THE HENRY J. KAISER FAMILY FOUNDATION

THE KAISER COMMISSION ON
Medicaid and the Uninsured

REPORT

January 2015

Modern Era Medicaid:

FINDINGS FROM A 50-STATE SURVEY OF ELIGIBILITY, ENROLLMENT, RENEWAL, AND COST-SHARING POLICIES IN MEDICAID AND CHIP AS OF JANUARY 2015

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Executive Summary

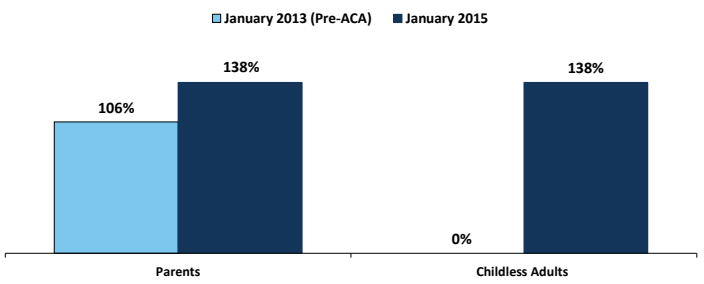
The Affordable Care Act (ACA) has contributed to a significant transformation of Medicaid, broadening it as the base of coverage for the low-income population and accelerating state efforts to move from antiquated, paper-driven enrollment processes to a new modernized enrollment experience for individuals. January 1, 2015 marks the first anniversary of key ACA Medicaid provisions, including the Medicaid expansion to low-income adults and new rules for streamlined enrollment and renewal processes that coordinate across insurance affordability programs, including Medicaid, the Children's Health Insurance Program (CHIP), and the Health Insurance Marketplaces. Throughout 2014, states continued to develop their data-driven systems and re-engineer their business practices to fulfill the ACA's vision. This 13th annual 50-state survey of Medicaid and CHIP eligibility, enrollment, renewal, and cost-sharing policies as of January 2015 provides a snapshot of state Medicaid and CHIP policies in place one year into the post-ACA era.

Eligibility for Adults, Children, and Pregnant Women

As of January 1, 2015, 28 states set their Medicaid income eligibility levels for parents and other adults to at least 138 percent of the federal poverty level (FPL), reflecting their implementation of the ACA Medicaid expansion. This count includes New Hampshire and Pennsylvania, which made decisions during 2014 to expand. Among these states, median income eligibility levels for adults have increased compared to pre-ACA levels, particularly for childless adults who were historically excluded from the Medicaid program (ES-Figure 1). There is no deadline for states to expand Medicaid, and additional states may decide to expand in the coming year.

ES- Figure 1

Median Medicaid Income Eligibility Levels for Adults as a Percent of the FPL in States that Adopted the Medicaid Expansion, January 2013 and January 2015

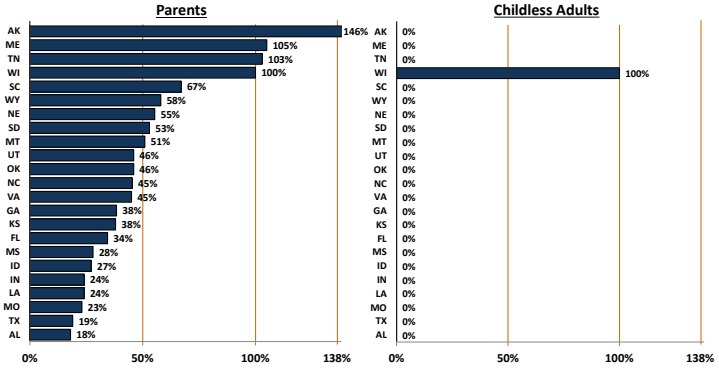


NOTE: January 2013 thresholds are for working adults and are based on 2103 federal poverty levels (FPLs). January 2015 levels are based on 2014 FPLs. In 2013,the FPL was $11,490 for an individual and $19,530 for a family of three. In 2014,the FPL was $19,790 for a family of three and $11,670 for an individual. January 2015 thresholds include the standard five percentage point of the FPL disregard.
SOURCE: Based on results from a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2015.

Eligibility levels remain very limited for adults in the 23 states not adopting the Medicaid expansion at this time. In all but one of these states (Wisconsin), childless adults remain ineligible for Medicaid regardless of their incomes, while Medicaid eligibility levels for parents are below poverty in 19 states (ES-Figure 2).[1] In these states, many poor adults earn too much to qualify for Medicaid, but not enough to qualify for tax subsidies to purchase Marketplace coverage, which are not available to those with incomes below 100 percent of the FPL. Other Kaiser Family Foundation analysis finds that nearly four million poor uninsured adults fall into a coverage gap as a result of these limited eligibility levels.[2]

ES- Figure 2

Medicaid Income Eligibility Limits for Adults in States Not Adopting the Medicaid Expansion at this Time, January 2015



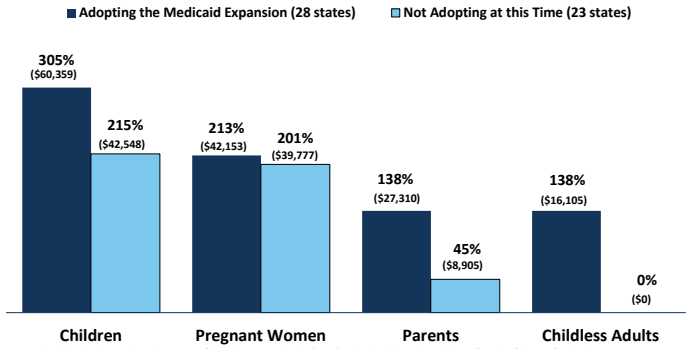
NOTE: Eligibility levels are based on 2014 federal poverty levels (FPLs) and are calculated based on a family of three for parents and an individual for childless adults. In 2014,the FPL was $19,790 for a family of three and $11,670 for an individual. Thresholds include the standard five percentage point of the federal poverty level (FPL) disregard.
SOURCE: Based on results from a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2015.

Medicaid and CHIP coverage for children and pregnant women remains strong. As of January 1, 2015, all but two states cover children at or above 200 percent of the FPL through Medicaid and CHIP with 19 states covering children at or above 300 percent of the FPL. A total of 33 states cover pregnant women at or above 200 percent of the FPL. Building on many years of progress, states also continued to take up options that expand children's access to coverage. Consistent with the ACA's vision of a seamless continuum of coverage options, 21 states eliminated waiting periods in CHIP, including California which transitioned its separate CHIP program into Medicaid. Illinois expanded CHIP coverage in 2013 to 317% FPL, with children above 209% FPL subject to a 3-month waiting period. Reflecting this state action, as of January 1, 2015, 33 states have no period of time that a child must be without group coverage prior to enrolling. In addition, 28 states have now eliminated the five-year waiting period for lawfully residing immigrant children, while 23 have done so for pregnant women, reflecting the recent adoption of this option in several states. Coverage for children remains protected through 2019 under ACA provisions that prohibit states from applying any restrictions in eligibility or enrollment for children.

Although eligibility levels for adults markedly increased over pre-ACA standards as a result of the Medicaid expansion, they remain well below those of children and pregnant women. Among states that expanded Medicaid, the median eligibility level for both parents and other adults is 138 percent of the FPL. However, among the 23 states that have not expanded, the median eligibility level is just 45 percent of the FPL for parents and 0 percent of the FPL for childless adults. Comparatively, the median limits for children and pregnant women are significantly higher in both expansion and non-expansion states (ES-Figure 3).

ES- Figure 3

Median Medicaid/CHIP Income Eligibility Thresholds, January 2015



NOTE: Eligibility levels are based on 2014 federal poverty levels (FPLs). Thresholds are based on a family of three for children, pregnant women, and parents and for an individual for childless adults. Levels include the standard five percentage point of the FPL disregard.
SOURCE: Based on results from a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2015.

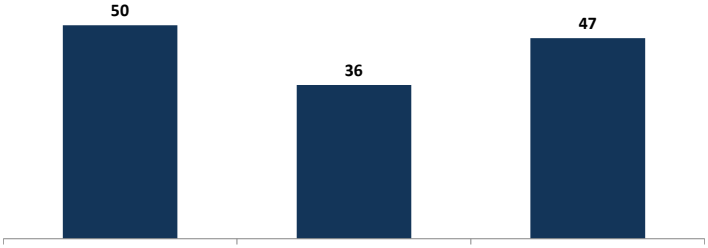
Progress Toward Streamlined Enrollment and Renewal Processes

States have achieved major progress implementing the modernized and streamlined enrollment and renewal processes under the ACA, but work continues in many areas. Reflecting this ongoing effort, the functionality of eligibility and enrollment systems is rapidly changing and improving on a week-to-week basis. Thus, what is reported here is a snapshot of processes and system capabilities as of January 2015.

As of January 1, 2015, individuals can apply online for Medicaid at the state level in all but one state, and the majority of states are accepting Medicaid applications by phone (ES-Figure 4). Under the ACA, states must provide individuals the option to apply online for Medicaid at the state level, which currently is available in all

ES- Figure 4

Number of States with Online and Telephone Applications and Online Accounts in Medicaid, January 2015



SOURCE: Based on results from a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2015.

states, except Tennessee, where individuals can only apply online through the Federally-facilitated Marketplace (FFM). Most states (36) also provide individuals the opportunity to create an online account for management of their Medicaid coverage. States continue to build features into these accounts, such as the ability to report changes, view notices, and upload documents. States also are required to provide individuals the option to apply by phone. Most states (47) accept telephone applications for Medicaid through the Medicaid agency and/or the State-based Marketplace (SBM), while the remaining states are delayed in providing this option.

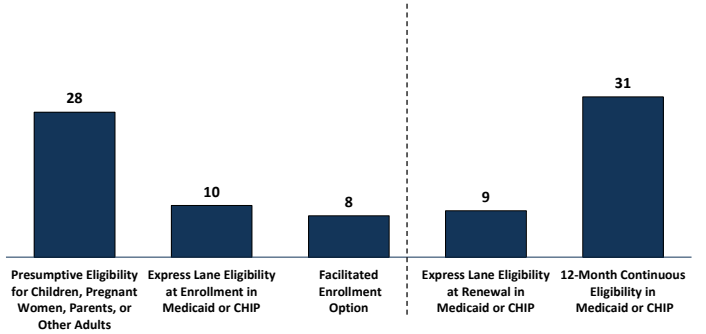
States have established eligibility verification policies that seek to rely on electronic data and minimize paperwork for individuals. As required by the ACA, all states seek to rely on electronic data sources to verify incomes of Medicaid and CHIP applicants, with 40 states verifying income prior to enrollment and 11 verifying after enrollment. Some states are relying solely on the federal data services hub, which consolidates data from the Internal Revenue Services, the Social Security Administration, the Department of Homeland Security, and a commercial wage database, while others are tapping state data sources in addition to or in lieu of the federal data hub. For cases in which there are differences between self-reported income and data from electronic sources, two-thirds of states (33) have elected to provide a broader standard than required to consider the data to be "reasonably compatible" and accept the self-reported income. Further, most states have taken up options to minimize paperwork burdens for applicants and states by relying on self-attestation of at least some non-financial eligibility criteria, such as age, state residency, and/or household size.

Work continues to implement streamlined renewal processes. Similar to enrollment processes, the ACA also calls for highly automated, paperless renewal procedures for Medicaid and CHIP. To ease the transition to new renewal processes, CMS offered states an option to temporarily delay renewals, which 34 states took up in Medicaid and 22 states took up in CHIP during 2014. Most states have completed all renewals that were originally due in 2014, although 17 states are extending some of these renewals into 2015. However, many states are continuing work to transition to new streamlined renewal procedures and face a range of challenges, including developing system capacity, transferring data for existing enrollees from old mainframe-based systems to their new modern technology platforms, and generating notices for individuals. In the interim, a number of states are relying on mitigation strategies such as mailing forms to individuals to request the information needed to complete renewal.

A range of additional options facilitates enrollment and renewal of eligible individuals in some states. The ACA establishes new authority for hospitals to provide temporary access to Medicaid coverage by conducting presumptive eligibility determinations while a full application is in process, which states are in varying stages of implementing. In addition, longstanding policy allows states to authorize qualified entities, such as hospitals, community health centers, and schools, to make presumptive eligibility determinations for children and pregnant women, which the ACA expanded to include parents and other adults. As of January 2015, 28 states authorize entities to conduct presumptive eligibility determinations for children, pregnant women, parents, or other adults (ES-Figure 5). Moreover,

ES- Figure 5

Number of States Adopting Targeted Strategies to Streamline Enrollment and Renewal of Eligible Individuals, January 2015



SOURCE: Based on results from a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2015.

since Express Lane Eligibility (ELE) was established in 2009, states have had the option to use findings from other means-tested programs, such as the Supplemental Nutrition Assistance Program (SNAP), to determine children eligible for Medicaid or CHIP, which ten states currently utilize. In 2013, CMS offered states additional facilitated enrollment options, including using SNAP data to identify and enroll eligible individuals and using child enrollment data to expedite parent enrollment. Eight states have taken up one or both of these strategies, which have contributed to success enrolling newly eligible adults and children and reduced administrative costs.[3] In addition, to support stable coverage over time, nine states utilize ELE at renewal and 31 states provide 12-month continuous eligibility for children in Medicaid or CHIP.

States' choices with regard to the integration of their Medicaid and Marketplace eligibility determination systems affect coordination across coverage programs. All states must maintain a Medicaid eligibility determination system, but states with an SBM may operate a single, integrated system that determines eligibility for both Medicaid and Marketplace coverage, which 12 states do. The remaining states have separate eligibility determination systems for Medicaid and Marketplace coverage. In states with separate systems (including all 37 states relying on the FFM for eligibility and enrollment functions and 2 SBM states with separate state-level Medicaid and Marketplace systems), electronic data, known as account transfers, must be exchanged between the systems to provide a seamless enrollment experience for individuals. During 2014, difficulties with this coordination contributed to delays in Medicaid enrollment. The federal government and states have sought to address these issues, but the extra steps needed to determine eligibility, along with the higher volume of applications during open enrollment, may still result in backlogs in some states.[4]

Premiums and Cost- Sharing

In general, premiums and cost-sharing remain limited in Medicaid and CHIP. As of January 2015, 30 states charge premiums or enrollment fees for children, primarily in CHIP, and 26 states have cost-sharing for children. No states charge premiums for parents or ACA expansion adults in traditional Medicaid, reflecting the fact that eligibility limits for adults in most states are below the level at which they can be charged under federal rules. However, four states (AR, IA, MI, and PA) have received waiver approval to charge monthly payments not otherwise allowed under federal rules for some adults. Most states charge nominal cost-sharing for low-income parents and expansion adults.

Looking Ahead

One year after the launch of the major Medicaid provisions of the ACA, there have been significant gains in coverage opportunities for low-income adults, most notably with increased eligibility levels for parents and childless adults in states that have expanded Medicaid. There is no deadline for states to expand Medicaid, and debate over the adult expansion will continue in some states in 2015. Medicaid and CHIP coverage for children and pregnant women remains strong across states, but without Congressional action there will not be continued funding for CHIP beyond September 2015. If CHIP funding expires, some children may lose coverage and some may face higher premiums and cost-sharing for coverage.[5] The loss of enhanced CHIP funding would also have budgetary implications for states. On the operational and systems side, many states have achieved significant progress toward realizing the ACA's vision of a modernized, streamlined enrollment system, but work continues in many areas, including establishing automated renewal processes as well as enhancing and expanding the functionalities of their systems.

Introduction

At the one-year anniversary of implementation of the Affordable Care Act's (ACA) coverage provisions, states continue work to transform Medicaid and the Children's Health Insurance Program (CHIP) to realize the ACA's goals of expanded coverage and a streamlined enrollment system. While many states have worked to enhance access to coverage and simplify Medicaid and CHIP enrollment and renewal processes for a number of years, particularly for children, the ACA has served as a key impetus to accelerate these efforts and move the Medicaid program into a new era to serve as a broad base of coverage for the low-income population and provide a modernized enrollment experience for individuals.

Pivotal action took place in 2014, with the Centers for Medicare and Medicaid Services (CMS) and states working together to implement the ACA's new eligibility, enrollment, and renewal rules. More than half of the states moved forward with the ACA's Medicaid expansion to low-income adults, and states made significant headway in adopting the law's streamlined enrollment and renewal processes. However, implementation remains a work in progress with some states further ahead than others. Looking ahead, many states are now focused on enhancing and improving system functionalities, smoothing out transitions between Medicaid and Marketplace coverage, and progressing to highly-automated renewal procedures.

This report annually surveys Medicaid and CHIP program officials to track eligibility, enrollment, renewal, and premium and cost-sharing policies. Given the fast-paced policy environment leading up to January 1, 2014, when key ACA coverage provisions went into effect, an abbreviated report based on publicly available data was released in November 2013. For this 13th annual report, we return to conducting interviews with state Medicaid and CHIP officials to gather information on key policies that are in effect as of January 1, 2015.

The report includes information on Medicaid policies for children, pregnant women, parents, and the new adult expansion group, as well as coverage for children and pregnant women under CHIP.[6] Given that state eligibility and enrollment systems and ACA implementation efforts are rapidly evolving, this report provides a point-in-time view, a snapshot. Importantly, it provides a key measure of state Medicaid and CHIP policies in a new era under the ACA. The report is organized into four sections: Medicaid and CHIP Eligibility, Enrollment and Renewal Processes, Eligibility Determination Systems, and Premiums and Cost-Sharing. State-specific information is available in Tables 1 to 19 at the end of the report.

Medicaid and CHIP Eligibility

As enacted, the ACA expanded Medicaid eligibility to adults with incomes at or below 138 percent of the federal poverty level (FPL) ($27,310 for a family of three in 2014), although this core provision was effectively made a state option by the Supreme Court's 2012 ruling on the ACA. However, other eligibility changes in the law were unaffected by the Court's decision, including establishing a new minimum coverage level of 138 percent of the FPL for children of all ages in Medicaid, helping to align Medicaid coverage across children. The ACA also changed the method for determining financial eligibility for Medicaid for children, pregnant women, parents, and adults and CHIP to a standard based on modified adjusted gross income (MAGI).[7] This new approach is intended to prevent gaps in coverage between programs by largely adopting the rules for determining eligibility for subsidies to purchase Marketplace coverage. While these changes went into effect on January 1, 2014, some states continued to refine the conversion of their pre-ACA eligibility levels to MAGI-based standards. The findings below reflect eligibility levels for parents and other non-disabled adults, children, and pregnant

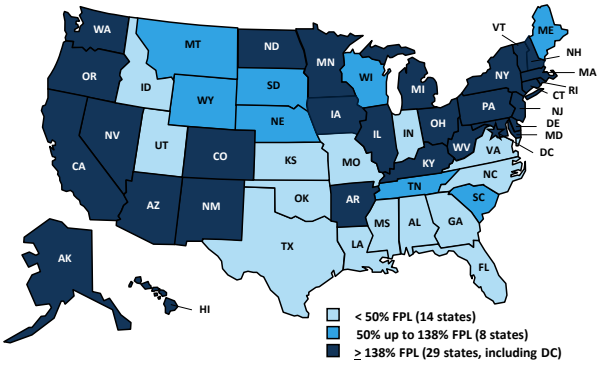
women in Medicaid and CHIP as of January 1, 2015. They highlight Medicaid's expanded role for low-income adults under the ACA and its continued role as a primary source of coverage for children and pregnant women.

Parents and Adults

As of January 1, 2015, 28 states set their Medicaid income eligibility levels for parents and other adults to at least 138 percent of the FPL, reflecting their implementation of the ACA Medicaid expansion (Figures 1 and 2). This count includes New Hampshire and Pennsylvania, which made decisions during 2014 to expand. Most states adopted the expansion consistent with federal rules and options provided under the ACA, but four states (AR, IA, MI, and PA) obtained Section 1115 waivers to expand Medicaid in ways that extend beyond the flexibility provided by the law.[8] There is no deadline for states to expand Medicaid and additional states may decide to expand in the coming year. Two expansion states extend Medicaid income eligibility for adults to higher levels. Specifically, in the District of Columbia, parents with incomes up to 221 percent of the FPL and other adults with incomes up to 215 percent of the FPL are eligible, and Connecticut covers parents with incomes up to 201 percent of the FPL. Minnesota became the first state to implement a Basic Health Program (BHP) established by the ACA and transferred coverage for Medicaid enrollees with incomes between 138 and 200 percent of the FPL to the BHP as of January 1, 2015.

Figure 1

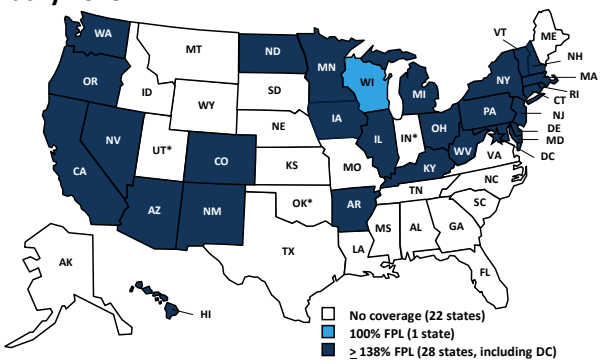
Medicaid Income Eligibility Levels for Parents of Dependent Children, January 2015



NOTE: Eligibility levels are based on 2014 federal poverty levels (FPLs) for a family of three. The FPL for a family of three in 2014 was $19,790. Thresholds include the standard five percentage point of the FPL disregard.
SOURCE: Based on results from a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2015.

Figure 2

Medicaid Income Eligibility Levels for Childless Adults, January 2015

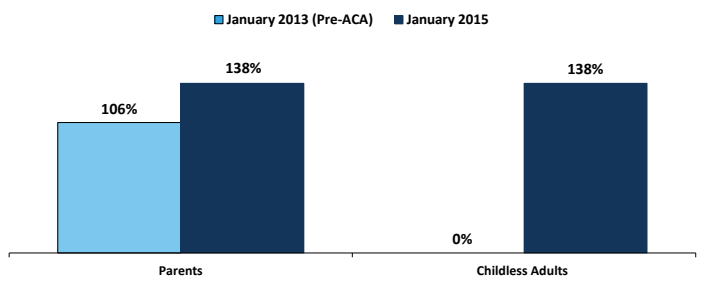


NOTE: Eligibility levels are based on 2014 federal poverty levels (FPLs) for an individual. The FPL for an individual in 2014 was $11,670. Thresholds include the standard five percentage point of the FPL disregard.
*IN, OK, and UT provide more limited coverage to some childless adults under Section 1115 waiver authority.
SOURCE: Based on results from a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2015.

Among states that have implemented the Medicaid expansion, there have been increases in income eligibility levels for adults compared to pre-ACA levels. In these states, the median income eligibility level for parents rose from 106 percent of the FPL to 138 percent of the FPL. Increases in income eligibility levels for childless adults were even more significant, rising from a median of 0 to 138 percent of the FPL, reflecting the historic exclusion of childless adults from Medicaid prior to the ACA (Figure 3).

Figure 3

Median Medicaid Income Eligibility Levels for Adults as a Percent of the FPL in States that Adopted the Medicaid Expansion, January 2013 and January 2015

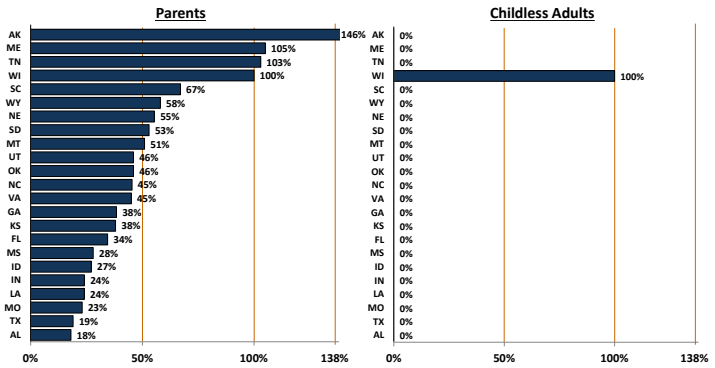


NOTE: January 2013 thresholds are for working adults and are based on 2013 federal poverty levels (FPLs). January 2015 levels are based on 2014 FPLs. In 2013,the FPL was $11,490 for an individual and $19,530 for a family of three. In 2014 ,the FPL was $19,790 for a family of three and $11,670 for an individual. January 2015 thresholds include the standard five percentage point of the FPL disregard.
SOURCE: Based on results from a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2015.

Medicaid income eligibility levels for parents remain very low, and, with only one exception, childless adults are ineligible for Medicaid in the 23 states that are not adopting the Medicaid expansion at this time. Fourteen states limit parent eligibility levels to less than half of the poverty level, and only four of the non-expansion states set their income eligibility levels for parents at or above 100 percent of the FPL, including Maine and Wisconsin, which both reduced eligibility levels for parents from pre-ACA levels (Figure 4). Wisconsin is also the only non-expansion state providing full Medicaid coverage to any childless adults, although eligibility at 100 percent of the FPL remains below the expansion level.[9] In the other non-expansion states, where Medicaid income eligibility limits for adults are below poverty, many adults earn too much to qualify for Medicaid, but not enough to qualify for tax subsidies to purchase Marketplace coverage, which are not available to those with incomes below 100 percent of the FPL. Other Kaiser Family Foundation analysis finds that nearly four million poor uninsured adults fall into a coverage gap as a result of these limited eligibility levels.[10] While this study reports FPL equivalents, it also is important to note that 17 non-expansion states base eligibility for parents on dollar thresholds. Most of these states do not routinely update these dollar-based standards, resulting in eligibility levels that erode over time relative to the cost of living.

Figure 4

Medicaid Income Eligibility Limits for Adults in States Not Adopting the Medicaid Expansion at this Time, January 2015



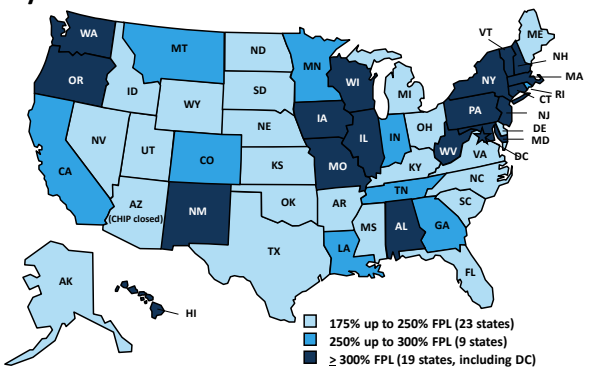
NOTE: Eligibility levels are based on 2014 federal poverty levels (FPLs) and are calculated based on a family of three for parents and an individual for childless adults. In 2014,the FPL was $19,790 for a family of three and $11,670 for an individual. Thresholds include the standard five percentage point of the federal poverty level (FPL) disregard.
SOURCE: Based on results from a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2015.

Children and Pregnant Women

Coverage for children in Medicaid and CHIP remains strong and steady with the median income eligibility limit at 255 percent of the FPL. As of January 1, 2015, 28 states cover children with family incomes at or above 250 percent of the FPL, with 19 extending coverage to 300 percent of the FPL or higher (Figure 5). Only two states (ID, ND) limit children's eligibility to below 200 percent of the FPL. Underlying these upper limits, eligibility levels reflect the ACA's new minimum Medicaid eligibility level of 138 percent of the FPL for children of all ages. This change resulted in the shift of older children (ages 6 up to 19) with incomes between 100 and 138 percent of the FPL from CHIP to Medicaid in 18 of the 36 states maintaining separate CHIP programs, while California, New Hampshire, and Vermont have transitioned all of the children from their separate CHIP programs to Medicaid. States still receive enhanced federal CHIP matching funds for children transferred from CHIP to Medicaid under this requirement. Enrollment remains open for children in all states with separate CHIP programs, except for Arizona, which froze enrollment in its separate CHIP program prior to the ACA. The ACA established protections that prohibit states from applying any restrictions in eligibility or enrollment for children through September 2019.

Figure 5

Income Eligibility Levels for Children in Medicaid/CHIP, January 2015

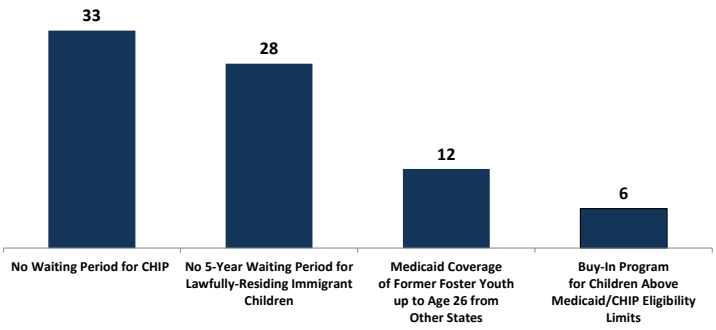


NOTE: Eligibility levels are based on 2014 federal poverty levels (FPLs) for a family of three. The FPL for a family of three in 2014 was $19,790. Thresholds include the standard five percentage point of the FPL disregard.
SOURCE: Based on results from a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2015.

States have continued to take up options that expand children's access to coverage. Consistent with the ACA's vision of a seamless continuum of coverage options, 21 states eliminated waiting periods in CHIP, including California which transitioned its separate CHIP program into Medicaid, and seven states reduced their waiting periods to 90 days or less, consistent with new federal rules. Illinois expanded CHIP coverage in 2013, with the expansion group between 209% and 317% FPL subject to a three-month waiting period. Reflecting this state action, as of January 1, 2015, 33 states do not have a waiting period that requires that a child be without group coverage for a specified period of time before enrolling in CHIP (Figure 6). In addition, more than half of all states (28) have taken up the option, established in 2009, to eliminate the five-year waiting period for lawfully-residing immigrant children, with Kentucky, Ohio and, West Virginia recently adopting the option. Additionally, seven states provide fully state- or locally-funded coverage to some children regardless of their immigration status. Under the ACA, all states must provide Medicaid coverage to former foster youth up to age 26 if they were in foster care in the state and enrolled in Medicaid on their 18th birthday. Nearly a quarter of states (12) have chosen to extend this coverage to former foster youth from other states. Six states have maintained programs that allow families with incomes over the upper limit for children's coverage to buy into Medicaid or CHIP for their children, although this number has declined from its peak of 15 in 2011, reflecting the fact that higher income families now have new coverage options through the Marketplaces.

Figure 6

Number of States Adopting Selected Options to Expand Children's Access to Medicaid and CHIP, January 2015

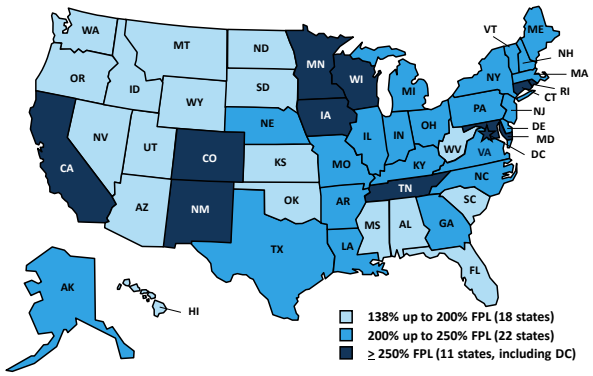


SOURCE: Based on results from a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2015.

Nearly two-thirds of states (33) cover pregnant women with incomes at or above 200 percent of the FPL (Figure 7). This count reflects the reinstatement of CHIP coverage for pregnant women with incomes up to 205 percent of the FPL in Virginia during 2014. Ohio, West Virginia, and Wyoming also recently took up the option to eliminate the five-year waiting period for lawfully residing immigrant pregnant women, increasing the total number of states that have adopted this option since it was established in 2009 to 23. Further, 15 states cover income-eligible pregnant women regardless of immigration status through CHIP's unborn child option, while four states provide fully state-funded coverage to some immigrant pregnant women.

Figure 7

Income Eligibility Levels for Pregnant Women in Medicaid/CHIP, January 2015

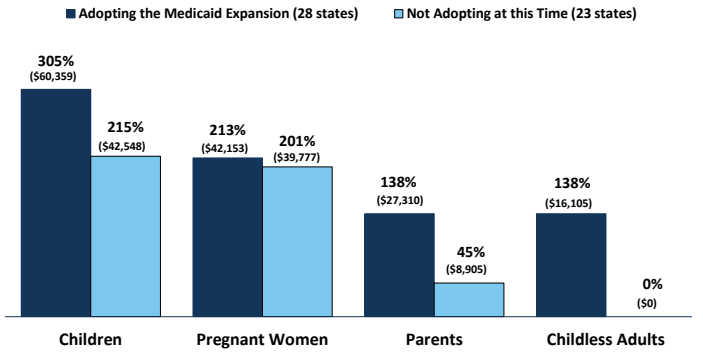


NOTE: Eligibility levels are based on 2014 federal poverty levels (FPLs) for a family of three. The FPL for a family of three in 2014 was $19,790. Thresholds include the standard five percentage point of the FPL disregard.
SOURCE: Based on results from a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2015.

Even with the Medicaid expansion, income eligibility levels for parents and other adults remain lower than those for children and pregnant women. The differences between parents and other adults and children and pregnant women are even starker among states that have not implemented the Medicaid expansion. In the non-expansion states, the median Medicaid income eligibility level is 45 percent of the FPL for parents and 0 percent of the FPL for other adults, compared to 138 percent of the FPL for parents and adults in expansion states and the significantly higher median Medicaid and CHIP eligibility levels for children and pregnant women in both expansion and non-expansion states (Figure 8).

Figure 8

Median Medicaid/CHIP Income Eligibility Thresholds, January 2015



NOTE: Eligibility levels are based on 2014 federal poverty levels (FPLs) for a family of three for children, pregnant women, and parents, and for an individual for childless adults. In 2014,the FPL was $19,790 for a family of three and $11,670 for an individual. Thresholds include the standard five percentage point of the federal poverty level (FPL) disregard.
SOURCE: Based on results from a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2015.

Enrollment and Renewal Processes

The ACA enacted sweeping changes to transform application, enrollment, and renewal processes in Medicaid and CHIP and coordinate with the new Marketplaces. Together these processes are intended to achieve the ACA's vision to provide "no wrong door" access to all health coverage options, minimize the paperwork burden on consumers and state agencies, and enhance the consumer experience. Specifically, under the ACA, states must provide multiple options for individuals to apply for health coverage, including online, by phone, by mail, and in person, using a single streamlined application for Medicaid, CHIP, and Marketplace coverage. In addition, states must seek to rely on electronic data to verify eligibility criteria and renew coverage based on electronic data matches. Adoption of these procedures represents major modernization in many states that previously had relied on antiquated, paper-based enrollment processes for Medicaid and CHIP. States have achieved significant progress adopting many of these processes, but work continues in many areas.

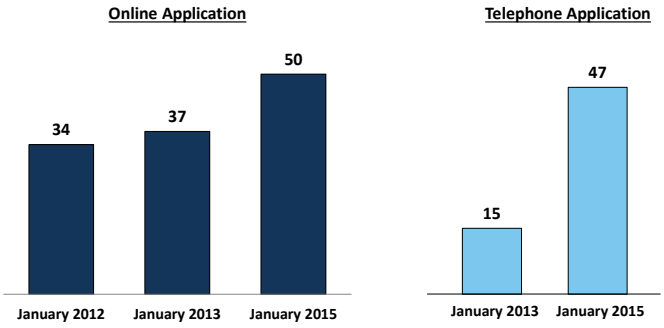
Applications

As of January 1, 2015, individuals can apply online for Medicaid at the state level in all states, except Tennessee. Most states with a State-based Marketplace (SBM) (12 of 17) provide a single integrated online application portal for Medicaid and Marketplace coverage. All states relying on the Federally-facilitated Marketplace (FFM) for Marketplace eligibility and enrollment functions maintain their own online Medicaid application separate from Healthcare.gov, as required, except Tennessee, where individuals can only apply online for Medicaid through Healthcare.gov. In about half of all states (25), an online multi-benefit application is available that allows individuals to apply simultaneously for Medicaid and other benefits, such as SNAP or Temporary Assistance for Needy Families (TANF). The availability of an online Medicaid application in nearly all states represents substantial progress from just several years ago; an online option was available in only two-thirds of states (34) as of January 2012 and 37 states as of January 2013 (Figure 9, next page).

The majority of states are accepting Medicaid applications by phone as of January 1, 2015. Medicaid applications can be submitted by telephone at the state level in most states (47) either through the Medicaid agency or the SBM call center, but work continues in the remaining states to support phone-based applications. The broad availability of a telephone application across states also represents marked progress among states in modernizing enrollment processes as only 15 provided this option as of January 2013.

Figure 9

Number of States with Online and Telephone Medicaid Applications

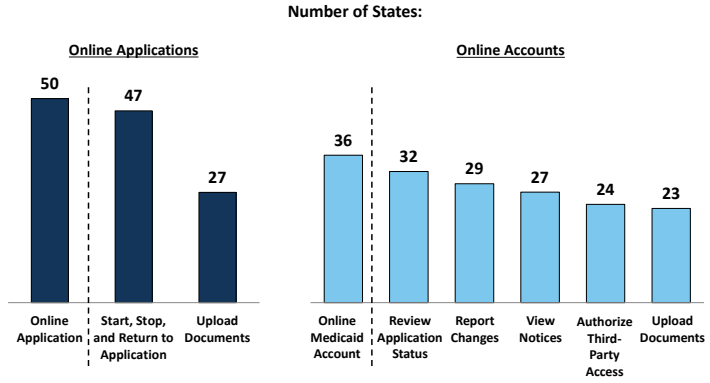


NOTE: Online applications refer to applications that can be submitted electronically, not those that may only be downloaded from websites.
SOURCE: Based on results from national surveys conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families in 2012, 2013, and 2015.

There is variation across states in the functions of online applications and the availability and features of online Medicaid accounts. In most states (47), applicants can start, stop, and return to the online application, and, in just over half of states (27), the online application provides applicants the ability to upload electronic copies of documentation if it is required (Figure 10). More than two-thirds of states (36) also provide individuals the opportunity to create an online account for ongoing management of their Medicaid coverage, which may include the ability to review the status of their application (32 states), report changes (29 states), view notices (27 states), authorize third-party access (24 states), and upload documentation (23 states). Many of these states plan to add capabilities over time and additional states plan to add online accounts in 2015 or beyond.

Figure 10

Selected Features of Online Medicaid Applications and Accounts, January 2015



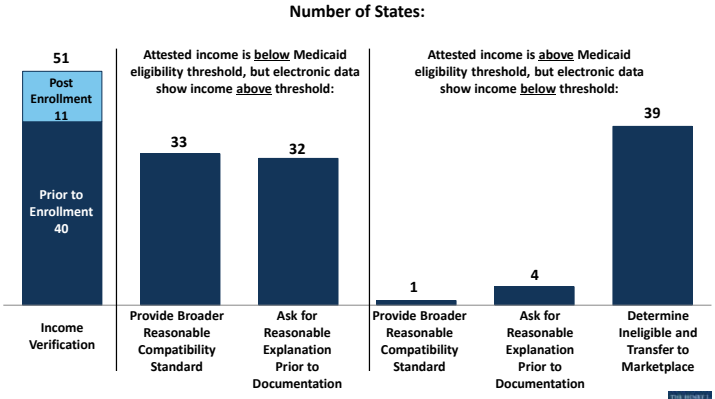
SOURCE: Based on results from a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2015.

Verification of Eligibility Criteria

All states are developing their capacities to tap electronic data sources to verify incomes of Medicaid and CHIP applicants, as required by the ACA. States must verify income using electronic data sources to the extent possible. Forty states confirm applicants' income prior to enrollment, while 11 states process eligibility based on an applicant's attestation and verify after enrollment (Figure 11). To facilitate electronic verification, a federal data hub was established that allows states to access information from multiple federal agencies, including the Internal Revenue Service, the Social Security Administration, and the

Figure 11

Income Verification Policies and Procedures in Medicaid, January 2015



SOURCE: Based on results from a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2015.

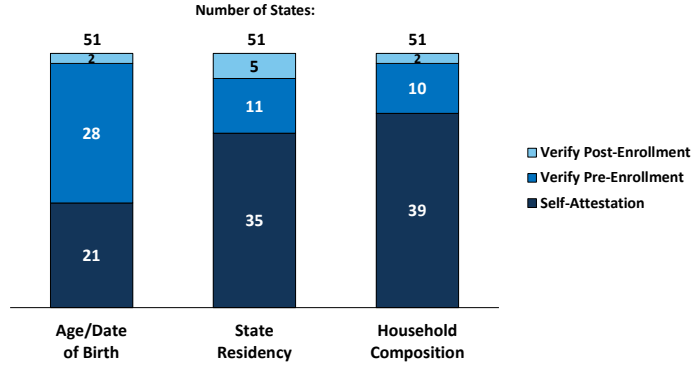
Department of Homeland Security. In addition, states can access other databases that collect state wage information, unemployment compensation, vital statistics, and eligibility for other public programs. Verifying eligibility elements is not only technically complicated, but also requires the establishment of data sharing agreements between agencies that protect the privacy and security of personally identifiable information. These challenges can slow state progress in accessing electronic data sources on a timely basis to verify eligibility. Looking ahead, states are continuing to enhance their data matching capabilities.

Over half of states have opted to set a broader "reasonable compatibility standard" than required to address cases in which there are differences between self-reported income and data from electronic sources. Federal rules require states to disregard differences between self-reported income and an electronic data source if the difference does not affect eligibility (i.e., both are at, above, or below the Medicaid or CHIP eligibility threshold). Thirty-three states have taken up an option to establish a broader reasonable compatibility standard for cases in which self-attested income is below but electronic data sources show income above the Medicaid or CHIP eligibility limit. If the difference is within this reasonable compatibility standard, which is most often 10 percent, the self-reported income is accepted. Regardless of whether they have set a broader reasonable compatibility standard, if data are not reasonably compatible, states may accept a reasonable explanation of the difference (e.g., the individual lost a job) before requiring paper documentation, which 32 states do. Only one state (New Jersey) provides a broader reasonable compatibility standard for cases in which self-reported income is above the Medicaid or CHIP income threshold and electronic data sources show income below the threshold. In these circumstances, most states (39) determine the individual ineligible for Medicaid or CHIP and transfer the account to the Marketplace for determination of eligibility for subsidies.

Many states minimize burdens for applicants and states by relying on self-attestation of non-financial eligibility criteria. As is the case with income, states must verify citizenship and immigration status for new applicants through electronic data sources. However, states have additional options to verify other non-financial eligibility criteria, including age/date of birth, state residency, and household composition. For these criteria, states can either verify pre- or post-enrollment or accept self-attestation. Many states accept self–attestation of age/date of birth (21), state residency (35), or household size (39), although verification is required if a state has any conflicting information on file (Figure 12). The remaining states confirm these eligibility criteria prior to enrollment or post enrollment, although most do not verify the information at renewal. Accepting self-attestation simplifies the enrollment process for states and applicants, and past experience shows that reducing paperwork burdens boosts enrollment and retention.[11] Historically, some states have been reluctant to minimize documentation requirements due to concerns about penalties associated with inaccurate eligibility determinations. However, moving forward, audits of state eligibility determinations will focus on validating that states' systems and processes are consistent with the verification plans they must submit to CMS that outline their policies for determining eligibility.

Figure 12

Non-Financial Verification Procedures Used by Medicaid Agencies at Application, January 2015



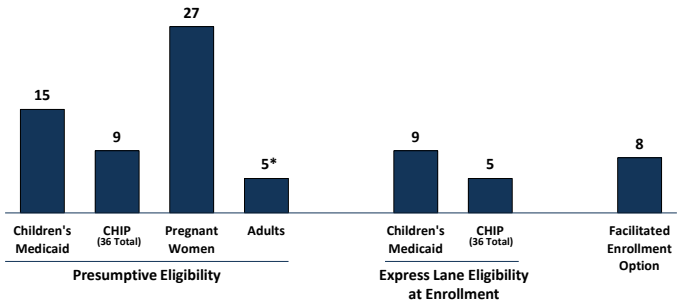
SOURCE: Based on results from a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2015.

Facilitated Enrollment Options

A range of additional streamlining options further facilitate enrollment of eligible individuals in some states. Under the longstanding presumptive eligibility option in Medicaid and CHIP, states can allow qualified entities to expedite access to coverage for children and pregnant women. The ACA allows states to expand this option to parents and other adults if the state offers it to children or pregnant women. States have taken mixed action with regard to providing presumptive eligibility. Since 2013, several states have eliminated presumptive eligibility for children (MA, MI and UT) or pregnant women (AR, DE, MA, MI, and OK), likely given that new data-driven enrollment processes are designed to enable faster eligibility determinations. Conversely, five states (ID, MT, NH, NJ and OH) have expanded presumptive eligibility to parents or other adults. Following this state action, as of January 2015, 15 states provide presumptive eligibility for children in Medicaid, 9 for children in CHIP, 27 for pregnant women, and 5 for adults (Figure 13). The ACA also establishes new authority for hospitals to conduct presumptive eligibility determinations, although states are in various stages of effecting this requirement. In addition, since 2009, states have had the option to utilize Express Lane Eligibility (ELE) to enroll children in Medicaid or CHIP based on eligibility findings from other programs, like SNAP. As of January 1, 2015, nine states use ELE to enroll children in Medicaid, while five use ELE to enroll CHIP-eligible children. In 2013, CMS offered states additional facilitated enrollment options, including using SNAP data to identify and enroll eligible individuals and using child enrollment data to expedite parent enrollment. To date, eight states have taken up one or both of these strategies, which analysis has shown contributed to success in enrolling newly eligible adults and children and reducing administrative costs.[12] These options remain available for other states to take up moving forward.

Figure 13

Number of States Adopting Targeted Strategies to Streamline Enrollment of Eligible Individuals, January 2015



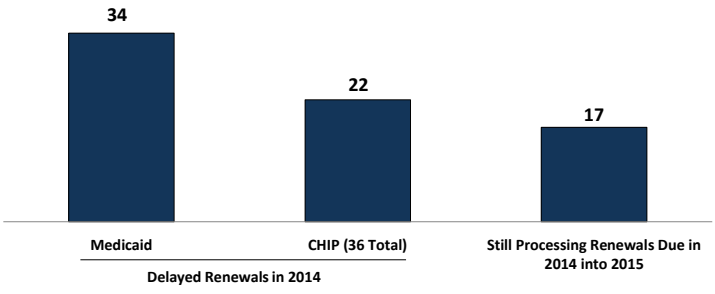
NOTE: *Idaho and Montana only offer presumptive eligibility to Section 1931 Medicaid parents; neither state has adopted the Medicaid expansion to adults. Facilitated Enrollment Option includes states using SNAP data to facilitate enrollment and/or using child data to facilitate enrollment of parents.
SOURCE: Based on results from a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2015.

Renewal

States are making progress adopting automated renewal processes, but transition work continues. Similar to enrollment processes, the ACA calls for new highly automated, paperless renewal processes for Medicaid and CHIP. When possible, states must use available data to renew coverage automatically (also called ex parte renewal). Many states are still implementing and transitioning to these new processes, given a range of challenges including developing system capacity to process automated renewals, transferring data for existing enrollees from old legacy systems to new systems, and creating notices for individuals. In the interim, a number of states are relying on mitigation

Figure 14

Number of States that Delayed Renewals in Medicaid and CHIP



SOURCE: Based on results from a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2015.

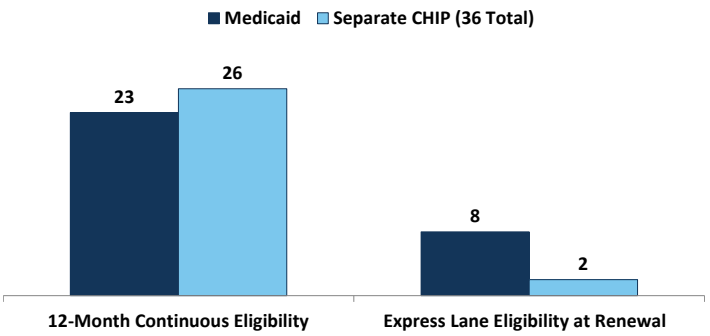
strategies such as mailing forms to individuals to request the information needed to complete renewal. To ease the transition to new renewal procedures, CMS offered states the opportunity to temporarily delay renewals, an option which 34 states took up for Medicaid and 22 states took up in CHIP during 2014 (Figure 14). About half have completed all of their delayed renewals, although 17 states have extended some of these renewals into 2015. Continued work to address the challenges of adopting new automated renewal processes will be important for preventing coverage losses and gaps and supporting more stable coverage over time.

In July 2014, CMS offered states additional flexible renewal strategies. CMS clarified that states can continue to conduct renewals based on available information without collecting the additional information necessary to coordinate with Marketplace coverage, which includes tax-filing status and access to employer coverage. However, states can only affirmatively renew coverage using this approach and cannot deny coverage without collecting all required information. Additionally, states can receive expedited waiver approval from CMS to renew coverage using information from SNAP, as well as to facilitate renewals for enrollees with no change in circumstances that affect eligibility.

Some states are utilizing other policy options to boost retention and support stable coverage over time. Under the ACA, all states must conduct renewals once every 12 months. States can further support stable coverage and reduce churn resulting from small fluctuations in income by opting to provide 12-month continuous eligibility, which allows individuals to remain enrolled for a full year regardless of changes in circumstances. As of January 1, 2015, 23 states provide 12-month continuous eligibility to children in Medicaid, and 26 have adopted it in their separate CHIP programs (Figure 15). States also can extend 12-month continuous eligibility to parents and other adults under Section 1115 waiver authority, which New York has done for parents to provide consistent procedures for all enrolled family members. Another option available to states to streamline renewal is ELE, which eight states use to renew children's Medicaid coverage and two states utilize for CHIP renewals. Massachusetts is also using ELE to renew parents in Medicaid under Section 1115 waiver authority.

Figure 15

Number of States Adopting Selected Strategies to Streamline Renewals for Children, January 2015



SOURCE: Based on results from a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2015.

Eligibility and Enrollment Systems

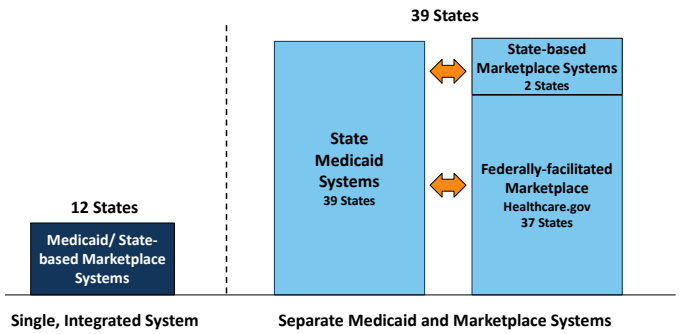
In order to implement the new modernized, data-driven enrollment and renewal processes outlined in the ACA, most states needed to make major improvements to or build new Medicaid and CHIP eligibility determination systems, often replacing decades-old legacy systems. Harnessing technology within Medicaid and CHIP can enhance the consumer experience and improve the reliability, timeliness and administrative efficiency of eligibility determinations and ongoing case management for enrollees. To support system upgrades and builds, the federal government provided 90 percent federal funding for system design and development. This increased funding was initially set to expire at the end of 2015, but, in October 2014, CMS announced plans to extend the higher federal match permanently.[13] The ongoing availability of enhanced funding will give states more time to phase in additional functionality and help systems stay current as

technology evolves in the future. States have made significant progress developing efficient, interconnected eligibility and enrollment systems, but ongoing efforts will be needed to refine and enhance systems to fulfill the vision of the ACA.

States have made varied choices with regard to the integration of their Medicaid and Marketplace eligibility determination systems, largely influenced by their Marketplace structure. All states must have a Medicaid eligibility determination system, but SBM states may operate a single, integrated system that makes eligibility determinations for both Medicaid and Marketplace coverage, which 12 states do. In the remaining 39 states, separate eligibility determination systems are used for Medicaid and Marketplace coverage. These include two SBM states that have separate state-level systems, three SBM states that are relying on the FFM for Marketplace eligibility and enrollment functions, and all 34 FFM and Partnership Marketplace states (Figure 16). Nearly all states with a separate CHIP program (34 of 36) have integrated CHIP into their Medicaid eligibility determination system.

Figure 16

Integration of Medicaid and Marketplace Eligibility Determination Systems, January 2015



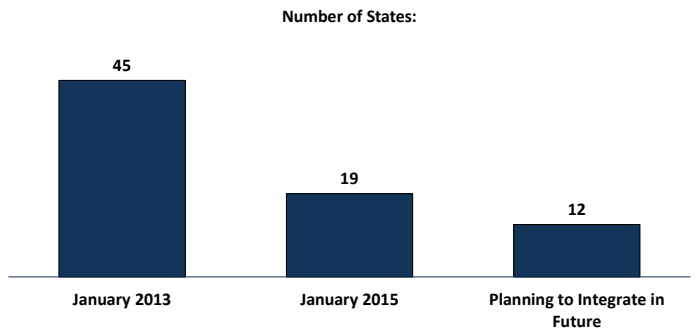
SOURCE: Based on results from a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2015.

When systems are not integrated, coordination between Medicaid and Marketplace systems is key to smooth enrollment. The SBM states with a single integrated Medicaid and Marketplace eligibility determination system do not need to transfer accounts between systems to coordinate eligibility determinations across coverage programs, although, in some cases, transfers of data and additional actions must occur after the eligibility determination to complete enrollment. However, in states with separate systems, including all 37 states relying on the FFM for eligibility and enrollment functions, electronic data, known as account transfers, must be exchanged between systems to provide a coordinated, seamless enrollment experience for individuals, as envisioned by the ACA. Ten of the FFM states have authorized the federal system to make final Medicaid eligibility determinations, which can speed the enrollment process. Alternatively, 27 states allow the FFM only to assess rather than determine Medicaid eligibility. These states must review accounts transferred from the FFM and potentially check other data sources or gather additional information from applicants prior to making a final Medicaid eligibility determination. There were technical difficulties with Medicaid and Marketplace coordination during 2014 that contributed to some delays in Medicaid enrollment. The federal government and states have sought to address these issues for 2015, but the extra steps needed to determine eligibility, along with the higher volume of applications generated during open enrollment, may still result in backlogs in some states.[14]

Many states delinked Medicaid eligibility determination systems from other benefit programs as they deployed new MAGI-based systems, but a number plan to reintegrate eligibility for other programs in the future. Prior to the ACA, the majority (45) of state Medicaid eligibility determination systems were integrated with other assistance programs, such as SNAP or TANF. As states implemented new ACA eligibility determination and enrollment processes for Medicaid and upgraded or built new eligibility systems, many delinked Medicaid from these other programs due to the large scale of the changes. As of January 1, 2015, 19 states maintain systems that administer eligibility for Medicaid and other benefit programs (Figure 17). However, this number will likely grow over time, as 12 states indicate that they plan to phase in other assistance programs in 2015 or beyond. These efforts are further supported by CMS' intent to extend the opportunity for non-health programs to pay only the add-on costs associated with integrating into newly enhanced Medicaid systems through 2018.[15]

Figure 17

Integration of MAGI-Based Medicaid Eligibility Determination Systems with Other Non-Health Programs



NOTE: Other non-health programs may include SNAP, TANF, childcare subsidy, or other benefit programs.
SOURCE: Based on results from a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2015.

Premiums and Cost- Sharing

Recognizing the limited family budgets of low-income individuals, federal rules set parameters in Medicaid and CHIP on the amount of premiums and cost-sharing, such as copayments, coinsurance, and deductibles, that states may charge (see Box 1). Consistent with federal rules, the findings presented below show that premiums and cost-sharing for selected services generally remain low in Medicaid and CHIP as of January 1, 2015. Even with flexibility to charge premiums and cost-sharing, many states limit charges in their programs to minimize barriers for enrollees in accessing care and reduce administrative burdens and complexities for state agencies.

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

States have flexibility to impose premiums and cost-sharing in Medicaid, with the maximum allowable amounts varying by income and group. Medicaid enrollees, including children, pregnant women, parents and the adult expansion group, with incomes below 150 percent of the FPL may not be charged premiums. Cost-sharing generally is not allowed for children with incomes below 133 percent of the FPL. Adults enrolled in Medicaid may be charged cost-sharing, but charges for those below 100 percent of the FPL are limited to nominal amounts. Medicaid enrollees (both children and adults) with incomes above 150 percent of the FPL can be charged premiums and relatively higher cost-sharing compared to those at lower incomes. Cost-sharing cannot be charged for preventive services for children or emergency, family planning, and pregnancy-related services in Medicaid. Overall premium and cost-sharing amounts for a family members enrolled in Medicaid may not exceed five percent of household income. States have somewhat greater flexibility to charge premiums and cost-sharing for children covered by CHIP, although there remain federal limits on the amounts that can be charged, including the overall five percent of household income cap.[16]

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

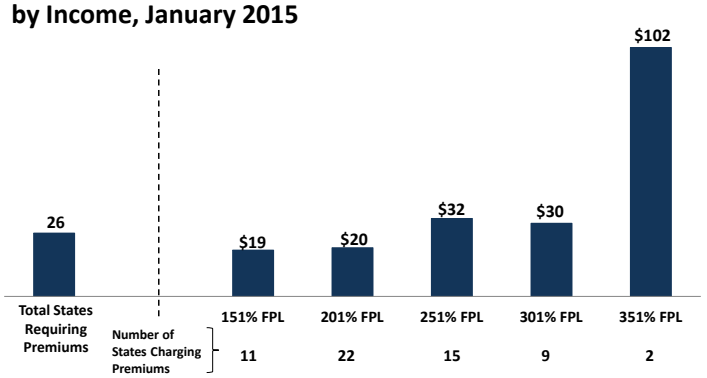
The ACA did not make direct changes to premium and cost-sharing rules for Medicaid and CHIP, but its adjustments to eligibility thresholds impacted how some states assess premiums and cost-sharing. Specifically, the ACA's establishment of a minimum threshold for children's Medicaid eligibility at 138 percent of the FPL effectively raised the income level at which premiums and cost-sharing start in some states. All children, regardless of age, with family incomes between 100 and 138 percent of the FPL now fall under Medicaid's premium and cost-sharing protections. As a result, the income threshold above which premiums begin for children increased to 138 percent of the FPL in seven states. Similarly, changes in eligibility thresholds resulted in an increase in the income level at which cost-sharing begins in 14 states that charge cost-sharing in CHIP but not Medicaid. Other states adjusted the income level at which cost-sharing begins to align with their MAGI-converted eligibility thresholds.[17]

PREMIUMS

Overall, 30 states charge premiums or enrollment fees for children in Medicaid or CHIP. This total includes three states (CA, MD and VT) that charge premiums for children in Medicaid with incomes above 150 percent of the FPL, 23 states that charge monthly or quarterly premiums in their CHIP programs, and four states that charge annual enrollment fees in CHIP. The greater prevalence of premiums and enrollment fees in CHIP reflects the relatively higher family incomes of children covered by the program as well as its more flexible premium rules. Among the 26 states charging monthly or quarterly premiums for children in Medicaid or CHIP, most (21) limit the charges to children in families with incomes at or above 150 percent of the FPL, including eight that only assess the charges at income levels at or above 200 percent of the FPL. Median premium amounts per child range from $19 at 151 percent of the FPL to $102 at 351 percent of the FPL, although only two states provide coverage at this income level (Figure 18). The ACA protects children's coverage through 2019, and, thus, premium increases are permitted only if specific methods for raising premiums were approved in the state Medicaid or CHIP plan as of March 23, 2010.

Figure 18

Median Monthly Premiums for Children in Medicaid/CHIP by Income, January 2015



NOTE: Premiums listed at 201%, 251%, 301%, and 351% include states whose upper income levels are 200%, 250%, 300%, and 351% FPL. NV and UT require quarterly premiums that have been calculated to be monthly equivalents. Data exclude four states charging annual enrollment fees (AL, CO, NC, and TX).
SOURCE: Based on results from a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2015.

There is variation across states in policies related to non-payment of premiums.[18] If states charge premiums in Medicaid, they must offer a 60-day grace period before coverage can be cancelled for nonpayment. While unpaid premiums may result in termination of Medicaid coverage, states cannot require enrollees to repay premiums as a condition for re-enrollment, nor can they prevent eligible individuals from re-enrolling immediately. In CHIP, states are required to offer a minimum grace period of 30 days. Grace periods vary across the 23 states charging monthly or quarterly premiums in CHIP, with seven states providing the minimum 30-day grace period and 17 states providing grace periods of 60 days or longer. Following cancellations of coverage for nonpayment of premiums, states may delay re-enrolling former enrollees in CHIP coverage, but the ACA limits such lock-out periods to no more than 90 days. As of January 1, 2015, 13 of 23 states that charge monthly or quarterly premiums in their separate CHIP programs have lock-out periods. This count reflects newly established lock-out periods in eight states (IN, KS, LA, MA, NV, UT, VT and WA) and the elimination of lock-out periods in four states (CT, IL, OR, and WV) since January 2013. Missouri,

Pennsylvania, and Wisconsin also reduced their lock out periods for non-payment of premiums from six months to 90 days. In 16 states, families who have been dis-enrolled due to non-payment of premiums must reapply to re-enroll in coverage. Eight states allow families to receive retroactive coverage if they pay outstanding premiums.

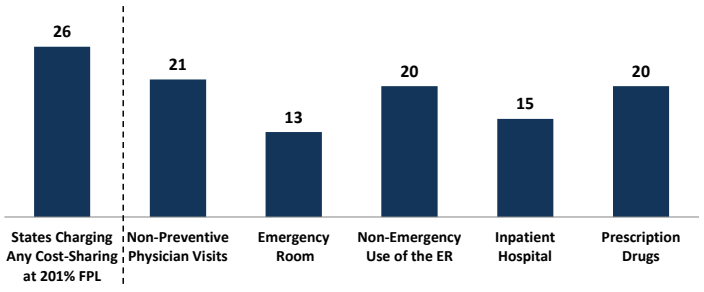
In general, states do not charge low-income parents and other adults premiums in Medicaid. This reflects the fact that eligibility for parents and other adults is generally limited to levels below which premiums can be charged. However, four states (AR, IA, MI, and PA) have received Section 1115 waiver approval to impose monthly payments that are not otherwise permitted under federal rules for some adults covered through their Medicaid expansions. As of January 1, 2015, these payments had been implemented in Iowa and Michigan. Although the specific policies vary across the four states, payment of these monthly contributions is not always a condition of enrollment, and, in some cases, individuals do not have to make the payments if they participate in certain activities or obtain an exemption.

Cost- Sharing

Overall 26 states charge cost-sharing for children in Medicaid or CHIP. Four states charge cost-sharing for children in Medicaid, while 24 of 36 states with separate CHIP programs charge cost-sharing, although cost-sharing requirements vary by income. Cost-sharing for children begins at or above 133 percent of the FPL in all of these states, except Tennessee, which assesses cost-sharing at lower income levels under Section 1115 waiver authority. Cost-sharing also varies by service type. For example, for a child with family income at 201 percent of the FPL, 21 states charge cost-sharing for a physician visit, 13 charge for an emergency room visit, 20 charge for non-emergency use of the emergency room, 15 charge for an inpatient hospital visit, and 20 have charges for prescription drugs, although, in some cases, charges only apply to brand name or non-preferred brand name drugs (Figure 19).

Figure 19

Number of States with Cost-Sharing for Selected Services for Children at 201% FPL, January 2015

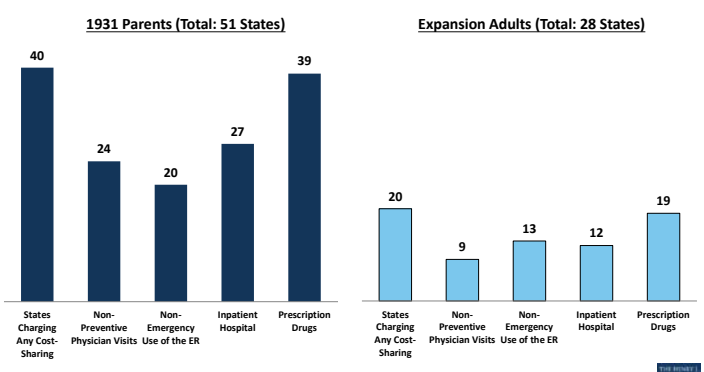


SOURCE: Based on results from a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2015.

Most states (40) charge cost-sharing for Section 1931 parents in Medicaid and 20 of the 28 states that have expanded Medicaid have cost-sharing for expansion adults (Figure 20). Reflecting the low incomes of parents and adults covered by Medicaid, this cost-sharing is generally limited to nominal amounts. For parents, 24 states charge cost-sharing for a physician visit, 20 charge for non-emergency use of the emergency room, 27 charge for an inpatient hospital visit, and 39 charge for prescription drugs, although, in some

Figure 20

Number of States with Cost-Sharing for Selected Services for Adults, January 2015



SOURCE: Based on results from a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, 2015.

cases, the charges only apply to brand name drugs. Among the 28 states with coverage for Medicaid expansion adults, 9 charge cost-sharing for a physician visit, 13 charge for non-emergency use of the emergency room, 12 charge for an inpatient hospital visit, and 19 charge for prescription drugs.

Looking Ahead

Taken together, these findings show that, one year into implementation, the ACA has accelerated meaningful transformation of the Medicaid program, broadening it as a base of coverage for the low-income population and leading to substantial modernization of its enrollment processes and systems. There have been significant increases in eligibility levels for low-income adults in states that expanded Medicaid, but eligibility levels remain low in states that have not expanded, resulting in gaps in coverage. Medicaid and CHIP coverage for children and pregnant women remains strong across states. On the operational and systems side, many states have achieved notable progress toward realizing the ACA's vision of a streamlined, technology-driven enrollment system, but work continues in many areas.

Looking ahead to 2015, state and federal officials will continue efforts to refine Medicaid and CHIP procedures and systems to move closer toward the ACA's vision of a real-time, data-driven eligibility and enrollment experience. Enhancing information technology systems, implementing streamlined renewal processes, and improving coordination between Medicaid and the Marketplaces will be among the top priorities going forward. At the same time, other changes in Medicaid and the broader health care system, such as delivery and payment system reforms, CHIP reauthorization, and continued action related to the ACA, including the Supreme Court's consideration of *King v. Burwell* regarding the provision of premium tax credits in FFM states, all have important implications for coverage. Following are key issues to consider looking ahead to 2015.

The Medicaid expansion to low-income adults will likely lead to continued gains in enrollment. Newly tracked Medicaid and CHIP eligibility and enrollment performance metric data released monthly by CMS show large gains in Medicaid enrollment across states since the initial open enrollment period for the Marketplaces began in October 2013.[19] The data show that Medicaid expansion states have experienced significantly greater enrollment gains than states that have not yet expanded. However, there have been gains across nearly all states, reflecting increased enrollment among both adults made newly eligible by the expansion as well as individuals who were previously eligible but not enrolled who were reached through outreach and enrollment efforts. Emerging data also suggest that these gains in Medicaid enrollment are leading to reductions in the number of uninsured. Although data from the large federal population-based surveys are not yet available to measure changes in uninsured rates, several recent private surveys have consistently shown corresponding reductions in the uninsured rate since implementation of the ACA, and one study found that the uninsured rate dropped by 4 percentage points in expansion states, compared to 1.4 percentage points in non-expansion states.[20] However, gaps in coverage remain in the 23 states that have not expanded Medicaid, leaving nearly four million poor adults without access to an affordable health coverage option. Moreover, continued progress in adopting streamlined renewal procedures will be important for preventing potential coverage losses or gaps over time.

Additional states may move forward with the Medicaid expansion. There is no deadline by which states must decide to implement the Medicaid expansion to low-income adults and debate continues in several states. However, the 100 percent federal financing for newly eligible individuals begins to phase down after 2016 to 90 percent by 2020. To date, a limited number of states have obtained or are seeking approval through

Section 1115 waivers to implement the expansion in ways that extend beyond the flexibility provided by the law. Looking ahead, more states may pursue alternative models through waivers to extend coverage with federal dollars. These waivers are intended to be research and demonstration projects, and, as such, it will be important to evaluate their impacts to provide greater insight into serving Medicaid's low-income beneficiaries. What happens with Medicaid waivers between 2014 and 2016 also will be important to inform the use of the new state innovation waiver authority available in 2017, which will allow states waive certain Marketplace provisions and may be combined with Medicaid waivers to implement state-specific health reform approaches.

As of 2015, states may also expand coverage through a new option established by the ACA, the Basic Health Program (BHP). In March 2014, CMS published final regulations that describe how states can provide coverage through a BHP for individuals who do not qualify for Medicaid or CHIP but have income under 200 percent of the FPL. This option allows states to finance a state-run program with 95 percent of the federal funding these enrollees would receive for premium tax credits and cost-sharing reductions. As noted, Minnesota became the first state to implement a BHP and converted existing Medicaid coverage for enrollees with incomes between 138 and 200 percent of the FPL to a BHP. In addition, New York has indicated plans to pursue a BHP.

States will continue work to advance enrollment and renewal processes and enhance their system functionality, supported by ongoing 90 percent federal funding for Medicaid eligibility and enrollment systems. High-performing eligibility and enrollment systems are central to moving toward a paperless process for determining eligibility for new applicants and keeping eligible enrollees covered at renewal. While challenges exist to achieving real-time, data-driven eligibility determinations, the shift from paper documentation to electronic sources will improve over time as states use the enhanced federal funds to harness technology and secure access to more data sources. Moreover, the funding will help support continued system enhancement to move states closer toward the automated, electronic data-driven renewal processes called for in the ACA, as states work to resolve challenges transitioning to new renewal processes and phase out mitigation strategies. Similarly, continued work will be important for ensuring smooth account transfers between Medicaid and Marketplaces to assure "no wrong door" access to coverage and prevent delays in enrollment. In addition, the three-year extension of flexibility to charge other public benefits programs only the added cost of consolidating eligibility determinations into the new Medicaid systems will support state efforts to phase-in integration of other programs.

Lastly, 2015 will be a pivotal year for children's health coverage as CHIP funding will not extend beyond September 2015 without congressional action. Together, CHIP and Medicaid have led the way to historically high levels of coverage for children. When CHIP was enacted, it spurred improvements in children's coverage, which have served as a catalyst for many of the innovations in streamlining eligibility and enrollment that were adopted by the ACA. The future of CHIP will have important implications for children's coverage. As debates over extended funding for CHIP advances, it will be important to consider barriers to coverage as well as differences in coverage between CHIP and the Marketplace to understand the implications of CHIP funding decisions.

The authors extend our sincere appreciation to the many state officials who generously shared their time and expertise with us to participate in this survey and help us to understand the nuances of their programs. This report would not be possible without them, and we greatly value their contributions during such a busy time. We also extend our thanks to Martha Heberlein, formerly with the Georgetown University Center for Children and Families, for her work on this report.

Endnotes

[1] Indiana, Oklahoma, and Utah provide more limited coverage to some childless adults under Section 1115 waiver authority.

[2] R. Garfield, *et al.*, "The Coverage Gap: Uninsured Poor Adults in State that Do Not Expand Medicaid – An Update," Kaiser Family Foundation, November 2014.

[3] J. Guyer, T. Schwartz, S. Artiga, "Fast Track to Coverage: Facilitating Enrollment of Eligible People into the Medicaid Expansion, Kaiser Commission on Medicaid and the Uninsured, November 2013.

[4] Smith, V., et al.., "Medicaid in an Era of Health and Delivery System Reform: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2014 and 2015," Kaiser Commission on Medicaid and the Uninsured, October 14, 2014, http://kff.org/report-section/medicaid-in-an-era-of-health-delivery-system-reform-eligibility-and-enrollment/

[5] The Medicaid and CHIP Payment and Access Commission, "Report to the Congress on Medicaid and CHIP," June 2014.

[6] As in past reports, information is not included for low income seniors or people with disabilities covered by Medicaid.

[7] The ACA established new standards for determining eligibility based on tax law in order to align coverage across the insurance affordability programs, including Medicaid, CHIP and subsidies in the health insurance marketplaces. MAGI rules establish specific guidelines for counting income and household size, although there are some exceptions in determining Medicaid eligibility only. States can no longer use asset tests in determining eligibility and were required to convert their pre-ACA eligibility levels accounting for the use of income disregards and deductions to the new MAGI standards, which were implemented on January 1, 2014. A standard five-percentage point disregard applies to the upper eligibility limits in determining MAGI-based eligibility. MAGI rules apply only to coverage for children, pregnant women, parents and the new expansion adult group, not to seniors or the disabled.

[8] The newly elected governor in Pennsylvania has indicated plans to move to the state option for expansion.

[9] Indiana, Oklahoma, and Utah provide more limited coverage to some childless adults under Section 1115 waiver authority.

[10] R. Garfield, *et al.*, "The Coverage Gap: Uninsured Poor Adults in State that Do Not Expand Medicaid – An Update," Kaiser Family Foundation, November 2014.

[11] J. Edwards, et al., "Reducing Paperwork to Improve Enrollment and Retention in Medicaid and CHIP," Medical Institute at United Hospital Fund, October 2009.

[12] J. Guyer, T. Schwartz, S. Artiga, "Fast Track to Coverage: Facilitating Enrollment of Eligible People into the Medicaid Expansion, Kaiser Commission on Medicaid and the Uninsured, November 2013.

[13] CMS announced its plan in a letter dated October 28, 2014 from Cindy Mann, Director of the Center for Medicaid and CHIP Services, to the American Public Human Services Association and the National Association of Medicaid Directors. http://ccf.georgetown.edu/wp-content/uploads/2014/10/Letter-to-APHSA-and-NAMD-from-Cindy-Mann-10-28-14-.pdf

[14] Smith, V., et al.., "Medicaid in an Era of Health and Delivery System Reform: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2014 and 2015," Kaiser Commission on Medicaid and the Uninsured, October 14, 2014, http://kff.org/report-section/medicaid-in-an-era-of-health-delivery-system-reform-eligibility-and-enrollment/

[15] Letter from Cindy Mann, October 28, 2014, op cit.

[16] CHIP rules also limit the amounts that may be charged to enrollees. For families earning less than 150 percent of FPL, premiums cannot exceed $19 per month depending on income and family size while co-payments and other cost-sharing limits are slightly higher than Medicaid. No limits apply to families with income above 150 percent of the FPL, except the total annual cost-sharing cap of five percent of income, which applies to all CHIP enrollees.

[17] An interim study published in November 2013 compares the pre-ACA eligibility levels with the MAGI-converted levels. For more information see, "Getting into Gear for 2014: Shifting New Medicaid Eligibility and Enrollment Policies into Drive."

[18] If states charge premiums in Medicaid, they must provide a 60-day grace period because cancelling coverage due to nonpayment of premiums. Additionally, they are prohibited from locking beneficiaries out of coverage or making them repay outstanding amounts in order to re-enroll. See 42 CFR 447.55**.**

[19] CMS posts state-by-state, monthly Medicaid and CHIP application and enrollment data, which can be found at http://medicaid.gov/medicaid-chip-program-information/program-information/medicaid-and-chip-enrollment-data/medicaid-and-chip-application-eligibility-determination-and-enrollment-data.html.

[20] L. Clemans-Cope, et al., "Increase in Medicaid under the ACA Reduces Uninsurance, According to Early Estimates," The Urban Institute, June 25, 2014.

Trend and State-by-State Tables

Table A
Expanding Eligibility and Simplifying Enrollment:
Trends in State Medicaid and CHIP Eligibility and Enrollment Policies[1]
July 1997 to January 2015

		July 1997	November 1998	July 2000	January 2002	April 2003	July 2004	July 2005	July 2006	January 2008	January 2009	December 2009	January 2011	January 2012	January 2013	January 2015
ELIGIBILITY																
Cover children ≥200% FPL[2]		6	22	36	40	39	39	41	41	45	44	47	47	47	47	48
Cover children ≥300% FPL[2]		2	4	5	6	6	6	6	8	9	10	16	16	17	17	19
Cover lawfully-residing immigrant children without five-year wait		Option Not Available										17	21	24	25	28
Cover pregnant women ≥200% FPL[2]		Not Collected				17	16	17	17	20	21	24	25	25	25	33
Cover lawfully-residing immigrant pregnant women without five-year wait		Option Not Available										14	17	18	20	23
Cover parents ≥100% FPL[2]		Not Collected			20	16	17	17	16	18	18	17	18	18	18	31
Cover childless adults		Not Collected											7	8	25	29
Enrollment freeze[3]	**Medicaid**	Not Collected			0	1	1	1	1	1	1	1	0	0	0	0
	CHIP				3	2	7	3	1	2	0	2	1	1	1	1
Asset test not required	**Medicaid**	36	40	42	45	45	46	47	47	47	47	48	48	48	48	51[4]
	CHIP		17	31	34	34	33	33	34	35	36	37	36	37	36	
	Parents	Not Collected			19	21	22	22	21	22	23	24	24	24	24	
STREAMLINED ENROLLMENT PROCESSES																
Joint Medicaid/CHIP application		N/A	Not Collected	28	33	34	34	34	33	33	35	36	36	36	36	Not Collected
Medicaid application can be submitted online	**Medicaid**	Not Collected											32	34	36	50[4]
Medicaid application can be submitted by telephone	**Medicaid**	Not Collected													17	47[4]
Presumptive eligiblity for children	**Medicaid**	Option Not Available	6	8	9	7	8	9	9	14	14	14	16	16	17	15
	CHIP		0	4	5	4	6	6	6	9	9	9	10	11	12	9
Presumptive eligibility for pregnant Women		Not Collected				29	29	30	31	30	30	30	31	31	32	27
No face-to-face interview at enrollment	**Medicaid**	22	33	40	47	46	45	45	46	46	48	48	49	49	49	51[4]
	CHIP		Not Collected	31	34	33	33	33	33	34	38	38	37	38	37	
	Parents				35	36	36	36	39	40	41	41	44	45	45	
STREAMLINED RENEWAL PROCESSES																
No face-to-face interview at renewal	**Medicaid**	Not Collected		43	48	49	48	48	48	48	49	50	50	50	50	51[4]
	CHIP			32	34	35	35	35	35	36	38	38	37	38	37	
	Parents	Not Collected			35	42	42	43	45	46	46	46	46	48	48	
12-month eligibility period	**Medicaid**	Not Collected		39	42	42	41	42	44	45	44	47	49	49	49	51[4]
	CHIP			23	33	33	32	34	34	37	39	39	38	28	38	
	Parents	Not Collected			38	38	36	36	39	40	40	43	45	46	46	
12-month continuous eligibility	**Medicaid**	Option Not Available	10	14	18	15	15	17	16	16	18	22	23	23	23	23
	CHIP		Not Collected	22	23	21	21	24	25	27	30	30	28	28	28	26

SOURCES: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Center on Budget and Policy Priorities, 1997-2009; and with the Georgetown University Center for Children and Families, 2011-2015.

1. The numbers in this table reflect the net change in actions taken by states from year to year. Specific strategies may be adopted and retracted by several states during a given year.

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

3. States are not allowed to impose enrollment limits or caps in their Medicaid programs, except under a waiver.

4. Required across all states under the Affordable Care Act (ACA). States are in varied stages of implementing the new streamlined enrollment and renewal processes under the ACA, and mitigation strategies are in place in cases in which requirements have not been met as of January 1, 2015. *See* S. Artiga, M. Musumeci, and R. Rudowitz, "Medicaid Eligibility, Enrollment Simplification, and Coordination Under the Affordable Care Act: A Summary of CMS's March 23, 2012 Final Rule," December 2012.

Table 1
Adult Income Eligibility Limits as a Percent of the Federal Poverty Level[1,2]
January 2015

State	Parents (in a family of three)		Childless Adults (for an individual)
	Section 1931 Limit	Upper Limit	
Alabama	18%	18%	0%
Alaska	146%	146%	0%
Arizona	106%	138%	138%
Arkansas	17%	138%	138%
California	109%	138%	138%
Colorado	68%	138%	138%
Connecticut	201%	201%	138%
Delaware	87%	138%	138%
District of Columbia	221%	221%	215%
Florida	34%	34%	0%
Georgia	38%	38%	0%
Hawaii	100%	138%	138%
Idaho	27%	27%	0%
Illinois	26%	138%	138%
Indiana[3]	24%	24%	0%
Iowa	53%	138%	138%
Kansas	38%	38%	0%
Kentucky	20%	138%	138%
Louisiana	24%	24%	0%
Maine	105%	105%	0%
Maryland	123%	138%	138%
Massachusetts[4]	138%	138%	138%
Michigan	54%	138%	138%
Minnesota[5]	138%	138%	138%
Mississippi	28%	28%	0%
Missouri	23%	23%	0%
Montana	51%	51%	0%
Nebraska	55%	55%	0%
Nevada	30%	138%	138%
New Hampshire	59%	138%	138%
New Jersey	31%	138%	138%
New Mexico	46%	138%	138%
New York	92%	138%	138%
North Carolina	45%	45%	0%
North Dakota	53%	138%	138%
Ohio	90%	138%	138%
Oklahoma[6]	46%	46%	0%
Oregon	37%	138%	138%
Pennsylvania	33%	138%	138%
Rhode Island	116%	138%	138%
South Carolina	67%	67%	0%
South Dakota	53%	53%	0%
Tennessee	103%	103%	0%
Texas	19%	19%	0%
Utah[7]	46%	46%	0%
Vermont[8]	46%	138%	138%
Virginia	45%	45%	0%
Washington	50%	138%	138%
West Virginia	19%	138%	138%
Wisconsin[9]	100%	100%	100%
Wyoming	58%	58%	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, 2015.

Table presents rules in effect as of January 1, 2015.

Table 1 Notes

1. Eligibility levels are based on 2014 federal poverty levels (FPLs). The FPL for a family of three in 2014 was $19,790. The FPL for an individual in 2014 was $11,670. January 2015 income limits reflect MAGI-converted income standards, and include a disregard equal to five percentage points of the FPL applied to the highest income limit for the group. In some states, eligibility limits for Section 1931 parents are based on a dollar threshold, and values listed represent the FPL equivalents calculated from these dollar limits.
2. This table reflects state decisions on the Medicaid expansion under the ACA. As of January 1, 2015, 27 states (AZ, AR, CA, CO, CT, DE, HI, IL, IA, KY, MA, MD, MI, MN, ND, NH, NJ, NM, NV, NY, OH, OR, PA, RI, VT, WA, and WV) and DC had adopted the Medicaid expansion. For more information, see Kaiser Family Foundation, "Status of State Action on the Medicaid Expansion Decision" available at: http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/. Arkansas, Iowa, Michigan, and Pennsylvania have approved Section 1115 waivers for their Medicaid expansions.
3. Indiana provides more limited coverage to parents and childless adults through its Healthy Indiana Plan Section 1115 waiver program. The program currently covers adults with incomes up to 100% FPL. The state has a pending waiver amendment with CMS to increase eligibility to adults with incomes up to 138% in 2015.
4. Massachusetts also provides subsidies to parents and childless adults with incomes above 133% FPL and up to 300% FPL to purchase Marketplace coverage through its ConnectorCare program. In addition, HIV positive individuals with incomes between 133% and 200% FPL, uninsured individuals with breast or cervical cancer with incomes between 133% and 250% FPL, and individuals who work for a small employer and purchase ESI are eligible for coverage or premium assistance through MassHealth (Medicaid).
5. Minnesota received approval to implement a Basic Health Program (BHP) established by the ACA in December 2014 and transferred coverage for Medicaid enrollees with incomes between 138 and 200% FPL to the BHP as of January 1, 2015.
6. In Oklahoma, individuals without a qualifying employer with incomes up to 100% FPL are eligible for more limited subsidized insurance though the Insure Oklahoma Section 1115 waiver program. Individuals working for certain qualified employers with incomes at or below 200% FPL are eligible for premium assistance for employer-sponsored insurance.
7. In Utah, adults with incomes up to 150% FPL are eligible for coverage of primary care services under the Primary Care Network Section 1115 waiver program; enrollment is closed. The state also provides premium assistance for employer-sponsored coverage to working adults with incomes up to 200% FPL under the Utah Premium Partnership (UPP) Health Insurance Section 1115 waiver program.
8. Vermont provides a 1.5% reduction in the federal applicable percentage of the share of premium costs for individuals who qualify for advance premium tax credits to purchase Marketplace coverage with incomes up to 300% FPL.
9. Wisconsin amended its Medicaid state plan and existing Section 1115 waiver to cover adults up to 100% FPL in Medicaid but did not adopt the ACA Medicaid expansion.

Table 2

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

January 2015

State	Upper Income Limit	Medicaid Coverage[2]						Separate CHIP Coverage Ages 0-18[3]
		Ages 0-1		Ages 1-5		Ages 6-18		
		Title XIX Medicaid Funding	Title XXI CHIP Funding	Title XIX Medicaid Funding	Title XXI CHIP Funding	Title XIX Medicaid Funding	Title XXI CHIP Funding	
Total								**36**
Alabama	317%	146%		146%		107%	146%	317%
Alaska[5]	208%	177%	208%	177%	208%	177%	208%	
Arizona[4]	200% (closed)	152%		146%		104%	138%	200% (closed)
Arkansas[5]	216%	142%	216%	142%	216%	107%	216%	
California[5,6]	266%	208%	266%	142%	266%	133%	266%	
Colorado	265%	147%		147%		108%	147%	265%
Connecticut[7]	323%	201%		201%		201%		323%
Delaware[5]	217%	194%	217%	147%		100%	138%	217%
District of Columbia[5,8]	324%	206%	324%	146%	324%	112%	324%	
Florida[5, 7, 9, 10]	215%	192%	211%	145%		112%	138%	215%
Georgia[11]	252%	210%		154%		113%	138%	252%
Hawaii[5]	313%	191%	313%	139%	313%	133%	313%	
Idaho[5]	190%	147%		147%		133%	155%	190%
Illinois[5, 12]	318%	147%		147%		108%	147%	318%
Indiana[5]	255%	213%		141%	163%	106%	163%	255%
Iowa[5, 9]	380%	240%	380%	172%		122%	172%	307%
Kansas[13]	247%	171%		154%		113%	138%	247%
Kentucky[5]	218%	200%		142%	164%	142%	164%	218%
Louisiana[5, 14]	255%	142%	217%	142%	217%	142%	217%	255%
Maine[5, 7, 15]	213%	196%		162%		162%		213%
Maryland[5]	322%	194%	322%	133%	322%	133%	322%	
Massachusetts[5]	305%	185%	205%	133%	155%	114%	155%	305%
Michigan	217%	200%		143%	165%	110%	165%	217%
Minnesota[5, 16]	288%	275%	288%	280%		280%		
Mississippi	214%	199%		148%		107%	138%	214%
Missouri[5]	305%	201%		153%		148%	155%	305%
Montana[5]	266%	148%		148%		148%		266%
Nebraska[5]	218%	162%	218%	145%	218%	133%	218%	
Nevada	205%	165%		165%		122%	138%	205%
New Hampshire[5]	323%	196%	323%	196%	323%	196%	323%	
New Jersey[5]	355%	199%		147%		107%	147%	355%
New Mexico[5]	305%	240%	305%	240%	305%	190%	245%	
New York[5, 7]	405%	223%		154%		110%	154%	405%
North Carolina[5,7]	216%	194%	215%	141%	215%	107%	138%	216%
North Dakota	175%	152%		152%		111%	138%	175%
Ohio[5]	211%	156%	211%	156%	211%	156%	211%	
Oklahoma[5]	210%	169%	210%	151%	210%	115%	210%	
Oregon[17]	305%	190%		138%		100%	138%	305%
Pennsylvania[7]	319%	220%		162%		119%	138%	319%
Rhode Island[5]	266%	190%	266%	142%	266%	109%	266%	
South Carolina[5]	213%	194%	213%	143%	213%	133%	213%	
South Dakota[5]	209%	147%	187%	140%	187%	111%	187%	209%
Tennessee[18]	255%	200%		147%		138%		255%
Texas	206%	203%		149%		109%	138%	206%
Utah	205%	144%		144%		105%	138%	205%
Vermont[5]	317%	237%	317%	237%	317%	237%	317%	
Virginia[5]	205%	148%		148%		109%	148%	205%
Washington	317%	215%		215%		215%		317%
West Virginia	305%	163%		146%		108%	138%	305%
Wisconsin[5, 9]	306%	306%		191%		133%	156%	306%
Wyoming	205%	159%		159%		119%	138%	205%

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2015.

Table presents rules in effect as of January 1, 2015.

Table 2 Notes

1. Eligibility levels are based on 2014 federal poverty levels (FPLs). The FPL for a family of three in 2014 was $19,790. January 2015 income limits reflect MAGI-converted income standards. The levels include a disregard equal to five percentage points of the FPL that is applied to the upper limit for Medicaid coverage for each age group and the upper limit for separate CHIP coverage.
2. Medicaid coverage eligibility levels show eligibility thresholds for children covered under Medicaid for whom the state receives regular Title XIX Medicaid match funds and for whom the state can receive enhanced Title XXI CHIP matching payments. Those children for whom the state can receive Title XXI CHIP funds include children covered under a CHIP-funded Medicaid expansion program and older children and teens with family incomes above 100% FPL who were moved from separate CHIP programs into Medicaid as a result of the new minimum Medicaid threshold for children of 138% FPL established by the ACA (sometimes referred to as stairstep children). Title XXI CHIP funds are limited to coverage for uninsured children. For the older children moved from separate CHIP programs to Medicaid as a result of the new ACA minimum (i.e., stairstep children), states must use Title XIX Medicaid funds to cover children who have insurance. States may choose to use Title XIX funds to cover children who have insurance up to higher incomes who are in the CHIP-funded Medicaid expansion income range (see Table Note 5). To be eligible in the infant category, a child has not yet reached his or her first birthday; to be eligible in the 1-5 category, the child is age one or older, but has not yet reached his or her sixth birthday; and to be eligible in the 6-18 category, the child is age six or older, but has not yet reached his or her 19th birthday.
3. The states noted use federal CHIP funds to operate separate child health insurance programs for children not eligible for Medicaid. Such programs may provide benefits similar to Medicaid or they may provide a somewhat more limited benefit package. They also may impose premiums or other cost-sharing obligations on some or all families with eligible children. These programs typically provide coverage until the child's 19th birthday.
4. Arizona instituted an enrollment freeze in its CHIP program, KidsCare, on December 21, 2009, prior to the ACA's maintenance of effort requirement. A temporary successor program, KidsCare II, was eliminated on January 31, 2014. Only a few thousand children remain enrolled in the original KidsCare program.
5. The states noted operate a CHIP-funded Medicaid expansion program (Title XXI). In AR, CA DE, FL, HI, KY, MD, NE, NH, NJ, NM, OH, OK, SD, and VT, coverage under the Medicaid expansion program is limited to uninsured children. In Massachusetts, the CHIP-funded Medicaid expansion is limited to children who are uninsured at the time of application.
6. In California, children with higher income may be eligible for CHIP coverage in certain counties. Infants born to mothers in California's Medi-Cal Access Program for Infants and Pregnant Women (formerly called 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 322% FPL.
7. Connecticut, Florida, Maine, New York, North Carolina, and Pennsylvania allow families with incomes above the levels shown to buy into Medicaid/CHIP. For details, see Table 3.
8. In the District of Columbia, children between ages 15-18 with incomes up to 63% FPL are covered with Title XIX Medicaid funds; other eligible children in this age group are covered with Title XXI CHIP funds.
9. In Florida, Iowa, and Wisconsin, there is no separate CHIP coverage for children younger than age one.
10. Florida operates three CHIP-funded separate programs. Healthy Kids covers children ages 5 through 19, as well as younger siblings in some locations; MediKids covers children ages 1 through 4; and the Children's Medical Service Network serves children with special health care needs from birth through age 18.
11. In Georgia, infants born to mothers on Medicaid are covered up to 225% FPL; whereas infants born to non-Medicaid mothers are covered up to 210% FPL.

12. In Illinois, infants born to non-Medicaid covered mothers are covered up to 147% FPL in Medicaid, and up to 318% FPL under CHIP. Infants born to mothers enrolled in Medicaid coverage are deemed eligible for Medicaid until age 1.
13. Kansas covers children in a separate CHIP program up to 250% of the 2008 FPL or approximately 247% of the 2014 FPL.
14. In Louisiana, uninsured children ages 6-18 with incomes between 108% and 142% FPL who are covered by Medicaid receive Title XXI CHIP funding. All other children with incomes under 142% FPL are covered with Title XIX Medicaid funds.
15. In Maine, children ages 0-1 not born to mothers covered under Medicaid are eligible up to 196% FPL.
16. In Minnesota, the infant category under Title XIX-funded Medicaid includes children up to age two with incomes up to 275% FPL. Under CHIP, eligibility for infants is up to 283% FPL.
17. Oregon covers children through 305% FPL.
18. 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% FPL or are medically eligible.

Table 3
Waiting Period for CHIP Enrollment
January 2015

State	Waiting Period[1]	Income-Related Groups Exempt from Waiting Period (Percent of the FPL)
Total No Waiting Period	**33**	
Alabama	None	
Alaska	None	
Arizona	None	
Arkansas[2]	90 days	
California	None	
Colorado	None	
Connecticut	None	
Delaware	None	
District of Columbia	None	
Florida	2 months	
Georgia	2 months	
Hawaii	None	
Idaho	None	
Illinois	90 days	Below 209%
Indiana	90 days	
Iowa	1 month	Below 200%
Kansas	90 days	Below 200%
Kentucky	None	
Louisiana	90 days	
Maine	90 days	
Maryland	None	
Massachusetts	None	
Michigan[3]	90 days	
Minnesota	None	
Mississippi	None	
Missouri	None	
Montana	None	
Nebraska	None	
Nevada	None	
New Hampshire	None	
New Jersey	90 days	Below 200%
New Mexico	None	
New York	90 days	Below 250%
North Carolina	None	
North Dakota	90 days	
Ohio	None	
Oklahoma	None	
Oregon	None	
Pennsylvania	None	
Rhode Island	None	
South Carolina	None	
South Dakota	90 days	
Tennessee	None	
Texas	90 days	
Utah	90 days	
Vermont	None	
Virginia	None	
Washington	None	
West Virginia	None	
Wisconsin[4]	90 days	Below 151%
Wyoming	1 month	

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2015.
Table presents rules in effect as of January 1, 2015.

Table 3 Notes

1. "Waiting period" refers to the length of time a child is required to be without group coverage prior to enrolling in CHIP coverage. Waiting periods generally apply to separate CHIP programs only, as they are not permitted in Medicaid without a waiver. The ACA limits waiting periods to no more than 90 days, and states must waive the waiting period for specific good cause waivers established in federal regulations. States may adopt additional exceptions to the waiting period, which vary by state. In addition to the income exemptions shown, specific categories of children such newborns may be exempt from the waiting periods.
2. In Arkansas, the waiting period only applies to those children covered under its Section 1115 waiver.
3. In Michigan, exceptions to the waiting period are provided on a case-by-case basis.
4. In Wisconsin, children are exempt from the waiting period at ages 6-18 under 151% FPL and at ages 1-5 under 186% FPL. All eligible infants are exempt. In Wisconsin, a child is not eligible for CHIP if they have access to health insurance coverage through a job where the employer covers at least 80% of the cost.

Table 4
Optional Medicaid and CHIP Coverage for Children
January 2015

State	Income Eligibility for Buy-In Program (Percent of the FPL)[1]	Coverage for Dependents of State Employees in CHIP[2]	Lawfully-Residing Immigrants Covered without 5-Year Wait (ICHIA Option)[3]	Medicaid Coverage of Former Foster Youth up to Age 26 Extends to Youth from Other States[4]
Total	**6**	**13**	**28**	**12**
Alabama		Y		
Alaska		N/A (M-CHIP)		
Arizona				
Arkansas		Y		
California[5]		N/A (M-CHIP)	Y	Y
Colorado[6]		Y		
Connecticut	>323% FPL	Y	Y	
Delaware			Y	
District of Columbia[7]		N/A (M-CHIP)	Y	
Florida[8]	>215% FPL	Y		
Georgia		Y		Y
Hawaii		N/A (M-CHIP)	Y	
Idaho				
Illinois			Y	
Indiana				
Iowa[7]			Y	
Kansas				
Kentucky		Y	Y	Y
Louisiana				Y
Maine[9]	>213% FPL		Y	
Maryland		N/A (M-CHIP)	Y	
Massachusetts[7,10]			Y	Y
Michigan				Y
Minnesota		N/A (M-CHIP)	Y	
Mississippi		Y		
Missouri				
Montana		Y	Y	Y
Nebraska		N/A (M-CHIP)	Y	
Nevada				
New Hampshire		N/A (M-CHIP)		
New Jersey			Y	
New Mexico		N/A (M-CHIP)	Y	
New York	>405% FPL		Y	Y
North Carolina[11]	211%-225% FPL	Y	Y	
North Dakota				
Ohio		N/A (M-CHIP)	Y	
Oklahoma		N/A (M-CHIP)		
Oregon			Y	
Pennsylvania[12]	>319% FPL	Y	Y	Y
Rhode Island		N/A (M-CHIP)	Y	
South Carolina		N/A (M-CHIP)		
South Dakota				Y
Tennessee				
Texas		Y	Y	
Utah				
Vermont		N/A (M-CHIP)	Y	
Virginia			Y	Y
Washington			Y	
West Virginia		Y	Y	
Wisconsin			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, 2015.
Table presents rules in effect as of January 1, 2015.

TABLE 4 NOTES

1. States with a buy-in program allow families with incomes over the upper limit for children's coverage to buy in to Medicaid or CHIP for their children. Income eligibility for the buy-in program is based on 2014 federal poverty levels (FPLs). January 2015 income limits reflect MAGI-converted income standards and include a disregard equal to five percentage points of the FPL.
2. This column indicates whether the state has adopted the option to cover otherwise eligible children of state employees in a separate CHIP program. Under the option, states may receive federal funding to extend CHIP eligibility where the state has maintained its contribution levels for health coverage for employees with dependent coverage or where it can demonstrate that the state employees' out-of-pocket health care costs pose a financial hardship for families. Arkansas covers these children under its ARKids B waiver. Mississippi and North Carolina cover dependents of state employees and are exempt from limitations on such coverage because there is no employer contribution for dependent coverage.
3. This column indicates whether the state has received approval through a State Plan Amendment and implemented coverage for immigrant children who have been lawfully residing in the U.S. for less than five years, otherwise known as the Immigrant Children's Health Improvement Act (ICHIA) option.
4. Under the ACA, all states must provide Medicaid coverage to youth up to age 26 who were in foster care as of their 18th birthday and enrolled in Medicaid. This column indicates whether the state has elected the option to also provide Medicaid coverage to former foster youth up to age 26 who were enrolled in Medicaid in another state as of their 18th birthday.
5. In California, some local programs cover immigrant children regardless of immigration status.
6. Colorado passed legislation authorizing coverage of lawfully residing immigrant children in 2012, but has not implemented the expansion as of January 1, 2015.
7. The District of Columbia, Iowa, Illinois, Massachusetts, New York, and Washington cover some children, regardless of immigration status using state-only funds.
8. In Florida, families can buy in to Healthy Kids coverage for children ages 5 to 19 and to MediKids coverage for children ages 1 to 4.
9. In Maine, the buy-in program, called the Full Cost Purchase Option, is limited to those who had been previously enrolled in Medicaid or CHIP. A child can participate for up to 18 months.
10. Massachusetts offers more limited state-subsidized coverage to children at any income through its Children's Medical Security Plan.
11. In North Carolina, eligibility for the buy-in program is limited to those who had been previously enrolled in CHIP. A child can participate for up to 12 months.
12. In Pennsylvania, CHIP coverage for dependents of state employees is limited to part-time and seasonal employees who meet a hardship exemption.

Table 5
Medicaid and CHIP Coverage for Pregnant Women
January 2015

State	Income Eligibility Limits[1] (Percent of the FPL)			Lawfully-Residing Immigrants Covered without 5-Year Wait (ICHIA Option)[3]	Full Medicaid/CHIP Benefit Package Offered to All Pregnant Beneficiaries[4]	
	Medicaid (Title XIX)	CHIP (Title XXI)	Unborn Child Option[2] (Title XXI)		Medicaid	CHIP
Total	**51**	**5**	**15**	**23**	**37**	**5**
Alabama	146%					N/A
Alaska	205%					N/A
Arizona	161%				Y	N/A
Arkansas[5]	214%		214%			
California	213%		322%	Y		N/A
Colorado[6]	200%	265%		Y	Y	Y
Connecticut	263%			Y	Y	N/A
Delaware	217%			Y	Y	N/A
District of Columbia[7]	211%	324%		Y	Y	Y
Florida	196%					N/A
Georgia	225%				Y	N/A
Hawaii	196%			Y	Y	N/A
Idaho	138%					N/A
Illinois	213%		213%		Y	Y
Indiana	213%				Y	N/A
Iowa	380%				Y	N/A
Kansas	171%				Y	
Kentucky[8]	200%					N/A
Louisiana	138%		214%			
Maine	214%			Y		N/A
Maryland	264%			Y	Y	N/A
Massachusetts	205%		205%	Y	Y	N/A
Michigan	200%		200%		Y	N/A
Minnesota	283%		283%	Y	Y	N/A
Mississippi	199%				Y	N/A
Missouri	201%				Y	N/A
Montana	162%				Y	N/A
Nebraska	199%		202%	Y	Y	N/A
Nevada	165%				Y	N/A
New Hampshire	201%				Y	N/A
New Jersey	199%	205%		Y	Y	Y
New Mexico[9]	255%			Y		N/A
New York[10]	223%			Y		
North Carolina	201%			Y	Y	N/A
North Dakota	152%				Y	N/A
Ohio	205%			Y	Y	N/A
Oklahoma	138%		190%		Y	
Oregon	190%		190%		Y	N/A
Pennsylvania	220%			Y	Y	N/A
Rhode Island	195%	258%	258%			
South Carolina	199%				Y	N/A
South Dakota	138%					
Tennessee	200%		255%		Y	N/A
Texas	203%		207%		Y	
Utah	144%				Y	N/A
Vermont	213%			Y	Y	N/A
Virginia	148%	205%		Y	Y	Y
Washington	198%		198%	Y	Y	
West Virginia	163%			Y	Y	N/A
Wisconsin	306%		306%	Y	Y	N/A
Wyoming	159%			Y		N/A

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2015.
Table presents rules in effect as of January 1, 2015.

Table 5 Notes

1. Eligibility levels are based on 2014 federal poverty levels (FPLs). The federal poverty level (FPL) for a family of three in 2014 was $19,790. January 2015 income limits reflect MAGI converted income standards, and include a disregard equal to five percentage points of the FPL.
2. The unborn child option permits states to consider the fetus a "targeted low-income child" for purposes of CHIP coverage.
3. This column indicates whether the state received approval through a State Plan Amendment to adopt and implemented the option to cover immigrant pregnant women who have been lawfully residing in the U.S. for less than five years, otherwise known as the ICHIA option.
4. These columns indicate whether all pregnant beneficiaries in the state receive the full Medicaid or CHIP benefit package. N/A responses indicate that the state does not provide CHIP coverage to pregnant women.
5. Arkansas provides the full Medicaid benefits package to pregnant women with incomes up to levels established for the old AFDC program, which are $124 per month. Above those levels, more limited pregnancy-related benefits are provided to pregnant women covered under Medicaid and the unborn child option in CHIP with incomes up to 209% FPL.
6. In Colorado, recent lawfully-residing immigrant pregnant women are covered in Medicaid only. CHIP coverage for recent lawfully-residing immigrant pregnant women has been approved but was not implemented as of January 1, 2015.
7. The District of Columbia, Massachusetts, New Jersey, and New York cover some eligible pregnant women regardless of immigration status using state-only funds.
8. In Kentucky, pregnant women receive a more limited pregnancy-related benefits package during a period of presumptive eligibility.
9. New Mexico provides a more-limited pregnancy-related benefits package to most pregnant women enrolled in Medicaid, but some managed care plans cover a broader set of services.
10. New York uses state funds to cover income eligible pregnant women regardless of immigration status while labor and delivery costs are covered under emergency Medicaid.

Table 6
Online and Telephone Medicaid Applications
January 2015

State	Medicaid Applications Can be Submitted Online at the State Level[1]	Online Application for Medicaid Allows Individuals to:		Combined Online Multi-Benefit Application for Medicaid and Non-Health Programs[2]	Medicaid Applications Can be Submitted by Telephone at the State Level[3]
		Start, Stop, and Return to an Application	Upload Documentation		
Total	**50**	**47**	**27**	**25**	**47**
Alabama	Y	Y			Y
Alaska	Y	Y			Y
Arizona	Y	Y	Y	Y	Y
Arkansas	Y	Y			
California	Y	Y	Y	Y	Y
Colorado	Y	Y	Y	Y	Y
Connecticut[4]	Y	Y	Y		Y
Delaware[5]	Y	Y		Y	Y
District of Columbia	Y	Y	Y		Y
Florida	Y	Y	Y	Y	
Georgia	Y	Y		Y	Y
Hawaii	Y	Y			Y
Idaho	Y	Y			Y
Illinois	Y	Y	Y	Y	Y
Indiana[6]	Y	Y			Y
Iowa	Y	Y			Y
Kansas	Y	Y			Y
Kentucky	Y	Y	Y	Y	Y
Louisiana	Y	Y			Y
Maine	Y	Y		Y	Y
Maryland[7]	Y	Y	Y	Y	Y
Massachusetts	Y	Y			Y
Michigan	Y	Y	Y	Y	Y
Minnesota	Y	Y			
Mississippi	Y		Y		Y
Missouri	Y	Y			Y
Montana	Y	Y	Y	Y	Y
Nebraska	Y	Y	Y		Y
Nevada	Y	Y	Y	Y	Y
New Hampshire	Y	Y	Y	Y	Y
New Jersey	Y				Y
New Mexico	Y	Y	Y	Y	Y
New York	Y	Y	Y		Y
North Carolina	Y	Y		Y	Y
North Dakota	Y	Y	Y	Y	Y
Ohio	Y	Y	Y		Y
Oklahoma	Y	Y			Y
Oregon	Y				Y
Pennsylvania	Y	Y	Y	Y	Y
Rhode Island	Y	Y	Y	Y	Y
South Carolina	Y	Y			Y
South Dakota	Y	Y	Y	Y	Y
Tennessee					
Texas[8]	Y	Y	Y	Y	Y
Utah	Y	Y		Y	Y
Vermont	Y	Y			Y
Virginia	Y	Y	Y	Y	Y
Washington	Y	Y	Y		Y
West Virginia	Y	Y		Y	Y
Wisconsin	Y	Y	Y	Y	Y
Wyoming	Y	Y	Y		Y

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2015.
Table presents rules in effect as of January 1, 2015.

TABLE 6 NOTES

1. This column indicates whether individuals can complete and submit an online application for Medicaid through a state-level portal. For State-based Marketplace (SBM) states, such a portal may be either exclusive to Medicaid or integrated with the Marketplace. For Federally-facilitated Marketplace (FFM) and Partnership-Marketplace states, state Medicaid agency portals are indicated.
2. In these states a combined online multi-benefit application is available that allows applicants to apply for multiple assistance programs, such as SNAP (food stamps) or cash assistance, along with health coverage, using a single application.
3. This column indicates whether individuals can complete MAGI-based Medicaid applications over the telephone at the state level, either through the Medicaid agency or the State-based Marketplace.
4. In Connecticut, individuals can apply online for Medicaid and other benefits at the same time using two separate applications, but there is not a single integrated multi-benefit online application.
5. In Delaware, families can call an eligibility worker to complete a Medicaid application; the application is then mailed to the applicant for signature.
6. Indiana only allows individuals to start, stop, and return to an application within 30 days of starting the application.
7. In Maryland, a separate online application (SAIL) remains available at the Medicaid agency, but consumers are primarily directed to the integrated Medicaid/Marketplace application. Individuals may still apply online for Medicaid and other benefits through the Medicaid agency application (SAIL). However, the integrated Medicaid/Marketplace application is limited to health programs.
8. In Texas, the multi-benefit application is only available for parents applying for Section 1931 Medicaid.

Table 7
Online Account Capabilities for Medicaid
January 2015

State	Individual Can Create an Online Account for Medicaid[1]	Online Account Allows Individuals to:				
		Review Application Status	Report Changes	View Notices	Upload Documentation	Authorize Third-Party Access
Total	**36**	**32**	**29**	**27**	**23**	**24**
Alabama	Y	Y	Y			Y
Alaska						
Arizona	Y	Y	Y	Y	Y	Y
Arkansas						
California	Y	Y	Y	Y	Y	Y
Colorado	Y	Y	Y	Y	Y	Y
Connecticut	Y	Y	Y	Y	Y	Y
Delaware[2]	Y	Y	Y	Y		
District of Columbia	Y	Y	Y	Y	Y	Y
Florida	Y	Y	Y	Y	Y	
Georgia	Y	Y	Y	Y		Y
Hawaii	Y					
Idaho	Y	Y				Y
Illinois						
Indiana[3]						
Iowa						
Kansas						
Kentucky	Y	Y	Y	Y	Y	Y
Louisiana	Y					
Maine	Y	Y	Y	Y		
Maryland	Y	Y	Y	Y	Y	Y
Massachusetts	Y	Y		Y		
Michigan	Y	Y	Y	Y	Y	Y
Minnesota						
Mississippi						
Missouri	Y		Y			
Montana	Y	Y	Y	Y	Y	Y
Nebraska	Y	Y	Y	Y	Y	Y
Nevada						
New Hampshire	Y	Y	Y	Y	Y	Y
New Jersey						
New Mexico	Y	Y	Y		Y	
New York	Y	Y	Y	Y	Y	Y
North Carolina						
North Dakota						
Ohio	Y	Y	Y	Y	Y	Y
Oklahoma	Y	Y	Y	Y	Y	Y
Oregon	Y	Y	Y	Y	Y	Y
Pennsylvania	Y	Y	Y	Y	Y	
Rhode Island	Y	Y	Y	Y	Y	Y
South Carolina						
South Dakota						
Tennessee						
Texas	Y	Y	Y		Y	Y
Utah	Y	Y	Y	Y		Y
Vermont	Y	Y		Y		Y
Virginia	Y	Y	Y		Y	Y
Washington[4]	Y	Y		Y		
West Virginia	Y	Y		Y		
Wisconsin	Y	Y	Y		Y	
Wyoming	Y		Y	Y	Y	Y

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2015.

Table presents rules in effect as of January 1, 2015.

Table 7 Notes

1. This column indicates whether individuals can create an online account for ongoing management of their MAGI-based Medicaid case at the state level, either through the Medicaid agency or a case management system that is integrated with the SBM.
2. In Delaware, the ability to review application status is limited to applications filed online through a self-service portal.
3. Medicaid enrollees in Indiana can view some of their information online, but not in a separate portal. Enrollees can review application status, report changes, and authorize third-party access to their information, but not through an account.
4. In Washington, applicants for Medicaid have an option to establish an online account within the SBM. An account within the SBM provides the individual with access to saved application information, a description of their coverage, a history of eligibility, and a history of correspondence.

Table 8
Income Verification Procedures Used by Medicaid Agencies at Application[1]
January 2015

State	Pre-Enrollment Verification	Post-Enrollment Verification	Reasonable Compatibility Approach[2]						
			If attestation is below and data are above the income standard			If attestation is above and data are below the income standard			
			Reasonable Compatibility Standard	*If not reasonably compatible:*		Reasonable Compatibility Standard	*If not reasonably compatible:*		
				Ask for a Reasonable Explanation	Paper Documentation Required		Ask for a Reasonable Explanation	Paper Documentation Required	Transfer to Marketplace
Total	**40**	**11**	**33**	**32**	**19**	**1**	**4**	**8**	**39**
Alabama	Y		10%	Y		None			Y
Alaska	Y		10%	Y		None			Y
Arizona	Y		None		Y	None			Y
Arkansas	Y		10%		Y	None			Y
California	Y		None		Y	None		Y	
Colorado		Y	10%	Y		None			Y
Connecticut		Y	10%	Y		None			Y
Delaware		Y	10%	Y		None			Y
District of Columbia	Y		10%		Y	None		Y	
Florida	Y		10%	Y		None			Y
Georgia	Y		None		Y	None			Y
Hawaii		Y	10%	Y		None			Y
Idaho	Y		None	Y		None			Y
Illinois	Y		5%	Y		None			Y
Indiana	Y		None		Y	None			Y
Iowa	Y		10%	Y		None			Y
Kansas	Y		20%	Y		None			Y
Kentucky	Y		10%	Y		None			Y
Louisiana	Y		25%	Y		None			Y
Maine	Y		None	Y		None			Y
Maryland	Y		10%	Y		None			Y
Massachusetts		Y	10%		Y	None			Y
Michigan	Y		10%	Y		None			Y
Minnesota	Y		10%	Y		None			Y
Mississippi	Y		$50	Y		None	Y		
Missouri	Y		10%	Y		None	Y		
Montana		Y	10%	Y		None			Y
Nebraska	Y		10%		Y	None			Y
Nevada	Y		None	Y		None			Y
New Hampshire		Y	10%	Y		None			Y
New Jersey	Y		10%	Y		10%			Y
New Mexico	Y		None		Y	None		Y	
New York	Y		10%		Y	None			Y
North Carolina	Y		None	Y		None	Y		
North Dakota	Y		None	Y		None	Y		
Ohio	Y		5%		Y	None			Y
Oklahoma		Y	5%		Y	None			Y
Oregon		Y	None		Y	None			Y
Pennsylvania	Y		5%	Y		None		Y	
Rhode Island	Y		10%	Y		None			Y
South Carolina	Y		10%	Y		None			Y
South Dakota	Y		None	Y		None			Y
Tennessee	Y		10%		Y	None			Y
Texas	Y		None		Y	None		Y	
Utah[3]	Y		None		Y	None		Y	
Vermont		Y	None		Y	None		Y	
Virginia	Y		10%	Y		None			Y
Washington		Y	None	Y		None			Y
West Virginia	Y		10%	Y		None			Y
Wisconsin	Y		None		Y	None			Y
Wyoming	Y		None		Y	None		Y	

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2015.

Table presents rules in effect as of January 1, 2015.

TABLE 8 NOTES

1. States are expected to verify income through an electronic source; they can verify information prior to enrollment or enroll based on an individual's self-attestation and conduct a post-enrollment verification. Only in cases where there is no electronic data source for a type of income are states able to accept self-attestation of income without verification.
2. If the information obtained from electronic data sources and the information provided by or on behalf of the individual are both above, at, or below the applicable income standard, the state must determine the applicant eligible or ineligible for Medicaid/CHIP. In these cases, any difference does not impact eligibility. If the data are not consistent, states have the option to apply a reasonable compatibility standard by establishing a threshold (e.g., a percentage or dollar figure) in which they will still consider the data to be reasonably compatible. States have the option to set different standards based on whether the applicant's attestation is above or below the eligibility threshold. In both cases, if the difference between the attested income and the electronic data source are within the reasonably compatible standard, the state will process eligibility based on the individual's attestation. If the applicant reports income below the standard and the electronic source indicates income above the standard, and the difference is not reasonably compatible, the state may accept a reasonable explanation and/or request paper documentation. If the applicant reports income above the Medicaid or CHIP limit but the electronic source reflects income below, and the data are not reasonably compatible, the state may accept a reasonable explanation, request paper documentation, or determine the individual ineligible and transfer the application to the Marketplace.
3. In Utah, if an individual reports income above the Medicaid cutoff but a reliable data source qualifies the individual, Utah will approve the application.

Table 9
Non-Financial Eligibility Criteria Verification Procedures Used by Medicaid Agencies[1]
January 2015

State	Age/Date of Birth[2]			State Residency[2]				Household Composition[2]			
				At Application				At Application			
	Self-Attestation	Pre-Enrollment Verification	Post-Enrollment Verification	Self-Attestation	Pre-Enrollment Verification	Post-Enrollment Verification	Verify at Renewal	Self-Attestation	Pre-Enrollment Verification	Post-Enrollment Verification	Verify at Renewal
Total	**21**	**28**	**2**	**35**	**11**	**5**	**10**	**39**	**10**	**2**	**5**
Alabama		Y			Y			Y			
Alaska	Y			Y				Y			
Arizona		Y			Y			Y			
Arkansas		Y		Y				Y			
California		Y				Y		Y			
Colorado	Y			Y				Y			
Connecticut	Y			Y				Y			
Delaware	Y			Y				Y			
District of Columbia	Y			Y				Y			
Florida	Y			Y				Y			
Georgia	Y			Y				Y			
Hawaii	Y			Y				Y			
Idaho	Y				Y				Y		
Illinois		Y			Y		Y	Y			
Indiana		Y			Y		Y		Y		Y
Iowa		Y		Y			Y		Y		Y
Kansas	Y			Y				Y			
Kentucky		Y			Y				Y		
Louisiana	Y			Y				Y			
Maine	Y			Y				Y			
Maryland		Y		Y				Y			
Massachusetts	Y					Y	Y	Y			
Michigan		Y			Y				Y		
Minnesota		Y		Y				Y			
Mississippi		Y		Y				Y			
Missouri	Y			Y				Y			
Montana	Y				Y		Y		Y		Y
Nebraska		Y		Y				Y			
Nevada		Y		Y				Y			
New Hampshire			Y	Y				Y			
New Jersey		Y		Y				Y			
New Mexico	Y				Y				Y		
New York	Y			Y				Y			
North Carolina		Y			Y			Y			
North Dakota		Y		Y				Y			
Ohio		Y			Y				Y		
Oklahoma		Y		Y				Y			
Oregon			Y	Y				Y			
Pennsylvania		Y		Y				Y			
Rhode Island[3]		Y		Y			Y		Y		
South Carolina		Y		Y				Y			
South Dakota	Y			Y				Y			
Tennessee[4]		Y				Y				Y	Y
Texas[5]		Y		Y			Y	Y			
Utah	Y			Y				Y			
Vermont	Y			Y				Y			
Virginia	Y			Y				Y			
Washington		Y		Y				Y			
West Virginia		Y		Y			Y	Y			
Wisconsin		Y				Y	Y			Y	
Wyoming		Y				Y	Y		Y		Y

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2015.

Table presents rules in effect as of January 1, 2015.

TABLE 9 NOTES

1. In addition to the eligibility criteria shown in the table, all states must verify citizenship and immigration status through electronic data matches with the Social Security Administration (SSA) or the Department of Homeland Security (DHS).
2. States have the option to accept self-attestation for the non-financial eligibility criteria listed. If states verify non-financial eligibility criteria at application or renewal, they are expected to use electronic data and eliminate or minimize requirements for paper documentation. In states accepting self-attestation without further verification, the state may have access to electronic data for some applicants (for example, if the consumer is also enrolled in SNAP), which may be used to confirm eligibility. Verification is required if a state has any information on file that conflicts with the self-attestation. In states noted as conducting pre-enrollment verification, the state will confirm eligibility prior to enrolling an individual into coverage. States conducting post-enrollment verification enroll an individual based on their self-attested information and confirm the criteria after enrollment.
3. Rhode Island accepts self-attestation for date of birth, but will confirm the data through SSA or DHS for purposes of paying the correct capitation rate to a managed care plan. Eligibility will not be denied based on this verification.
4. Tennessee is relying upon the FFM verification processes at application.
5. Texas accepts self-attestation for children, but verifies state residency for parents.

Table 10
Adoption of Targeted Strategies to Streamline Enrollment of Eligible Individuals
January 2015

State	Presumptive Eligibility[1]					Express Lane Eligibility for Children at Enrollment[2]		Use of SNAP Data to Facilitate Enrollment of Eligible Individuals[3]	Use of Child Enrollment Data to Facilitate Enrollment of Parents[3]
	Children's Medicaid	Children's CHIP	Pregnant Women	Parents	Childless Adults	Medicaid	CHIP		
Total	**15**	**9**	**27**	**5**	**3**	**9**	**5**	**8**	**3**
Alabama					N/A	Y			
Alaska		N/A (M-CHIP)			N/A		N/A (M-CHIP)		
Arizona									
Arkansas		N/A (M-CHIP)					N/A (M-CHIP)	Y	
California[4]	Y	N/A (M-CHIP)	Y				N/A (M-CHIP)	Y	
Colorado	Y	Y	Y			Y	Y	Y	
Connecticut	Y	Y	Y						
Delaware									
District of Columbia		N/A (M-CHIP)	Y				N/A (M-CHIP)		
Florida			Y		N/A				
Georgia			Y		N/A	Y	Y		
Hawaii		N/A (M-CHIP)					N/A (M-CHIP)		
Idaho	Y	Y	Y	Y	N/A				
Illinois	Y	Y	Y					Y	
Indiana[5]			Y		N/A				
Iowa	Y	Y	Y		N/A	Y			
Kansas	Y	Y			N/A				
Kentucky			Y						
Louisiana					N/A	Y			
Maine			Y		N/A				
Maryland		N/A (M-CHIP)				Y	N/A (M-CHIP)		
Massachusetts									
Michigan[6]									
Minnesota		N/A (M-CHIP)					N/A (M-CHIP)		
Mississippi					N/A				
Missouri	Y		Y		N/A				
Montana	Y	Y	Y	Y	N/A				
Nebraska		N/A (M-CHIP)	Y		N/A		N/A (M-CHIP)		
Nevada									
New Hampshire	Y	N/A (M-CHIP)	Y	Y	Y		N/A (M-CHIP)		
New Jersey	Y	Y	Y	Y	Y	Y	Y	Y	Y
New Mexico[7]	Y	N/A (M-CHIP)	Y				N/A (M-CHIP)		
New York	Y	Y	Y						
North Carolina			Y		N/A				
North Dakota									
Ohio	Y	N/A (M-CHIP)	Y	Y	Y		N/A (M-CHIP)		
Oklahoma		N/A (M-CHIP)			N/A		N/A (M-CHIP)		
Oregon						Y	Y	Y	Y
Pennsylvania			Y		N/A		Y		
Rhode Island		N/A (M-CHIP)					N/A (M-CHIP)		
South Carolina		N/A (M-CHIP)			N/A	Y	N/A (M-CHIP)		
South Dakota					N/A			Y	
Tennessee			Y		N/A				
Texas			Y		N/A				
Utah			Y		N/A				
Vermont									
Virginia					N/A				
Washington									
West Virginia								Y	Y
Wisconsin	Y		Y						
Wyoming			Y		N/A				

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2015.

Table presents rules in effect as of January 1, 2015.

TABLE 10 NOTES

1. Presumptive eligibility (PE) allows authorized qualified entities such as hospitals, community health centers, and schools to make presumptive eligibility determinations for Medicaid and/or CHIP and extend coverage to individuals temporarily until a full eligibility determination is made. This table does not reflect state implementation of ACA-required hospital presumptive eligibility, which allows hospitals to conduct presumptive eligibility determinations to expedite access to Medicaid coverage, regardless of whether a state has otherwise adopted presumptive eligibility.
2. The Express Lane Eligibility (ELE) option allows states to use data and eligibility findings from other public benefit programs to determine children eligible for Medicaid and CHIP at application or renewal. States are designated as having ELE if they have an approved and implemented State Plan Amendment from CMS.
3. These facilitated enrollment strategies were highlighted in guidance to states in May 2013. For details, see C. Mann, Director of Centers for Medicaid and CHIP Services, letter to State Health Officials and State Medicaid Directors, SHO #13-003 (May 17, 2013). States are designated as adopting a strategy if they have a CMS-approved waiver and have implemented the strategy.
4. In California, presumptive eligibility is only available to pregnant women in Medicaid
5. Indiana has an approved contingency plan to use SNAP data to facilitate enrollment if the state has a backlog in applications but has not implemented the policy.
6. Michigan received approval to use SNAP data to facilitate enrollment of eligible individuals but has not implemented the policy as of January 1, 2015.
7. New Mexico has presumptive eligibility for parents and other adults in Medicaid, but it is limited to those in correctional facilities (state prisons/county jails) and health facilities operated by the Indian Health Service, a Tribe, or Tribal organization, or an Urban Indian Organization.

Table 11
Renewal Delays and Targeted Strategies to Streamline Renewal
January 2015

State	State Delayed Any Renewals Scheduled for 2014[1]		Processing Renewals Due in 2014 into 2015[2]	12-Month Continuous Eligibility for Children		Express Lane Eligibility for Children at Renewal[3]	
	Medicaid	CHIP		Medicaid	CHIP	Medicaid	CHIP
Total	**34**	**22**	**17**	**23**	**26**	**8**	**2**
Alabama		Y		Y	Y	Y	
Alaska		N/A(M-CHIP)	N/A	Y	N/A(M-CHIP)		N/A (M-CHIP)
Arizona			N/A				
Arkansas[4]	Y	N/A(M-CHIP)			N/A(M-CHIP)		N/A (M-CHIP)
California	Y	N/A(M-CHIP)		Y	N/A (M-CHIP)	Y	N/A (M-CHIP)
Colorado			N/A	Y	Y	Y	
Connecticut	Y	Y	Y				
Delaware	Y				Y		
District of Columbia	Y	N/A(M-CHIP)	Y		N/A(M-CHIP)		N/A (M-CHIP)
Florida[5]	Y	Y			Y		
Georgia	Y	Y					
Hawaii	Y	N/A(M-CHIP)			N/A(M-CHIP)		N/A (M-CHIP)
Idaho	Y	Y	Y	Y	Y		
Illinois	Y	Y	Y	Y	Y		
Indiana[6]			N/A				
Iowa			N/A	Y	Y	Y	
Kansas	Y	Y		Y	Y		
Kentucky	Y	Y	Y				
Louisiana	Y	Y	Y	Y	Y	Y	
Maine			N/A	Y	Y		
Maryland[7]	Y	N/A(M-CHIP)			N/A (M-CHIP)		N/A (M-CHIP)
Massachusetts[8]	Y	Y	Y			Y	Y
Michigan	Y			Y	Y		
Minnesota	Y	N/A(M-CHIP)	Y		N/A (M-CHIP)		N/A (M-CHIP)
Mississippi	Y	Y	Y	Y	Y		
Missouri	Y	Y					
Montana	Y	Y					
Nebraska		N/A(M-CHIP)	N/A		N/A (M-CHIP)		N/A (M-CHIP)
Nevada	Y	Y	Y		Y		
New Hampshire		N/A(M-CHIP)	N/A		N/A (M-CHIP)		N/A (M-CHIP)
New Jersey	Y	Y	Y	Y	Y		
New Mexico		N/A(M-CHIP)	N/A	Y	N/A (M-CHIP)		N/A (M-CHIP)
New York[9]				Y	Y	Y	
North Carolina	Y	Y		Y	Y		
North Dakota	Y	Y		Y	Y		
Ohio	Y	N/A(M-CHIP)	Y	Y	N/A (M-CHIP)		N/A (M-CHIP)
Oklahoma	Y	N/A(M-CHIP)			N/A(M-CHIP)		N/A (M-CHIP)
Oregon	Y		Y	Y	Y		
Pennsylvania		Y			Y		Y
Rhode Island	Y	N/A(M-CHIP)			N/A(M-CHIP)		N/A (M-CHIP)
South Carolina	Y	N/A(M-CHIP)	Y	Y	N/A(M-CHIP)	Y	N/A (M-CHIP)
South Dakota							
Tennessee	Y	Y	Y		Y		
Texas[10]			N/A		Y		
Utah			N/A		Y		
Vermont	Y	N/A (M-CHIP)	Y				
Virginia[11]			N/A		Y		
Washington	Y	Y		Y	Y		
West Virginia	Y	Y	Y	Y	Y		
Wisconsin			N/A				
Wyoming	Y	Y		Y	Y		

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2015.

Table presents rules in effect as of January 1, 2015.

Table 11 Notes

1. This column indicates whether states took up the targeted renewal strategy highlighted in CMS guidance to states in May 2013, which allowed states to delay renewals that would otherwise occur during 2014. For details, see C. Mann, Director of Centers for Medicaid and CHIP Services, letter to State Health Officials and State Medicaid Directors, SHO #13-003 (May 17, 2013).
2. This column indicates whether states that delayed 2014 renewals for Medicaid and/or CHIP are still processing any renewals originally due during 2014 into 2015. States marked as N/A did not delay renewals in 2014.
3. The Express Lane Eligibility (ELE) option allows states to use data and eligibility findings from other public benefit programs to determine children eligible for Medicaid and CHIP at enrollment or renewal. States are designated as having ELE at renewal if they have an approved and implemented State Plan Amendment from CMS.
4. In Arkansas, children with incomes above 200% FPL receive 12-month continuous eligibility. Children with incomes below 200% FPL receive six months of continuous eligibility.
5. In Florida's Medicaid program, children younger than age five receive 12-month continuous eligibility and children ages five and older receive six months of continuous eligibility.
6. Indiana has 12-month continuous eligibility for children under age three in Medicaid and CHIP
7. Newborns in Maryland receive 12-month continuous eligibility.
8. Massachusetts extends ELE to pregnant women, childless adults, and parents through a Section 1115 waiver.
9. New York has a Section 1115 waiver that authorizes 12-month continuous eligibility for parents; however, the state has not implemented the provision as of January 1, 2015.
10. In Texas, children covered in CHIP with incomes below 185% FPL receive 12-month continuous eligibility.
11. In Virginia, children covered in CHIP receive 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
Integration between Eligibility Systems for Medicaid and Other Programs
January 2015

State	Marketplace Type[1]	FFM Makes Assessment or Final Determination for Medicaid Eligibility[2]	MAGI-Based Medicaid Eligibility System Integrated with SBM[3]	CHIP Integrated into MAGI-Based Medicaid Eligibility System	MAGI-Based Medicaid System Integrated with Other Non-Health Programs[4]
Total	**FFM: 28; Partnership: 6 SBM: 17**	**Assessment: 27 Determination: 10**	**12**	**34**	**19**
Alabama	FFM	Determination	N/A (FFM)	Y	
Alaska	FFM	Assessment	N/A (FFM)	N/A (M-CHIP)	
Arizona	FFM	Assessment	N/A (FFM)	Y	
Arkansas	Partnership	Determination	N/A (Partnership)	N/A (M-CHIP)	
California[5]	SBM	N/A (SBM)		N/A (M-CHIP)	Y
Colorado	SBM	N/A (SBM)	Y	Y	Y
Connecticut	SBM	N/A (SBM)	Y	Y	
Delaware	Partnership	Assessment	N/A (Partnership)	Y	Y
District of Columbia	SBM	N/A(SBM)	Y	N/A (M-CHIP)	
Florida	FFM	Assessment	N/A (FFM)	Y	
Georgia	FFM	Assessment	N/A (FFM)		
Hawaii	SBM	N/A(SBM)		N/A (M-CHIP)	
Idaho	SBM	N/A (SBM)	Y	Y	Y
Illinois	Partnership	Assessment	N/A (Partnership)	Y	Y
Indiana	FFM	Assessment	N/A (FFM)	Y	Y
Iowa	FFM	Assessment	N/A (FFM)	Y	
Kansas	FFM	Assessment	N/A (FFM)		
Kentucky	SBM	N/A (SBM)	Y	Y	
Louisiana	FFM	Determination	N/A (FFM)	Y	
Maine	FFM	Assessment	N/A (FFM)	Y	Y
Maryland	SBM	N/A(SBM)	Y	N/A (M-CHIP)	
Massachusetts	SBM	N/A (SBM)	Y	Y	
Michigan	Partnership	Assessment	N/A (Partnership)	Y	
Minnesota	SBM	N/A (SBM)	Y	Y	
Mississippi	FFM	Assessment	N/A (FFM)	Y	
Missouri	FFM	Assessment	N/A (FFM)	Y	
Montana	FFM	Determination	N/A (FFM)	Y	Y
Nebraska	FFM	Assessment	N/A (FFM)	N/A (M-CHIP)	Y
Nevada	Federally-supported SBM	Assessment	N/A (Federally-supported SBM)	Y	Y
New Hampshire	Partnership	Assessment	N/A (Partnership)	N/A (M-CHIP)	Y
New Jersey	FFM	Determination	N/A (FFM)	Y	
New Mexico	Federally-supported SBM	Assessment	N/A (Federally-supported SBM)	N/A (M-CHIP)	Y
New York	SBM	N/A (SBM)	Y	Y	
North Carolina	FFM	Assessment	N/A (FFM)	Y	Y
North Dakota	FFM	Determination	N/A (FFM)	Y	
Ohio	FFM	Assessment	N/A (FFM)	N/A (M-CHIP)	
Oklahoma	FFM	Assessment	N/A (FFM)	N/A (M-CHIP)	
Oregon	Federally-supported SBM	Determination	N/A (Federally-supported SBM)	Y	
Pennsylvania	FFM	Assessment	N/A (FFM)	Y	Y
Rhode Island	SBM	N/A (SBM)	Y	N/A (M-CHIP)	
South Carolina	FFM	Assessment	N/A (FFM)	N/A (M-CHIP)	
South Dakota	FFM	Assessment	N/A (FFM)	Y	
Tennessee	FFM	Determination	N/A (FFM)		
Texas	FFM	Assessment	N/A (FFM)	Y	Y
Utah	FFM	Assessment	N/A (FFM)	Y	Y
Vermont	SBM	N/A (SBM)	Y	N/A (M-CHIP)	
Virginia	FFM	Assessment	N/A (FFM)	Y	Y
Washington	SBM	N/A (SBM)	Y	Y	
West Virginia	Partnership	Determination	N/A (Partnership)	Y	Y
Wisconsin	FFM	Assessment	N/A (FFM)	Y	Y
Wyoming	FFM	Determination	N/A (FFM)	Y	

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children
Table presents rules in effect as of January 1, 2015.

TABLE 12 NOTES

1. This column indicates whether a state has elected to establish and operate its own State-based Marketplace (SBM), establish a State-based Marketplace with federal support, use the Federally-facilitated Marketplace (FFM), or establish a Marketplace in partnership with the federal government (Partnership). States running an SBM are responsible for performing all Marketplace functions, except for three SBM states (NV, NM, OR) that rely on the FFM information technology (IT) platform for eligibility determinations. In a Federally-facilitated Marketplace (FFM), the US Department of Health and Human Services (HHS) conducts all Marketplace functions. States with a Partnership Marketplace may administer plan management functions, in-person consumer assistance functions, or both, and HHS is responsible for the remaining Marketplace functions.
2. This column indicates whether states using the FFM IT platform for eligibility determinations (including FFM, Partnership, and Federally-supported SBM states) have elected to allow the FFM to make assessments or determinations of Medicaid/CHIP eligibility for MAGI-based groups. In assessment states, applicants' accounts must be transferred to the state Medicaid/CHIP agency for a final determination. In determination states, the FFM makes a final Medicaid/CHIP eligibility determination and transfers the account to the state Medicaid/CHIP agency for enrollment. States marked as N/A operate a full SBM.
3. This column indicates whether the state operates a single integrated eligibility determination system for MAGI-based Medicaid and Marketplace coverage. Such integration is possible in the 14 states with a full SBM. States marked as N/A use the FFM for Marketplace eligibility and enrollment functions.
4. This column indicates whether the MAGI-based Medicaid eligibility determination system is used to determine eligibility for at least one other non-health benefit program such as the Supplemental Nutrition Assistance Program (SNAP), cash assistance, or child care subsidies.
5. In California, county-based eligibility systems are integrated with other non-health programs.

Table 13

Premium, Enrollment Fee, and Cost-Sharing Requirements for Children[1, 2]

January 2015

State	Premiums/Enrollment Fees			Cost-Sharing Requirements		
	Required in Medicaid	Required in CHIP	Income at Which Premiums Begin (% FPL)[3]	Required in Medicaid	Required in CHIP	Income at Which Cost-Sharing Begins (% FPL)[3]
Total	**3**	**27**		**4**	**24**	
Alabama		Y	>141%		Y	>141%
Alaska		N/A (M-CHIP)			N/A (M-CHIP)	
Arizona[4]		Y	>138%			
Arkansas		N/A (M-CHIP)		Y	N/A (M-CHIP)	>142%
California	Y	N/A (M-CHIP)	>160%		N/A (M-CHIP)	
Colorado		Y	>157%		Y	>142%
Connecticut		Y	>249%		Y	>201%
Delaware		Y	>138%		Y	>138%
District of Columbia		N/A (M-CHIP)			N/A (M-CHIP)	
Florida[5]		Y	>133%		Y	>133%
Georgia[6]		Y	>133%		Y	>133%
Hawaii		N/A (M-CHIP)			N/A (M-CHIP)	
Idaho		Y	>138%		Y	>138%
Illinois		Y	>157%		Y	>147%
Indiana		Y	>163%		Y	>163%
Iowa		Y	>182%		Y	>182%
Kansas[7]		Y	>166%			
Kentucky					Y	>159%
Louisiana		Y	>213%			
Maine		Y	>162%			
Maryland[8]	Y	N/A (M-CHIP)	>211%		N/A (M-CHIP)	
Massachusetts		Y	>155%			
Michigan		Y	>165%			
Minnesota		N/A (M-CHIP)			N/A (M-CHIP)	
Mississippi					Y	>151%
Missouri		Y	>150%			
Montana					Y	>148%
Nebraska		N/A (M-CHIP)			N/A (M-CHIP)	
Nevada		Y	>138%			
New Hampshire		N/A (M-CHIP)			N/A (M-CHIP)	
New Jersey		Y	>200%		Y	>150%
New Mexico		N/A (M-CHIP)		Y	N/A (M-CHIP)	>190%
New York		Y	>160%			
North Carolina		Y	>159%		Y	>138%
North Dakota					Y	>138%
Ohio		N/A (M-CHIP)			N/A (M-CHIP)	
Oklahoma		N/A (M-CHIP)			N/A (M-CHIP)	
Oregon						
Pennsylvania		Y	>208%		Y	>208%
Rhode Island		N/A (M-CHIP)			N/A (M-CHIP)	
South Carolina		N/A (M-CHIP)			N/A (M-CHIP)	
South Dakota						
Tennessee[9]				Y	Y	>100%
Texas		Y	>151%		Y	>133%
Utah		Y	>133%		Y	>133%
Vermont	Y	N/A (M-CHIP)	>195%		N/A (M-CHIP)	
Virginia					Y	>143%
Washington		Y	>201%			
West Virginia		Y	>211%		Y	>133%
Wisconsin[10]		Y	>200%	Y	Y	>138%
Wyoming					Y	>138%

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, 2015.

Table presents rules in effect as of January 1, 2015.

Table 13 notes

1. Eligibility levels are based on 2014 federal poverty levels (FPLs). The FPL for a family of three in 2014 was $19,790.
2. States have flexibility to impose premiums and cost-sharing in Medicaid, with the maximum allowable amounts varying by income and group. Medicaid enrollees, including children, pregnant women, parents and the adult expansion group, with incomes below 150% of the federal poverty level (FPL) may not be charged premiums without a waiver. Cost-sharing generally is not allowed for children with incomes below 133% FPL. Medicaid enrollees with incomes above 150% FPL can be charged premiums and relatively higher cost-sharing compared to those at lower incomes. Cost-sharing cannot be charged for preventive services for children or emergency, family planning, and pregnancy-related services in Medicaid. Overall premium and cost-sharing amounts for all family members enrolled in Medicaid may not exceed 5% of household income. States have somewhat greater flexibility to charge premiums and cost-sharing for children covered by CHIP, although there remain federal limits on the amounts that can be charged, including the overall 5% of household income cap.
3. Income eligibility limits at which premiums and cost-sharing begin include the five percentage point of FPL disregard only for states where the lowest level for premiums and/or cost-sharing coincides with the upper income limit for Medicaid and lower threshold for CHIP eligibility.
4. In Arizona, the income at which premiums begin varies by the child's age: 138% FPL for children ages 6-18, 146% FPL for children ages 1-5, and 152% FPL for children under age one.
5. Florida does not charge copayments to children age four and under.
6. In Georgia, premiums are not charged to children under age six.
7. In Kansas, there are three premium levels: $20 for children with family incomes up to 191% FPL; $30 for children with family incomes up to 218% FPL; and $50 for children with family incomes up to 242% FPL.
8. In Maryland, most children are enrolled in MCOs and only have copayments for mental health and HIV/AIDS drugs.
9. Tennessee does not charge copays for children under age 6.
10. Wisconsin does not charge premiums for newborns.

Table 14

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

January 2015

State	Premiums/Enrollment Fees at:				
	151% FPL	201% FPL	251% FPL	301% FPL	351% FPL
MONTHLY PAYMENTS					
Arizona[4,5]	$40|$60	$50|$70	N/A	N/A	N/A
California[6]	$0	$13|$26|$39	$13|$26|$39	N/A	N/A
Connecticut[4]	$0	$0	$30|$50	$30|$50	N/A
Delaware[7,8]	$15	$25	N/A	N/A	N/A
Florida	$20	$20	N/A	N/A	N/A
Georgia	$20	$29	N/A	N/A	N/A
Idaho	$15	N/A	N/A	N/A	N/A
Illinois	$15	$15	N/A	N/A	N/A
Indiana[4]	$22|$33	$33|$50	$53|$70	N/A	N/A
Iowa[4]	$0	$10|$20	$20|$40	$20|$40	N/A
Kansas	$0	$30	N/A	N/A	N/A
Louisiana[7]	$0	$0	$50	N/A	N/A
Maine	$0	$32	N/A	N/A	N/A
Maryland[7]	$0	$0	$50	$63	N/A
Massachusetts	$12	$20	$28	$28	N/A
Michigan[7]	$0	$10	N/A	N/A	N/A
Missouri	$28	$76	$186	N/A	N/A
New Jersey[7]	$0	$43	$86	$144.50	$144.50
New York	$0	$9	$30	$45	$60
Pennsylvania[9]	$0	$51	$71	N/A	N/A
Vermont[7,10]	$0	$15	$20/$60	$20/$60	N/A
Washington	$0	$20	$30	$30	N/A
West Virginia	$0	$35	$35	N/A	N/A
Wisconsin	$0	$10	$34	$97	N/A
QUARTERLY PAYMENTS					
Nevada[7]	$50	$80	N/A	N/A	N/A
Utah[7]	$75	$75	N/A	N/A	N/A
ANNUAL PAYMENTS					
Alabama[3]	$104	$104	$104	$104	N/A
Colorado[4]	$0	$25|$35	$75|$105	N/A	N/A
North Carolina[4]	$0	$50|$100	N/A	N/A	N/A
Texas	$35	$50	N/A	N/A	N/A
NO PREMIUMS OR ENROLLMENT FEES					
Alaska	--	--	--	--	--
Arkansas	--	--	--	--	--
District of Columbia	--	--	--	--	--
Hawaii	--	--	--	--	--
Kentucky	--	--	--	--	--
Minnesota	--	--	--	--	--
Mississippi	--	--	--	--	--
Montana	--	--	--	--	--
Nebraska	--	--	--	--	--
New Hampshire	--	--	--	--	--
New Mexico	--	--	--	--	--
North Dakota	--	--	--	--	--
Ohio	--	--	--	--	--
Oklahoma	--	--	--	--	--
Oregon	--	--	--	--	--
Rhode Island	--	--	--	--	--
South Carolina	--	--	--	--	--
South Dakota	--	--	--	--	--
Tennessee	--	--	--	--	--
Virginia	--	--	--	--	--
Wyoming	--	--	--	--	--

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2015.

Table presents rules in effect as of January 1, 2015.

TABLE 14 NOTES

1. States have flexibility to impose premiums and cost-sharing in Medicaid, with the maximum allowable amounts varying by income and group. Medicaid enrollees, including children, pregnant women, parents and the adult expansion group, with incomes below 150% of the federal poverty level (FPL) may not be charged premiums without a waiver. Medicaid enrollees with incomes above 150% FPL can be charged premiums and relatively higher cost-sharing compared to those at lower incomes. Overall premium and cost-sharing amounts for all family members enrolled in Medicaid may not exceed 5% of household income. States have somewhat greater flexibility to charge premiums and cost-sharing for children covered by CHIP, although there remain federal limits on the amounts that can be charged, including the overall 5% of household income cap. N/A indicates that coverage is not available at the specified income level. If a state does not charge premiums at all, it is noted as "- -".
2. Enrollment fees are charged annually and families are typically not allowed to enroll in coverage without paying the fee.
3. Alabama's premium is an annual fee and is not required before a child enrolls in coverage.
4. In Arizona, Connecticut, Indiana, Iowa, Colorado, and North Carolina, the values before the vertical line represent premiums or enrollment fees for one child. Those after the line represent premiums for two or more children.
5. In Arizona, amounts shown at 201% FPL reflect premiums at 200% FPL (the upper income eligibility level in the state).
6. California premium amounts are shown for one child | two children | three or more children. Premium discounts are provided to families who pay in advance, set up automatic payments, or pay by electronic funds transfer.
7. In Delaware, Louisiana, Maryland, Michigan, New Jersey, Vermont, Nevada, and Utah, premiums are family-based and not based on costs per child.
8. Delaware has an incentive system for premiums where families can pay three months and get one premium-free month, pay six months and get two premium-free months, and pay nine months and get three premium-free months.
9. In Pennsylvania, premiums vary by contractor. The average amount is shown.
10. In Vermont, for those above 242% FPL, the monthly charge is $20 if the family has other health insurance and $60 if there is no other health insurance.

Table 15
Disenrollment Policies for Non-Payment of Premiums in Children's Coverage
January 2015

State	Grace Period for Non-Payment of Premiums[1]	After Disenrollment for Failure to Pay Premiums:		
		Lock-Out Period in Separate CHIP Program[2]	Families Must Reapply for Coverage to Reenroll	Retroactive Reinstatement of Coverage if Family Pays Outstanding Premiums
Total		**13**	**16**	**8**
MONTHLY PAYMENTS				
Arizona	60 days	Enrollment Closed	Enrollment Closed	Enrollment Closed
California	60 days	N/A (M-CHIP)	Y	
Connecticut	30 days	None		Y
Delaware	2 months	None		Y
Florida	30 days	1 month		
Georgia	60 days	1 month		
Idaho	60 days	None	Y	
Illinois	60 days	None		Y
Indiana	60 days	90 days		
Iowa	44 days	None	Y	
Kansas	60 days	90 days	Y	
Louisiana[3]	60 days	90 days	Y	
Maine[4]	12 months	up to 90 days	Y	
Maryland	45 days	N/A (M-CHIP)	Y	
Massachusetts[5]	60 days	90 days		
Michigan[6]	30 days	None	Y	
Missouri[7]	30 days	90 days	Y	
New Jersey	60 days	None		
New York[8]	30 days	None	Y	
Pennsylvania[9]	90 days	90 days	Y	Y
Vermont[10]	30 days	N/A (M-CHIP)	Y	Y
Washington[11]	90 days	90 days	Y	Y
West Virginia[12]	120 days	None		
Wisconsin[13]	60 days	90 days	Y	Y
QUARTERLY PAYMENTS				
Nevada	60 days	90 days	Y	
Utah[14]	30 days	90 days	Y	Y
ANNUAL PAYMENTS				
Alabama[15]	--	--	--	--
Colorado	--	--	--	--
North Carolina	--	--	--	--
Texas	--	--	--	--
NO PREMIUMS OR ENROLLMENT FEES				
Alaska	--	--	--	--
Arkansas	--	--	--	--
District of Columbia	--	--	--	--
Hawaii	--	--	--	--
Kentucky	--	--	--	--
Minnesota[11]	--	--	--	--
Mississippi	--	--	--	--
Montana	--	--	--	--
Nebraska	--	--	--	--
New Hampshire	--	--	--	--
New Mexico	--	--	--	--
North Dakota	--	--	--	--
Ohio	--	--	--	--
Oklahoma	--	--	--	--
Oregon	--	--	--	--
Rhode Island[15]	--	--	--	--
South Carolina	--	--	--	--
South Dakota	--	--	--	--
Tennessee	--	--	--	--
Virginia	--	--	--	--
Wyoming	--	--	--	--

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2015.
Table presents rules in effect as of January 1, 2015.

Table 15 notes

1. This column indicates the grace period for payment of Medicaid or CHIP premiums before a child is disenrolled from coverage. If premiums are charged in Medicaid, a state must provide a 60-day grace period. CHIPRA required states to provide a minimum 30-day premium payment grace period under CHIP before cancelling a child's coverage.
2. A lock-out period is a period of time during which the disenrolled person is prohibited from returning to the CHIP program. Lock-outs are not permitted in Medicaid and the ACA limited such lock-out periods in CHIP to no more than 90 days.
3. In Louisiana, children in the 12-month continuous eligibility period do not need to reapply for coverage.
4. 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.
5. 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. In Massachusetts, after the 90 day lock-out period children may re-enroll for prospective coverage without paying the past due premiums. Children may re-enroll for prospective coverage during the 90 day lock-out period if the past due premiums are paid, if a payment plan is set up, or if the family is determined eligible for a premium waiver.
6. In Michigan, families do not have to pay past due premiums over 6 months old.
7. In Missouri, only children in families with incomes above 225% FPL are subject to the lock-out period and required to pay past due premiums.
8. In New York, if the family pays the premium within 30 days of cancellation they do not need to reapply for coverage.
9. In Pennsylvania, if the family pays past due premiums prior to the end of the renewal period, they do not have to re-apply for coverage.
10. In Vermont, there is a 90 day lock-out period for uninsured children enrolled in the CHIP-funded Medicaid expansion under Section 1115 waiver authority.
11. In Washington, the family must reapply only if they do not pay the delinquent premium. If they pay the delinquent premium then coverage is automatically reinstated back to the month coverage ended for non-payment of premiums.
12. In West Virginia, children are not dis-enrolled for non-payment of premiums, but past due amounts are subject to third-party collections after 120 days.
13. In Wisconsin, only families that reapply within 3 months after losing coverage are required to repay past due premiums.
14. In Utah, families don't have to pay past due premiums that are over 3 months old.
15. Alabama charges an annual enrollment fee in its CHIP program. If the fee is not paid, the child is not able to renew coverage.

Table 16
Cost-Sharing Amounts for Selected Services for Children at Selected Income Levels[1,2]
January 2015

State	Family Income at 151% FPL				Family Income at 201% FPL			
	Non-Preventive Physician Visit	ER Visit	Non-Emergency Use of ER[3]	Inpatient Hospital Visit	Non-Preventive Physician Visit	ER Visit	Non-Emergency Use of ER[3]	Inpatient Hospital Visit
Total	**18**	**12**	**19**	**15**	**21**	**13**	**20**	**15**
Alabama[3]	$13	$60	$60	$200	$13	$60	$60	$200
Alaska	- -	- -	- -	- -	- -	- -	- -	- -
Arizona	- -	- -	- -	- -	- -	- -	- -	- -
Arkansas	$10	$10	$10	20% of reimbursement rate for first day	$10	$10	$10	20% of reimbursement rate for first day
California[3,4]	- -	- -	- -	- -	- -	- -	- -	- -
Colorado	$5	$30	$30	$20	$10	$50	$50	$50
Connecticut	- -	- -	- -	- -	$10	$0	$0	$0
Delaware	$0	$0	$10	$0	$0	$0	$10	$0
District of Columbia	- -	- -	- -	- -	- -	- -	- -	- -
Florida[5]	$5	$0	$10	$0	$5	$0	$10	$0
Georgia	$.50-$3	$0	$0	$12.50	$.50-$3	$0	$0	$12.50
Hawaii	- -	- -	- -	- -	- -	- -	- -	- -
Idaho	$0	$0	$3	$0	N/A	N/A	N/A	N/A
Illinois	$3.90	$0	$0	$3.90	$5	$5	$25	$5
Indiana	$0	$0	$0	$0	$0	$0	$0	$0
Iowa[#]	$0	$0	$25	$0	$0	$0	$25	$0
Kansas	- -	- -	- -	- -	- -	- -	- -	- -
Kentucky[6]	$3	$0	$8	$50	$3	$0	$8	$50
Louisiana[3]	- -	- -	- -	- -	- -	- -	- -	- -
Maine	- -	- -	- -	- -	- -	- -	- -	- -
Maryland	- -	- -	- -	- -	- -	- -	- -	- -
Massachusetts	- -	- -	- -	- -	- -	- -	- -	- -
Michigan	- -	- -	- -	- -	- -	- -	- -	- -
Minnesota	- -	- -	- -	- -	- -	- -	- -	- -
Mississippi	$5	$15	$15	$0	$5	$15	$15	$0
Missouri	- -	- -	- -	- -	- -	- -	- -	- -
Montana[7]	$3	$5	$5	$25	$3	$5	$5	$25
Nebraska	- -	- -	- -	- -	- -	- -	- -	- -
Nevada	- -	- -	- -	- -	- -	- -	- -	- -
New Hampshire	- -	- -	- -	- -	- -	- -	- -	- -
New Jersey	$5	$10	$10	$0	$5	$35	$35	$0
New Mexico[8]	$0	$0	$0	$0	$5	$0	$8	$25
New York	- -	- -	- -	- -	- -	- -	- -	- -
North Carolina	$5	$0	$10	$0	$5	$0	$25	$0
North Dakota	$0	$5	$5	$50	N/A	N/A	N/A	N/A
Ohio	- -	- -	- -	- -	- -	- -	- -	- -
Oklahoma	- -	- -	- -	- -	- -	- -	- -	- -
Oregon[3]	- -	- -	- -	- -	- -	- -	- -	- -
Pennsylvania[3]	$0	$0	$0	$0	$5	$25	$25	$0
Rhode Island	- -	- -	- -	- -	- -	- -	- -	- -
South Carolina	- -	- -	- -	- -	- -	- -	- -	- -
South Dakota	- -	- -	- -	- -	- -	- -	- -	- -
Tennessee[3,9]	$5|$15-$20	$10|$50	$10|$50	$5|$100	$15-$20	$50	$50	$100
Texas	$20	$0	$75	$75	$25	$0	$75	$125
Utah[10]	$25-$40	$300	$100-$200	20% of daily reimbursement rate	$25-$40	$300	$100-$200	20% of daily reimbursement rate
Vermont	- -	- -	- -	- -	- -	- -	- -	- -
Virginia	$5	$5	$25	$25	$5	$5	$25	$25
Washington	- -	- -	- -	- -	- -	- -	- -	- -
West Virginia[3,11]	$15	$35	$35	$25	$20	$35	$35	$25
Wisconsin	$.50-$3	$0	$0	$3	$.50-$3	$0	$0	$3
Wyoming[3, 12]	$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, 2015.

Table presents rules in effect as of January 1, 2015.

TABLE 16 NOTES

1. States have flexibility to impose premiums and cost-sharing in Medicaid and CHIP, with the maximum allowable amounts varying by income and group. Cost-sharing generally is not allowed for children with incomes below 133% FPL, though charges may be imposed for non-emergent use of the emergency room and non-preferred drugs. Medicaid enrollees with incomes above 150% FPL can be charged premiums and relatively higher cost-sharing compared to those at lower incomes. Cost-sharing cannot be charged for preventive services for children or emergency, family planning, and pregnancy-related services in Medicaid. Overall premium and cost-sharing amounts for all family members enrolled in Medicaid or CHIP may not exceed 5% of household income.
2. If a state charges cost-sharing for selected services or drugs shown in Tables 16 and 17, but either does not charge them at the income level shown or for the specific service, it is recorded as $0; if a state does not provide coverage at a particular income level, it is noted as "N/A;" if a state does not charge copayments at all, it is noted as "- -". Some states require 18-year-olds to meet the copayments of adults in Medicaid. These data are not shown.
3. In California, Louisiana, Oregon, Pennsylvania, Tennessee, West Virginia, and Wyoming, the emergency room copayment is waived if the child is admitted. In New Mexico, the emergency room copayment is waived if the child is admitted, but the inpatient copayment is still applied.
4. In California, no coverage is provided if the services received in an emergency room are not for an emergency condition.
5. In Florida, copayments only apply to children over the age of five.
6. In Kentucky, enrollees are charged 5% coinsurance for non-emergency use of the emergency room, which is capped at $8.
7. In Montana, cost-sharing is limited to $215 per family
8. In New Mexico, children below the eligibility limits for Title XXI-funded coverage (305% for children 0-5 and 245% for older children) are only subject to the $8 copayment for non-emergency use of the emergency room.
9. Tennessee has two CHIP programs. At 151% FPL, families with children in TennCare Standard pay the first amount and those in CoverKids pay the second amount. At 201% FPL, cost-sharing amounts for listed services are the same in both programs.
10. Utah has a $300 deductible.
11. In West Virginia the emergency room copayment is waived if the child is admitted. The copayments for a non-preventive physician visit are waived if the child goes to his or her medical home.
12. In Wyoming, the emergency room copayment is waived if the child is admitted.

Table 17
Cost-Sharing Amounts for Prescription Drugs for Children at Selected Income Levels[1,2]
January 2015

State	Family Income at 151% FPL			Family Income at 201% FPL[2]		
	Generic	Preferred Brand Name	Non-Preferred Brand Name	Generic	Preferred Brand Name	Non-Preferred Brand Name
Total	**16**	**17**	**14**	**19**	**20**	**16**
Alabama	$5	$25	$28	$5	$25	$28
Alaska	--	--	--	--	--	--
Arizona	--	--	--	--	--	--
Arkansas	$5	$5	$5	$5	$5	$5
California	--	--	--	--	--	--
Colorado	$3	$10	N/C	$5	$15	N/C
Connecticut	--	--	--	$5	$10	$10
Delaware	$0	$0	$0	$0	$0	$0
District of Columbia	--	--	--	--	--	--
Florida[3]	$5	$5	$5	$5	$5	$5
Georgia	$0.50	$0.50-$3	$.50- $3	$0.50	$0.50-$3	$.50- $3
Hawaii	--	--	--	--	--	--
Idaho	$0	$0	$0	N/A	N/A	N/A
Illinois	$2	$3.90	$3.90	$3	$5	$5
Indiana	$0	$0	$0	$3	$10	$10
Iowa	$0	$0	$0	$0	$0	$0
Kansas	--	--	--	--	--	--
Kentucky	$1	$4	$8	$1	$4	$8
Louisiana	--	--	--	--	--	--
Maine	--	--	--	--	--	--
Maryland	--	--	--	--	--	--
Massachusetts	--	--	--	--	--	--
Michigan	--	--	--	--	--	--
Minnesota	--	--	--	--	--	--
Mississippi	$0	$0	$0	$0	$0	$0
Missouri	--	--	--	--	--	--
Montana	$0	$0	$0	$0	$0	$0
Nebraska	--	--	--	--	--	--
Nevada	--	--	--	--	--	--
New Hampshire	--	--	--	--	--	--
New Jersey	$1	$5	$5	$5	$5	$5
New Mexico[4]	$0	$0	$0	$2	$3	$3
New York	--	--	--	--	--	--
North Carolina[5]	$1	$1	$3	$1	$1	$10
North Dakota	$2	$2	$2	N/A	N/A	N/A
Ohio	--	--	--	--	--	--
Oklahoma	--	--	--	--	--	--
Oregon	--	--	--	--	--	--
Pennsylvania	$0	$0	$0	$6	$9	N/C
Rhode Island	--	--	--	--	--	--
South Carolina	--	--	--	--	--	--
South Dakota	--	--	--	--	--	--
Tennessee[6]	$5	$20	$40	$5	$20	$40
Texas	$10	$35	N/C	$10	$35	N/C
Utah[7]	$15	25% of cost	50% of cost	$15	25% of cost	50% of cost
Vermont	--	--	--	--	--	--
Virginia	$5	$5	$5	$5	$5	$5
Washington	--	--	--	--	--	--
West Virginia	$0	$10	$15	$0	$10	$15
Wisconsin	$1	$3	$3	$1	$3	$3
Wyoming	$5	$10	N/C	$5	$10	N/C

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and Families, 2015.

Table presents rules in effect as of January 2015.

Table 17 Notes

1. Cost-sharing is 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.
2. If a state charges cost-sharing, but either does not charge 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.
3. In Florida, copayments only apply to children over the age of five.
4. In New Mexico, children below the eligibility limits for Title XXI-funded coverage (305% FPL for children ages 0-5 and 245% FPL for older children) are only subject to a $3 copayment per brand name drug when there is a less expensive drug available and $8 for non-emergent use of the emergency room.
5. In North Carolina, the copayment for brand-name drugs only applies if a generic version is available.
6. In Tennessee, children in TennCare Standard do not pay copayments for prescription drugs. The listed amounts apply to children in CoverKids.
7. Utah has a $300 deductible.

Table 18
Premium and Cost-Sharing Requirements for Selected Services for Section 1931 Parents[1, 2]
January 2015

State	Monthly Contributions/ Premiums Required?	Cost-Sharing Required?	Income at Which Cost-Sharing Begins (%FPL)	Cost-Sharing Amounts for Selected Services					
				Non-Preventive Physician Visit	Non-Emergency Use of ER	Inpatient Hospital Visit	Generic Drug	Preferred Brand Name Drug	Non-Preferred Brand Name Drug
Total Requiring Fees		**40**		**24**	**20**	**27**	**37**	**39**	**38**
Alabama		Y	0%	$1.30 - $3.90	$3.90	$50	$.65-$3.90	$.65-$3.90	$.65-$3.90
Alaska		Y	0%	$10	$0	$50/day	$3	$3	$3
Arizona		Y	0%	$3.40	$0	$0	$2.30	$2.30	$2.30
Arkansas		Y	0%	$0	$0	10% cost of first day	$.50-$3	$.50-$3	$.50-$3
California		Y	0%	$1	$5	$0	$1	$1	$1
Colorado		Y	0%	$2	$3	$10/day	$1	$3	$3
Connecticut			--	--	--	--	--	--	--
Delaware		Y	0%	$0	$0	$0	$.50-$3	$.50-$3	$.50-$3
District of Columbia			--	--	--	--	--	--	--
Florida		Y	0%	$0	$15	$0	$0	$0	$0
Georgia		Y	0%	$0	$0	$12.50	$.50-$3	$.50-$3	$.50-$3
Hawaii			--	--	--	--	--	--	--
Idaho			--	--	--	--	--	--	--
Illinois		Y	0%	$3.90	$3.90	$3.90	$2	$3.90	$3.90
Indiana		Y	0%	$0	$0	$0	$3	$3	$3
Iowa[3]		Y	0%	$3	$0	$0	$1	$1	$2 or $3
Kansas			--	--	--	--	--	--	--
Kentucky		Y	0%	$3	$8	$50	$1	$4	$8
Louisiana		Y	0%	$0	$0	$0	$.50-$3	$.50-$3	$.50-$3
Maine[4]		Y	0%	$0	up to $3/day	$3	$3	$3	$3
Maryland		Y	0%	$0	$0	$3	$1-$3	$1-$5	$1-$5
Massachusetts[5]		Y	0%	$0	$0	$3	$3.65	$3.65	$3.65
Michigan		Y	0%	$0	$0	$1	$1	$1	$1
Minnesota		Y	0%	$3	$3.50	$0	$1	$3	$3
Mississippi		Y	0%	$3	$0	$10	$3	$3	$3
Missouri		Y	0%	$1	$3	$10	$.50-$2	$.50-$2	$.50-$2
Montana		Y	0%	$4	$5	$100	$1-$5	$1-$5	$1-$5
Nebraska		Y	0%	$2	$0	$15	$2	$2	$3
Nevada			--	--	--	--	--	--	--
New Hampshire		Y	0%	$0	$0	$0	$1	$2	$2
New Jersey			--	--	--	--	--	--	--
New Mexico			--	--	--	--	--	--	--
New York		Y	0%	$0	$3	$25/discharge	$1	$3	$3
North Carolina		Y	0%	$3	$0	$3/day	$3	$3	$3
North Dakota		Y	0%	$2	$3	$75	$0	$3	$3
Ohio		Y	0%	$0	$3	$0	$0	$2	$3
Oklahoma		Y	0%	$4	$4	$10 day/$90 max	$0-3.50	$0-3.50	$0-$3.50
Oregon[6]		Y	0%	$0	$3	$0	$2	$3	$3
Pennsylvania		Y	0%	$.65-$3.80	$.50-$3	$3/day	$1	$3	$3
Rhode Island			--	--	--	--	--	--	--
South Carolina		Y	0%	$2.30	$0	$25	$3.40	$3.40	$3.40
South Dakota[12]		Y	0%	$3	full amount	$50	$1	$3.30	N/C
Tennessee		Y	>100%	$0	$0	$0	$1.50	$3	$3
Texas			--	--	--	--	--	--	--
Utah[8]		Y	>40%	$3	$6	$220	$3	$3	$3
Vermont		Y	0%	$0	$0	$75	$1-$3	$1-$3	$1-$3
Virginia		Y	0%	$1	$0	$100	$1	$3	$3
Washington			--	--	--	--	--	--	--
West Virginia		Y	0%	$0-$4	$8	$0-$75	$0-$3	$0-$3	$0-$3
Wisconsin[10]		Y	>0%	$.50-$3	$0	$3	$1	$3	$3
Wyoming		Y	0%	$2.45	$3.65	$0	$0.65	$3.65	$3.65

SOURCE: Based on a national survey conducted by the Kaiser Commission on Medicaid and the Uninsured with the Georgetown University Center for Children and
Table presents rules in effect as of January 2015.

TABLE 18 NOTES

1. States have flexibility to impose premiums and cost-sharing in Medicaid, with the maximum allowable amounts varying by income and group. Medicaid enrollees with incomes below 150 percent of the federal poverty level (FPL) may not be charged premiums without a waiver. Adults enrolled in Medicaid may be charged cost-sharing, but charges for those below 100 % FPL are limited to nominal amounts.
2. If a state charges cost-sharing, but does not charge for the specific service, it is recorded as $0; if a state does not charge cost-sharing at all, it is noted as "- -"; if a state does not cover a type of drug, it is noted as "N/C".
3. In Iowa, charges are $2 for non-preferred name brand drugs that cost between $25.01 and $50; and $3 for non-preferred brand name drugs that cost >$50.
4. In Maine, for Section 1931 Medicaid parents, there are separate $30 monthly maximums for inpatient hospital and drug copayments.
5. In Massachusetts, generic drugs for diabetes, high blood pressure and high cholesterol have a $1 copayment. There is a cap of $36 per year for non-pharmacy copayments and a cap of $250 per year for pharmacy copayments.
6. In Oregon, for Section 1931 parents, there are no copayments for drugs ordered through home-delivery pharmacy programs.
7. In Pennsylvania, copayments for Section 1931 parents vary based on the cost of service. The inpatient hospital copayment is subject to a maximum of $21 per year.
8. In Utah, enrollees under the TANF payment limit are exempt from paying copayments.
9. In West Virginia, copayment amounts vary by income and enrollees have a quarterly out-of-pocket maximum. For individuals with incomes up to 50% FPL, the maximum is $8, for those with incomes between 50% and 100% FPL it is $71, and for those with incomes above 100% FPL, it is $143.
10. Wisconsin charges a monthly premium oft 2% of income to parents in its Transitional Medical Assistance (TMA) program under its Section 1115 BadgerCare waiver. Non-pregnant, non-disabled parents with income over 133% FPL pay premiums during the entire TMA extension. Parents with income between 100 and 133% pay no premiums until the 7th month of TMA coverage.

Table 19
Cost-Sharing Requirements for Selected Services for Medicaid Expansion Adults[1, 2]
January 2015

State	Monthly Contributions/ Premiums Required?	Cost-Sharing Required?	Income at Which Cost-Sharing Begins (%FPL)	Cost-Sharing Amounts for Selected Services					
				Non-Preventive Physician Visit	Non-Emergency Use of ER	Inpatient Hospital Visit	Generic Drug	Preferred Brand Name Drug	Non-Preferred Brand Name Drug
ADOPTED MEDICAID EXPANSION (28 states)									
Total Requiring Fees		**20**		**9**	**13**	**12**	**16**	**18**	**19**
Arizona			- -	- -	- -	- -	- -	- -	- -
Arkansas[3]		Y	>100%	$8	$0	$140/day	$4	$4	$8
California[4]		Y	0%	$5	$50	$100/day	$3	$5	$5
Colorado		Y	0%	$2	$3	$10/day	$1	$3	$3
Connecticut			- -	- -	- -	- -	- -	- -	- -
Delaware		Y	0%	$0	$0	$0	$0.50-$3	$0.50-$3	$0.50-$3
District of Columbia			- -	- -	- -	- -	- -	- -	- -
Hawaii			- -	- -	- -	- -	- -	- -	- -
Illinois		Y	0%	$3.90	$3.90	$3.90	$2	$3.90	$3.90
Iowa[5]	Y, >50% FPL	Y	>50%	$0	$8	$0	$0	$0	$0
Kentucky		Y	0%	$3	$8	$50	$1	$4	$8
Maryland		Y	0%	$0	$0	$3	$1-$3	$1-$5	$1-$5
Massachusetts[6]		Y	0%	$0	$0	$3	$3.65	$3.65	$3.65
Michigan[7]	Y, >100% FPL	Y	0%	$0	$0	$0	$1	$1	$1
Minnesota		Y	0%	$3	$3.50	$0	$1	$3	$3
Nevada			- -	- -	- -	- -	- -	- -	- -
New Hampshire		Y	>100%	$0	$8	$0	$1	$1	$4
New Jersey			- -	- -	- -	- -	- -	- -	- -
New Mexico		Y	0%	$0	$8	$0	$0	$3	$3
New York		Y	0%	$0	$3	$25	$1	$3	$3
North Dakota		Y	0%	$2	$3	$75	$0	$3	$3
Ohio		Y	0%	$0	$0	$0	$0	$0	$3
Oregon		Y	0%	$0	$3	$0	$2	$3	$3
Pennsylvania[8]		Y	0%	$.65-$3.80	$.50-$3	$3/day	$1	$3	$3
Rhode Island			- -	- -	- -	- -	- -	- -	- -
Vermont		Y	0%	$0	$0	$75	$1-$3	$1-$3	$1-$3
Washington			- -	- -	- -	- -	- -	- -	- -
West Virginia[9]		Y	0%	$0-$4	$8	$0-$75	$0-$3	$0-$3	$0-$3
NOT ADOPTING THE MEDICAID EXPANSION AT THIS TIME (23 States)									
Alabama									
Alaska									
Florida									
Georgia									
Idaho									
Indiana									
Kansas									
Louisiana									
Maine									
Mississippi									
Missouri									
Montana									
Nebraska									
North Carolina									
Oklahoma									
South Carolina									
South Dakota									
Tennessee									
Texas									
Utah									
Virginia									
Wisconsin[10]									
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, 2015.
Table presents rules in effect as of January 2015.

TABLE 19 NOTES

1. Data in the table represent premium (or other monthly contribution) and cost-sharing requirements for adults covered through the ACA Medicaid expansion to adults with incomes up to 138% of the federal poverty level (FPL). This group includes parents above Section 1931 limits and childless adults.
2. States have flexibility to impose premiums and cost-sharing in Medicaid, with the maximum allowable amounts varying by income and group. Medicaid enrollees with incomes below 150% FPL may not be charged premiums without a waiver. Adults enrolled in Medicaid may be charged cost-sharing, but charges for those below 100% FPL are limited to nominal amounts. If a state charges cost-sharing, but does not charge for the specific service or drug, it is recorded as $0; if a state does not charge cost-sharing at all, it is noted as "- -."
3. Arkansas has received waiver approval to implement monthly contributions to an "independence account" for coverage in the Private Option (Arkansas' Medicaid expansion program). Enrollees will make monthly payments between $5 and $25 based on income, with contributions for enrollees between 50% and 100% FPL limited to $5, and no contributions for those below 50% FPL. Payments to the account are not required for enrollment. Individuals who make the contribution will not be charged copayments or cost-sharing in the month following each payment. Individuals who do not make a monthly contribution will be billed for all cost-sharing charges. The new payments were not in effect as of January 1, 2015.
4. In California, inpatient hospital copayments for Medicaid expansion adults are limited to a $200 per admission.
5. In Iowa, Medicaid expansion beneficiaries above 100% FPL pay premiums of $10 per month. Beneficiaries from 50-100% FPL pay premiums of $5 per month and cannot be disenrolled for non-payment. Premiums are waived for the first year of enrollment. In subsequent years, premiums are waived if beneficiaries complete specified healthy behaviors. The state must grant waivers of payment of the premiums to beneficiaries who self-attest to a financial hardship. Beneficiaries have the opportunity to self-attest to hardship on each monthly invoice.
6. In Massachusetts, generic drugs for diabetes, high blood pressure, and high cholesterol have a $1 copayment. There is a $36 annual cap for non-pharmacy copayments and a $250 annual cap for pharmacy copayments.
7. In Michigan, under Section 1115 waiver authority, expansion adults with incomes above 100% FPL are charged monthly premiums that are equal to 2% of income. Expansion adults have cost-sharing contributions based on their prior 6 months of copays incurred, billed at the end of each quarter. There is no cost-sharing for the first six months of enrollment in the plan. Beneficiaries cannot lose or be denied Medicaid eligibility, be denied health plan enrollment or be denied access to services, and providers may not deny services for failure to pay copayments or premiums. Cost-sharing can be reduced through compliance with healthy behaviors. Cost-sharing and premiums cannot exceed 5% of household income.
8. In Pennsylvania, premiums and copayments for adults enrolled in the Section 1115 Medicaid expansion waiver in 2015 are equal to those for parents in Section 1931 Medicaid. Beginning in 2016, individuals with income greater than 100% FPL will have a monthly premium equal to 2% of income, and no copayments except for $8 for non-emergent of the emergency room. Beneficiaries who fail to pay premiums for 90 days may be disenrolled from coverage and may re-enroll without a waiting period. Beneficiaries below 100% FPL will continue to have copayments according to state plan amounts.
9. In West Virginia, copayment amounts vary by income and enrollees have a quarterly out-of-pocket maximum. Up to 50% FPL, the maximum is $8; between 50% and 100%, $71; and above 100%, $143.
10. Wisconsin offers Medicaid coverage to childless adults up to 100% FPL, but not under the ACA's Medicaid expansion. Enrollees pay no premiums but pay cost-sharing equal to those reported for parents in Table 18.

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