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Medicaid and CHIP Eligibility and Enrollment Policies as of January 2021: Findings from a 50-State Survey

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Executive Summary

During the coronavirus pandemic, Medicaid has played a key role in providing coverage to millions of people who have lost their jobs or their health coverage. In addition, provisions included in the Families First Coronavirus Response Act (FFCRA) and the Coronavirus Aid, Relief and Economic Security (CARES) Act require states to maintain eligibility standards and provide continuous enrollment in Medicaid until the end of the public health emergency (PHE) in order to qualify for enhanced federal Medicaid funding. This report provides data on state Medicaid and CHIP eligibility levels and presents a snapshot of key aspects of state enrollment and renewal procedures in place during the COVID-19 PHE based on information from the 19th annual survey of Medicaid and CHIP program officials in the 50 states and DC. The report includes policies for children, pregnant women, parents and other non-elderly adults whose eligibility is based on Modified Adjusted Gross Income (MAGI) financial rules. Key findings from the survey include the following.

- **In 2020, Medicaid and CHIP eligibility is largely unchanged from 2020 as a result of [maintenance of eligibility \(MOE\) requirements](#).** State eligibility levels across all groups remained steady throughout 2020 due to the FFCRA's increased FMAP and MOE provisions. Children and pregnant women continue to be covered at higher income levels while the coverage gap for low-income adults persists in the 14 states that have not implemented the expansion. In October 2020, Nebraska became the 37th state, including the District of Columbia, to implement the Medicaid expansion following its adoption through a ballot initiative in 2018. Voters in Missouri and Oklahoma approved similar initiatives in 2020 and will implement the expansion later in 2021.
- **Even with the MOE, most states are renewing coverage when possible and taking other steps to prepare for the end of the PHE.** Most states are renewing coverage when they are able to confirm ongoing eligibility through electronic data sources. Two-thirds of states processing renewals also indicate they are sending renewal forms or requests for information when they are unable to renew coverage automatically through other data sources. Although states may not now terminate coverage for lack of response or ineligibility, sending renewal requests enables states to extend coverage for those who respond with proof that they remain eligible. In addition, just over a third of states have established a new 12-month renewal period when processing a change in circumstances that results in a new eligibility pathway. As states prepare for the end of the PHE, more than one-third are continuing or plan to take proactive steps to update enrollee mailing addresses. These actions will help to reduce backlogs and minimize coverage disruptions at the end of the PHE. Only 17 states reported an increase in new applications since the beginning of the COVID-19 PHE. This could be because of smaller than expected [declines](#) in employer-sponsored insurance, drops in [applications](#) at the beginning of the pandemic due to office closures, and the elimination of reapplications (where an individual loses coverage, often due to procedural reasons, then reapplies a short time later) due to the MOE requirements.
- **Administrative actions and Congressional proposals will have implications for Medicaid coverage and enrollment as well as for state efforts to plan for resuming normal operations after the PHE.** In a [letter to Governors](#), the Biden administration noted that the PHE is likely to extend

for the entirety of 2021 and promised a 60-day notice before the PHE is terminated or is allowed to expire. In December 2020, CMS released [guidance](#) outlining how states are expected to unwind emergency authorities and resume normal eligibility and enrollment processing after the end of the PHE. Although the extension of the PHE gives states more time to prepare for it to end, it is possible CMS will issue additional clarifying guidance, which would affect states' planning efforts. The administration also recently announced it will revise Medicaid waiver demonstration policy and rescind guidance related to work requirements and may also revise demonstration policy related to capped financing. In addition, the latest [COVID relief legislative package](#) includes provisions to provide states the option to extend coverage for pregnant women to 12 months postpartum in both Medicaid and CHIP and to provide financial incentives for non-expansion states to adopt the Medicaid expansion. The eligibility and enrollment policies presented here provide a baseline for assessing changes states may make in response to these federal policy shifts.

Introduction

Since its emergence a year ago, the coronavirus has had implications for the health of the nation and our economy, exposing gaps in the public health infrastructure and further highlighting the importance of health coverage. During this time, enrollment in Medicaid has increased as people sought coverage after losing jobs or income because of the pandemic. Through the Families First Coronavirus Response Act (FFCRA) and the Coronavirus Aid, Relief and Economic Security Act (CARES), states are required to maintain eligibility standards and provide continuous enrollment in Medicaid until the end of the public health emergency (PHE) in order to qualify for a 6.2 percentage point increase in Federal Medical Assistance Percentage (FMAP). The continuous coverage provision, along with new applications, resulted in Medicaid enrollment [growth](#) of 6.7% between February and September 2020 (the most recently available data). States were also able to adopt a range of options through temporary changes in their state Medicaid plans (SPAs), through [disaster-related waivers](#), and through other administrative authorities to streamline processes and connect individuals to coverage more quickly, such as expanding use of presumptive eligibility and allowing self-attestation of certain eligibility criteria.

This 19th annual survey of the 50 states and the District of Columbia (DC), provides data on state Medicaid and CHIP eligibility levels and presents a snapshot of key aspects of state enrollment and renewal procedures in place during the COVID-19 public health emergency. In light of the ongoing COVID-19 pandemic, the survey was scaled back in length and scope and focuses on state actions taken or planned in response to the pandemic. The report is based on a survey of state Medicaid and CHIP program officials conducted by the Kaiser Family Foundation (KFF) and the Georgetown University Center for Children and Families during January 2021. The report includes policies for children, pregnant women, parents and other non-elderly adults whose eligibility is based on Modified Adjusted Gross Income (MAGI) financial eligibility rules; it does not include policies for groups eligible through Medicaid pathways for adults over the age of 65 or on the basis of disability.

Medicaid and CHIP Eligibility

As of January 2021, Medicaid and CHIP eligibility is largely unchanged from 2020 due to maintenance of eligibility (MOE) requirements tied to enhanced federal funding. To help support states and promote stability of coverage amidst the COVID-19 pandemic, the FFCRA provides a 6.2 percentage point increase in the federal share (FMAP) of certain Medicaid spending if states meet certain [MOE requirements](#). The MOE provisions prohibit states from tightening eligibility and enrollment standards beyond policies in place as of January 1, 2020 and require states to provide continuous coverage and to cover COVID-19 testing and treatment for Medicaid enrollees. The MOE continuous coverage requirement remains in place until the end of the month when the public health emergency (PHE) expires or is terminated. The MOE does not apply to CHIP programs, but other MOE requirements remain in place for CHIP.¹ While states continue to have the flexibility to increase eligibility or implement new enrollment and renewal processes, the impact of the COVID-19 pandemic and the economic recession have limited states' ability to do so, resulting in few changes in eligibility outside of temporary emergency authorities.

Figure 1

Medicaid Income Eligibility Levels for Other Adults, January 2021

Legend:

- No coverage (13 states)
- 100% FPL (1 state)
- ≥ 138% FPL (37 states, including DC)

NOTES: Eligibility levels are based on 2021 federal poverty levels (FPLs) for a family of three. In 2021, the FPL was \$21,960 for a family of three. Thresholds include the standard five percentage point of the FPL disregard. *OK provides more limited coverage to some childless adults under Section 1115 waiver authority.

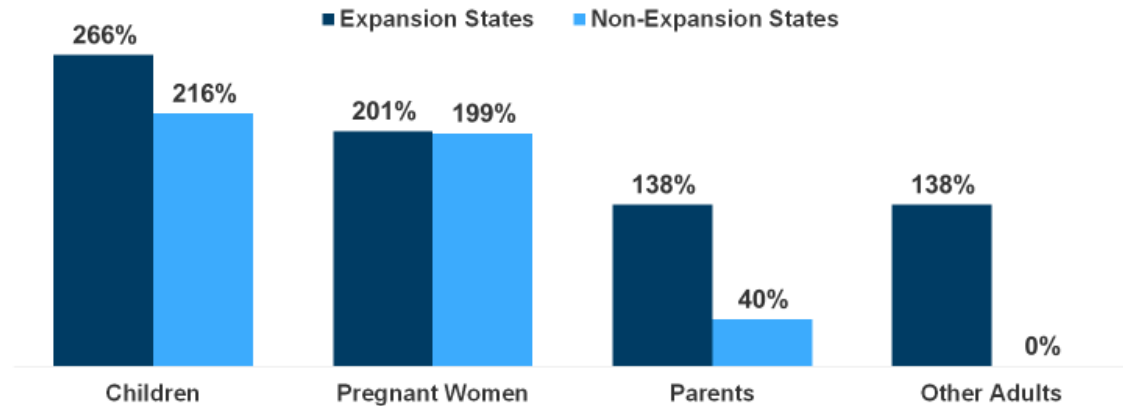
SOURCE: Based on results from a national survey conducted by KFF and the Georgetown University Center for Children and Families, 2021.

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Medicaid and CHIP Eligibility and Enrollment Policies as of January 2021: Findings from a 50-State Survey

Figure 2

Median Medicaid Income Eligibility Limits based on Implementation of Medicaid Expansion as of January 2021



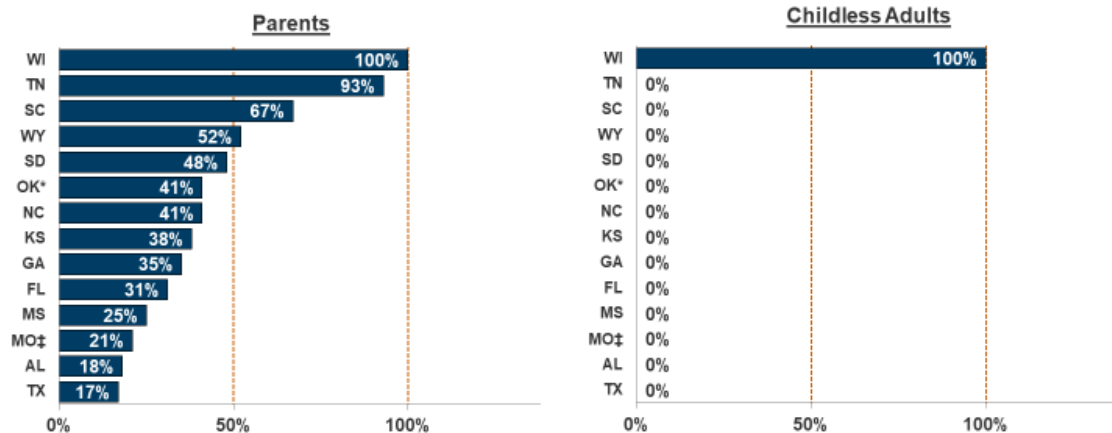
NOTES: Eligibility levels are based on a family of three for parents and an individual for childless adults. In 2021, the FPL was \$21,960 for a family of three and \$12,880 for an individual. Thresholds include the standard five percentage point of FPL disregard. UT provided more limited coverage to some childless adults under Section 1115 waiver authority prior to adopting expansion. OK provides more limited coverage to some childless adults under Section 1115 waiver authority.

SOURCE: Based on results from a national survey conducted by KFF and the Georgetown University Center for Children and Families, 2021.

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Figure 3

Medicaid Income Eligibility Limits for Adults in States that Have Not Implemented the Medicaid Expansion, January 2021



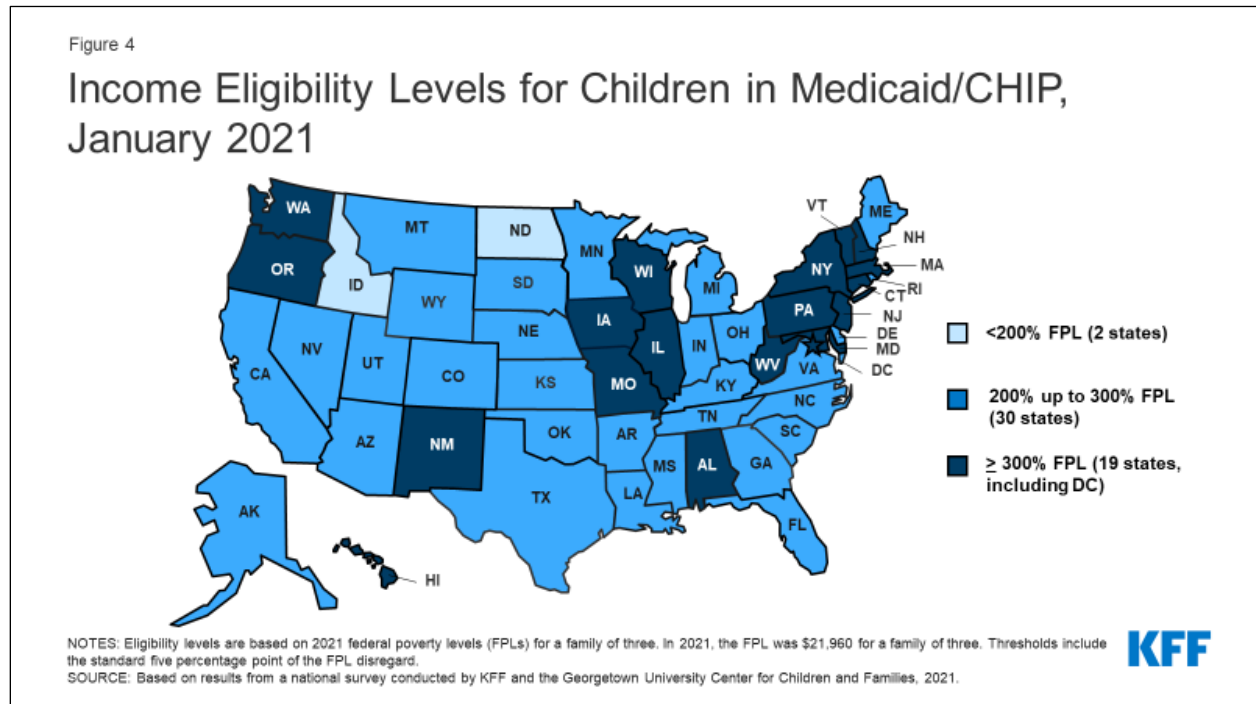
NOTES: *Oklahoma voters approved a Medicaid ballot expansion measures in June 2020 and an expansion state plan amendment was approved in December 2020. Medicaid expansion implementation for both states is set to begin in 2021. ‡ Missouri voters approved a Medicaid ballot expansion measure in August 2020 and an expansion state plan amendment has been submitted.

SOURCE: Based on results of a national survey conducted by KFF and the Georgetown Center for Children and Families, 2021.

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Children's upper income eligibility in Medicaid and CHIP continues to be the highest of all eligibility groups with 49 states covering children at or above 200% FPL (Figure 4). In 2020, the median eligibility level for children held steady at 255% FPL, ranging from a low of 175% FPL in North Dakota to a high of 405% FPL in New York. More than a third of the states (19) cover children at or above

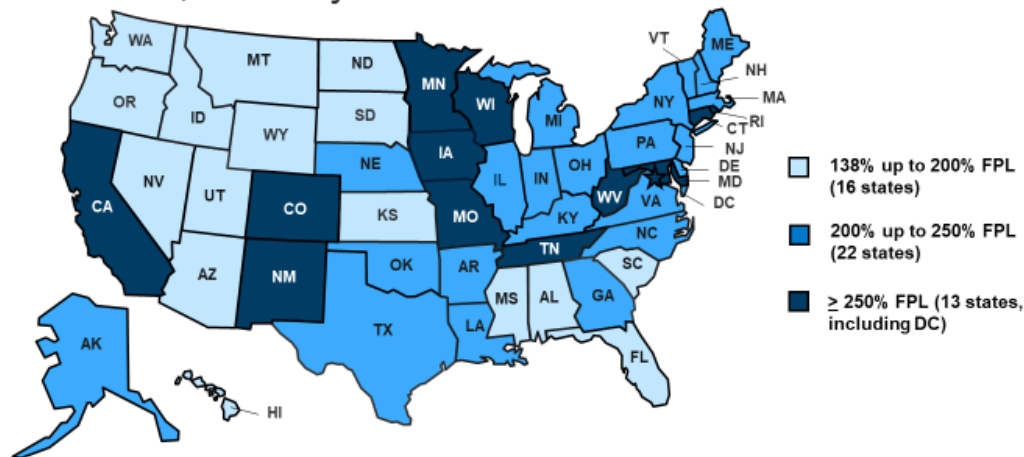
300% FPL. The only change in eligibility levels for children's coverage was in Kansas, where CHIP eligibility is linked to a dollar-based income level tied to the 2008 FPL. While the dollar value remains the same, over time, the equivalent eligibility level will decrease when the federal poverty level is adjusted upward to account for inflation.



The median eligibility limit for coverage for pregnant women in Medicaid and CHIP is stable at 205% FPL (Figure 5). Across states, eligibility levels for pregnant women in Medicaid and CHIP range from a low of 138% FPL (the federal minimum level) in Idaho and South Dakota to a high of 380% FPL in Iowa. A total of 35 states cover pregnant women at or above 200% FPL. Six states have expanded coverage for pregnant women through CHIP, an option for states that cover pregnant women in Medicaid up to at least 185% FPL.

Figure 5

Income Eligibility Levels for Pregnant Women in Medicaid/CHIP, January 2021



NOTES: Eligibility levels are based on 2021 federal poverty levels (FPLs) for a family of three. In 2021, the FPL was \$21,960 for a family of three. Thresholds include the standard five percentage point of the FPL disregard.

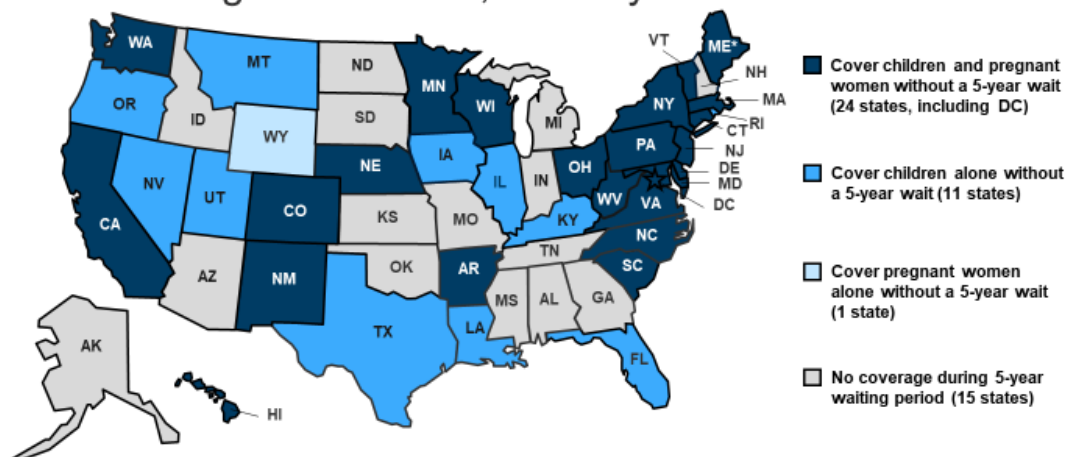
SOURCE: Based on results from a national survey conducted by KFF and the Georgetown University Center for Children and Families, 2021.

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As of January 2021, 41 states have adopted federal options or use state-only funds to extend coverage or limited benefits to some immigrant children, pregnant women, or non-elderly adults. CHIP's enactment in 1997 included the unborn child option that allows states to provide coverage from conception to birth, thereby extending coverage to pregnant women regardless of immigration status. A total of 17 states have adopted this option. Then, the 2009 CHIP Reauthorization Act (CHIPRA) offered a new option for states to receive federal funding to cover lawfully-residing children and pregnant women in Medicaid and CHIP without the five-year waiting period. Since then, two-thirds of states (35) have implemented the option for children in Medicaid and all of those states with separate CHIP programs (24 states) cover lawfully-residing children in CHIP (Figure 6). Twenty-five states have adopted the CHIPRA option to cover lawfully-residing pregnant women. Additionally, eight states use state funds to cover children who are ineligible for federal funding due to immigration status, five states provide pre-natal or postpartum services to some immigrant pregnant women, and eight states cover other immigrant adults.

Figure 6

Medicaid/CHIP Coverage for Lawfully Residing Immigrant Children and Pregnant Women, January 2021



NOTES: *In Maine, the coverage does not extend to pregnant women covered through CHIP.

SOURCE: Based on results from a national survey conducted by KFF and the Georgetown University Center for Children and Families, 2021.

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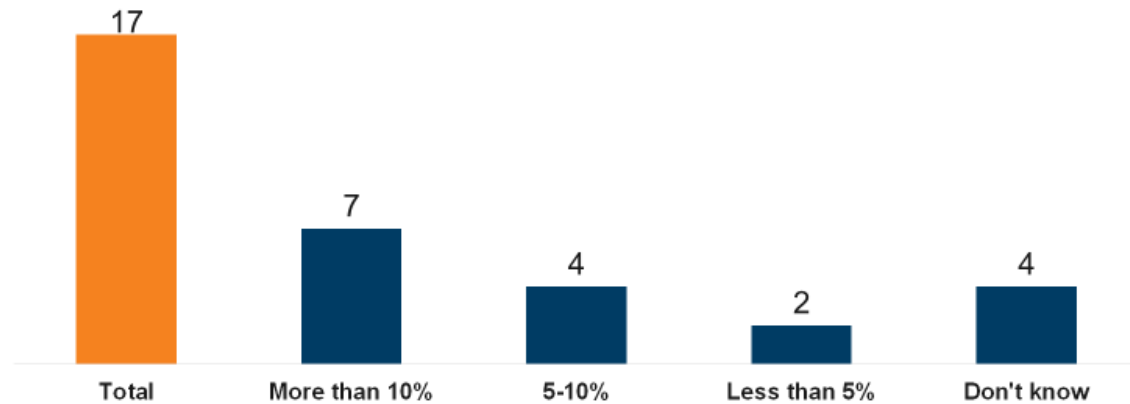
The median eligibility level for family planning services is 206% FPL, but eligibility levels range from 138% FPL in Louisiana and Oklahoma to a high of 306% FPL in Wisconsin. In 2020, Texas became the 30th state to provide family planning services using federal funds. Texas offers family planning services through a Section 1115 demonstration [waiver](#), Healthy Texas Women, which includes restrictions on free choice of family planning providers.

Enrollment and Renewal Processes During the PHE

One third of states have experienced an increase in new applications since the beginning of the COVID-19 PHE (Figure 7) and few states reported application backlogs. Seventeen states report that the volume of new applications increased during the COVID-19 PHE compared to the same period in 2019. Seven of these states (Delaware, Hawaii, Illinois, Nebraska, New York, Nevada, and Tennessee) report increases of greater than 10%. Despite overall Medicaid enrollment growth, states may not be experiencing large increases in applications for a variety of reasons, including smaller than expected [declines](#) in employer-sponsored insurance, a drop in [applications](#) early in the pandemic due to office closures and the elimination of reapplications (where an individual loses coverage, often due to procedural reasons, then reapplies a short time later) due to the MOE requirements. Only five states report current delays in processing new applications beyond the current timeliness standards. Two of the five states with backlogs indicated their current backlogs were lower than in the prior year, while one state indicated that the backlog was the result of decreased administrative capacity due to the pandemic. CMS [expects](#) that states will resume timely processing of all applications within four months of the end of the PHE. Since most states are not currently experiencing application backlogs, they can potentially focus resources on processing renewals or changes in circumstances before the end of the PHE.

Figure 7

States Indicating an Increase in Applications by Percent Change in Application Volume, January 2021



NOTES: Increase refers to new applications in the period March – October 2020 compared to the prior year.

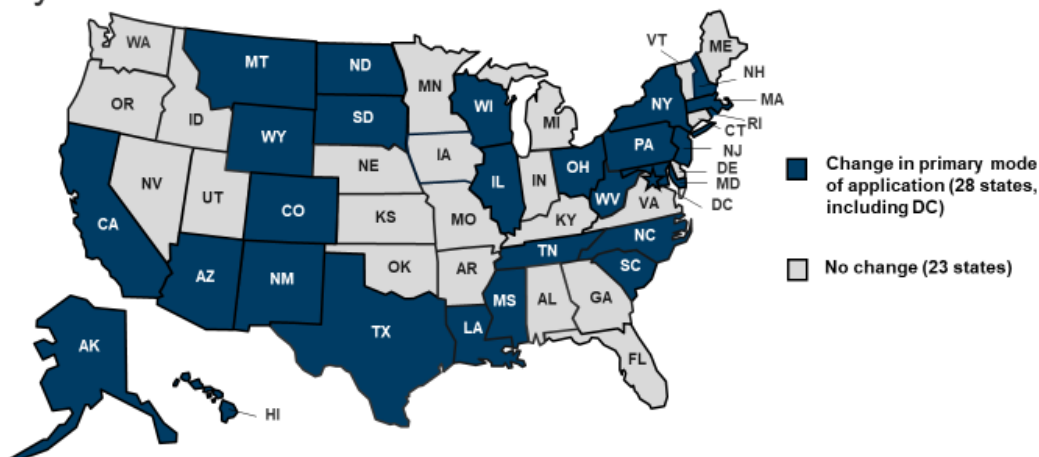
SOURCE: Based on results from a national survey conducted by KFF and the Georgetown University Center for Children and Families, 2021.

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Just over half of states (28) report a shift in how individuals are applying for Medicaid coverage, largely driven by an increase in online applications (Figure 8). The ACA required states to create a single streamlined application for Medicaid, CHIP, and Marketplace coverage and to provide options for individuals to apply for and renew coverage through multiple modes, including online and phone. Most states reporting a change in the primary mode of application experienced an increase in online applications, likely driven by limited access to in-person application assistance at state and local eligibility offices or through community-based assisters due to COVID-19.

Figure 8

States Reporting A Change in Primary Mode of Application, January 2021



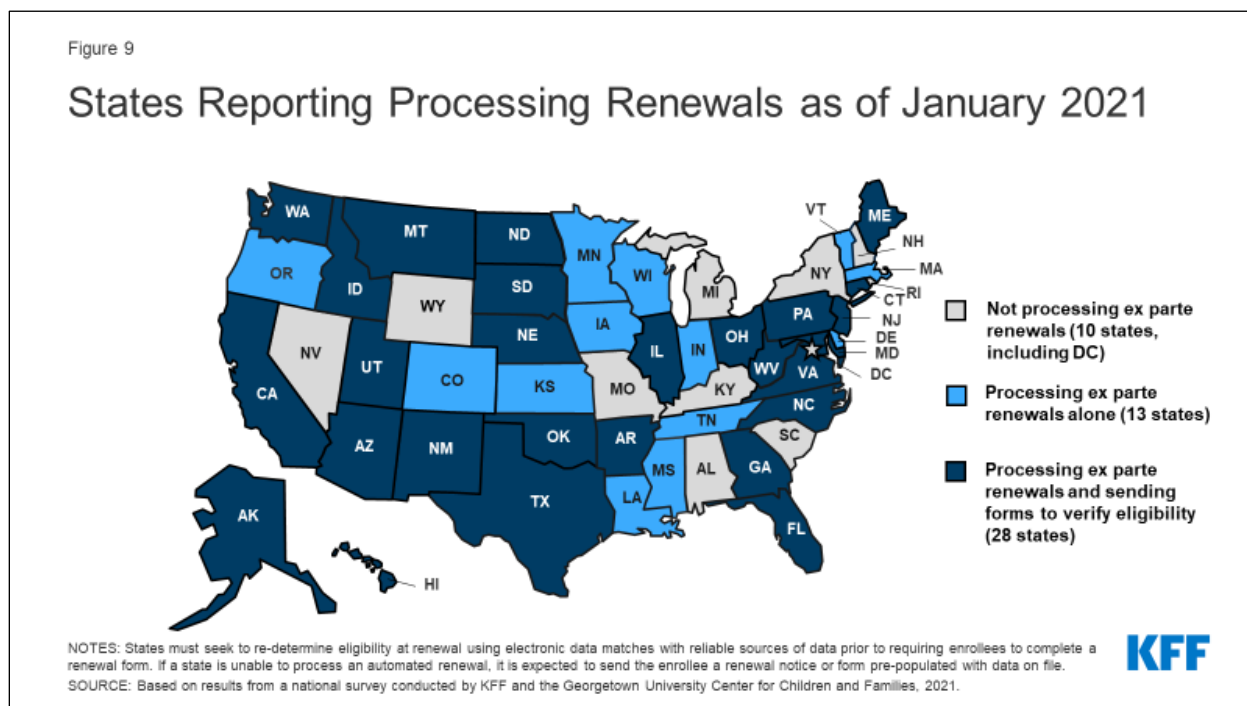
NOTES: States are required to offer four application modes: online, over the phone, in person, or mail. States were asked whether they were currently experiencing any change in primary mode of applications. Most states reporting changes in the primary mode of application experienced an increase in online applications. SOURCE: Based on results from a national survey conducted by KFF and the Georgetown University Center for Children and Families, 2021.

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CMS has recommended that states take steps to increase the share of online applications in a [planning tool](#) it developed to help states prepare for the end of the PHE. Electronic applications can expedite determinations and reduce both administrative costs and errors associated with manual data entry. As [reported](#) in the 2020 survey, the share of applications received online varies considerably among states, ranging from less than 10% to more than 90%. Both states that reported high and low shares of online applications in 2020 reported experiencing an increase in online applications. States can use a variety of strategies to increase the volume of online applications, including actively promoting the weblink in all outreach and marketing efforts to developing mobile-based apps and creating portals for assisters to facilitate applications.²

As of January 2021, most states (41) report processing ex parte (automated) renewals to extend coverage for individuals during the PHE (Figure 9) and two-thirds of those states (28 of 41) are sending renewal forms or requests for documentation when they are unable to confirm ongoing eligibility through electronic data sources. Under the ACA, states must seek to complete automated or ex parte renewals by verifying ongoing eligibility through available data sources, such as state wage databases, before sending a renewal form or requesting documentation from an enrollee. While some states suspended renewals as they implemented the MOE [continuous coverage requirements](#) and made other COVID-related adjustments to operations, most states are now actively processing renewals. Other states will likely restart the renewal process in response to CMS [guidance](#) that outlines actions states should take during the PHE to resume normal operations to the extent possible. When states are able to confirm ongoing eligibility on an ex parte basis, including the 41 states currently processing automated or ex parte renewals, they have the option to extend the renewal date out to 12 months from the original renewal date or 12 months from when the renewal was processed to stagger renewal dates, but this may

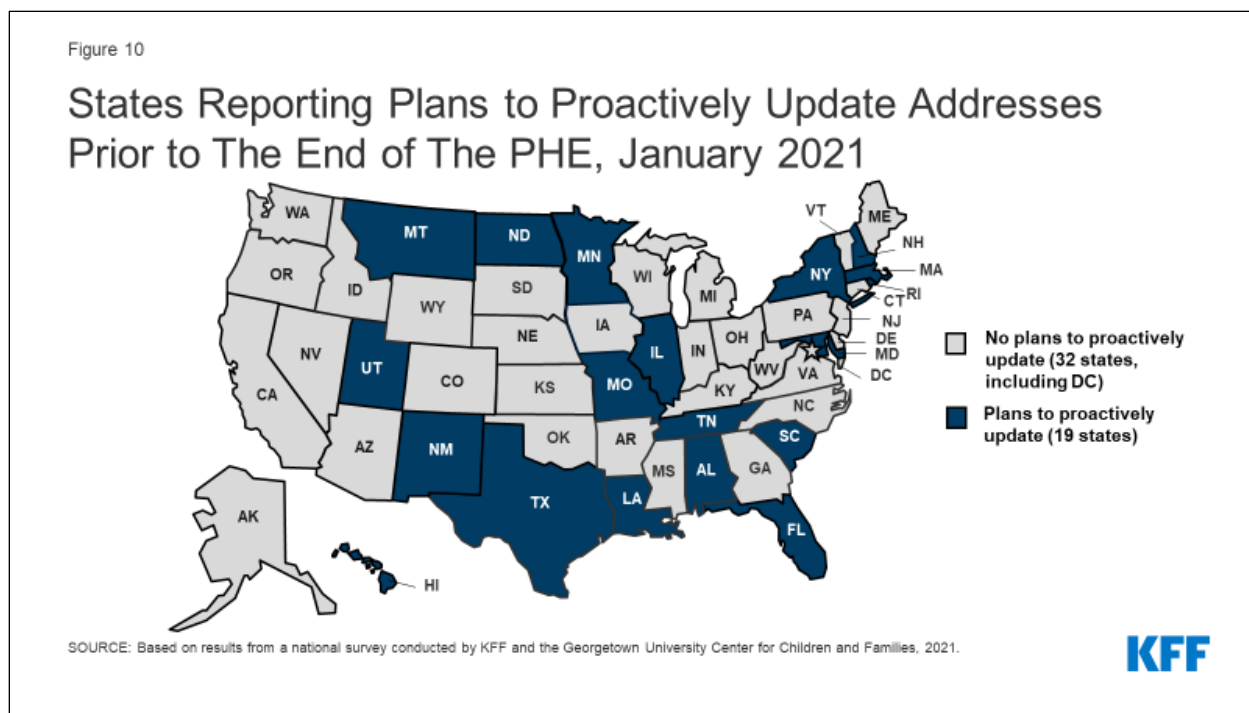
result in renewal periods for enrollees that are shorter than 12 months. If an enrollee submits documentation to verify ongoing eligibility at renewal, the state must extend coverage for a full 12 months.



Slightly more than a third of states (19) have established a new 12-month renewal period when processing a change in circumstances that results in a new eligibility pathway. In November 2020, CMS published an [interim final rule](#) that provided options for states to transition enrollees determined ineligible for their current coverage to different coverage pathways for which they are eligible if such a transition is in the same tier of coverage (though it may cover fewer benefits or have higher patient cost-sharing). States may then retain the original renewal date or extend a new 12-month eligibility period if they have information needed to confirm ongoing eligibility. Some states report that pregnant women and children aging out of coverage are most likely to be given a new 12-month renewal period, while other states say enrollees in all MAGI-based eligibility groups are given a new 12-month renewal period.

Just over one third of states (19) proactively take steps to update mailing addresses or plan to do so before the end of the PHE (Figure 10). Once the PHE expires and states resume normal operations under current federal rules, states may automatically terminate coverage without the advance ten-day notice when an enrollee cannot be located.³ Prior to the COVID-19 pandemic, a number of states terminated coverage when mail was returned as undeliverable, potentially contributing to [enrollment declines](#). Ongoing issues with the United States Postal Service (USPS) and the impact of the COVID-19 economic crisis on housing may exacerbate difficulties in reaching enrollees by mail. In 2020, states that took proactive steps to keep mailing addresses current reported using the USPS National Change of Address Database or contracting with vendors to facilitate the process. States may also check other public programs for more updated information or engage Medicaid managed care organizations in

updating addresses. Additionally, as of 2020, 43 states [offered](#) online accounts, which make it easier for enrollees to update addresses among other features. A few states also reported taking additional action, such as attempting to contact enrollees via telephone.



Most states are not planning changes to eligibility or enrollment that are currently disallowed when the PHE ends. While all states will phase out the continuous coverage requirement, five states are planning to make other changes. Two states reported plans to move forward with implementing work requirements and three states plan to charge premiums for some adults. The Biden Administration has announced it intends to rescind work requirements demonstration waivers and may take additional action to revise waiver guidance, impacting states' ability to implement these policies.

Looking Ahead

State eligibility and enrollment policies in place as of January 2021 provide a baseline for assessing state actions after the PHE ends and in response to new Medicaid policy options that may be adopted at the federal level. Currently, states cannot implement more restrictive eligibility policies than those in place as of January 1, 2020 and must provide continuous coverage to Medicaid enrollees until the PHE ends in order to receive enhanced federal funding. Their policy choices at the end of the PHE and decisions around adopting potential coverage options will have coverage implications for those who are currently enrolled and those who may become eligible.

The Biden Administration's recent announcement regarding the likely extension of the PHE gives states more time to prepare for the end the PHE. In a [letter to Governors](#), the Biden administration

noted that the PHE is likely to extend for the entirety of 2021 and promised a 60-day notice before the PHE is terminated or is allowed to expire. Advance notice before the end of the PHE was one of the top responses when states were asked what additional guidance they need from CMS to plan for resuming normal operations.

States are taking steps now to prepare for the end of the PHE, but some indicate additional guidance would be helpful to reduce backlogs and minimize coverage disruptions. While most states are processing automated renewals when possible, states will still have a backlog of renewals that were not able to be completed. Some states noted the need for additional guidance to avoid unevenly distributed workloads due to large numbers of renewals and other changes occurring in a short period of time. When the PHE ends, CMS guidance issued under the Trump administration allows states to send coverage termination notices to individuals who did not respond to requests for information, did not return renewal forms, or lost eligibility for other reasons within six months of the end of the PHE. This approach may result in coverage losses at the end of the PHE for individuals who remain eligible. CMS guidance also gives states six months to catch up on pending renewals and other changes once the PHE ends; however, several states indicated that 12 months would allow for a smoother resumption of operations. While states can use this guidance to help plan for the end of the PHE, it is possible the Biden administration could revise the guidance, which would affect states' planning efforts.

As states prepare to return to normal operations at the end of the PHE, there are additional considerations beyond resuming routine eligibility and enrollment procedures. In addition to the MOE requirements, states implemented a variety of temporary strategies to deal with the pandemic including, but not limited to eligibility, enrollment or renewal. These changes were wide ranging, impacting all aspects of Medicaid from improving access to telehealth and easing prior authorization requirements to waiving premiums or cost-sharing and modifying appeals and fair hearing requirements. CMS has developed two planning tools to aid states in preparing for the end of the PHE. The first focuses on [eligibility and enrollment pending actions](#) and the second provides assistance in general planning to [restore regular Medicaid and CHIP operations](#). Together, the tools prompt states to consider actions that will aid in a smooth return to normal operations, including how they communicate with beneficiaries and stakeholders and how to extend or permanently implement flexibilities adopted through Section 1135 emergency waivers or disaster-related temporary state plan amendments.

Administration actions and Congressional proposals would reduce some barriers to Medicaid enrollment and support targeted Medicaid coverage expansions. The Biden administration has already reopened the marketplace and will restore funding for outreach, marketing and consumer assistance that will help connect uninsured individuals with Medicaid and CHIP. The administration also recently announced it will revise waiver demonstration policy and rescind guidance related to work requirements and may also revise demonstration policy related to capped financing. In addition, the latest COVID relief legislative package includes provisions to provide states the option to extend coverage for pregnant women to 12 months postpartum in both Medicaid and CHIP and to provide financial incentives for non-expansion states to adopt the Medicaid expansion.

Endnotes

¹ Medicaid and CHIP Payment Advisory Commission, CHIP Eligibility.
<https://www.macpac.gov/subtopic/eligibility-2/>

² Maximizing Enrollment, Consumer Assistance in the Digital Age: New Tools to Help People Enroll in Medicaid, CHIP and Exchange, (July 2012).
<http://www.maxenroll.org/files/maxenroll/resources/Maximizing%20Enrollment%20-%20Consumer%20Assistance%20-%20July%202012.pdf>

³ 42 CFR §431.213 - Exception from advance notice. The agency may send a notice not later than the date of action if: (d) The beneficiary's whereabouts are unknown and the post office returns agency mail directed to him indicating no forwarding address (See §431.231 (d) of this subpart for procedure if the beneficiary's whereabouts become known).

Table A: Trends in State Medicaid and CHIP Eligibility Policies, July 2000-January 2021 ¹																				
	Program	July 2000	Jan 2002	April 2003	July 2004	July 2005	July 2006	Jan 2008	Jan 2009	Dec 2009	Jan 2011	Jan 2012	Jan 2013	Jan 2015	Jan 2016	Jan 2017	Jan 2018	Jan 2019	Jan 2020	Jan 2021
ELIGIBILITY																				
Cover children >200% FPL	N/A	36	40	39	39	41	41	45	44	47	47	47	47	48	48	49	49	49	49	49
Cover children >300% FPL	N/A	5	6	6	6	6	8	9	10	16	16	17	17	19	19	19	19	19	19	19
Cover lawfully-residing immigrant children without five-year wait	Medicaid	Option Not Available								17	21	24	25	28	29	31	33	34	35	35
	CHIP														19	21	22	23	24	24
Cover pregnant women >200% FPL	N/A	NC		17	16	17	17	20	21	24	25	25	25	33	33	34	34	34	35	35
Cover lawfully-residing immigrant pregnant women without five-year wait	Medicaid	Option Not Available								14	17	18	20	23	23	23	25	25	25	25
	CHIP														4	3	3	3	4	4
Cover parents ≥100% FPL ²	N/A	NC	20	16	17	17	16	18	18	17	18	18	18	31	34	35	34	35	37	38
Cover other adults ^{2,3}	N/A	NC									7	8	25	29	32	33	33	35	37	37

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, 2011-2021.

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

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

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

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

Table 1: Income Eligibility Limits for Children's Health Coverage as a Percent of the Federal Poverty Level, January 2021 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%	148%	216%	138%	155%	255%
Alabama ⁵	317%	146%		146%		146%	107%-146%	317%
Alaska	208%	177%	159%-208%	177%	159%-208%	177%	124%-208%	
Arizona	205%	152%		146%		138%	104%-138%	205%
Arkansas	216%	147%		147%		147%	107%-147%	216%
California ⁶	266%	208%	208%-266%	142%	142%-266%	133%	108%-266%	
Colorado	265%	147%		147%		147%	108%-147%	265%
Connecticut	323%	201%		201%		201%		323%
Delaware	217%	217%	194%-217%	147%	143%-217%	138%	110%-138%	217%
District of Columbia ⁵	324%	324%	206%-324%	324%	146%-324%	324%	112%-324%	
Florida ⁷	215%	211%	192%-211%	145%		138%	112%-138%	215%
Georgia	252%	210%		154%		138%	113%-138%	252%
Hawaii	313%	191%	191%-313%	139%	139%-313%	133%	105%-313%	
Idaho	190%	147%		147%		138%	107%-138%	190%
Illinois	318%	147%		147%		147%	108%-147%	318%
Indiana ⁸	255%	213%	157%-213%	163%	141%-163%	163%	106%-163%	255%
Iowa	380%	380%	240%-380%	172%		172%	122%-172%	307%
Kansas ⁹	232%	171%		154%		138%	113%-138%	232%
Kentucky	218%	200%		142%	142%-164%	133%	109%-164%	218%
Louisiana	255%	142%	142%-217%	142%	142%-217%	142%	108%-217%	255%
Maine	213%	196%		162%	140%-162%	162%	132%-162%	213%
Maryland	322%	194%	194%-322%	138%	138%-322%	133%	109%-322%	
Massachusetts ¹⁰	305%	205%	185%-205%	155%	133%-155%	155%	114%-155%	305%
Michigan ¹¹	217%	195%	195%-217%	160%	143%-217%	160%	109%-217%	
Minnesota ¹²	288%	275%	275%-288%	280%		280%		
Mississippi	214%	199%		148%		138%	107%-138%	214%
Missouri	305%	201%		148%	148%-155%	148%	110%-155%	305%
Montana	266%	148%		148%		133%	109%-148%	266%
Nebraska	218%	162%	162%-218%	145%	145%-218%	133%	109%-218%	
Nevada	205%	165%		165%		138%	122%-138%	205%
New Hampshire	323%	196%	196%-323%	196%	196%-323%	196%	196%-323%	
New Jersey	355%	199%		147%		147%	107%-147%	355%
New Mexico	305%	240%	200%-305%	240%	200%-305%	190%	138%-245%	
New York	405%	223%		154%		154%	110%-154%	405%
North Carolina ¹³	216%	215%	194%-215%	215%	141%-215%	138%	107%-138%	216%
North Dakota	175%	147%	147%-175%	147%	147%-175%	133%	111%-175%	
Ohio	211%	156%	141%-211%	156%	141%-211%	156%	107%-211%	
Oklahoma ^{5,14}	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 ^{5,15}	255%	195%	195%-216%	142%	142%-216%	133%	109%-216%	255%
Texas	206%	203%		149%		138%	109%-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 KFF with the Georgetown University Center for Children and Families, 2021.

Table presents rules in effect as of January 1, 2021.

Table 1 Notes

1. January 2021 income limits are reported as a percentage of the federal poverty level (FPL). The 2021 FPL for a family of three is \$21,960. The reported levels reflect Modified Adjusted Gross Income (MAGI)-converted income standards and include a disregard equal to five percentage points of the FPL applied at the highest income level for Medicaid and separate CHIP coverage. In states without a separate CHIP program, the disregard is added to the highest Medicaid or the CHIP-funded Medicaid expansion limit. In states with a separate CHIP program, the disregard is applied to the highest Medicaid or CHIP-funded Medicaid expansion limit as well as to the upper eligibility limit of the separate CHIP program. Because CHIP funding is limited to uninsured children, in states that have a higher eligibility limit for their CHIP-funded Medicaid expansion than regular Medicaid, there may be a small number of children who have another source of coverage that would be eligible for Medicaid when the 5-percentage point disregard is applied, which is not reflected in the table. Eligibility levels are reported as percentage of the FPL.
2. States may use Title XXI CHIP funds to cover children through CHIP-funded Medicaid expansion programs and/or separate child health insurance programs for children not eligible for Medicaid. Use of Title XXI CHIP funds is limited to uninsured children. The Medicaid income eligibility levels listed indicate thresholds for children covered with Title XIX Medicaid funds and uninsured children covered with Title XXI funds through CHIP-funded Medicaid expansion programs. To be eligible in the infant category, a child has not yet reached his or her first birthday; to be eligible in the 1-5 category, the child is age one or older, but has not yet reached his or her sixth birthday; and to be eligible in the 6-18 category, the child is age six or older, but has not yet reached his or her 19th birthday.
3. The states noted use federal CHIP funds to operate separate child health insurance programs for children not eligible for Medicaid. Such programs may either provide benefits similar to Medicaid or a somewhat more limited benefit package. They also may impose premiums or other cost sharing obligations on some or all families with eligible children. Unlike Medicaid, which allows states to cover 19 and 20 years as children, CHIP coverage is limited to uninsured children under the age of 19.
4. Medians for CHIP-funded uninsured children are based on the upper limit of coverage.
5. Alabama, the District of Columbia, Oklahoma, and Tennessee have different lower bounds for adolescents in Title XXI funded Medicaid expansions depending on age. The lower bound for Title XXI funded Medicaid is 18% for children ages 14 through 18 in Alabama, 63% for children ages 15 through 18 in the District of Columbia, 69% for children ages 14 through 18 in Oklahoma, and 29% for children ages 14 through 18 in Tennessee.
6. In California, children with higher incomes are eligible for separate CHIP coverage in certain counties.
7. In Florida, all infants ages 0 to 1 are covered in Medicaid. Florida operates three separate CHIP programs: Healthy Kids covers children ages 5 through 18; MediKids covers children ages 1 through 4; and the Children's Medical Services Managed Care Plan serves children with special health care needs from birth through age 21. In Florida, families can buy in to Healthy Kids for children ages 5-19 and to MediKids children ages 1 to 4.

8. As of December 2020, Indiana has amended its 5% MAGI disregard calculations to meet the federal requirements (5% of FPL).
9. In Kansas, eligibility for children in the separate CHIP program is a dollar-based income level equal to 250% FPL in 2008. This amount increased in 2014 for the MAGI conversion, but as a fixed dollar amount, the equivalent FPL level may erode over time.
10. Massachusetts covers insured children in its separate CHIP program with Title XIX Medicaid funds under its Section 1115 waiver. Massachusetts also covers uninsured 18-year olds with incomes up to 155% FPL under its Medicaid expansion and up to 305% under separate CHIP.
11. Michigan provides CHIP-funded Medicaid expansion coverage to children with incomes between 212% FPL to 400% FPL affected by the Flint water crisis.
12. In Minnesota, the infant category under Title XIX-funded Medicaid includes insured and uninsured children up to age two with incomes up to 275% FPL, and insured children up to age 2 from 275-288% FPL.
13. In North Carolina, all children ages 0 through 5 are covered in Medicaid while the separate CHIP program covers children ages 6 through 18 with incomes above Medicaid limits.
14. Oklahoma offers a premium assistance program through its Insure Oklahoma program to children ages 0 through 18 with income up to 222% FPL with access to employer sponsored insurance.
15. In Tennessee, Title XXI funds are used for two programs, TennCare Standard (a Medicaid expansion program) and CoverKids (a separate CHIP program). TennCare Standard provides Medicaid coverage to uninsured children who lose eligibility under TennCare (Medicaid), have no access to insurance, and have family income below 216% FPL or are medically eligible.
16. In Wisconsin, children are not eligible for its separate CHIP program if they have access to health insurance coverage through a job where the employer covers at least 80% of the cost.

Table 2: Medicaid and CHIP Coverage for Pregnant Women and Medicaid Family Planning Expansion								
State	Income Eligibility Limits for Pregnant Women (% of the FPL)				Full Medicaid/CHIP Benefit Package for Pregnant Women ⁵			Income Eligibility Limit for Family Planning Expansion Program (% of the FPL) ⁶
	Medicaid ¹	CHIP ¹	Unborn Child Option (CHIP-Funded) ^{1,2}	Upper Income Limit	Medicaid	CHIP ^{3,4} (Total = 6)	Unborn Child Option ^{3,4} (Total = 17)	
Median or Total	200%	262%	213%	205%	47	6	12	206%
Alabama	146%			146%	Y	N/A	N/A	146%
Alaska	205%			205%	Y	N/A	N/A	N/A
Arizona	161%			161%	Y	N/A	N/A	N/A
Arkansas ⁷	214%		214%	214%		N/A		N/A
California ⁸	213%		322%	322%	Y	N/A	Y	205%
Colorado ⁹	200%	265%		265%	Y	Y	N/A	N/A
Connecticut	263%			263%	Y	N/A	N/A	263%
Delaware	217%			217%	Y	N/A	N/A	N/A
District of Columbia	324%			324%	Y	N/A	N/A	N/A
Florida	196%			196%	Y	N/A	N/A	190%
Georgia	225%			225%	Y	N/A	N/A	216%
Hawaii	196%			196%	Y	N/A	N/A	N/A
Idaho	138%			138%	Y	N/A	N/A	N/A
Illinois	213%		213%	213%	Y	N/A	Y	N/A
Indiana ¹⁰	213%			213%	Y	N/A	N/A	146%
Iowa ¹¹	380%			380%	Y	N/A	N/A	N/A
Kansas	171%			171%	Y	N/A	N/A	N/A
Kentucky	200%			200%	Y	N/A	N/A	218%
Louisiana	138%		214%	214%	Y	N/A	Y	138%
Maine	214%			214%	Y	N/A	N/A	214%
Maryland	264%			264%	Y	N/A	N/A	264%
Massachusetts	205%		205%	205%	Y	N/A	Y	N/A
Michigan ¹²	200%		200%	200%	Y	N/A	Y	N/A
Minnesota	283%		283%	283%	Y	N/A	Y	205%
Mississippi	199%			199%	Y	N/A	N/A	199%
Missouri	201%	305%	305%	305%	Y	Y	Y	206%
Montana	162%			162%	Y	N/A	N/A	216%
Nebraska	199%		202%	202%	Y	N/A		N/A
Nevada	165%			165%	Y	N/A	N/A	N/A
New Hampshire	201%			201%	Y	N/A	N/A	201%
New Jersey	199%	205%		205%	Y	Y	N/A	205%
New Mexico ¹³	255%			255%		N/A	N/A	255%
New York	223%			223%	Y	N/A	N/A	223%
North Carolina ¹⁴	201%			201%		N/A	N/A	200%
North Dakota	162%			162%	Y	N/A	N/A	N/A
Ohio	205%			205%	Y	N/A	N/A	N/A
Oklahoma ¹⁵	138%		210%	210%	Y	N/A	Y	138%
Oregon	190%		190%	190%	Y	N/A	Y	255%
Pennsylvania	220%			220%	Y	N/A	N/A	220%
Rhode Island	195%	258%	258%	258%	Y	Y	Y	258%
South Carolina	199%			199%	Y	N/A	N/A	199%
South Dakota ¹⁶	138%		138%	138%		N/A		N/A
Tennessee	200%		255%	255%	Y	N/A		N/A
Texas ¹⁷	203%		207%	207%	Y	N/A		209%
Utah	144%			144%	Y	N/A	N/A	N/A
Vermont ¹⁸	213%			213%	Y	N/A	N/A	200%
Virginia	148%	205%		205%	Y	Y	N/A	205%
Washington	198%		198%	198%	Y	N/A	Y	265%
West Virginia	190%	305%		305%	Y	Y	N/A	N/A
Wisconsin	306%		306%	306%	Y	N/A	Y	306%
Wyoming	159%			159%	Y	N/A	N/A	159%

SOURCE: Based on a national survey conducted by KFF with the Georgetown University Center for Children and Families, 2021. Table presents rules in effect as of January 1, 2021.

Table 2 Notes

1. January 2021 income limits reflect Modified Adjusted Gross Income (MAGI)-converted income standards and include a disregard equal to five percentage points of the federal poverty level (FPL). The FPL for a family of three is \$21,960 as of 2021.
2. The unborn child option permits states to cover "targeted low-income children" from conception to birth in CHIP.
3. The totals in column headers indicate that the option only applies to the limited number of states that have adopted the coverage pathway. As of January 2021, 6 states use CHIP funding to cover pregnant women and 17 states provide coverage through the unborn child option.
4. N/A responses indicate that the state does not provide CHIP-funded coverage to pregnant women or that the state does not provide coverage through the unborn child option.
5. These columns indicate whether 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 lists income eligibility limits for programs in states that use federal funds under a state option or waiver to provide family planning services to individuals who do not qualify for full Medicaid benefits. January 2021 income limits include 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 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. In California, pregnant women below 138% receive the full Medicaid package while women with income above 138% receive coverage for all medically-necessary pregnancy-related services.
9. In Colorado, pregnant women covered by CHIP do not receive vision benefits.
10. As of December 2020, Indiana has amended its 5% MAGI disregard calculations to meet the federal requirements (5% of FPL).
11. Iowa has a state-funded family planning program for women with incomes up to 300% FPL who lose Medicaid at the end of the postpartum period.
12. Michigan provides coverage to pregnant women with incomes up to 400% FPL affected by the Flint water crisis.
13. In New Mexico, family planning coverage is limited to individuals age 50 and under without health insurance and under age 65 with Medicare.
14. 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.
15. Oklahoma offers a premium assistance program through its Insure Oklahoma program to pregnant women with incomes up to 205% FPL who have access to employer sponsored insurance.

16. South Dakota provides full Medicaid benefits to pregnant women with incomes up to \$591 per month (for a family of three). Above that level, more limited pregnancy-related benefits are provided to pregnant women covered under Medicaid. South Dakota provides limited pregnancy-related benefits to pregnant women covered under the CHIP unborn child option.
17. In January 2020, Texas received approval for federal funding through a section 1115 waiver for the state's family planning program, Healthy Texas Women. The program was previously state-funded.
18. 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 3: State Adoption of Options to Cover Immigrant Populations, January 2021								
State	Lawfully-Residing Immigrant Children Covered without 5-Year Wait ¹		Lawfully-Residing Immigrant Pregnant Women Covered without 5-Year Wait ¹		Unborn Child Option ³	Coverage with State-Only Funds ⁴		
	Medicaid	CHIP ² (Total =35)	Medicaid	CHIP (Total =6)		Children	Pregnant Women	Other Adults
Total	35	24	25	4	17	8	6	8
Alabama				N/A				
Alaska		N/A (M-CHIP)		N/A				
Arizona				N/A				
Arkansas	Y	Y	Y	N/A	Y			
California ^{5,6}	Y	N/A (M-CHIP)	Y	N/A	Y	Y		Y
Colorado	Y	Y	Y	Y				
Connecticut	Y	Y	Y	N/A				
Delaware	Y	Y	Y	N/A				
District of Columbia ^{5,6,7}	Y	N/A (M-CHIP)	Y	N/A		Y	Y	Y
Florida	Y	Y		N/A				
Georgia				N/A				
Hawaii ^{6,8}	Y	N/A (M-CHIP)	Y	N/A				Y
Idaho				N/A				
Illinois ^{5,6,9}	Y	Y		N/A	Y	Y		Y
Indiana				N/A				
Iowa ¹⁰	Y	Y		N/A		Y		
Kansas				N/A				
Kentucky	Y	Y		N/A				
Louisiana	Y	Y		N/A	Y			
Maine	Y	Y	Y	N/A				
Maryland	Y	N/A (M-CHIP)	Y	N/A				
Massachusetts ^{5,6,7,11}	Y	Y	Y	N/A	Y	Y	Y	Y
Michigan		N/A (M-CHIP)		N/A	Y			
Minnesota	Y	N/A (M-CHIP)	Y	N/A	Y			
Mississippi				N/A				
Missouri					Y			
Montana	Y	Y		N/A				
Nebraska	Y	N/A (M-CHIP)	Y	N/A	Y			
Nevada	Y	Y		N/A				
New Hampshire		N/A (M-CHIP)		N/A				
New Jersey ⁷	Y	Y	Y	Y			Y	
New Mexico ⁶	Y	N/A (M-CHIP)	Y	N/A				Y
New York ^{5,6,7}	Y	Y	Y	N/A		Y	Y	Y
North Carolina	Y	Y	Y	N/A				
North Dakota		N/A (M-CHIP)		N/A				
Ohio	Y	N/A (M-CHIP)	Y	N/A				
Oklahoma		N/A (M-CHIP)		N/A	Y			
Oregon ^{5,7}	Y	Y		N/A	Y	Y	Y	
Pennsylvania ⁶	Y	Y	Y	N/A				Y
Rhode Island	Y	N/A (M-CHIP)			Y			
South Carolina	Y	N/A (M-CHIP)	Y	N/A				
South Dakota				N/A	Y			
Tennessee				N/A	Y			
Texas	Y	Y		N/A	Y			
Utah	Y	Y		N/A				
Vermont	Y	N/A (M-CHIP)	Y	N/A				
Virginia	Y	Y	Y	Y				
Washington ^{5,7}	Y	Y	Y	N/A	Y	Y	Y	
West Virginia	Y	Y	Y	Y				
Wisconsin	Y	Y	Y	N/A	Y			
Wyoming			Y	N/A				

SOURCE: Based on a national survey conducted by KFF with the Georgetown University Center for Children and Families, 2021.
Table presents rules in effect as of January 1, 2021.

Table 3 Notes

1. These columns indicate whether the state has adopted the option to provide coverage for immigrant children and pregnant women 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.
2. N/A (M-CHIP) responses indicate that the state does not provide a separate CHIP program for uninsured children.
3. The unborn child option permits states to cover “targeted low-income child” from conception to birth in CHIP.
4. These columns indicate if the state uses state-only funds to cover some services for children, pregnant women or adults, regardless of immigration status. In some cases, coverage is limited to targeted groups, such as lawfully present immigrants who are in the five-year waiting period for Medicaid coverage.
5. 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.
6. California, the District of Columbia, Hawaii, Illinois, Massachusetts, New Mexico, New York, and Pennsylvania cover some income-eligible adults who are not otherwise eligible due to immigration status using state-only funds. In some cases, the coverage is limited to targeted groups, such as lawfully present immigrants who are in the five-year waiting period for Medicaid coverage.
7. The District of Columbia, Massachusetts, New Jersey, New York, Oregon, and Washington provide some services not covered through emergency Medicaid for some income-eligible pregnant women or women in the postpartum period who are not otherwise eligible due to immigration status using state-only funds.
8. Hawaii provides state-funded coverage to Aged, Blind, and Disabled (ABD) legally present immigrants who do not qualify for Medicaid due to immigration status and those who have been here less than 5 years. Hawaii also uses state funding to provide supplemental premium assistance for Marketplace plans to lawfully present immigrants who do not qualify for Medicaid due to immigration status.
9. In December 2020, Illinois began using state funds to cover individuals over age 65 who do not have a qualified immigration status and otherwise meet the Aged, Blind, and Disabled (ABD) eligibility criteria.
10. Iowa covers immigrant children in foster care with state-only funds.
11. Massachusetts covers immigrant adults over 65, with disabilities, and certain immigrants who are not qualified due to immigration status through state-only funds.

Table 4: Medicaid Income Eligibility Limits for Adults as a Percent of the Federal Poverty Level, January 2021 ¹			
State	Parents (in a family of three)		Other Adults (for an individual)
	Section 1931 Limit	Upper Limit	
Median	44%	138%	138%
Alabama	18%	18%	0%
Alaska ²	131%	138%	138%
Arizona	106%	138%	138%
Arkansas	15%	138%	138%
California	109%	138%	138%
Colorado	68%	138%	138%
Connecticut	160%	160%	138%
Delaware	87%	138%	138%
District of Columbia	221%	221%	215%
Florida	31%	31%	0%
Georgia	35%	35%	0%
Hawaii	100%	138%	138%
Idaho	19%	138%	138%
Illinois ³	29%	138%	138%
Indiana ⁴	16%	138%	138%
Iowa	47%	138%	138%
Kansas	38%	38%	0%
Kentucky	18%	138%	138%
Louisiana	19%	138%	138%
Maine	100%	138%	138%
Maryland	123%	138%	138%
Massachusetts ⁵	138%	138%	138%
Michigan	54%	138%	138%
Minnesota ⁶	138%	138%	138%
Mississippi	25%	25%	0%
Missouri ⁷	21%	21%	0%
Montana	24%	138%	138%
Nebraska ⁸	63%	138%	138%
Nevada	27%	138%	138%
New Hampshire	52%	138%	138%
New Jersey	27%	138%	138%
New Mexico	41%	138%	138%
New York ⁶	89%	138%	138%
North Carolina	41%	41%	0%
North Dakota	47%	138%	138%
Ohio	90%	138%	138%
Oklahoma ^{7,9}	41%	41%	0%
Oregon	33%	138%	138%
Pennsylvania	33%	138%	138%
Rhode Island	116%	138%	138%
South Carolina	67%	67%	0%
South Dakota	48%	48%	0%
Tennessee	93%	93%	0%
Texas ¹⁰	17%	17%	0%
Utah	37%	138%	138%
Vermont ¹¹	41%	138%	138%
Virginia ¹²	33%	138%	138%
Washington	44%	138%	138%
West Virginia	17%	138%	138%
Wisconsin ¹³	100%	100%	100%
Wyoming	52%	52%	0%

SOURCE: Based on a national survey conducted by KFF with the Georgetown University Center for Children and Families, 2021. Table presents rules in effect as of January 1, 2021.

Table 4 Notes

1. January 2021 income limits reflect Modified Adjusted Gross Income (MAGI)-converted income standards and include a disregard equal to five percentage points of the Federal Poverty Level (FPL) applied to the highest eligibility limit for the group. In some states, eligibility limits for Section 1931 parents are based on a dollar threshold. The values listed represent the truncated FPL equivalents calculated from these dollar limits. Eligibility levels for parents are presented as a percentage of the 2021 FPL for a family of three, which is \$21,960. Eligibility limits for other adults are presented as a percentage of the 2021 FPL for an individual, which is \$12,880.
2. In Alaska, the dollar threshold is updated every January 1 based on the CPI-U plus an adjustment for annual dividend payments to Alaska residents.
3. In Illinois, traditional 1931 Medicaid coverage is based on a dollar threshold tied to TANF levels, which increased in 2019. Parents are also covered up to 133% FPL based on prior waiver eligibility and are not considered Section VIII expansion adults. In December 2020, Illinois began using state funds to cover individuals over age 65 who have a qualified immigrant status and otherwise meet the Aged, Blind and Disability eligibility category.
4. As of December 2020, Indiana has amended its 5% MAGI disregard calculations to meet the federal requirements (5% of FPL).
5. Massachusetts provides state subsidies for Marketplace coverage for parents and childless adults with incomes up to 300% FPL 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 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. The state also reimburses eligible MassHealth members with access to employer-sponsor insurance for some or all the premium cost of their private insurance.
6. 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.
7. Missouri and Oklahoma voters approved Medicaid ballot expansion measures in August 2020 and June 2020 respectively. Missouri has submitted a state plan amendment (SPA) for the expansion. Oklahoma's expansion SPAs were approved in December 2020. Medicaid expansion implementation for both states is set to begin in 2021.
8. Nebraska implemented the Affordable Care Act Medicaid expansion for adults effective October 1, 2020. Nebraska was approved for a Section 1115 waiver that authorizes two alternative benefit packages with specific stipulations to receive greater benefits to be implemented April 2021.
9. In Oklahoma, individuals without a qualifying employer with incomes up to 100% FPL are eligible for more limited subsidized insurance through the Insure Oklahoma Section 1115 waiver program. Individuals working for certain qualified employers with incomes at or below 222% FPL are eligible for premium assistance for employer-sponsored insurance.

10. 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.
11. 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.
12. In Virginia, eligibility levels for 1931 parents vary by region. The value shown is the eligibility level for Region 2, the most populous region.
13. Wisconsin covers adults up to 100% FPL in Medicaid but did not adopt the ACA Medicaid expansion.

Table 5: Medicaid and CHIP Applications During the COVID-19 Public Health Emergency, January 2021			
State	Increase in Applications ¹	Percent Change in Application Volume ²	Change in Primary Mode of Application ³
Total	17	<5% change: 2 5-10% change: 4 >10% change: 7 Unknown: 4	28
Alabama			
Alaska			Y
Arizona			Y
Arkansas			
California			Y
Colorado			Y
Connecticut			
Delaware	Y	>10% increase	
District of Columbia			Y
Florida	Y	<5% increase	
Georgia	Y	Unknown	
Hawaii	Y	>10% increase	Y
Idaho			
Illinois	Y	>10% increase	Y
Indiana			
Iowa			
Kansas			
Kentucky	Not reported	Not reported	
Louisiana			Y
Maine			
Maryland			Y
Massachusetts			Y
Michigan			
Minnesota			
Mississippi			Y
Missouri			
Montana			Y
Nebraska	Y	>10% increase	
Nevada	Y	>10% increase	
New Hampshire			Y
New Jersey			Y
New Mexico	Y	5%-10% increase	Y
New York	Y	>10% increase	Y
North Carolina			Y
North Dakota	Y	5%-10% increase	Y
Ohio			Y
Oklahoma			
Oregon	Y	Unknown	
Pennsylvania			Y
Rhode Island			Y
South Carolina			Y
South Dakota	Y	Unknown	Y
Tennessee	Y	>10% increase	Y
Texas	Y	<5% increase	Y
Utah			
Vermont	Y	5%-10% increase	
Virginia	Y	Unknown	
Washington	Y	5%-10% increase	
West Virginia			Y
Wisconsin			Y
Wyoming			Y

SOURCE: Based on a national survey conducted by KFF with the Georgetown University Center for Children and Families, 2021.
Table presents rules in effect as of January 1, 2021.

Table 5 Notes

1. This column indicates if the state experienced an increase in new applications in the period March – October 2020 compared to the prior year.
2. This column indicates the percentage increase in new applications for the states reporting an increase in new applications in the period March – October 2020 compared to the prior year.
3. States are required to offer four application modes: online, over the phone, in person, or mail. This column indicates if the state has experienced a shift in the primary application mode during the public health emergency period.

Table 6: Renewals, Changes in Circumstances, and Returned Mail, January 2021 ¹				
State	Renewals		Changes in Circumstances	
	Processing ex parte renewals and extending renewal dates ²	Renewal form sent if unable to process ex parte renewal ³	New 12-month renewal period if moved to new eligibility category ⁴	Proactively update addresses or plans to prior to the end of the PHE ⁵
Total	41	28	19	19
Alabama			Y	Y
Alaska	Y	Y		
Arizona	Y	Y		
Arkansas	Y	Y		
California	Y	Y	Y	
Colorado	Y	Not reported	Y	
Connecticut	Y	Y	Y	
Delaware	Y			
District of Columbia				
Florida	Y	Y	Y	Y
Georgia	Y	Y		
Hawaii	Y	Y		Y
Idaho	Y	Y		
Illinois	Y	Y	Y	Y
Indiana	Y			
Iowa	Y			
Kansas	Y		Y	
Kentucky				
Louisiana	Y			Y
Maine	Y	Y		
Maryland	Y	Y	Y	Y
Massachusetts	Y		Y	Y
Michigan				
Minnesota	Y			Y
Mississippi	Y			
Missouri				Y
Montana	Y	Y	Y	Y
Nebraska	Y	Y		
Nevada				
New Hampshire	Y	Y		Y
New Jersey	Y	Y	Y	
New Mexico	Y	Y		Y
New York			Y	Y
North Carolina	Y	Y	Y	
North Dakota	Y	Y		Y
Ohio	Y	Y		
Oklahoma	Y	Y		
Oregon	Y	Not reported		
Pennsylvania	Y	Y		
Rhode Island			Y	Y
South Carolina			Y	Y
South Dakota	Y	Y	Y	
Tennessee	Y			Y
Texas	Y	Y	Y	Y
Utah	Y	Y	Y	Y
Vermont	Y			
Virginia	Y	Y		
Washington	Y	Y		
West Virginia	Y	Y		
Wisconsin	Y		Y	
Wyoming				

SOURCE: Based on a national survey conducted by KFF with the Georgetown University Center for Children and Families, 2021.
Table presents rules in effect as of January 1, 2021.

Table 6 Notes

1. Normal state operations were disrupted in 2020 as a result of the COVID-19 pandemic. The Families First Coronavirus Response Act requires states to maintain continuous eligibility during the public health emergency. As a result, some states suspended or altered their renewal processes.
2. 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 or passive renewals. This column indicates if the state was continuing to conduct ex parte renewals as of January 2021.
3. 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. This column indicates if a state was continuing to send pre-populated renewal forms as of January 2021.
4. This column indicates if the state is currently moving beneficiaries to a new eligibility pathway when changes in circumstances are processed. In early November 2020, CMS released an [Interim Final Rule](#) establishing new regulations requiring states to move beneficiaries with changes in circumstances to a new eligibility pathway if it is in the same or a higher benefit tier. The guidance establishes three benefit tiers: tier 1 meets minimum essential coverage (MEC); tier 2 benefits are not MEC but are robust enough to include access to coverage of both testing services and treatment for COVID-19; tier 3 benefits are not MEC and do not cover COVID-19 testing and treatment.
5. This column indicates whether the state routinely takes steps to update address information for enrollees prior to receiving returned mail or plans to do so prior to the end of the public health emergency.

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