THE HENRY J. KAISER FAMILY FOUNDATION

REPORT

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Medicaid and CHIP Eligibility, Enrollment, Renewal, and Cost Sharing Policies as of January 2018: Findings from a 50-State Survey

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Executive Summary

Key Takeaways

This 16th annual 50-state survey provides data on Medicaid and the Children's Health Insurance Program (CHIP) eligibility, enrollment, renewal and cost sharing policies as of January 2018. It shows:

- Medicaid and CHIP provide a robust base of coverage for low-income children. All but two states cover children with incomes up to at least 200% of the federal poverty level (FPL, $41,560 per year for a family of three in 2018), including 19 states that cover children with incomes at or above 300% FPL. The ten-year extension of federal funding for CHIP approved by Congress provides states stable funding to maintain children's coverage and continues protections for children's coverage moving forward.
- There have been major gains in Medicaid eligibility for parents and other adults under the Affordable Care Act (ACA) Medicaid expansion, but eligibility remains limited in the 19 states that have not implemented the expansion. Among non-expansion states, the median eligibility level for parents is 43% FPL ($8,935 for a family of three in 2018) and other adults generally are ineligible. Alabama and Texas have the lowest parent eligibility limits at 18% FPL or $3,740 per year for a family of three. Additional states may expand Medicaid for adults in the coming year, which would reduce the number of poor uninsured adults who fall into the coverage gap. States moving forward with expansion may seek waivers to add requirements or restrictions for adults as a condition of expanding.
- Through significant investments of time and resources, most states have transformed their Medicaid and CHIP enrollment and renewal processes to provide a modernized, streamlined experience as outlined in the ACA. With these processes, a growing number of states are processing real-time eligibility determinations and automated renewals through electronic data matches with trusted data sources. Looking ahead, waivers and other proposed changes for adults, including premiums and cost sharing, work requirements, and lockout periods, require complex documentation and costly administrative processes that run counter to the simplified enrollment and renewal processes states have implemented under the ACA.

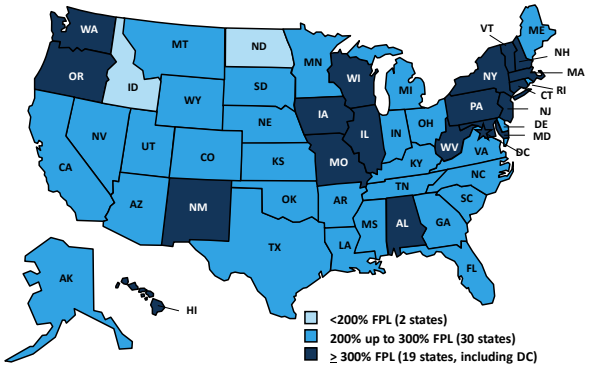
This 16th annual 50-state survey provides data on Medicaid and the Children's Health Insurance Program (CHIP) eligibility, enrollment, renewal and cost sharing policies as of January 2018. It takes stock of how the programs have evolved as the fifth year of implementation of the Affordable Care Act (ACA) begins, discusses policy changes made during 2017, and looks ahead to issues that may affect state policies moving forward. It is based on a survey of state Medicaid and CHIP officials conducted by the Kaiser Family Foundation and the Georgetown University Center for Children and Families. State data are available in Appendix Tables 1-20.

ELIGIBILITY

Medicaid and CHIP eligibility for children and pregnant women has remained robust under the ACA. Reflecting expansions prior to the ACA, all but two states cover children with incomes up to at least 200% FPL ($41,560 per year for a family of three in 2018) through Medicaid and CHIP (Figure 1), and 34 states cover pregnant women up to at least 200% FPL. Eligibility levels for children and pregnant women did not change significantly under the ACA. The ACA protected children's eligibility under its maintenance of effort (MOE) provision, which requires states to maintain eligibility levels for children that are at least as high as those in place when the ACA was enacted in 2010. The recent ten-year extension of CHIP continues the MOE. Under this legislation, the MOE will only apply to children in families with incomes at or below 300% FPL (305% FPL after the five percentage point of income disregard) after October 1, 2019, although states can maintain current higher eligibility levels and receive federal matching funds.

Figure 1

Income Eligibility Levels for Children in Medicaid/CHIP, January 2018



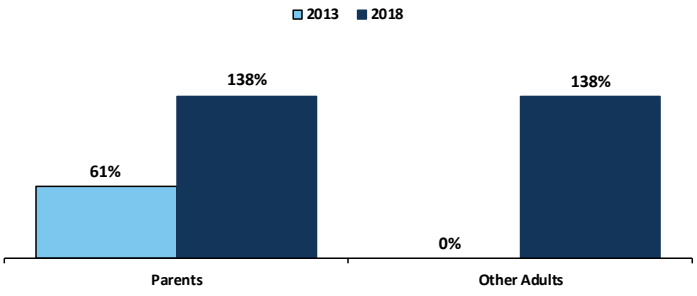
NOTE: Eligibility levels are based on 2018 federal poverty levels (FPLs) for a family of three. In 2018, the FPL was $20,780 for a family of three. Thresholds include the standard five percentage point of the FPL disregard.
SOURCE: Based on results from a national survey conducted by the Kaiser Family Foundation and the Georgetown University Center for Children and Families, 2018.

Over time, states have continued to take up options to expand coverage to targeted groups that primarily focus on children and pregnant women. These include options like expanding access to coverage for lawfully residing immigrant children and pregnant women without a five-year waiting period and covering dependents of state employees in CHIP. Many of these options were available to states before the ACA, but states have continued to take up these options since implementing the ACA to increase access to and minimize gaps in coverage.

As of January 2018, 32 states have implemented the Medicaid expansion, which significantly increased eligibility for parents and other adults. Under the ACA, the median eligibility level for parents across states increased from 61% FPL ($11,913 per year for a family of three) in 2013 to 138% FPL ($28,676 per year for a family of three) in 2018 (Figure 2). The median eligibility level for other adults increased from 0% FPL ($0 per year for an individual) to 138% FPL ($16,753 per year for an individual) between 2013 and 2018, since adults without dependent children were not eligible for Medicaid under federal rules prior to the ACA.

Figure 2

Median Medicaid Eligibility Levels for Adults as a Percent of the Federal Poverty Level, 2013 and 2018

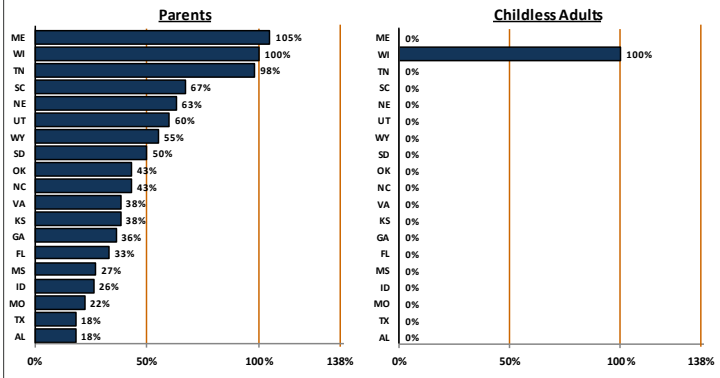


SOURCE: Based on results of a national survey conducted by the Kaiser Family Foundation and the Georgetown Center for Childre n and Families, 2013 and 2018.

In the 19 states that have not implemented the Medicaid expansion, eligibility for parents and other adults is very limited. In 17 of these states, parent eligibility is limited to less than the poverty level, including 11 states that limit parent eligibility to less than half of poverty, which is just over $10,000 per year for a family of three (Figure 3). Other adults remain ineligible for Medicaid regardless of their income in all of these states, except Wisconsin. In these states, 2.4 million poor adults fall into a coverage gap because they earn too much to qualify for Medicaid but not enough to receive subsidies for Marketplace coverage, which become available at 100% FPL.[1]

Figure 3

Medicaid Income Eligibility Limits for Adults in States that Have Not Implemented the Medicaid Expansion, January 2018



NOTES: Eligibility levels are based on 2018 federal poverty levels (FPLs) and are calculated based on a family of three for parents and an individual for childless adults. In 2018,the FPL was $20,780 for a family of three and $12,140 for an individual. Thresholds include the standard five percentage point of FPL disregard. OK and UT provide more limited coverage to some childless adults under Section 1115 waiver authority
SOURCE: Based on results from a national survey conducted by the Kaiser Family Foundation and the Georgetown University Center for Children and Families, 2018.

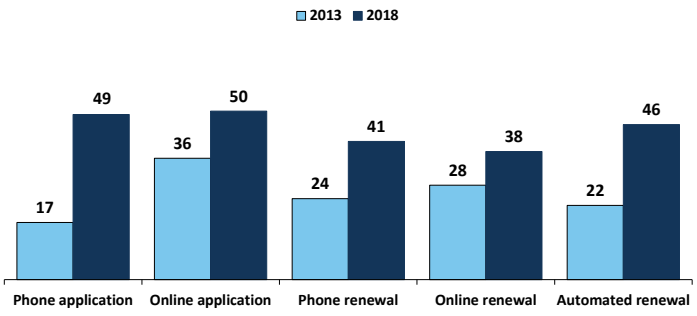
Eligibility remained largely stable during 2017, with a few states making changes. During 2017, Maine adopted the Medicaid expansion through a ballot initiative, but it has not yet been implemented. In addition, Utah increased parent eligibility from 45% FPL to 60% FPL and obtained a waiver that expanded coverage to a limited number of adults without dependent children with incomes below 5% FPL who have behavioral health needs. In contrast, at the direction of the state legislature, Connecticut reduced parent eligibility from 150% FPL to the Medicaid expansion limit of 138% FPL. Outside of these changes, a few states adopted targeted options to expand coverage, while others discontinued use of certain coverage options.

Enrollment and Renewal

Under the ACA, most states have transformed their Medicaid and CHIP enrollment and renewal processes to provide a modernized, streamlined experience as outlined in the ACA. In addition to expanding Medicaid to low-income adults, the ACA established electronic data-driven, streamlined enrollment and renewal processes for Medicaid and CHIP across all states. The ACA also provided enhanced federal funding to support states in replacing or upgrading their antiquated eligibility systems to implement these new processes. Before the ACA, individuals could not apply for Medicaid by phone or online in many states and typically had to provide documentation like pay stubs and wait weeks for an eligibility determination. Further, they often had to repeat these steps at renewal. Through major investments of time and resources, most states have largely realized the streamlined processes established by the ACA. As of January 2018, individuals can apply for and renew Medicaid online or by phone in nearly every state (Figure 4). In 40 states, individuals can receive a real-time eligibility determination within 24 hours without having to submit pay stubs or documentation when the state can electronically verify information. Nearly all states also are using electronic data matches to renew coverage without the individual having to submit paperwork.

Figure 4

Number of States with Selected Enrollment and Renewal Processes, 2013 and 2018



SOURCE: Based on results of a national survey conducted by the Kaiser Family Foundation and the Georgetown Center for Children and Families, 2013 and 2018.

In 2017, some states continued to advance enrollment and renewal processes, but states also focused attention and resources on other priorities. Some states continued to implement simplifications and enhancements to their processes and systems. Several additional states implemented real-time determinations or automated renewals and a few states continued progress to reintegrate Medicaid eligibility determinations for seniors and people with disabilities and non-health programs into their upgraded systems. Many other changes were incremental, such as expanding features of online applications and accounts and increasing the share of applications that receive real-time determinations. This leveling off of continued advancement in part reflects that states have largely achieved improved processes now that they are five years into implementation. However, other policy proposals over the past year, including proposals to repeal the ACA, change the financing and structure of Medicaid, and an extended gap in federal funding for CHIP, may have shifted attention away from the focus on improvements to enrollment and renewal processes.

Premiums and Cost Sharing

Premiums and cost sharing remain limited for most Medicaid enrollees. Consistent with previous years, premiums and cost sharing are more prevalent in CHIP, which covers families with incomes above Medicaid eligibility limits. Premiums and cost sharing for most Medicaid enrollees remain limited, reflecting federal requirements designed to ensure enrollees do not face financial barriers to coverage and care. However, through recent waivers, several states have implemented higher premiums than otherwise allowed under federal rules, with some including lockout periods for non-payment of premiums.

Looking Ahead

Coverage for children and pregnant women will likely remain strong, bolstered by a ten-year extension in federal funding for CHIP. After a four-month lapse in funding, Congress extended federal funding for CHIP for ten years, providing states stable funding to maintain children's coverage. The legislation also extended the MOE provision that requires states to maintain Medicaid and CHIP eligibility levels for children through 2027. After October 1, 2019, the MOE will only apply to children in families with income at or below 300% FPL (305% FPL after accounting for the five percentage point of income disregard) although states may keep current eligibility at a higher level and receive federal CHIP matching funds. The legislation continues the 23 percentage point enhanced federal match rate for CHIP established by the ACA through 2019, but phases down the match rate to the regular CHIP rate in 2021.

There could be continued gains in eligibility for adults if additional states adopt the Medicaid expansion, but some may add new requirements or restrictions for adults as a condition of expanding coverage. As noted, Maine adopted the Medicaid expansion through a ballot initiative in 2017, although it has not yet been implemented. Additional states may move forward with the expansion over the coming year, which would reduce the number of poor uninsured adults that currently fall into the coverage gap in non-expansion states. States moving forward with expansion may seek waivers to add requirements or restrictions for adults as a condition of expanding.

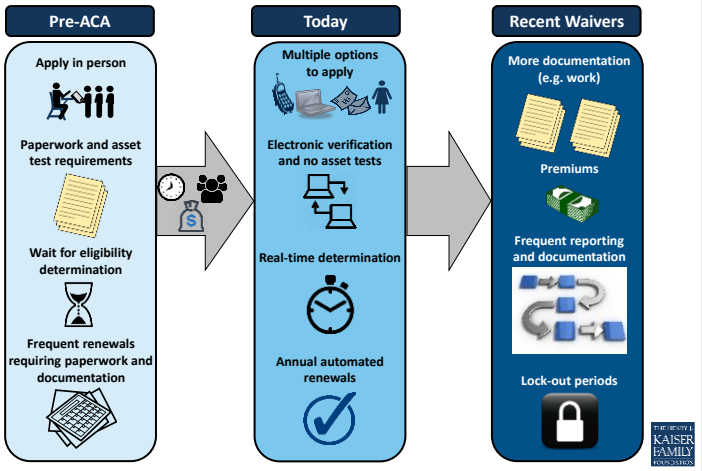
Proposals to make significant changes to Medicaid's structure and financing are likely to continue to be debated. While efforts to cap and limit Medicaid financing stalled in 2017, proposals to restructure Medicaid and reduce federal spending are likely to reemerge. The President's FY2019 budget proposes reductions to Medicaid and some Congressional leaders continue to express interest in reducing spending on entitlement programs, including Medicaid and Medicare. Changes to the financing and structure

of Medicaid would have significant implications for the coverage gains achieved for children and adults to date. Moreover, uncertainty around the future of the program could limit state interest in continuing efforts to expand coverage and improve enrollment and renewal processes.

Waivers and other proposed changes require complex documentation and costly administrative processes for adults that run counter to simplified enrollment and renewal processes states have implemented under the ACA. Recently approved and proposed Section 1115 waivers include new restrictions and requirements for adults such as work requirements, premiums, cost sharing, time limits on coverage, drug screening and testing requirements, asset tests, more frequent redeterminations, waivers of reasonable promptness and retroactive eligibility, and lockout periods. In addition, the President's FY2019 budget proposes to allow states once again to require individuals to meet an asset test and to provide documentation to verify citizenship and immigration status before receipt of Medicaid, although states already must verify citizenship and immigration status under current law. Research and previous state experience shows that such changes would likely create barriers for eligible individuals to obtain and maintain coverage and access needed care. They also will be complex and costly for states to implement.

Figure 5

Medicaid Enrollment and Renewal Processes Over Time



Taken together, the survey data show that Medicaid and CHIP continue to provide a strong base of coverage for our nation's low-income children and pregnant women. There have been significant gains in eligibility for parents and other adults under the ACA Medicaid expansion, but gaps in coverage remain in states that have not implemented the expansion. Through major investments of time and resources, states have largely realized modernized, streamlined enrollment and renewal processes as outlined in the ACA, which have created a more consumer-friendly experience for individuals and reduced administrative burdens for states. Looking ahead, coverage for children and pregnant women will remain strong, bolstered by a ten-year extension in federal funding for CHIP. Opportunity remains for states to expand eligibility for parents and other adults by implementing the Medicaid expansion. States may continue to refine and enhance enrollment and renewal processes, but some states are seeking to include new requirements and restrictions for adults that require complex documentation and administrative processes, which would likely create barriers for eligible individuals to obtain and maintain coverage and access needed care.

Introduction

This 16th annual 50-state survey provides data on Medicaid and the Children's Health Insurance Program (CHIP) eligibility, enrollment, renewal and cost sharing policies as of January 2018. It takes stock of how the programs have evolved as we enter into the fifth year of implementation of the ACA, discusses policy changes made during 2017, and looks ahead to issues that may affect state policies moving forward.

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 2018. 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 1-20. The report includes policies for children, pregnant women, parents, and other adults under age 65; it does not include policies for groups covered through Medicaid eligibility pathways for seniors and individuals with disabilities.

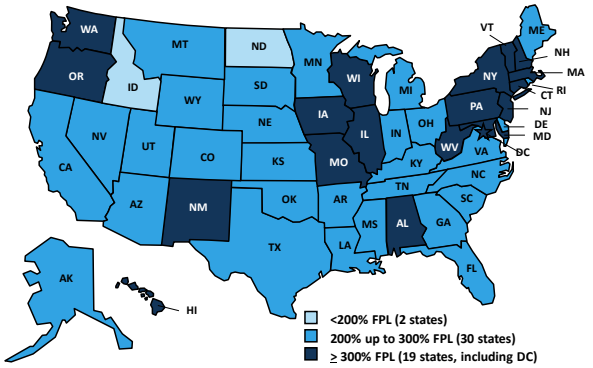
Medicaid and CHIP Eligibility

Eligibility Limits

As of January 2018, 49 states cover children with incomes up to at least 200% FPL ($41,560 per year for a family of three in 2018) through Medicaid and CHIP, including 19 states that cover children with incomes at or above 300% FPL ($62,340 per year for a family of three in 2018) (Figure 6). Only two states (Idaho and North Dakota) limit children's Medicaid and CHIP eligibility to lower incomes. The median income eligibility limit for children is 255% FPL ($52,989 per year for a family of three in 2018). Across states, the upper Medicaid/CHIP eligibility limit for children ranges from 175% FPL in North Dakota to 405% FPL in New York. Children's eligibility levels remained stable under the ACA, reflecting its maintenance of effort (MOE) provision that requires states to maintain eligibility levels for children that are at least as high as those in place when the ACA was enacted in 2010. The recent ten-year extension of CHIP continues the MOE. Beginning after October 1, 2019, the MOE will only apply to children in families with incomes at or below 300% FPL (305% FPL after the five percentage point of income disregard), although states can maintain current eligibility above that level and receive federal CHIP matching funds.

Figure 6

Income Eligibility Levels for Children in Medicaid/CHIP, January 2018

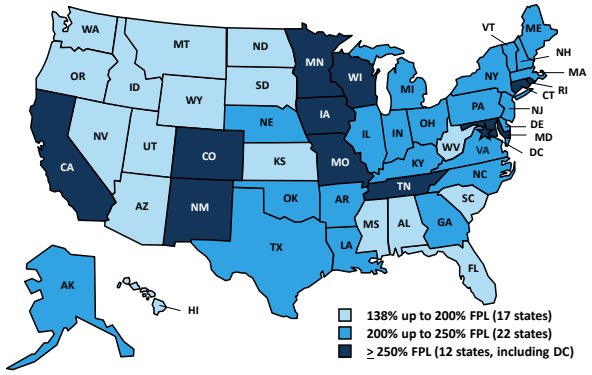


NOTE: Eligibility levels are based on 2018 federal poverty levels (FPLs) for a family of three. In 2018, the FPL was $20,780 for a family of three. Thresholds include the standard five percentage point of the FPL disregard.
SOURCE: Based on results from a national survey conducted by the Kaiser Family Foundation and the Georgetown University Center for Children and Families, 2018.

All states cover pregnant women with incomes up to at least 138% FPL ($28,676 per year for a family of three in 2018), and 34 states cover pregnant women with incomes at or above 200% FPL ($41,560 per year for a family of three in 2018) as of January 2018 (Figure 7). Across states, eligibility for pregnant women ranges from 138% FPL in Idaho and South Dakota to 380% FPL in Iowa. These eligibility levels reflect extensions in coverage through CHIP in five states (Colorado, Missouri, New Jersey, Rhode Island, and Virginia). Similar to eligibility levels for children, eligibility for pregnant women remained largely stable across states under the ACA.

Figure 7

Income Eligibility Levels for Pregnant Women in Medicaid/CHIP, January 2018

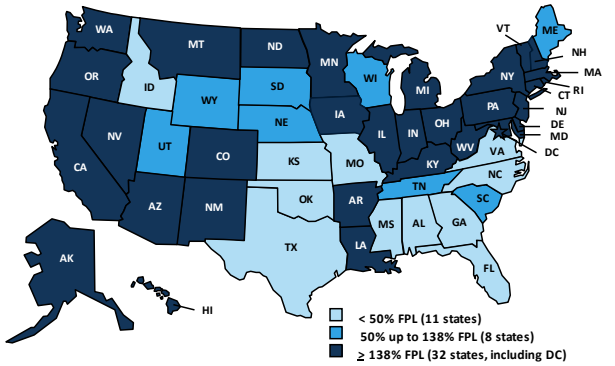


NOTE: Eligibility levels are based on 2018 federal poverty levels (FPLs) for a family of three. In 2018, the FPL was $20,780 for a family of three. Thresholds include the standard five percentage point of the FPL disregard.
SOURCE: Based on results from a national survey conducted by the Kaiser Family Foundation and the Georgetown University Center for Children and Families, 2018.

As of January 2018, 32 states cover parents and other adults with incomes up to at least 138% FPL ($28,676 per year for a family of three and $16,753 per year for an individual in 2018) under the ACA Medicaid expansion to low-income adults (Figures 8 and 9). The District of Columbia extends eligibility beyond the expansion limit to parents with incomes up to 221% FPL and other adults with incomes up to 215% FPL, and Alaska covers parents with incomes up to 139% FPL. In addition, Minnesota and New York use the ACA Basic Health Program option to cover adults with incomes between 138% and 200% FPL, rather than having individuals in this income range access coverage through the Marketplace.

Figure 8

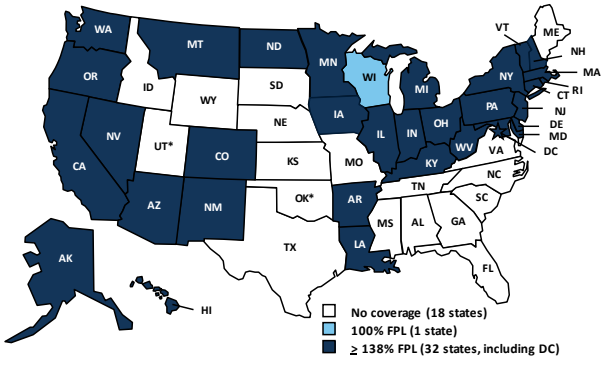
Medicaid Income Eligibility Levels for Parents, January 2018



NOTE: Eligibility levels are based on 2018 federal poverty levels (FPLs) for a family of three. In 2018, the FPL was $20,780 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 the Kaiser Family Foundation and the Georgetown University Center for Children and Families, 2018.

Figure 9

Medicaid Income Eligibility Levels for Other Adults, January 2018

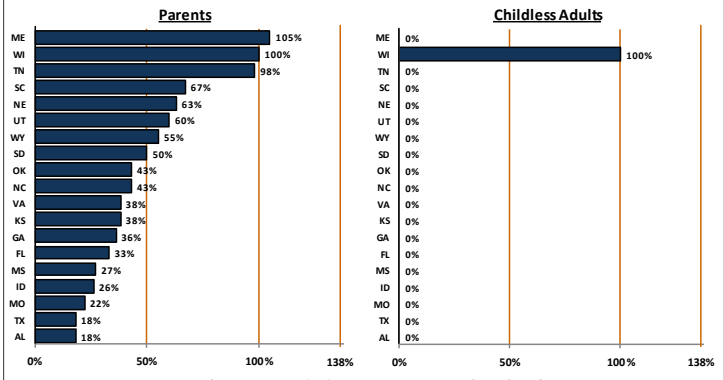


NOTE: Eligibility levels are based on 2018 federal poverty levels (FPLs) for an individual. In 2018, the FPL was $12,140 for an individual. Thresholds include the standard five percentage point of the FPL disregard.
*OK and UT provide more limited coverage to some childless adults under Section 1115 waiver authority.
SOURCE: Based on results from a national survey conducted by the Kaiser Family Foundation and the Georgetown University Center for Children and Families, 2018.

In the 19 states that have not expanded Medicaid, parent eligibility is limited to those with very low incomes and other adults generally remain ineligible, leaving many in a coverage gap. Among non-expansion states, the median eligibility level for parents is 43% FPL ($8,935 per year for a family of three in 2018), and other adults remain ineligible for Medicaid regardless of income, except in Wisconsin. Only Maine and Wisconsin cover parents at or above 100% FPL ($20,780 per year for a family of three in 2018), while 11 states limit parent eligibility to less than half the poverty level (Figure 10). Alabama and Texas have the lowest parent eligibility levels at 18% FPL or $3,740 per year for a family of three in 2018. Given these limited eligibility levels, 2.4 million poor adults fall into a coverage gap in non-expansion states.[2] These adults earn too much to qualify for Medicaid but not enough to qualify for subsidies for Marketplace coverage, which become available at 100% FPL.

Figure 10

Medicaid Income Eligibility Limits for Adults in States that Have Not Implemented the Medicaid Expansion, January 2018

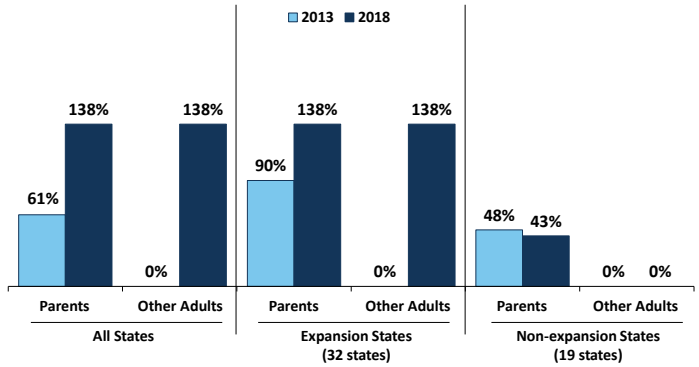


NOTES: Eligibility levels are based on 2018 federal poverty levels (FPLs) and are calculated based on a family of three for parents and an individual for childless adults. In 2018,the FPL was $20,780 for a family of three and $12,140 for an individual. Thresholds include the standard five percentage point of FPL disregard. OK and UT provide more limited coverage to some childless adults under Section 1115 waiver authority
SOURCE: Based on results from a national survey conducted by the Kaiser Family Foundation and the Georgetown University Center for Children and Families, 2018.

Eligibility for parents and other adults has significantly increased compared to before the ACA, and the disparity in eligibility for adults in expansion and non-expansion states widened. Prior to the ACA, 34 states limited parent eligibility to less than 100% FPL, including 16 states that had eligibility limits below half of poverty. Moreover, before the ACA, states could not cover other low-income adults with federal Medicaid funds; as such, they generally were not eligible except in some states that obtained waivers. The ACA Medicaid expansion significantly increased eligibility for both parents and other adults. Across states, the median eligibility level for parents increased from 61% FPL ($11,913 per year for a family of three) in 2013 to 138% FPL ($28,676 per year for a family of three) in 2018 (Figure 11). Median eligibility increased from 0% to 138% FPL ($0 to $16,753 per year for an individual) for other adults. States that implemented the Medicaid expansion began with broader eligibility for adults compared to non-expansion states before the ACA. As of 2013, expansion states had a median parent eligibility level of 90% versus 48% in non-expansion states. This gap widened with the expansion.

Figure 11

Median Medicaid Eligibility Levels for Adults as a Percent of the Federal Poverty Level, 2013 and 2018



SOURCE: Based on results of a national survey conducted by the Kaiser Family Foundation and the Georgetown Center for Children and Families, 2013 and 2018.

Eligibility levels remained largely stable during 2017. During 2017, Maine adopted the Medicaid expansion through a ballot initiative, but it has not yet been implemented. . In addition, Utah increased parent eligibility from 45% FPL to 60% FPL and obtained a waiver that expanded coverage to a limited number of adults without dependent children with incomes below 5% FPL who have behavioral health needs.[3] In contrast, at the direction of the state legislature, Connecticut reduced parent eligibility from 150% FPL to the Medicaid expansion limit of 138% FPL. Outside of these changes, eligibility levels for parents, adults, children, and pregnant women remained stable.

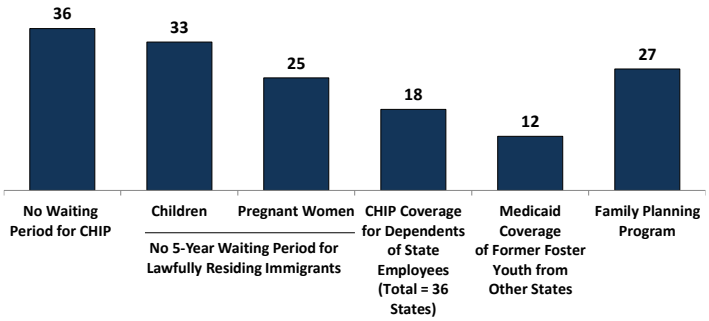
Targeted Coverage Expansions

Over time, states have continued to take up options to expand coverage to targeted groups that primarily focus on children and pregnant women. Many of these options were available to states before the ACA, but states have continued to adopt them since implementing the ACA to minimize gaps in and increase access to coverage.

- ***Eliminating waiting periods for CHIP.*** In 2013, 38 states had waiting periods for CHIP that required children to be uninsured for a period of time before enrolling. These waiting periods were intended to discourage families from dropping private coverage to enroll in the program but contributed to coverage gaps for children. As of January 2018, only 15 states still have waiting periods, while 36 states do not have any waiting period (Figure 12). Between 2013 and 2018, 23 states eliminated their waiting periods and two states (California and Michigan) moved all children from their separate CHIP programs into Medicaid, which does not allow waiting periods.

Figure 12

Number of States that have Adopted Selected Options to Expand Children's Access to Medicaid and CHIP, January 2018



SOURCE: Based on results from a national survey conducted by the Kaiser Family Foundation and the Georgetown University Center for Children and Families, 2018.

- ***Coverage for lawfully residing immigrant children and pregnant women.*** Under federal law, most lawfully present immigrants must wait five years after obtaining lawful status before they may enroll in Medicaid or CHIP. Since 2009, states have had the option to eliminate this five-year wait for lawfully residing immigrant children and pregnant women. By 2013, 25 states had taken up this option for children in Medicaid and/or CHIP and 20 had adopted it for pregnant women. These numbers have increased to 33 states for children and 25 states for pregnant women as of January 2018. In addition, 16 states use CHIP funds to provide coverage through the unborn child option, under which they cover income-eligible pregnant women who are not eligible due to immigration status. Some states also use state-only funds to cover income-eligible individuals who do not qualify for federally funded Medicaid or CHIP coverage due to immigration status; this coverage is often limited to children, pregnant women, or other specified groups.[4]
- ***Coverage for dependents of state employees in CHIP.*** Since 2009, states have had an option to enroll dependents of state employees in CHIP in certain circumstances. Through this option, states can provide a coverage option to children of part-time workers and other state employees who lack access to affordable dependent coverage in the state employee health plan. By 2013, 12 states had implemented the option, and that number grew to 18 of 36 states with a separate CHIP program as of January 2018.
- ***Coverage for former foster youth from other states.*** The ACA extended the age that youth who were formerly in foster care could qualify for Medicaid from age 21 to 26. This change mirrors the ACA provision that allows young adults to remain on their parents' private health plan until age 26. However, a technical error in the law limited the provision to those who were formerly in foster care within the state they were seeking Medicaid coverage. Initially, the Centers for Medicare and Medicaid Services (CMS) allowed states to cover former foster youth from other states as a state plan option. However, it later

clarified that states must obtain a waiver to provide coverage to former foster youth from other states. As of January 2018, 12 states were covering former foster youth from other states.

- ***Family planning programs.*** States must provide family planning services as a covered benefit to Medicaid enrollees. Historically, some states also used waivers to provide family planning services to women or men who did not qualify for full Medicaid coverage. The ACA made a new state plan option available for states to expand family planning services coverage. As of January 2018, 27 states use federal funds to provide family planning coverage through a waiver or the state plan option.

During 2017, a few states continued to adopt targeted options to expand coverage while others discontinued use of certain coverage options. For example, Arkansas and South Carolina took up the option to eliminate the five-year waiting period for lawfully residing immigrant children and pregnant women, Maine began covering dependents of state employees in CHIP, Delaware added coverage for former foster children from other states, and Georgia increased eligibility for its family planning program from 205% FPL to 216% FPL. In contrast, several states phased out coverage of former foster youth from other states (Louisiana, Montana, and New York). Iowa ended its Medicaid family planning program, but is now covering family planning services with state-only funds.

Medicaid and CHIP Enrollment and Renewal Processes

In addition to expanding Medicaid to reach many previously ineligible low-income adults, the ACA established streamlined, modernized enrollment and renewal processes for low-income children and adults across all states (Box 1). The policies and practices standardized by the ACA drew on previous innovations some states pursued that proved effective and efficient for enrolling and retaining eligible children in coverage. Many states needed to make major upgrades to or replace antiquated eligibility systems to implement these new processes. The federal government supported the development of these systems by providing 90% federal match for their development and by only requiring non-health programs to pay the incremental add-on costs to be integrated into the updated Medicaid eligibility systems.

Box 1: Key Medicaid and CHIP Enrollment and Renewal Policies Established Under the ACA

- Use of single, streamlined application for Medicaid, CHIP, and Marketplace coverage
- Application can be submitted online, by phone, in-person, or mail
- Eliminated use of asset tests for groups eligible through income-based eligibility pathways (MAGI groups)
- Eliminated in-person interview requirements
- States must utilize electronic data matches to verify eligibility criteria to the greatest extent possible and only request paper documentation if they are unable to obtain information electronically
- Renewals cannot be completed more frequently than once every 12 months for groups eligible through income-based eligibility pathways (MAGI groups)
- States must seek to renew coverage based on information from available data sources before requesting information from the individual

Since the ACA was enacted, states have invested significant time and resources to upgrade or build new eligibility systems and re-engineer their business processes. As outlined in the findings below, with these efforts, the Medicaid enrollment and renewal experience has moved from a paper-based, manual process that could take days and weeks in some states to a modernized, technology-driven approach that can happen in real-time through electronic data matches to verify eligibility criteria. States use these same methods to automate the renewals without requiring enrollees to complete forms or submit paperwork when they can verify information through electronic data matches. Five years into implementation, leading states are now using automated processes to verify and renew eligibility for a majority of applicants and enrollees.

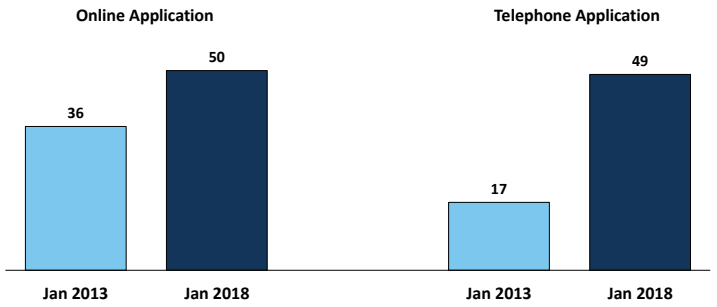
In 2017, states continued to advance enrollment and renewal processes but also focused attention and resources on other priorities. Some states continued to implement simplifications and enhancements to their processes and systems. Several additional states implemented real-time determinations or automated renewals and a few states reintegrated eligibility determinations for seniors and people with disabilities and non-health programs into their upgraded systems. Many other changes were incremental, such as expanding features of online applications and accounts and increasing the share of applications that receive real-time determinations. This leveling off of continued advancement in part reflects that states have largely achieved improved processes now that they are five years into implementation. However, other policy proposals over the past year, including proposals to repeal the ACA, change the financing and structure of Medicaid, and an extended gap in federal funding for CHIP, may have shifted attention away from the focus on improvements to enrollment and renewal processes.

Applications, Online Accounts, and Mobile Access

Individuals can apply for Medicaid online and by phone in nearly all states as of January 2018. To facilitate access to coverage, under the ACA, states must provide multiple application methods for individuals, including online, by phone, by mail, and in person. Prior to the ACA, some states had made progress offering online applications for Medicaid, but only 36 states had online applications that could be completed using an electronic signature, and less than a third of states (17) allowed applicants to apply over the phone (Figure 13). As of January 2018, Tennessee is the only state without an electronic application and telephone applications are available in 49 states.

Figure 13

Number of States with Online and Telephone Medicaid Applications, January 2013 and 2018



NOTE: Online applications refer to applications that can be submitted electronically, not those that may only be downloaded from websites.
SOURCE: Based on results from national surveys conducted by the Kaiser Family Foundation and the Georgetown University Center for Children and Families in 2013 and 2018.

In some states, online applications have become the predominant mode of application for individuals, but use of the online application varies across states and other application modes remain important. At least 50% of Medicaid applications are submitted online in 20 of the 39 states that were able to report the share of applications received online. However, in other states, online applications account for just a small share of applications. Telephone applications represent a smaller share of applications, less than 25% in most of the states able to report these data. As such, other application modes, including in person and mail, remain important, particularly for individuals who lack access to high speed internet or who feel more comfortable applying in-person.

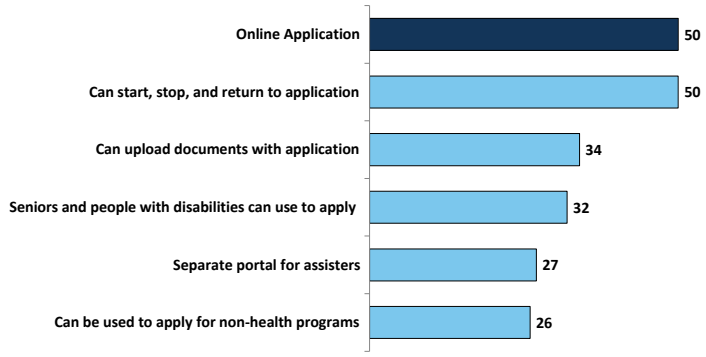
States have expanded consumer friendly features of online applications over time. In all 50 states with an online application, applicants can start, stop, and return to finish the application at a later time (Figure 14). In addition, states have increasingly added the ability for individuals to upload electronic copies of documentation with their application if needed. Between 2013 and 2018, the number of states with this functionality grew from 15 to 34, including Utah, which added this option in 2017.

The number of states offering a multi-benefit online application is growing, but individuals still must complete separate applications for Medicaid and non-health programs in about half of states. As of January 2018, 32 states offer an online application for all Medicaid groups, including seniors and people with disabilities. Individuals can also apply for a non-health program, such as SNAP or TANF, using the online application in more than half of the states. These counts include Ohio, which added a multi-benefit application that incorporates SNAP and TANF, and New Jersey, which added seniors and individuals with disabilities to its Medicaid application for low-income children and adults during 2017.

Just over half of the states (27) have a web portal or secure login that enables consumer assisters to submit applications on behalf of consumers they help. In 2017, Utah added a portal for consumer assisters. This functionality helps states track, monitor, and report the work of assisters. In some states, these portals have additional functions or features that support the work of assisters, such as the ability to check a renewal date. Providing assisters with more tools may help reduce workloads on state administrative staff, for example, if assisters are able to update addresses and other information.

Figure 14

Number of States with Selected Features and Functions for Online Medicaid Applications, January 2018

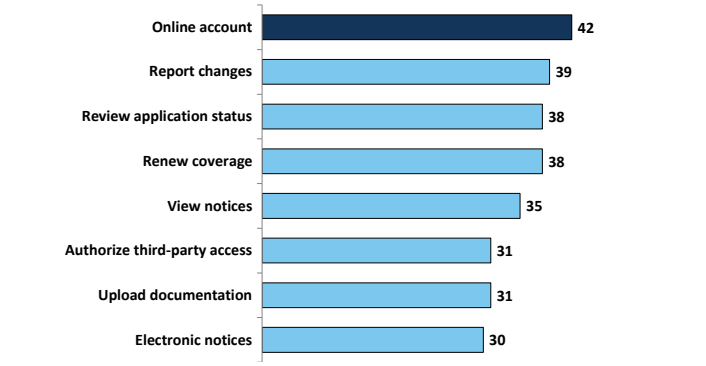


SOURCE: Based on results from a national survey conducted by the Kaiser Family Foundation and the Georgetown University Center for Children and Families, 2018.

Many states provide online accounts for enrollees to manage their Medicaid coverage, and states have expanded the features and functions of these accounts over time. Online accounts create administrative efficiencies by reducing mailing costs, call volume, and manual processing of updates such as an address change. They also provide enrollees increased autonomy to manage and monitor their coverage. Between 2013 and 2018, the number of states providing online accounts grew from 36 to 42. As of January 2018, these online accounts offer a wide array of functions (Figure 15). Although many states have made online accounts available to enrollees, it is unclear what share of enrollees use these accounts on a regular basis.

Figure 15

Number of States with Selected Features for Online Accounts, January 2018



SOURCE: Based on results from a national survey conducted by the Kaiser Family Foundation and the Georgetown University Center for Children and Families, 2018.

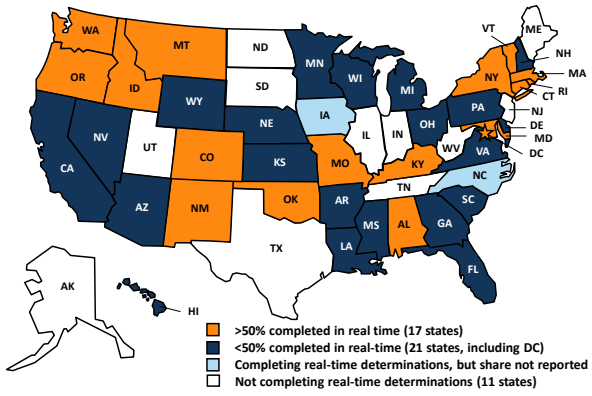
In more than half of states, individuals can access online applications and accounts through mobile devices, but many of the applications and accounts do not have mobile-friendly formatting. As of January 2018, individuals in 31 states can complete and submit the online Medicaid application through a mobile device. Eleven of these states have designed a mobile-friendly version of the application and/or developed a mobile "app" for individuals to apply through a mobile device. Similarly, in 30 of the 42 states with online accounts, enrollees can access their account through a mobile device. In 14 of these states there is a mobile-friendly version of the account and/or the state has created an "app." A number of states indicate that they plan to enhance mobile access to online applications and accounts in the future.

Eligibility Determinations and System Integration

As of January 2018, 40 states are able to make real-time Medicaid eligibility determinations (defined as within 24 hours). This count reflects the addition of Georgia, which began determining eligibility in real-time in 2017. Prior to the ACA, states could verify some information electronically, like Social Security information or dates of birth, but for other aspects of eligibility, particularly income, eligibility workers often had to review paper documents like pay stubs or manually look up information in other data sources. This process often resulted in backlogs of applications, follow-up requests for information, and delays associated with matching up applications with verification documents. Today's upgraded eligibility systems are able to check against other electronic data sources in real-time or overnight, providing timely eligibility decisions and reducing burdens for both individuals and staff. As state systems and processes have matured, they are able to process an increasing share of applications in real time. As of January 2018, at least 50% of applications receive a real-time determination in 17 of the 38 states that complete real-time determinations and were able to report this data (Figure 16), up from 15 in 2017. This count includes 11 states that report over 75% of applications receive a real-time decision, up from nine states in 2017.

Figure 16

Share of Medicaid Applications Conducted in Real-Time (<24 Hours), January 2018



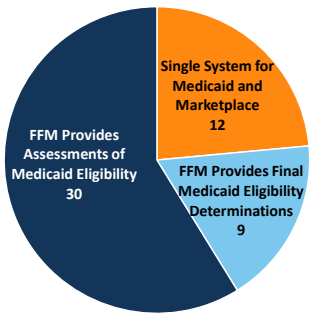
NOTE: Real-time defined as <24 hours. Share of total applications for non-disabled children, pregnant women, parents, and expansion adults.
SOURCE: Based on results from a national survey conducted by the Kaiser Family Foundation and the Georgetown University Center for Children and Families, 2018.

When making Medicaid and CHIP eligibility determinations, all states verify citizenship or qualified immigration status of applicants, as well as income. States must verify citizenship or qualified immigration status for individuals prior to enrollment, although 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 also must verify income. Nearly all states (44 states) verify income prior to enrollment, while seven states complete the verification after enrollment. Verification policies for other eligibility criteria, such as age/date of birth, state residency, and household size, vary across states, reflecting state options to confirm this information before or after enrollment or to accept self-attestation of information. If a state has any data that conflicts with the self-attestation, it must validate the information.

Reflecting ACA provisions for states to coordinate coverage across insurance affordability programs, all states have their Medicaid eligibility system integrated with or connected to CHIP and Marketplace systems. Prior to the ACA, half of states with separate CHIP programs (16 of 38) had separate eligibility systems for Medicaid and CHIP. As of January 2018, nearly all (34 of the 36) states with a separate CHIP program use a single system for Medicaid and CHIP. States' integration and coordination with Marketplace systems varies reflecting differences in Marketplace structure (Figure 17). Most states with State-based Marketplaces (SBMs) (12 of 17) use the same system for Medicaid and Marketplace coverage. The other five SBM states rely on the Federally-Facilitated Marketplace's (FFM's) technology platform (Healthcare.gov) for Marketplace coverage, as do the remaining 34 FFM states. States using Healthcare.gov must electronically transfer data with the FFM to coordinate Medicaid and Marketplace coverage. Nine of these states have authorized the FFM to make final Medicaid eligibility determinations and enroll individuals in Medicaid immediately after receiving data from the FFM. In the other 30 states, the FFM preliminarily assesses Medicaid or CHIP eligibility and then the state may check state data sources or request additional documentation before completing the eligibility determination. When the ACA was first implemented, there were significant problems with account transfers that contributed to delays in Medicaid or CHIP enrollment. As of January 2018, only two states report ongoing, regular delays or difficulties with transfers.

Figure 17

Relationship of Marketplace and Medicaid Eligibility Systems, January 2018

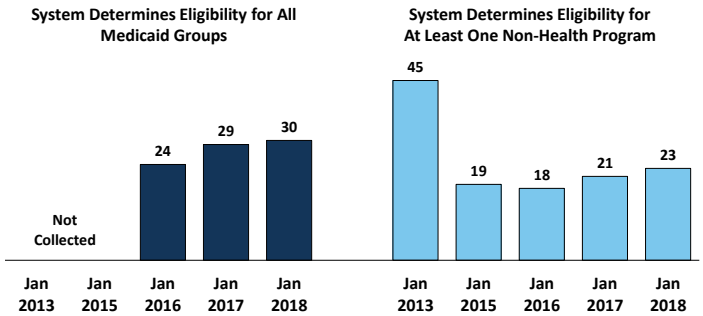


SOURCE: Based on results from a national survey conducted by the Kaiser Family Foundation and the Georgetown University Center for Children and Families, 2018.

States are reintegrating Medicaid eligibility determinations for seniors and people with disabilities and non-health programs into their upgraded systems, but Medicaid eligibility remains separate from non-health programs in more than half of states, limiting the ability to coordinate services across programs. Given the complexity and resources associated with updating eligibility systems and processes, when states first implemented new systems and policies, many focused on groups directly affected by the ACA changes, including children, pregnant women, parents, and expansion adults. As such, when states rolled out new systems, most continued to process determinations for seniors and people with disabilities and non-health programs through their old systems. Therefore, Medicaid eligibility determinations were separated from non-health programs in many states. As new systems have matured, a growing number of states have reintegrated determinations for individuals with disabilities and seniors and non-health programs into their upgraded systems (Figure 18). As of January 2018, 30 states use one system to determine eligibility for all Medicaid groups, including New Jersey, which integrated seniors and people with disabilities into its system in 2017. In 23 states, the Medicaid system includes at least one non-health

Figure 18

Number of States in which Medicaid Eligibility System Determines Eligibility for All Groups and Non-Health Programs, January 2013 to 2018



SOURCE: Based on results from national surveys conducted by the Kaiser Family Foundation and the Georgetown University Center for Children and Families in 2013 to 2018.

program, including Kansas and Ohio, which added some non-health programs in 2017. However, in more than half of states, Medicaid eligibility remains separate from non-health programs, limiting the ability to coordinate services for individuals across programs.

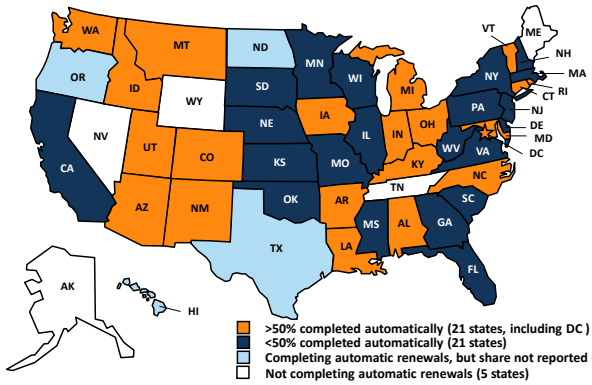
Some states have taken up the option to provide presumptive eligibility, which can help facilitate access to coverage for individuals who cannot have their eligibility verified in real-time. Presumptive eligibility is a longstanding option in Medicaid and CHIP that allows states to authorize qualified entities—such as community health centers or schools—to make a temporary eligibility determination to expedite access to care for children and pregnant women while the full application is processed. The ACA broadened the use of presumptive eligibility in two ways. First, it allowed states that provide presumptive eligibility for children or pregnant women to extend the option to parents, adults, or other groups. Second, the ACA gave hospitals nationwide the authority to determine eligibility presumptively for all non-disabled individuals under age 65. Use of presumptive eligibility for children and pregnant women has remained largely stable under the ACA. As of January 2018, 20 states use the option for children and 30 states use it for pregnant women. A total of 15 states are utilizing the new option provided by the ACA to expand presumptive eligibility to other groups, including parents and other adults.

Renewal Processes

As of January 2018, 46 states use electronic data matches to automatically renew coverage in Medicaid and CHIP without requiring enrollees to submit paperwork. This reflects the implementation of automated renewals in four states (Illinois, Iowa, Oregon, and Wisconsin) during 2017. Similar to data-driven enrollment under the ACA, states are using electronic data matches to renew coverage when possible without requiring an individual to fill out a renewal form or provide documentation. This approach minimizes paperwork for individuals and reduces workloads for states. As of January 2018, among the 42 states completing automated renewals and able to report the share of renewals completed through automatic processes, 21 states reported that more than 50% of renewals are completed automatically, up from 19 in 2017 (Figure 19). This includes seven states that complete more than 75% of renewals automatically. Continued state progress in conducting automated renewals has enabled states to largely resolve backlogs or delays in renewals.

Figure 19

Share of Medicaid Renewals Completed Using Automated Processes, January 2018



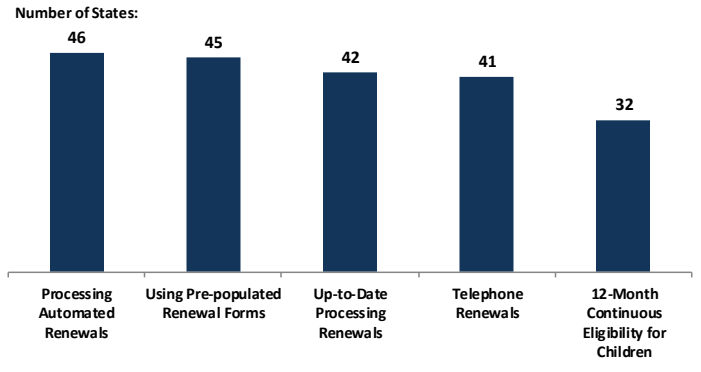
NOTE: Share of renewals for non-disabled children, pregnant women, parents and expansion adults.
SOURCE: Based on results from a national survey conducted by the Kaiser Family Foundation and the Georgetown University Center for Children and Families, 2018.

Forty-five states use prepopulated forms to facilitate renewal when a state is not able to complete an automatic renewal through electronic data sources (Figure 20). In 14 states, the state populates the form with updated sources of data from electronic data matches. In cases where the automatic renewal process is unable to affirm ongoing eligibility, 41 states allow individuals to renew by phone, compared to 24 states that offered telephone renewals in 2013.

More than half of states have taken up the option to support stable coverage for children by providing 12-month continuous eligibility. Since prior to the ACA, states have had an option to provide 12-month continuous eligibility for children. Continuous eligibility promotes retention and reduces "churn" – that is, individuals moving on and off coverage due to small income changes, which can be administratively costly and result in gaps in health care access. Many quality measures require at least 12 months of continuous enrollment, so the policy also enhances states' ability to assess quality of care. As of January 2018, 32 states provide 12-month continuous eligibility to children. In addition, Montana and New York offer 12-month continuous eligibility to parents and other adults under Section 1115 waiver authority.

Figure 20

Medicaid Renewal Processes and Status of Renewals, January 2018



SOURCE: Based on results from a national survey conducted by the Kaiser Family Foundation and the Georgetown University Center for Children and Families, 2018.

Premiums and Cost Sharing

Given that Medicaid and CHIP enrollees have limited ability to pay out-of-pocket costs due to their modest incomes, federal rules establish parameters for premiums and cost sharing for Medicaid and CHIP enrollees (Box 2). Some states charge higher premiums for adults than otherwise allowed under federal rules through waivers, and additional states have proposed waivers to charge higher premiums and/or cost sharing.

Box 2: Medicaid and CHIP Premium and Cost Sharing Rules

Premiums in Medicaid. States may charge premiums for children and adults with incomes above 150% FPL. Medicaid enrollees with incomes below 150% FPL may not be charged premiums.

Cost Sharing in Medicaid. States may charge cost sharing for adults in Medicaid, but allowable charges vary by income (Table 1). Cost sharing cannot be charged for emergency, family planning, pregnancy-related services in Medicaid, preventive services for children, or for preventive services in Alternative Benefit Plans in Medicaid, which have been defined as essential health benefits. In addition, children with incomes below 133% FPL generally cannot be charged cost sharing.

Limit on Out-of-Pocket Costs. Overall, premium and cost sharing amounts for family members enrolled in Medicaid may not exceed 5% of household income.

Premiums and Cost Sharing in CHIP. States have somewhat greater flexibility to charge premiums and cost sharing for children covered by CHIP, although there remain limits on the amounts that can be charged, including an overall cap of 5% of household income.

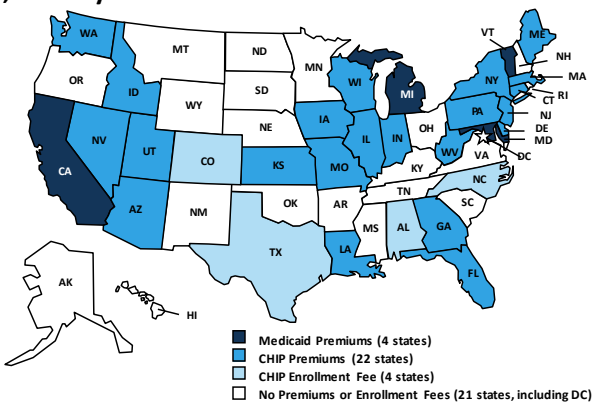
Table 1: Allowable Cost Sharing Amounts for Adults in Medicaid by Income			
	<100% FPL	100% – 150% FPL	>150% FPL
Outpatient Services	up to $4	up to 10% of state cost	up to 20% of state cost
Non-Emergency use of ER	up to $8	up to $8	No limit
Prescription Drugs	Preferred: up to $4 Non-Preferred: up to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

Some states have eliminated premiums for children since implementing the ACA, and the ACA protected children from premium increases. Prior to the ACA in 2013, five states charged premiums or enrollment fees for children in Medicaid, and 30 of 38 states with separate CHIP programs charged premiums or enrollment fees. Under the ACA, states were required to move older children with incomes between 100%-138% FPL from CHIP to Medicaid, which does not allow premiums for children below 150% FPL. In eight states, children were no longer charged premiums due to this transition. The ACA MOE also protected children from new premiums or premium increases.[5] Between 2013 and 2018, Minnesota and Rhode Island eliminated premiums for children in Medicaid, and Oregon eliminated premiums in CHIP. California, Michigan, and Vermont eliminated their separate CHIP programs and moved all children from CHIP to Medicaid, although they still charge premiums in Medicaid for higher-income children. Reflecting these changes, as of January 2018, four states charge premiums or enrollment fees for children in Medicaid, and 26 of 36 states with separate CHIP programs charge premiums or enrollment fees (Figure 21). Premiums begin for children with incomes between 133% and 150% in eight states, and for children with incomes at or above 150% FPL in 22 states. Of the total, 30 states that charge premiums or enrollment fees for children in Medicaid and/or CHIP, 11 states charge premiums or fees that are family-based and 14 other states have a family maximum amount.

Figure 21

Premiums or Enrollment Fees for Children in Medicaid and CHIP, January 2018



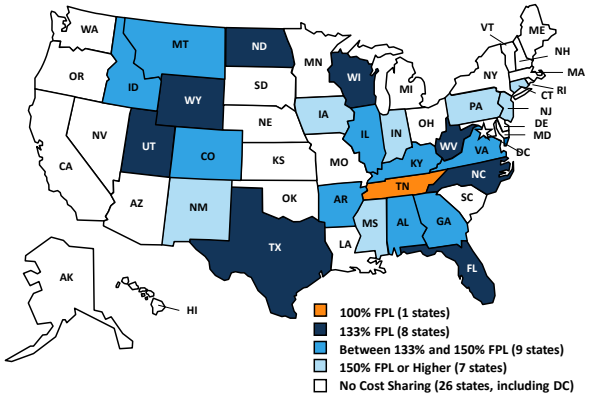
SOURCE: Based on results from a national survey conducted by the Kaiser Family Foundation and the Georgetown University Center for Children and Families, 2018.

The ACA limited lockout periods in CHIP to minimize gaps in coverage for children. In Medicaid, states must provide enrollees a minimum 60-day grace period before cancelling coverage for non-payment of premiums, and states cannot delay re-enrollment or require enrollees to repay outstanding premiums as a condition of reenrollment. In contrast, CHIP programs must provide a minimum 30-day grace period and may impose a "lockout period" during which a child who has been disenrolled is not allowed to reenroll. Prior to the ACA, CHIP lockout periods ranged from one to six months in the 12 states that imposed them. The ACA limited lockout periods to no more than 90 days; 15 states have a lock out period in CHIP as of January 2018.

Cost sharing for children remains more prevalent in CHIP compared to Medicaid. Between 2013 and 2018, four states (California, Delaware, Louisiana and Oregon) eliminated copayments for children. As of 2018, three states charge cost sharing for children in Medicaid, and 24 of the 36 states with separate CHIP programs charge cost sharing. In eight states, cost sharing begins at the federal minimum level of 133% FPL, while 16 states begin cost sharing at a higher income (Figure 22). Tennessee has a longstanding waiver that allows it to begin cost sharing at 100% FPL. The number of states charging cost sharing varies by income and service.

Figure 22

Income at Which Cost Sharing for Children in Medicaid and/or CHIP Begins, January 2018



SOURCE: Based on results from a national survey conducted by the Kaiser Family Foundation and the Georgetown University Center for Children and Families, 2018.

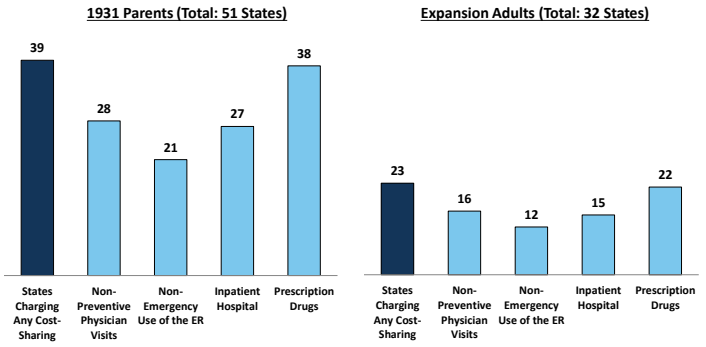
Premiums and Cost Sharing for Parents and Other Adults

Most states do not charge premiums for parents and other adults, but some states charge higher premiums than otherwise allowed under federal rules through waivers. In most states, eligibility levels for parents and other adults are below the levels at which states can charge premiums or cost sharing. However, as of January 2018, five states (Arkansas, Indiana, Iowa, Michigan, and Montana) charged premiums or monthly contributions that are not otherwise allowed under federal rules through waivers.

Most states charge cost sharing for parents and other adults in Medicaid. A total of 39 states charge cost sharing for parents and 22 of the 32 Medicaid expansion states charge cost sharing for expansion adults (Figure 23). Most cost sharing amounts remain nominal consistent with federal law. Indiana had received waiver approval to charge a higher copayment for non-emergent use of the emergency room, which was in place as of January 2018. However, the state subsequently removed this copayment when it renewed its waiver. As noted below, other states are seeking to charge higher copayments through waivers.

Figure 23

Number of States with Cost Sharing for Selected Services for Adults, January 2018



SOURCE: Based on results from a national survey conducted by the Kaiser Family Foundation and the Georgetown University Center for Children and Families, 2018.

Looking Ahead

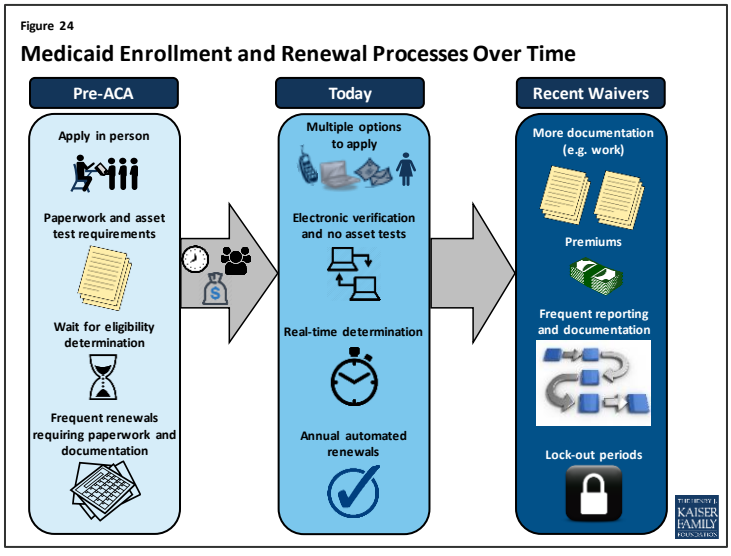
Coverage for children and pregnant women will likely remain strong, bolstered by a ten-year extension in federal funding for CHIP. At the end of September 2017, federal funding for CHIP ended beginning a four-month lapse in federal funding before Congress passed legislation that extended federal funding for ten years. The extension in federal funding enables states to maintain coverage for children and pregnant women and continues the ACA MOE provision that requires states to maintain Medicaid and CHIP eligibility levels for children through 2027. After October 1, 2019, the MOE will only apply to children in

families with incomes at or below 300% FPL (305% FPL after accounting for the five percentage point income disregard). The 14 states that have CHIP eligibility above 305% FPL can maintain higher eligibility levels and receive federal CHIP matching funds, but they could reduce eligibility to 305% FPL at that time or later. The legislation continues the 23 percentage point enhanced federal match rate for CHIP established by the ACA through 2019 to give states time to plan for a phase down to the regular CHIP matching rate in 2021.

There could be continued gains in eligibility for adults if additional states adopt the Medicaid expansion, but some may add new requirements or restrictions for adults as a condition of expanding coverage. As noted, Maine adopted the Medicaid expansion through a ballot initiative in 2017, although it has not yet been implemented. Additional states may move forward with the expansion over the coming year, which would reduce the number of poor uninsured adults that currently fall into the coverage gap in non-expansion states. Some states examining the potential to expand coverage to adults may also seek waivers adding new requirements or restrictions for adults as a condition of expanding coverage. A substantial body of research shows that Medicaid expansion results in significant coverage gains and reductions in uninsured rates, improvements in access to care and families' financial security, and economic benefits to states and providers.

Proposals to make significant changes to Medicaid's structure and financing are likely to continue to be debated. While proposals to cap and limit Medicaid financing stalled in 2017, proposals to restructure Medicaid and reduce federal spending are likely to reemerge. The President's FY2019 budget proposes reductions to Medicaid and some Congressional leaders continue to express interest in reducing spending on entitlement programs, including Medicaid and Medicare. Changes to the financing and structure of Medicaid would have significant implications for the coverage gains achieved for children and adults to date. Moreover, uncertainty around the future of the program could limit state interest in continuing efforts to expand coverage and improve enrollment and renewal processes.

Waivers and other proposed changes require complex documentation and administrative processes for adults that run counter to simplified enrollment and renewal and increase costs for individuals (Figure 24). Recently approved and proposed Section 1115 waivers include new restrictions and requirements for adults such as work requirements, premiums, increased cost sharing, time limits on coverage, drug screening and testing requirements, asset tests, more frequent redeterminations, waivers of reasonable promptness and retroactive eligibility, and lockouts for failure to pay premiums or provide timely information about changes in circumstances or for renewal. To date, CMS has approved certain eligibility and enrollment restrictions as part of ACA Medicaid expansion waivers; in some cases, provisions also apply to other groups, including very low-income parents eligible through traditional eligibility pathways. Many of these provisions had not yet been implemented as of January 2018, although waivers of retroactive eligibility and reasonable promptness and higher premiums had been implemented in some states. In addition, the President's FY2019 budget proposes to allow states



once again to require individuals to meet an asset test and to provide documentation to verify citizenship and immigration status before receipt of Medicaid, although states already must verify citizenship and immigration status under current law. These provisions run counter to the streamlined processes states have put in place under the ACA. Research and previous state experience shows that such changes would likely create barriers for eligible individuals to obtain and maintain coverage and access needed care. They also will be complex and costly for states to implement.

Conclusion

Taken together, the survey data show that Medicaid and CHIP continue to provide a strong base of coverage for our nation's low-income children and pregnant women. There have been significant gains in eligibility for parents and other adults under the ACA Medicaid expansion, but gaps in coverage remain in states that have not implemented the expansion. Through major investments of time and resources, states have largely realized modernized, streamlined enrollment and renewal processes as outlined in the ACA, which have made the processes more consumer-friendly for individuals and reduced administrative burdens for states. In 2017, some states continued to take up targeted expansions in coverage and improvements to enrollment and renewal processes, although there was some leveling off of continued advancement and states focused attention on other priorities. Looking ahead, coverage for children and pregnant women will remain strong, bolstered by a ten-year extension in federal funding for CHIP. Opportunity remains for states to expand eligibility for parents and other adults by implementing the Medicaid expansion. States may continue to refine and enhance enrollment and renewal processes, but some states are seeking to include new requirements and restrictions for adults that require complex documentation and administrative processes, which would likely create barriers for eligible individuals to obtain and maintain coverage and access needed care.

Endnotes

[1] Rachel Garfield and Anthony Damino, *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid,* (Washington, DC: Kaiser Family Foundation, November 2017), https://www.kff.org/uninsured/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/

[2] Ibid.

[3] Utah also changed from using a dollar threshold to a threshold tied to the FPL for parent eligibility.

[4] These include seven states (California, District of Columbia, Illinois, Massachusetts, New York, Oregon, and Washington) that provide state-only coverage for income-eligible children, two states (New Jersey and New York) and the District of Columbia that provide state-only coverage for income-eligible pregnant women, and seven (California, Hawaii, Massachusetts, New Mexico, New York, Oregon, and Pennsylvania) and the District of Columbia provide state-only funded coverage for some income-eligible adults.

[5] Under the MOE, states may not impose new premiums or increase premiums for children outside of inflation or routine increases approved before 2010.

Trend and State-by-State Tables

Table A

Trends in State Medicaid and CHIP Eligibility, Enrollment, and Renewal Policies, July 2000-January 2018[1]

	Program	July 2000	January 2002	April 2003	July 2004	July 2005	July 2006	January 2008	January 2009	December 2009	January 2011	January 2012	January 2013	January 2015	January 2016	January 2017	January 2018
ELIGIBILITY																	
Cover children ≥200% FPL	N/A	36	40	39	39	41	41	45	44	47	47	47	47	48	48	49	49
Cover children ≥300% FPL	N/A	5	6	6	6	6	8	9	10	16	16	17	17	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
	CHIP														19	21	22
Cover pregnant women ≥200% FPL	N/A	NC		17	16	17	17	20	21	24	25	25	25	33	33	34	34
Cover lawfully-residing immigrant pregnant women without five-year wait	Medicaid	Option Not Available								14	17	18	20	23	23	23	25
	CHIP														4	3	3
Cover parents ≥100% FPL[2]	N/A	NC	20	16	17	17	16	18	18	17	18	18	18	31	34	35	34
Cover other adults[2, 3]	N/A	NC									7	8	25	29	32	33	33
Asset test not required[4]	Medicaid Children	42	45	45	46	47	47	47	47	48	48	48	48	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
Online Medicaid application[4]	Medicaid	NC									32	34	36	50	50	50	50
Telephone Medicaid application[4]	Medicaid	NC											17	47	49	49	49
Presumptive eligiblity for children	Medicaid	8	9	7	8	9	9	14	14	14	16	16	17	15	18	20	20
	CHIP	4	5	4	6	6	6	9	9	9	10	11	12	9	10	11	11
Presumptive eligibility for pregnant women	Medicaid	NC		29	29	30	31	30	30	30	31	31	32	27	29	30	30
	CHIP														2	3	3
No face-to-face interview at enrollment[4]	Medicaid Children	40	47	46	45	45	46	46	48	48	49	49	49	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
Telephone Medicaid renewal	N/A	NC													41	41	41
No face-to-face interview at renewal[4]	Medicaid Children	43	48	49	48	48	48	48	49	50	50	50	50	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[4]	Medicaid Children	39	42	42	41	42	44	45	44	47	49	49	49	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
	CHIP	22	23	21	21	24	25	27	30	30	28	28	27	25	26	26	26

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, 2011-2018.

NC indicates that data were not collected for the period.

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.

Table 1

Income Eligibility Limits for Children's Health Coverage as a Percent of the Federal Poverty Level, January 2018[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	
Median[4]	**255%**	**195%**	**217%**	**149%**	**216%**	**142%**	**155%**	**254%**
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	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[8]	318%	147%		147%		147%	108%-147%	318%
Indiana[9]	262%	218%	157%-218%	165%	141%-165%	165%	106%-165%	262%
Iowa	380%	380%	240%-380%	172%		172%	122%-172%	307%
Kansas[10]	241%	171%		154%		138%	113%-138%	241%
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[11]	305%	205%	185%-205%	155%	133%-155%	155%	114%-155%	305%
Michigan	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%		148%	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	175%	152%		152%		138%	111% - 138%	175%
Ohio	211%	156%	141%-211%	156%	141%-211%	156%	107%-211%	
Oklahoma[14]	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[15]	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[16]	306%	306%		191%		133%	101%-156%	306%
Wyoming	205%	159%		159%		138%	119%-138%	205%

SOURCE: Based on a national survey conducted by the Kaiser Family Foundation with the Georgetown University Center for Children and Families, 2018.
Table presents rules in effect as of January 1, 2018.

Table 1 Notes

1. January 2018 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 at the highest income level for Medicaid and separate CHIP coverage. Eligibility levels are reported as percentage of the FPL. The 2018 FPL for a family of three was $20,780.
2. States may use Title XXI CHIP funds to cover children through CHIP-funded Medicaid expansion programs and/or separate child health insurance programs for children not eligible for Medicaid. Use of Title XXI CHIP funds is limited to uninsured children. The Medicaid income eligibility levels listed indicate thresholds for children covered with Title XIX Medicaid funds and uninsured children covered with Title XXI funds through CHIP-funded Medicaid expansion programs. To be eligible in the infant category, a child has not yet reached his or her first birthday; to be eligible in the 1-5 category, the child is age one or older, but has not yet reached his or her sixth birthday; and to be eligible in the 6-18 category, the child is age six or older, but has not yet reached his or her 19th birthday.
3. The states noted use federal CHIP funds to operate separate child health insurance programs for children not eligible for Medicaid. Such programs may either provide benefits similar to Medicaid or a somewhat more limited benefit package. They also may impose premiums or other cost sharing obligations on some or all families with eligible children. These programs typically provide coverage for uninsured children until the child's 19th birthday.
4. 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 are 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 Service Network serves children with special health care needs from birth through age 18.
8. In Illinois, infants born to non-Medicaid covered mothers are covered up to 147% FPL in Medicaid and up to 318% FPL under CHIP.
9. Indiana uses a state-specific income disregard that is equal to five percent of the highest income eligibility threshold for the group.
10. Kansas covers children in a separate CHIP program at a dollar-based income level equal to 238% FPL in 2008. As a result, the equivalent FPL level may erode over time although it was increased in 2014 to account for the MAGI conversion and includes the five percentage point disregard required under MAGI.
11. Massachusetts also covers insured children in its separate CHIP program with Title XIX Medicaid funds under its Section 1115 waiver.
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
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. 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.
15. In Tennessee, Title XXI funds are used for two programs, TennCare Standard and CoverKids (a separate CHIP program). TennCare Standard provides Medicaid coverage to uninsured children who lose eligibility under TennCare (Medicaid), have no access to insurance, and have family income below 216% FPL or are medically eligible.

16. In Wisconsin, children are not eligible for CHIP if they have access to health insurance coverage through a job where the employer covers at least 80% of the cost.

Table 2
Waiting Period for CHIP Enrollment, January 2018

State	Waiting Period[1]	Income-Related Groups Exempt from Waiting Period (Percent of the FPL)
Total No Waiting Period	**36**	
Alabama	None	
Alaska	None	
Arizona	90 days	
Arkansas	90 days	
California	None	
Colorado	None	
Connecticut	None	
Delaware	None	
District of Columbia	None	
Florida	2 months	
Georgia	None	
Hawaii	None	
Idaho	None	
Illinois	90 days	Below 209%
Indiana	90 days	
Iowa	1 month	Below 200%
Kansas	90 days	Below 219%
Kentucky	None	
Louisiana	90 days	Below 212%
Maine	90 days	
Maryland	None	
Massachusetts	None	
Michigan	None	
Minnesota	None	
Mississippi	None	
Missouri	None	
Montana	None	
Nebraska	None	
Nevada	None	
New Hampshire	None	
New Jersey	90 days	Below 200%
New Mexico	None	
New York	None	
North Carolina	None	
North Dakota	90 days	
Ohio	None	
Oklahoma	None	
Oregon	None	
Pennsylvania	None	
Rhode Island	None	
South Carolina	None	
South Dakota	90 days	
Tennessee	None	
Texas	90 days	
Utah	90 days	
Vermont	None	
Virginia	None	
Washington	None	
West Virginia	None	
Wisconsin	None	
Wyoming	1 month	

SOURCE: Based on a national survey conducted by the Kaiser Family Foundation with the Georgetown University Center for Children and Families, 2018.
Table presents rules in effect as of January 1, 2018.

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.

Table 3
State Adoption of Optional Medicaid and CHIP Coverage for Children, January 2018

State	Coverage for Dependents of State Employees in CHIP[1, 2] (Total = 36)	Lawfully-Residing Immigrants Covered without 5-Year Wait[3]		Provides Medicaid Coverage to Former Foster Youth up to Age 26 from Other States[4]
		Medicaid	CHIP[2] (Total = 36)	
Total	**18**	**33**	**22**	**12**
Alabama	Y			
Alaska	N/A (M-CHIP)		N/A (M-CHIP)	
Arizona				
Arkansas[5]	Y	Y	Y	
California[6]	N/A (M-CHIP)	Y	N/A (M-CHIP)	Y
Colorado	Y	Y	Y	
Connecticut	Y	Y	Y	
Delaware[7]		Y	Y	Y
District of Columbia[6]	N/A (M-CHIP)	Y	N/A (M-CHIP)	
Florida	Y	Y	Y	
Georgia	Y			Y
Hawaii	N/A (M-CHIP)	Y	N/A (M-CHIP)	
Idaho				
Illinois[6]		Y	Y	
Indiana				
Iowa[8]		Y	Y	
Kansas	Y			
Kentucky	Y	Y	Y	Y
Louisiana[9]				
Maine[10]	Y	Y	Y	
Maryland	N/A (M-CHIP)	Y	N/A (M-CHIP)	
Massachusetts[6]		Y	Y	Y
Michigan	N/A (M-CHIP)		N/A (M-CHIP)	Y
Minnesota	N/A (M-CHIP)	Y	N/A (M-CHIP)	
Mississippi	Y			
Missouri				
Montana[9]	Y	Y	Y	
Nebraska	N/A (M-CHIP)	Y	N/A (M-CHIP)	
Nevada	Y			
New Hampshire	N/A (M-CHIP)		N/A (M-CHIP)	
New Jersey		Y	Y	
New Mexico	N/A (M-CHIP)	Y	N/A (M-CHIP)	Y
New York[6,. 9]		Y	Y	
North Carolina	Y	Y	Y	
North Dakota				
Ohio	N/A (M-CHIP)	Y	N/A (M-CHIP)	
Oklahoma	N/A (M-CHIP)		N/A (M-CHIP)	
Oregon[6]		Y	Y	
Pennsylvania[11]	Y	Y	Y	Y
Rhode Island	N/A (M-CHIP)	Y	N/A (M-CHIP)	
South Carolina[12]	N/A (M-CHIP)	Y	N/A (M-CHIP)	
South Dakota				Y
Tennessee	Y			
Texas	Y	Y	Y	
Utah		Y	Y	Y
Vermont	N/A (M-CHIP)	Y	N/A (M-CHIP)	
Virginia	Y	Y	Y	Y
Washington[6]		Y	Y	
West Virginia	Y	Y	Y	
Wisconsin		Y	Y	Y
Wyoming				

SOURCE: Based on a national survey conducted by the Kaiser Family Foundation with the Georgetown University Center for Children and Families, 2018.

Table presents rules in effect as of January 1, 2018.

Table 3 Notes

1. 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.
2. N/A (M-CHIP) responses indicate that the state does not provide a separate CHIP program for uninsured children.
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. Arkansas began using federal funds to cover lawfully residing immigrant children without the five-year wait in Medicaid and CHIP as of January 1, 2018.
6. 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. Coverage in Oregon began on January 1, 2018.
7. Delaware began covering former foster youth up to age 26 who were enrolled in Medicaid in another state as of their 18th birthday as of January 1, 2018.
8. Iowa covers income-eligible children who are in foster care and are not otherwise eligible due to immigration status using state-only funds.
9. Louisiana, Montana, and New York stopped providing coverage for former foster youth up to age 26 who were enrolled in Medicaid in another state as of their 18th birthday in 2017.
10. Maine began covering children of state employees in its separate CHIP program in 2017.
11. 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.
12. South Carolina began using federal funds to cover lawfully residing immigrant children without the five-year wait in Medicaid as of January 1, 2018.

Table 4
Medicaid and CHIP Coverage for Pregnant Women and Medicaid Family Planning Expansion Programs, January 2018

State	Income Eligibility Limits for Pregnant Women (Percent of the Federal Poverty Level)			Lawfully-Residing Immigrants Covered without 5-Year Wait[3]		Full Medicaid/CHIP Benefit Package for Pregnant Women[5]			Income Eligibility Limit for Family Planning Expansion Program (Percent of the Federal Poverty Level)[6]
	Medicaid[1]	CHIP[1]	Unborn Child Option (CHIP-Funded)[1,2]	Medicaid	CHIP[4] (Total = 5)	Medicaid	CHIP[4] (Total = 5)	Unborn Child Option[4] (Total = 16)	
Median or Total	**200%**	**258%**	**214%**	**25**	**3**	**46**	**5**	**11**	**205%**
Alabama	146%				N/A	Y	N/A	N/A	146%
Alaska	205%				N/A	Y	N/A	N/A	N/A
Arizona	161%				N/A	Y	N/A	N/A	N/A
Arkansas[7]	214%		214%	Y	N/A		N/A		N/A
California	213%		322%	Y	N/A	Y	N/A	Y	205%
Colorado	200%	265%		Y	Y	Y	Y	N/A	N/A
Connecticut	263%			Y	N/A	Y	N/A	N/A	263%
Delaware	217%			Y	N/A	Y	N/A	N/A	N/A
District of Columbia[8]	324%			Y	N/A	Y	N/A	N/A	N/A
Florida[9]	196%				N/A	Y	N/A	N/A	190%
Georgia[10]	225%				N/A	Y	N/A	N/A	216%
Hawaii	196%			Y	N/A	Y	N/A	N/A	N/A
Idaho	138%				N/A		N/A	N/A	N/A
Illinois	213%		213%		N/A	Y	N/A	Y	N/A
Indiana[11]	218%				N/A	Y	N/A	N/A	148%
Iowa[12]	380%				N/A	Y	N/A	N/A	N/A
Kansas	171%				N/A	Y	N/A	N/A	N/A
Kentucky[9]	200%				N/A	Y	N/A	N/A	218%
Louisiana	138%		214%		N/A	Y	N/A	Y	138%
Maine	214%			Y	N/A	Y	N/A	N/A	214%
Maryland	264%			Y	N/A	Y	N/A	N/A	205%
Massachusetts	205%		205%	Y	N/A	Y	N/A	Y	N/A
Michigan	200%		200%		N/A	Y	N/A	Y	N/A
Minnesota	283%		283%	Y	N/A	Y	N/A	Y	205%
Mississippi	199%				N/A	Y	N/A	N/A	199%
Missouri	201%	305%	305%			Y	Y	Y	206%
Montana	162%				N/A	Y	N/A	N/A	216%
Nebraska	199%		202%	Y	N/A	Y	N/A		N/A
Nevada	165%				N/A	Y	N/A	N/A	N/A
New Hampshire	201%				N/A	Y	N/A	N/A	201%
New Jersey[8]	199%	205%		Y	Y	Y	Y	N/A	N/A
New Mexico	255%			Y	N/A		N/A	N/A	255%
New York[8]	223%			Y	N/A	Y	N/A	N/A	223%
North Carolina[13]	201%			Y	N/A		N/A	N/A	200%
North Dakota	152%				N/A	Y	N/A	N/A	N/A
Ohio	205%			Y	N/A	Y	N/A	N/A	N/A
Oklahoma[14]	138%		210%		N/A	Y	N/A		138%
Oregon	190%		190%		N/A	Y	N/A	Y	255%
Pennsylvania	220%			Y	N/A	Y	N/A	N/A	220%
Rhode Island[15]	195%	258%	258%			Y	Y	Y	258%
South Carolina[16]	199%			Y	N/A	Y	N/A	N/A	199%
South Dakota[17]	138%				N/A		N/A	N/A	N/A
Tennessee[18]	200%		255%		N/A	Y	N/A		N/A
Texas[19]	203%		207%		N/A	Y	N/A		N/A
Utah	144%				N/A	Y	N/A	N/A	N/A
Vermont[20]	213%			Y	N/A	Y	N/A	N/A	N/A
Virginia	148%	205%		Y	Y	Y	Y	N/A	205%
Washington	198%		198%	Y	N/A	Y	N/A	Y	265%
West Virginia	163%			Y	N/A	Y	N/A	N/A	N/A
Wisconsin	306%		306%	Y	N/A	Y	N/A	Y	306%
Wyoming[15]	159%			Y	N/A	Y	N/A	N/A	164%

SOURCE: Based on a national survey conducted by the Kaiser Family Foundation with the Georgetown University Center for Children and Families, 2018.

Table presents rules in effect as of January 1, 2018.

Table 4 Notes

1. January 2018 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). As of 2018, the FPL for a family of three was $20,780.
2. The unborn child option permits states to consider the fetus a "targeted low-income child" for purposes of CHIP coverage.
3. These columns indicate whether the state 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.
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 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.
6. This column provides income eligibility limits for programs offered by states under a state option or waiver to provide family planning services to individuals who do not qualify for full Medicaid benefits. January 2018 income limits reflect a disregard equal to five percentage points of the FPL.
7. 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.
8. The District of Columbia, New Jersey, and New York provide pregnancy-related services not covered through emergency Medicaid for some income-eligible pregnant women who are not otherwise eligible due to immigration status using state-only funds.
9. Florida and Kentucky limit eligibility for their family planning expansion programs to those losing Medicaid eligibility.
10. Georgia increased its income eligibility limit for family planning services from 205% FPL to 211% during 2017.
11. Indiana uses a state-specific income disregard that is equal to five percent of the highest income eligibility threshold for the group.
12. Iowa terminated its family planning waiver on June 30, 2017 and established a family planning program with state-only funds on July 1, 2018.
13. North Carolina provides full Medicaid benefits to pregnant women with incomes up to roughly 43% FPL. Above that level, more limited pregnancy-related benefits are provided to pregnant women covered under Medicaid.
14. 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.
15. Rhode Island and Wyoming limit eligibility for their family planning expansion programs to those losing Medicaid at the end of their post-part partum period.
16. South Carolina began using federal funds to cover lawfully residing immigrant pregnant women without the five-year wait in Medicaid as of January 1, 2018.
17. 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.
18. In Tennessee, women covered under the unborn child option receive comprehensive medical services but do not receive chiropractic, dental or vision benefits that CHIP children receive.

19. Texas has a state-funded program that offers family planning services.
20. 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 5

Medicaid Income Eligibility Limits for Adults as a Percent of the Federal Poverty Level, January 2018[1]

State	Parents (in a family of three)		Other Adults (for an individual)
	Section 1931 Limit	Upper Limit	
Median	**50%**	**138%**	**138%**
Alabama	18%	18%	0%
Alaska	139%	139%	138%
Arizona[2]	106%	138%	138%
Arkansas[2]	15%	138%	138%
California[3]	109%	138%	138%
Colorado	68%	138%	138%
Connecticut[4]	138%	138%	138%
Delaware	87%	138%	138%
District of Columbia[5]	221%	221%	215%
Florida	33%	33%	0%
Georgia	36%	36%	0%
Hawaii[5]	100%	138%	138%
Idaho	26%	26%	0%
Illinois[6]	24%	138%	138%
Indiana[2, 7]	17%	139%	139%
Iowa[2]	50%	138%	138%
Kansas	38%	38%	0%
Kentucky	19%	138%	138%
Louisiana	19%	138%	138%
Maine[8]	105%	105%	0%
Maryland	123%	138%	138%
Massachusetts[5, 9]	138%	138%	138%
Michigan[2]	54%	138%	138%
Minnesota[10]	138%	138%	138%
Mississippi	27%	27%	0%
Missouri	22%	22%	0%
Montana[2]	24%	138%	138%
Nebraska	63%	63%	0%
Nevada	28%	138%	138%
New Hampshire[2]	55%	138%	138%
New Jersey	29%	138%	138%
New Mexico[5]	44%	138%	138%
New York[5, 10]	89%	138%	138%
North Carolina	43%	43%	0%
North Dakota	50%	138%	138%
Ohio	90%	138%	138%
Oklahoma[11]	43%	43%	0%
Oregon[5]	35%	138%	138%
Pennsylvania[5]	33%	138%	138%
Rhode Island	116%	138%	138%
South Carolina	67%	67%	0%
South Dakota	50%	50%	0%
Tennessee	98%	98%	0%
Texas[12]	18%	18%	0%
Utah[13]	60%	60%	0%
Vermont[14]	43%	138%	138%
Virginia[15]	38%	38%	0%
Washington	47%	138%	138%
West Virginia	18%	138%	138%
Wisconsin[16]	100%	100%	100%
Wyoming	55%	55%	0%

SOURCE: Based on a national survey conducted by the Kaiser Family Foundation with the Georgetown University Center for Children and Families, 2018.

Table presents rules in effect as of January 1, 2018.

Table 5 Notes

1. January 2018 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 income limit for the group. In some states, eligibility limits for Section 1931 parents are based on a dollar threshold. The values listed represent the truncated FPL equivalents calculated from these dollar limits. Eligibility levels for parents are presented as a percentage of the 2018 FPL for a family of three, which is $20,780. Eligibility limits for other adults are presented as a percentage of the 2018 FPL for an individual, which is $12,140.
2. Arizona, Arkansas, Indiana, Iowa, Michigan, Montana and New Hampshire implemented the Medicaid expansion under Section 1115 waiver authority.
3. In 2017, California began using state-only funds to cover otherwise eligible adults regardless of immigration status.
4. Connecticut decreased eligibility for parents and caretaker relatives as of January 1, 2018.
5. 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. Oregon began providing reproductive health benefits regardless of immigration status as of January 1, 2018.
6. Parents have been covered in Illinois in an optional group under Title XIX up to 133% FPL from July 2012 to January 2014.
7. Indiana uses a state-specific income disregard that is equal to five percent of the highest income eligibility threshold for the group.
8. Maine has passed a ballot initiative to expand Medicaid but it had not yet been implemented as of January 2018.
9. 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.
10. 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.
11. In Oklahoma, individuals without a qualifying employer with incomes up to 100% FPL are eligible for more limited subsidized insurance though the Insure Oklahoma Section 1115 waiver program. Individuals working for certain qualified employers with incomes at or below 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 is one or two-parents in the family. The eligibility level shown is for a single parent household and a family size of three.
13. In 2017, Utah increased eligibility for parents from 45% to 60% FPL, including the 5 percentage point disregard, and changed parent eligibility from a dollar to FPL based threshold. In 2017, Utah also received waiver approval and is covering childless adults with incomes up to 5% FPL who are chronically homeless or in need of behavioral health treatment as of January 2018. Adults with incomes up to 100% FPL continue to be eligible for coverage of primary care services under the Primary Care Network Section 1115 waiver program in Utah. Enrollment is opened periodically when there is capacity to accept new enrollees.
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 6

Online and Telephone Medicaid Applications for Children, Pregnant Women, Parents, and Expansion Adults, January 2018

State	Applications Can be Submitted Online at the State Level[1]	Applications Can be Submitted by Telephone at the State Level[2]	Share of Applications Submitted:[3]		
			Online	Phone	Other
Total or Median	**50**	**49**	**50%**	**4%**	**40%**
Alabama	Y	Y		Not Reported	
Alaska[4]	Y	Y	11%	0%	59%
Arizona	Y	Y	64%	10%	26%
Arkansas	Y	Y		Not Reported	
California[5]	Y	Y	20%	3%	77%
Colorado	Y	Y	62%	1%	27%
Connecticut	Y	Y	39%	41%	about 20%
Delaware	Y	Y	64%	1%	35%
District of Columbia	Y	Y	56%	<1%	44%
Florida	Y	Y	89%	<1%	12%
Georgia	Y	Y		Not Reported	
Hawaii[6]	Y	Y	54%		46%
Idaho	Y	Y	19%	30%	51%
Illinois	Y	Y	75%	1%	24%
Indiana	Y	Y		Not Reported	
Iowa	Y	Y	40%	2%	58%
Kansas	Y	Y	33%	<1.0%	67%
Kentucky	Y	Y	35%	10%	55%
Louisiana	Y	Y	32%	28%	40%
Maine	Y	Y	26%	12%	62%
Maryland	Y	Y		Not Reported	
Massachusetts	Y	Y	24%	19%	57%
Michigan	Y	Y	63%	1%	35%
Minnesota	Y		85%	N/A	15%
Mississippi[7]	Y	Y	5%	3%	92%
Missouri	Y	Y	84%	10%	6%
Montana	Y	Y	50%	5%	45%
Nebraska[8]	Y	Y	56%	24%	20%
Nevada	Y	Y	40%	<5%	>50%
New Hampshire	Y	Y	69%	4%	27%
New Jersey	Y	Y	33%	11%	55%
New Mexico	Y	Y	63%	<1%	37%
New York	Y	Y	94%	6%	0%
North Carolina	Y	Y		Not Reported	
North Dakota	Y	Y	54%	0%	46%
Ohio	Y	Y		Not Reported	
Oklahoma	Y	Y	89%	0%	11%
Oregon	Y	Y		Not Reported	
Pennsylvania	Y	Y	63%	35%	2%
Rhode Island	Y	Y		Not Reported	
South Carolina	Y	Y	18%	6%	76%
South Dakota	Y	Y		Not Reported	
Tennessee				Not Reported	
Texas	Y	Y	93%	2%	5%
Utah	Y	Y	34%		
Vermont[9]	Y	Y	52%		48%
Virginia	Y	Y	35%	25%	41%
Washington	Y	Y		Not Reported	
West Virginia	Y	Y	47%	2%	51%
Wisconsin	Y	Y	38%	22%	39%
Wyoming	Y	Y	46%	41%	14%

SOURCE: Based on a national survey conducted by the Kaiser Family Foundation with the Georgetown University Center for Children and Families, 2018.

Table presents rules in effect as of January 1, 2018.

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 whether individuals can complete Medicaid applications over the telephone at the state level, either through the Medicaid agency or the SBM.
3. These columns indicate the share of total applications for non-disabled groups (children, pregnant women, parents, and expansion adults) that are submitted through different modes, including online, telephone, or other. Other includes mail or in-person applications.
4. In Alaska, families can call an eligibility worker to complete a Medicaid application; the application is then mailed to the applicant for signature.
5. In California, the share of applications ranges between 15% - 25% online, 2% - 3% over the phone, and 50% - 80% other.
6. In Hawaii telephone applications are included in the online share.
7. Mississippi's online application is a downloadable PDF that can be submitted via email. Required documentation can be added as additional attachments to the email.
8. Nebraska's applications include applications submitted by seniors and individuals with disabilities.
9. In Vermont, telephone applications are included in the "other" category, because they cannot be separated out.

Table 7

Functions of Online Medicaid Applications for Children, Pregnant Women, Parents, and Expansion Adults, January 2018

State	Individuals Can Start, Stop, and Return to Application	Individuals Can Scan and Upload Documents	Online Portal for Application Assisters[1]	Can be Used for:	
				Medicaid for Seniors and Individuals with Disabilities	At Least One Non-Health Program[2]
Total	**50**	**34**	**27**	**32**	**26**
Alabama	Y				
Alaska	Y			Y	
Arizona	Y	Y	Y	Y	Y
Arkansas	Y				
California	Y	Y	Y		Y
Colorado	Y	Y		Y	Y
Connecticut	Y	Y			
Delaware	Y		Y	Y	Y
District of Columbia	Y	Y	Y		
Florida	Y	Y	Y	Y	Y
Georgia	Y	Y		Y	Y
Hawaii	Y	Y	Y		
Idaho	Y	Y	Y	Y	
Illinois	Y	Y	Y	Y	Y
Indiana	Y			Y	
Iowa	Y				
Kansas	Y	Y		Y	
Kentucky	Y	Y	Y	Y	Y
Louisiana	Y		Y	Y	
Maine	Y			Y	Y
Maryland	Y	Y			Y
Massachusetts	Y		Y		
Michigan	Y	Y		Y	Y
Minnesota	Y		Y		
Mississippi	Y	Y			
Missouri	Y				
Montana	Y	Y		Y	Y
Nebraska[3]	Y	Y		Y	
Nevada	Y	Y		Y	Y
New Hampshire	Y	Y		Y	Y
New Jersey[4]	Y		Y	Y	
New Mexico	Y	Y	Y	Y	Y
New York	Y	Y	Y		
North Carolina	Y			Y	Y
North Dakota	Y	Y	Y	Y	Y
Ohio[5]	Y	Y	Y	Y	Y
Oklahoma	Y	Y	Y		
Oregon	Y	Y	Y		
Pennsylvania	Y	Y	Y	Y	Y
Rhode Island	Y	Y	Y	Y	Y
South Carolina	Y				
South Dakota	Y	Y		Y	Y
Tennessee[6]	N/A	N/A	N/A		
Texas	Y	Y	Y	Y	Y
Utah[7]	Y	Y	Y	Y	Y
Vermont	Y		Y		
Virginia	Y	Y		Y	Y
Washington	Y	Y	Y		
West Virginia	Y		Y	Y	Y
Wisconsin	Y	Y	Y	Y	Y
Wyoming	Y	Y		Y	

SOURCE: Based on a national survey conducted by the Kaiser Family Foundation with the Georgetown University Center for Children and Families, 2018.

Table presents rules in effect as of January 1, 2018.

Table 7 Notes

1. 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.
2. 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 Supplemental Nutrition Assistance Program (SNAP; food stamps) or cash assistance.
3. In Nebraska, applicants can return to and complete an application for 30 days only.
4. New Jersey implemented a combined online application for all Medicaid groups in December 2017.
5. Ohio launched its multi-benefit application as of January 1, 2018.
6. Tennessee does not have an online application, so responses are indicated as N/A.
7. Utah implemented functionality to scan and upload documents when submitting an application in 2017.

Table 8
Features of Online Medicaid Accounts, January 2018

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	**42**	**39**	**38**	**38**	**35**	**31**	**31**	**30**
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[3]	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[4]	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				
Maine	Y	Y	Y	Y	Y			Y
Maryland	Y	Y	Y	Y	Y	Y	Y	Y
Massachusetts	Y	Y	Y	Y	Y			
Michigan	Y	Y	Y	Y	Y	Y	Y	Y
Minnesota[5]	Y				Y			
Mississippi								
Missouri[6]								
Montana	Y	Y	Y	Y	Y	Y	Y	Y
Nebraska	Y	Y	Y	Y	Y	Y	Y	Y
Nevada	Y		Y					
New Hampshire	Y	Y	Y	Y	Y	Y	Y	Y
New Jersey								
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	Y
Pennsylvania	Y	Y	Y	Y	Y		Y	Y
Rhode Island	Y	Y	Y	Y	Y	Y	Y	Y
South Carolina	Y		Y					
South Dakota	Y	Y		Y			Y	
Tennessee								
Texas[7]	Y	Y	Y	Y		Y	Y	Y
Utah[8]	Y	Y	Y	Y	Y	Y	Y	Y
Vermont	Y	Y	Y	Y	Y	Y		
Virginia[9]	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 the Kaiser Family Foundation with the Georgetown University Center for Children and Families, 2018.

Table presents rules in effect as of January 1, 2018.

Table 8 Notes

1. This column indicates whether individuals can create an online account for ongoing management of their Medicaid coverage 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. Georgia implemented functionality for enrollees to go paperless and receive notices electronically in 2017.
4. Illinois implemented online accounts in October 2017.
5. In Minnesota, not all notices can be viewed online. All notices are always mailed.
6. Missouri does not offer online accounts but online applications are able to return to the application to check its status.
7. In Texas, only certain notices can be viewed from a client's online account if the client does not elect to receive electronic notices.
8. Utah implemented functionality for enrollees to upload verification documentation to their online accounts in 2017.
9. Virginia implemented functionality for enrollees to view notices and receive notices electronically in 2017.

Table 9
Mobile Access to Online Medicaid Applications and Accounts, January 2018

State	Online Application[1] (Total = 50)			Online Account[1] (Total = 42)		
	Can Complete and Submit using Mobile Device	Mobile-Friendly Design	Mobile App Available	Can Access using Mobile Device	Mobile-Friendly Design	Mobile App Available
Total	**31**	**9**	**4**	**30**	**13**	**5**
Alabama	Y					
Alaska	Y			N/A		N/A
Arizona						
Arkansas				N/A		N/A
California						
Colorado				Y	Y	Y
Connecticut[2]	Y	Y		Y	Y	
Delaware	Y			Y		
District of Columbia						
Florida						
Georgia	Y			Y		
Hawaii	Y			Y		
Idaho	Y			Y		
Illinois	Y			Y		
Indiana				Y		
Iowa	Y		Y	N/A		N/A
Kansas	Y			N/A		N/A
Kentucky	Y			Y		
Louisiana	Y			Y		
Maine	Y			Y		
Maryland	Y	Y	Y	Y	Y	Y
Massachusetts						
Michigan	Y	Y		Y	Y	
Minnesota				Y		
Mississippi				N/A		N/A
Missouri				N/A		N/A
Montana				Y	Y	
Nebraska						
Nevada	Y			Y		
New Hampshire	Y			Y	Y	
New Jersey[3]	Y	Y	Y	N/A		N/A
New Mexico	Y	Y		Y	Y	
New York	Y			Y		
North Carolina	Y			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						
South Dakota						
Tennessee	N/A		N/A	N/A		N/A
Texas	Y	Y		Y	Y	Y
Utah	Y			Y	Y	
Vermont						
Virginia						
Washington[4]	Y		Y	Y		Y
West Virginia	Y			Y		
Wisconsin	Y			Y		
Wyoming	Y	Y		Y	Y	

SOURCE: Based on a national survey conducted by the Kaiser Family Foundation with the Georgetown University Center for Children and Families, 2018.

Table presents rules in effect as of January 1, 2018.

Table 9 notes

1. N/A responses indicate that the state does not have an online application and/or an online account.
2. Connecticut implemented mobile-friendly designs for online applications and accounts in 2017.
3. New Jersey implemented a mobile-friendly design for online applications in 2017.
4. Washington launched a downloadable mobile application that allows enrollees to apply for Medicaid and manage their accounts in April 2017.

Table 10
Medicaid Eligibility Systems for Children, Pregnant Women, Parents, and Expansion Adults, January 2018

State	Able to Make Real-Time Determinations[1] (<24 Hours)	Share of Determinations Completed in Real-Time[1]				State Regularly Checks Databases for Updated Data[2]
		<25%	25%-50%	50%-75%	75%+	
Total	**40**	**16**	**5**	**6**	**11**	**28**
Alabama	Y				Y	Y
Alaska						
Arizona	Y		Y			
Arkansas	Y	Y				
California	Y	Y				Y
Colorado	Y			Y		Y
Connecticut	Y				Y	
Delaware	Y	Y				Y
District of Columbia	Y			Y		
Florida	Y		Y			Y
Georgia[3]	Y	Y				
Hawaii	Y		Y			Y
Idaho	Y			Y		
Illinois						Y
Indiana						Y
Iowa	Y		Not Reported			Y
Kansas	Y	Y				Y
Kentucky	Y			Y		Y
Louisiana	Y	Y				
Maine						Y
Maryland	Y				Y	
Massachusetts	Y			Y		Y
Michigan	Y		Y			Y
Minnesota	Y		Y			
Mississippi	Y	Y				
Missouri	Y				Y	Y
Montana	Y				Y	
Nebraska	Y	Y				Y
Nevada	Y	Y				Y
New Hampshire	Y	Y				
New Jersey						Y
New Mexico	Y				Y	
New York	Y				Y	
North Carolina	Y		Not Reported			
North Dakota						
Ohio	Y	Y				Y
Oklahoma	Y				Y	Y
Oregon	Y			Y		Y
Pennsylvania	Y	Y				Y
Rhode Island	Y				Y	Y
South Carolina	Y	Y				
South Dakota						Y
Tennessee						
Texas						Y
Utah						Y
Vermont	Y				Y	
Virginia	Y	Y				
Washington	Y				Y	
West Virginia						Y
Wisconsin	Y	Y				Y
Wyoming	Y	Y				

SOURCE: Based on a national survey conducted by the Kaiser Family Foundation with the Georgetown University Center for Children and Families, 2018.

Table presents rules in effect as of January 1, 2018.

Table 10 Notes

1. Under the Affordable Care Act (ACA), states must seek to verify eligibility criteria based on electronic data matches with reliable sources of data. These columns reflect whether the state system is able to make real-time eligibility determinations, defined as within 24 hours, and the share of applications for non-disabled groups (children, pregnant women, parents, and expansion adults) that are determined eligible in real-time.
2. This column indicates whether the state checks against other databases on a routine basis for changes in circumstances that would affect eligibility for enrollees.
3. Georgia added functionality to complete real-time eligibility determinations in 2017.

Table 11
Coordination between Medicaid and Other Systems, January 2018

State	System determines eligibility for: CHIP[1, 2] (Total = 36)	Seniors and Individuals with Disabilities[1]	At Least One Non-Health Programs[1]	Marketplace Structure[3]	FFM Conducts Assessment or Final Determination for Medicaid Eligibility[4] (Total Using FFM = 39)
Total	**34**	**30**	**23**	**FFM: 28 Partnership: 6 SBM-FP: 5 SBM: 12**	**Assessment: 30 Determination: 9**
Alabama	Y			FFM	Determination
Alaska	N/A (M-CHIP)			FFM	Determination
Arizona	Y	Y		FFM	Assessment
Arkansas	Y			SBM-FP	Determination
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		FFM	Assessment
Georgia[6]	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			Partnership	Assessment
Kansas[7]	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	Y	Y	Y	SBM-FP	Assessment
New Hampshire	N/A (M-CHIP)	Y	Y	Partnership	Assessment
New Jersey[8]	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	Y	Y	FFM	Assessment
North Dakota	Y			FFM	Assessment
Ohio[9]	N/A (M-CHIP)	Y	Y	FFM	Assessment
Oklahoma	N/A (M-CHIP)			FFM	Assessment
Oregon	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)			FFM	Assessment
South Dakota				FFM	Assessment
Tennessee				FFM	Determination
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	Assessment
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 the Kaiser Family Foundation with the Georgetown University Center for Children and Families, 2018.

Table presents rules in effect as of January 1, 2018.

Table 11 Notes

1. These columns indicate whether the state Medicaid eligibility system for non-disabled groups also determines eligibility for CHIP, seniors and individuals with disabilities, 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 provide 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 non-disabled 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 with disabilities, and non-health programs.
6. Georgia integrated CHIP into its Medicaid eligibility system in 2017.
7. Kansas integrated non-health programs into its Medicaid eligibility system in 2017.
8. New Jersey integrated eligibility decisions for seniors and individuals with disabilities into its Medicaid eligibility system for non-disabled groups in 2017.
9. Ohio integrated non-health programs into its Medicaid eligibility system as of January 1, 2018.
10. In Wyoming, the FFM conducts assessments rather than final determinations of CHIP eligibility.

Table 12
Presumptive Eligibility in Medicaid and CHIP, January 2018[1]

State	Children		Pregnant Women		Parents	Adults[2] (Total = 33)	Family Planning Expansion[2] (Total = 29)	Former Foster Youth
	Medicaid	CHIP[2] (Total =36)	Medicaid	CHIP[2] (Total = 5)				
Total	**20**	**11**	**30**	**3**	**9**	**6**	**6**	**10**
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				Y
Colorado	Y	Y	Y	Y			N/A	
Connecticut	Y	Y	Y	N/A			Y	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	Y	Y	Y	N/A	Y	N/A	N/A	Y
Illinois	Y	Y	Y	N/A			N/A	
Indiana	Y	Y	Y	N/A	Y	Y	Y	Y
Iowa	Y	Y	Y	N/A	Y			Y
Kansas[3]	Y	Y	Y	N/A		N/A	N/A	
Kentucky			Y	N/A				
Louisiana				N/A				
Maine			Y	N/A		N/A		
Maryland		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	N/A	
New Mexico[4]	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			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		N/A (M-CHIP)		N/A		N/A		
South Dakota				N/A		N/A	N/A	
Tennessee[5]	Y		Y	N/A		N/A	N/A	
Texas			Y	N/A		N/A	N/A	
Utah			Y	N/A		N/A	N/A	
Vermont		N/A (M-CHIP)		N/A				
Virginia						N/A		
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 the Kaiser Family Foundation with the Georgetown University Center for Children and Families, 2018.

Table presents rules in effect as of January 1, 2018.

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 coverage to individuals temporarily 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 provide 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. Kansas limits presumptive eligibility for children to six sites.
4. 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.
5. Tennessee limits presumptive eligibility to infants.

Table 13
Medicaid Renewal Processes for Children, Pregnant Women, Parents, and Expansion Adults, January 2018

State	Processing Automated Renewals[1]	Percentage of Renewals that are Automated[1]				Prepopulated Renewal Form[2]	Form Populated with Updated Data[2]	Telephone Renewals[3]	12-Month Continuous Eligibility[4]	
		<25%	25%-50%	50%-75%	75%+				Medicaid	CHIP[5] (Total =36)
Total	**46**	**11**	**10**	**14**	**7**	**45**	**14**	**41**	**24**	**26**
Alabama	Y				Y	Y		Y	Y	Y
Alaska						Y			Y	N/A (M-CHIP)
Arizona	Y			Y		Y	Y	Y		
Arkansas	Y				Y			Y		Y
California	Y		Y			Y	Y	Y	Y	N/A (M-CHIP)
Colorado	Y				Y	Y	Y	Y	Y	Y
Connecticut	Y			Y		Y		Y		
Delaware	Y	Y				Y	Y	Y		Y
District of Columbia[6]	Y				Y	Y	Y	Y		N/A (M-CHIP)
Florida[7]	Y		Y					Y		Y
Georgia	Y	Y				Y				
Hawaii	Y		Not Reported			Y	Y	Y		N/A (M-CHIP)
Idaho	Y				Y	Y	Y	Y	Y	Y
Illinois[8]	Y	Y				Y			Y	Y
Indiana[9]	Y			Y		Y	Y	Y		
Iowa[8]	Y			Y		Y	Y	Y	Y	Y
Kansas[10]	Y		Y			Y			Y	Y
Kentucky	Y			Y		Y		Y		
Louisiana	Y			Y				Y	Y	Y
Maine						Y		Y	Y	Y
Maryland[11]	Y			Y		Y		Y		N/A (M-CHIP)
Massachusetts	Y	Y				Y		Y		
Michigan	Y			Y		Y			Y	N/A (M-CHIP)
Minnesota	Y		Y			Y	Y			N/A (M-CHIP)
Mississippi	Y		Y			Y		Y	Y	Y
Missouri	Y	Y				Y		Y		
Montana[12]	Y			Y		Y		Y	Y	Y
Nebraska	Y	Y				Y		Y		N/A (M-CHIP)
Nevada						Y		Y		Y
New Hampshire	Y	Y				Y	Y	Y		N/A (M-CHIP)
New Jersey	Y	Y				Y		Y	Y	Y
New Mexico	Y			Y		Y		Y	Y	N/A (M-CHIP)
New York[12]	Y		Y			Y		Y	Y	Y
North Carolina[6]	Y			Y		Y	Y	Y	Y	Y
North Dakota	Y		Not Reported			Y		Y	Y	Y
Ohio	Y				Y	Y		Y	Y	N/A (M-CHIP)
Oklahoma	Y		Y					Y		N/A (M-CHIP)
Oregon[8]	Y		Not Reported			Y		Y	Y	Y
Pennsylvania	Y	Y				Y		Y		Y
Rhode Island	Y				Y	Y	Y	Y		N/A (M-CHIP)
South Carolina	Y		Y			Y			Y	N/A (M-CHIP)
South Dakota	Y		Y			Y		Y		
Tennessee										Y
Texas[13]	Y		Not Reported			Y	Y	Y		Y
Utah[10, 14]	Y			Y		Y				Y
Vermont[15]	Y			Y				Y		N/A (M-CHIP)
Virginia	Y		Y			Y		Y		
Washington	Y			Y		Y		Y	Y	Y
West Virginia[10]	Y	Y				Y			Y	Y
Wisconsin[8]	Y	Y				Y		Y		
Wyoming						Y		Y	Y	Y

SOURCE: Based on a national survey conducted by the Kaiser Family Foundation with the Georgetown University Center for Children and Families, 2018.

Table presents rules in effect as of January 1, 2018.

Table 13 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. These columns indicate whether the state system is able to process automated renewals and the share of renewals for non-disabled groups that are successfully completed via automated processes.
2. Under the ACA, when a state is unable to process an automated renewal, it is expected to send the enrollee a renewal notice or form pre-populated with data on file. These columns indicate if a state is able to produce pre-populated renewal forms and whether the pre-populated information is updated with information accessed from electronic sources of data.
3. This column indicates whether enrollees are able to complete a Medicaid renewal over the phone at the state level, either through the Medicaid agency or a State-based Marketplace call center.
4. Under state option, states may provide 12-month continuous eligibility for children, allowing them to remain enrolled by disregarding changes in income or family size until renewal.
5. N/A (M-CHIP) responses indicate that the state does not provide a separate CHIP program for uninsured children.
6. The District of Columbia and North Carolina began producing prepopulated renewal forms in 2017.
7. Florida's renewal form is prepopulated when the enrollee completes an online renewal, but the state does not mail prepopulated forms. In Florida, children in Medicaid younger than age five receive 12-month continuous eligibility and children ages five and older receive six months of continuous eligibility.
8. Illinois, Iowa, Oregon and Wisconsin began completing automated renewals in 2017.
9. In Indiana, 12-month continuous eligibility is provided only to children under age 3.
10. In Kansas, Utah, and West Virginia, families may report changes by telephone but still need to sign and return the pre-populated renewal form.
11. In Maryland, newborns are provided 12-month continuous eligibility.
12. Montana and New York provide 12-month continuous eligibility to parents and expansion adults through a Section 1115 waiver.
13. In Texas, a child in CHIP with income below 185% receives 12 months of continuous eligibility; at or above 185% of the federal poverty level (FPL), a child in CHIP 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.
14. In Utah, enrollees must confirm/verify renewal information if they submit information over the phone.
15. Vermont prepopulates renewal forms with contact information only.

Table 14
Premium, Enrollment Fee, and Cost Sharing Requirements for Children, January 2018

State	Premiums/Enrollment Fees			Cost Sharing		
	Required in Medicaid	Required in CHIP (Total = 36)[1]	Lowest Income at Which Premiums Begin (Percent of the FPL)[2]	Required in Medicaid	Required in CHIP (Total = 36)[1]	Lowest Income at Which Cost Sharing Begins (Percent of the FPL)[2]
Total	**4**	**26**		**3**	**24**	
Alabama		Y	141%		Y	141%
Alaska		N/A (M-CHIP)			N/A (M-CHIP)	
Arizona		Y	133%			
Arkansas					Y	142%
California	Y	N/A (M-CHIP)	160%		N/A (M-CHIP)	
Colorado		Y	157%		Y	142%
Connecticut		Y	249%		Y	196%
Delaware		Y	142%			
District of Columbia		N/A (M-CHIP)			N/A (M-CHIP)	
Florida[3]		Y	133%		Y	133%
Georgia[4]		Y	133%		Y	138%
Hawaii		N/A (M-CHIP)			N/A (M-CHIP)	
Idaho		Y	142%		Y	142%
Illinois		Y	157%		Y	142%
Indiana		Y	158%		Y	158%
Iowa		Y	182%		Y	182%
Kansas		Y	166%			
Kentucky					Y	143%
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	150%
New Mexico		N/A (M-CHIP)		Y	N/A (M-CHIP)	190%
New York		Y	160%			
North Carolina		Y	159%		Y	133%
North Dakota					Y	133%
Ohio		N/A (M-CHIP)			N/A (M-CHIP)	
Oklahoma		N/A (M-CHIP)			N/A (M-CHIP)	
Oregon						
Pennsylvania		Y	208%		Y	208%
Rhode Island		N/A (M-CHIP)			N/A (M-CHIP)	
South Carolina		N/A (M-CHIP)			N/A (M-CHIP)	
South Dakota						
Tennessee[5]				Y	Y	100%
Texas		Y	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		Y	201%	Y	Y	133%
Wyoming					Y	133%

SOURCE: Based on a national survey conducted by the Kaiser Family Foundation with the Georgetown University Center for Children and Families, 2018.

Table presents rules in effect as of January 1, 2018.

Table 14 notes

1. N/A (M-CHIP) responses indicate that the state does not provide 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. Tennessee has waiver authority to charge cost sharing for children between 100% and 133% FPL.

Table 15

Premiums and Enrollment Fees for Children at Selected Income Levels, January 2018[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)	Family Maximum[3]
MONTHLY PAYMENTS (24 states)						
Arizona[4]	$40	$50	N/A	N/A	N/A	Y
California[5]	$0	$13	$13	N/A	N/A	Y
Connecticut[6]	$0	$0	$30	$30	N/A	Y
Delaware[7]	$15	$25	N/A	N/A	N/A	Family Based Premium
Florida	$15	$20	N/A	N/A	N/A	Family Based Premium
Georgia	$11	$29	N/A	N/A	N/A	
Idaho	$15	N/A	N/A	N/A	N/A	
Illinois[8]	$0	$15	$40	$40	N/A	Y
Indiana[9]	$0	$33	$53	N/A	N/A	Y
Iowa[10]	$0	$10	$20	$20	N/A	Y
Kansas[11]	$0	$30	N/A	N/A	N/A	Family Based Premium
Louisiana	$0	$0	$50	N/A	N/A	Family Based Premium
Maine[12]	$0	$32	N/A	N/A	N/A	Y
Maryland	$0	$0	$66	$66	N/A	Family Based Premium
Massachusetts[13]	$12	$20	$28	$28	N/A	Y
Michigan	$0	$10	N/A	N/A	N/A	Family Based Premium
Missouri[14]	$19 | $24 | $29	$62 | $78 | $95	$152 | $191 | $231	$152 | $191 | $231	N/A	
New Jersey	$0	$43	$86	$145	$145	Y
New York[15]	$0	$9	$30	$45	$60	Family Based Premium
Pennsylvania[16]	$0	$0	$55	$88	N/A	
Vermont[17]	$0	$15	$20/$60	$20/$60	N/A	Family Based Premium
Washington[18]	$0	$0	$20	$30	N/A	Y
West Virginia[19]	$0	$0	$35	$35	N/A	Y
Wisconsin	$0	$10	$34	$98	N/A	
QUARTERLY PAYMENTS (2 states)						
Nevada	$50	$80	N/A	N/A	N/A	Family Based Premium
Utah	$75	$75	N/A	N/A	N/A	Family Based Premium
ANNUAL PAYMENTS (4 states)						
Alabama[20]	$104	$104	$104	$104	N/A	Y
Colorado[21]	$0	$25	$75	N/A	N/A	Y
North Carolina[22]	$0	$50	N/A	N/A	N/A	Y
Texas	$35	$50	N/A	N/A	N/A	Family Based Enrollment Fee
NO PREMIUMS OR ENROLLMENT FEES (21 states)						
Alaska	--	--	--	--	--	--
Arkansas	--	--	--	--	--	--
District of Columbia	--	--	--	--	--	--
Hawaii	--	--	--	--	--	--
Kentucky	--	--	--	--	--	--
Minnesota	--	--	--	--	--	--
Mississippi	--	--	--	--	--	--
Montana	--	--	--	--	--	--
Nebraska	--	--	--	--	--	--
New Hampshire	--	--	--	--	--	--
New Mexico	--	--	--	--	--	--
North Dakota	--	--	--	--	--	--
Ohio	--	--	--	--	--	--
Oklahoma	--	--	--	--	--	--
Oregon	--	--	--	--	--	--
Rhode Island	--	--	--	--	--	--
South Carolina	--	--	--	--	--	--
South Dakota	--	--	--	--	--	--
Tennessee	--	--	--	--	--	--
Virginia	--	--	--	--	--	--
Wyoming	--	--	--	--	--	--

SOURCE: Based on a national survey conducted by the Kaiser Family Foundation with the Georgetown University Center for Children and Families, 2018.

Table presents rules in effect as of January 1, 2018.

TABLE 15 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 in premiums. Family based premium indicates that the premium amount listed in the table is per family rather than per child.
4. 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.
5. In California, the family maximum premium is $39.
6. In Connecticut, the family maximum premium is $50.
7. 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.
8. 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.
9. 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.
10. 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.
11. 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 incomes up to 241% FPL.
12. In Maine, the family maximum premium is $64.
13. In Massachusetts, the family maximum premium is $28.
14. In Missouri premiums vary by family size. Amounts shown are for 2-person, 3-person, and 4-person family. Rates increase based on family size with no cap. Premiums are tied to a percentage of the FPL and change annually.
15. In New York, there is a maximum premium of three times the child rate.
16. In Pennsylvania, premiums vary by contractor. The average amount is shown.
17. 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.
18. In Washington, there is a maximum premium of $40 for families with incomes at 251% FPL and $60 for families with incomes at 301% FPL.
19. In West Virginia, the family maximum premium is $71.
20. In Alabama, the family maximum annual enrollment fee is $312.
21. 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.
22. In North Carolina, the family maximum annual enrollment fee is $100.

Table 16
Disenrollment Policies for Non-Payment of Premiums in Children's Coverage, January 2018

State	Grace Period (amount of time) Before a Child Loses Coverage for Nonpayment[1]	Lockout Period in Separate CHIP Program[2]
Total		**15**
MONTHLY PAYMENTS (24 states)		
Arizona	60 days	2 months
California	60 days	N/A (M-CHIP)
Connecticut[3]	Until Renewal	None
Delaware	60 days	None
Florida	30 days	1 month
Georgia	60 days	1 month
Idaho[3]	Until renewal	None
Illinois	60 days	None
Indiana	60 days	90 days
Iowa	44 days	None
Kansas	60 days	90 days
Louisiana	60 days	90 days
Maine[4]	12 months	up to 90 days
Maryland	60 days	N/A (M-CHIP)
Massachusetts	60 days	90 days
Michigan	60 days	N/A (M-CHIP)
Missouri[5]	30 days	90 days
New Jersey	60 days	90 days
New York	30 days	None
Pennsylvania	90 days	90 days
Vermont[3]	Until Renewal	N/A (M-CHIP)
Washington	90 days	90 days
West Virginia[3, 6]	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[7]	--	--
Colorado[8]	--	--
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 the Kaiser Family Foundation with the Georgetown University Center for Children and Families, 2018.

Table presents rules in effect as of January 1, 2018.

TABLE 16 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 provide a separate CHIP program for uninsured children.
3. 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.
4. 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.
5. In Missouri, only children in families with incomes above 225% of the federal poverty level (FPL) are subject to the lockout period.
6. In West Virginia, children are not disenrolled for non-payment of premiums, but past due amounts are subject to third-party collections after 120 days.
7. 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 30 days to pay the annual enrollment fee to avoid disenrollment.
8. Colorado's annual enrollment fee is required before a child enrolls in coverage.
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 17
Cost Sharing Amounts for Selected Services for Children at Selected Income Levels, January 2018[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	**19**	**12**	**17**	**15**	**20**	**12**	**17**	**15**
Alabama	$13	$60	$60	$200	$13	$60	$60	$200
Alaska	--	--	--	--	--	--	--	--
Arizona	--	--	--	--	--	--	--	--
Arkansas	$10	$10	$10	20% of reimbursement rate for first day	$10	$10	$10	20% of reimbursement rate for first day
California	--	--	--	--	--	--	--	--
Colorado	$5	$30	$30	$20	$10	$50	$50	$50
Connecticut	$0	$0	$0	$0	$10	$0	$0	$0
Delaware	--	--	--	--	--	--	--	--
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	$3	$0	$8	$50	$3	$0	$8	$50
Louisiana	--	--	--	--	--	--	--	--
Maine	--	--	--	--	--	--	--	--
Maryland	--	--	--	--	--	--	--	--
Massachusetts	--	--	--	--	--	--	--	--
Michigan	--	--	--	--	--	--	--	--
Minnesota	--	--	--	--	--	--	--	--
Mississippi	$5	$15	$15	$0	$5	$15	$15	$0
Missouri	--	--	--	--	--	--	--	--
Montana	$3	$5	$5	$25	$3	$5	$5	$25
Nebraska	--	--	--	--	--	--	--	--
Nevada	--	--	--	--	--	--	--	--
New Hampshire	--	--	--	--	--	--	--	--
New Jersey	$5	$10	$10	$0	$5	$35	$35	$0
New Mexico	$0	$0	$0	$0	$5	$0	$0	$25
New York	--	--	--	--	--	--	--	--
North Carolina	$5	$0	$10	$0	$5	$0	$25	$0
North Dakota	$0	$5	$5	$50	N/A	N/A	N/A	N/A
Ohio	--	--	--	--	--	--	--	--
Oklahoma	--	--	--	--	--	--	--	--
Oregon	--	--	--	--	--	--	--	--
Pennsylvania[2, 3]	$0	$0	$0	$0	$0	$0	$0	$0
Rhode Island	--	--	--	--	--	--	--	--
South Carolina	--	--	--	--	--	--	--	--
South Dakota	--	--	--	--	--	--	--	--
Tennessee[4]	$5	$0	$10	$5	$15/$20	$0	$50	$100
Texas	$5	$0	$5	$35	$25	$0	$75	$125
Utah[5]	$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, 6]	$15	$35	$35	$25	$20	$35	$35	$25
Wisconsin[7]	$0.50-$3	$0	$0	$3	$0.50-$3	$0	$0	$3
Wyoming[2]	$10	$25	$25	$50	$10	$25	$25	$50

SOURCE: Based on a national survey conducted by the Kaiser Family Foundation with the Georgetown University Center for Children and Families, 2018.
Table presents rules in effect as of January 1, 2018.

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 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, West Virginia, and Wyoming, the emergency room copayment is waived if the child is admitted.
3. Pennsylvania charges cost sharing but it does not begin charging until >208% of the federal poverty level (FPL), so no charges are reported in the table.
4. Tennessee covers children in its regular Medicaid program, called TennCare, with incomes up to 195% of the federal poverty level (FPL) for infants, 142% for children ages 1 – 5, and 133% FPL for children 6 – 18. Children who lose eligibility in TennCare qualify for coverage under a Medicaid expansion program, called TennCare Standard, if they are uninsured, have no access to insurance, and have family incomes below 211% FPL. Tennessee also operates a separate CHIP program, called Cover Kids, which covers uninsured children of all ages who do not qualify for TennCare or TennCare Standard and have incomes below 250% FPL. Children enrolled in TennCare have no copayments. The values shown before the "|" represent copayments for children enrolled in TennCare Standard, whereas the values after the "|" represent copayments for children enrolled in Cover Kids. The values shown before a "/" represent copayments for a primary care provider, whereas the values after the "/" represent copayments for a provider that is a specialist.
5. 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.
6. In West Virginia, the copayment for a non-preventive physician visit is waived if the child goes to his or her medical home.
7. In Wisconsin, the copayment for children's non-preventive physician visits will vary depending on the cost of the visit.

Table 18
Cost Sharing Amounts for Prescription Drugs for Children at Selected Income Levels, January 2018[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	**15**	**17**	**14**	**18**	**19**	**16**
Alabama	$5	$25	$28	$5	$25	$28
Alaska	--	--	--	--	--	--
Arizona	--	--	--	--	--	--
Arkansas	$5	$5	$5	$5	$5	$5
California	--	--	--	--	--	--
Colorado	$3	$10	N/C	$5	$15	N/C
Connecticut	$0	$0	$0	$5	$10	$10
Delaware	--	--	--	--	--	--
District of Columbia	--	--	--	--	--	--
Florida	$5	$5	$5	$5	$5	$5
Georgia	$0.50	$0.50-$3	$0.50-$3	$0.50	$0.50-$3	$0.50-$3
Hawaii	--	--	--	--	--	--
Idaho	$0	$0	$0	N/A	N/A	N/A
Illinois	$2	$3.90	$3.90	$3	$5	$5
Indiana	$0	$0	$0	$3	$10	$10
Iowa	$0	$0	$0	$0	$0	$0
Kansas	--	--	--	--	--	--
Kentucky	$1	$4	$8	$1	$4	$8
Louisiana	--	--	--	--	--	--
Maine	--	--	--	--	--	--
Maryland	--	--	--	--	--	--
Massachusetts	--	--	--	--	--	--
Michigan	--	--	--	--	--	--
Minnesota	--	--	--	--	--	--
Mississippi	$0	$0	$0	$0	$0	$0
Missouri	--	--	--	--	--	--
Montana[2]	$0	$0	$0	$0	$0	$0
Nebraska	--	--	--	--	--	--
Nevada	--	--	--	--	--	--
New Hampshire	--	--	--	--	--	--
New Jersey	$1	$5	$5	$5	$5	$5
New Mexico	$0	$0	$0	$2	$2	$2
New York	--	--	--	--	--	--
North Carolina	$1	$1	$3	$1	$1	$10
North Dakota	$2	$2	$2	N/A	N/A	N/A
Ohio	--	--	--	--	--	--
Oklahoma	--	--	--	--	--	--
Oregon	--	--	--	--	--	--
Pennsylvania[3]	$0	$0	N/C	$0	$0	N/C
Rhode Island	--	--	--	--	--	--
South Carolina	--	--	--	--	--	--
South Dakota	--	--	--	--	--	--
Tennessee[4]	$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	$0	$10	$15	$0	$10	$15
Wisconsin	$1	$3	$3	$1	$3	$3
Wyoming	$5	$10	N/C	$5	$10	N/C

SOURCE: Based on a national survey conducted by the Kaiser Family Foundation with the Georgetown University Center for Children and Families, 2018.
Table presents rules in effect as of January 1, 2018.

Table 18 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 "- -"; 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. Pennsylvania charges cost sharing but it does not begin charging until >208% of the federal poverty level (FPL), so no charges are reported in the table.
4. 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.

Table 19

Premium and Cost Sharing Requirements for Selected Services for Section 1931 Parents, January 2018[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**	**39**		**28**	**21**	**27**	**34**	**38**	**37**
Alabama		Y	0%	$1.30-$3.90	$3.90	$50	$0.65-$3.90	$0.65-$3.90	$0.65-$3.90
Alaska		Y	0%	$10	$0	$50/day	$3	$3	$3
Arizona		Y	0%	$3.40	$0	$0	$2.30	$2.30	$2.30
Arkansas		Y	0%	$0	$0	10% cost of first day	$0.50-$3.90	$0.50-$3.90	$0.50-$3.90
California		Y	0%	$1	$5	$0	$1	$1	$1
Colorado[2]		Y	0%	$2	$6	$4	$3	$3	$3
Connecticut			--	--	--	--	--	--	--
Delaware[3]		Y	0%	$0	$0	$0	$0.50-$3	$0.50-$3	$0.50-$3
District of Columbia			--	--	--	--	--	--	--
Florida		Y	0%	$2	5% of first $300	$3	$0	$0	$0
Georgia		Y	0%	$0	$0	$12.50	$0.50-$3	$0.50-$3	$0.50-$3
Hawaii			--	--	--	--	--	--	--
Idaho			--	--	--	--	--	--	--
Illinois		Y	0%	$3.90	$3.90	$3.90/day	$2	$3.90	$3.90
Indiana[4]	Y, >0%	Y	0%	$4	$8/$25 subsequent visits	$75	$4	$4	$8
Iowa[5]		Y	0%	$3	$3	$0	$1	$1	$2-3
Kansas			--	--	--	--	--	--	--
Kentucky[6]		Y	0%	$3	$8	$50	$1	$4	5% cost ($8 min/ $20 max)
Louisiana		Y	0%	$0	$0	$0	$0.50-$3	$0.50-$3	$0.50-$3
Maine[7]		Y	0%	$0	$3	up to $3 per day	$3	$3	$3
Maryland		Y	0%	$0	$0	$0	$1-$3	$1-$3	$1-$3
Massachusetts[8]		Y	0%	$0	$0	$3	$3.65	$3.65	$3.65
Michigan[9]		Y	0%	$4	$8	$100	$4	$4	$8
Minnesota		Y	0%	$3	$3.50	$0	$1	$3	$3
Mississippi		Y	0%	$3	$0	$10	$3	$3	$3
Missouri		Y	0%	$1	$3	$10	$0.50-$2	$0.50-$2	$0.50-$2
Montana		Y	0%	$4	$8	$75	$0	$4	$8
Nebraska		Y	0%	$2	$0	$15	$2	$3	$3
Nevada			--	--	--	--	--	--	--
New Hampshire		Y	100%	$0	$0	$0	$0	$1	$2
New Jersey			--	--	--	--	--	--	--
New Mexico			--	--	--	--	--	--	--
New York		Y	100%	$0	$3	$25/discharge	$1	$3	$3
North Carolina		Y	0%	$3	$0	$3/day	$3	$3	$3
North Dakota		Y	0%	$2	$0	$75	$0	$3	$3
Ohio		Y	0%	$0	$3	$0	$0	$2	$3
Oklahoma		Y	0%	$4	$4	$10/day; $90 max	$4	$4	$4
Oregon			--	--	--	--	--	--	--
Pennsylvania[10]		Y	0%	$0.65-$3.80	$0.50-$3	$3/day	$1	$3	$3
Rhode Island			--	--	--	--	--	--	--
South Carolina		Y	0%	$3.30	$0	$25	$3.40	$3.40	$3.40
South Dakota		Y	0%	$3	Full amount	$50	$1	$3.30	N/C
Tennessee		Y	0%	$0	$0	$0	$1.50	$3	$3
Texas			--	--	--	--	--	--	--
Utah[11]		Y	20%	$4	$8	$75	$4	$4	$4
Vermont		Y	0%	$3	$0	$0	$1-$3	$1-$3	$1-$3
Virginia[12]		Y	0%	$1	$0	$75	$1	$3	$3
Washington			--	--	--	--	--	--	--
West Virginia[13]		Y	0%	$0-$4	$8	$0-$75	$0-$3	$0-$3	$0-$3
Wisconsin[7]		Y	0%	$0.50-$3	$0	$3	$1	$3	$3
Wyoming		Y	0%	$2.45	$3.65	$0	$0.65	$3.65	$3.65

SOURCE: Based on a national survey conducted by the Kaiser Family Foundation with the Georgetown University Center for Children and Families, 2018.

Table presents rules in effect as of January 1, 2018.

TABLE 19 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. Colorado increased copayments for non-emergency use of the ER and generic drugs, and decreased copayments for inpatient hospital visits in 2017.
3. In Delaware, parents have a $15 per month cap on out of pocket expenses from copayments.
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 and $25 for subsequent use of emergency room for a non-emergency. Indiana changed its monthly payments to a tiered structure instead of a flat 2% of income and removed the $25 copay for subsequent use of the emergency room when it renewed its waiver in February 2018. These changes are not reflected in the table since data are reported as of January 2018.
5. 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.
6. In Kentucky, enrollees are charged 5% coinsurance for non-preferred brand-name drugs, with a minimum of $8 and a maximum of $20.
7. In Maine and Wisconsin, copayments begin above 0% of the federal poverty level (FPL).
8. 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.
9. Michigan increased cost sharing amounts in 2017. Parents with incomes greater than 100% FPL have cost sharing listed in the table. For parents with incomes less than or equal to 100% FPL cost sharing is: non-preventative physician visit is $2, non-emergency use of ER is $3, inpatient hospital visit is $50, preferred drugs are $1, and non-preferred drugs are $3.
10. In Pennsylvania, the inpatient hospital copayment is subject to a maximum of $21 per stay.
11. In Utah, enrollees under the Temporary Aid to Needy Families (TANF) payment limit are exempt from paying copayments. In 2017, Utah increased copayments non-preventive physician visits, non-emergency use of the ER, and all prescription drugs. Utah decreased copayments for inpatient hospital visits.
12. Virginia decreased copayments for inpatient hospital visits in 2017.
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%.

Table 20

Premium and Cost Sharing Requirements for Selected Services for Medicaid Adults, January 2018[1]

State	Monthly Contributions/ Premiums	Cost Sharing	Income at Which Cost Sharing Begins (%FPL)	Cost Sharing Amounts for Selected Services					
				Non-Preventive Physician Visit	Non-Emergency Use of ER	Inpatient Hospital Visit	Generic Drug	Preferred Brand Name Drug	Non-Preferred Brand Name Drug
ADOPTED MEDICAID EXPANSION (32 states)									
Total	**5**	**22**		**15**	**12**	**14**	**18**	**20**	**21**
Alaska		Y	0%	$10	$0	$50/day	$3	$3	$3
Arizona			--	--	--	--	--	--	--
Arkansas[2]	Y, >100%	Y	100%	$8/10	$0	$140/day	$4	$4	$8
California		Y	0%	$1	$5	$0	$1	$1	$1
Colorado		Y	0%	$2	$3	$10/day	$1	$3	$3
Connecticut			--	--	--	--	--	--	--
Delaware[3]		Y	0%	$0	$0	$0	$0.50-$3	$0.50-$3	$0.50-$3
District of Columbia			--	--	--	--	--	--	--
Hawaii			--	--	--	--	--	--	--
Illinois		Y	0%	$3.90	$3.90	$3.90/day	$2	$3.90	$3.90
Indiana[4]	Y, >0%	Y	0%	$4	$8/ $25 subsequent visits	$75	$4	$4	$8
Iowa[5]	Y, >50%	Y	0%	$0	$8	$0	$0	$0	$0
Kentucky		Y	0%	$3	$8	$50	$1	$4	5% cost ($8 min/ $20 max)
Louisiana		Y	0%	$0	$0	$0	$0.50-$3	$0.50-$3	$0.50-$3
Maryland		Y	0%	$0	$0	$0	$1-$3	$1-$3	$1-$3
Massachusetts[6]		Y	0%	$0	$0	$3	$3.65	$3.65	$3.65
Michigan[7]	Y, >100%	Y	0%	$4	$8	$100	$4	$4	$4
Minnesota		Y	0%	$3	$3.50	$0	$1	$3	$3
Montana[8]	Y, >51%	Y	0%	$4/10% of state payment	$8	$75/10% of state peyment	$0	$4	$8
Nevada			--	--	--	--	--	--	--
New Hampshire[9]		Y	100%	$5	$0	$125	$4	$4	$8
New Jersey			--	--	--	--	--	--	--
New Mexico			--	--	--	--	--	--	--
New York		Y	100%	$0	$3	$25/discharge	$1	$3	$3
North Dakota		Y	0%	$2	$0	$75	$0	$3	$3
Ohio		Y	0%	$0	$0	$0	$0	$0	$3
Oregon			--	--	--	--	--	--	--
Pennsylvania[10]		Y	0%	$0.65-$3.80	$0.50-$3	$3/day	$1	$3	$3
Rhode Island			--	--	--	--	--	--	--
Vermont		Y	0%	$3	$0	$0	$1-$3	$1-$3	$1-$3
Washington			--	--	--	--	--	--	--
West Virginia[11]		Y	0%	$0-$4	$8	$0-$75	$0-$3	$0-$3	$0-$3
NOT ADOPTING MEDICAID EXPANSION AT THIS TIME (19 states)									
Total	**0**	**1**		**1**	**0**	**1**	**1**	**1**	**1**
Alabama									
Florida									
Georgia									
Idaho									
Kansas									
Maine									
Mississippi									
Missouri									
Nebraska									
North Carolina									
Oklahoma									
South Carolina									
South Dakota									
Tennessee									
Texas									
Utah									
Virginia									
Wisconsin[12]		Y	0%	$0.50-$3	$0	$3	$1	$3	$3
Wyoming									

SOURCE: Based on a national survey conducted by the Kaiser Family Foundation with the Georgetown University Center for Children and Families, 2018.

Table presents rules in effect as of January 1, 2018.

TABLE 20 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. 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. 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 and $25 for subsequent use of emergency room for a non-emergency. Indiana changed its monthly payments to a tiered structure instead of a flat 2% of income and removed the $25 copay for subsequent use of the emergency room when it renewed its waiver in February 2018. These changes are not reflected in the table since data are reported as of January 2018.
5. 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 on each monthly invoice.
6. In Massachusetts, generic drugs for diabetes, high blood pressure, and high cholesterol have a $1 copayment. There is a $36 annual cap for non-pharmacy copayments and a $250 annual cap for pharmacy copayments.
7. In Michigan, under Section 1115 waiver authority, expansion adults with incomes above 100% FPL are charged monthly premiums that are equal to 2% of income. Michigan increased cost sharing amounts in 2017. Expansion adults with incomes greater than 100% FPL have cost sharing listed in the table. For expansion adults with incomes less than or equal to 100% FPL cost sharing is: non-preventative physician visit is $2, non-emergency use of ER is $3, inpatient hospital visit is $50, preferred drugs are $1, and non-preferred drugs are $3. Beneficiaries cannot lose or be denied Medicaid eligibility, be denied health plan enrollment or be denied access to services, and providers may not deny services for failure to pay copayments or premiums. Cost sharing can be reduced through compliance with healthy behaviors Cost sharing and premiums cannot exceed 5% of household income.
8. In Montana, under Section 1115 waiver authority, non-medically frail expansion adults with incomes above 50% FPL have monthly premiums of 2% of income. Enrollees receive a credit toward their copayment obligations in the amount of their premiums. Individuals with incomes at or below 100% FPL will not be disenrolled due to unpaid premiums. Individuals with incomes above 100% FPL will be disenrolled for unpaid premiums after notice and a 90-day grace period. Disenrollment lasts until arrears are paid or until the state assesses debt against income taxes, which must happen by the end of the calendar quarter (maximum disenrollment period is 3 months). For copayments, amounts before the slash are for adults with incomes at or below 100% FPL; amounts after the slash are for adults with incomes above 100% FPL.
9. New Hampshire increased copayments for non-preventive physician visits in 2017.
10. In Pennsylvania, the inpatient hospital copayment is subject to a maximum of $21 per stay.

11. 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%.
12. Wisconsin offers Medicaid coverage to childless adults up to 100% FPL, but has not adopted the ACA Medicaid expansion. Copayments begin above 0% FPL.

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