsin[28]	200%			200%*(closed)*		
Wyoming	51%					

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, 2012.

▲Indicates that a state has expanded eligibility in at least one of its adult coverage programs between January 1, 2011 and January 1, 2012, unless noted otherwise.

▼Indicates that a state has reduced eligibility in at least one of its adult coverage programs between January 1, 2011 and January 1, 2012, unless noted otherwise.

Table presents rules in effect as of January 1, 2012, 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 (such as child care expenses) in determining eligibility that are not accounted for here. 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 some point between January 1, 2011 and January 1, 2012.

2. Arizona froze enrollment in its waiver coverage for childless adults on July 8, 2011.

3. 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. In 2011, the state opened up the program to those who are also self-employed.

4. California covers adults through two programs: the Medicaid Coverage Expansion (MCE) up to 133% FPL and the Health Care Coverage Initiative (HCCI) between 133% and 200% FPL. While both coverage options offer more limited benefits than full Medicaid, the MCE benefit package is more comprehensive.

5. In 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 and adults at any income can buy into the program at the full cost of $446 per month. Enrollment was limited to those applicants who do not qualify for the CT Pre-Existing Condition Insurance Plan effective September 1, 2011.

6. 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. Hawaii is awaiting CMS approval to reduce eligibility from 200% to 133% FPL in QUEST ACE and from 300% to 133% FPL in QUEST NET.

7. 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.

8. Illinois provides premium assistance for parents and children between 133% and 200% FPL through its state-funded Family Care Rebate program.

9. In Indiana, adults up to 200% FPL are eligible for more limited coverage under the Healthy Indiana waiver program. Enrollment is closed for childless adults. During 2011, the state opened the waiting in an effort to add members up to the cap.

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

11. 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 DirigoChoice program.

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

13. 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.

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

15. In March of 2011, Minnesota adopted the ACA option for adults up to 75% FPL and obtained a waiver to expand coverage to childless adults above 75% and up to 250% FPL effective August 1, 2011. Childless adults were previously covered in a fully state-funded program, which the state has continued. In Minnesota, parents up to 275% FPL and childless adults up to 250% FPL are eligible for coverage under the MinnesotaCare waiver program; parents above 215% FPL and childless adults in the waiver program receive more limited coverage.

16. Nevada eliminated its premium assistance program (Check Up Plus) when its waiver expired in November 2011. The state stopped taking new enrollees as of June 2011.

17. In New Jersey, parents up to 200% FPL are covered under the FamilyCare waiver program. Waiver enrollment closed in 2010 for parents who do not qualify for Medicaid using an enhanced income disregard. In April 2011, New Jersey obtained a waiver to expand coverage to childless adults who had previously been covered through the state's general assistance program. The eligibility levels shown apply to individuals who are "employable;" those considered "unemployable" have a lower threshold.

18. 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.

19. 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.

20. 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.

21. 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. FHIAP is open for both individual and employer sponsored insurance, however, the state is only enrolling individuals from the reservation list.

22. In February 2011, Pennsylvania eliminated its state-funded adultBasic program that covered adults up to 200% FPL.

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

24. 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.

25. 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.

26. 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.

27. Washington converted its state-funded program (Basic Health) to waiver coverage. The state-funded Basic Health program covered adults up to 200% FPL; coverage under the section 1115 waiver covers adults up to 133% FPL.

28. 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 2012

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**	**18**	**44**	**31**
Alabama[4]	133%				Y	
Alaska	175%				Y	
Arizona	150%				Y	
Arkansas	162%	200%	200%		$3,100	Y
California[5]	200%		300%	Y	Y	Y
Colorado[6]	133%	250%		Y	Y	Y
Connecticut	250%			Y	Y	Y
Delaware	200%			Y	Y	Y
District of Columbia[7]	300%			Y	Y	Y
Florida	185%				Y	Y
Georgia	200%				Y	Y
Hawaii[8]	185%			Y	Y	
Idaho	133%				$5,000	Y
Illinois	200%		200%		Y	Y
Indiana	200%				Y	Y
Iowa	300%				$10,000	Y
Kansas	150%				Y	
Kentucky	185%				Y	Y
Louisiana[4]	200%		200%		Y	
Maine	200%			Y	Y	Y
Maryland[4]	250%			Y	Y	
Massachusetts	200%		200%	Y	Y	Y
Michigan	185%		185%		Y	Y
Minnesota	275%		275%	Y	Y	
Mississippi	185%				Y	
Missouri	185%				Y	Y
Montana	150%				$3,000	Y
Nebraska	185%			Y	Y	Y
Nevada[9] ▼	133%				Y	
New Hampshire	185%				Y	Y
New Jersey[7]	185%	200%		Y	Y	Y
New Mexico	235%			Y	Y	Y
New York[7, 10]	200%			Y	Y	Y
North Carolina	185%			Y	Y	Y
North Dakota	133%				Y	
Ohio[4]	200%				Y	
Oklahoma	185%		185%		Y	Y
Oregon	185%		185%		Y	
Pennsylvania	185%				Y	Y
Rhode Island[11]	185%	250% (350%)	250%		Y	
South Carolina[4]	185%				$30,000	
South Dakota	133%				$7,500	
Tennessee	185%		250%		Y	Y
Texas	185%		200%		Y	Y
Utah[12]	133%				$5,000	Y
Vermont[2] ▲	200%			Y	Y	
Virginia	133%	200%			Y	
Washington	185%		185%	Y	Y	
West Virginia	150%				Y	
Wisconsin	300%		300%	Y	Y	Y
Wyoming	133%				Y	Y

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2012.

▲Indicates that a state has expanded eligibility or adopted a simplified procedure for pregnant women between January 1, 2011 and January 1, 2012, unless noted otherwise.

▼Indicates that a state has reduced eligibility or eliminated a simplifed procedure for pregnant women between January 1, 2011 and January 1, 2012, unless noted otherwise.

Table presents rules in effect as of January 1, 2012, 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. States that have adopted this option (and received CMS approval of their state plan amendment) in 2011 are denoted as expanding coverage. Vermont received CMS approval of its SPA to provide coverage to lawfully-residing pregnant women without the five-year wait and Pennsylvania has submitted a state plan amendment, but is awaiting CMS approval.

3. With the exception of Arkansas and Utah, all states with an asset test for pregnancy coverage rely on a standard limit regardless of family size. In Arkansas and Utah, the asset limit shown is for a family of three. In South Carolina, pregnant women do not have to provide documentation of their assets. As of September 2011, pregnant women in Idaho were no longer required to provide paper documentation unless their declared assets were within 10% of the asset limit threshold.

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

5. In California, presumptive eligibility is available only to women through Medicaid.

6. In Colorado, lawfully-residing immigrant pregnant women are covered in Medicaid only.

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

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

9. Nevada’s waiver covering pregnant women to 185% FPL expired November 30, 2011. The state chose not to renew the waiver and stopped taking applications as of June 1, 2011. Nevada continued coverage for any woman enrolled in the program through the 60-day post-partum period.

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

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

12. Women who exceed the asset limit in Utah may still qualify if they pay a one-time fee of 4% of their assets up to a maximum of $3,367.

Table 7
Streamlined Application Requirements for Children's Health Coverage
January 2012

State	Joint Medicaid/ CHIP Application	Face-to-Face Interview NOT Required		Asset Test NOT Required (or Asset Test Limit)[1]		State Attempts to Administratively Verify Income[2]	
		Medicaid	CHIP	Medicaid	CHIP	Medicaid	CHIP
Total	**36**	**49**	**38**	**48**	**37**	**41**	**30**
Aligned Medicaid and CHIP[3]	**48**	**49**		**47**		**40**	
Alabama	Y	Y	Y	Y	Y	Y	Y
Alaska	N/A	Y	N/A	Y	N/A	Y	N/A
Arizona	Y	Y	Y	Y	Y	Y	Y
Arkansas	N/A	Y	N/A	Y	N/A	Y	N/A
California[4]		Y	Y	Y	Y		
Colorado	Y	Y	Y	Y	Y	Y	Y
Connecticut	Y	Y	Y	Y	Y	Y	Y
Delaware	Y	Y	Y	Y	Y	Y	Y
District of Columbia	N/A	Y	N/A	Y	N/A	Y	N/A
Florida	Y	Y	Y	Y	Y	Y	Y
Georgia[5]	Y	Y	Y	Y	Y		
Hawaii[7]	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	Y	Y
Iowa[5]	Y	Y	Y	Y	Y	Y	Y
Kansas	Y	Y	Y	Y	Y		
Kentucky	Y	Y	Y	Y	Y	Y	Y
Louisiana	Y	Y	Y	Y	Y	Y	Y
Maine	Y	Y	Y	Y	Y		
Maryland	N/A	Y	N/A	Y	N/A	Y	N/A
Massachusetts	Y	Y	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	Y	Y
Missouri[8]	Y	Y	Y	Y	$250,000		
Montana	Y	Y	Y	Y	Y	Y	Y
Nebraska	N/A	Y	N/A	Y	N/A	Y	N/A
Nevada		Y	Y	Y	Y	Y	
New Hampshire	Y	Y	Y	Y	Y		
New Jersey	Y	Y	Y	Y	Y	Y	Y
New Mexico	N/A	Y	N/A	Y	N/A	Y	N/A
New York	Y	Y	Y	Y	Y		
North Carolina	Y	Y	Y	Y	Y	Y	Y
North Dakota	Y	Y	Y	Y	Y	Y	Y
Ohio	N/A	Y	N/A	Y	N/A	Y	N/A
Oklahoma[9]	N/A	Y	N/A	Y	N/A	Y	N/A
Oregon	Y	Y	Y	Y	Y	Y	Y
Pennsylvania	Y	Y	Y	Y	Y	Y	Y
Rhode Island	N/A	Y	N/A	Y	N/A		N/A
South Carolina[7]	N/A	Y	N/A	$30,000	N/A	Y	N/A
South Dakota	Y	Y	Y	Y	Y	Y	Y
Tennessee			Y	Y	Y	Y	Y
Texas[5, 10]	Y	Y	Y	$2,000	$10,000	Y	Y
Utah[7, 11]	Y	Y	Y	$3,025	Y	Y	Y
Vermont	Y	Y	Y	Y	Y	Y	Y
Virginia	Y	Y	Y	Y	Y	Y	Y
Washington	Y	Y	Y	Y	Y	Y	Y
West Virginia	Y	Y	Y	Y	Y	Y	Y
Wisconsin	Y	Y	Y	Y	Y	Y	Y
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, 2012.

▲Indicates that a state has simplified one or more of its procedures between January 1, 2011 and January 1, 2012, unless noted otherwise.

▼Indicates that a state has rescinded one or more of its simplified procedures between January 1, 2011 and January 1, 2012, unless noted otherwise.

Table presents rules in effect as of January 1, 2012, unless noted otherwise.

Table 7 Notes

1. In states with asset limits, the limit noted is for a family of three, except for in South Carolina where the same asset limit applies regardless of family size. In Missouri, South Carolina, and Texas families do not need to provide proof of assets. In Utah, it is at caseworker discretion whether or not proof of assets is required.

2. The state attempts to verify income administratively either through available databases or collateral contacts with third parties, such as employers. A state may make such attempts prior to asking the family for documentation, if the family is unable to provide the documentation, or conduct a behind-the-scenes verification of self-attested information. This is a change from how it was defined in last year's report so data are not compared year to year.

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 39 states with separate CHIP programs.

4. In California, separate applications are used to apply for Medicaid and CHIP. However, the programs will accept the other's application with the family's consent to the application transfer. The state does not consider this a "joint application."

5. In Georgia, Iowa, and Texas although separate applications are used to apply for Medicaid and CHIP, the programs will accept the other's application.

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

7. Hawaii automatically enrolls families receiving TANF into Medicaid but has not received CMS approval for an Express Lane eligibility state plan amendment.

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

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

10. In Texas, the asset 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.

11. 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 2012

State		Presumptive Eligibility		Express Lane Eligibility[1]		Social Security Administration (SSA) Data Match to Verify Citizenship[2]		Out-Stationed State Eligibility Workers[3]	
		Medicaid	CHIP	Medicaid	CHIP	Medicaid	CHIP	Medicaid	CHIP
Total		**16**	**11**	**7**	**5**	**41**	**31**	**32**	**17**
Aligned Medicaid and CHIP[4]		**13**		**5**		**40**		**26**	
Alabama				Y		Y	Y	Y	
Alaska			N/A		N/A	Y	N/A	Y	N/A
Arizona								Y	
Arkansas			N/A		N/A	Y	N/A	Y	N/A
California[2]	▲	Y	Y			Y	Y	Y	
Colorado[2]	▲	Y	Y			Y	Y		
Connecticut[5]	▲	Y	Y			Y	Y	Y	Y
Delaware						Y	Y		
District of Columbia			N/A		N/A	Y	N/A	Y	N/A
Florida								Y	Y
Georgia[1, 2]	▲			Y	Y		Y	Y	Y
Hawaii			N/A		N/A	Y	N/A		N/A
Idaho						Y	Y		
Illinois[2, 6]	▲	Y	Y			Y	Y		
Indiana									
Iowa[1]	▲	Y	Y	Y	Y	Y	Y	Y	
Kansas[7]		Y	Y					Y	Y
Kentucky[2]	▲					Y	Y		
Louisiana				Y		Y	Y	Y	Y
Maine						Y	Y		
Maryland[8]			N/A	Y	N/A	Y	N/A	Y	N/A
Massachusetts[2]	▲	Y	Y			Y	Y		
Michigan[9]		Y	Y			Y		Y	Y
Minnesota[10]			N/A		N/A	Y	N/A	Y	N/A
Mississippi	▲					Y	Y	Y	Y
Missouri[11]		Y						Y	Y
Montana[2]	▲	Y	Y			Y	Y		
Nebraska[2]	▲		N/A		N/A	Y	N/A		N/A
Nevada							Y		
New Hampshire		Y				Y	Y		
New Jersey[1]	▲	Y	Y	Y	Y	Y	Y	Y	Y
New Mexico[2]	▲	Y	N/A		N/A	Y	N/A	Y	N/A
New York		Y	Y			Y	Y	Y	Y
North Carolina						Y	Y	Y	Y
North Dakota								Y	Y
Ohio		Y	N/A		N/A	Y	N/A	Y	N/A
Oklahoma			N/A		N/A	Y	N/A	Y	N/A
Oregon				Y	Y	Y	Y		
Pennsylvania[1]	▲				Y	Y	Y		
Rhode Island[2]	▲		N/A		N/A	Y	N/A		N/A
South Carolina[2]	▲		N/A		N/A	Y	N/A	Y	N/A
South Dakota						Y	Y		
Tennessee							Y	Y	
Texas[2]	▲					Y	Y	Y	Y
Utah[2]	▲					Y	Y	Y	Y
Vermont									
Virginia						Y	Y	Y	Y
Washington						Y	Y	Y	Y
West Virginia						Y	Y	Y	
Wisconsin		Y				Y	Y	Y	Y
Wyoming						Y	Y		

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for
▲Indicates that a state has simplified one or more of its procedures between January 1, 2011 and January 1, 2012, unless noted otherwise.
▼Indicates that a state has rescinded one or more of its simplified procedures between January 1, 2011 and January 1, 2012, unless noted
Table presents rules in effect as of January 1, 2012, 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 in 2011 are denoted as implementing a simplification in the table and include Georgia, Iowa (CHIP), New Jersey (CHIP), and Pennsylvania (CHIP). Arizona, Colorado, and Massachusetts have submitted state plan amendments to implement Express Lane Eligibility. They are awaiting approval from CMS.

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 in 2011 are denoted as implementing a simplification in the table and include California (CHIP), Colorado, Georgia (CHIP), Illinois, Kentucky, Massachusetts, Montana (Medicaid), Nebraska, New Mexico, Rhode Island, South Carolina, Texas, and Utah.

3. While states are required to establish out-station locations to process applications, they do not have to have state eligibility workers. States may choose instead to utilize volunteers or community-based organizations to serve this function. These alternative plans to provide application assistance at locations other than government offices may be equally effective in connecting eligible individuals to Medicaid and CHIP.

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 39 states with separate CHIP programs.

5. Connecticut implemented presumptive eligibility for the state's CHIP children in April 2011.

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

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

8. Maryland is conducting a pilot for an accelerated eligibility process that is available to children who already have an open case for other benefits at a local eligibility office.

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

10. In Minnesota, the SSA match can only be used with the system for Medical Assistance eligibility, which is administered by the counties, and not the system that determines eligibility for coverage under the 1115 waiver.

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

Table 9
Use of Online Application Forms in Medicaid and CHIP[1]
January 2012

State	Application Form Can be Submitted Electronically		Electronic Signature[2]		Ability to Start/Stop an Application		Online Account has Enhanced Functionality[3]	
	Medicaid	CHIP	Medicaid	CHIP	Medicaid	CHIP	Medicaid	CHIP
Total	**34**	**30**	**33**	**28**	**30**	**25**	**19**	**17**
Aligned Medicaid and CHIP[4]	**34**		**32**		**29**		**17**	
Alabama	Y	Y	Y	Y	Y	Y		
Alaska		N/A	N/A	N/A	N/A	N/A	N/A	N/A
Arizona	Y	Y	Y	Y	Y	Y	Y	Y
Arkansas	Y	N/A	Y	N/A	Y	N/A	Y	N/A
California	Y	Y	Y	Y	Y	Y		Y
Colorado[5] ▲	Y	Y	Y	Y	Y	Y	Y	Y
Connecticut			N/A	N/A	N/A	N/A	N/A	N/A
Delaware	Y	Y	Y	Y	Y	Y		
District of Columbia		N/A	N/A	N/A	N/A	N/A	N/A	N/A
Florida	Y	Y	Y	Y	Y	Y	Y	Y
Georgia[2] ▲		Y	N/A	Y	N/A		N/A	Y
Hawaii		N/A	N/A	N/A	N/A	N/A	N/A	N/A
Idaho			N/A	N/A	N/A	N/A	N/A	N/A
Illinois	Y	Y			Y	Y		
Indiana[6]	Y	Y	Y	Y				
Iowa	Y	Y	Y	Y	Y	Y		Y
Kansas			N/A	N/A	N/A	N/A	N/A	N/A
Kentucky			N/A	N/A	N/A	N/A	N/A	N/A
Louisiana	Y	Y	Y	Y	Y	Y	Y	Y
Maine[5] ▲	Y	Y	Y	Y	Y	Y		
Maryland	Y	N/A	Y	N/A		N/A	N/A	N/A
Massachusetts[7]			N/A	N/A	N/A	N/A	N/A	N/A
Michigan[8]	Y	Y	Y	Y	Y	Y		
Minnesota		N/A	N/A	N/A	N/A	N/A	N/A	N/A
Mississippi			N/A	N/A	N/A	N/A	N/A	N/A
Missouri	Y	Y	Y	Y	Y	Y	Y	Y
Montana	Y	Y	Y	Y	Y	Y	Y	Y
Nebraska	Y	N/A	Y	N/A	Y	N/A	Y	N/A
Nevada	Y	Y	Y	Y	Y			
New Hampshire[2, 9] ▲	Y	Y	Y	Y	Y	Y	Y	Y
New Jersey	Y	Y	Y	Y			N/A	N/A
New Mexico		N/A	N/A	N/A	N/A	N/A	N/A	N/A
New York			N/A	N/A	N/A	N/A	N/A	N/A
North Carolina			N/A	N/A	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	Y	N/A
Oklahoma	Y	N/A	Y	N/A	Y	N/A	Y	N/A
Oregon	Y	Y	Y	Y				
Pennsylvania	Y	Y	Y	Y	Y	Y	Y	
Rhode Island		N/A	N/A	N/A	N/A	N/A	N/A	N/A
South Carolina		N/A	N/A	N/A	N/A	N/A	N/A	N/A
South Dakota			N/A	N/A	N/A	N/A	N/A	N/A
Tennessee	Y	Y	Y	Y	Y	Y		Y
Texas	Y	Y	Y	Y	Y	Y	Y	Y
Utah	Y	Y	Y	Y	Y	Y	Y	Y
Vermont	Y	Y	Y	Y	Y	Y	Y	Y
Virginia	Y	Y	Y	Y	Y	Y	Y	Y
Washington	Y	Y	Y	Y	Y	Y		
West Virginia[2, 8] ▲	Y	Y	Y		Y	Y	Y	
Wisconsin	Y	Y	Y	Y	Y	Y	Y	Y
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, 2012.

▲Indicates that a state has simplified one or more of its procedures between January 1, 2011 and January 1, 2012, unless noted otherwise.
▼Indicates that a state has rescinded one or more of its simplified procedures between January 1, 2011 and January 1, 2012, unless noted otherwise.
Data on all elements were not collected last year, so changes are only noted for states that began allowing for electronic submission of applications and/or electronic signature between January 1, 2011 and January 1, 2012. Table presents rules in effect as of January 1, 2012, 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." In 2011, Georgia (CHIP), New Hampshire, and West Virginia began allowing for electronic signatures and, as a result, are denoted as implementing a simplification in the table.

3. Online accounts with enhanced functionality allow applicants and beneficiaries to do more than start, stop, and return to an application. For example, they may be able to review the application status, report changes in circumstances, view notices, pay premiums and/or renew coverage.

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 39 states with separate CHIP programs.

5. Colorado and Maine adopted electronically submitted applications in 2011. Both allow for electronic signatures.

6. Indiana allows for online submission of applications in all but one county.

7. In Massachusetts, online applications may only be submitted by authorized users, who are usually providers. Electronic signatures were implemented for these online applications in October 2011.

8. The online application in Michigan and West Virginia can only be used to apply for coverage for children but not parents.

9. New Hampshire's NHEasy online application was made available to the public in 2011.

Table 10
Integration and Upgrade of Medicaid and CHIP Eligibility Systems
January 2012

State	Medicaid System Used for Other Assistance Programs (e.g., SNAP, TANF)	Same Eligibility System for Medicaid and CHIP	Approved APD for Upgrading Medicaid Eligibility System[1]	Submitted APD for Upgrading Medicaid Eligibility System[1]
Total	**44**	**24**	**18**	**11**
Alabama			Y	
Alaska	Y	N/A		Y
Arizona	Y		Y	
Arkansas[2]	Y	N/A		
California[2]	Y			
Colorado[2]	Y	Y		
Connecticut[2]	Y			
Delaware[2]	Y	Y		
District of Columbia	Y	N/A		Y
Florida	Y			
Georgia	Y		Y	
Hawaii	Y	N/A	Y	
Idaho[2]	Y	Y		
Illinois	Y	Y	Y	
Indiana[2]	Y	Y		
Iowa	Y			Y
Kansas	Y	Y	Y	
Kentucky	Y	Y	Y	
Louisiana		Y	Y	
Maine	Y	Y		
Maryland	Y	N/A	Y	
Massachusetts		Y	Y	
Michigan[2]	Y			
Minnesota[3]	Y			Y
Mississippi[2]		Y		
Missouri[2]	Y	Y		
Montana[4]		Y	Y	
Nebraska[2]	Y	N/A		
Nevada	Y		Y	
New Hampshire	Y	Y		Y
New Jersey	Y	Y	Y	
New Mexico	Y	N/A	Y	
New York[2]	Y			
North Carolina	Y	Y		Y
North Dakota[2]	Y	Y		
Ohio[2]	Y	N/A		
Oklahoma		N/A	Y	
Oregon	Y	Y	Y	
Pennsylvania[2]	Y			
Rhode Island	Y	N/A	Y	
South Carolina		N/A		Y
South Dakota	Y	Y		Y
Tennessee[2]	Y			
Texas	Y			Y
Utah	Y	Y		
Vermont	Y	Y		Y
Virginia[2]	Y			
Washington[2]	Y	Y		
West Virginia[2]	Y	Y		
Wisconsin	Y	Y		Y
Wyoming	Y		Y	

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2012.
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

1. The state has submitted or received approval of an Advanced Planning Document (APD) for the enhanced federal match (i.e., the 90/10 match) to upgrade the Medicaid eligibility system.

2. An additional 19 states have indicated that they plan to submit an APD in the next 12 months to upgrade the Medicaid eligibility system. They are Arkansas, California, Colorado, Connecticut, Delaware, Idaho, Indiana, Michigan, Mississippi, Missouri, Nebraska, New York, North Dakota, Ohio, Pennsylvania, Tennessee, Virginia, Washington, and West Virginia.

3. In Minnesota separate systems are used to determine eligibility for the states Medicaid program (Medical Assistance) and its Section 1115 Waiver (MinnesotaCare).

4. Montana integrated its Medicaid and CHIP eligibility systems in November 2011.

Table 11
Renewal Periods and Streamlined Renewal Requirements for Children's Health Coverage
January 2012

State	Frequency of Renewal[1] (Months)		12-Month Continuous Eligibility		Face-to-Face Interview Not Required		State Attempts to Administratively Verify Income[2]	
	Medicaid	CHIP	Medicaid	CHIP	Medicaid	CHIP	Medicaid	CHIP
Total Adopting Simplification	**49**	**39**	**23**	**28**	**50**	**38**	**43**	**31**
Aligned Medicaid and CHIP[3]	**49**		**23**		**50**		**41**	
Alabama	12	12	Y	Y	Y	Y	Y	Y
Alaska	12	N/A	Y	N/A	Y	N/A	Y	N/A
Arizona[4]	12	12			Y	Y	Y	Y
Arkansas[5]	12	N/A		N/A	Y	N/A	Y	N/A
California	12	12	Y	Y	Y	Y		
Colorado	12	12		Y	Y	Y	Y	Y
Connecticut	12	12			Y	Y	Y	Y
Delaware	12	12		Y	Y	Y	Y	Y
District of Columbia	12	N/A		N/A	Y	N/A	Y	N/A
Florida[6]	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[7, 8]	12	12			Y	Y	Y	Y
Iowa	12	12	Y	Y	Y	Y	Y	Y
Kansas	12	12	Y	Y	Y	Y	Y	Y
Kentucky[9]	12	12			Y	Y	Y	Y
Louisiana	12	12	Y	Y	Y	Y	Y	Y
Maine[9]	12	12	Y	Y	Y	Y		
Maryland[10]	12	N/A		N/A	Y	N/A	Y	N/A
Massachusetts	12	12			Y	Y	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			Y	Y
Missouri	12	12			Y	Y		
Montana	12	12	Y	Y	Y	Y	Y	Y
Nebraska	12	N/A		N/A	Y	N/A	Y	N/A
Nevada[9]	12	12		Y	Y	Y	Y	
New Hampshire	12	12			Y	Y		
New Jersey	12	12	Y	Y	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[9]	12	12	Y	Y	Y	Y	Y	Y
North Dakota	12	12	Y	Y	Y	Y	Y	Y
Ohio[9]	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	Y	
Pennsylvania[12]	12	12		Y	Y	Y	Y	Y
Rhode Island	12	N/A		N/A	Y	N/A		N/A
South Carolina	12	N/A	Y	N/A	Y	N/A	Y	N/A
South Dakota	12	12			Y	Y	Y	Y
Tennessee[13]	12	12		Y	Y	Y	Y	Y
Texas[14]	6	12		Y	Y	Y	Y	Y
Utah	12	12		Y	Y	Y	Y	Y
Vermont	12	12			Y	Y	Y	Y
Virginia[15]	12	12		Y	Y	Y	Y	Y
Washington	12	12	Y	Y	Y	Y	Y	Y
West Virginia[9]	12	12	Y	Y	Y	Y	Y	Y
Wisconsin	12	12			Y	Y	Y	Y
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, 2012.

▲Indicates that a state has simplified one or more of its procedures between January 1, 2011 and January 1, 2012, unless noted otherwise.

▼Indicates that a state has rescinded one or more of its simplified procedures between January 1, 2011 and January 1, 2012, unless noted otherwise.

Table presents rules in effect as of January 1, 2012, unless noted otherwise.

Table 11 Notes

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

2. The state attempts to verify income administratively either through available databases or collateral contacts with third parties, such as employers. A state may make such attempts prior to asking the family for documentation, if the family is unable to provide the documentation, or conduct a behind-the-scenes verification of self-attested information. This is a change from how it was defined in last year’s report so data are not compared year to year.

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 39 states with separate CHIP programs.

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

5. In Arkansas, children in the 1115 waiver (those above 133% FPL and less than 6 years of age and those above 100% FPL and older than 6 years of age), receive 12 months of continuous eligibility.

6. 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.

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

8. In Indiana, county offices may require telephone interviews, but not face-to-face interviews. The state began to allow for mail-in renewals without an interview in all but one county in 2011, with the last county scheduled to adopt this policy in the first quarter of 2012.

9. Families in Kentucky, Maine, Nevada (Medicaid only), North Carolina, Ohio, and West Virginia are not required to provide documentation if income has not changed.

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

11. In Minnesota, children and parents who qualify under the state’s 1115 waiver 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. In Pennsylvania 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.

13. Tennessee Medicaid requires a phone interview at renewal.

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

15. 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 2012

State	Joint Medicaid/CHIP Renewal Form	Administrative Renewal[1]		Telephone		Online		Express Lane[2]	
		Medicaid	CHIP	Medicaid	CHIP	Medicaid	CHIP	Medicaid	CHIP
Total	**32**	**21**	**17**	**19**	**16**	**20**	**19**	**3**	**0**
Aligned Medicaid and CHIP[3]	**44**	**20**		**14**		**19**		**0**	
Alabama[4] ▲	Y			Y	Y	Y	Y	Y	
Alaska	N/A	Y	N/A		N/A		N/A		N/A
Arizona					Y	Y	Y		
Arkansas	N/A	Y	N/A		N/A		N/A		N/A
California[5, 6]									
Colorado[1, 7] ▲	Y	Y	Y	Y	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[8]		Y	Y	Y		Y	Y		
Georgia[7] ▲				Y		Y			
Hawaii	N/A	Y	N/A		N/A		N/A		N/A
Idaho[1] ▲	Y	Y	Y						
Illinois	Y	Y	Y	Y	Y				
Indiana	Y								
Iowa[9]	Y						Y		
Kansas[10]	Y	Y	Y						
Kentucky	Y	Y	Y						
Louisiana[11]	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								
Michigan	Y	Y	Y			Y	Y		
Minnesota	N/A		N/A		N/A		N/A		N/A
Mississippi	Y								
Missouri	Y								
Montana[1, 9] ▲	Y	Y	Y	Y	Y				
Nebraska	N/A		N/A		N/A	Y	N/A		N/A
Nevada									
New Hampshire	Y								
New Jersey	Y					Y	Y		
New Mexico	N/A	Y	N/A	Y	N/A		N/A		N/A
New York[12]		Y		Y					
North Carolina[1, 4] ▲	Y	Y	Y	Y	Y				
North Dakota	Y								
Ohio	N/A		N/A	Y	N/A	Y	N/A		N/A
Oklahoma[13]	N/A	Y	N/A		N/A	Y	N/A		N/A
Oregon	Y			Y	Y	Y	Y		
Pennsylvania	Y				Y	Y	Y		
Rhode Island	N/A		N/A		N/A		N/A		N/A
South Carolina[10] ▲	N/A		N/A		N/A		N/A	Y	N/A
South Dakota	Y								
Tennessee			Y	Y		Y	Y		
Texas[4, 9] ▲	Y			Y	Y		Y		
Utah[7, 14] ▲	Y		Y	Y	Y	Y	Y		
Vermont	Y					Y	Y		
Virginia[4] ▲	Y		Y	Y	Y		Y		
Washington	Y			Y	Y	Y	Y		
West Virginia[1, 15] ▲	Y	Y	Y			Y	Y		
Wisconsin	Y	Y	Y	Y	Y	Y	Y		
Wyoming[7, 9] ▲	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, 2012.

▲Indicates that a state has simplified one or more of its procedures between January 1, 2011 and January 1, 2012, unless noted otherwise.

Table 12 Notes

1. A state is classified as conducting administrative renewals if it sends a pre-populated form with all eligibility information available or a renewal letter to the family in advance of the renewal date. The family is required to either sign and return the form, signaling that they wish to continue coverage, or take no action. States that send a pre-populated form, but require families to submit paper documentation to continue coverage do not qualify has having implemented administrative renewals. In addition, there are some states that conduct administrative renewals through other means that does not involve sending out a pre-populated form to families; these states are also counted. States that have adopted this renewal approach in 2011 are denoted as implementing a simplification in the table and include Colorado, Idaho, Montana (Medicaid), North Carolina, and West Virginia.

2. 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 in 2011 are denoted as implementing a simplification in the table. South Carolina received approval for a State Plan Amendment to conduct renewals through Express Lane Eligibility in 2011. Colorado has submitted a state plan amendment and is awaiting approval from CMS. New Jersey has approval to conduct renewals through ELE, but has not yet implemented them.

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 39 states with separate CHIP programs.

4. Alabama (CHIP), North Carolina, Texas, and Virginia added telephone renewals in 2011

5. In California, separate applications are used to apply for Medicaid and CHIP. However, the programs will accept the other's application with the family's consent to the application transfer. The state does not consider this a "joint application."

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

7. Colorado, Georgia (Medicaid), Utah, and Wyoming (Medicaid) added online renewals in 2011.

8. In Florida, the administrative renewal process is only available in KidCare (CHIP) when enrolled using the joint Medicaid/CHIP application and not the family Medicaid application.

9. In Iowa, Montana, Texas, and Wyoming, although separate forms are used for Medicaid and CHIP, the programs will accept the other's renewal form.

10. Kansas and South Carolina send out renewal letters confirming ongoing eligibility based on information available to the state. They do not use a pre-populated form.

11. Louisiana has an administrative renewal process that does not require sending a pre-populated form to the family.

12. Administrative renewals are not done in New York City.

13. Oklahoma conducts rolling renewals through its online account management system. If a beneficiary has not accessed their online account in twelve months, the state will send a paper notification directing them to update their information online.

14. 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.

15. A pre-populated renewal form is used for every renewal in CHIP in West Virginia. In prior years, it was used for every other renewal.

Table 13
Streamlined Application Processes for Parents in Medicaid[1]
January 2012

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]	State Attempts to Administratively Verify Income[5]	Simplifications Consistent with Children's Programs[6]
Total		**31**	**45**	**24**	**41**	**40**	**13**
Alabama		Y	Y	Y	Y	Y	Y
Alaska[7, 8]			Y	$2,000	Y	Y	
Arizona		Y	Y	Y		Y	
Arkansas[9]		Y		$1,000	Y	Y	
California[10]			Y	$3,150	Y		
Colorado[4]	▲	Y	Y	Y	Y	Y	Y
Connecticut		Y	Y	Y	Y	Y	Y
Delaware		Y	Y	Y	Y	Y	Y
District of Columbia		Y	Y	Y	Y	Y	Y
Florida			Y	$2,000		Y	
Georgia		Y	Y	$1,000			
Hawaii			Y	$3,250	Y	Y	
Idaho			Y	$1,000	Y	Y	
Illinois[4]	▲	Y	Y	Y	Y		
Indiana[8, 10]			Y	$1,000		Y	
Iowa[10]			Y	$2,000	Y	Y	
Kansas		Y	Y	Y			
Kentucky[4]	▲			$2,000	Y	Y	
Louisiana[11]			Y	Y	Y	Y	
Maine[12]		Y	Y	$2,000	Y		
Maryland		Y	Y	Y	Y	Y	Y
Massachusetts[4]	▲	Y	Y	Y	Y	Y	Y
Michigan			Y	$3,000	Y	Y	
Minnesota[13, 14]		Y	Y	$10,000	Y		
Mississippi		Y		Y	Y	Y	
Missouri		Y	Y	Y			
Montana[4, 10]	▲		Y	$3,000	Y	Y	
Nebraska[4,8]	▲		Y	$6,000	Y	Y	
Nevada			Y	$2,000		Y	
New Hampshire				$1,000	Y		
New Jersey		Y	Y	Y	Y	Y	Y
New Mexico[4]	▲	Y	Y	Y	Y	Y	Y
New York		Y	Y	Y	Y		
North Carolina[10]			Y	$3,000	Y	Y	
North Dakota		Y	Y	Y		Y	
Ohio		Y	Y	Y	Y	Y	Y
Oklahoma			Y	Y	Y	Y	
Oregon		Y	Y	$2,500	Y	Y	
Pennsylvania		Y	Y	Y	Y	Y	Y
Rhode Island[4]	▲	Y	Y	Y	Y		
South Carolina[4]	▲	Y	Y	$30,000	Y	Y	
South Dakota		Y	Y	$2,000	Y	Y	
Tennessee				$2,000			
Texas[4]	▲			$2,000	Y	Y	
Utah[4, 15]	▲	Y	Y	$3,025	Y	Y	
Vermont		Y	Y	$3,150		Y	
Virginia			Y	Y	Y	Y	
Washington			Y	$1,000	Y	Y	
West Virginia[16]	▲	Y	Y	$1,000	Y	Y	
Wisconsin		Y	Y	Y	Y	Y	Y
Wyoming		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, 2012.

▲Indicates that a state has simplified one or more of its procedures between January 1, 2011 and January 1, 2012, unless noted otherwise.

▼Indicates that a state has rescinded one or more of its simplified procedures between January 1, 2011 and January 1, 2012, unless noted

Table presents rules in effect as of January 1, 2012, 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. However, in Georgia, Iowa, Kentucky, Michigan, Nevada, North Carolina, South Carolina and South Dakota, the asset limits apply regardless of family size. Documentation of assets is not required by parents in Alaska, Florida, Georgia, Hawaii, Oregon, South Carolina, Tennessee, Vermont, and Washington. As of September 2011, parents covered through 1931 Medicaid coverage in Idaho are no longer required to provide documentation of assets if declared assets are within 10 percent of the asset limit threshold.

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 in 2011 are denoted as implementing a simplification in the table and include Colorado, Illinois, Kentucky, Massachusetts, Montana, Nebraska, New Mexico, Rhode Island, South Carolina, Texas, and Utah.

5. The state attempts to verify income administratively either through available databases or collateral contacts with third parties, such as employers. A state may make such attempts prior to asking the family for documentation, if the family is unable to provide the documentation, or conduct a behind-the-scenes verification of self-attested information. This is a change from how it was defined in last year's report so data are not compared year to year.

6. States are classified as having consistent policies for children and parents if they have adopted all of the simplification measures listed in Medicaid for children and parents. At application, states must also have a simplified family application.

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

8. Telephone interviews are required in Alaska and Nebraska. In Indiana, county offices may require telephone interviews, but not face-to-face interviews.

9. 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.

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

11. 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.

12. 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.

13. In Minnesota, the asset limit is $10,000 for any single household. For those households of two or more, the asset limit is $20,000.

14. In Minnesota, the SSA match can only be used with the system for Medical Assistance eligibility, which is administered by the counties, and not the system that determines eligibility for coverage under the 1115 waiver.

15. 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.

16. West Virginia eliminated the face-to face interview requirement for parents and instituted a simplified family application in 2011.

Table 14
Renewal Periods and Streamlined Renewal Processes for Parents in Medicaid[1]
January 2012

State	Frequency of Renewal (Months)[2]	Face-to-Face Interview NOT Required	State Attempts to Administratively Verify Income[3]	Simplifications Consistent with Children's Programs[4]
Total Adopting Simplification	**46**	**48**	**41**	**36**
Alabama	12	Y	Y	Y
Alaska	12	Y	Y	Y
Arizona	12	Y	Y	Y
Arkansas[5]	12	Y	Y	Y
California[6]	12	Y		
Colorado	12	Y	Y	Y
Connecticut	12	Y	Y	Y
Delaware	12	Y	Y	Y
District of Columbia	12	Y	Y	Y
Florida[7]	12	Y	Y	Y
Georgia	6	Y		
Hawaii	12	Y	Y	Y
Idaho	12	Y	Y	Y
Illinois	12	Y		
Indiana[8]	12	Y	Y	Y
Iowa	12	Y	Y	Y
Kansas	12	Y		
Kentucky[9]	12		Y	
Louisiana	12	Y	Y	Y
Maine[9]	12	Y		
Maryland	12	Y	Y	Y
Massachusetts[10]	12	Y	Y	Y
Michigan	12	Y	Y	Y
Minnesota[11]	12	Y		
Mississippi	12		Y	
Missouri	12	Y		
Montana	12	Y	Y	Y
Nebraska[12]	12	Y	Y	Y
Nevada[9, 13]	12	Y	Y	Y
New Hampshire	6	Y		
New Jersey	12	Y	Y	Y
New Mexico	12	Y	Y	Y
New York	12	Y	Y	Y
North Carolina[9]	6	Y	Y	
North Dakota[14]	12	Y	Y	Y
Ohio[9]	12	Y	Y	Y
Oklahoma	12	Y	Y	Y
Oregon[15]	12	Y	Y	Y
Pennsylvania[6]	12	Y	Y	Y
Rhode Island	12	Y		
South Carolina[16]	12	Y	Y	Y
South Dakota	12	Y	Y	Y
Tennessee[12]	12	Y		
Texas	6		Y	
Utah[17]	12	Y	Y	Y
Vermont	12	Y	Y	Y
Virginia	12	Y	Y	Y
Washington[18]	6	Y	Y	
West Virginia[9, 19] ▲	12	Y	Y	Y
Wisconsin	12	Y	Y	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, 2012.

▲Indicates that a state has simplified one or more of its procedures between January 1, 2011 and January 1, 2012, unless noted otherwise.

▼Indicates that a state has rescinded one or more of its simplified procedures between January 1, 2011 and January 1, 2012, unless noted otherwise.

Table presents rules in effect as of January 1, 2012, 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. The state attempts to verify income administratively either through available databases or collateral contacts with third parties, such as employers. A state may make such attempts prior to asking the family for documentation, if the family is unable to provide the documentation, or conduct a behind-the-scenes verification of self-attested information. This is a change from how it was defined in last year’s report so data are not compared year to year.

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

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

6. California and Pennsylvania have a 12-month renewal period, but perform income reviews every 6 months.

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. The state began to allow for mail-in renewals without an interview in all but one county in 2011, with the last county schedule to adopt this policy in the first quarter of 2012.

9. Families in Kentucky, Maine, Nevada, North Carolina, Ohio, and West Virginia are not required to provide documentation if income has not changed.

10. Massachusetts received approval for a waiver to implement Express Lane Eligibility at renewal for 1931 parents in 2011.

11. In Minnesota, children and parents who qualify under the state’s 1115 waiver 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. Nebraska and Tennessee require a telephone interview for parents at Medicaid renewal.

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

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

15. In Oregon, the renewal period is up to 12 months.

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

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

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

19. West Virginia eliminated the face-to face interview requirement in 2011.

Table 15

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

January 2012

State	Premiums/Enrollment Fees: Change in 2011[2]	Premiums/Enrollment Fees: Required in Medicaid	Premiums/Enrollment Fees: Required in CHIP	Premiums/Enrollment Fees: Income at Which Premiums Begin (% FPL)	Co-payments: Change[2]	Co-payments: Required in Medicaid	Co-payments: Required in CHIP	Co-payments: Income at Which Copays Begin (% FPL)
Total		**4**	**31**			**2**	**26**	
Alabama			Y	101%			Y	101%
Alaska			N/A				N/A	
Arizona			Y	101%				
Arkansas			N/A			Y	N/A	200%
California			Y	101%			Y	101%
Colorado[3]	Increased		Y	151%			Y	101%
Connecticut[4]			Y	235%			Y	185%
Delaware[5]			Y	101%	Decreased		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							Y	101%
Louisiana			Y	201%			Y	201%
Maine			Y	151%				
Maryland[8, 9]		Y	N/A	200%			N/A	
Massachusetts			Y	150%				
Michigan			Y	151%				
Minnesota[8, 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]			Y	185%			Y	185%
New Jersey[8]			Y	201%			Y	151%
New Mexico			N/A			Y	N/A	185%
New York			Y	160%				
North Carolina[13]			Y	151%	Decreased		Y	100%
North Dakota							Y	100%
Ohio			N/A				N/A	
Oklahoma			N/A				N/A	
Oregon[8, 13]			Y	201%			Y	201%
Pennsylvania[8]			Y	201%			Y	201%
Rhode Island[12]		Y	N/A	150%			N/A	
South Carolina			N/A				N/A	
South Dakota								
Tennessee							Y	101%
Texas[15]			Y	151%	Increased		Y	101%
Utah[14]			Y	101%	Increased		Y	101%
Vermont		Y	Y	186%				
Virginia							Y	134%
Washington			Y	201%				
West Virginia			Y	201%			Y	101%
Wisconsin			Y	200%			Y	101%
Wyoming							Y	101%

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2012.

Table 15 Notes

1. Except for “mandatory children” (children under age six with family income below 133% FPL and children ages six to 17 with family income below 100% FPL), a state may impose premiums for children, with some limitations based on family income. Copayments are also allowed, with some restrictions for children with family incomes up to 150% 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 copayments of adults in Medicaid. These data are not shown.

2. "Increased" indicates that a state has increased premiums or copayments or lowered the income level at which they are required in either Medicaid or CHIP. "Decreased" indicates that a state has decreased premiums or copayments or raised the income level at which they are required in either Medicaid or CHIP. Changes occurred between January 1, 2011 and January 1, 2012, unless noted otherwise.

3. In Colorado, the enrollment fees increased for children between 205% and 250% FPL from $25 to $75.

4. Connecticut eliminated its July 2010 increase in premiums for children in CHIP to comply with maintenance-of-effort requirements. During 2011, the state also eliminated, but then later reinstated, increases in copayments made in July 2010.

5. Delaware eliminated the copayment for non-emergency transportation in 2011. For infants, the copayment charge begins at 186% 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. The premium changes in Maryland, Minnesota, New Jersey, Oregon and Pennsylvania are annual adjustments.

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

10. Minnesota received approval in June 2011 for an amendment to its section 1115 waiver to eliminate premiums for children at or below 200% FPL; however, the state has not yet implemented the change.

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

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

13. North Carolina reduced the cost of generic prescriptions (and non-generics when a generic is unavailable) to $1. They also reduced the charge for a non-emergency visit to the emergency room for lower-income children.

14. Utah increased copayments for the emergency room from $100 to $250 and for generic drugs from $10 to $15. The state also changed the generic prescription drug copayment for low-income children from 50% of cost to $15.

15. In Texas, copayments for non-preventive physician visits increased for those at 151% FPL from $7 to $12 and for those at 201% FPL increased from $10 to $16. Prescription drug copayments also increased from $5 to $8 for generics and from $20 to $25 for brand-name drugs.

Table 16
Premiums and Enrollment Fees for Children at Selected Income Levels[1, 2]
January 2012

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	$30	$30	N/A
Delaware[5]	$10	$15	$25	N/A	N/A	N/A
Florida	$15	$20	$20	N/A	N/A	N/A
Georgia	$10	$20	$29	N/A	N/A	N/A
Idaho	$0	$15	N/A	N/A	N/A	N/A
Illinois	$0	$15	$15	N/A	N/A	N/A
Indiana	$0	$22	$33	$42	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	$55	$67	$67	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	$58	$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	$40.50	$80	$134.50	$134.50
New York	$0	$0	$9	$30	$45	$60
Oregon[8]	$0	$0	$28.50	$43.25	$43.25	N/A
Pennsylvania[8]	$0	$0	$43	$66	N/A	N/A
Rhode Island[6]	$0	$61	$92	$92	N/A	N/A
Vermont[9]	$0	$0	$15	$20/$60	$20/$60	N/A
Washington	$0	$0	$20	$30	$30	N/A
West Virginia	$0	$0	$35	$35	N/A	N/A
Wisconsin	$0	$0	$10	$34	$97	N/A
QUARTERLY PAYMENTS						
Nevada[6]	$25	$50	$80	N/A	N/A	N/A
Utah[6]	$30	$75	$75	N/A	N/A	N/A
ANNUAL PAYMENTS						
Alabama	$50	$100	$100	$100	$100	N/A
Colorado	$0	$25	$25	$75	N/A	N/A
North Carolina	$0	$50	$50	N/A	N/A	N/A
Texas	$0	$35	$50	N/A	N/A	N/A

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2012.
Table presents rules in effect as of January 1, 2012, unless noted otherwise.

Table 16 Notes

1. Except for “mandatory children” (children under age six with family income below 133% FPL and children ages six to 17 with family income below 100% 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 CHIP 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 the MinnesotaCare section 1115 waiver program, 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 2012

State	Grace Period for Non-Payment[2]	Lock-Out Period[3]	Requirements to Reenroll	
			Reapply for Coverage	Repay Outstanding Premiums
Total		**15**	**24**	**22**
Alabama	- -	- -	- -	- -
Alaska	- -	- -	- -	- -
Arizona	60 days	None	Y	Y
Arkansas	- -	- -	- -	- -
California	60 days	None	Y	Y
Colorado	- -	- -	- -	- -
Connecticut[4]	30 days	3 months		Y
Delaware	60 days	None		
District of Columbia	- -	- -	- -	- -
Florida[5]	30 days	1 month		
Georgia	30 days	1 month		Y
Hawaii	- -	- -	- -	- -
Idaho	60 days	None	Y	Y
Illinois	60 days	3 months	Y	Y
Indiana	60 days	None	Y	Y
Iowa	44 days	None	Y	Y
Kansas[6]	12 months	None	Y	Y
Kentucky	- -	- -	- -	- -
Louisiana[5]	60 days	None		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	None	Y	Y
Vermont[16]	None	None	Y	
Virginia	- -	- -	- -	- -
Washington	90 days	3 months	Y	Y
West Virginia[17] ▲	30 days	3 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, 2012.

Table presents rules in effect as of January 1, 2012, 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 the 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.

11. In Missouri, only children in families with incomes above 225% 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.

17. West Virginia decreased its lock-out period from 6 months to 3 months.

Table 18
Copayment Amounts for Selected Services for Children at Selected Income Levels[1]
January 2012

State	Family Income at 151% FPL				Family Income at 201% FPL[2] (200% if upper limit)			
	Non-Preventive Physician Visit	ER Visit	Non-Emergency Use of ER[3]	Inpatient Hospital Visit	Non-Preventive Physician Visit	ER Visit	Non-Emergency Use of ER[3]	Inpatient Hospital Visit
Total	**17**	**13**	**20**	**12**	**22**	**17**	**25**	**13**
Alabama	$5	$15	$20	$10	$5	$15	$20	$10
Alaska	- -	- -	- -	- -	- -	- -	- -	- -
Arizona	- -	- -	- -	- -	- -	- -	- -	- -
Arkansas	$10	$10	$0	20% of reimbursement rate for first day	$10	$10	$10	20% of reimbursement rate for first day
California[4, 5]	$10	$15	N/C	$0	$10	$15	N/C	$0
Colorado	$5	$15	$20	$0	$10	$20	$20	$0
Connecticut	$0	$0	$0	$0	$10	$0	$10	$0
Delaware	$0	$0	$10	$0	$0	$0	$10	$0
District of Columbia	- -	- -	- -	- -	- -	- -	- -	- -
Florida[6]	$5	$0	$10	$0	$5	$0	$10	$0
Georgia	- -	- -	- -	- -	- -	- -	- -	- -
Hawaii	- -	- -	- -	- -	- -	- -	- -	- -
Idaho	$0	$0	$3	$0	N/A	N/A	N/A	N/A
Illinois	$5	$5	$25	$5	$10	$30	$30	$100
Indiana	$0	$0	$0	$0	$0	$0	$0	$0
Iowa[3]	$0	$0	$25	$0	$0	$0	$25	$0
Kansas	- -	- -	- -	- -	- -	- -	- -	- -
Kentucky[7]	$0	$0	$6	$0	$0	$0	$6	$0
Louisiana[5]	$0	$0	$0	$0	$0	$150	$150	$0
Maine	- -	- -	- -	- -	- -	- -	- -	- -
Maryland	- -	- -	- -	- -	- -	- -	- -	- -
Massachusetts	- -	- -	- -	- -	- -	- -	- -	- -
Michigan	- -	- -	- -	- -	- -	- -	- -	- -
Minnesota	- -	- -	- -	- -	- -	- -	- -	- -
Mississippi	$5	$15	$15	$0	$5	$15	$15	$0
Missouri	- -	- -	- -	- -	- -	- -	- -	- -
Montana[8]	$3	$5	$5	$25	$3	$5	$5	$25
Nebraska	- -	- -	- -	- -	- -	- -	- -	- -
Nevada	- -	- -	- -	- -	- -	- -	- -	- -
New Hampshire[5]	$0	$0	$0	$0	$10	$100	$100	$0
New Jersey	$5	$10	$10	$0	$5	$35	$35	$0
New Mexico[5]	$0	$0	$0	$0	$5	$15	$15	$25
New York	- -	- -	- -	- -	- -	- -	- -	- -
North Carolina[3]	$5	$0	$10	$0	$5	$0	$25	$0
North Dakota	$0	$5	$5	$50	N/A	N/A	N/A	N/A
Ohio	- -	- -	- -	- -	- -	- -	- -	- -
Oklahoma	- -	- -	- -	- -	- -	- -	- -	- -
Oregon[5]	$0	$0	$0	$0	$5	$100	$100	$100
Pennsylvania[5]	$0	$0	$0	$0	$5	$25	$25	$0
Rhode Island	- -	- -	- -	- -	- -	- -	- -	- -
South Carolina	- -	- -	- -	- -	- -	- -	- -	- -
South Dakota	- -	- -	- -	- -	- -	- -	- -	- -
Tennessee[5, 9]	$10/$15	$0/$15	$50/$50	$200/$100	$10/$15	$0/$15	$50/$50	$200/$100
Texas	$12	$0	$50	$50	$16	$0	$50	$100
Utah	$20	$250	$250	20% of daily reimbursement rate	$20	$250	$250	20% of daily reimbursement rate
Vermont	- -	- -	- -	- -	- -	- -	- -	- -
Virginia[3]	$5	$0	$25	$25	$5	$0	$25	$25
Washington	- -	- -	- -	- -	- -	- -	- -	- -
West Virginia[5, 10]	$15	$35	$35	$25	$20	$35	$35	$25
Wisconsin	$1-$3	$0	$0	$3	$15	$0	$60	$100
Wyoming[5]	$10	$25	$25	$50	$10	$25	$25	$50

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2012.

Table presents rules in effect as of January 1, 2012, unless noted otherwise.

Table 18 Notes

1. Copayments are allowed, with some restrictions for children with family incomes up to 150% 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 copayments, but either does not charge them at the income level shown or for the specific service, it is recorded as $0; if a state does not provide coverage at a particular income level it is noted as "N/A;" if a state does not charge copayments at all, it is noted as "- -;" if a state does not cover a type of service, it is noted as "N/C." Some states require 18-year-olds to meet the copayments of adults in Medicaid. These data are not shown.

2. If the upper income eligibility level is 200% FPL, the copayments shown reflect the cost at 200% FPL.

3. In Iowa, North Carolina, and Virginia, the copayment for non-emergency use of the ER does not apply for those with income below 150% FPL.

4. In California's CHIP program, 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 copayment is waived if the child is admitted. In New Mexico, the inpatient copayment is still applied.

6. In Florida, copayments only apply to children in the Healthy Kids program.

7. In Kentucky, enrollees are charged 5% co-insurance for non-emergency use of the ER, which is capped at $6.

8. In Montana, families may be responsible for the full costs associated with non-emergency use of the ER.

9. Tennessee has two CHIP programs. The first set of copayments is for TennCare Standard and the second is for CoverKids.

10. In West Virginia, the copayments 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 2012

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**	**15**	**24**	**26**	**20**
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	N/C	$5	$10	N/C
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]	$0	$0	$0	$10	$20	$30
New Jersey	$1	$5	$5	$5	$5	$5
New Mexico	$0	$0	$0	$2	$2	$2
New York	- -	- -	- -	- -	- -	- -
North Carolina[3]	$1	$1	$3	$1	$1	$10
North Dakota	$2	$2	$2	N/A	N/A	N/A
Ohio	- -	- -	- -	- -	- -	- -
Oklahoma	- -	- -	- -	- -	- -	- -
Oregon	$0	$0	$0	$0	$10	N/C
Pennsylvania[7]	$0	$0	N/C	$6	$9	N/C
Rhode Island	- -	- -	- -	- -	- -	- -
South Carolina	- -	- -	- -	- -	- -	- -
South Dakota	- -	- -	- -	- -	- -	- -
Tennessee[8]	$0/$5	$3/$20	$3/$40	$0/$5	$3/$20	$3/$40
Texas	$8	$25	N/C	$8	$25	N/C
Utah	$15	25% of cost	50% of cost	$15	25% of cost	50% of cost
Vermont	- -	- -	- -	- -	- -	- -
Virginia	$5	$5	$5	$5	$5	$5
Washington	- -	- -	- -	- -	- -	- -
West Virginia	$0	$10	$15	$0	$10	$15
Wisconsin[9]	$1	$3	N/C	$5	N/C	N/C
Wyoming	$5	$10	N/C	$5	$10	N/C

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2012.

Table presents rules in effect as of January 2012, unless noted otherwise.

Table 19 Notes

1. Copayments 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 copayments, but either does not charge them at the income level shown or for the specific service, it is recorded as $0; if a state does not provide coverage at a particular income level it is noted as "N/A;" if a state does not charge copayments at all, it is noted as "- -;" if a state does not cover a type of drug, it is noted as "N/C." Some states require 18-year-olds to meet the copayments of adults in Medicaid. These data are not shown.

2. If the upper income eligibility level is 200% FPL, the copayments shown reflect the cost at 200% FPL.

3. In California, New Hampshire, and North Carolina, the copayment 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, copayments only apply to children in the Healthy Kids program.

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 copayment 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 copayments 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% FPL. When they do cover them, they have the same copayment as generic drugs.

Table 20
Premium and Copayment Requirements for 1931 Parents[1]
January 2012

State	Change in 2011?[2]	Premiums/ Enrollment Fees?	Income Premiums/ Fees Begin (% FPL)	Change in 2011?[2]	Copays	Income Copays Begin (% FPL)
Total		**2**			**40**	
Alabama		- -			Y	0%
Alaska[3]		- -		Increased	Y	0%
Arizona		- -			Y	0%
Arkansas		- -			Y	0%
California[4]		- -			Y	0%
Colorado		- -			Y	0%
Connecticut		- -			- -	
Delaware[5]		- -		Decreased	Y	0%
District of Columbia		- -			- -	
Florida		- -			Y	0%
Georgia		- -			Y	0%
Hawaii		- -			- -	
Idaho		- -			- -	
Illinois		Y	151%		Y	0%
Indiana		- -			Y	0%
Iowa		- -			Y	0%
Kansas		- -			Y	0%
Kentucky		- -			Y	0%
Louisiana		- -			Y	0%
Maine		- -			Y	0%
Maryland[6]		- -			- -	
Massachusetts[7]		- -		Increased	Y	0%
Michigan		- -			Y	0%
Minnesota[8]		- -		Increased/ Decreased	Y	0%
Mississippi		- -			Y	0%
Missouri		- -			Y	0%
Montana		- -			Y	0%
Nebraska[9]		- -		Increased	Y	0%
Nevada		- -			- -	
New Hampshire		- -			Y	0%
New Jersey		- -			- -	
New Mexico		- -			- -	
New York		- -			Y	0%
North Carolina		- -			Y	0%
North Dakota		- -			Y	0%
Ohio		- -			Y	0%
Oklahoma		- -			Y	0%
Oregon		- -			Y	0%
Pennsylvania		- -			Y	0%
Rhode Island		- -			- -	
South Carolina		- -			Y	0%
South Dakota		- -			Y	0%
Tennessee		- -			Y	0%
Texas		- -			- -	
Utah		- -			Y	0%
Vermont		- -			Y	0%
Virginia		- -			Y	0%
Washington		- -			- -	
West Virginia		- -			Y	0%
Wisconsin		Y	150%		Y	0%
Wyoming		- -			Y	0%

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2012.
Table presents rules in effect as of January 1, 2012, unless noted otherwise.

Table 20 Notes

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

2. "Increased" indicates that a state has increased premiums or copayments or lowered the income level at which they are required in Medicaid. "Decreased" indicates that a state has decreased premiums or copayments or raised the income level at which they are required in Medicaid. Changes occurred between January 1, 2011 and January 1, 2012, unless noted otherwise.

3. Alaska increased copayments for non-preventive visits from $3 to $10. The state also increased copayments for prescription drugs from $2 to $3.

4. In California, it is optional for the provider to collect copayments.

5. Delaware eliminated the copayment for non-emergency transportation in 2011.

6. Maryland does not charge copayments for section 1931 parents except for mental health and HIV/AIDS related drugs.

7. Massachusetts increased copayments for most prescription coverage from $3 to $3.65 in October 2011.

8. In 2011 in Minnesota, the preventive visit copayment was restored and the emergency room copayments (for both a true emergency and a non-emergency visit) were reduced from $6 to $3.50.

9. Nebraska increased copayments for inpatient hospital coverage from $0 to $15 and non-preferred prescription drugs from $2 to $3.

Table 21
Premium and Copayment Amounts for Selected Services for Section 1931 Parents[1, 2]
January 2012

State	Premiums (per month)	Non-Preventive Physician Visit	Emergency Room Visit	Non-Emergency Use of ER[3]	Inpatient Hospital Visit	Generic Drug	Preferred Brand Name Drug	Non-Preferred Brand Name Drug
Total Requiring Fees		**23**	**2**	**17**	**25**	**39**	**44**	**44**
Alabama	- -	$1	$0	$3	$50	$.50-$3	$.50-$3	$.50-$3
Alaska[3]	- -	$10	$0	$0	$50/day	$3	$3	$3
Arizona	- -	$3.40	$0	$0	$0	$2.30	$2.30	$2.30
Arkansas	- -	$0	$0	$0	10% cost of first day	$.50-$3	$.50-$3	$.50-$3
California	- -	$1	$0	$5	$0	$1	$1	$1
Colorado	- -	$0	$0	$0	$10	$1	$3	$3
Connecticut	- -	- -	- -	- -	- -	- -	- -	- -
Delaware	- -	$0	$0	$0	$0	$.50-$3	$.50-$3	$.50-$3
District of Columbia	- -	- -	- -	- -	- -	- -	- -	- -
Florida	- -	$0	$0	$15	$0	$0	$0	$0
Georgia	- -	$0	$0	$0	$12.50	$.50-$3	$.50-$3	$.50-$3
Hawaii	- -	- -	- -	- -	- -	- -	- -	- -
Idaho	- -	- -	- -	- -	- -	- -	- -	- -
Illinois[4]	$15-40	$2	$0	$0	up to $3	$0	$3	$3
Indiana[5]	- -	$0	$0	$3	$0	$3	$3	$3
Iowa[6]	- -	$3	$0	$0	$0	$1	$1	$2 or $3
Kansas	- -	$2	$0	$0	$48	$3	$3	$3
Kentucky[7]	- -	$2	$0	$6	$50	$1	$2	5% coinsurance up to $20
Louisiana	- -	$0	$0	$0	$0	$.50-$3	$.50-$3	$.50-$3
Maine[8]	- -	$0	$0	$0	$3	$3	$3	$3
Maryland	- -	- -	- -	- -	- -	- -	- -	- -
Massachusetts	- -	$0	$0	$0	$3	$3.65	$3.65	$3.65
Michigan	- -	$0	$0	$0	$0	$1	$1	$1
Minnesota	- -	$3	$0	$3.50	$0	$1	$3	$3
Mississippi	- -	$3	$0	$0	$10	$3	$3	$3
Missouri	- -	$1	$0	$3	$10	$.50-$2	$.50-$2	$.50-$2
Montana	- -	$4	$0	$5	$100	$1-$5	$1-$5	$1-$5
Nebraska	- -	$2	$0	$0	$15	$2	$2	$3
Nevada	- -	- -	- -	- -	- -	- -	- -	- -
New Hampshire	- -	$0	$0	$0	$0	$1	$2	$2
New Jersey	- -	- -	- -	- -	- -	- -	- -	- -
New Mexico	- -	- -	- -	- -	- -	- -	- -	- -
New York	- -	$0	$3	$3	$25/discharge	$1	$3	$3
North Carolina	- -	$3	$0	$0	$3/day	$3	$3	$3
North Dakota	- -	$2	$0	$3	$75	$0	$3	$3
Ohio	- -	$0	$0	$3	$0	$0	$2	$3
Oklahoma[9]	- -	$3	$0	$0	$10 day/$90 max	$0 - $3.50	$0 - $3.50	$0 - $3.50
Oregon[10]	- -	$0	$0	$3	$0	$2	$3	$3
Pennsylvania[11]	- -	$.50-$3	$0	$.50-$3	$3/day	$1	$3	$3
Rhode Island[12]	- -	- -	- -	- -	- -	- -	- -	- -
South Carolina	- -	$2	$0	$0	$25	$3	$3	$3
South Dakota[12]	- -	$3	$0	$50	$50	$0	$3	$3
Tennessee	- -	$0	$0	$0	$0	$0	$3	$3
Texas	- -	- -	- -	- -	- -	- -	- -	- -
Utah[13]	- -	$3	$0	$6	$220	$3	$3	$3
Vermont	- -	$0	$0	$0	$75	$1-$3	$1-$3	$1-$3
Virginia	- -	$1	$0	$0	$100	$1	$3	$3
Washington	- -	- -	- -	- -	- -	- -	- -	- -
West Virginia	- -	$0	$0	$0	$0	$.50-$3	$.50-$3	$.50-$3
Wisconsin	$10-$268	$.50-$3	$.50-$3	$.50-$3	$.50-$3	$.50-$3	$.50-$3	$.50-$3
Wyoming	- -	$2	$0	$6	$0	$1	$2	$3

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2012.
Table presents rules in effect as of January 1, 2012, unless noted otherwise.

Table 21 Notes

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

2. If a state charges copayments, but either does not charge them for the specific service, it is recorded as $0; if a state does not charge copayments at all, it is noted as "- -"; if a state does not cover a service or type of drug, it is noted as "N/C."

3. In Alaska, the inpatient hospital copay is for the first 4 days.

4. In Illinois, premium costs vary based on the number of people covered.

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

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

7. In Kentucky, enrollees are charged 5% co-insurance for non-emergency use of the ER, which is capped at $6.

8. In Maine, for 1931 Medicaid parents there is a $30 monthly maximum for inpatient hospital and drug copayments.

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

10. In Oregon 1931 Medicaid coverage, drugs ordered through the home-delivery pharmacy program do not have copays.

11. In Pennsylvania, copayments for 1931 parents vary based on cost of service; the inpatient hospital copay is subject to a maximum of $21.

12. In South Dakota, the non-emergency cost for the ER is 5% of allowable Medicaid reimbursement, up to $50 dollars.

13. For 1931 Medicaid parents in Utah, there is a monthly out-of-pocket maximum for prescription drug copays of $15.

Table 22
Premium, Enrollment Fee, and Copayment Requirements for Expanded Adult Coverage[1]
January 2012

State	Expansion Program Name	Change in 2011?[2]	Premiums/ Enrollment Fees?	Income Premiums/ Fees Begin (% FPL)	Change in 2011?[2]	Copays	Income Copays Begin (% FPL)
Total			**21**			**26**	
Arizona	AHCCCS (1115 Waiver)		- -			Y	0%
Arkansas	ARHealthNetworks (1115 Waiver)		Y	0%		Y	0%
California[3]	Medicaid Coverage Expansion (1115 Waiver)		--	--		Y	0%
	Health Care Coverage Initiative (1115 Waiver)		Y	150%		Y	0%
Connecticut[4]	Medicaid for Low-Income Adults (ACA Option)		--			--	
	Charter Oak (State-funded)	Increased	Y	0%		Y	0%
Delaware	Diamond State Health Plan (1115 Waiver)		- -			Y	0%
District of Columbia	ACA adult expansion		- -			- -	
	ACA Expansion (1115 Waiver)		- -			- -	
	DC Healthcare Alliance (District-funded)		- -			- -	
Hawaii[5]	QUEST (1115 Waiver)		- -			- -	
	QUEST-ACE (1115 Waiver)		- -			- -	
Idaho	Access to Health Insurance (1115 Waiver)		Y	0%		Y	0%
Illinois	FamilyCare Rebate (State-funded)		Y	133%		Y	133%
Indiana[6]	Healthy Indiana Plan (1115 Waiver)		Y	>0%		Y	0%
Iowa[7]	IowaCare (1115 Waiver)		Y	150%		Y	133%
Maine	Maine Care (1115 Waiver)		--	--		--	--
	DirigoChoice (State-funded)		Y	0%		Y	0%
Maryland[7]	Primary Adult Coverage (1115 Waiver)		- -			Y	0%
Massachusetts[7, 8]	MassHealth Basic & Essential (1115 Waiver)		--	--	Increased	Y	0%
	Commonwealth Care (1115 Waiver)		Y	150%	Increased/ Decreased	Y	0%
Michigan	Adult Benefits Waiver (1115 Waiver)		- -			Y	0%
Minnesota[7, 9]	ACA adult expansion		--	--		Y	0%
	MinnesotaCare (1115 Waiver)		Y	0%		Y	0%
	MinnesotaCare (State-funded)		Y	0%		Y	0%
New Jersey[7]	Family Care (1115 Waiver)		Y	150%		Y	151%
	New Jersey Childless Adults (1115 Waiver)		- -			- -	
New Mexico	SCI (1115 Waiver)		Y	101%		Y	101%
New York	Family Health Plus (1115 Waiver)		- -			Y	0%
Oklahoma	O-EPIC (1115 Waiver)		Y	0%		Y	0%
Oregon	OHP Standard (1115 Waiver)		Y	10%		--	--
	FHIAP (1115 Waiver)		Y	0%		Y	0%
Rhode Island	RIte Care/Share (1115 Waiver)		Y	150%		- -	
Tennessee	CoverTN (State-funded)		Y	0%		Y	0%
Utah	Primary Care Network (1115 Waiver)		Y	0%		Y	101%
	Utah Premium Partnership (1115 Waiver)		Y	varies		Y	varies
Vermont[7]	VHAP (1115 Waiver)		Y	50%		Y	0%
	Catamount Care (1115 Waiver)		Y	0%		Y	0%
Washington[10]	Basic Health (1115 Waiver)	Decreased	Y	0%		Y	0%
Wisconsin[11]	BadgerCare Plus Core Plan (1115 Waiver)		--	--		Y	0%

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2012.
Table presents rules in effect as of January 1, 2012, unless noted otherwise.

Table 22 Notes

1. Expansion coverage includes waiver, state-funded, and ACA adult option coverage for low-income adults.

2. "Increased" indicates that a state has increased premiums or copayments or lowered the income level at which they are required. "Decreased" indicates that a state has decreased premiums or copayments or raised the income level at which they are required. Changes occurred between January 1, 2011 and January 1, 2012, unless noted otherwise.

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

4. Connecticut increased premiums in its state-funded Charter Oak program in September 2011. There are no premium or cost sharing charges in the state's ACA option coverage for adults.

5. In Hawaii, 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.

6. In the Healthy Indiana Plan, individuals with zero income are exempt from monthly contributions.

7. Premium increases in Iowa, Maryland, Massachusetts, Minnesota, New Jersey, and Vermont are annual increases and not the result of policy changes.

8. Massachusetts increased copayments for most prescription coverage in MassHealth and Commonwealth Care from $3 to $3.65 in October 2011. In Commonwealth Care, the state also eliminated copayment for preventive services and added new copayments for certain imaging services.

9. In 2011 in Minnesota, the preventive visit copayment was restored and the emergency room copayments (for both a true emergency and a non-emergency visit) were reduced from $6 to $3.50.

10. As part of Washington's waiver negotiations, premiums in Basic Health were reduced for those below 101% FPL. They now are $17 for those between 0% and 65% FPL and $45 for those between 66% and 100% FPL.

11. In Wisconsin, childless adults in Core Plan pay a one-time application fee of $60.

Table 23

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

January 2012

State	Expansion Program Name	101% FPL (100% if upper limit)	151% FPL (150% if upper limit)	201% FPL (200% if upper limit)	251% FPL (250% if upper limit)	300% FPL (301% if upper limit)	351% FPL (350% if upper limit)
MONTHLY PAYMENTS							
Arizona	AHCCCS (1115 Waiver)	--	--	--	--	--	--
Arkansas[4]	ARHealthNetworks (1115 Waiver)	$25	$25	$25	N/A	N/A	N/A
California[5]	Medicaid Coverage Expansion (1115 Waiver)	--	--	--	--	--	--
	Health Care Coverage Initiative (1115 Waiver)	--	vary by county		N/A	N/A	N/A
Connecticut[6]	Medicaid for Low-Income Adults (ACA Option)	--	--	--	--	--	--
	Charter Oak (State-funded)	$446	$446	$446	$446	$446	N/A
Delaware	Diamond State Health Plan (1115 Waiver)	--	--	--	--	--	--
District of Columbia	ACA adult expansion	--	--	--	--	--	--
	ACA Expansion (1115 Waiver)	--	--	--	--	--	--
	DC Healthcare Alliance (District-funded)	--	--	--	--	--	--
Hawaii[7]	QUEST (1115 Waiver)	--	--	--	--	--	--
	QUEST-ACE (1115 Waiver)	--	--	--	--	--	--
Idaho[8]	Access to Health Insurance (1115 Waiver)	vary based on ESI plan		N/A	N/A	N/A	N/A
Illinois[8]	FamilyCare Rebate (State-funded)	N/A	vary based on ESI plan		N/A	N/A	N/A
Indiana[9]	Healthy Indiana Plan (1115 Waiver)	$27	$68	$90	N/A	N/A	N/A
Iowa	IowaCare (1115 Waiver)	$0	$50	$63	$63	N/A	N/A
Maine[10]	Maine Care (1115 Waiver)	--	--	--	--	--	--
	DirigoChoice (State-funded)	20% cost	45% cost	70% cost	90% cost	90% cost	N/A
Maryland	Primary Adult Coverage (1115 Waiver)	--	--	--	--	--	--
Massachusetts[11]	MassHealth Basic & Essential (1115 Waiver)	--	--	--	--	--	--
	Commonwealth Care (1115 Waiver)	$0-$34	$39-$91	$77-$152	$116-$197	$116-$197	N/A
Michigan	Adult Benefits Waiver (1115 Waiver)	--	--	--	--	--	--
Minnesota[12]	ACA adult expansion	N/A	N/A	N/A	N/A	N/A	N/A
	MinnesotaCare (1115 Waiver)	$20	$50	$102	$163	N/A	N/A
	MinnesotaCare (State-funded)	$20	$50	$102	$163	N/A	N/A
New Jersey	Family Care (1115 Waiver)	N/A	$43	$43	N/A	N/A	N/A
	New Jersey Childless Adults (1115 Waiver)	N/A	N/A	N/A	N/A	N/A	N/A
New Mexico[13]	SCI (1115 Waiver)	$25/$95	$35/$110	$35/$110	N/A	N/A	N/A
New York	Family Health Plus (1115 Waiver)	--	--	--	--	--	--
Oklahoma[14]	Insure Oklahoma (1115 Waiver)	$36.46	$54.51	N/A	N/A	N/A	N/A
Oregon[15]	OHP Standard (1115 Waiver)	$20	N/A	N/A	N/A	N/A	N/A
	FHIAP (1115 Waiver)		vary by plan		N/A	N/A	N/A
Rhode Island[16]	RIte Care/Share (1115 Waiver)	$0	$61	N/A	N/A	N/A	N/A
Tennessee[17]	CoverTN (State-funded)	$38-$220	$38-$220	$38-$220	$38-$220	$38-$220	$38-$220
Vermont[18]	VHAP (1115 Waiver)	$25	$33	N/A	N/A	N/A	N/A
	Catamount Care (1115 Waiver)	$60 or $119	$60 or $119	$124 or $160	$180 or $183	$208 or $300	N/A
Washington[19]	Basic Health (1115 Waiver)	$60	$89	$155	N/A	N/A	N/A
Wisconsin[20]	BadgerCare Plus Core Plan (1115 Waiver)	--	--	--	N/A	N/A	N/A
ANNUAL PAYMENTS							
Utah	Primary Care Network (1115 Waiver)	$15-$50	$15-$50	N/A	N/A	N/A	N/A
	Utah Premium Partnership (1115 Waiver)	up to $150	up to $150	N/A	N/A	N/A	N/A

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2012. Table presents rules in effect as of January 1, 2012, unless noted otherwise.

Table 23 Notes

1. Expansion coverage includes waiver, state-funded, and ACA adult option coverage for low-income adults.

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

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

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

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

6. Connecticut stopped subsidizing premiums for new enrollees in its state-funded Charter Oak program in 2010, but adults at any income can buy in at full cost for $307 per month. There are no premium or cost sharing charges in the states ACA option coverage for adults.

7. 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.

8. In Idaho and Illinois, expansion coverage is premium assistance program; as such, actual costs vary based on ESI plan.

9. 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.

10. In Maine's DirigoChoice program, individuals receive percentage discounts on costs based on income.

11. In the Massachusetts Commonwealth Care waiver program, costs vary by income and plan type.

12. In the MinnesotaCare waiver program, costs vary based on income, family size, and the number of people in the family who enroll. Values shown are for an individual adult.

13. In New Mexico's SCI waiver program, numbers before the slash represent the cost if an employer pays the employer share and numbers after the slash represent the cost if the individual pays both the employee and employer share.

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

15. In Oregon, OHP Standard waiver program premiums begin at 10% FPL and range from $9-$20. 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.

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

17. In the 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.

18. In Catamount Health the costs vary by plan. Individuals above 300% FPL can buy into Catamount Health at full cost for $416 per month.

19. In Washington, the 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.

20. In Wisconsin, childless adults in Core Plan pay a one-time application fee of $60.

Table 24

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

January 2012

State	Expansion Program Name	<100% FPL				100-200% FPL			
		Non-Preventive Physician Visit	Emergency Room Visit	Non-Emergency Use of ER	Inpatient Hospital Visit	Non-Preventive Physician Visit	Emergency Room Visit	Non-Emergency Use of ER	Inpatient Hospital Visit
Arizona	AHCCCS (1115 Waiver)	$5	$0	$30	$0	N/A			
Arkansas	ARHealthNetworks (1115 Waiver)	15% coinsurance				15% coinsurance			
California	Medicaid Coverage Expansion (1115 Waiver)	$1	$5	N/C	$0	N/A			
	Health Care Coverage Initiative (1115 Waiver)	N/A				$1	$5	N/C	$0
Connecticut[3]	Medicaid for Low-Income Adults (ACA Option)	--	--	--	--	--	--	--	--
	Charter Oak (State-funded)	$25	$100	$100	10% after deductible	$25	$100	$100	10% after deductible
Delaware	Diamond State Health Plan (1115 Waiver)	$0	$0	$0	$0	N/A			
District of Columbia	ACA adult expansion	- -	- -	- -	- -	- -	- -	- -	- -
	ACA Expansion (1115 Waiver)	- -	- -	- -	- -	- -	- -	- -	- -
	DC Healthcare Alliance (District-funded)	- -	- -	- -	- -	- -	- -	- -	- -
Hawaii	QUEST (1115 Waiver)	- -	- -	- -	- -	- -	- -	- -	- -
	QUEST-ACE (1115 Waiver)	- -	- -	- -	- -	- -	- -	- -	- -
Idaho[4]	Access to Health Insurance (1115 Waiver)	Vary based on ESI plan				Vary based on ESI plan			
Illinois[4]	FamilyCare Rebate (State-funded)	Vary based on ESI plan				N/A			
Indiana[3, 5]	Healthy Indiana Plan (1115 Waiver)	$0	Up to $25	Up to $25	$0	$0	Up to $25	Up to $25	$0
Iowa	IowaCare (1115 Waiver)	$0	$0	$0	$0	$0	$0	$0	$0
Maine[6]	Maine Care (1115 Waiver)	- -	- -	- -	- -	N/A			
	DirigoChoice (State-funded)	$25	$500 deductible, then 30% coins.			$25	$500-$750 deductible, then 30% coins.		
Maryland[7]	Primary Adult Coverage (1115 Waiver)	$0	N/C	N/C	N/C	$0	N/C	N/C	N/C
Massachusetts[3, 8]	MassHealth Basic & Essential (1115 Waiver)	$0	$0	$0	$0	- -	- -	- -	- -
	Commonwealth Care (1115 Waiver)	$0	$0	$0	$0	$10	$50	$50	$50
Michigan	Adult Benefits Waiver (1115 Waiver)	$3	$0	$0	$0	N/A			
Minnesota[7]	ACA adult expansion	$3	$0	$3.50	$0	N/A			
	MinnesotaCare (1115 Waiver)	$3	$0	$6	$0	$3	$0	$6	$0
	MinnesotaCare (State-funded)	$3	$0	$6	$0	$3	$0	$6	$0
New Jersey[7]	Family Care (1115 Waiver)	N/A				$0	$35	$35	$0
	New Jersey Childless Adults (1115 Waiver)	- -	- -	- -	- -	- -	- -	- -	- -
New Mexico[3, 9]	SCI (1115 Waiver)	$0	$0	$0	$0	$5-$7	$15-$20	$15-$20	$25-$30
New York	Family Health Plus (1115 Waiver)	$0	$3	$3	$25/discharge	$0	$3	$3	$25/discharge
Oklahoma[3]	O-EPIC (1115 Waiver)	$10	$30	$30	$50	$10	$30	$30	$50
Oregon[10]	OHP Standard (1115 Waiver)	- -	- -	- -	- -	N/A			
	FHIAP (1115 Waiver)	vary based on plan				vary based on plan			
Rhode Island	RIte Care/Share (1115 Waiver)	- -	- -	- -	- -	- -	- -	- -	- -
Tennessee[11]	CoverTN (State-funded)	$15-$20	$0	$0	$100	$15-$20	$0	$0	$100
Utah[12]	Primary Care Network (1115 Waiver)	$15	$30 (if covered)		N/C	$15	$30 (if covered)		N/C
	Utah Premium Partnership (1115 Waiver)	vary based on plan				vary based on plan			
Vermont[2, 13]	VHAP (1115 Waiver)	$0	$25	$60	$0	N/A			
	Catamount Care (1115 Waiver)	$10	$500 deductible, then 20% coins.			$10	$500 deductible, then 20% coins.		
Washington[3, 14]	Basic Health (1115 Waiver)	$15	$100	$100	$250 deductible, then 20%	$15	$100	$100	$250 deductible, then 20%
Wisconsin[3, 15]	BadgerCare Plus Core Plan (1115 Waiver)	$.50-$3	$0	$0	$3 per day	$.50-$3	$60	$60	$100 per stay

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2012.

Table presents rules in effect as of January 1, 2012, unless noted otherwise.

Table 24 Notes

1. Expansion coverage includes waiver, state-funded, and ACA adult option coverage for low-income adults.

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

3. In Connecticut, Indiana, Massachusetts (Commonwealth Care), New Mexico, Oklahoma, Washington, and Wisconsin (BadgerCare Plus Core enrollees between 100% and 200%) the emergency room visit copay is waived if admitted.

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

5. In the Healthy Indiana Plan, an emergency room visit has a sliding scale copay based on income and parental status.

6. In Maine's Dirigo Health, costs are based on an individual. Out-of-pocket costs are subject to a $800 annual limit.

7. In Maryland, there is no coverage for the enrollee for inpatient hospital and emergency room visits; however, there is coverage for the facility costs associated with these visits.

8. In Massachusetts, out-of-pocket costs in Commonwealth Care are subject to annual maximums that vary by income.

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

10. There are no copays in OHP Standard expansion coverage per court order. FHIAP is a premium assistance program; as such cost sharing varies by plan.

11. In CoverTN, copays for physician visits vary based on plan.

12. For the Primary Care Network (PCN), ER care is only covered for approved emergency diagnoses. Utah Premium Partnership (UPP) is a premium assistance program; as such, costs vary by plan.

13. 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.

14. In Washington's Basic Health, the maximum facility charge per admittance for inpatient care is $300.

15. 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 25

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

January 2012

State	Expansion Program Name	<100% FPL			100-200% FPL		
		Generic	Preferred Brand Name	Non-Preferred Brand Name	Generic	Preferred Brand Name	Non-Preferred Brand Name
Arizona	AHCCCS (1115 Waiver)	$4	$10	$10		N/A	
Arkansas	ARHealthNetworks (1115 Waiver)	$5	$15	$30	$5	$15	$30
California	Medicaid Coverage Expansion (1115 Waiver)	$0	$0	$0	$0	$0	$0
	Health Care Coverage Initiative (1115 Waiver)	$0	$0	$0	$0	$0	$0
Connecticut	Medicaid for Low-Income Adults (ACA Option)	--	--	--	--	--	--
	Charter Oak (State-funded)	$10	$35	$35	$10	$35	$35
Delaware[3]	Diamond State Health Plan (1115 Waiver)	$.50-$3	$.50-$3	$.50-$3		N/A	
District of Columbia	ACA adult expansion	- -	- -	- -	- -	- -	- -
	ACA Expansion (1115 Waiver)	- -	- -	- -	- -	- -	- -
	DC Healthcare Alliance (District-funded)	- -	- -	- -	- -	- -	- -
Hawaii	QUEST (1115 Waiver)	- -	- -	- -	- -	- -	- -
	QUEST-ACE (1115 Waiver)	- -	- -	- -	- -	- -	- -
Idaho[4]	Access to Health Insurance (1115 Waiver)		Vary based on ESI plan			Vary based on ESI plan	
Illinois[4]	FamilyCare Rebate (State-funded)		Vary based on ESI plan			N/A	
Indiana	Healthy Indiana Plan (1115 Waiver)	$3	$3	$3	$3	$3	$3
Iowa	IowaCare (1115 Waiver)		N/C				
Maine[5]	Maine Care (1115 Waiver)	- -	- -	- -	- -	- -	- -
	DirigoChoice (State-funded)	$10-$50	$10-$50	$10-$50	$10-$50	$10-$50	$10-$50
Maryland[6]	Primary Adult Coverage (1115 Waiver)	$2.50	$7.50	$7.50	$2.50	$7.50	$7.50
Massachusetts[7]	MassHealth Basic & Essential (1115 Waiver)	$3.65	$3.65	$3.65		N/A	
	Commonwealth Care (1115 Waiver)	$3.65	$3.65	$3.65	$10	$20	$40
Michigan	Adult Benefits Waiver (1115 Waiver)	$1	$1	$1		N/A	
Minnesota	ACA adult expansion	$1	$3	$3		N/A	
	MinnesotaCare (1115 Waiver)	$3	$3	$3	$3	$3	$3
	MinnesotaCare (State-funded)	$3	$3	$3	$3	$3	$3
New Jersey	Family Care (1115 Waiver)		N/A		$5	$5	$5
	New Jersey Childless Adults (1115 Waiver)	- -	- -	- -	- -	- -	- -
New Mexico[8]	SCI (1115 Waiver)	$0	$0	$0	$3	$3	$3
New York	Family Health Plus (1115 Waiver)	$3	$6	$6	$3	$6	$6
Oklahoma	O-EPIC (1115 Waiver)	$5	$10	$10	$5	$10	$10
Oregon[9]	OHP Standard (1115 Waiver)	- -	- -	- -	- -	- -	- -
	FHIAP (1115 Waiver)		Vary based on plan			Vary based on plan	
Rhode Island	RIte Care/Share (1115 Waiver)	- -	- -	- -	- -	- -	- -
Tennessee[10]	CoverTN (State-funded)	$8-$10	N/C	N/C	$8-$10	N/C	N/C
Utah[11]	Primary Care Network (1115 Waiver)	$5	25% cost	25% cost	$5	25% cost	25% cost
	Utah Premium Partnership (1115 Waiver)		Vary based on plan			Vary based on plan	
Vermont	VHAP (1115 Waiver)	$1-$2	$1-$2	$1-$2	N/A	N/A	N/A
	Catamount Care (1115 Waiver)	$10	$35	$55	$10	$35	$55
Washington	Basic Health (1115 Waiver)	$10	50% cost	N/C	$10	50% cost	N/C
Wisconsin[12]	BadgerCare Plus Core Plan (1115 Waiver)	<$4	<$8	<$8	<$4	<$8	<$8

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2012.
Table presents rules in effect as of January 1, 2012, unless noted otherwise.

Table 25 Notes

1. Expansion coverage includes waiver, state-funded, and ACA adult option coverage for low-income adults.

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

3. In Delaware costs vary based on cost of drug.

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

5. In Maine, costs for DirigoChoice are based on an individual. Drug costs vary based on drug tier and out-of-pocket costs are subject to a $800 annual limit.

6. In Maryland's Primary Adult Coverage, depending on which managed care plan an in individual is enrolled in, there may be drug copayments ranging from $2.50-$7.50 per drug.

7. In Massachusetts, generic drugs for diabetes, high blood pressure, and high cholesterol have a $1 copay in MassHealth and for Commonwealth Care enrollees below 100% FPL. In Commonwealth Care, copays are lower for three-month supplies of prescription drugs obtained through mail order. Prescription drug copays in Commonwealth Care are subject to annual out-of-pocket maximums that vary by income.

8. In New Mexico, under SCI waiver coverage, drug copays are subject to a $12 monthly maximum.

9. In Oregon, there are no copayments in OHP Standard per court order. FHIAP is a premium assistance program; as such, costs vary based on plan.

10. In CoverTN expansion coverage, copays for generics vary based on plan and there is no coverage for brand name drugs except insulin and diabetic test strips.

11. The Primary Care Network (PCN) has a limit of 4 drugs per month. Utah Premium Partnership (UPP) is a premium assistance program; as such costs vary by plan.

12. In expansion coverage under BadgerCare Plus Core Plan for childless adults, there is a $24 per month, per provider limit for prescription drug copays.

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