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Medicaid and CHIP Eligibility, Enrollment, and Cost Sharing Policies as of January 2020: Findings from a 50-State Survey

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Executive Summary

As the COVID-19 pandemic expands, needs for health insurance coverage through Medicaid and CHIP will increase for people who get sick and who lose private coverage due to the declining economy. Increasing enrollment for the [6.7 million uninsured individuals](#) who are eligible for Medicaid and facilitating enrollment for the growing numbers of individuals who will become eligible for Medicaid as they lose jobs and incomes decrease will help expand access to care for COVID-19-related needs and health care needs and more broadly. [States can adopt a range of options](#) under current rules to increase Medicaid eligibility, facilitate enrollment and continuity of coverage, and eliminate out-of-pocket costs. States can seek additional flexibility through waivers. The [Families First Coronavirus Response Act](#) provides states additional options and enhanced federal funding to support state response.

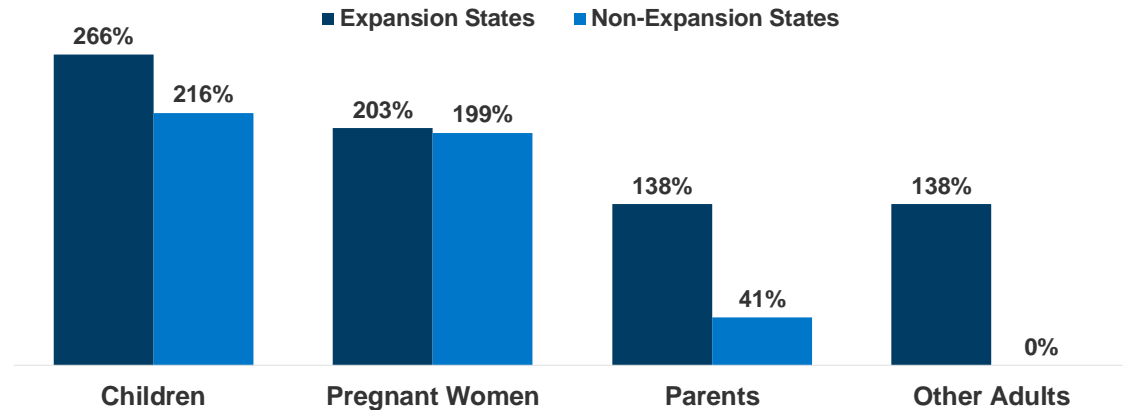
This 18th annual survey of the 50 states and the District of Columbia (DC) provides data on Medicaid and the Children's Health Insurance Program (CHIP) eligibility, enrollment, renewal, and cost sharing policies as of January 2020. The survey findings highlight state variation in policies that affect individuals' ability to access coverage and care amid the COVID-19 public health crisis. They also provide examples of actions states can take to expand eligibility and simplify enrollment to respond to the COVID-19 epidemic. Further, the survey findings highlight how changes under the ACA to expand Medicaid eligibility and streamline enrollment and renewal processes have better positioned the Medicaid program to respond to a public health crisis such as COVID-19.

Key Findings

More individuals can access Medicaid coverage in states that have implemented the ACA Medicaid expansion to low-income adults than states that have not expanded. Across eligibility groups, eligibility levels are higher in expansion states compared to non-expansion states (Figure 1). In 2019, two additional states (Idaho and Utah) implemented the ACA Medicaid expansion, bringing the total to 36 states that extend eligibility to low-income adults with incomes up to at least 138% federal poverty level (FPL, \$29,974 for a family of three) as of January 2020. Eligibility for children and pregnant women held steady in 2019, with median income levels of 255% FPL and 205% FPL across all states, respectively, as of January 2020. Eligibility for parents and other adults remains very limited in the 15 states that have not implemented the ACA Medicaid expansion. In non-expansion states, the median eligibility level for parents is just 41% of the FPL (\$8,905 for a family of three), and, with the exception of Wisconsin, other adults are not eligible regardless of their income level.

Figure 1

Median Medicaid Income Eligibility Limits based on Implementation of Medicaid Expansion as of January 2020



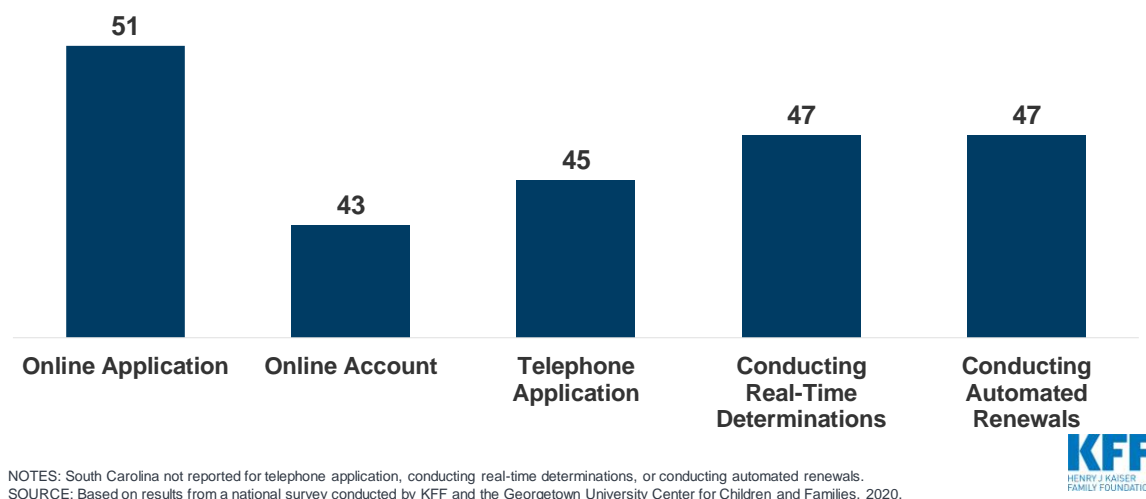
NOTES: Eligibility levels are based on a family of three for parents and an individual for childless adults. In 2020, the FPL was \$21,720 for a family of three and \$12,760 for an individual. Thresholds include the standard five percentage point of FPL disregard. UT provided more limited coverage to some childless adults under Section 1115 waiver authority prior to adopting expansion. OK provides more limited coverage to some childless adults under Section 1115 waiver authority.
SOURCE: Based on results from a national survey conducted by KFF and the Georgetown University Center for Children and Families, 2020.



Largely because of the ACA, individuals can apply for Medicaid and CHIP online or via phone, and states can connect individuals to coverage quickly through real-time eligibility determinations and renewals using electronic data matches. In addition to expanding coverage to low-income adults, the ACA established streamlined, electronic data-driven enrollment and renewal processes across states and made enhanced federal funding available to states for system upgrades to implement these processes. As of January 2020, online and phone applications and renewals have become largely standard across states, and most states (43) provide online accounts that enable enrollees to manage their coverage (Figure 2). In contrast, prior to the ACA, individuals could only apply online in two-thirds of states and by phone in one-third of states. Further, as of January 2020, nearly all states are able to make real-time determinations (defined as within 24 hours) and to conduct automated renewals through electronic data matches, with some states achieving high rates of real-time determinations and automated renewals. These advancements mean that individuals may be able to access Medicaid and CHIP coverage more quickly with less administrative burden as coverage needs increase in response to COVID-19.

Figure 2

Number of States with Selected Modernized Enrollment and Renewal Processes, January 2020



Eligible individuals may face barriers to maintaining coverage at renewal or when states conduct periodic data matches between renewals. States must renew coverage every 12 months and try to complete renewals using available data before requesting information from an enrollee. When a state requires additional information to complete a renewal, it must provide the enrollee at least 30 days to verify eligibility before terminating coverage. Between annual renewals, enrollees generally must report changes that may affect eligibility, such as fluctuations in income, which are more common among the low-income population. States also may conduct periodic data checks to identify potential changes between renewals, which 30 states reported doing as of January 2020. When states identify a potential change, they must request information to confirm continued eligibility. In contrast to the minimum 30 days provided at renewal, a number of states provide only 10 days from the date of notice for enrollees to respond to information requests for potential changes in circumstances. Eligible individuals may lose coverage at renewal or when these periodic data checks occur if they do not respond to information requests in required timeframes. Enrollees may face a range of challenges to these requests, particularly when given limited time to respond. States can delay or suspend renewals and periodic data checks as one strategy to promote stable coverage as part of COVID-19 response efforts. To access enhanced federal funding under Families First Coronavirus Response Act, states must provide continuous eligibility for enrollees through the end of the month of the emergency period unless an individual asks to be disenrolled or ceases to be a state resident.

Some states have adopted policy options to facilitate enrollment in coverage and promote continuity of coverage. For example, 31 states use presumptive eligibility for one or more groups to expedite enrollment in Medicaid or CHIP coverage by providing temporary coverage to individuals who

appear likely eligible while the state processes their full application. In addition, 32 states provide 12-month continuous eligibility to children in Medicaid or CHIP, enabling them to maintain coverage even if their households have small fluctuations in income. Further, 35 states take into account reasonably predictable changes in income when determining eligibility for Medicaid and 12 states take into account projected annual income for the remainder of the calendar year when determining ongoing eligibility at renewal or when an individual has a potential change in circumstances. Some states also have adopted processes to improve communications with enrollees. For example, 10 states reported taking proactive steps to update enrollee address information, and 24 states report routinely following up on returned mail by calling and/or sending email or text notifications. Additional states could take up these policy and processes as part of COVID-19 response efforts.

Premiums and cost sharing are limited consistent with federal rules that reflect enrollees' limited ability to pay out-of-pocket health care costs. Under federal rules, states may not charge premiums in Medicaid for enrollees with incomes less than 150% FPL and cost-sharing amounts are limited. Only five states charge premiums or cost sharing for children within Medicaid, while most separate CHIP programs (32 of 35 states) charge premiums, enrollment fees, and/or copayments. Similarly, few states charge premiums, enrollment fees, or other monthly contributions for parents or other adults in Medicaid. However, several states have obtained waivers to impose premiums or other charges in Medicaid for parents or other adults that federal rules do not otherwise allow, and two-thirds of states (35 states) charge copayments for parents and other adults. States can waive or eliminate out-of-pocket costs in response to COVID-19.

Responding to COVID-19

Prior to the COVID-19 outbreak, the federal government and some states were taking actions to add eligibility requirements and increase eligibility verification for Medicaid coverage. The administration approved waivers in several states to allow work requirements and other eligibility restrictions and released guidance for [new "Healthy Adult Opportunity" demonstrations](#) that would allow for such requirements and other changes. [Recent court decisions](#) set aside or struck down work requirements and suggested that similar approvals are likely to be successfully challenged in litigation. The administration also indicated plans to increase eligibility verification requirements as part of [program integrity efforts](#). Outside of Medicaid, other policy changes were contributing to downward trends in coverage, including decreased federal funding for outreach and enrollment and shifting immigration policies. However, given increasing health care needs stemming from COVID-19, states and Congress are taking action to expand eligibility, expedite enrollment, promote continuity of coverage, and facilitate access to care.

[States can take a range of actions](#) under existing rules to facilitate access to coverage and care in response to COVID-19. They can take some of these actions quickly without federal approval. For example, they can allow self-attestation of eligibility criteria other than citizenship and immigration status and verify income post enrollment. They can also provide greater flexibility to enroll individuals who have small differences between self-reported income and income available through data matches. Further,

they can suspend or delay renewals and periodic data checks between renewals. States can take other actions allowed under existing rules by submitting a state plan amendment (SPA, which is retroactive to the first day of the quarter submitted). Changes states can implement through a SPA include expanding eligibility, adopting presumptive eligibility, providing 12-month continuous eligibility for children, and modifying benefit and cost sharing requirements, among others. Beyond these options, states can seek additional flexibility through Section 1135 and Section 1115 waivers.

The [Families First Coronavirus Response Act](#) provides additional options for states and increases federal funding for Medicaid, subject to states meeting certain eligibility and enrollment requirements. Specifically, it provides coverage for COVID-19 testing with no cost sharing under Medicaid and CHIP (as well as other insurers) and provides 100% federal funding through Medicaid for testing provided to uninsured individuals for the duration of the emergency period associated with COVID-19. The law also provides states and territories a temporary 6.2 percentage point increase in the federal matching rate for Medicaid for the emergency period. To receive this increase, states must meet certain requirements including: not implementing more restrictive eligibility standards or higher premiums than those in place as of January 1, 2020; providing continuous eligibility for enrollees through the end of the month of the emergency period unless an individual asks to be disenrolled or ceases to be a state resident; and not charging any cost sharing for any testing services or treatments for COVID-19, including vaccines, specialized equipment or therapies.

Introduction

This 18th annual survey of the 50 states and DC provides data on Medicaid and CHIP eligibility, enrollment, renewal, and cost-sharing policies as of January 2020 and highlights changes in 2019 and over the past decade, under the ACA. The report is based on a telephone survey of state Medicaid and CHIP program officials conducted by the Kaiser Family Foundation and the Georgetown University Center for Children and Families during January 2020. It includes findings in three key areas: Medicaid and CHIP eligibility, enrollment and renewal processes, and premiums and cost-sharing. State-specific information is available in Appendix Tables 1-19. The report includes policies for children, pregnant women, parents, and other adults under age 65 who are determined eligible based on Modified Adjusted Gross Income (MAGI) financial eligibility rules; it does not include policies for groups eligible through Medicaid pathways for seniors and individual eligible based on a disability (non-MAGI groups).

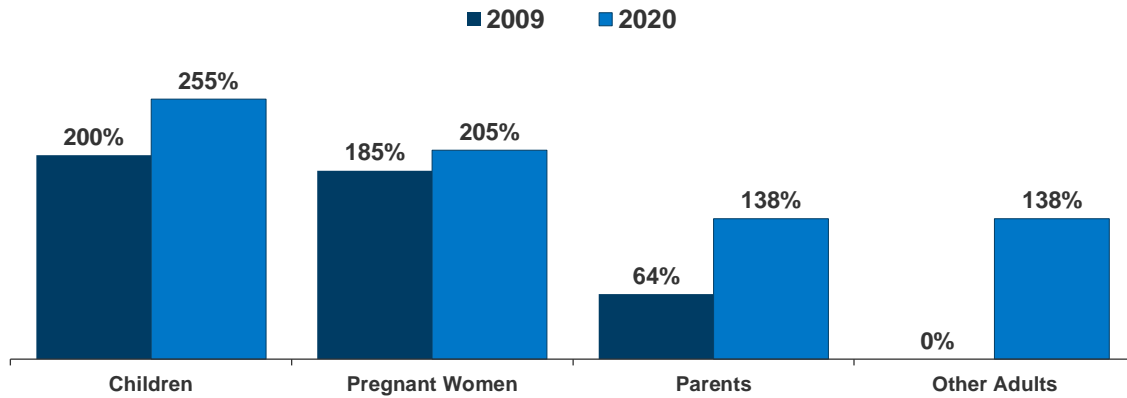
Medicaid/CHIP Eligibility

Medicaid and CHIP eligibility has evolved over time to provide a comprehensive base of coverage for low-income children, pregnant women, parents, and adults. Leading up to and following the creation of the CHIP in 1997, coverage for children and pregnant women expanded through federal eligibility expansions and state take-up of options to increase coverage for these groups. However, Medicaid eligibility for parents lagged behind. In 2009, the year before passage of the ACA, the median Medicaid eligibility level for working parents was below the poverty level (64% FPL). Moreover, prior to the ACA, states could not use federal Medicaid funds to cover adults without dependent children who did not qualify through a disability- or age-based pathway. As such, adults without dependent children were largely ineligible except in a handful of states with waivers that offered limited benefits and often capped enrollment. The CHIP Reauthorization Act of 2009 (CHIPRA) provided states additional options to expand coverage for children and pregnant women. Then, the enactment of the ACA in 2010 newly allowed states to receive federal Medicaid funds to cover adults without dependent children without a waiver and, as of 2014, provided enhanced federal matching funds for this coverage. As enacted, the ACA expanded Medicaid to nearly all adults with incomes at or below 138% FPL across states effective 2014. However, the 2012 Supreme Court ruling on the ACA effectively made the expansion a state option. Beyond the ACA Medicaid expansion to low-income adults, states have options available under federal rules to increase Medicaid eligibility above the federal minimum income limit of 138% FPL, at regular state match.

Over the past decade, median income eligibility levels significantly increased for parents and other adults, reflecting adoption of the ACA expansion. Median eligibility levels for children and pregnant women also rose over the period as states continued to take up of options to expand coverage for these groups. Specifically, the median Medicaid eligibility level for parents rose from 64% FPL in December 2009 to 138% FPL as of January 2020, while the median eligibility level for other adults increased from 0% FPL to 138% FPL. The median Medicaid/CHIP eligibility levels for children and pregnant women rose from 200% FPL to 255% FPL and from 185% FPL to 205% FPL, respectively, over the period. Despite the increases in eligibility for parents and other adults, eligibility levels for children and pregnant women remain higher than levels for parents and other adults (Figure 3).

Figure 3

Median Medicaid Eligibility Levels as a Percent of the Federal Poverty Level, 2009 and 2020



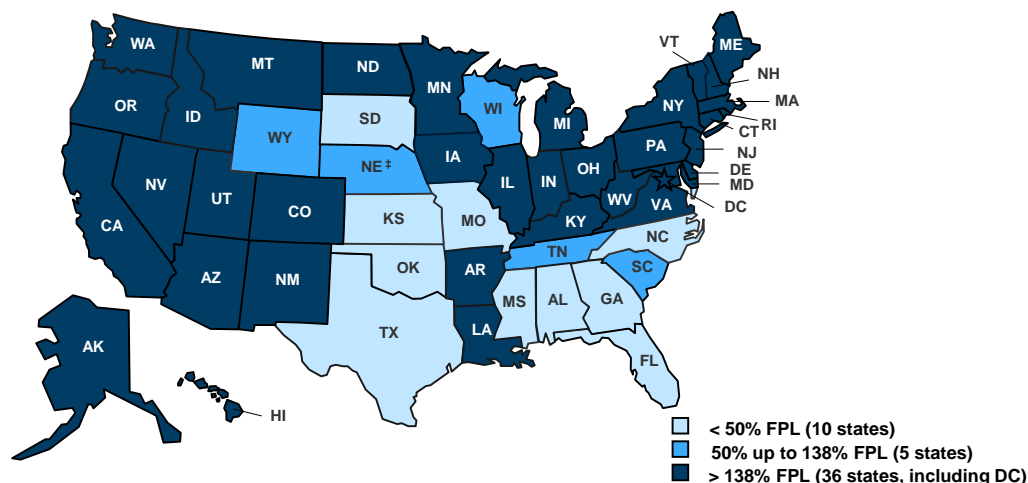
SOURCE: Based on results of a national survey conducted by KFF and the Georgetown Center for Children and Families, 2009 and 2020.



In 2019, two additional states (Idaho and Utah) implemented the ACA Medicaid expansion, bringing the total to 36 states that extend eligibility to low-income adults with incomes up to at least 138% federal poverty level (FPL, \$29,974 for a family of three) as of January 2020 (Figures 4 and 5). In 2019, Connecticut raised Medicaid eligibility for parents to 160% FPL. DC also covers parents and other adults above the minimum threshold, at 221% FPL and 215% FPL, respectively.

Figure 4

Medicaid Income Eligibility Levels for Parents, January 2020



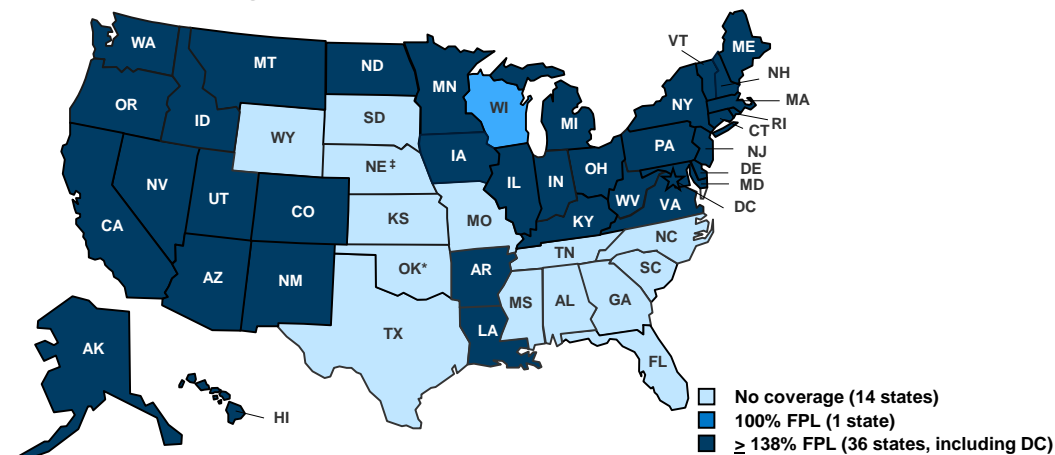
NOTE: Eligibility levels are based on 2020 federal poverty levels (FPLs) for a family of three. In 2020, the FPL was \$21,720 for a family of three. Thresholds include the standard five percentage point of the FPL disregard. ‡ NE passed a ballot initiative requiring the state to implement the ACA Medicaid expansion, but it was not implemented as of January 2020.

SOURCE: Based on results from a national survey conducted by KFF and the Georgetown University Center for Children and Families, 2020.



Figure 5

Medicaid Income Eligibility Levels for Other Adults, January 2020



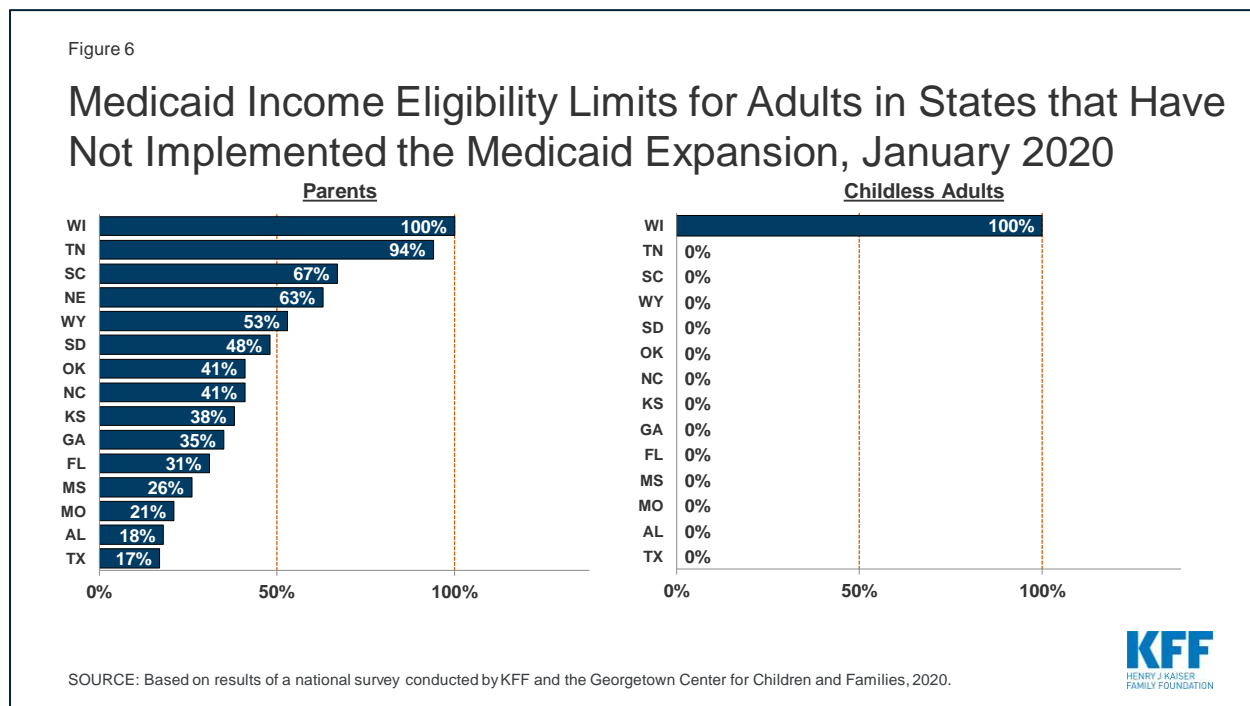
NOTE: Eligibility levels are based on 2020 federal poverty levels (FPLs) for a family of three. In 2020, the FPL was \$21,720 for a family of three. Thresholds include the standard five percentage point of the FPL disregard. *OK provides more limited coverage to some childless adults under Section 1115 waiver authority. ‡ NE passed a ballot initiative requiring the state to implement the ACA Medicaid expansion, but it was not implemented as of January 2020.

SOURCE: Based on results from a national survey conducted by KFF and the Georgetown University Center for Children and Families, 2020.



Eligibility for parents and other adults remains very limited in the 15 states that have not implemented the ACA Medicaid expansion. In non-expansion states, the median eligibility level for parents is just 41% of the FPL (\$8,905 for a family of three as of January 2020), and, with the exception of Wisconsin, other adults are not eligible regardless of their income level (Figure 6). Moreover, the

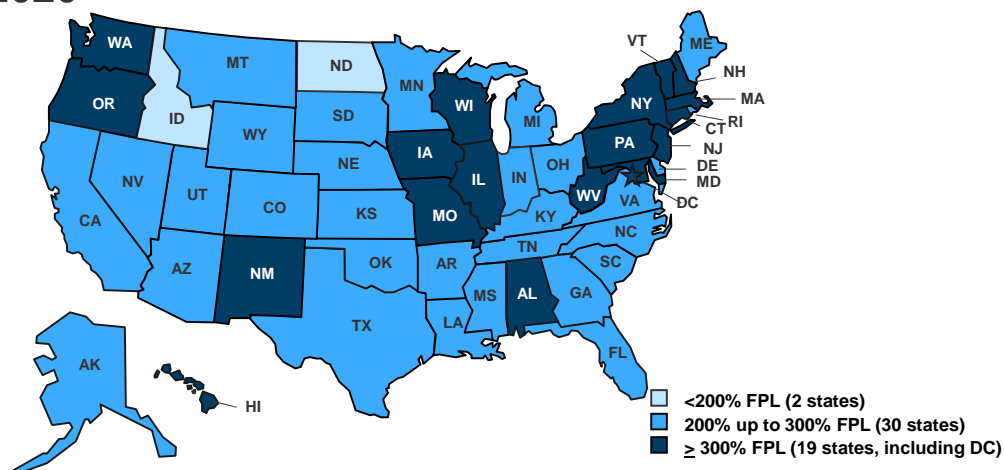
median eligibility level for parents in non-expansion states declined from 49% FPL to 41% FPL between 2019 and 2020. This erosion largely reflects the fact that ten non-expansion states base parent eligibility on a fixed dollar amount that states do not update on routine basis. As a result, the FPL equivalency declines over time as federal poverty levels adjust annually to account for inflation.



As of January 2020, nearly all states (49) cover children with family incomes up to at least 200% FPL through Medicaid and CHIP (Figure 7). Nineteen states cover children with family incomes at or above 300% FPL. However, eligibility levels vary widely across states, ranging from 175% FPL in North Dakota to 405% in New York.

Figure 7

Income Eligibility Levels for Children in Medicaid/CHIP, January 2020



NOTE: Eligibility levels are based on 2020 federal poverty levels (FPLs) for a family of three. In 2020, the FPL was \$21,720 for a family of three. Thresholds include the standard five percentage point of the FPL disregard.
 SOURCE: Based on results from a national survey conducted by KFF and the Georgetown University Center for Children and Families, 2020.

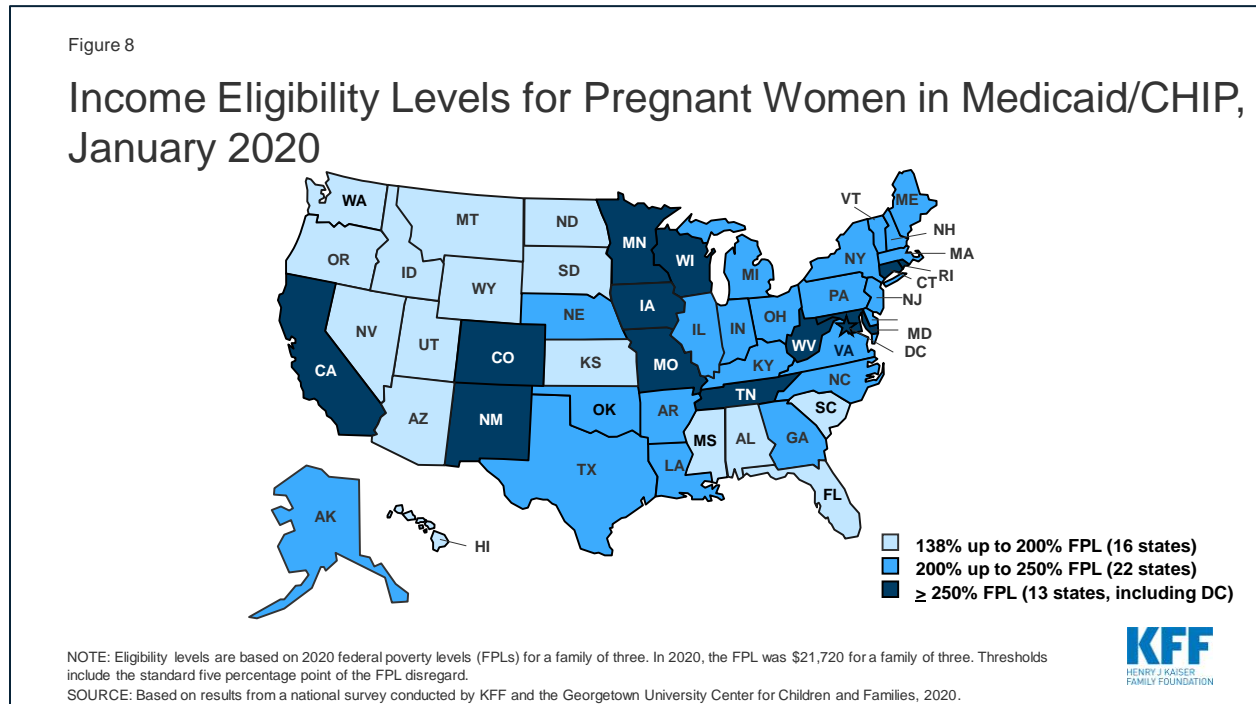
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Over time, states have increasingly integrated their Medicaid and CHIP programs. States can operate their CHIP program as a Medicaid expansion program, as a separate CHIP program, or use a combination of both approaches. In 2019, North Dakota eliminated its separate CHIP program and moved all children covered by CHIP into a Medicaid expansion program. With this change, 16 states administer their CHIP programs solely as extensions of Medicaid. CHIP coverage provided through Medicaid covers full Medicaid benefits, including EPSDT, and is subject to all Medicaid rules and protections. Operating CHIP as a Medicaid expansion makes the coverage between the two programs seamless for families and may be more administratively efficient for states since it eliminates the need to operate two distinct programs. Over the past decade, three other states (CA, MI, and NH) transitioned their separate CHIP programs into Medicaid.

As of January 2020, 35 states operate a separate CHIP program (alone or in combination with a CHIP Medicaid expansion). States have some flexibility over how they operate separate CHIP programs that is not available in Medicaid. For example, they can require children to be uninsured for a certain period before they can enroll in CHIP. As of January 2020, 13 of the 35 separate CHIP programs had a waiting period for children, which the ACA limited to no more than 90 days. Two states (ND and KS) eliminated CHIP waiting periods as of January 2020, continuing a trend of states removing waiting periods over the past decade. In December 2009, 35 of the 39 states with separate CHIP programs had waiting periods, 13 of which were 6 months or longer.¹

In 2019, two states increased Medicaid/CHIP eligibility for pregnant women, and the median eligibility level for pregnant women remained stable at 205% FPL. North Dakota raised its eligibility Medicaid eligibility limit for pregnant women to 162% FPL, while West Virginia expanded eligibility to

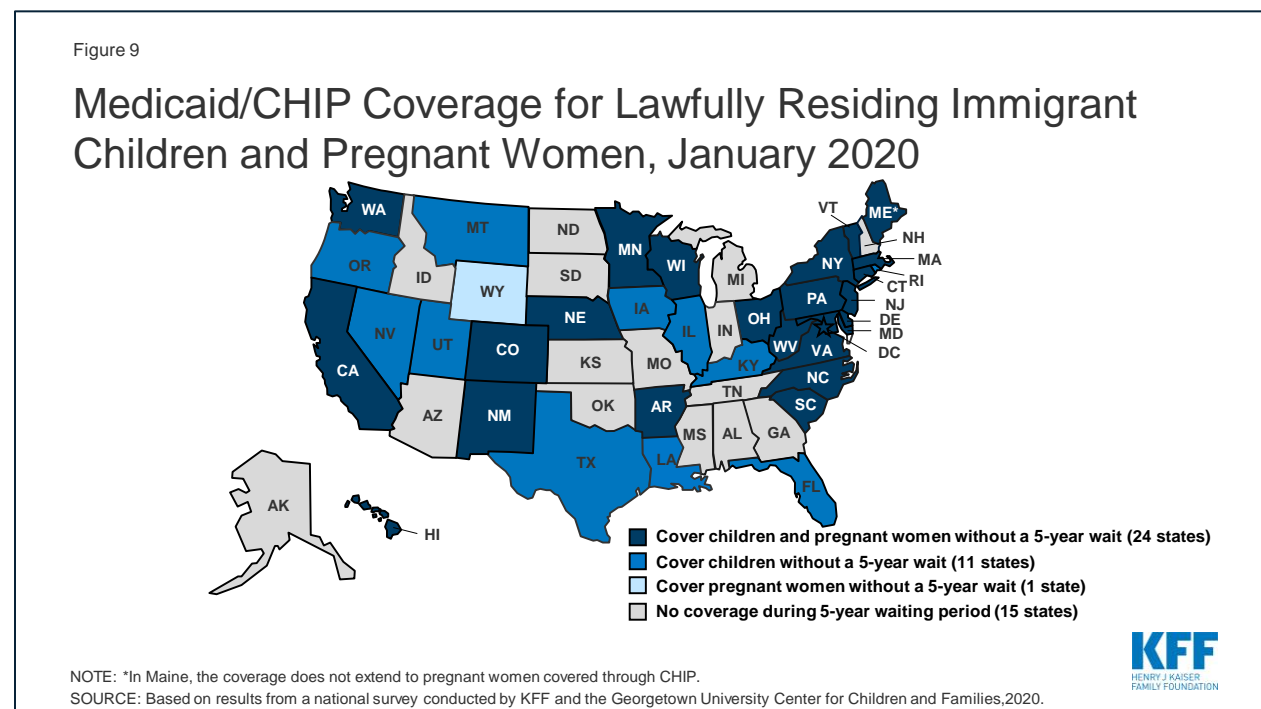
305% FPL through CHIP. As of January 2020, nearly all states (49 states) extend eligibility for pregnant women beyond the federal minimum of 138% FPL. A total of 35 states extend eligibility to at least 200% FPL, including 12 states that cover pregnant women above 250% FPL (Figure 8). However, eligibility varies from a low of 138% FPL in Idaho and South Dakota to a high of 380% FPL in Iowa.



Nine states reported plans to extend the postpartum eligibility period for pregnant women. In response to increasing rates of maternal mortality and severe morbidity, some states and federal legislative proposals are seeking to extend the length of the postpartum Medicaid eligibility period.² Under current Medicaid rules, pregnancy-related coverage extends through 60 days postpartum. Because Medicaid/CHIP eligibility levels for pregnant women are higher than eligibility levels for parents in most states, women may lose Medicaid coverage at the end of the 60-day postpartum period. This risk of coverage loss is particularly high in states that have not implemented the ACA Medicaid expansion, where eligibility for parents remains very low. As of January 2020, nine states reported plans to extend the Medicaid postpartum eligibility period. Additional states may have pending legislative activity. Most of the nine states that reported activity were in the early planning stages. However, Illinois, Missouri, and New Jersey have developed Section 1115 waiver proposals to extend postpartum coverage, which vary in the length of extension and scope of pregnant women who would receive extended coverage. South Carolina received waiver approval in 2019 to extend postpartum coverage for a limited number of women with substance use disorder (SUD) and/or serious mental illness (SMI). California plans to use state-only funds to implement 12-month postpartum coverage for women with a documented mental health condition during pregnancy beginning July 1, 2020.

As of January 2020, New Jersey became the 29th states to offer family planning services using federal funds. The median eligibility level for family planning services is 205% FPL, but eligibility levels range from 138% in Louisiana and Oklahoma to a high of 306% FPL in Wisconsin. Two states limit eligibility for family planning services to individuals who have lost Medicaid coverage through another eligibility pathway.

A total of 35 states have eliminated the five-year waiting period for Medicaid/CHIP coverage for lawfully residing immigrant children and/or pregnant women (Figure 9). Lawfully residing immigrants may qualify for Medicaid and CHIP but are subject to eligibility restrictions that require many to wait five years before they may enroll even when they meet all other eligibility requirements. CHIPRA provided states an option to eliminate the five-year wait for lawfully residing immigrant children and pregnant women. Nearly half (24) of states apply the option to both children and pregnant women, while 11 states use it for children only, and one state (WY) uses it only for pregnant women. This count reflects Louisiana's adoption of the option for children in Medicaid and CHIP in 2019 and West Virginia's expansion of the option to pregnant women covered under CHIP up to 305% FPL. Since 2002, states also have had the option to provide prenatal care to women regardless of immigration status by extending CHIP coverage to the unborn child, which 17 states provided as of January 2020. Some states have state-funded programs that cover certain groups of immigrants that do not qualify for Medicaid or CHIP.



Enrollment and Renewal Processes

Changes under the ACA

Prior to the ACA, the enrollment and renewal process for Medicaid typically was a lengthy, paper-based process that could take weeks or, in some cases, months to complete. In many states, individuals could only apply via mail or in-person. Some states still required face-to-face interviews and/or imposed asset tests as part of the eligibility determination process and individuals generally had to provide paper documentation to verify eligibility criteria, such as income. Moreover, individuals often would have to repeat these steps at renewal, which could occur more frequently than once a year. These processes reflected the program's historic ties to cash assistance and most states' reliance on decades-old, mainframe-based eligibility systems that were difficult to reprogram and upgrade and generally had limited online functions or capabilities to conduct electronic data matches.

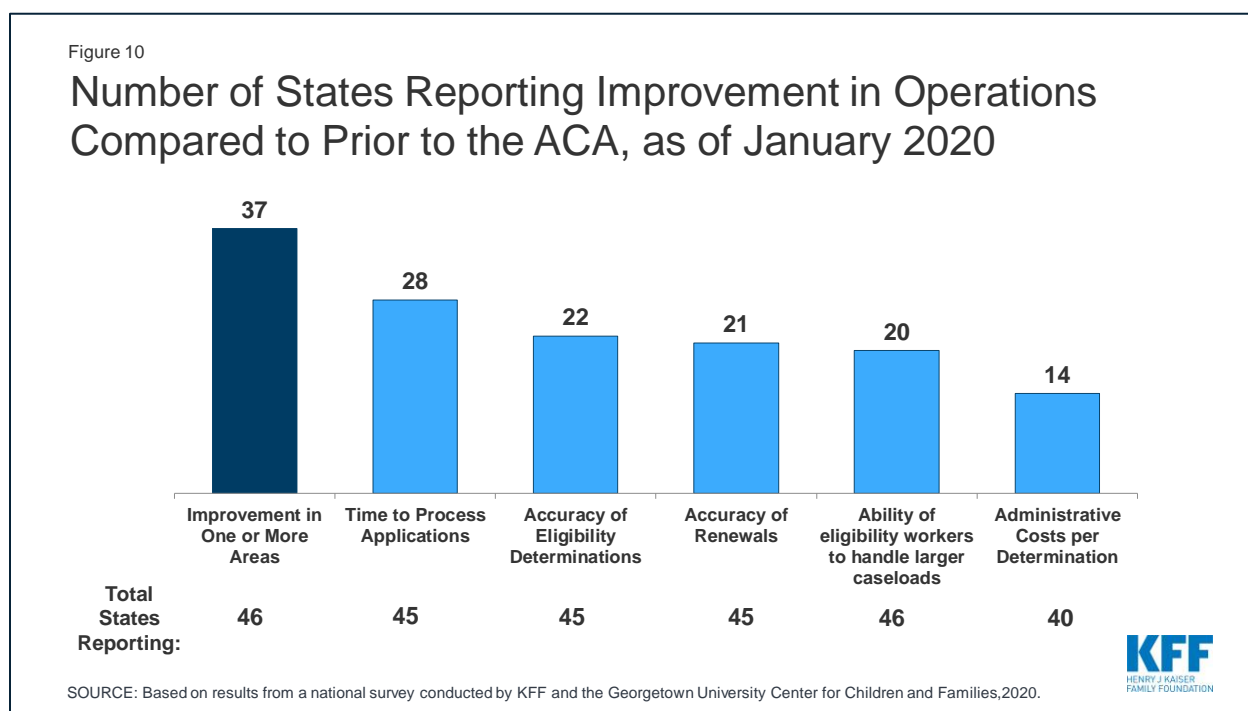
After the passage of CHIP, many states began streamlining enrollment and renewal processes to promote enrollment and retention of eligible children. For example, some states eliminated in-person interviews, worked to coordinate rules between Medicaid and CHIP, expanded availability of online and phone applications, reduced documentation requirements, and reduced the frequency of renewal for children.³ State experience showed that these actions contributed to increased enrollment and retention.⁴ State experience also showed that reinstatement of enrollment barriers led to significant enrollment declines. For example, in 2003, Texas experienced a nearly 30% enrollment decline after it increased premiums, established a waiting period, and moved from a 12- to 6-month renewal period for children in CHIP.⁵ When Washington State increased documentation requirements, moved from a 12- to 6-month renewal period, and ended continuous eligibility for children in Medicaid and CHIP in 2003, there was a sharp drop off in enrollment.⁶ Enrollment quickly rebounded when it reinstated the 12-month renewal period and continuous eligibility.⁷

In addition to expanding coverage to low-income adults, the ACA established streamlined enrollment and renewal rules that drew on previous state experience. These changes included removing face-to-face interviews and asset tests and establishing a 12-month renewal period, which became effective across all states as of January 2014. Prior to the ACA, most states had already removed face-to-face interview requirements and asset tests for children. However, as of December 2009, ten states still required in person interviews for parents and 25 states imposed an asset test for parents. Additionally, while most states had already adopted a 12-month renewal period for children (47 states) and parents (41 states), the remaining states still required renewals more frequently (e.g., every six months). The ACA required states to create a single streamlined application for Medicaid, CHIP, and Marketplace coverage and to provide options for individuals to apply for and renew coverage through multiple modes, including online and phone. The ACA also sought to modernize and improve the efficiency of eligibility determinations and renewals by requiring states to seek to use electronic data matches with reliable data sources to verify eligibility criteria before requesting information or documentation from individuals. To support states in upgrading and modernizing outdated eligibility systems to implement these processes, the Centers for Medicare and Medicaid Services (CMS) provided

states 90 percent federal funding for system development and 75 percent funding for ongoing operations. This influx of federal funding was key to enabling states to upgrade and replace systems, particularly at a time when many state budgets had not recovered from the Great Recession.

Eligibility System Upgrades and Integration

Most states report that system upgrades and modernized processes have contributed to improvements in eligibility and enrollment operations compared to before the ACA. Nearly all states have worked to upgrade or replace their eligibility systems to implement the new processes established under the ACA. However, system statuses and capabilities vary across states, reflecting differences in when they implemented system updates and whether they replaced or upgraded existing systems. The majority (37 of 46 reporting) states report improvement in at least one area of eligibility operations (Figure 10) compared to before the ACA, with 20 states indicating that operations had improved in three or more areas. Only five states report that one or more of these aspects of operations were worse, but several of those states continue to grapple with system implementation challenges, which are resolved as systems are tested and refined. Some states reported that these aspects of operations have not changed since the ACA.

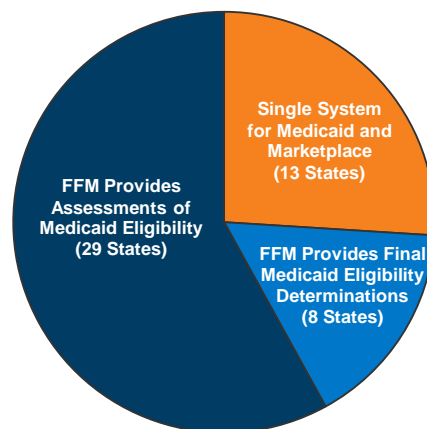


All state systems coordinate enrollment in Medicaid, CHIP, and the Marketplace coverage, but how this coordination occurs varies based on a state's Marketplace structure. In 2019, Nevada transitioned from using the federal marketplace, Healthcare.gov, for eligibility and enrollment functions (SBM-FP) to become a State-Based Marketplace (SBM). With this transition, 13 states operate a SBM as of January 2020 (Figure 11). An additional 4 states (Maine, New Jersey, New Mexico and Pennsylvania)

indicated plans to transition to an SBM in the future. SBM states typically have a single integrated system through which individuals can apply for and renew Medicaid, CHIP and Marketplace subsidies. The 38 states utilizing the FFM as of January 2020 electronically exchange data with the FFM to coordinate Medicaid and Marketplace coverage. While these transfers got off to a rocky start in 2014, states report that they are generally running smoothly with the occasional glitch that may occur when system updates are incorporated and/or amid large volume increases during the open enrollment period for Marketplace coverage. Eight states authorize the FFM to make final Medicaid eligibility determinations for MAGI groups and automatically enroll individuals the FFM deems eligible. The remaining states conduct full eligibility determinations for individuals after the FFM assesses them as eligible for Medicaid.

Figure 11

Relationship of Marketplace and Medicaid Eligibility Systems, January 2020



NOTES: South Carolina not reported.

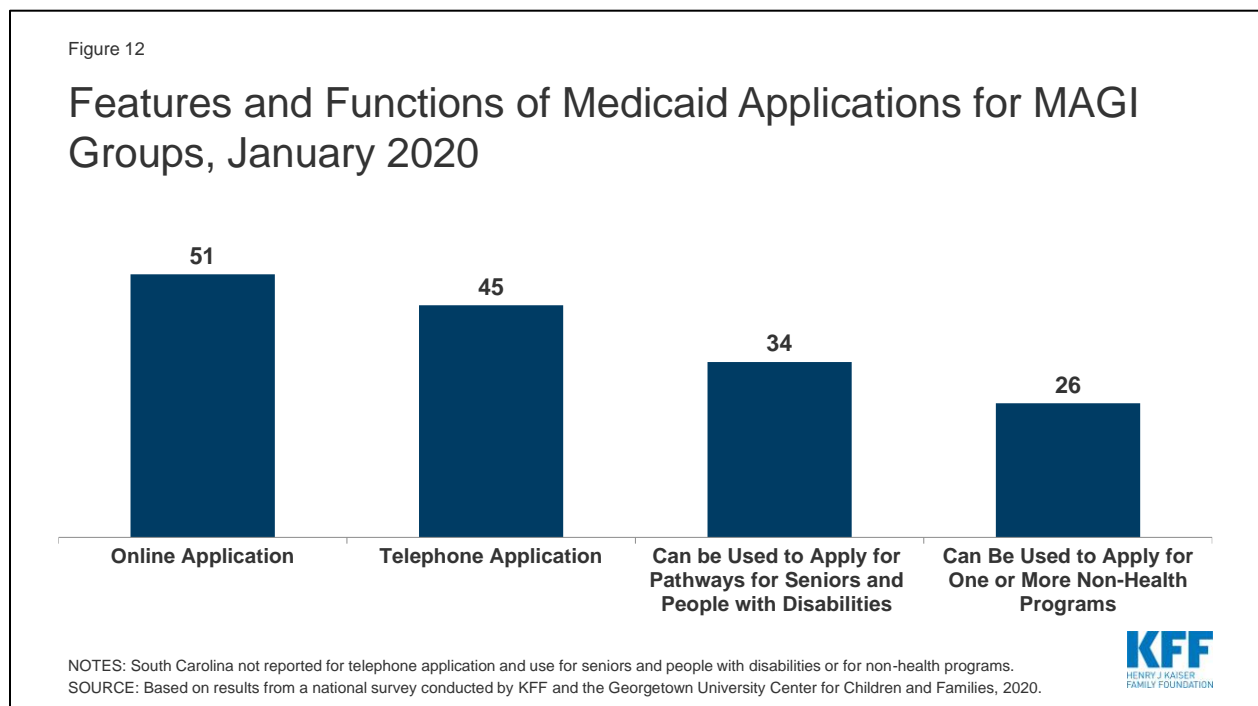
SOURCE: Based on results from a national survey conducted by KFF and the Georgetown University Center for Children and Families, 2020.



States continue to integrate non-MAGI Medicaid and non-health programs into their upgraded MAGI Medicaid systems. Prior to the ACA, all states determined eligibility for MAGI groups as well as seniors and individuals with disabilities (non-MAGI groups) through a single system. In addition, 44 state eligibility systems incorporated eligibility determinations for Medicaid and at least one non-health program, including the Supplemental Nutrition Assistance Program (SNAP), Temporary Aid to Needy Families with Dependent Children (TANF), and/or childcare subsidies. When states upgraded their MAGI Medicaid systems, a number separated them from non-MAGI groups and/or non-health programs. As new systems have matured, states have reintegrated determinations for non-MAGI groups and/or non-health programs into MAGI systems. As of January 2020, 31 states have an integrated system for MAGI and non-MAGI determinations and, in 24 states, the MAGI system is integrated with one or more non-health programs. A number of states reported plans to integrate non-MAGI Medicaid and/or non-health programs into their systems during or after 2020.

Applications, Online Accounts, and Mobile Access

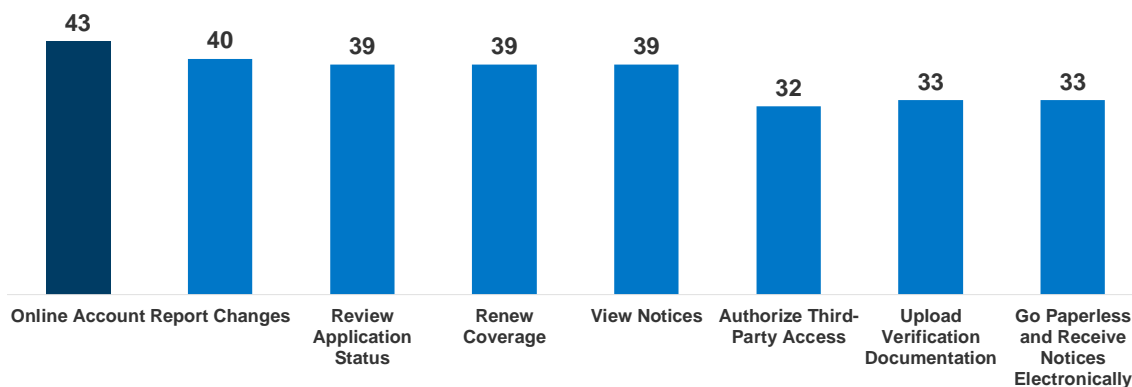
As of January 2020, online and phone applications have become standard options across the states. Just prior to the ACA in 2009, 32 states had an online application, some of which were fillable PDFs that did not connect to the eligibility system, and 16 states accepted telephone applications. Moreover, about half of states (24) had separate applications for children and parents. Today, all states offer a single application for parents and children that can be submitted online, and most states (45) process applications by phone (Figure 12). In 34 states, the application can also be used by individuals applying for non-MAGI eligibility pathways for seniors and people with disabilities and, in just over half of states (26), the application can also be used for at least one non-health program. Online applications have become the predominant mode of submission in nearly half the states (22), although the share of applications submitted online varies significantly across states and other modes of application, including in-person and mail, remain a primary method in some states.



Most states (43) offer online accounts that provide options for enrollees to report changes, submit documentation, or renew coverage as of January 2020 (Figure 13). By providing individuals an avenue to self-report changes, these accounts can help states maintain up-to-date information on enrollees and may reduce administrative tasks for eligibility workers. They also provide an avenue for enrollees to elect to receive communications from the state through text or email. Only a couple of states with advanced systems had online accounts before the ACA.

Figure 13

Number of States with Selected Features and Functions for Online Medicaid Accounts, January 2020



NOTES: South Carolina online account functions were not reported.

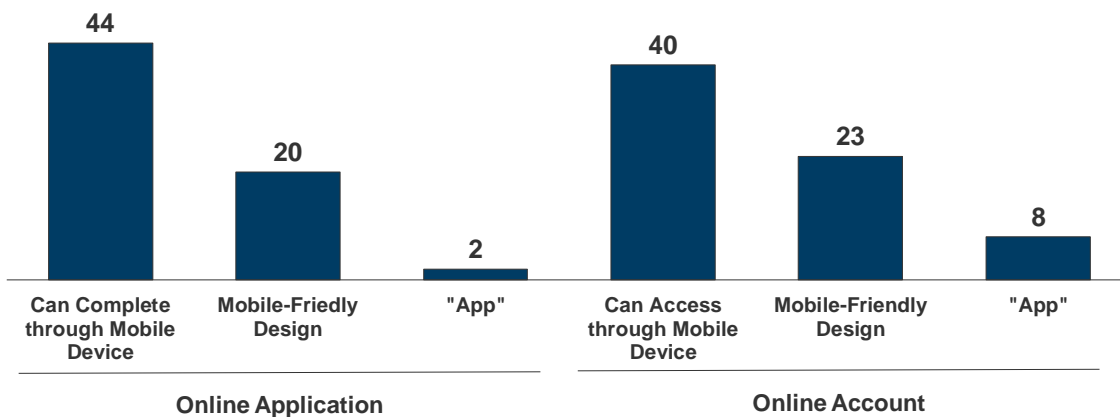
SOURCE: Based on results from a national survey conducted by KFF and the Georgetown University Center for Children and Families, 2020.



A growing number of states offer mobile access to applications and online accounts. As of January 2020, individuals can submit online applications through a mobile device in 44 states, up from 28 states in 2017, when this survey first collected these data. Enrollees can access online accounts via mobile devices in 40 states, up from 27 states in 2017 (Figure 14). Close to half of these states have taken steps to provide mobile-friendly designs for their application (20 states) and online accounts (23 states). Two states have also taken the next step to create a smart device ‘app’ for their application, while eight states offer an ‘app’ for their online account.

Figure 14

Number of States with Mobile Access to Online Medicaid Applications and Accounts, January 2020



NOTES: South Carolina not reported.

SOURCE: Based on results from a national survey conducted by KFF and the Georgetown University Center for Children and Families, 2020.



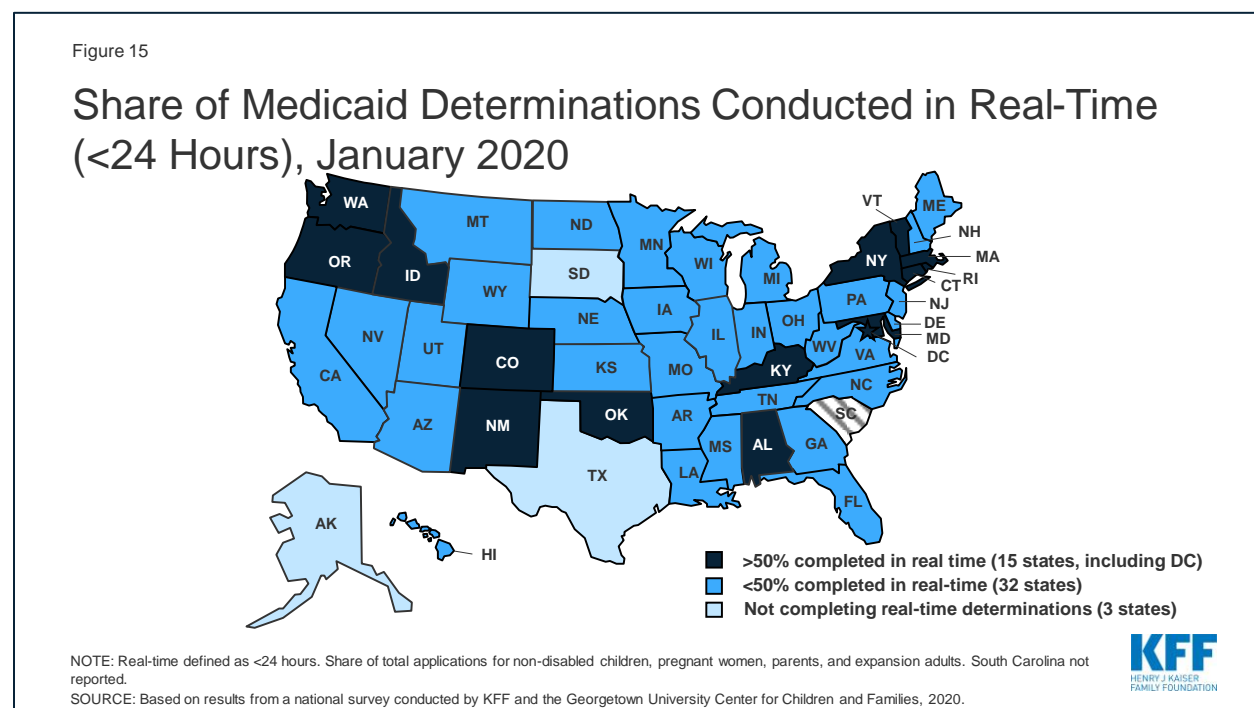
Eligibility Verification Policies

Under the ACA, states must seek to use data available through electronic data matches with reliable data sources to verify eligibility before requesting information from the individual. This process was designed to reduce paperwork burdens on states and enrollees and to allow for faster determinations. Under the ACA, all states must verify citizenship or qualified immigration status, as well as income, to determine eligibility for Medicaid and CHIP. States can electronically verify citizenship or immigration status directly with the Social Security Administration (SSA) or Department of Homeland Security (DHS), or through the federal data services hub that consolidates access to these and other data sources. States must verify citizenship status prior to determining eligibility, however, individuals who attest to a qualified status must be given a reasonable amount of time to provide documentation if eligibility cannot be confirmed electronically. States must also verify income and can do so through the SSA; the federal data hub; state databases, including unemployment, wage, and tax databases; and/or commercial databases. States can verify income prior to enrollment or enroll based on the applicant's reported income and verify post-enrollment. For other eligibility criteria, including age/date of birth, state residency, and household size, states can verify this information before or after enrollment or accept an individual's self-attestation unless there is discrepant information in the agency's records. To expedite enrollment as part of response to COVID-19, under existing rules, states can allow for self-attestation for all eligibility criteria, excluding citizenship and immigration status, on a case-by-case for individuals subject to a disaster when documentation is not available.

Today, all states use electronic data matches with one or more data sources to verify income, and most states (45) verify income prior to enrollment. Prior to the ACA, most states relied on paper

documentation to verify eligibility criteria, with less than a third of states (12) using other data sources to verify financial eligibility for children at application. As of January 2020, two-thirds of the states (34) use at least four electronic data sources to verify financial eligibility. A total of 46 states use state wage databases and 46 use state unemployment databases, while 41 states utilize the federal data services hub. Additionally, two-thirds of states (33) use commercial wage databases while just under half (23) access SNAP income data. Nearly two-thirds of states (31) indicate that most income data checks are conducted automatically by the system while another third (16 states) indicate that they conduct these data matches through a mix of automatic matches and manual lookups by eligibility workers. Only three states rely mostly on manual lookups. Most states (33) utilize a reasonable compatibility standard, typically 10%, under which they will determine an individual eligible even if there is a small difference between the amount of reported income and the amount identified through electronic data matches that would otherwise affect eligibility.

Reflecting use of electronic data matches, as of January 2020, 47 states are able to make real-time eligibility determinations (defined as within 24 hours). Nearly one third of these states (15) report that they make more than half of MAGI-based determinations in real time, including 10 that report making over three-quarters of determinations in less than 24 hours (Figure 15). States processing the majority of their applications in real-time are more likely to report that their eligibility system conducts most income verifications automatically without caseworker action. Most states (42) indicate they do not have delays or backlogs in processing applications; the 8 states reporting delays or backlogs generally cite ongoing system challenges or increased application volume due to open enrollment or implementation of the Medicaid expansion.



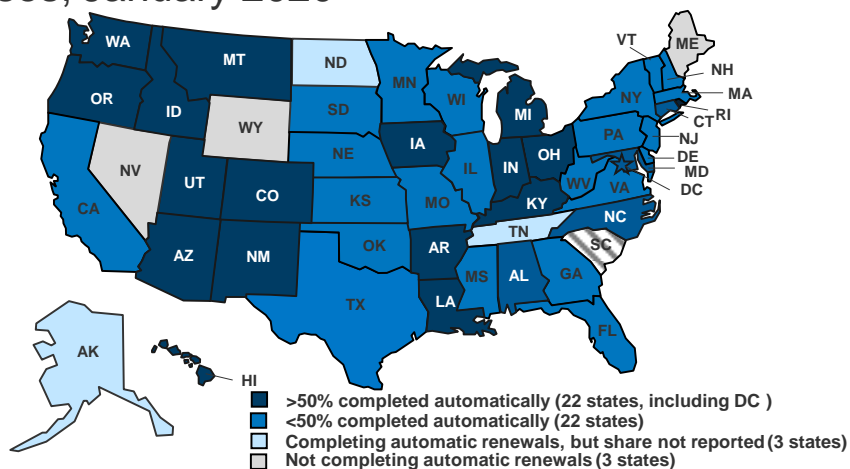
Renewal Processes

Under the ACA, states must seek to complete automated or ex parte renewals by verifying ongoing eligibility through available data sources before requesting a form or documentation from an enrollee. If a state cannot determine that an individual remains eligible based on available information, it must provide the enrollee with a pre-populated form containing the information relevant to renewal and a reasonable period, at least 30 days, for the individual to provide the necessary information and correct any inaccuracies online, in person, by telephone or by mail.

As of January 2020, 47 states are conducting automated or ex parte renewals. This count reflects two states (Alaska and Tennessee), that implemented automated renewals in 2019. In contrast, just 16 states were completing automated or ex parte renewals in 2009, prior to the ACA. In 22 states, at least half of renewals are completed automatically, including 9 states where least three-quarters of renewals are automated and do not require enrollee action (Figure 16). Nearly two-thirds of states (31) report that their system conducts most automated or ex parte renewals without any manual caseworker action, while seven states report that these transactions include a mix of automated actions by the system and manual actions by caseworkers. Nine states report that most ex parte renewals require manual caseworker action. The majority of states (41) allow enrollees to renew by phone without a paper form or signature if the state cannot complete an automated renewal and the enrollee must submit information. However, the large majority of states only contact enrollees 1-2 times to request additional information before terminating coverage, and in a number of cases, enrollees only receive a second contact if they have elected to receive electronic notices through an online account.

Figure 16

Share of Medicaid Renewals Completed Using Automated Processes, January 2020



NOTE: Share of renewals for non-disabled children, pregnant women, parents and expansion adults. South Carolina not reported.
SOURCE: Based on results from a national survey conducted by KFF and the Georgetown University Center for Children and Families, 2020.

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Ten states report delays or backlogs in processing renewals in Medicaid or CHIP. These largely are states in the midst of new system builds or major system upgrades that also have delays in processing applications. Three states report that some renewals have been temporarily suspended or delayed, a mitigation strategy that CMS has allowed when states are dealing with system issues or increased volume that inhibit timely processing of applications and renewals. Additional states may delay or suspend renewals as part of their response to COVID-19. Moreover, under the Families First Coronavirus Response Act, to receive the enhanced federal match rate provided under the law, states must provide continuous eligibility for enrollees through the end of the month of the emergency period unless an individual asks to be disenrolled or ceases to be a state resident

Identifying Changes in Circumstances

Although the ACA established a 12-month renewal period, states disenroll individuals within that 12-month period if they have a change in circumstances that affects eligibility, such as an increase in income. Enrollees are required to report changes in circumstances that may affect eligibility. States may also conduct periodic electronic data matches to identify potential changes in circumstances between annual renewal periods. If a state receives information from the enrollee or through another data source about a change that may affect eligibility, it will review the information to determine ongoing eligibility and may request additional information or documentation from the individual to continue coverage. If the individual does not respond to a request within the required timeframe, the state will disenroll the individual from coverage. The Trump administration has promoted use of periodic data matches between renewals as a program integrity strategy.⁸ However, as noted above, to access enhanced federal funding under the Families First Response Act, states generally must provide continuous eligibility for enrollees through the end of the emergency period.

As of January 2020, 30 states reported that they conduct data matches on a periodic basis to identify potential changes that may affect financial or other eligibility criteria between annual renewal periods (Figure 17). The frequency of these checks varies across states and the data sources used for the review. For example, since 2014, Texas has checked income for households with children on Medicaid in the fifth, sixth, seventh, and eighth month of enrollment. These checks are timed to the child's start date, so households with multiple children who enrolled in coverage at different times face checks even more frequently. In contrast to the minimum 30 days provided at renewal, a number of states that conduct data matches provide only 10 days from the date of notice for enrollees to respond to information requests. Similar to the processes used at renewal, most states only contact enrollees 1-2 times to request this information before terminating coverage with the second notice often sent only to individuals opting for electronic notices through their online accounts.

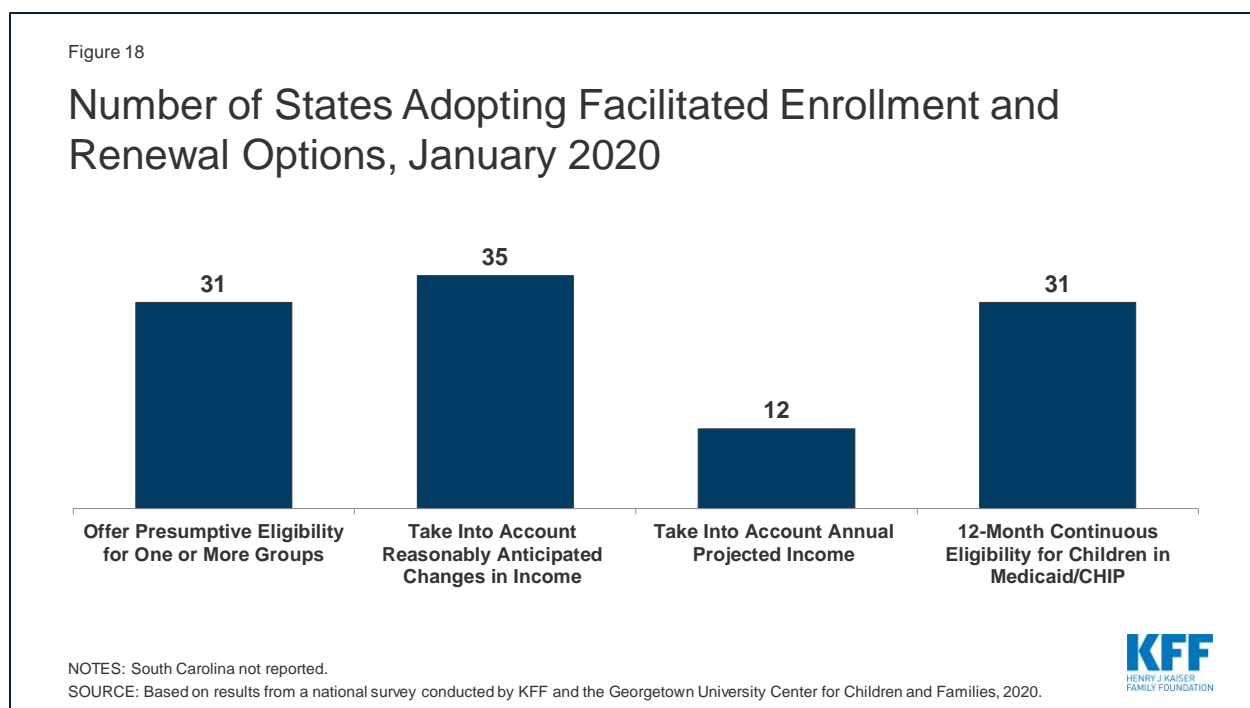
Number of States Conducting Periodic Data Matches, January 2020



States can adopt policy options and processes to promote continuity of coverage and minimize coverage gaps or churn—that is, people moving on and off of coverage over relatively short periods of time. These include policy options that can expedite enrollment and prevent coverage gaps due to small fluctuations in income. Income volatility is common among the low-income population, for example, due to seasonal work or fluctuating hours due to employment in industries such as food service and construction.^{9,10} States can also implement processes that enhance communications with enrollees to help prevent individuals from losing coverage because they are not receiving or responding to notices from the state. Enrollees may not receive mailed notices if they move frequently, which also is more common among the low-income population.¹¹ Stable coverage and reduction of churn promotes more continuous access to care, enhances the state's ability to measure the quality of care, and can reduce administrative costs and burden associated with moving people on and off of coverage.

As of January 2020, 31 states are using presumptive eligibility for one or more groups to expedite enrollment in Medicaid or CHIP coverage (Figure 18). Presumptive eligibility is a longstanding option that allows states to authorize certain qualified entities, like community health centers or schools, to enroll children or pregnant women who appear likely eligible for coverage while the state processes the full application. Presumptive eligibility can be particularly helpful when individuals may need extra time to collect documents needed to complete a full eligibility determination. Under the ACA, states were required to allow hospitals to conduct presumptive eligibility determinations regardless of whether the state had otherwise adopted the policy. The ACA also allowed states that use presumptive eligibility for pregnant women or children to extend the policy for other groups, including parents and other adults. As of January

2020, most states use presumptive eligibility for pregnant women (30 states) and children (19 states) while fewer have implemented the option for parents (9 states), other adults (8 states), family planning coverage (6 states) and former foster youth (8 states).



A total of 35 states take into account reasonably predictable changes in income when determining eligibility for Medicaid as of January 2020. This option enables states to account for anticipated income changes, such as recurring seasonable employment or a job change, when determining eligibility at application or renewal. For example, under this option, if a teacher receives a salary under a 10-month contract, the state would divide that income over 12 months to determine current monthly income for assessing eligibility. In addition, 12 states have adopted a similar option to take into account projected annual income for the remainder of the calendar year when determining ongoing eligibility at renewal or when an individual has a potential change in circumstances between renewal periods. This enables individuals to maintain coverage if their projected annual income is below the Medicaid threshold, even if their current monthly income is above the threshold when eligibility is assessed.¹² In most cases, the individual or an eligibility caseworker must request or take action to have anticipated income changes or projected annual considered rather than the system accounting for these options automatically.

As of January 2020, 31 states provide 12-month continuous eligibility to children in either Medicaid or CHIP. Under this option, states allow a child to remain enrolled for a full year unless the child ages out of coverage, moves out of state, voluntarily withdraws, or does not make premium payments. As such, 12-month continuous eligibility eliminates coverage gaps due to fluctuations in income over the course of the year. Additionally, two states (Montana and New York) have extended 12-month continuous eligibility to adults under waiver authority.

Some states have implemented processes to facilitate communication with enrollees. For example, ten states reported taking proactive steps to update address information for enrollees. These include regular data matches with the U.S. Postal Service National Change of Address Database and working with managed care plans and providers to update address information. In addition, just under half of states reported routinely taking additional action such as calling enrollees or sending email or text notifications when they receive returned mail from a notice sent to an enrollee.

Premiums and Cost Sharing

Federal rules limit premiums and cost sharing in Medicaid and CHIP given enrollees' limited ability to pay out of pocket costs. Under these rules, states may not charge premiums in Medicaid for enrollees with incomes less than 150% FPL. However, some states have obtained waivers to impose charges in Medicaid that federal rules do not otherwise allow. Maximum allowable cost sharing varies by type of service and income in Medicaid (Table 1). CHIP programs have more flexibility to charge premiums and cost sharing, but both Medicaid and CHIP limit total family out-of-pocket costs to no more than 5% of family income, and states are required to maintain tracking systems to cease cost-sharing once a family meets the cap. Under the Families First Coronavirus Response Act, states must provide COVID-19 testing with no cost sharing under Medicaid and CHIP. Moreover, to access the increased federal match rate for Medicaid provided under the law, states may not charge any cost sharing for any testing or treatments for COVID-19, including vaccines, specialized equipment, or therapies.

Table 1: Allowable Cost Sharing Amounts for Adults in Medicaid by Income			
	<100% FPL	100% – 150% FPL	>150% FPL
Outpatient Services	up to \$4	up to 10% of state cost	up to 20% of state cost
Non-Emergency use of ER	up to \$8	up to \$8	No limit
Prescription Drugs	Preferred: up to \$4 Non-Preferred: up to \$8	Preferred: up to \$4 Non-Preferred: up to \$8	Preferred: up to \$4 Non-Preferred: up to 20% of state cost
Inpatient Services	up to \$75 per stay	up to 10% of state cost	up to 20% of state cost

Premiums and Cost Sharing for Children

The number of states (30) charging premiums or enrollment fees for children remained steady in 2019 (Figure 19). The total number of states charging premiums or enrollment fees for children has decreased from 34 in 2009, just prior to the ACA. This decrease, in part, reflects some states transitioning their separate CHIP programs to Medicaid expansions. The stability of premiums since then reflects that extensions in CHIP funding have included a maintenance of effort provision, under which states may not implement new premiums or increase premiums outside of routine increases that were approved in the state's plan as of 2010. As of January 2020, four states without separate CHIP programs charge premiums to children in Medicaid starting at 160% FPL, and 26 of the 35 separate CHIP programs charge

[illegible]

As of January 2020, the majority of states (29) do not charge copayments to children in Medicaid or CHIP. In 2019, North Dakota eliminated copayments for children in Medicaid and Wisconsin stopped charging copayments in both Medicaid and CHIP. With these changes, as of January 2020, 21 of the 35 states with separate CHIP programs charge copayments (Figure 20). Tennessee is the only state that charges copayments for children in Medicaid, and, under a longstanding waiver, it charges copayments for families with incomes below the federal minimum of 133% FPL. Cost sharing varies by state and service. At 151% FPL, 16 states charge cost sharing for non-preventive physician visits, 11 states charge for an inpatient hospital visit, and 12 charge for generic drugs.

Income at Which Cost Sharing for Children in Medicaid and/or CHIP Begins, January 2020

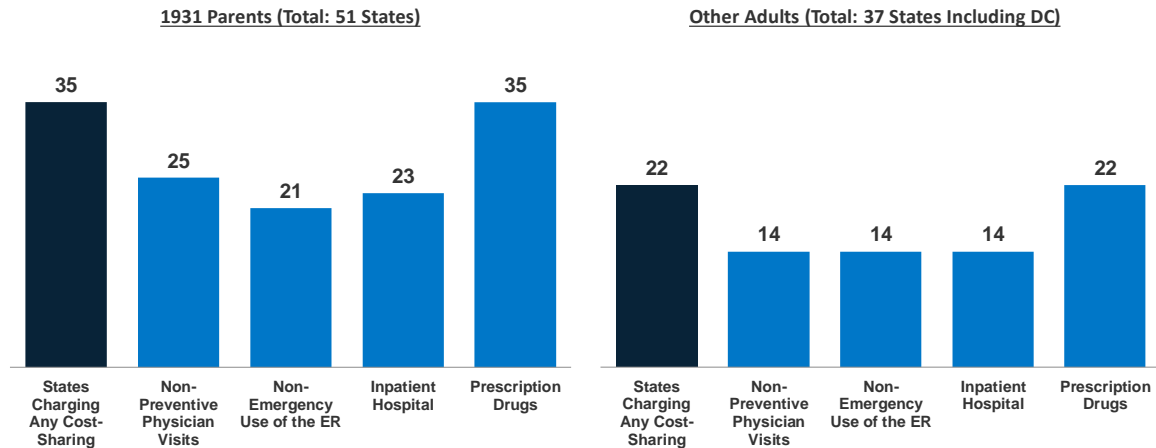


As of January 2020, seven states have approved waivers to charge premiums or monthly contributions for adults in Medicaid that federal rules do not otherwise allow, but only five states have implemented these charges.¹³ Arkansas, Indiana, Iowa, Michigan, and Montana charge premiums or monthly contributions for parents and other adults covered through the ACA Medicaid expansion. In Indiana, these charges also apply to parents covered through the traditional eligibility pathway that existed before the ACA. Some of these waivers also allow individuals to be locked out of coverage for a specified period if they are disenrolled due to non-payment and to delay coverage until after the first premium is paid.

As of January 2020, the majority of states charge cost sharing for parents and other adults, regardless of income. However, the total number of states charging cost sharing fell during 2019, with Illinois, Montana, and North Dakota eliminating copayments for parents and adults. Wisconsin also suspended copayments but plans to reinstate them in July 2020. As of January 2020, 35 states charge copayments for parents eligible for Medicaid under the traditional pathway that existed before the ACA (Figure 21). In addition, of the 37 states that cover other adults (counting the 36 states Medicaid expansion states and Wisconsin, which covers other adults but has not adopted the expansion), 22 charge copayments, including Utah, which expanded Medicaid as of January 2020.

Figure 21

Number of States with Cost Sharing for Selected Services for Adults, January 2020



NOTES: Wisconsin suspended copayments until July 2020.

SOURCE: Based on results from a national survey conducted by KFF and the Georgetown University Center for Children and Families, 2020.



Looking Ahead

Prior to the COVID-19 outbreak, the federal government and some states were taking actions to **add eligibility requirements and increase eligibility verification for Medicaid coverage**. The administration approved waivers in several states to allow work requirements and other eligibility restrictions and released guidance for [new “Healthy Adult Opportunity” demonstrations](#) that would allow for such requirements and other changes. [Recent court decisions](#) set aside or struck down work requirements and suggested that similar approvals are likely to be successfully challenged in litigation. The administration also indicated plans to increase eligibility verification requirements as part of [program integrity efforts](#). Outside of Medicaid, other policy changes were also contributing to downward trends in coverage, including decreased federal funding for outreach and enrollment and shifting immigration policies. However, given increasing health care needs stemming from COVID-19, states and Congress are taking action to expand eligibility, expedite enrollment, promote continuity of coverage, and facilitate access to care.

[States can take a range of actions](#) under existing rules to facilitate access to coverage and care in response to COVID-19. They can take some of these actions quickly without federal approval. For example, they can allow self-attestation of eligibility criteria other than citizenship and immigration status and verify income post enrollment. They can also provide greater flexibility to enroll individuals who have small differences between self-reported income and income available through data matches. Further, they can suspend or delay renewals and periodic data checks between renewals. States can take other actions allowed under existing rules by submitting a state plan amendment (SPA, which is retroactive to the first day of the quarter submitted). Changes states can implement through a SPA include expanding

eligibility, adopting presumptive eligibility, providing 12-month continuous eligibility for children, and modifying benefit and cost sharing requirements, among others. Beyond these options, states can seek additional flexibility through Section 1135 and Section 1115 waivers.

The [Families First Coronavirus Response Act](#) provides additional options for states and access to increased federal funding subject to states meeting certain eligibility and enrollment requirements. Specifically, it provides coverage for COVID-19 testing with no cost sharing under Medicaid and CHIP (as well as other insurers) and provides 100% federal funding through Medicaid for testing provided to uninsured individuals for the duration of the emergency period associated with COVID-19. The law also provides states and territories a temporary 6.2 percentage point increase in the federal matching rate for Medicaid for the emergency period. To receive this increase, states need to meet certain requirements including: not implementing more restrictive eligibility standards or higher premiums than those in place as of January 1, 2020; providing continuous eligibility for enrollees through the end of the month of the emergency period unless an individual asks to be disenrolled or ceases to be a state resident; and not charging any cost sharing for any testing services or treatments for COVID-19, including vaccines, specialized equipment or therapies.

Endnotes

¹ Donna Cohen Ross and Caryn Marks, *Challenges of Providing Health Coverage for Children and Parents in a Recession, A 50 State Update on Eligibility, Enrollment, Renewal, and Cost-Sharing Practices in Medicaid and SCHIP in 2009*, (Washington, DC: Kaiser Family Foundation, January 2009), <https://www.kff.org/medicaid/report/challenges-of-providing-health-coverage-for-children/>.

² Kaiser Family Foundation, "Analysis of Federal Bills to Strengthen Maternal Health Care," accessed March 9, 2020, <https://www.kff.org/womens-health-policy/fact-sheet/analysis-of-federal-bills-to-strengthen-maternal-health-care/>.

³ Kaiser Family Foundation, *Key Lessons from Medicaid and CHIP for Outreach and Enrollment Under the Affordable Care Act*, (Washington, DC: Kaiser Family Foundation, June 4, 2013), <https://www.kff.org/medicaid/issue-brief/key-lessons-from-medicaid-and-chip-for-outreach-and-enrollment-under-the-affordable-care-act/>.

⁴ Ibid.

⁵ Ibid.

⁶ Donna Cohen Ross and Laura Cox, *Beneath the Surface: Barriers Threaten to Slow Progress on Expanding Health Coverage of Children and Families, A 50 State Update on Eligibility, Enrollment, Renewal, and Cost-Sharing Practices in Medicaid and CHIP*, (Washington, DC: Kaiser Family Foundation, October 2004), <https://www.kff.org/wp-content/uploads/2013/01/beneath-the-surface-barriers-threaten-to-slow-progress-on-expanding-health-coverage-of-children-and-families-pdf.pdf> and Laura Summer and Cindy Mann, *Instability of Public Health Insurance Coverage for Children and their Families: Causes, Consequences, and Remedies*, (New York: The Commonwealth Fund, June 2006), <http://www.commonwealthfund.org/publications/fund-reports/2006/jun/instability-of-public-health-insurance-coverage-for-children-and-their-families--causes--consequence>.

⁷ Laura Summer and Cindy Mann, *Instability of Public Health Insurance Coverage for Children and their Families: Causes, Consequences, and Remedies*, (New York: The Commonwealth Fund, June 2006), <http://www.commonwealthfund.org/publications/fund-reports/2006/jun/instability-of-public-health-insurance-coverage-for-children-and-their-families--causes--consequence>.

⁸ Centers for Medicare and Medicaid Services, "Oversight of State Medicaid Claiming and Program Integrity Expectations," June 20, 2019, <https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/cib062019.pdf>.

⁹ Elaine Maag, H. Elizabeth Peters, Anthony Hannagan, Cary Lou, and Julie Siwicki, *Income Volatility: New Research Results with Implications for Income Tax Filing and Liabilities*, (Washington, DC: Urban Institute, 2017), https://www.urban.org/sites/default/files/publication/90431/2001284-income-volatility-new-research-results-with-implications-for-income-tax-filing-and-liabilities_0.pdf.

¹⁰ Rachel Garfield, Robin Rudowitz, Kendal Orgera and Anthony Damico, *Understanding the Intersection of Medicaid and Work: What Does the Data Say?*, (Washington, DC: Kaiser Family Foundation, August 2019), <https://www.kff.org/report-section/understanding-the-intersection-of-medicaid-and-work-what-does-the-data-say-issue-brief/>.

¹¹ Robin Phinney, "Exploring Residential Mobility among Low-Income Families." *Social Service Review* 87, no. 4 (2013): 780-815. Accessed March 8, 2020. doi:10.1086/673963.

¹² Centers for Medicare and Medicaid Services, "MAGI 2.0: Building MAGI Knowledge," September 1, 2016, <https://www.medicaid.gov/state-resource-center/mac-learning-collaboratives/downloads/part-2-income.pdf>.

¹³ Arizona has obtained waiver approval to charge premiums to certain expansion adults but the state has not implemented as of January 2020. In 2019, the courts struck down Kentucky's waiver that included monthly charges for adults, and, under new state leadership, the state ultimately withdrew its waiver request. New Mexico also had obtained a waiver to charge premiums for certain adults starting in

2019; however, the new governor amended the waiver to remove this authority and does not intend to implement premiums.

Trend and State-by-State Tables

- Table A:* Trends in State Medicaid and CHIP Eligibility, Enrollment, and Renewal Policies, July 2000 - January 2020
- Table 1:* Income Eligibility Limits for Children's Health Coverage as a Percent of the Federal Poverty Level, January 2020
- Table 2:* State Adoption of Optional Medicaid and CHIP Coverage for Children, January 2020
- Table 3:* Medicaid and CHIP Coverage for Pregnant Women and Medicaid Family Planning Expansion Programs, January 2020
- Table 4:* Medicaid Income Eligibility Limits for Adults as a Percent of the Federal Poverty Level, January 2020
- Table 5:* Coordination between Medicaid and Other Systems, January 2020
- Table 6:* Online and Telephone Medicaid Applications for Children, Pregnant Women, Parents, and Expansion Adults, January 2020
- Table 7:* Features of Online Medicaid Accounts, January 2020
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- Table 9:* Income Verification and Real-Time Eligibility Determinations, January 2020
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- Table 11:* State Adoption of Options to Promote Continuity of Coverage for Children, Pregnant Women, Parents, and Expansion Adults, January 2020
- Table 12:* Presumptive Eligibility in Medicaid and CHIP, January 2020
- Table 13:* Premium, Enrollment Fee, and Cost Sharing Requirements for Children, January 2020
- Table 14:* Premiums and Enrollment Fees for Children at Selected Income Levels, January 2020
- Table 15:* Disenrollment Policies for Non-Payment of Premiums in Children's Coverage, January 2020
- Table 16:* Cost Sharing Amounts for Selected Services for Children at Selected Income Levels, January 2020
- Table 17:* Cost Sharing Amounts for Prescription Drugs for Children at Selected Income Levels, January 2020
- Table 18:* Premium and Cost Sharing Requirements for Selected Services for Section 1931 Parents, January 2020
- Table 19:* Premium and Cost Sharing Requirements for Selected Services for Medicaid Adults, January 2020

Table A: Trends in State Medicaid and CHIP Eligibility, Enrollment, and Renewal Policies, July 2000-January 2020 ^d																					
	Program	July 2000	Jan 2002	April 2003	July 2004	July 2005	July 2006	Jan 2008	Jan 2009	Dec 2009	Jan 2011	Jan 2012	Jan 2013	Jan 2015	Jan 2016	Jan 2017	Jan 2018	Jan 2020	Jan 2020		
ELIGIBILITY																					
Cover children >200% FPL	N/A	36	40	39	39	41	41	45	44	47	47	47	47	48	48	49	49	49	49		
Cover children >300% FPL	N/A	5	6	6	6	6	8	9	10	16	16	17	17	19	19	19	19	19	19		
Cover lawfully-residing immigrant children without five-year wait	Medicaid	Option Not Available									17	21	24	25	28	29	31	33	34	35	
	CHIP															19	21	22	23	24	
Cover pregnant women >200% FPL	N/A	NC		17	16	17	17	20	21	24	25	25	25	33	33	34	34	34	35		
Cover lawfully-residing immigrant pregnant women without five-year wait	Medicaid	Option Not Available									14	17	18	20	23	23	23	25	25	25	
	CHIP															4	3	3	3	4	
Cover parents ≥100% FPL ²	N/A	NC	20	16	17	17	16	18	18	17	18	18	18	31	34	35	34	35	37		
Cover other adults ^{2,3}	N/A	NC										7	8	25	29	32	33	33	35	37	
Asset test not required ^d	Medicaid Children	42	45	45	46	47	47	47	47	48	48	48	48	51	51	51	51	51	51		
	CHIP	31	34	34	33	33	34	35	36	37	36	37	36								
	Parents	NC	19	21	22	22	21	22	23	24	24	24	24								
STREAMLINED ENROLLMENT PROCESSES																					
Real-time eligibility determinations	N/A	NC													37	39	40	46	47		
Online Medicaid application ^d	Medicaid	NC									32	34		36	50	50	50	50	51	51	
Telephone Medicaid application ^d	Medicaid	NC													17	47	49	49	49	47	45
Presumptive eligibility for children	Medicaid	8	9	7	8	9	9	14	14	14	16	16	17	15	18	20	20	20	19		
	CHIP	4	5	4	6	6	6	9	9	9	10	11	12	9	10	11	11	11	10		
Presumptive eligibility for pregnant women	Medicaid	NC		29	29	30	31	30	30	30	31	31	32	27	29	30	30	30	30		
	CHIP												2	3	3	3	3				
No face-to-face interview at enrollment ^d	Medicaid Children	40	47	46	45	45	46	46	48	48	49	49	49	51	51	51	51	51	51		
	CHIP	31	34	33	33	33	33	34	38	38	37	38	37								
	Parents	NC	35	36	36	36	39	40	41	41	44	45	45								
STREAMLINED RENEWAL PROCESSES																					
Processing automated renewals	N/A	NC													34	42	46	46	47		
Telephone Medicaid renewal	N/A	NC													41	41	41	41	41		
No face-to-face interview at renewal ^d	Medicaid Children	43	48	49	48	48	48	48	49	50	50	50	50	51	51	51	51	51	51		
	CHIP	32	34	35	35	35	35	36	38	38	37	38	37								
	Parents		35	42	42	43	45	46	46	46	46	48	48								
12-month eligibility period ^d	Medicaid Children	39	42	42	41	42	44	45	44	47	49	49	49	51	51	51	51	51	51		
	CHIP	23	33	33	32	34	34	37	39	39	38	28	38								
	Parents		38	38	36	36	39	40	40	43	45	46	46								
12-month continuous eligibility for children	Medicaid	14	18	15	15	17	16	16	18	22	23	23	23	21	24	24	24	24	23		
	CHIP	22	23	21	21	24	25	27	30	30	28	28	27	25	26	26	26	26	25		

SOURCES: Based on a national survey conducted by the Kaiser Family Foundation with the Center on Budget and Policy Priorities, 1997-2009; and with the Georgetown University Center for Children and Families, 2011-2020.

NC indicates that data were not collected for the period. South Carolina did not report some data for January 2020.

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. This count includes Wisconsin's coverage of adults to 100% FPL.

4. Required across all states under the Affordable Care Act (ACA). 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. Mitigation strategies are in place in cases in which requirements have not yet been met.

Medicaid and CHIP Eligibility, Enrollment, and Cost Sharing Policies as of January 2020

Table 1: Income Eligibility Limits for Children's Health Coverage as a Percent of the Federal Poverty Level, January 2020 ¹								
State	Upper Income Limit	Medicaid Coverage for Infants Ages 0-1 ²		Medicaid Coverage for Children Ages 1-5 ²		Medicaid Coverage for Children Ages 6-18 ²		Separate CHIP for Uninsured Children Ages 0-18 ³
		Medicaid Funded	CHIP-Funded for Uninsured Children	Medicaid Funded	CHIP-Funded for Uninsured Children	Medicaid Funded	CHIP-Funded for Uninsured Children	
Median⁴	255%	195%	217%	148%	216%	138%	155%	255%
Alabama ⁵	317%	146%		146%		146%	107%-146%	317%
Alaska	208%	177%	159%-208%	177%	159%-208%	177%	124%-208%	
Arizona	205%	152%		146%		138%	104%-138%	205%
Arkansas	216%	147%		147%		147%	107%-147%	216%
California ⁶	266%	208%	208%-266%	142%	142%-266%	133%	108%-266%	
Colorado	265%	147%		147%		147%	108%-147%	265%
Connecticut	323%	201%		201%		201%		323%
Delaware	217%	217%	194%-217%	147%		138%	110%-138%	217%
District of Columbia ⁵	324%	324%	206%-324%	324%	146%-324%	324%	112%-324%	
Florida ⁷	215%	211%	192%-211%	145%		138%	112%-138%	215%
Georgia	252%	210%		154%		138%	113%-138%	252%
Hawaii	313%	191%	191%-313%	139%	139%-313%	133%	105%-313%	
Idaho	190%	147%		147%		138%	107%-138%	190%
Illinois	318%	147%		147%		147%	108%-147%	318%
Indiana ⁸	262%	218%	157%-218%	165%	141%-165%	165%	106%-165%	262%
Iowa	380%	380%	240%-380%	172%		172%	122%-172%	307%
Kansas ⁹	240%	171%		154%		138%	113%-138%	240%
Kentucky	218%	200%		142%	142%-164%	133%	109%-164%	218%
Louisiana	255%	142%	142%-217%	142%	142%-217%	142%	108%-217%	255%
Maine	213%	196%		162%	140%-162%	162%	132%-162%	213%
Maryland	322%	194%	194%-322%	138%	138%-322%	133%	109%-322%	
Massachusetts ¹⁰	305%	205%	185%-205%	155%	133%-155%	155%	114%-155%	305%
Michigan ¹¹	217%	195%	195%-217%	160%	143%-217%	160%	109%-217%	
Minnesota ¹²	288%	275%	275%-288%	280%		280%		
Mississippi	214%	199%		148%		138%	107%-138%	214%
Missouri	305%	201%		148%	148%-155%	148%	110%-155%	305%
Montana	266%	148%		148%		133%	109%-148%	266%
Nebraska	218%	162%	162%-218%	145%	145%-218%	133%	109%-218%	
Nevada	205%	165%		165%		138%	122%-138%	205%
New Hampshire	323%	196%	196%-323%	196%	196%-323%	196%	196%-323%	
New Jersey	355%	199%		147%		147%	107%-147%	355%
New Mexico	305%	240%	200%-305%	240%	200%-305%	190%	138%-245%	
New York	405%	223%		154%		154%	110%-154%	405%
North Carolina ¹³	216%	215%	194%-215%	215%	141%-215%	138%	107%-138%	216%
North Dakota ¹⁴	175%	147%	147%-175%	147%	147%-175%	133%	111%-175%	
Ohio	211%	156%	141%-211%	156%	141%-211%	156%	107%-211%	
Oklahoma ^{5,15}	210%	210%	169%-210%	210%	151%-210%	210%	115%-210%	
Oregon	305%	190%	133%-190%	138%		138%	100%-138%	305%
Pennsylvania	319%	220%		162%		138%	119%-138%	319%
Rhode Island	266%	190%	190%-266%	142%	142%-266%	133%	109%-266%	
South Carolina	213%	194%	194%-213%	143%	143%-213%	133%	107%-213%	
South Dakota	209%	187%	147%-187%	187%	147%-187%	187%	111%-187%	209%
Tennessee ^{5,16}	255%	195%	195%-216%	142%	142%-216%	133%	109%-216%	255%
Texas	206%	203%		149%		138%	101%-138%	206%
Utah	205%	144%		144%		138%	105%-138%	205%
Vermont	317%	317%	237%-317%	317%	237%-317%	317%	237%-317%	
Virginia	205%	148%		148%		148%	109%-148%	205%
Washington	317%	215%		215%		215%		317%
West Virginia	305%	163%		146%		138%	108%-138%	305%
Wisconsin ¹⁷	306%	306%		191%		133%	101%-156%	306%
Wyoming	205%	159%		159%		138%	119%-138%	205%

SOURCE: Based on a national survey conducted by KFF with the Georgetown University Center for Children and Families, 2020.

Table presents rules in effect as of January 1, 2020.

Table 1 Notes

1. January 2020 income limits are reported as a percentage of the federal poverty level (FPL). The FPL for a family of three is \$21,720 as of 2020. The reported levels reflect Modified Adjusted Gross Income (MAGI)-converted income standards and include a disregard equal to five percentage points of the FPL applied at the highest income level for Medicaid and separate CHIP coverage. In states without a separate CHIP program, the disregard is added to the highest Medicaid or the CHIP-funded Medicaid expansion limit. In states with a separate CHIP program, the disregard is applied to the highest Medicaid or CHIP-funded Medicaid expansion limit as well as to the upper eligibility limit of the separate CHIP program. Because CHIP funding is limited to uninsured children, in states that have a higher eligibility limit for their CHIP-funded Medicaid expansion than regular Medicaid, there may be a small number of children who have another source of coverage that would be eligible for Medicaid when the 5 percentage point disregard is applied, which is not reflected in the table.
2. States may use Title XXI CHIP funds to cover children through CHIP-funded Medicaid expansion programs and/or separate child health insurance programs for children not eligible for Medicaid. Use of Title XXI CHIP funds is limited to uninsured children. The Medicaid income eligibility levels listed indicate thresholds for children covered with Title XIX Medicaid funds and uninsured children covered with Title XXI funds through CHIP-funded Medicaid expansion programs. To be eligible in the infant category, a child has not yet reached his or her first birthday; to be eligible in the 1-5 category, the child is age one or older, but has not yet reached his or her sixth birthday; and to be eligible in the 6-18 category, the child is age six or older, but has not yet reached his or her 19th birthday.
3. The states noted use federal CHIP funds to operate separate child health insurance programs for children not eligible for Medicaid. Such programs may either provide benefits similar to Medicaid or a somewhat more limited benefit package. They also may impose premiums or other cost sharing obligations on some or all families with eligible children. Unlike Medicaid, which allows states to cover 19 and 20 years as children, CHIP coverage is limited to uninsured children under the age of 19.
4. Medians for CHIP-funded uninsured children are based on the upper limit of coverage.
5. Alabama, the District of Columbia, Oklahoma, and Tennessee have different lower bounds for adolescents in Title XXI funded Medicaid expansions depending on age. The lower bound for Title XXI funded Medicaid is 18% for children ages 14 through 18 in Alabama, 63% for children ages 15 through 18 in the District of Columbia, 69% for children ages 14 through 18 in Oklahoma, and 29% for children ages 14 through 18 in Tennessee.
6. In California, children with higher incomes may be eligible for separate CHIP coverage in certain counties.
7. In Florida, all infants are covered in Medicaid. Florida operates three separate CHIP programs: Healthy Kids covers children ages 5 through 18; MediKids covers children ages 1 through 4; and the Children's Medical Services Managed Care Plan serves children with special health care needs from birth through age 18. In Florida, families can buy-in to Healthy Kids for children ages 5-19 and to MediKids children ages 1 to 4.

8. Indiana uses a state-specific income disregard that is equal to five percent of the highest income eligibility threshold for the group.
9. In Kansas, eligibility for children in the separate CHIP program is a dollar-based income level equal to 238% FPL in 2008. This amount increased in 2014 for the MAGI conversion, but as a fixed dollar amount, the equivalent FPL level may erode over time.
10. Massachusetts also covers insured children in its separate CHIP program with Title XIX Medicaid funds under its Section 1115 waiver. Massachusetts also covers uninsured 18 year olds with incomes up to 155% FPL under its Medicaid expansion and up to 305% under separate CHIP.
11. Michigan also provides CHIP-funded Medicaid expansion coverage to children with incomes between 212% FPL to 400% FPL affected by the Flint water crisis.
12. In Minnesota, the infant category under Title XIX-funded Medicaid includes insured and uninsured children up to age two with incomes up to 275% FPL, and insured children up to age 2 from 275-288% FPL.
13. In North Carolina, all children ages 0 through 5 are covered in Medicaid while the separate CHIP program covers children ages 6 through 18 with incomes above Medicaid limits.
14. North Dakota moved its separate CHIP program to a Medicaid expansion program as of January 2020.
15. Oklahoma offers a premium assistance program to children ages 0 through 18 with income up to 222% FPL with access to employer sponsored insurance through its Insure Oklahoma program.
16. In Tennessee, Title XXI funds are used for two programs, TennCare Standard (a Medicaid expansion program) and CoverKids (a separate CHIP program). TennCare Standard provides Medicaid coverage to uninsured children who lose eligibility under TennCare (Medicaid), have no access to insurance, and have family income below 216% FPL or are medically eligible.
17. In Wisconsin, children are not eligible for its separate CHIP program if they have access to health insurance coverage employer sponsored insurance that covers at least 80% of the cost.

Table 2: State Adoption of Optional Medicaid and CHIP Coverage for Children, January 2020							
State	No Waiting Period for CHIP ¹	Coverage for Dependents of State Employees in CHIP ^{2,7} (Total = 35)	Lawfully-Residing Immigrants Covered without 5-Year Wait ³		Provides Medicaid Coverage to Former Foster Youth up to Age 26 from Other States ⁴	EPSDT for Children Enrolled in Separate CHIP ⁵ (Total =35)	Health Services Initiative ⁶
Total	38	18	35	24	11	13	23
Alabama	None	Y					
Alaska	None	N/A (M-CHIP)		N/A (M-CHIP)		N/A (M-CHIP)	
Arizona	90 days					Y	
Arkansas	90 days	Y	Y	Y		Y	Y
California ^{11,15}	None	N/A (M-CHIP)	Y	N/A (M-CHIP)	Y	N/A (M-CHIP)	Y
Colorado	None	Y	Y	Y			
Connecticut	None	Y	Y	Y			
Delaware ¹⁶	None		Y	Y	Y	Not reported	Y
District of Columbia ¹¹	None	N/A (M-CHIP)	Y	N/A (M-CHIP)		N/A (M-CHIP)	
Florida ¹⁷	2 months	Y	Y	Y			Y
Georgia	None	Y			Y	Y	
Hawaii	None	N/A (M-CHIP)	Y	N/A (M-CHIP)		N/A (M-CHIP)	
Idaho ¹⁷	None					Y	Y
Illinois ^{11,18,19}	90 days		Y	Y		Y	Y
Indiana ^{14,15}	90 days						Y
Iowa ^{15,19}	1 month		Y	Y			Y
Kansas ⁸	None	Y				Y	
Kentucky	None	Y	Y	Y	Y		
Louisiana ¹²	90 days		Y	Y		Y	
Maine	90 days	Y	Y	Y		Y	Y
Maryland ^{15,21}	None	N/A (M-CHIP)	Y	N/A (M-CHIP)		N/A (M-CHIP)	Y
Massachusetts ^{11,13,17,22}	None		Y	Y	Y		Y
Michigan ^{15,21}	None	N/A (M-CHIP)		N/A (M-CHIP)		N/A (M-CHIP)	Y
Minnesota ¹⁸	None	N/A (M-CHIP)	Y	N/A (M-CHIP)		N/A (M-CHIP)	Y
Mississippi	None	Y					
Missouri ^{14,17,21,23}	None					Y	Y
Montana	None	Y	Y	Y			
Nebraska ¹⁵	None	N/A (M-CHIP)	Y	N/A (M-CHIP)		N/A (M-CHIP)	Y
Nevada ^{14,17,20}	None	Y	Y	Y			
New Hampshire	None	N/A (M-CHIP)		N/A (M-CHIP)		N/A (M-CHIP)	
New Jersey ^{15,17,24}	90 days		Y	Y		Y	Y
New Mexico	None	N/A (M-CHIP)	Y	N/A (M-CHIP)	Y	N/A (M-CHIP)	
New York ^{11,15,17,25}	None		Y	Y			Y
North Carolina	None	Y	Y	Y			
North Dakota ⁹	None	N/A (M-CHIP)		N/A (M-CHIP)		N/A (M-CHIP)	
Ohio ²¹	None	N/A (M-CHIP)	Y	N/A (M-CHIP)		N/A (M-CHIP)	Y
Oklahoma ²⁶	None	N/A (M-CHIP)		N/A (M-CHIP)		N/A (M-CHIP)	Y
Oregon ^{11,15}	None		Y	Y			Y
Pennsylvania ¹⁰	None	Y	Y	Y	Y		
Rhode Island	None	N/A (M-CHIP)	Y	N/A (M-CHIP)		N/A (M-CHIP)	
South Carolina	None	N/A (M-CHIP)	Y	N/A (M-CHIP)		N/A (M-CHIP)	
South Dakota	90 days				Y	Y	
Tennessee	None	Y					
Texas	90 days	Y	Y	Y			
Utah	90 days		Y	Y	Y		
Vermont	None	N/A (M-CHIP)	Y	N/A (M-CHIP)		N/A (M-CHIP)	
Virginia	None	Y	Y	Y	Y		
Washington ^{11,15}	None		Y	Y		Y	Y
West Virginia ^{17,27}	None	Y	Y	Y			Y
Wisconsin ^{15,21}	None		Y	Y	Y	Y	Y
Wyoming	1 month						

SOURCE: Based on a national survey conducted by KFF with the Georgetown University Center for Children and Families, 2020.

Table presents rules in effect as of January 1, 2020.

Medicaid and CHIP Eligibility, Enrollment, and Cost Sharing Policies as of January 2020

Table 2 Notes

1. "Waiting period" refers to the length of time a child is required to be without group coverage prior to enrolling in CHIP coverage. Waiting periods generally apply to separate CHIP programs only, as they are not permitted in Medicaid without a waiver. The Affordable Care Act (ACA) limits waiting periods to no more than 90 days, and states must waive the waiting period for specific good causes established in federal regulations. States may adopt additional exceptions to the waiting period, which vary by state. In addition to the income exemptions shown, specific categories of children such as newborns may be exempt from the waiting periods.
2. This column indicates whether the state has adopted the option to cover otherwise eligible children of state employees in a separate CHIP program. Under the option, states may receive federal funding to extend CHIP eligibility where the state has maintained its contribution levels for health coverage for employees with dependent coverage or where it can demonstrate that the state employees' out-of-pocket health care costs pose a financial hardship for families.
3. This column indicates whether the state has adopted the option to provide 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 Affordable Care Act (ACA), all states must provide Medicaid coverage to youth up to age 26 who were in foster care in the state as of their 18th birthday and enrolled in Medicaid. This column indicates whether the state also provides Medicaid coverage through a waiver to former foster youth up to age 26 who were enrolled in Medicaid in another state as of their 18th birthday.
5. The column indicates whether states with separate CHIP provide the full array of EPSDT or Early Periodic Screening Diagnosis and Treatment Services. EPSDT is the pediatric benefit standard in Medicaid. All Medicaid programs, including M-CHIP programs, must provide EPSDT services to all children but separate CHIP programs have more flexibility within federal parameters in regard to CHIP benefits.
6. States may use CHIP funds to support a state-designed health services initiative (HSI) to improve the health of low-income children, as long as overall CHIP administrative costs combined with HSI services do not exceed 10% of total CHIP expenditures. HSIs must directly improve the health of low-income children who are eligible for CHIP and/or Medicaid but may serve children regardless of income.
7. N/A (M-CHIP) responses indicate that the state does not administer a separate CHIP program for uninsured children.
8. Kansas eliminated its CHIP waiting period during 2019.
9. North Dakota transitioned its separate CHIP program to a Medicaid expansion program as of January 2020 and, as such, no longer has a waiting period for coverage.
10. In Pennsylvania, dependents of state employees are eligible during the employee's six-month probation period; after that period, dependents become eligible for State Employee Plan. Pennsylvania also provides CHIP coverage to dependents of part-time and seasonal state employees who are eligible for health benefits and meet a hardship exemption.

11. California, the District of Columbia, Illinois, Massachusetts, New York, Oregon, and Washington cover income-eligible children who are not otherwise eligible due to immigration status using state-only funds.
12. Louisiana began using federal funds to cover lawfully residing immigrant children in Medicaid and CHIP in February 2019.
13. In Massachusetts coverage for former foster youth extends to covered citizens or qualified immigrants to age 26, other former foster youth groups are covered up to age 21.
14. Indiana, Missouri and Nevada cover EPSDT services in CHIP with the exception of non-emergency transportation services.
15. California, Indiana, Iowa, Maryland, Michigan, Nebraska, New Jersey, New York, Oregon, Washington and Wisconsin use CHIP health service initiative funding to support the state's Poison Control Center.
16. Delaware's HSI provides vision exams and glasses to uninsured children in schools with a large share of children receiving free or reduced-cost school meals.
17. Florida, Idaho, Massachusetts, Missouri, Nevada, New Jersey, New York, and West Virginia use CHIP HSI's to fund various school-based health services programs.
18. Illinois and Minnesota use HSI funds to cover post-partum services for women covered under the CHIP unborn child option.
19. Illinois and Iowa use HSI funds to automatically cover children determined presumptive eligible until the application is registered in Illinois and until the final determination is made in Iowa.
20. Nevada uses HSI funds for a prevention program to target and address behavioral health issues early in after school programs.
21. Maryland, Michigan, Missouri, Ohio, and Wisconsin use HSI funds to support lead abatement programs.
22. Massachusetts has 18 different HSI programs with the overall goal of improving the health of children that are at least partially funded by CHIP. Due to the number of programs and the 10% cap of administrative services, the state does not currently claim federal funds under all programs.
23. Missouri uses its HSI to fund different health projects for children ranging from immunizations to newborn home visiting.
24. In addition to poison control and school-based health services, New Jersey uses HSI funds for a number of different health projects for children (7 total) ranging from respite care for children with developmental disabilities to a pediatric psychiatry collaborative to support children with mental health issues to a birth defects registry.
25. In addition to poison control and school-based services, New York uses HSI funds for a hunger preventive and assistance program and offers sickle cell screening for children.
26. Oklahoma uses HSI funding to support 18 different health projects for children and youth, including increasing access to long-acting reversible contraceptives (LARC), distributing Naloxone rescue kits in high need counties, improving evidence-based prescribing of antipsychotic medications in counties with high utilization, and providing newborns with safe sleep kits.
27. West Virginia's HSI pays for well-child visits for uninsured children.

State	Income Eligibility Limits for Pregnant Women (% of the FPL)				Lawfully-Residing Immigrants Covered without 5-Year Wait ⁵		Full Medicaid/CHIP Benefit Package for Pregnant Women ⁶			Income Eligibility Limit for Family Planning Expansion Program (% of the FPL) ⁷
	Medicaid ¹	CHIP ¹	Unborn Child Option (CHIP-Funded) ^{1,2}	Upper Income Limit	Medicaid	CHIP ⁴ (Total = 6)	Medicaid	CHIP ⁴ (Total = 6)	Unborn Child Option ⁴ (Total = 17)	
Median or Total³	200%	262%	213%	205%	25	4	47	6	12	205%
Alabama	146%			146%		N/A	Y	N/A	N/A	146%
Alaska	205%			205%		N/A	Y	N/A	N/A	N/A
Arizona	161%			161%		N/A	Y	N/A	N/A	N/A
Arkansas ⁸	214%		214%	214%	Y	N/A		N/A		N/A
California	213%		322%	322%	Y	N/A	Y	N/A	Y	205%
Colorado	200%	265%		265%	Y	Y	Y	Y	N/A	N/A
Connecticut	263%			263%	Y	N/A	Y	N/A	N/A	263%
Delaware	217%			217%	Y	N/A	Y	N/A	N/A	N/A
District of Columbia ¹⁴	324%			324%	Y	N/A	Y	N/A	N/A	N/A
Florida ¹⁷	196%			196%		N/A	Y	N/A	N/A	190%
Georgia	225%			225%		N/A	Y	N/A	N/A	216%
Hawaii	196%			196%	Y	N/A	Y	N/A	N/A	N/A
Idaho ¹⁵	138%			138%		N/A	Y	N/A	N/A	N/A
Illinois	213%		213%	213%		N/A	Y	N/A	Y	N/A
Indiana ⁹	218%			218%		N/A	Y	N/A	N/A	148%
Iowa ¹⁸	380%			380%		N/A	Y	N/A	N/A	N/A
Kansas	171%			171%		N/A	Y	N/A	N/A	N/A
Kentucky ¹⁷	200%			200%		N/A	Y	N/A	N/A	218%
Louisiana	138%		214%	214%		N/A	Y	N/A	Y	138%
Maine	214%			214%	Y	N/A	Y	N/A	N/A	214%
Maryland	264%			264%	Y	N/A	Y	N/A	N/A	264%
Massachusetts ¹⁴	205%		205%	205%	Y	N/A	Y	N/A	Y	N/A
Michigan ¹⁰	200%		200%	200%		N/A	Y	N/A	Y	N/A
Minnesota	283%		283%	283%	Y	N/A	Y	N/A	Y	205%
Mississippi	199%			199%		N/A	Y	N/A	N/A	199%
Missouri	201%	305%	305%	305%			Y	Y	Y	206%
Montana	162%			162%		N/A	Y	N/A	N/A	216%
Nebraska	199%		202%	202%	Y	N/A	Y	N/A		N/A
Nevada	165%			165%		N/A	Y	N/A	N/A	N/A
New Hampshire	201%			201%		N/A	Y	N/A	N/A	201%
New Jersey ^{14,19}	199%	205%		205%	Y	Y	Y	Y	N/A	205%
New Mexico	255%			255%	Y	N/A		N/A	N/A	255%
New York ¹⁴	223%			223%	Y	N/A	Y	N/A	N/A	223%
North Carolina	201%			201%	Y	N/A		N/A	N/A	200%
North Dakota ¹¹	162%			162%		N/A	Y	N/A	N/A	N/A
Ohio	205%			205%	Y	N/A	Y	N/A	N/A	N/A
Oklahoma ¹²	138%		210%	210%		N/A	Y	N/A	Y	138%
Oregon ¹⁴	190%		190%	190%		N/A	Y	N/A	Y	255%
Pennsylvania	220%			220%	Y	N/A	Y	N/A	N/A	220%
Rhode Island ²⁰	195%	258%	258%	258%			Y	Y	Y	258%
South Carolina	199%			199%	Y	N/A	Y	N/A	N/A	199%
South Dakota ¹⁶	138%		138%	138%		N/A		N/A		N/A
Tennessee ¹⁴	200%		255%	255%		N/A	Y	N/A		N/A
Texas ¹⁸	203%		207%	207%		N/A	Y	N/A		N/A
Utah	144%			144%		N/A	Y	N/A	N/A	N/A
Vermont ²¹	213%			213%	Y	N/A	Y	N/A	N/A	200%
Virginia	148%	205%		205%	Y	Y	Y	Y	N/A	205%
Washington ¹⁴	198%		198%	198%	Y	N/A	Y	N/A	Y	265%
West Virginia ¹³	190%	305%		305%	Y	Y	Y	Y	N/A	N/A
Wisconsin	306%		306%	306%	Y	N/A	Y	N/A	Y	306%
Wyoming ²⁰	159%			159%	Y	N/A	Y	N/A	N/A	159%

SOURCE: Based on a national survey conducted by KFF with the Georgetown University Center for Children and Families, 2020.
Table presents rules in effect as of January 1, 2020.

Table 3 Notes

1. January 2020 income limits reflect Modified Adjusted Gross Income (MAGI)-converted income standards, and include a disregard equal to five percentage points of the federal poverty level (FPL). The FPL for a family of three is \$21,720 as of 2020.
2. The unborn child option permits states to consider the fetus a "targeted low-income child" for purposes of CHIP coverage.
3. The totals in column headers indicate that the option only applies to the limited number of states that have adopted the coverage pathway. As of January 2020, six states use CHIP funding to cover pregnant women and 17 states provide coverage through the unborn child option
4. N/A responses indicate that the state does not provide CHIP-funded coverage to pregnant women or that the state does not provide coverage through the unborn child option.
5. These columns indicate whether the state adopted the option to cover immigrant pregnant women who have been lawfully residing in the U.S. for less than five years, known as the Immigrant Children's Health Improvement Act (ICHIA) option.
6. These columns indicate whether pregnant beneficiaries in the state receive the full Medicaid or CHIP benefit package. During a presumptive eligibility period, pregnant women receive only prenatal and pregnancy-related benefits.
7. This column lists income eligibility limits for programs in states that use federal funds under a state option or waiver to provide family planning services to individuals who do not qualify for full Medicaid benefits. January 2020 income limits include a disregard equal to five percentage points of the FPL.
8. Arkansas provides the full Medicaid benefits to pregnant women with incomes up to levels established for the old Aid to Families with Dependent Children (AFDC) program, which is \$220 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.
9. Indiana uses a state-specific income disregard that is equal to five percent of the highest income eligibility threshold for the group.
10. Michigan also provides coverage to pregnant women with incomes over 400% FPL affected by the Flint water crisis.
11. North Dakota increased eligibility for pregnant women from 152% FPL to 162% FPL effective January 2020.
12. Oklahoma offers a premium assistance program to pregnant women with incomes up to 205% FPL who have access to employer sponsored insurance through its Insure Oklahoma program.
13. West Virginia began covering pregnant women in CHIP with income up to 305% FPL effective July 2019.
14. District of Columbia, Massachusetts, New Jersey, New York, Oregon, Tennessee and Washington provide some services not covered through emergency Medicaid for some income-eligible pregnant women or women in the post-partum period who are not otherwise eligible due to immigration status using state-only funds.

15. In 2019, Idaho began providing the full Medicaid benefit package to pregnant women.
16. South Dakota provides full Medicaid benefits to pregnant women with incomes up to \$591 per month (for a family of three). Above that level, more limited pregnancy-related benefits are provided to pregnant women covered under Medicaid. South Dakota provides limited pregnancy-related benefits to pregnant women covered under the CHIP unborn child option.
17. Florida and Kentucky limit eligibility for their family planning expansion programs to those losing Medicaid eligibility.
18. Iowa and Texas offer family planning programs with state-only funds. Iowa has a state-funded family planning program for women with incomes up to 300% FPL who lose Medicaid at the end of the postpartum period.
19. New Jersey implemented family planning coverage in 2019.
20. Rhode Island and Wyoming limit eligibility for their family planning expansion programs to those losing Medicaid at the end of their postpartum period.
21. Vermont provides family planning services for women with incomes up to 200% FPL through Planned Parenthood health centers using funding under its Section 1115 Global Commitment waiver.

Table 4: Medicaid Income Eligibility Limits for Adults as a Percent of the Federal Poverty Level, January 2020 ¹			
State	Parents (in a family of three)		Other Adults (for an individual)
	Section 1931 Limit	Upper Limit	
Median	45%	138%	138%
Alabama	18%	18%	0%
Alaska ²	133%	138%	138%
Arizona	106%	138%	138%
Arkansas	15%	138%	138%
California ⁴	109%	138%	138%
Colorado	68%	138%	138%
Connecticut ³	160%	160%	138%
Delaware	87%	138%	138%
District of Columbia ⁴	221%	221%	215%
Florida	31%	31%	0%
Georgia	35%	35%	0%
Hawaii ⁴	100%	138%	138%
Idaho ⁵	20%	138%	138%
Illinois ⁶	29%	138%	138%
Indiana ⁷	17%	138%	138%
Iowa	48%	138%	138%
Kansas	38%	38%	0%
Kentucky	18%	138%	138%
Louisiana	19%	138%	138%
Maine	100%	138%	138%
Maryland	123%	138%	138%
Massachusetts ^{4,8}	138%	138%	138%
Michigan	54%	138%	138%
Minnesota ⁹	138%	138%	138%
Mississippi	26%	26%	0%
Missouri	21%	21%	0%
Montana	24%	138%	138%
Nebraska ¹⁰	63%	63%	0%
Nevada	27%	138%	138%
New Hampshire	53%	138%	138%
New Jersey	28%	138%	138%
New Mexico ⁴	42%	138%	138%
New York ^{4,9}	89%	138%	138%
North Carolina	41%	41%	0%
North Dakota	48%	138%	138%
Ohio	90%	138%	138%
Oklahoma ¹¹	41%	41%	0%
Oregon	33%	138%	138%
Pennsylvania ⁴	33%	138%	138%
Rhode Island	116%	138%	138%
South Carolina	67%	67%	0%
South Dakota	48%	48%	0%
Tennessee	94%	94%	0%
Texas ¹²	17%	17%	0%
Utah ^{5,13}	37%	138%	138%
Vermont ¹⁴	41%	138%	138%
Virginia ¹⁵	33%	138%	138%
Washington	45%	138%	138%
West Virginia	17%	138%	138%
Wisconsin ¹⁶	100%	100%	100%
Wyoming	53%	53%	0%

SOURCE: Based on a national survey conducted by KFF with the Georgetown University Center for Children and Families, 2020.
Table presents rules in effect as of January 1, 2020.

Table 4 Notes

1. January 2020 income limits reflect Modified Adjusted Gross Income (MAGI)-converted income standards, and include a disregard equal to five percentage points of the Federal Poverty Level (FPL) applied to the highest eligibility limit for the group. In some states, eligibility limits for Section 1931 parents are based on a dollar threshold. The values listed represent the truncated FPL equivalents calculated from these dollar limits. Eligibility levels for parents are presented as a percentage of the 2020 FPL for a family of three, which is \$21,720. Eligibility limits for other adults are presented as a percentage of the 2020 FPL for an individual, which is \$12,760.
2. In Alaska, the dollar threshold is generally updated every January 1 based on the CPI-U plus an adjustment for annual dividend payments to Alaska residents. However, due to a calculation error in 2015, Alaska income limits have been frozen until the error has been offset by CPI-U adjustments in the interim.
3. Connecticut increased parent eligibility from 155%FPL to 160% FPL effective October 2019.
4. California, the District of Columbia, Hawaii, Massachusetts, New Mexico, New York, and Pennsylvania cover some income-eligible adults who are not otherwise eligible due to immigration status using state-only funds. In some cases, the coverage is limited to targeted groups, such as lawfully present immigrants who are in the five-year waiting period for Medicaid coverage.
5. Idaho and Utah implemented the Affordable Care Act Medicaid expansion for adults effective January 2020.
6. In Illinois, traditional 1931 Medicaid coverage is based on a dollar threshold tied to TANF levels. Parents are also covered up to 133% FPL based on prior waiver eligibility and are not considered Section VIII expansion adults. In Illinois, the dollar threshold eligibility level for 1931 parents is linked to TANF levels, which increased in 2019.
7. Indiana uses a state-specific income disregard that is equal to five percent of the highest income eligibility threshold for the group.
8. Massachusetts provides subsidies for Marketplace coverage for parents and childless adults with incomes up to 300% through its Connector Care program. The state's Section 1115 waiver also authorizes MassHealth coverage for HIV-positive individuals with incomes up to 200% FPL, uninsured individuals with breast or cervical cancer with incomes up to 250% FPL, and individuals who work for a small employer and purchase employer-sponsored insurance (ESI) with incomes up to 300% FPL, as well as coverage through MassHealth CommonHealth for adults with disabilities with no income limit, provided that they have either met a one-time deductible or are working disabled adults.
9. Minnesota and New York have implemented Basic Health Programs (BHPs) established by the Affordable Care Act (ACA) for adults with incomes between 138%-200% FPL.
10. Nebraska voters approved a Medicaid expansion ballot measure in November 2018 and the state submitted a state plan amendment (SPA) for the expansion on April 2019. The SPA delays Medicaid expansion implementation until October 2020 to allow time for the state to seek a Section 1115

waiver to implement expansion with program elements that differ from what is allowed under federal law. The state submitted this waiver to CMS for review December 2019.

11. In Oklahoma, individuals without a qualifying employer with incomes up to 100% FPL are eligible for more limited subsidized insurance through the Insure Oklahoma Section 1115 waiver program. Individuals working for certain qualified employers with incomes at or below 222% FPL are eligible for premium assistance for employer-sponsored insurance.
12. In Texas, the income limit for parents and other caretaker relatives is based on monthly dollar amounts which differ depending on family size and whether there are one or two parents in the family. The eligibility level shown is for a single parent household and a family size of three.
13. As of January 2020, Utah has implemented the Medicaid expansion to adults using Section 1115 waiver authority with specific stipulations, including work requirements. With approval of the expansion waiver, Utah reverted its 1931 eligibility level to the pre-Affordable Care Act dollar threshold.
14. Vermont also provides a 1.5% reduction in the federal applicable percentage of the share of premium costs for individuals who qualify for advance premium tax credits to purchase Marketplace coverage with income up to 300% FPL.
15. In Virginia, eligibility levels for 1931 parents vary by region. The value shown is the eligibility level for Region 2, the most populous region.
16. Wisconsin covers adults up to 100% FPL in Medicaid but did not adopt the ACA Medicaid expansion.

Table 5: Coordination between Medicaid and Other Systems, January 2020					
State	System Determines Eligibility For:			Marketplace Structure ³	FFM Conducts Assessment or Final Determination for Medicaid Eligibility ⁴ (Total Using FFM = 38)
	CHIP ^{1, 2} (Total = 35)	Seniors and Individuals Eligible Based on a Disability ¹	At Least One Non-Health Program ¹		
Total	34	31	24	FFM: 28 Partnership: 6 SBM-FP: 4 SBM: 13	Assessment: 29 Determination: 8 Not Reported: 1
Alabama	Y			FFM	Determination
Alaska	N/A (M-CHIP)			FFM	Determination
Arizona	Y	Y		FFM	Assessment
Arkansas	Y			SBM-FP	Assessment
California ⁵	N/A (M-CHIP)			SBM	N/A (SBM)
Colorado	Y	Y	Y	SBM	N/A (SBM)
Connecticut	Y			SBM	N/A (SBM)
Delaware	Y	Y	Y	Partnership	Assessment
District of Columbia	N/A (M-CHIP)			SBM	N/A (SBM)
Florida	Y	Y	Y	FFM	Assessment
Georgia	Y	Y	Y	FFM	Assessment
Hawaii	N/A (M-CHIP)	Y		FFM	Assessment
Idaho	Y	Y	Y	SBM	N/A (SBM)
Illinois	Y	Y	Y	Partnership	Assessment
Indiana	Y	Y	Y	FFM	Assessment
Iowa	Y	Y		Partnership	Assessment
Kansas	Y	Y	Y	FFM	Assessment
Kentucky	Y	Y	Y	SBM-FP	Assessment
Louisiana	Y	Y		FFM	Determination
Maine	Y	Y	Y	FFM	Assessment
Maryland	N/A (M-CHIP)			SBM	N/A (SBM)
Massachusetts	Y			SBM	N/A (SBM)
Michigan	N/A (M-CHIP)			Partnership	Assessment
Minnesota	N/A (M-CHIP)			SBM	N/A (SBM)
Mississippi	Y	Y		FFM	Assessment
Missouri	Y			FFM	Assessment
Montana	Y	Y	Y	FFM	Determination
Nebraska	N/A (M-CHIP)	Y	Y	FFM	Assessment
Nevada ⁶	Y	Y	Y	SBM	N/A (SBM)
New Hampshire	N/A (M-CHIP)	Y	Y	Partnership	Assessment
New Jersey	Y	Y		FFM	Determination
New Mexico	N/A (M-CHIP)	Y	Y	SBM-FP	Assessment
New York	Y			SBM	N/A (SBM)
North Carolina	Y			FFM	Assessment
North Dakota ⁷	N/A (M-CHIP)		Y	FFM	Assessment
Ohio	N/A (M-CHIP)	Y	Y	FFM	Assessment
Oklahoma	N/A (M-CHIP)			FFM	Assessment
Oregon ⁸	Y			SBM-FP	Assessment
Pennsylvania	Y	Y	Y	FFM	Assessment
Rhode Island	N/A (M-CHIP)	Y	Y	SBM	N/A (SBM)
South Carolina	N/A (M-CHIP)	Not Reported		FFM	Not Reported
South Dakota				FFM	Assessment
Tennessee ⁹	Y	Y		FFM	Assessment
Texas	Y	Y	Y	FFM	Assessment
Utah	Y	Y	Y	FFM	Assessment
Vermont	N/A (M-CHIP)			SBM	N/A (SBM)
Virginia	Y	Y	Y	FFM	Determination
Washington	Y			SBM	N/A (SBM)
West Virginia	Y	Y	Y	Partnership	Determination
Wisconsin	Y	Y	Y	FFM	Assessment
Wyoming ¹⁰	Y	Y		FFM	Determination

SOURCE: Based on a national survey conducted by KFF with the Georgetown University Center for Children and Families, 2020.

Table presents rules in effect as of January 1, 2020.

Medicaid and CHIP Eligibility, Enrollment, and Cost Sharing Policies as of January 2020

Table 5 Notes

1. These columns indicate whether the state Medicaid eligibility system for MAGI-based groups (children, pregnant women, parents, and expansion adults) also determines eligibility for CHIP, seniors and individuals eligible based on a disability, or at least one non-health program, such as Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), and Child Care Subsidy.
2. N/A (M-CHIP) responses indicate that the state does not administer a separate CHIP program for uninsured children.
3. This column indicates whether a state has elected to use the Federally-facilitated Marketplace (FFM), establish a Marketplace in partnership with the federal government (Partnership), establish a State-based Marketplace that uses the federal platform (SBM-FP), or establish and operate its own State-based Marketplace (SBM). In an FFM state, 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. States running a SBM are responsible for performing all Marketplace functions, except for SBM-FP states that rely on the FFM for application processing and certain eligibility and enrollment activities.
4. This column indicates whether states using the FFM IT platform for eligibility activities (including FFM, Partnership, and SBM-FP states) have elected to have the FFM make assessments or final determinations of Medicaid/CHIP eligibility for MAGI-based groups. In assessment states, applicants' accounts must be transferred to the state Medicaid/CHIP agency for a final determination. In determination states, the FFM makes a final Medicaid/CHIP eligibility determination and transfers the account to the state Medicaid/CHIP agency for enrollment. States marked as "N/A (SBM)" do not rely on the FFM for eligibility functions.
5. California's statewide-integrated Marketplace and Medicaid system, CALHEERS is not integrated with other programs. However, cases for all Medicaid enrollees are transferred to and managed at the county level where systems are integrated for all Medicaid groups, including seniors and people eligible based on a disability and non-health programs.
6. Nevada has transitioned to an SBM (Nevada Health Link) effective January 2020.
7. In 2019, North Dakota integrated its SNAP, TANF, and Child Care Subsidy programs into its MAGI-based Medicaid eligibility determination system.
8. In Oregon, the system does make a determination for former foster care youth, but other non-MAGI disability related and transitional or adopted care are not yet integrated.
9. In April 2019, Tennessee became an assessment state.
10. In Wyoming, the FFM conducts assessments rather than final determinations of CHIP eligibility.

Table 6: Online and Telephone Medicaid Applications for Children, Pregnant Women, Parents, and Expansion Adults, January

State	Applications Can be Submitted Online at the State Level ¹	Share of Applications Submitted Online ²	Applications Can be Submitted by Telephone at the State Level ³	Online Portal for Application Assistants ⁴	Application Can be Used for: Seniors and Individuals Eligible Based on Disability	At Least One Non-Health Program ⁵
Total or Median	51	55%	45	30	34	26
Alabama	Y	40%	Y			
Alaska ^{6,7}	Y	9%			Y	
Arizona	Y	72%	Y	Y	Y	Y
Arkansas	Y	Not reported	Y			
California ⁸	Y	36%	Y	Y	Y	Y
Colorado	Y	36%	Y		Y	Y
Connecticut	Y	27%	Y			
Delaware	Y	64%	Y	Y	Y	Y
District of Columbia	Y	45%	Y	Y		
Florida	Y	90%	Y	Y	Y	Y
Georgia	Y	Not reported	Y	Y	Y	Y
Hawaii ⁹	Y	60%	Y	Y		
Idaho	Y	30%	Y	Y	Y	
Illinois	Y	57%	Y	Y	Y	Y
Indiana	Y	89%	Y		Y	
Iowa	Y	42%	Y		Y	
Kansas	Y	60%	Y		Y	
Kentucky	Y	65%	Y	Y	Y	Y
Louisiana	Y	57%	Y	Y	Y	
Maine ⁶	Y	26%			Y	Y
Maryland	Y	100%	Y			
Massachusetts	Y	16%	Y	Y		
Michigan	Y	63%	Y		Y	Y
Minnesota	Y	61%		Y		
Mississippi	Y	18%	Y			Y
Missouri	Y	69%	Y			
Montana	Y	25%	Y		Y	Y
Nebraska ⁷	Y	48%	Y		Y	
Nevada	Y	30-40%	Y		Y	Y
New Hampshire	Y	90%	Y		Y	Y
New Jersey	Y	51%	Y	Y	Y	
New Mexico	Y	65%	Y	Y	Y	Y
New York	Y	95%	Y	Y		
North Carolina ⁶	Y	6%		Y	Y	Y
North Dakota	Y	25%	Y	Y	Y	Y
Ohio	Y	Not reported	Y	Y	Y	Y
Oklahoma	Y	89%	Y	Y		
Oregon	Y	Not reported	Y	Y		
Pennsylvania	Y	54%	Y	Y	Y	Y
Rhode Island	Y	Not reported	Y	Y	Y	Y
South Carolina	Y	Not reported	Not reported	Not reported	Not reported	
South Dakota	Y	10%	Y			Y
Tennessee	Y	55%	Y	Y	Y	
Texas	Y	90%	Y	Y	Y	Y
Utah ⁶	Y	66%		Y	Y	Y
Vermont	Y	62%	Y	Y		
Virginia	Y	Not reported	Y		Y	Y
Washington	Y	Not reported	Y	Y		
West Virginia	Y	48%	Y	Y	Y	Y
Wisconsin	Y	42%	Y	Y	Y	Y
Wyoming	Y	20%	Y		Y	

SOURCE: Based on a national survey conducted by KFF with the Georgetown University Center for Children and Families, 2020.

Table presents rules in effect as of January 1, 2020.

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), Partnership Marketplace states and states with SBMs using the federal platform (SBM-FP), state Medicaid agency portals are indicated.
2. This column indicates the share of total applications for non-disabled, non-elderly groups (children, pregnant women, parents, and expansion adults) that is submitted online.
3. This column indicates whether individuals can complete Medicaid applications over the telephone at the state level, either through the Medicaid agency or the SBM without being required to send a follow-up paper form or written signature to complete the application.
4. This column indicates whether the Medicaid eligibility system provides either a separate online portal for application assisters or a secure log-in for assisters to submit facilitated applications. Some states are able to identify and collect information about assister-facilitated applications although they do not have a separate portal or secure log-in for assisters to submit facilitated applications.
5. In these states, a combined online multi-benefit application is available that allows applicants to apply for Medicaid and one or more non-health programs, such as the Supplemental Nutrition Assistance Program (SNAP; food stamps) or cash assistance.
6. In Alaska, Maine, North Carolina and Utah, a follow-up signature form is required to complete a telephone application. Maine is currently in the process of designing a method to accept a telephonic signature.
7. In Alaska and Nebraska, the share of applications submitted online includes MAGI and non-MAGI based Medicaid applications.
8. In California, multi-benefit applications are submitted at the county level, but individuals who apply through CALHEERS can request an evaluation of other programs and their application s routed to the county for action.
9. In Hawaii, telephone applications are included in the online share.

Table 7: Features of Online Medicaid Accounts, January 2020								
State	Online Medicaid Account ¹	Online Account Allows Individuals to:						
		Report Changes	Review Application Status	Renew Coverage	View Notices	Authorize Third-Party Access	Upload Verification Documentation	Go Paperless and Receive Notices Electronically
Total	43	40	39	39	39	32	33	33
Alabama	Y	Y	Y	Y		Y		
Alaska								
Arizona	Y	Y	Y	Y	Y	Y	Y	Y
Arkansas								
California ²	Y	Y	Y	Y	Y	Y	Y	Y
Colorado	Y	Y	Y	Y	Y	Y	Y	Y
Connecticut	Y	Y	Y	Y	Y	Y	Y	Y
Delaware	Y	Y	Y	Y	Y	Y		Y
District of Columbia	Y	Y	Y	Y	Y	Y	Y	Y
Florida	Y	Y	Y	Y	Y		Y	Y
Georgia	Y	Y	Y	Y	Y	Y	Y	Y
Hawaii	Y	Y	Y	Y	Y	Y	Y	Y
Idaho	Y	Y	Y	Y	Y	Y	Y	
Illinois	Y	Y	Y	Y	Y	Y	Y	Y
Indiana	Y	Y	Y			Y		
Iowa								
Kansas								
Kentucky	Y	Y	Y	Y	Y	Y	Y	Y
Louisiana	Y	Y		Y	Y		Y	
Maine	Y	Y	Y	Y	Y			Y
Maryland	Y	Y	Y	Y	Y	Y	Y	Y
Massachusetts	Y	Y	Y	Y				
Michigan	Y	Y	Y	Y	Y	Y	Y	Y
Minnesota ³	Y				Y			
Mississippi								
Missouri ⁴								
Montana	Y	Y	Y	Y	Y	Y	Y	Y
Nebraska	Y	Y	Y	Y	Y	Y	Y	Y
Nevada	Y	Y	Y	Y	Y	Y	Y	Y
New Hampshire	Y	Y	Y	Y	Y	Y	Y	Y
New Jersey ⁵	Y		Y		Y			Y
New Mexico	Y	Y	Y	Y	Y		Y	
New York	Y	Y	Y	Y	Y	Y	Y	Y
North Carolina								
North Dakota	Y	Y	Y	Y	Y	Y	Y	Y
Ohio	Y	Y	Y	Y	Y	Y	Y	
Oklahoma	Y	Y	Y	Y	Y	Y	Y	Y
Oregon	Y	Y	Y	Y	Y		Y	Y
Pennsylvania	Y	Y	Y	Y	Y		Y	Y
Rhode Island	Y	Y	Y	Y	Y	Y	Y	Y
South Carolina	Y				Not Reported			
South Dakota								
Tennessee	Y	Y	Y	Y	Y	Y	Y	Y
Texas ⁶	Y	Y	Y	Y	Y	Y	Y	Y
Utah	Y	Y	Y	Y	Y	Y	Y	Y
Vermont	Y	Y	Y	Y	Y	Y		
Virginia	Y	Y	Y	Y	Y	Y	Y	Y
Washington	Y	Y	Y	Y	Y	Y	Y	Y
West Virginia	Y	Y	Y	Y	Y			Y
Wisconsin	Y	Y	Y	Y	Y	Y	Y	Y
Wyoming	Y	Y		Y	Y	Y	Y	Y

SOURCE: Based on a national survey conducted by KFF with the Georgetown University Center for Children and Families, 2020.

Table presents rules in effect as of January 1, 2020.

Table 7 Notes

1. This column indicates whether individuals can create an online account to review, update, or submit information at the state level, either through the Medicaid case management system or the integrated State-based Marketplace (SBM) system.
2. In California, Medicaid applicants can access certain eligibility notices if they applied through CALHEERS, the state's integrated Medicaid and Marketplace system. However, cases for all Medicaid enrollees are transferred to and managed at the county level. The ability to view notices and go paperless varies by county.
3. In Minnesota, not all notices can be viewed online. All notices are always mailed.
4. Missouri does not offer online accounts but applicants who apply online are able to return to the application to check its status.
5. In 2019, New Jersey, implemented online accounts.
6. In Texas, only certain notices can be viewed from a client's online account if the client does not elect to receive electronic notices.

Table 8: Mobile Access to Online Medicaid Applications and Accounts, January 2020						
State	Online Application (Total = 51)			Online Account ¹ (Total = 43)		
	Can Submit using Mobile Device	Mobile-Friendly Design	Mobile App Available	Can Access using Mobile Device	Mobile-Friendly Design	Mobile App Available
Total	44	20	2	40	24	8
Alabama	Y					
Alaska	Y			N/A	N/A	N/A
Arizona ²	Y			Y		
Arkansas				N/A	N/A	N/A
California ³	Y	Y		Y	Y	
Colorado				Y	Y	Y
Connecticut	Y	Y		Y	Y	
Delaware	Y			Y		
District of Columbia	Y			Y		
Florida	Y			Y		Y
Georgia	Y			Y		
Hawaii	Y			Y		
Idaho	Y			Y		
Illinois	Y			Y		
Indiana	Y			Y		
Iowa	Y			N/A	N/A	N/A
Kansas	Y			N/A	N/A	N/A
Kentucky	Y	Y		Y	Y	
Louisiana	Y	Y		Y	Y	
Maine	Y			Y		
Maryland	Y	Y	Y	Y	Y	Y
Massachusetts	Y	Y		Y	Y	
Michigan	Y	Y		Y	Y	
Minnesota	Y			Y		
Mississippi ²	Y	Y		N/A	N/A	N/A
Missouri	Y	Y		N/A	N/A	N/A
Montana				Y	Y	
Nebraska	Y	Y		Y	Y	
Nevada	Y	Y		Y	Y	
New Hampshire	Y	Y		Y	Y	
New Jersey	Y	Y		Y	Y	
New Mexico	Y	Y		Y	Y	
New York	Y			Y		
North Carolina	Y			N/A	N/A	N/A
North Dakota	Y	Y		Y	Y	
Ohio	Y			Y		
Oklahoma	Y	Y		Y	Y	
Oregon	Y			Y		
Pennsylvania				Y	Y	Y
Rhode Island						
South Carolina	Not reported			Not reported		
South Dakota				N/A	N/A	N/A
Tennessee	Y			Y	Y	Y
Texas	Y	Y		Y	Y	Y
Utah	Y			Y	Y	
Vermont ²	Y			Y		
Virginia	Y			Y		
Washington	Y	Y	Y	Y	Y	Y
West Virginia	Y	Y		Y	Y	
Wisconsin ⁴	Y					Y
Wyoming	Y	Y		Y	Y	

SOURCE: Based on a national survey conducted by KFF with the Georgetown University Center for Children and Families, 2020.
Table presents rules in effect as of January 1, 2020.

Table 8 Notes

1. N/A responses indicate that the state does not have an online application and/or an online account.
2. Arizona, Mississippi, and Vermont added functionality to allow individuals to submit applications through a mobile device in 2019. Mississippi also provided a mobile-friendly design for their application.
3. In California, individuals can apply for MAGI-Medicaid only through the CALHEERS online application and user account, which are mobile-friendly. Certain information can be entered into the CALHEERS online account and passed the county where Medicaid cases are managed. Access to full Medicaid online accounts varies by county.
4. Wisconsin's Medicaid account "app" has more limited features than the web-based online account. It allows individuals to check benefits, get reminders of actions needed, and submit documents.

Table 9: Income Verification and Real-Time Eligibility Determinations, January 2020								
State	Verify Income Prior to Determining Eligibility ¹	Reasonable Compatibility Standard ²	Able to Make Real-Time Determinations ³ (<24 Hours)	Share of Determinations Completed in Real-Time ⁴				
				<25%	25%-50%	50%-75%	75%-90%	≥90%
Total	45	33	47	21	11	5	6	4
Alabama	Y	10%	Y				Y	
Alaska	Y	10%						
Arizona	Y	None	Y		Y			
Arkansas	Y	10%	Y			Y		
California	Y	None	Y	Y				
Colorado		10%	Y		Y			
Connecticut	Y	10%	Y					Y
Delaware		10%	Y	Y				
District of Columbia	Y	10%	Y				Y	
Florida ⁵	Y	10%	Y		Y			
Georgia	Y	None	Y	Y				
Hawaii		10%	Y		Y			
Idaho	Y	None	Y				Y	
Illinois	Y	5%	Y	Y				
Indiana	Y	None	Y	Y				
Iowa	Y	10%	Y	Y				
Kansas	Y	20%	Y	Y				
Kentucky	Y	10%	Y			Y		
Louisiana	Y	10%	Y		Y			
Maine	Y	None	Y	Y				
Maryland	Y	10%	Y					Y
Massachusetts	Y	10%	Y			Y		
Michigan	Y	10%	Y		Y			
Minnesota	Y	10%	Y		Y			
Mississippi	Y	\$50	Y	Y				
Missouri	Y	10%	Y		Y			
Montana	Y	10%	Y	Y				
Nebraska	Y	10%	Y	Y				
Nevada	Y	None	Y	Y				
New Hampshire	Y	10%	Y	Y				
New Jersey ⁵	Y	10%	Y	Y				
New Mexico ⁶	Y	None	Y				Y	
New York	Y	10%	Y					Y
North Carolina	Y	None	Y	Y				
North Dakota	Y	None	Y	Y				
Ohio	Y	5%	Y	Y				
Oklahoma		5%	Y					Y
Oregon	Y	10%	Y			Y		
Pennsylvania	Y	5%	Y	Y				
Rhode Island	Y	10%	Y				Y	
South Carolina	Not reported	Not reported	Not reported					
South Dakota	Y	None						
Tennessee ⁷	Y	10%	Y	Y				
Texas	Y	None						
Utah	Y	None	Y	Y				
Vermont	Y	None	Y			Y		
Virginia	Y	10%	Y		Y			
Washington		None	Y				Y	
West Virginia	Y	10%	Y	Y				
Wisconsin	Y	None	Y		Y			
Wyoming	Y	None	Y		Y			

SOURCE: Based on a national survey conducted by KFF with the Georgetown University Center for Children and Families, 2020.

Table presents rules in effect as of January 1, 2020.

Table 9 Notes

1. States attempt to verify income through an electronic source at application; they can verify information prior to enrollment or enroll based on an individual's self-attestation and conduct a post-enrollment verification.
2. This column indicates if the state has set a reasonable compatibility threshold when the applicant reports income below the Medicaid eligibility threshold but the electronic data source reflects income above the threshold. If the information obtained from electronic data sources and the information provided by or on behalf of the individual are both above, at, or below the applicable income standard, the state must determine the applicant eligible or ineligible for Medicaid/CHIP. In these cases, any difference does not impact eligibility. If the data are not consistent, states have the option to apply a reasonable compatibility standard by establishing a threshold (e.g., a percentage or dollar figure) in which they will still consider the data to be reasonably compatible. States have the option to set different standards based on whether the applicant's attestation is above or below the eligibility threshold. In both cases, if the difference between the attested income and the electronic data source are within the reasonable compatibility standard, the state will process eligibility based on the individual's attestation. If the applicant reports income below the standard and the electronic source indicates income above the standard, and the difference is not reasonably compatible, the state may accept a reasonable explanation and/or request paper documentation. If the applicant reports income above the Medicaid or CHIP limit but the electronic source reflects income below, and the data are not reasonably compatible, the state may accept a reasonable explanation, request paper documentation, or determine the individual ineligible and transfer the application to the Marketplace.
3. Under the Affordable Care Act (ACA), states must seek to verify eligibility criteria based on electronic data matches with reliable sources of data. This column reflects whether the state system is able to make real-time eligibility determinations, defined as within 24 hours. Not all states have programmed their eligibility systems to make real-time determinations without worker interaction. In some states, only a small share of applications completed in person or over the phone that can be verified by an eligibility worker immediately are processed in real time.
4. These columns indicate the share of applications for non-disabled groups (children, pregnant women, parents, and expansion adults) that are determined eligible in real-time.
5. Florida and New Jersey have a reasonable compatibility threshold of 10% when the applicant reports income above the Medicaid eligibility threshold but the electronic data source reflects income below the threshold.
6. New Mexico implemented real-time eligibility for online applications December 2019.
7. Tennessee implemented real-time eligibility when the state's new eligibility system was implemented statewide in 2019.

Table 10: Medicaid Renewal Processes and Use of Periodic Data Matches Between Renewals for Children, Pregnant Women, Parents, and Expansion Adults, January 2020								
State	Processing Automated Renewals ¹	Percentage of Renewals that are Automated (Completed without Enrollee Action) ²					Telephone Renewals ³	Conducts Periodic Data Matches Between Renewals ⁴
		<25%	25%-50%	50%-75%	75%-90%	≥90%		
Total	47	8	13	13	9	0	41	30
Alabama	Y				Y		Y	Y
Alaska	Y			Not Reported				
Arizona	Y			Y			Y	Y
Arkansas	Y				Y		Y	
California	Y			Y			Y	
Colorado	Y				Y		Y	
Connecticut	Y			Y			Y	
Delaware	Y			Not Reported			Y	Not Reported
District of Columbia	Y				Y		Y	Not Reported
Florida	Y		Y				Y	Y
Georgia	Y		Y					Y
Hawaii	Y			Y			Y	Y
Idaho	Y				Y		Y	
Illinois	Y		Y					Y
Indiana	Y			Y			Y	Y
Iowa	Y			Y			Y	Y
Kansas ⁵	Y		Y					
Kentucky	Y			Y			Y	Y
Louisiana	Y			Y			Y	Y
Maine ⁵								Y
Maryland	Y			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	
Nebraska	Y	Y					Y	Y
Nevada							Y	
New Hampshire	Y	Y					Y	Y
New Jersey	Y	Y					Y	Y
New Mexico	Y		Y				Y	
New York	Y		Y				Y	
North Carolina	Y				Y		Y	Y
North Dakota	Y			Not Reported			Y	Y
Ohio	Y				Y		Y	Y
Oklahoma	Y		Y				Y	Y
Oregon	Y			Y			Y	
Pennsylvania	Y		Y				Y	Y
Rhode Island	Y				Y		Y	Y
South Carolina	Not Reported			Not Reported			Not Reported	Not Reported
South Dakota	Y		Y				Y	Y
Tennessee ⁶	Y			Not Reported			Y	
Texas	Y	Y					Y	Y
Utah ⁵	Y			Y				Y
Vermont	Y		Y				Y	
Virginia	Y			Y			Y	
Washington	Y			Y			Y	
West Virginia ⁵	Y	Y						Y
Wisconsin	Y	Y					Y	Y
Wyoming							Y	Y

SOURCE: Based on a national survey conducted by KFF with the Georgetown University Center for Children and Families, 2020.

Table presents rules in effect as of January 1, 2020.

Table 10 Notes

1. Under the Affordable Care Act (ACA), states must seek to re-determine eligibility at renewal using electronic data matches with reliable sources of data prior to requiring enrollees to complete a renewal form. This process is technically called ex parte but is often referred to as automated renewals.
2. These columns indicate whether the state system is able to process automated renewals and the share of renewals for MAGI-based groups that are successfully completed via automated processes.
3. This column indicates whether enrollees are able to complete a Medicaid renewal over the phone at the state level, either through the Medicaid agency or a State-based Marketplace call center.
4. This column indicates whether the state conducts routine electronic data matches with one or more data sources between annual renewal periods to identify potential changes in circumstances that would affect financial or other eligibility.
5. In Kansas, Maine, Utah, and West Virginia, families may report changes by telephone but still need to sign and return the pre-populated renewal form.
6. Tennessee implemented automated renewals when the state's new eligibility system was implemented statewide in 2019.

Table 11: State Adoption of Options to Promote Continuity of Coverage for Children, Pregnant Women, Parents, and Expansion Adults, January 2020					
State	Account for Reasonably Anticipated Changes in Income ¹	Account for Projected Annual Income for Remainder of Calendar Year ²	Proactively Update Address Information for Enrollees ³	12-Month Continuous Eligibility ⁴	
				Medicaid	CHIP (Total =35)
Total	35	12	10	23	25
Alabama	Y		Y	Y	Y
Alaska	Y	Y		Y	N/A (M-CHIP)
Arizona	Y				
Arkansas	Y				Y
California	Y	Y		Y	N/A (M-CHIP)
Colorado	Y	Y	Y	Y	Y
Connecticut			Y		
Delaware	Y	Not Reported	Not Reported		Y
District of Columbia	Y	Y			N/A (M-CHIP)
Florida ⁵	Y				Y
Georgia					
Hawaii	Y		Y		N/A (M-CHIP)
Idaho	Y	Y	Y	Y	Y
Illinois	Y		Y	Y	Y
Indiana ⁶		Y			
Iowa	Y			Y	Y
Kansas				Y	Y
Kentucky					
Louisiana	Y		Y	Y	Y
Maine				Y	Y
Maryland	Y				N/A (M-CHIP)
Massachusetts	Y				
Michigan	Y			Y	N/A (M-CHIP)
Minnesota	Y				N/A (M-CHIP)
Mississippi	Y			Y	Y
Missouri	Y	Y			
Montana ⁷	Y			Y	Y
Nebraska	Y				N/A (M-CHIP)
Nevada	Y				Y
New Hampshire	Y				N/A (M-CHIP)
New Jersey	Y	Y	Y	Y	Y
New Mexico	Y			Y	N/A (M-CHIP)
New York ⁷	Y	Y	Y	Y	Y
North Carolina				Y	Y
North Dakota	Y			Y	N/A (M-CHIP)
Ohio				Y	N/A (M-CHIP)
Oklahoma	Y				N/A (M-CHIP)
Oregon	Y			Y	Y
Pennsylvania ⁸	Y				Y
Rhode Island		Not Reported			N/A (M-CHIP)
South Carolina	Not Reported	Not Reported	Not Reported	Not reported	Not reported
South Dakota	Y				
Tennessee			Y		Y
Texas ⁹		Y			Y
Utah	Y				Y
Vermont					N/A (M-CHIP)
Virginia					
Washington	Y	Y		Y	Y
West Virginia		Y		Y	Y
Wisconsin					
Wyoming	Y			Y	Y

SOURCE: Based on a national survey conducted by KFF with the Georgetown University Center for Children and Families, 2020.

Table presents rules in effect as of January 1, 2020.

Medicaid and CHIP Eligibility, Enrollment, and Cost Sharing Policies as of January 2020

Table 11 Notes

1. This column indicates whether the state takes into account anticipated income changes, such as recurring seasonable employment or a job change, when determining eligibility at application or renewal.
2. This column indicates if the state takes into account projected annual income for the remainder of the calendar year when determining ongoing eligibility at renewal or when an individual has an income change between renewal periods.
3. This column indicates whether the state routinely takes steps to update address information for enrollees prior to receiving returned mail.
4. This column indicates whether states have opted to cover children in Medicaid and/or CHIP for a full twelve months unless the child ages out, moves out of state, voluntarily withdraws, or does not make premium payments.
5. In Florida, children in Medicaid under the age of 5 receive 12-month continuous eligibility and children ages five and older receive six month of continuous eligibility.
6. Indiana provides 12-month continuous eligibility to children under age 3.
7. Montana and New York provide 12-month continuous eligibility to parents and expansion adults through a Section 1115 waiver.
8. Pennsylvania provides continuous eligibility for children under age 4.
9. Texas provides a child in CHIP with income below 185% FPL 12 months of continuous eligibility; children in CHIP at or above 185% FPL receives 12 months of continuous eligibility unless there is an indication of a change at a six-month income check that would make the child ineligible for CHIP.

Table 12: Presumptive Eligibility in Medicaid and CHIP, January 2020 ¹								
State	Children		Pregnant Women		Parents	Adults ² (Total = 37)	Family Planning Expansion ² (Total = 29)	Former Foster Youth
	Medicaid	CHIP ² (Total =35)	Medicaid	CHIP ² (Total = 5)				
Total	19	10	30	3	9	8	6	8
Alabama				N/A		N/A		
Alaska		N/A (M-CHIP)		N/A			N/A	
Arizona				N/A			N/A	
Arkansas				N/A			N/A	
California	Y	N/A (M-CHIP)	Y	N/A				
Colorado	Y	Y	Y	Y			N/A	
Connecticut	Y	Y	Y	N/A			Y	
Delaware				N/A			N/A	
District of Columbia		N/A (M-CHIP)	Y	N/A			N/A	
Florida			Y	N/A		N/A		
Georgia			Y	N/A		N/A		
Hawaii		N/A (M-CHIP)		N/A			N/A	
Idaho ³	Y	Y	Y	N/A	Y	Y	N/A	Y
Illinois	Y	Y	Y	N/A			N/A	
Indiana ⁴	Y		Y	N/A	Y	Y	Y	Y
Iowa	Y	Y	Y	N/A	Y	Y		Y
Kansas	Y	Y	Y	N/A		N/A	N/A	
Kentucky			Y	N/A				
Louisiana				N/A				
Maine			Y	N/A				
Maryland ⁵		N/A (M-CHIP)		N/A				
Massachusetts				N/A			N/A	
Michigan	Y	N/A (M-CHIP)	Y	N/A			N/A	Y
Minnesota		N/A (M-CHIP)		N/A			Y	
Mississippi				N/A		N/A		
Missouri	Y	Y	Y	Y		N/A		
Montana	Y	Y	Y	N/A	Y	Y		Y
Nebraska		N/A (M-CHIP)	Y	N/A		N/A	N/A	
Nevada				N/A			N/A	
New Hampshire	Y	N/A (M-CHIP)	Y	N/A	Y	Y	Y	
New Jersey	Y	Y	Y	Y	Y	Y		
New Mexico ⁶	Y	N/A (M-CHIP)	Y	N/A				
New York	Y	Y	Y	N/A			Y	
North Carolina			Y	N/A		N/A		
North Dakota		N/A (M-CHIP)		N/A			N/A	
Ohio	Y	N/A (M-CHIP)	Y	N/A	Y	Y	N/A	Y
Oklahoma		N/A (M-CHIP)		N/A		N/A		
Oregon				N/A				
Pennsylvania			Y	N/A				
Rhode Island		N/A (M-CHIP)						
South Carolina	Not Reported							
South Dakota				N/A		N/A	N/A	
Tennessee ⁷			Y	N/A		N/A	N/A	
Texas			Y	N/A		N/A	N/A	
Utah			Y	N/A			N/A	
Vermont		N/A (M-CHIP)		N/A				
Virginia								
Washington				N/A				
West Virginia	Y		Y	N/A	Y	Y	N/A	Y
Wisconsin	Y		Y	N/A			Y	
Wyoming	Y		Y	N/A	Y	N/A		Y

SOURCE: Based on a national survey conducted by KFF with the Georgetown University Center for Children and Families, 2020.
Table presents rules in effect as of January 1, 2020.

Table 12 Notes

1. These columns indicate whether a state has elected to implement presumptive eligibility, under which a state can authorize qualified entities such as hospitals, community health centers, and schools to make presumptive eligibility determinations for Medicaid and/or CHIP and extend temporary coverage to individuals until a full eligibility determination is made. The ACA also gave hospitals nationwide the authority to conduct presumptive eligibility determinations regardless of whether a state has otherwise adopted presumptive eligibility.
2. N/A (M-CHIP) responses indicate that the state does not administer a separate CHIP program for uninsured children. N/A responses indicate that the state does not provide CHIP for pregnant women, does not cover other adults under Medicaid expansion and/or does not have a family planning expansion program.
3. Idaho implemented the Affordable Care Act Medicaid expansion for adults effective January 2020. Presumptive eligibility is applied to expansion adults.
4. Indiana does not use CHIP funds or income limits for the child population.
5. Maryland utilizes presumptive eligibility for individuals leaving correctional facilities if an application cannot be submitted prior to release.
6. 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.
7. In 2019, Tennessee eliminated presumptive eligibility in Medicaid.

Table 13: Premium, Enrollment Fee, and Cost Sharing Requirements for Children, January 2020						
State	Premiums/Enrollment Fees			Cost Sharing		
	Medicaid	CHIP (Total = 35) ¹	Lowest Income at Which Premiums Begin (% of the FPL) ²	Medicaid	CHIP (Total = 35) ¹	Lowest Income at Which Cost Sharing Begins (% of the FPL) ²
Total	4	26		1	21	
Alabama		Y	141%		Y	141%
Alaska		N/A (M-CHIP)			N/A (M-CHIP)	
Arizona		Y	133%			
Arkansas					Y	142%
California	Y	N/A (M-CHIP)	160%		N/A (M-CHIP)	
Colorado		Y	157%		Y	143%
Connecticut		Y	249%		Y	196%
Delaware		Y	Not Reported			
District of Columbia		N/A (M-CHIP)			N/A (M-CHIP)	
Florida ³		Y	133%		Y	133%
Georgia ⁴		Y	139%		Y	139%
Hawaii		N/A (M-CHIP)			N/A (M-CHIP)	
Idaho		Y	143%		Y	143%
Illinois		Y	157%		Y	142%
Indiana		Y	158%		Y	158%
Iowa		Y	182%		Y	182%
Kansas		Y	167%			
Kentucky						
Louisiana		Y	213%			
Maine		Y	157%			
Maryland	Y	N/A (M-CHIP)	211%		N/A (M-CHIP)	
Massachusetts		Y	150%			
Michigan	Y	N/A (M-CHIP)	160%		N/A (M-CHIP)	
Minnesota		N/A (M-CHIP)			N/A (M-CHIP)	
Mississippi					Y	150%
Missouri		Y	150%			
Montana					Y	143%
Nebraska		N/A (M-CHIP)			N/A (M-CHIP)	
Nevada		Y	133%			
New Hampshire		N/A (M-CHIP)			N/A (M-CHIP)	
New Jersey		Y	200%		Y	151%
New Mexico		N/A (M-CHIP)			N/A (M-CHIP)	
New York		Y	160%			
North Carolina		Y	159%		Y	133%
North Dakota ⁵					N/A (M-CHIP)	
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 ⁶				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	210%			
West Virginia		Y	211%		Y	133%
Wisconsin ⁷		Y	201%			
Wyoming					Y	134%

SOURCE: Based on a national survey conducted by KFF with the Georgetown University Center for Children and Families, 2020.
Table presents rules in effect as of January 1, 2020.

Table 13 Notes

1. N/A (M-CHIP) responses indicate that the state does not administer a separate CHIP program for uninsured children.
2. In a number of states, the income at which premiums or cost sharing begins may vary by the child's age since Medicaid and CHIP eligibility levels vary by age and some states exempt younger children from cost sharing. The reported income eligibility limits at which premiums and cost sharing begin do not reflect the five percentage points of the federal poverty level (FPL) disregard that applies to eligibility determinations, although this disregard may apply when the income level at which premiums or cost sharing applies aligns with the eligibility cutoff between Medicaid and separate CHIP programs.
3. Florida charges premiums to children enrolled in its three separate CHIP programs, but it only charges cost sharing for children in one of its three separate CHIP programs, Healthy Kids.
4. Georgia does not charge premiums to children under age 6.
5. North Dakota eliminated copayments for children in CHIP when it transitioned them from separate CHIP coverage to Medicaid.
6. Tennessee has waiver authority to charge cost sharing for children between 100% and 133% FPL.
7. As of January 2020, Wisconsin suspended copayments for children in Medicaid and CHIP.

Table 14: Premiums and Enrollment Fees for Children at Selected Income Levels, January 2020 ^{1,2}							
State	151% FPL (or 150% if upper limit)	201% (or 200% if upper limit)	251% FPL (or 250% if upper limit)	301% FPL (or 300% if upper limit)	351% FPL (or 350% if upper limit)	Is Premium Family- Based?	Family Maximum ^{3,4}
Monthly Payments (24 states)							
Arizona ⁵	\$40	\$50	N/A	N/A	N/A		Yes
California ⁶	\$0	\$13	\$13	N/A	N/A		
Connecticut ⁷	\$0	\$0	\$30	\$30	N/A		Yes
Delaware ⁸	\$10	\$25	N/A	N/A	N/A	Yes	N/A
Florida ⁹	\$15	\$20	N/A	N/A	N/A	Yes	N/A
Georgia ¹⁰	\$11	\$29	\$32	N/A	N/A		Yes
Idaho ¹¹	\$15	N/A	N/A	N/A	N/A		No
Illinois ¹²	\$0	\$15	\$40	\$40	N/A		Yes
Indiana ¹³	\$0	\$33	\$53	N/A	N/A		Yes
Iowa ¹⁴	\$0	\$10	\$20	\$20	N/A		Yes
Kansas ¹⁵	\$0	\$30	N/A	N/A	N/A	Yes	N/A
Louisiana	\$0	\$0	\$50	N/A	N/A	Yes	N/A
Maine ¹⁶	\$0	\$32/\$64	N/A	N/A	N/A		Yes
Maryland	\$0	\$0	\$54	\$68	N/A	Yes	N/A
Michigan	\$0	\$10	N/A	N/A	N/A	Yes	N/A
Massachusetts ¹⁷	\$12	\$20	\$28	\$28	N/A		Yes
Missouri ¹⁸	\$19 \$24 \$29 \$63 \$79 \$96 \$154 \$195 \$235 \$154 \$195 \$235				N/A		
New Jersey ¹⁹	\$0	\$45	\$90	\$152	\$152	Yes	N/A
New York ²⁰	\$0	\$9 \$27	\$30 \$90	\$45 \$135	\$60 \$180		Yes
Pennsylvania ²¹	\$0	\$0	\$53	\$84	N/A		
Vermont ²²	\$0	\$15	\$20/\$60	\$20/\$60	N/A	Yes	N/A
Washington ²³	\$0	\$0	\$20 \$40	\$30 \$60	N/A		Yes
West Virginia ²⁴	\$0	\$0	\$35	\$35	N/A		Yes
Wisconsin	\$0	\$10	\$34	\$98	N/A		
Quarterly Payments (2 states)							
Nevada	\$50	\$80	N/A	N/A	N/A	Yes	N/A
Utah	\$75	\$75	N/A	N/A	N/A	Yes	N/A
Annual Payments (4 states)							
Alabama ²⁰	\$104	\$104	\$104	\$104	N/A		Yes
Colorado ²⁵	\$0	\$25	\$75	N/A	N/A		Yes
North Carolina ²⁶	\$0	\$50	N/A	N/A	N/A		Yes
Texas ²⁷	\$35	\$50	N/A	N/A	N/A	Yes	N/A
No Premiums or Enrollment Fees (21 states)							
Alaska	--	--	--	--	--		--
Arkansas	--	--	--	--	--		--
District of Columbia	--	--	--	--	--		--
Hawaii	--	--	--	--	--		--
Kentucky	--	--	--	--	--		--
Minnesota	--	--	--	--	--		--
Mississippi	--	--	--	--	--		--
Montana	--	--	--	--	--		--
Nebraska	--	--	--	--	--		--
New Hampshire	--	--	--	--	--		--
New Mexico	--	--	--	--	--		--
North Dakota	--	--	--	--	--		--
Ohio	--	--	--	--	--		--
Oklahoma	--	--	--	--	--		--
Oregon	--	--	--	--	--		--
Rhode Island	--	--	--	--	--		--
South Carolina	--	--	--	--	--		--
South Dakota	--	--	--	--	--		--
Tennessee	--	--	--	--	--		--
Virginia	--	--	--	--	--		--
Wyoming	--	--	--	--	--		--

SOURCE: Based on a national survey conducted by KFF with the Georgetown University Center for Children and Families, 2020.

Table presents rules in effect as of January 1, 2020.

Table 14 Notes

1. N/A indicates that coverage is not available at the specified income level. If a state does not charge premiums at all, it is noted as "--".
2. Cases in which premiums or enrollment fees are not a whole dollar value have been rounded to the nearest dollar.
3. This column indicates whether there is a maximum amount that a family with multiple children would be required to pay. Family based premium indicates that the premium amount listed in the table is per family rather than per child.
4. Federal rules limit total premiums and cost-sharing for all household members enrolled in Medicaid or CHIP to five percent of family income. States have the option to apply the cap on a monthly or quarterly basis. States are also required to have a mechanism in place to track family-based cost-sharing and waive cost-sharing for the remainder of the cost-sharing period selected by the state.
5. In Arizona, there is a maximum premium of \$60 for families with incomes at 151% FPL and \$70 for families with incomes at 200% FPL.
6. In California, the family maximum premium is \$39.
7. In Connecticut, the family maximum premium is \$50.
8. In Delaware, there is a maximum premium of \$10 for families with children ages 6-18 with incomes between 134%-142% FPL and children ages 1-18 between 143%-159% FPL. Families with incomes between 160%-176% FPL pay \$15 per family and families with incomes between 177%-212% FPL pay \$25 per family. 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. Florida charges premiums to children enrolled in its three separate CHIP programs, but it only charges cost sharing for children in its separate CHIP program, HealthyKids.
10. In Georgia, the family maximum is \$16 for families with incomes at 151% FPL and \$58 for families with incomes at 201% FPL.
11. In Idaho, if a child is up to date on wellness checks, premiums are waived.
12. In Illinois, CHIP premiums are \$15 per child, \$25 for two children, and \$5 for each additional child up to a \$40 maximum for families with incomes below 208% FPL. Above 208% FPL, families pay \$40 per child or \$80 for two or more children.
13. In Indiana, there is a maximum premium of \$33 for families with incomes between 175% and 200% FPL, \$50 for families with incomes between 200% and 225% FPL, \$53 for families with incomes between 225% and 250% FPL and \$70 for families with incomes at or above 250% FPL.
14. In Iowa, there is a maximum premium of \$20 for families with incomes at 201% FPL and \$40 for families with incomes at 251% FPL or 301% FPL.
15. In Kansas, there is a maximum premium of \$20 for families with incomes up to 191% FPL, \$30 for families with incomes up to 218% FPL, and \$50 for families with higher incomes.

16. In Maine, families with incomes between 157%-166% FPL pay \$8 for one child and \$16 for two or more children. Families with incomes between 166%-177% FPL pay \$16 for one child and \$32 for two or more children. Families with incomes between 177%-192% FPL pay \$24 for one child and \$48 for two or more children. Families with incomes between 192% -208% FPL pay \$32 for one child and \$64 for two or more children. The family maximum premium is \$64.
17. In Massachusetts, the family maximum premium is \$28. In Massachusetts, premiums are also charged for children covered at higher incomes through its CommonHealth and Children's Medical Security Plan program.
18. In Missouri premiums vary by family size. Amounts shown are for 2-person, 3-person, and 4-person family. Rates increase based on family size up to the family maximum cap of 5% of income.
19. In New Jersey, the family maximum varies by income and premiums are family-based. At 201% FPL, the family maximum is \$43. At 251%, the family max is \$86. At 301% FPL and 351%, the family max is \$144.50; at 301% FPL, the premium is \$144.50 but value shown is rounded to \$145.
20. In Alabama and New York, there is a maximum premium of three times the child rate. In New York, The figure on the left is the individual child rate and the figure to the right is the family max amount which tops out at 3x the individual rate.
21. In Pennsylvania, premiums vary by contractor. The average amount is shown.
22. In Vermont, for those above 238% FPL, the monthly premium is \$20 if the family has other health insurance and \$60 if there is no other health insurance.
23. Washington State charges premiums of \$20 for one child and \$40 of two or more children in families with incomes of 210%-260% FPL; \$30 for one child and \$60 for two or more children in families with incomes above 260% FPL but not exceeding 312% FPL. In Washington, the family maximum varies by income. At 251% FPL, the family maximum is \$40 and at 301% FPL, the family maximum is \$60.
24. In West Virginia, the family maximum premium is \$71.
25. In Colorado, there is a maximum annual enrollment fee of \$35 for families with incomes at 201% FPL and \$105 for families with incomes at 251% FPL.
26. In North Carolina, the family maximum annual enrollment fee is \$100.
27. In Texas, annual enrollment fees in CHIP are family-based with three tiers up to 151%, up to and including 186%, and then above 186%.

Table 15: Disenrollment Policies for Non-Payment of Premiums in Children's Coverage, January 2020		
State	Grace Period (Amount of Time) Before a Child Loses Coverage for Nonpayment ¹	Lockout Period in Separate CHIP Program ²
Monthly Payments (24 states)		
Arizona	60 days	2 months
California	60 Days	N/A (M-CHIP)
Connecticut ⁵	Until Renewal	None
Delaware	60 days	None
Florida	1 month	1 month
Georgia	60 days	None
Idaho ⁵	Until renewal	None
Illinois	60 days	None
Indiana	60 days	90 days
Iowa	45 days	None
Kansas	60 days	90 days
Louisiana	30 days	90 days
Maine ⁶	12 Months	90 days
Maryland	60 Days	N/A (M-CHIP)
Massachusetts ⁷	60 days	90 days
Michigan	60 days	N/A (M-CHIP)
Missouri ⁸	30 days	90 days
New Jersey	60 days	90 days
New York	30 days	None
Pennsylvania	90 days	90 days
Vermont ⁵	Until Renewal	N/A (M-CHIP)
Washington	90 days	90 days
West Virginia ⁵	Until Renewal	None
Wisconsin	60 days	90 days
Quarterly Payments (2 states)		
Nevada	60 days	90 days
Utah	30 days	90 days
Annual Payments (4 states)		
Alabama ³	--	--
Colorado ⁴	--	--
North Carolina ⁹	--	--
Texas ¹⁰	--	--
No Premiums or Enrollment Fees (21 states)		
Alaska	--	--
Arkansas	--	--
District of Columbia	--	--
Hawaii	--	--
Kentucky	--	--
Minnesota	--	--
Mississippi	--	--
Montana	--	--
Nebraska	--	--
New Hampshire	--	--
New Mexico	--	--
North Dakota	--	--
Ohio	--	--
Oklahoma	--	--
Oregon	--	--
Rhode Island	--	--
South Carolina	--	--
South Dakota	--	--
Tennessee	--	--
Virginia	--	--
Wyoming	--	--

SOURCE: Based on a national survey conducted by KFF with the Georgetown University Center for Children and Families, 2020.

Table presents rules in effect as of January 1, 2020.

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. States must provide a minimum 30-day premium payment grace period in CHIP before cancelling a child's coverage. States that charge an annual enrollment fee may require prepayment as a condition of enrollment.
2. A lockout period is an amount of time during which the disenrolled child is prohibited from returning to the CHIP program. Lockouts are not permitted in Medicaid, and the Affordable Care Act (ACA) limited lockout periods in CHIP to no more than 90 days. N/A (M-CHIP) responses indicate that the state does not administer a separate CHIP program for uninsured children.
3. Alabama's annual enrollment fee is not required before a child enrolls in coverage, nor is a child disenrolled for non-payment in the first year. Following the annual renewal, families have 90 days to pay the annual enrollment fee; after that time they will be disenrolled for nonpayment.
4. Colorado's annual enrollment fee is required before a child enrolls in coverage. Applications are pended until the enrollment fee is paid. Once individuals pay the enrollment fee, their eligibility is effective retroactively to the first of the month of application.
5. Connecticut, Idaho, Vermont and West Virginia do not disenroll children for unpaid premiums in CHIP. Renewal is considered a new application, and families need to pay the initial month to continue coverage at renewal. Vermont is not currently disenrolling children for unpaid premiums due to system limitations.
6. In Maine, for each month there is an unpaid premium, there is a month of ineligibility up to a maximum of three months. The penalty period begins in the first month following the enrollment period in which the premium was overdue. For example, if a family does not pay the last two months of premiums, they will have a two-month penalty. If they do not pay three or more months, they will have a three-month lockout period.
7. In Massachusetts, if the premium payment is not paid within 60 days of the due date, a final notice is sent giving the family 15 days to pay before the case is closed. 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. Premiums that are more than 24 months overdue are waived.
8. In Missouri, only children in families with incomes above 225% FPL are subject to the lockout period. Families are given the option to catch up on the premiums and coverage can be reinstated.
9. In North Carolina, families have 12 days to pay the annual enrollment fee. They may request an additional 12 days before disenrollment.
10. In Texas, children who renew coverage are given 30 days to pay the annual enrollment fee.

Table 16: Cost Sharing Amounts for Selected Services for Children at Selected Income Levels, January 2020 ¹								
State	Family Income at 151% FPL (or 150% if upper eligibility limit)				Family Income at 201% FPL (or 200% if upper eligibility limit)			
	Non- Preventive Physician Visit	ER Visit	Non- Emergency Use of ER	Inpatient Hospital Visit	Non- Preventive Physician Visit	ER Visit	Non- Emergency Use of ER	Inpatient Hospital Visit
Total	16	10	14	11	17	12	16	12
Alabama	\$13	\$60	\$60	\$200	\$13	\$60	\$60	\$200
Alaska	--	--	--	--	--	--	--	--
Arizona	--	--	--	--	--	--	--	--
Arkansas	\$10	\$10	\$10	20% of reimbursement rate for first day	\$10	\$10	\$10	20% of reimbursement rate for first day
California	--	--	--	--	--	--	--	--
Colorado	\$5	\$30	\$30	\$20	\$10	\$50	\$50	\$50
Connecticut	\$0	\$0	\$0	\$0	\$10	\$0	\$0	\$0
Delaware	--	--	--	--	--	--	--	--
District of Columbia	--	--	--	--	--	--	--	--
Florida ²	\$5	\$10	\$10	\$0	\$5	\$10	\$10	\$0
Georgia	\$0.50-\$3	\$0	\$0	\$12.50	\$0.50-\$3	\$0	\$0	\$12.50
Hawaii	--	--	--	--	--	--	--	--
Idaho	\$3.65	\$0	\$3.65	\$0	N/A	N/A	N/A	N/A
Illinois	\$3.90	\$0	\$0	\$3.90/day	\$5	\$5	\$25	\$5/day
Indiana	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Iowa	\$0	\$0	\$0	\$0	\$0	\$0	\$25	\$0
Kansas	--	--	--	--	--	--	--	--
Kentucky	--	--	--	--	--	--	--	--
Louisiana	--	--	--	--	--	--	--	--
Maine	--	--	--	--	--	--	--	--
Maryland	--	--	--	--	--	--	--	--
Massachusetts	--	--	--	--	--	--	--	--
Michigan	--	--	--	--	--	--	--	--
Minnesota	--	--	--	--	--	--	--	--
Mississippi	\$5	\$15	\$15	\$0	\$5	\$15	\$15	\$0
Missouri	--	--	--	--	--	--	--	--
Montana	\$3	\$5	\$5	\$25	\$3	\$5	\$5	\$25
Nebraska	--	--	--	--	--	--	--	--
Nevada	--	--	--	--	--	--	--	--
New Hampshire	--	--	--	--	--	--	--	--
New Jersey	\$5	\$10	\$10	\$0	\$5	\$35	\$35	\$0
New Mexico	--	--	--	--	--	--	--	--
New York	--	--	--	--	--	--	--	--
North Carolina	\$5	\$0	\$10	\$0	\$5	\$0	\$25	\$0
North Dakota ³	--	--	--	--	--	--	--	N/A
Ohio	--	--	--	--	--	--	--	--
Oklahoma	--	--	--	--	--	--	--	--
Oregon	--	--	--	--	--	--	--	--
Pennsylvania ^{2,4}	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Rhode Island	--	--	--	--	--	--	--	--
South Carolina	--	--	--	--	--	--	--	--
South Dakota	--	--	--	--	--	--	--	--
Tennessee ^{2,5}	\$5	\$0	\$10 \$50	\$5	\$15/\$20	\$0	\$50	\$100
Texas	\$5	\$0	\$5	\$35	\$25	\$0	\$75	\$125
Utah ⁶	\$25/\$40	\$300	\$100-\$200	20% daily reimbursement rate	\$25/\$40	\$300	\$100-\$200	20% daily reimbursement rate
Vermont	--	--	--	--	--	--	--	--
Virginia	\$5	\$5	\$25	\$25	\$5	\$5	\$25	\$25
Washington	--	--	--	--	--	--	--	--
West Virginia ^{2,7}	\$0	\$0	\$0	\$0	\$15	\$35	\$35	\$25
Wisconsin ⁸	--	--	--	--	--	--	--	--
Wyoming ²	\$10	\$25	\$25	\$50	\$10	\$25	\$25	\$50

SOURCE: Based on a national survey conducted by KFF with the Georgetown University Center for Children and Families, 2020. Table presents rules in effect as of January 1, 2020.

Table 16 Notes

1. If a state charges cost sharing for selected services or drugs shown in Tables 17 and 18 but either does not charge them at the income level shown or for the specific service, it is recorded as \$0; if a state does not provide coverage at a particular income level, it is noted as "N/A;" if a state does not charge copayments at all, it is noted as "--". Some states require 18-year-olds to meet the copayments of adults in Medicaid. These data are not shown.
2. In Florida, Pennsylvania, Tennessee, West Virginia, and Wyoming, the emergency room copayment is waived if the child is admitted.
3. North Dakota eliminated copayments for children in CHIP when it transitioned them from separate CHIP coverage to Medicaid.
4. Pennsylvania charges cost sharing starting at >208% of the federal poverty level (FPL), so no charges are reported in the table.
5. In Tennessee, children enrolled in TennCare have no copayments. The values shown before the "I" represent copayments for children enrolled in TennCare Standard, whereas the values after the "I" represent copayments for children enrolled in Cover Kids. The values shown before a "/" represent copayments for a primary care provider, whereas the values after the "/" represent copayments for a provider that is a specialist in Cover Kids.
6. Utah has a \$40 deductible for all hospital services for families with incomes up to 150% FPL. Families with incomes above 150% FPL have a \$500 per child or \$1,500 per family deductible for hospital services. In Utah, for a non-preventive physician visit, the value before the "/" is the copayment amount for a visit with a primary care doctor, the value after the "/" is the copayment for a visit with a specialist.
7. In West Virginia, the copayment for a non-preventive physician visit is waived if the child goes to his or her medical home.
8. As of January 2020, Wisconsin suspended copayments for children in Medicaid and CHIP.

Table 17: Cost Sharing Amounts for Prescription Drugs for Children at Selected Income Levels, January 2020 ¹						
State	Family Income at 151% FPL (or 150% if upper limit)			Family Income at 201% FPL (or 200% if upper limit)		
	Generic	Preferred Brand Name	Non-Preferred Brand Name	Generic	Preferred Brand Name	Non-Preferred Brand Name
Total	12	14	10	15	16	12
Alabama	\$5	\$25	\$28	\$5	\$25	\$28
Alaska	--	--	--	--	--	--
Arizona	--	--	--	--	--	--
Arkansas	\$5	\$5	\$5	\$5	\$5	\$5
California	--	--	--	--	--	--
Colorado	\$3	\$10	N/C	\$5	\$15	N/C
Connecticut	\$0	\$0	\$0	\$5	\$10	\$10
Delaware	--	--	--	--	--	--
District of Columbia	--	--	--	--	--	--
Florida	\$5	\$5	\$5	\$5	\$5	\$5
Georgia	\$0.50	\$0.50-\$3	\$0.50-\$3	\$1	\$0.50-\$3	\$0.50-\$3
Hawaii	--	--	--	--	--	--
Idaho	\$0	\$0	\$0	N/A	N/A	N/A
Illinois	\$2	\$3.90	\$3.90	\$3	\$5	\$5
Indiana	\$0	\$0	\$0	\$3	\$10	\$10
Iowa	\$0	\$0	\$0	\$0	\$0	\$0
Kansas	--	--	--	--	--	--
Kentucky	--	--	--	--	--	--
Louisiana	--	--	--	--	--	--
Maine	--	--	--	--	--	--
Maryland	--	--	--	--	--	--
Massachusetts	--	--	--	--	--	--
Michigan	--	--	--	--	--	--
Minnesota	--	--	--	--	--	--
Mississippi	\$0	\$0	\$0	\$0	\$0	\$0
Missouri	--	--	--	--	--	--
Montana ²	\$0	\$0	\$0	\$0	\$0	\$0
Nebraska	--	--	--	--	--	--
Nevada	--	--	--	--	--	--
New Hampshire	--	--	--	--	--	--
New Jersey	\$1	\$5	\$5	\$5	\$5	\$5
New Mexico	--	--	--	--	--	--
New York	--	--	--	--	--	--
North Carolina	\$1	\$1	\$3	\$1	\$1	\$10
North Dakota ³	--	--	--	--	--	--
Ohio	--	--	--	--	--	--
Oklahoma	--	--	--	--	--	--
Oregon	--	--	--	--	--	--
Pennsylvania ⁴	\$0	\$0	N/C	\$0	\$0	N/C
Rhode Island	--	--	--	--	--	--
South Carolina	Not Reported			Not Reported		
South Dakota	--	--	--	--	--	--
Tennessee ⁵	\$1.50 \$1	\$3	\$3 \$5	\$1.50 \$5	\$3 \$20	\$3 \$40
Texas	\$0	\$5	N/C	\$10	\$35	N/C
Utah	\$15	25% of cost	50% of cost	\$15	25% of cost	50% of cost
Vermont	--	--	--	--	--	--
Virginia	\$5	\$5	\$5	\$5	\$5	\$5
Washington	--	--	--	--	--	--
West Virginia ⁶	\$0	\$5	N/C	\$0	\$10	N/C
Wisconsin ⁷	--	--	--	--	--	--
Wyoming	\$5	\$10	N/C	\$5	\$10	N/C

SOURCE: Based on a national survey conducted by KFF with the Georgetown University Center for Children and Families, 2020.

Table presents rules in effect as of January 1, 2020.

Table 17 Notes

1. If a state charges cost sharing for selected services or drugs shown in Tables 17 and 18, but either does not charge them at the income level shown or for the specific service, it is recoded as a \$0; if a state does not provide coverage at a particular income level, it is noted as “N/A;” if a state does not charge copayments at all, it is noted as “- -”; if a state does not cover a type of drug, it is noted as “N/C”. Some states require 18-year-olds to meet the copayments of adults in Medicaid. These data are not shown.
2. In Montana, if families order prescriptions through the mail, they pay \$6 for a three-month supply of a generic drug.
3. North Dakota eliminated copayments for children in CHIP when it transitioned them from separate CHIP coverage to Medicaid.
4. Pennsylvania charges cost sharing starting at >208% of the federal poverty level (FPL), so no charges are reported in the table.
5. Tennessee covers children in its regular Medicaid program, called TennCare, with incomes up to 195% FPL for infants, 142% for children ages 1 – 5, and 133% FPL for children 6 – 18. Children who lose eligibility in TennCare qualify for coverage under a Medicaid expansion program, called TennCare Standard, if they are uninsured, have no access to insurance, and have family incomes below 211% FPL. Tennessee also operates a separate CHIP program, called Cover Kids, which covers uninsured children of all ages who do not qualify for TennCare or TennCare Standard and have incomes below 250% FPL. Children enrolled in TennCare have no copayments. The values shown before the “|” represent copayments for children enrolled in TennCare Standard, whereas the values after the “|” represent copayments for children enrolled in Cover Kids.
6. In West Virginia, unless the drug is specified as a medical necessity or the child came into the program already established on the drug, then client would get preferred drug co-pay.
7. As of January 2020, Wisconsin suspended copayments for children in Medicaid and CHIP.

Table 18: Premium and Cost Sharing Requirements for Selected Services for Section 1931 Parents, January 2020 ¹									
State	Monthly Contribution /Premiums	Cost Sharing	Income at Which Cost Sharing Begins (%FPL)	Cost Sharing Amounts for Selected Services					
				Non-Preventive Physician Visit	Non-Emergency Use of ER	Inpatient Hospital Visit	Generic Drug	Preferred Brand Name Drug	Non-Preferred Brand Name Drug
Total	1	35		24	21	22	32	34	33
Alabama		Yes	0%	\$1.30-\$3.90	\$3.90	\$50	\$0.65-\$3.90	\$0.65-\$3.90	\$0.65-\$3.90
Alaska		Yes	0%	\$3	\$0	\$50/day-\$200/discharge	\$0.50-\$3.50	\$0.50-\$3.50	\$0.50-\$3.50
Arizona		Yes	0%	\$3.4	\$0		\$2.30	\$2.30	\$2.30
Arkansas		Yes	0%	\$0	\$0	10% cost of first day	\$0.50-\$3.90	\$0.50-\$3.90	\$0.50-\$3.90
California		Yes	0%	\$1	\$5	\$0	\$1	\$1	\$1
Colorado		Yes	101%	\$2	\$6	\$4	\$3	\$3	\$3
Connecticut		No	--	--	--	--	--	--	--
Delaware ²		Yes	0%	\$0	\$0	\$0	\$50-\$3	\$50-\$3	\$50-\$3
District of Columbia		No	--	--	--	--	--	--	--
Florida		Yes	0%	\$2	5% of first \$300	\$0	\$0	\$0	\$0
Georgia		Yes	0%	\$0	\$0	\$12.50	\$50-\$3	\$50-\$3	\$50-\$3
Hawaii		No	--	--	--	--	--	--	--
Idaho		No	--	--	--	--	--	--	--
Illinois ³		No	--	--	--	--	--	--	--
Indiana ⁴	Yes, >0%	Yes	0%	\$4	\$8	\$75	\$4	\$4	\$8
Iowa ¹³		Yes	0%	\$3	\$3	\$0	\$1	\$1	\$2-3
Kansas		No	--	--	--	--	--	--	--
Kentucky ¹⁴		Yes	0%	\$3	\$8	\$50	\$1	\$4	5% cost (\$8 min/ \$20 max)
Louisiana		Yes	0%	\$0	\$0	\$0	\$50-\$3	\$50-\$3	\$50-\$3
Maine ⁵		Yes	0%	\$0	\$3	Up to \$3/day	\$3	\$3	\$3
Maryland		Yes	0%	\$0	\$0	\$0	\$1-\$3	\$1-\$3	\$1-\$3
Massachusetts ¹⁵		Yes	0%	\$0	\$0	\$3	\$3.65	\$3.65	\$3.65
Michigan ⁶		Yes	0%	\$2 \$4	\$3 \$8	\$50 \$100	\$1 \$4	\$1 \$4	\$3 \$8
Minnesota ⁷		Yes	0%	\$3	\$3.50	\$0	\$1	\$3	\$3
Mississippi		Yes	0%	\$3	\$0.00	\$10	\$3	\$3	\$3
Missouri		Yes	0%	\$1	\$3	\$10	\$50-\$2	\$50-\$2	\$50-\$2
Montana ³		No	--	--	--	--	--	--	--
Nebraska ⁸		Yes	0%	\$2	\$0	\$15	\$2	\$3	\$3
Nevada		No	--	--	--	--	--	--	--
New Hampshire		Yes	100%	\$0	\$0	\$0	\$0	\$1	\$2
New Jersey		No	--	--	--	--	--	--	--
New Mexico		No	--	--	--	--	--	--	--
New York		Yes	100%	\$0	\$3	\$25/discharge	\$1	\$3	\$3
North Carolina ¹²		Yes	0%	\$3	\$3	\$3/day	\$3	\$3	\$3
North Dakota ³		No	--	--	--	--	--	--	--
Ohio		Yes	0%	\$0	\$3	\$0	\$0	\$2	\$3
Oklahoma		Yes	0%	\$4	\$4	\$10/day; \$90 max	\$4	\$4	\$4
Oregon		No	--	--	--	--	--	--	--
Pennsylvania ¹⁶		Yes	0%	\$0.65-\$3.80	\$0.50-\$3	\$3/day	\$1	\$3	\$3
Rhode Island		No	--	--	--	--	--	--	--
South Carolina		Yes	0%	\$3.30	\$0	\$25	\$3.40	\$3.40	\$3.40
South Dakota		Yes	0%	\$3	Full amount	\$50	\$1	\$3.30	N/C
Tennessee		Yes	0%	\$0	\$0	\$0	\$1.50	\$3	\$3
Texas		No	--	--	--	--	--	--	--
Utah ⁹		Yes	20%	\$4	\$8	\$75	\$4	\$4	\$4
Vermont		Yes	0%	\$3	\$0	\$0	\$1-\$3	\$1-\$3	\$1-\$3
Virginia		Yes	0%	\$1	\$75	\$75	\$1	\$3	\$3
Washington		No	--	--	--	--	--	--	--
West Virginia ¹⁰		Yes	0%	\$0-\$4	\$8	\$0-\$75	\$0-\$3	\$0-\$3	\$0-\$3
Wisconsin ^{5,11}		No	--	--	--	--	--	--	--
Wyoming		Yes	0%	\$2.45	\$3.65	\$0	\$0.65	\$3.65	\$3.65

SOURCE: Based on a national survey conducted by KFF with the Georgetown University Center for Children and Families, 2020. Table presents rules in effect as of January 1, 2020.

Table 18 Notes

1. Data in the table present premiums or other monthly contributions and cost sharing requirements for Section 1931 parents. If a state charges cost sharing, but does not charge for the specific service, it is recorded as \$0; if a state does not charge cost sharing at all, it is noted as "--". In some states, copayments vary based on the cost of the service.
2. In Delaware, parents have a \$15 per month cap on out of pocket expenses from copayments.
3. Illinois and Montana, eliminated copayments on parents and adults in Medicaid as of January 2020. North Dakota eliminated copayments for parents and other adults as of October 2019.
4. In Indiana, Section 1931 parents who fail to pay monthly contributions will not be disenrolled but will receive Healthy Indiana Plan (HIP) Basic, a more limited benefit package with state plan level copayments. In Indiana, copayments are only required if enrolled in HIP Basic. In the HIP Plus plan, there are no copayments except for \$8 for first time use of the emergency room.
5. In Maine and Wisconsin, copayments begin above 0% of the federal poverty level (FPL).
6. In Michigan, copayments vary by income levels. The values shown before the "I" represent copayments for individuals with incomes less than or equal to 100%FPL, whereas the value after the "I" represent copayments for individuals with incomes above 100%FPL.
7. In Minnesota, co-payments are limited to \$12 a month. There are no co-payment for some mental health drugs. Minnesota does have a monthly deductible (\$3.20).
8. In Nebraska, if 1931 parents are enrolled in managed care, all co-payments are waived.
9. In Utah, enrollees under the Temporary Aid to Needy Families (TANF) payment limit are exempt from paying copayments.
10. In West Virginia, copayment amounts for services may vary by income. Enrollees have a quarterly out-of-pocket maximum of \$8 up to 50% FPL; \$71 between 50% and 100%; and \$143 above 100%.
11. Wisconsin suspended copayments in Medicaid for parents and adults as of January 2020.
12. North Carolina also added a copayment for non-emergency use of the emergency room to \$3.
13. In Iowa, there is a \$2 copay for non-preferred brand name drugs between \$25.01 and \$50 and a \$3 copay for non-preferred brand name drugs above \$50.
14. In Kentucky, enrollees are charged 5% coinsurance for non-preferred brand-name drugs, with a minimum of \$8 and a maximum of \$20.
15. 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.
16. In Pennsylvania, the inpatient hospital copayment is subject to a maximum of \$21 per stay.

Table 19: Premium and Cost Sharing Requirements for Selected Services for Medicaid Adults, January 2020 ¹									
State	Monthly Contribution s /Premiums	Cost Sharing	Income at Which Cost Sharing Begins (%FPL)	Cost Sharing Amounts for Selected Services					
				Non- Preventive Physician Visit	Non- Emergency Use of ER	Inpatient Hospital Visit	Generic Drug	Preferred Brand Name Drug	Non-Preferred Brand Name Drug
Implemented Medicaid Expansion (36 states)									
Total	5	22		13	14	13	18	21	21
Alaska	Yes, >100%	Yes	0%	\$3	\$0	\$50/day- \$200/discharge	\$0.50- \$3.50	\$0.50-\$3.50	\$0.50-\$3.50
Arizona		No	--	--	--	--	--	--	--
Arkansas ²		Yes	100%	\$8/\$10	\$0	\$140/day	\$4	\$4	\$8
California		Yes	0%	\$1	\$5	\$0	\$1	\$1	\$1
Colorado		Yes	0%	\$2	\$6	\$10/day	\$1	\$3	\$3
Connecticut		No	--						
Delaware ³		Yes	0%	\$0	\$0	\$0	\$0.50-\$3	\$0.50-\$3	\$0.50-\$3
District of Columbia		No	--	--	--	--	--	--	--
Hawaii		No	--	--	--	--	--	--	--
Idaho		No	--	--	--	--	--	--	--
Illinois ⁴	No	--	--	--	--	--	--	--	
Indiana ⁵	Yes, >0%	Yes	0%	\$4	\$8	\$75	\$4	\$4	\$8
Iowa ⁶	Yes, >50%	Yes	0%	\$0	\$8	\$0	\$0	\$0	\$0
Kentucky		Yes	0%	\$3	\$8	\$50	\$1	\$4	5% cost (\$8 min/ \$20 max)
Louisiana		Yes	0%	\$0	\$0	\$0	\$.50-\$3	\$.50-\$3	\$.50-\$3
Maine		Yes	0%	\$0	\$3	Up to \$3 per day	\$3	\$3	\$3
Maryland		Yes	0%	\$0	\$0	\$0	\$1-\$3	\$1-\$3	\$1-\$3
Massachusetts ⁷		Yes	0%	\$0	\$0	\$3	\$3.65	\$3.65	\$3.65
Michigan ⁸	Yes, >100%	Yes	0%	\$2 \$4	\$3 \$8	\$50 \$100	\$1 \$4	\$1 \$4	\$3 \$8
Minnesota ⁹		Yes	0%	\$3	\$3.50	\$0	\$1	\$3	\$3
Montana ¹⁰	Yes, >51%	No	--	--	--	--	--	--	--
Nevada		No	--	--	--	--	--	--	--
New Hampshire		Yes	100%	\$0	\$0	\$0	\$0	\$1	\$2
New Jersey		No	--	--	--	--	--	--	--
New Mexico		No	--	--	--	--	--	--	--
New York		Yes	100%	\$0	\$3	\$25/ discharge	\$1	\$3	\$3
North Dakota ¹¹		No	--	--	--	--	--	--	--
Ohio		Yes	0%	\$0	\$3	\$0	\$0	\$2	\$3
Oregon		No	--	--	--	--	--	--	--
Pennsylvania ¹²		Yes	0%	\$0.65-\$3.80	\$0.50-\$3	\$3/day	\$1	\$3	\$3
Rhode Island		No	--	--	--	--	--	--	--
Utah		Yes	0%	\$4	\$8	\$75	\$4	\$4	\$4
Vermont		Yes	0%	\$3	\$0	\$0	\$1-\$3	\$1-\$3	\$1-\$3
Virginia		Yes	0%	\$1	\$75	\$75	\$1	\$3	\$3
Washington		No	--	--	--	--	--	--	--
West Virginia ¹³		Yes	0%	\$0-\$4	\$8	\$0-\$75	\$0-\$3	\$0-\$3	\$0-\$3
Expansion Not Yet Implemented (15 states)									
Total	0	0	0	0	0	0	0	0	0
Alabama									
Florida									
Georgia									
Kansas									
Mississippi									
Missouri									
Nebraska									
North Carolina									
Oklahoma									
South Carolina									
South Dakota									
Tennessee									
Texas									
Wisconsin ¹⁴									
Wyoming									

SOURCE: Based on a national survey conducted by KFF with the Georgetown University Center for Children and Families, 2020.

Table presents rules in effect as of January 1, 2020.

Table 19 Notes

1. Data in the table represent premium or other monthly contributions and cost sharing requirements for non-disabled adults. This group includes parents above Section 1931 limits. If a state charges cost sharing, but does not charge for the specific service or drug, it is recorded as \$0; if a state does not charge cost sharing at all, it is noted as "--." In some states, copayments vary based on the cost of the service. Cost sharing and premiums may not exceed 5% of household income.
2. Arkansas may charge enrollees with income above 100% of the federal poverty level (FPL) a monthly premium up to 2% of income. Expansion adults with income above 100% FPL pay \$8 for a non-preventive primary care visit and \$10 for a specialist visit.
3. In Delaware, adults have a \$15 per month cap on out of pocket expenses from copayments.
4. Illinois eliminated copayments for parents and other adults as of January 2020.
5. In Indiana, under Section 1115 waiver authority, adults with incomes above poverty who fail to pay monthly contributions will be disenrolled from coverage after a 60-day grace period and barred from reenrolling for 6 months. Beneficiaries with incomes at or below 100% FPL who fail to pay monthly contributions will receive Healthy Indiana Plan (HIP) Basic, a more limited benefit package with state plan level copayments.
6. In Iowa, under Section 1115 waiver authority, Medicaid expansion beneficiaries above 100% FPL pay contributions of \$10 per month. Beneficiaries at or above 50% FPL through 100% FPL pay \$5 per month and cannot be disenrolled for non-payment. Contributions are waived for the first year of enrollment. In subsequent years, contributions are waived if beneficiaries complete specified healthy behaviors. The state must grant waivers of payment to beneficiaries who self-attest to a financial hardship. Beneficiaries have the opportunity to self-attest to hardship monthly.
7. In Massachusetts, premiums are also charged for some adults with incomes above 150% FPL covered through waiver programs. Generic drugs for diabetes, high blood pressure, and high cholesterol have a \$1 copayment. There is a \$36 annual cap for non-pharmacy copayments and a \$250 annual cap for pharmacy copayments.
8. In Michigan, copayments vary by income levels. The values shown before the "|" represent copayments for individuals with incomes less than or equal to 100%FPL, whereas the value after the "|" represent copayments for individuals with incomes above 100%FPL.
9. Minnesota has a buy-in group for people with disabilities which is based on income and a formula for the premiums.
10. Montana eliminated copayments for parents and other adults effective January 2020.
11. North Dakota eliminated copayments for parents and other adults effective October 2019.
12. In Pennsylvania, the inpatient hospital copayment is subject to a maximum of \$21 per stay.
13. In West Virginia, copayment amounts for services may vary by income. Enrollees have a quarterly out-of-pocket maximum of \$8 up to 50% FPL; \$71 between 50% and 100%; and \$143 above 100%.
14. Wisconsin suspended copayments in Medicaid for parents and adults as of January 2020.

Filling the need for trusted information on national health issues.

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