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Medicaid and CHIP Eligibility, Enrollment, and Cost Sharing Policies as of January 2019: Findings from a 50-State Survey

Prepared by:

Tricia Brooks and Lauren Roygardner
Georgetown University Center for Children and Families

and

Samantha Artiga
Kaiser Family Foundation

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HENRY J KAISER FAMILY FOUNDATION

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Key Takeaways

This 17th annual survey of the 50 states and the District of Columbia (DC) provides data on Medicaid and the Children's Health Insurance Program (CHIP) eligibility, enrollment, renewal, and cost sharing policies as of January 2019. See Appendix Tables 1-20 for state data. Over time, Medicaid has evolved from a program with limited eligibility and burdensome enrollment rules that excluded many low-income adults and created barriers to enrollment for eligible individuals to a modernized program that, along with CHIP, provides a broad base of health coverage for the low-income population and more effectively and efficiently connects eligible individuals to coverage. The survey data show:

- **Under the Affordable Care Act (ACA), most states have expanded Medicaid to low-income adults, helping to fill longstanding gaps in coverage.** In the past year, there was an uptick in state activity to expand Medicaid, with five additional states taking steps forward. With this state action, 37 states, including DC, had adopted the ACA Medicaid expansion as of January 2019. Eligibility remains very restricted for adults in the 14 states that have not yet adopted the expansion, with the median eligibility level for parents at 40% FPL ($8,532 per year for a family of three as of 2019) and other adults remaining ineligible regardless of their income in all of these states, except Wisconsin.
- **Reflecting ACA policies, all states have implemented more streamlined enrollment and renewal processes, regardless of whether they have adopted the ACA Medicaid expansion**. As of January 2019, individuals can apply online for Medicaid in all states for the first time and most states can complete real-time determinations (within 24 hours) (46 states) and automated renewals (46 states). These modernized, streamlined processes can facilitate individuals' ability to enroll in and maintain coverage and reduce state administrative burdens.

Looking ahead, one key question is whether there will be continued advances to expand coverage and streamline enrollment or whether emerging policies will erode coverage gains and enrollment simplifications realized under the ACA. The Trump Administration is promoting new Medicaid eligibility requirements through waivers and its proposed budget and has approved a growing number of waiver requests from states, including work requirements, which have never previously been approved for the program. These provisions require complex and costly documentation and administrative efforts that would likely increase barriers to coverage and lead to coverage losses among eligible individuals. Other factors outside of Medicaid may also be contributing to enrollment declines among eligible individuals, including shifting immigration policy.

This 17th annual survey of the 50 states and the District of Columbia (DC) provides data on Medicaid and the Children's Health Insurance Program (CHIP) eligibility, enrollment, renewal, and cost sharing policies as of January 2019. It is based on a telephone survey of state Medicaid and CHIP officials conducted by the Kaiser Family Foundation and the Georgetown University Center for Children and Families. Appendix Tables 1-20 include state data. The survey data over the past 17 years document how Medicaid has evolved from a program with limited eligibility and burdensome enrollment rules that excluded many low-income adults and created barriers to enrollment for eligible individuals to a modernized program that, with CHIP, provides a broad base of health coverage for the low-income population and more effectively and efficiently connects eligible individuals to coverage. Emerging policies to add Medicaid eligibility requirements could lead to coverage losses and increase the complexity of enrollment processes, eroding coverage gains and enrollment simplifications realized under the ACA.

Eligibility

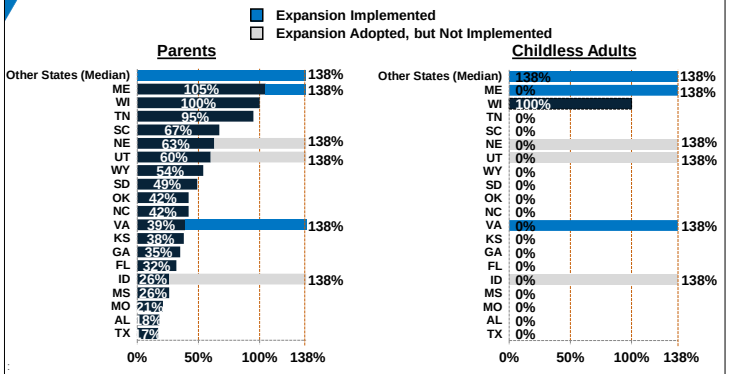
Prior to the Affordable Care Act (ACA), many poor parents and other adults remained ineligible for Medicaid. Under previous rules, Medicaid eligibility was limited to certain groups of individuals with limited incomes. Eligibility for parents was very restricted and states could not receive federal Medicaid matching funds to cover other non-disabled adults. The ACA helped fill longstanding gaps in coverage by expanding Medicaid to adults with incomes up to 138% of the Federal Poverty Level (FPL) ($29,435 for a family of three or $17,236 for an individual as of 2019) and provided enhanced federal funding to states for expansion coverage.

Most states have expanded Medicaid to low-income adults under the ACA, and five additional states took steps forward with expansion in the past year. Virginia and Maine became the latest states to implement the Medicaid expansion as of January 2019, significantly increasing eligibility for parents and other adults (Figure 1). Voters in Idaho, Nebraska, and Utah passed ballot initiatives in 2018 to adopt the expansion, although it had not been implemented as of January 2019, and Utah and Idaho are seeking to add restrictions to the expansion. With this action, 37 states, including DC, had adopted the Medicaid expansion as of January 2019.

In the 14 states that had not yet adopted the Medicaid expansion as of January 2019, eligibility for parents and other adults remains very restrictive. The median eligibility level for parents in these states is 40% FPL ($8,532 per year for a family of three as of 2019) and other adults remain ineligible regardless of their income in all of these states, except Wisconsin. In these states, 2.5 million poor uninsured adults fall into a coverage gap, earning too much to qualify for Medicaid but not enough to qualify for subsidies to purchase insurance through the Marketplace, which become available at 100% FPL.[1]

Figure 1

Medicaid Income Eligibility Limits for Adults based on Adoption of Medicaid Expansion as of January 2019

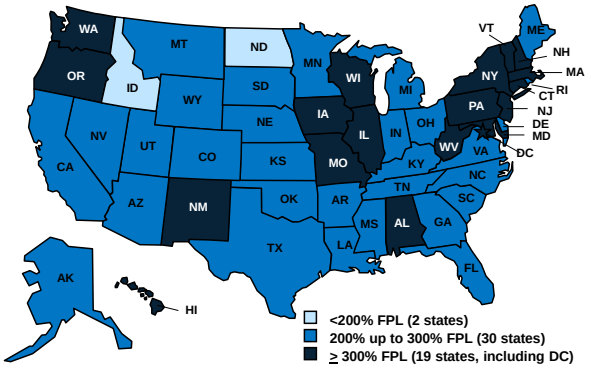


NOTES: Eligibility levels are based on a family of three for parents and an individual for childless adults. In 2019, the FPL was $21,330 for a family of three and $12,490 for an individual. Thresholds include the standard five percentage point of FPL disregard. UT provided more limited coverage to some 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 the Kaiser Family Foundation and the Georgetown University Center for Children and Families, 2019.

Medicaid and CHIP eligibility for children and pregnant women remains stable and robust. Eligibility levels for children and pregnant women are well above those for parents and other adults in almost all states. As of January 2019, 19 states, including DC, extend eligibility levels for children to 300% FPL or above (Figure 2), and nearly half of states provide eligibility to pregnant women above 200% FPL. The median income

Figure 2

Income Eligibility Levels for Children in Medicaid/CHIP, January 2019



NOTE: Eligibility levels are based on 2019 federal poverty levels (FPLs) for a family of three. In 2019, the FPL was $21,330 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, 2019.

eligibility limit is 255% FPL ($54,392 per year for a family of three as of 2019) for children and 200% FPL ($42,660 for a family of three as of 2019) for pregnant women as of January 2019. The stability of children's coverage reflected Congressional action in 2018 to continue CHIP funding through 2027 and retain the maintenance of effort (MOE) provision that preserves eligibility levels and enrollment procedures for children.

In 2018, additional states obtained Section 1115 waivers to add new eligibility requirements to their Medicaid programs. As of January 2019, 13 states had approved waivers allowing one or more eligibility requirements including conditioning eligibility on meeting a work requirement, adding completion of a health risk assessment as an eligibility requirement, charging premiums or monthly contributions, eliminating retroactive eligibility, delaying coverage until the first premium payment, and/or locking enrollees out of coverage for a period of time if they have unpaid premiums or do not complete timely renewals or report changes in circumstances.[2] Many of these provisions require complex and costly administrative efforts that run counter to the streamlined enrollment processes under the ACA and lead to increased barriers to coverage and coverage losses among eligible individuals.

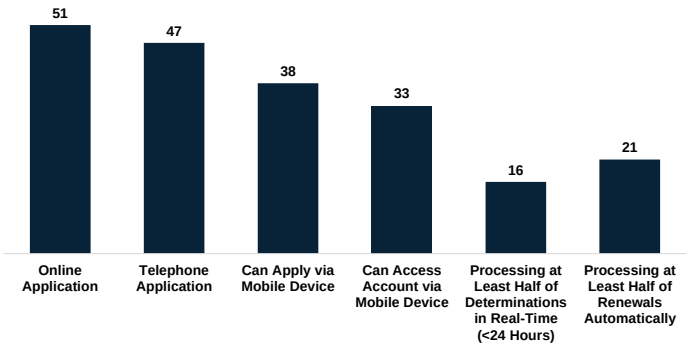
Enrollment and Renewal

Prior to the ACA, many states relied on paper-based, manual enrollment processes with burdensome requirements that could take days and weeks in some states. In addition to expanding Medicaid to adults, the ACA accelerated the adoption of new data-driven enrollment and renewal processes to connect individuals to coverage more quickly and conveniently and reduce the paperwork burden on states and individuals. These changes applied to all states regardless of whether they adopted the Medicaid expansion. The ACA also provided states enhanced federal funding for system upgrades to facilitate these improvements.

As of January 2019, many states provide a modernized, streamlined enrollment and renewal experience for individuals, reflecting the policies established by the ACA. With Tennessee rolling out a new eligibility system, individuals can apply online for Medicaid in all states for the first time as of January 2019 (Figure 3). Individuals can also apply by phone in the majority of states and, in many states, individuals can use a mobile device to apply or access an online account. Although online applications offer potential benefits to individuals and states, other application pathways, including in-person and mail, remain important, particularly for people with limited computer or internet access. Reflecting increased use of electronic data matches to verify eligibility criteria, the majority of states can complete real-time determinations (within 24 hours) (46

Figure 3

Number of States with Selected Modernized Enrollment and Renewal Processes, January 2019



SOURCE: Based on results from a national survey conducted by the Kaiser Family Foundation and the Georgetown University Center for Children and Families, 2019.

states) and automated renewals (46 states), with 16 states making at least half of determinations in real-time and 21 states completing at least half of renewals automatically. Reflecting these broad system and process changes, most states indicated improvements in one or more areas of eligibility operations compared to before the ACA.

Premiums and Cost-Sharing

Federal regulations establish parameters for premiums and cost sharing for Medicaid and CHIP enrollees that reflect their limited ability to pay health care costs. Given their modest incomes, research shows that premiums serve as a barrier to enrollment for low-income families and copayments can limit utilization of needed health care.[3]

Kentucky and New Mexico eliminated cost sharing for children during 2018; otherwise, premiums and cost sharing for children remained largely stable. This stability, in part, reflects that states generally cannot increase premiums for children under the MOE provision included in the CHIP funding extension through 2027.

Premiums remain limited among parents and other adults, although additional states received waiver approval to impose premiums or monthly contributions on these groups during 2018. Some states have obtained waiver approval to charge premiums or monthly contributions not otherwise allowed under federal rules. As of January 2019, five states (Arkansas, Iowa, Indiana, Michigan, and Montana) were charging premiums or monthly contributions for parents or other adults. Several additional states have received waiver approval for premiums or monthly contributions for adults, but they were not implemented as of January 2019. Some of these waivers also allow individuals to be locked out of coverage for a period of time if they are disenrolled due to non-payment and to delay coverage until after the first premium is paid. States can charge nominal cost sharing for adults in Medicaid under federal rules, and most states charge cost sharing for parents who were eligible for Medicaid through traditional pathways prior to the ACA and other adults.

Looking Ahead

Looking ahead, one key question is whether there will be continued advances to expand coverage and streamline enrollment processes or whether emerging policy changes will erode coverage gains and enrollment simplifications realized under the ACA.

Additional states may expand Medicaid, which would increase access to coverage for low-income adults and have positive effects on access to and use of care and state budgets and economies.[4] However, if states attach waiver provisions such as work requirements or other restrictions to expansion, the positive reach and impact would be limited. Recently, some states have indicated interest in a partial expansion to an income level below 138% FPL with the ACA enhanced federal match rate.[5] Relative to full expansion, partial expansions could limit coverage and potentially increase federal costs. While states can pursue waivers to extend coverage to a lower income level without access to the enhanced federal match, no waivers to allow an enhanced match for a partial expansion have been approved to date, and guidance from the previous administration prohibited use of the enhanced match for “partial expansions.”

Renewed CHIP funding protects children's eligibility levels through 2027, but states that extend eligibility above 300% FPL will have the option to reduce eligibility starting in October 2019. When Congress continued funding for CHIP in 2018, it retained the MOE provision that requires states to preserve Medicaid and CHIP eligibility and enrollment policies for children. However, starting in October 2019, the MOE only applies to children's coverage up to 300% FPL, meaning that states with eligibility limits above this level could reduce eligibility in the future. This change coincides with the beginning of the phase-out of the temporary 23-percentage point boost in federal CHIP matching rates, leaving states to resume paying a larger share of CHIP costs.

Emerging state and federal policies to add Medicaid eligibility requirements could erode the coverage gains and enrollment simplifications realized under the ACA. The Trump Administration is promoting new Medicaid eligibility requirements through waivers and its proposed budget and has approved a growing number of waiver requests from states, including work requirements, which have never previously been approved for the program. Some states are no longer moving forward with implementing waiver provisions following a change in leadership in the 2018 elections,[6,7] while other states are considering adding waiver provisions.[8,9,10,11] These types of requirements create barriers to coverage and increase administrative burdens and costs for states.[12,13] As such, they will likely dampen potential coverage gains and lead to coverage losses.

Other policy changes may lead to coverage losses among eligible low-income families and growing administrative burdens on states. In 2017, coverage gains stalled and began to reverse for the first time since implementation of the ACA, and Medicaid enrollment of adults and children declined in 2018.[14,15,16] Some of the decline in Medicaid enrollment could reflect the improving economy. However, some factors may be leading to a drop in enrollment among eligible individuals. While states' growing use of technology and automation has led to improvements for individuals and states, there are concerns emerging in some states that eligible individuals may be losing coverage due to process-related issues.[17,18,19] Further, other policy changes outside of Medicaid could be dampening enrollment. For example, the Trump administration substantially decreased funding for outreach and enrollment assistance, which is pivotal for helping eligible individuals get and stay enrolled in coverage. In addition, shifting immigration policies, including a proposed rule to make changes to public charge policy, will likely lead to broad decreases in participation in Medicaid among legal immigrant families and their primarily U.S.-born children and increase administrative burdens on states.[20] Twenty states reported that they would need to change applications, forms, or other guidance, conduct additional staff training, and/or increase outreach and education to immigrant families if the public charge rule is finalized, while most of the remaining states indicated they could not yet determine how the rule would impact their operations.

Introduction

This 17th annual survey of the 50 states and DC provides data on Medicaid and CHIP eligibility, enrollment, renewal, and cost sharing policies as of January 2019 and changes implemented in 2018. 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 2019. 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 (who are determined eligible based on Modified Adjusted Gross Income (MAGI) financial eligibility rules); it does not include policies for groups eligible through Medicaid eligibility pathways for seniors and individuals eligible based on a disability (non-MAGI groups).

Evolution of Medicaid Eligibility and Enrollment

Medicaid has expanded over time to fill gaps in coverage and provide a broad base of coverage for the low-income population. Historically, Medicaid eligibility was tied to cash assistance and limited to low-income individuals in certain categories, including children, pregnant women, parents, seniors, and individuals with a disability. Over time, Congress gradually expanded Medicaid eligibility for children, and it was formally delinked from cash assistance in 1996. Following this delinking and the enactment of CHIP in 1997, many states continued to expand eligibility for children and pregnant women. Moreover, many states pursued innovative outreach and enrollment efforts to help mitigate coverage losses associated with delinking Medicaid from cash assistance and facilitate enrollment of eligible but uninsured children and pregnant women under the broader eligibility rules. However, eligibility for parents remained limited and other nondisabled adults were excluded from the program regardless of income. The ACA filled these coverage gaps by expanding Medicaid to low-income adults with incomes up to 138% FPL and providing enhanced federal funding to states for expansion coverage.

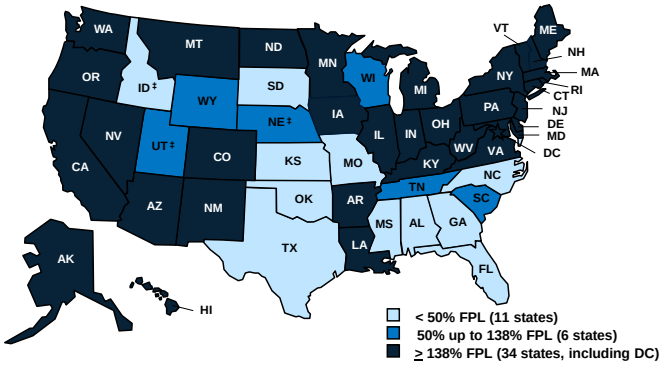
In addition, the Medicaid and CHIP enrollment and renewal experience has evolved from a paper-based, cumbersome process to a modernized, streamlined approach. Prior to the ACA, Medicaid enrollment processes in many states reflected the program's historic ties to cash assistance. As of January 2013, over half of states imposed an asset test on parents, and some still required parents to complete a face-to-face interview at enrollment or renewal. Applications could only be completed by mail or in-person in a number of states and eligibility determinations could sometimes take days or weeks. The ACA accelerated the adoption of new data-driven enrollment and renewal processes that align and coordinate with the Marketplaces. These processes allow individuals to connect to coverage more quickly and conveniently and reduce the paperwork burden on states and individuals. The streamlined enrollment and renewal policies apply to all states regardless of whether they expanded Medicaid under the ACA. Many of the ACA policies built on innovations states implemented to facilitate enrollment when they expanded coverage for children following the enactment of CHIP. This previous state experience and research showed that complex enrollment processes with burdensome requirements create barriers for eligible individuals to obtain and maintain coverage and increase administrative burdens and costs for states.[21,22]

Eligibility as of January 2019

Under the ACA, most states have expanded Medicaid to low-income adults. As of January 2019, 34 states, including DC, had implemented the Medicaid expansion, extending eligibility to parents and other adults with incomes up to 138% FPL ($29,435 for a family of three or $17,236 for an individual as of 2019) (Figures 4 and 5). Connecticut and DC provide eligibility to higher levels. DC covers parents to 221% FPL and other adults to 215% FPL, and Connecticut restored parent eligibility to 155% FPL in 2018, after it had been reduced to 138% FPL in 2017.

Figure 4

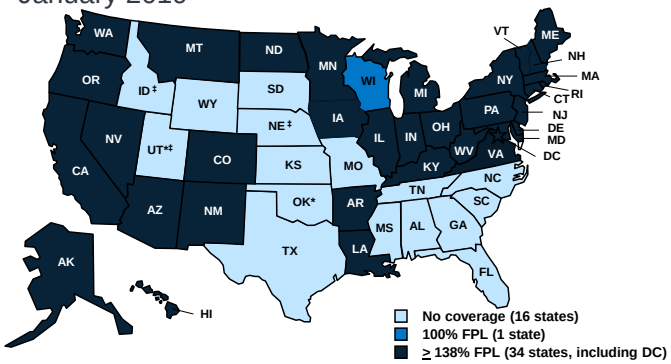
Medicaid Income Eligibility Levels for Parents, January 2019



NOTE: Eligibility levels are based on 2019 federal poverty levels (FPLs) for a family of three. In 2019, the FPL was $21,330 for a family of three. Thresholds include the standard five percentage point of the FPL disregard. ‡ID, NE, and UT passed ballot initiatives requiring the state to implement the ACA Medicaid expansion, but it was not implemented as of January 2019.
SOURCE: Based on results from a national survey conducted by the Kaiser Family Foundation and the Georgetown University Center for Children and Families, 2019.

Figure 5

Medicaid Income Eligibility Levels for Other Adults, January 2019



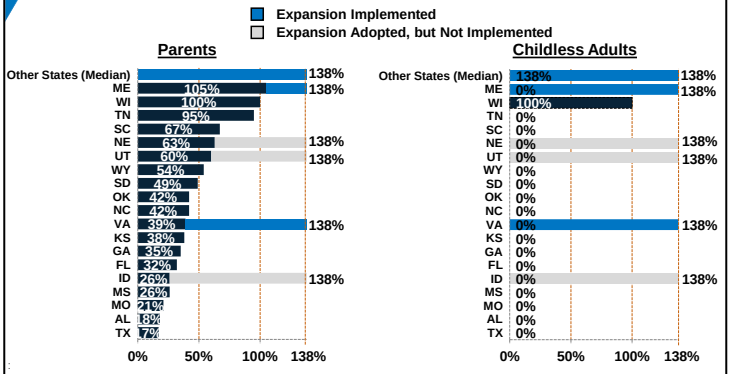
NOTE: Eligibility levels are based on 2019 federal poverty levels (FPLs) for an individual. In 2019, the FPL was $12,490 for an individual. Thresholds include the standard five percentage point of the FPL disregard. *OK and UT provide more limited coverage to some childless adults under Section 1115 waiver authority. ‡ ID, NE, and UT passed ballot initiatives requiring the state to implement the ACA Medicaid expansion, but it was not implemented as of January 2019.
SOURCE: Based on results from a national survey conducted by the Kaiser Family Foundation and the Georgetown University Center for Children and Families, 2019.

There was an uptick in state action to expand in the past year, with five additional states taking steps forward. In January 2019, Maine and Virginia implemented the Medicaid expansion, significantly increasing eligibility for parents and other adults (Figure 6). Through ballot initiatives in November 2018, Idaho, Nebraska, and Utah voters adopted the expansion, although it had not yet been implemented as of January 2019, and Utah and Idaho are seeking to add restrictions to their expansions. With this state action, 37 states, including DC, had adopted the expansion as of January 2019.

In the 14 states that have not yet adopted or implemented the Medicaid expansion, eligibility levels remain limited to very low-income parents, and other adults are largely ineligible. In these states, the median eligibility level for parents was 40% FPL, or $8,532 for a family of three, with ten states limiting parent eligibility to less than half of the poverty level. Other adults remain ineligible for Medicaid regardless of their income in all of these states, except Wisconsin. Moreover, in 10 of these 14 states, the parent eligibility level has been eroding over time as a percent of the FPL (from 42% FPL to 39% FPL

Figure 6

Medicaid Income Eligibility Limits for Adults based on Adoption of Medicaid Expansion as of January 2019



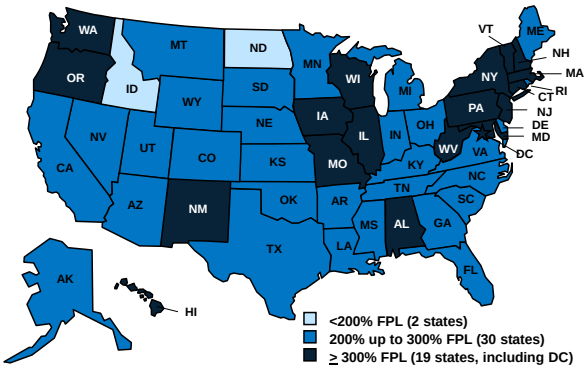
NOTES: Eligibility levels are based on a family of three for parents and an individual for childless adults. In 2019, the FPL was $21,330 for a family of three and $12,490 for an individual. Thresholds include the standard five percentage point of FPL disregard. UT provided more limited coverage to some 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 the Kaiser Family Foundation and the Georgetown University Center for Children and Families, 2019.

between January 2014 and January 2019), because it is tied to a static dollar threshold, while the FPL generally increases each year. This erosion further widens the disparity in coverage available for adults in expansion states versus those that have not yet adopted the expansion.

As of January 2019, eligibility levels for children were robust, with 49 states covering children with incomes above 200% FPL (Figure 7). Eligibility levels for children ranged from 175% FPL to 405% FPL across states, with a median level of 255% FPL. All states use CHIP funding to extend children's coverage through a Medicaid expansion, a separate CHIP program, or a combination of both approaches. As of January 2019, 36 states had a separate CHIP program, which provides states additional flexibility with regard to benefits, premiums, and cost sharing. However, 16 of these states provide children in their separate CHIP program the full Early, Periodic, Screening, Diagnosis and Treatment Services (EPSDT) benefit that is the Medicaid benefit standard for children.

Figure 7

Income Eligibility Levels for Children in Medicaid/CHIP, January 2019



NOTE: Eligibility levels are based on 2019 federal poverty levels (FPLs) for a family of three. In 2019, the FPL was $21,330 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, 2019.

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In 2018, Congress extended CHIP funding through 2027, which supports stable coverage for children. This action followed the longest funding lapse since the CHIP program was enacted in 1997, which had put continued coverage in jeopardy. The legislation retained the MOE provision requiring states to preserve children's eligibility levels and enrollment policies. Starting in October 2019, however, the MOE will not apply to eligibility levels above 300% FPL.[23] At that time, states may continue covering children at these higher income levels and receive federal funding, but they would newly have the option to reduce eligibility to 300% FPL. This change in the MOE coincides with the beginning of a phase-out of the 23-percentage point temporary boost in federal CHIP matching rates. Also in 2018, Congress passed legislation requiring states to cover all former foster youth up to age 26 in Medicaid, regardless of where the youth was in foster care.[24] Previously, states were only required to cover those who had been in foster care within the state. This provision will become effective in 2023. In the interim, as of January 2019, 11 states have a waiver to cover former foster children regardless of whether they had been in care within the state, with Michigan discontinuing this coverage in 2018.

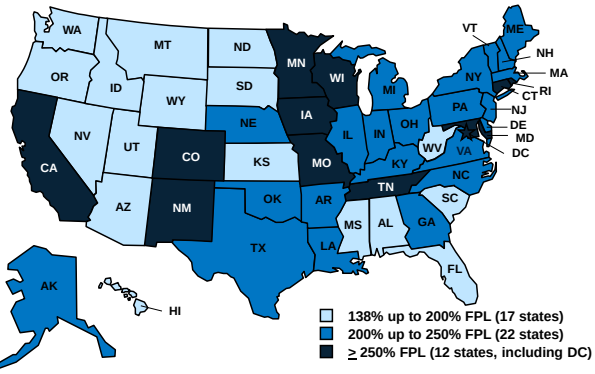
Almost half of states (22) report using CHIP funds to support a Health Services Initiative (HSI). Since the enactment of CHIP in 1997, states have had an option to utilize CHIP funds to support a state-designed HSI to improve the health of low-income children, as long as CHIP administrative costs combined with HSI services do not exceed 10% of total CHIP expenditures. HSIs must directly improve the health of low-income children who are eligible for CHIP and/or Medicaid but may serve children regardless of income. States reported a variety of purposes for their HSIs with the most common including supporting poison control systems, enhancing access to health services in schools, providing immunization services, and funding lead abatement efforts. Several states have enacted multiple

initiatives through HSI funding with unique purposes ranging from supporting early reading programs in Oklahoma to providing respite care for children with developmental disabilities in New Jersey.

The median eligibility level for pregnant women remained steady at 200% FPL, with the upper eligibility limit ranging from 138% FPL to 380% FPL across states. The majority of states (47) provide Medicaid eligibility to pregnant women beyond the federal minimum of 138% FPL, and nearly half of states (22) extend eligibility to above 200% FPL (Figure 8). Five states use CHIP funds to cover pregnant women above Medicaid levels. In 46 states, pregnant women receive full Medicaid benefits (versus pregnancy-related services only), and all five states covering pregnant women with CHIP funds provide full CHIP benefits. All states are required to provide family planning services to individuals in Medicaid, while 28 states offer family planning services to individuals not otherwise eligible for Medicaid through a state option or waiver.[25] In 2018, Maryland expanded family planning eligibility to 264% FPL to match its eligibility level for pregnant women and extended eligibility to men while New Mexico added age restrictions to its coverage.

Figure 8

Income Eligibility Levels for Pregnant Women in Medicaid/CHIP, January 2019

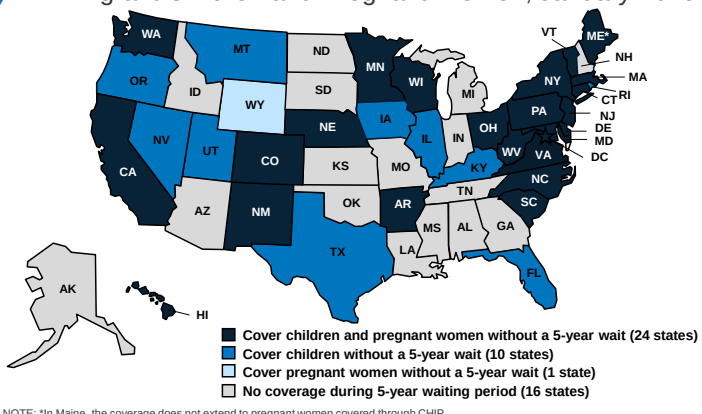


NOTE: Eligibility levels are based on 2019 federal poverty levels (FPLs) for a family of three. In 2019, the FPL was $21,330 for a family of three. Thresholds include the standard five percentage point of the FPL disregard.
SOURCE: Based on results from a national survey conducted by the Kaiser Family Foundation and the Georgetown University Center for Children and Families, 2019.

A total of 35 states have taken up the option to eliminate the five-year waiting period for Medicaid/CHIP coverage for lawfully-residing immigrant children and/or pregnant women (Figure 9). Lawfully residing immigrants may qualify for Medicaid and CHIP but are subject to eligibility restrictions. In general, they must have a "qualified" immigration status and many, including most lawful permanent residents or "green card" holders, must wait five years after obtaining qualified status before they may enroll.[26] States have an option to eliminate the five-year wait for lawfully residing immigrant children and pregnant women.[27] Half of states (24) apply the option to both children and pregnant women, while ten states use it for children only, and one state (Wyoming) uses it only for pregnant women. This count includes Nevada, which implemented the option for children in January 2019. Since 2002, states also have had the option to provide prenatal care to women regardless of immigration status by extending CHIP coverage to the unborn

Figure 9

Medicaid/CHIP Coverage for Lawfully Residing Immigrant Children and Pregnant Women, January 2019



NOTE: *In Maine, the coverage does not extend to pregnant women covered through CHIP.
SOURCE: Based on results from a national survey conducted by the Kaiser Family Foundation and the Georgetown University Center for Children and Families, 2019.

child, which 16 states provided as of January 2019. Undocumented immigrants are not eligible to enroll in Medicaid or CHIP, but some states have fully state-funded programs that cover certain groups of immigrants regardless of immigration status, including seven states that cover all income-eligible children.[28]

Emerging Eligibility Restrictions in Section 1115 Waivers

In 2018, some states obtained Section 1115 waivers to add eligibility requirements to their Medicaid programs not otherwise allowed under federal rules. Many of these provisions are targeted to low-income adults made eligible by the ACA Medicaid expansion, although, in some states, they also affect poor parents and other traditional groups that existed prior to the ACA.[29,30] As of January 2019, 13 states had approved waivers that allow one or more eligibility requirements, including conditioning eligibility on meeting a work requirement, adding completion of a health risk assessment as an eligibility requirement, charging premiums or monthly contributions, eliminating retroactive eligibility, delaying coverage until the first premium payment, and/or locking enrollees out of coverage for a period of time if they have unpaid premiums or do not complete timely renewals or report changes in circumstances.[31] However, many of these provisions had not yet been implemented as of January 2019.

These new eligibility requirements will increase barriers to coverage and contribute to coverage losses.[32,33] Under these new requirements, eligible people may lose coverage due to their inability to navigate more complicated enrollment processes and requirements, such as documenting work or a qualifying exemption.[34] Moreover, a large and longstanding body of research shows that premiums serve as an enrollment barrier among the low-income population.[35] As such, implementation of the eligibility restrictions will likely lead to reductions in Medicaid enrollment and erode coverage gains achieved under the ACA. For example, in Arkansas, the first state to implement a work requirement under a waiver, over 18,000 individuals lost coverage between September and December 2018 due to not meeting the work reporting requirements.[36] Additional research is needed to understand more about enrollees who lost coverage, but an early study found that many enrollees in Arkansas were unaware of or confused by the new requirements (despite outreach efforts) and faced multiple barriers complying with the work and reporting requirements that initially could only be reported online.[37]

Recent waiver provisions also would make enrollment processes more complex and increase administrative burdens on states.[38] Implementing these types of eligibility provisions increases documentation requirements on individuals and states and can be administratively complex and costly. A number of states reported that implementing or preparing to implement these waivers increased administrative costs, staff time, the length of time to process renewals, and/or required changes to systems. For example, states implementing work requirements likely have to make system changes to reflect new eligibility rules; document compliance with new requirements; interface with other programs; implement coverage lockout periods; and exchange information among the state, enrollment broker, health plans, and providers. Additional staff may be required to educate enrollees, develop notices, evaluate and process exemptions, and review applications as churn increases and enrollees reapply or appeal coverage lockout periods.

Enrollment and Renewal Processes as of January 2019

The ACA accelerated the adoption of data-driven enrollment and renewal processes that align and coordinate with the Marketplaces. Prior years of the survey documented that states have made significant progress upgrading or building new systems and re-engineering their business processes to provide a more modernized and streamlined enrollment and renewal experience that increasingly relies on electronic data matches to verify eligibility criteria. As noted in last year's report, continued advancement leveled off as these systems and processes matured, although states continued to implement targeted improvements and some states are still engaged in system upgrades. This year's data shows continued progress in some areas, plans for continued improvements, and insight into how states' current eligibility operations compare to prior to the ACA.

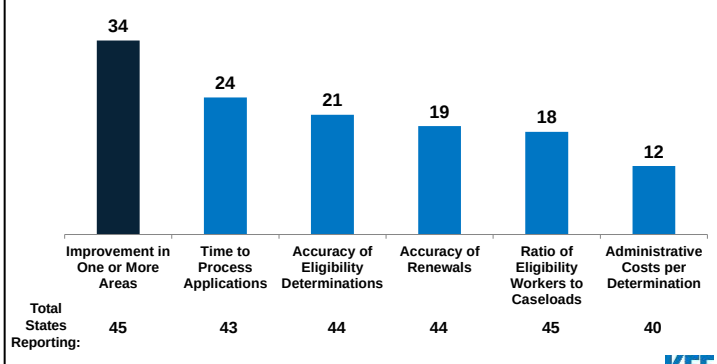
Eligibility Systems and Operations

Implementation of the ACA required states to change eligibility systems to implement new MAGI-based financial eligibility methodology for pregnant women, children, parents, and expansion adults and to apply streamlined eligibility and enrollment processes for MAGI groups that coordinate with the Marketplaces. To assist states with ACA implementation and accelerate the use of technology, the federal government increased the federal match available for states to implement new or upgraded systems to 90%.

States took varied approaches to implement system changes to reflect MAGI-based Medicaid and CHIP eligibility and enrollment processes. As of January 2019, most states had launched a new eligibility system or made a significant system upgrade, while others made only necessary adjustments to existing systems. Some states implemented new systems or major upgrades when the ACA was first implemented in 2014, while others have done so more recently. Some states are still implementing new systems or upgrades, either to replace older legacy systems or to build upon and continue to improve newer systems. Tennessee, which had relied solely on the Federally-facilitated Marketplace (FFM) to implement ACA policies, launched its new combined Medicaid and CHIP eligibility system on a pilot basis in select counties in 2018, with statewide expansion planned for early 2019.

Figure 10

Eligibility Operations as of January 2019 Compared to Prior to the ACA



SOURCE: Based on results from a national survey conducted by the Kaiser Family Foundation and the Georgetown University Center for Children and Families, 2019.

In many states, these system upgrades and re-engineered processes have contributed to improvements in eligibility and enrollment operations compared to before the ACA. Most states (34 of 46 reporting states) reported improvement in at least one area of eligibility operations compared to prior to the ACA (Figure 10). Officials in some states described how new systems provided increased efficiency and accuracy and freed up eligibility workers to work on more complex cases. Some states reported no change in their operations compared to prior to the ACA. Only six states reported that one or

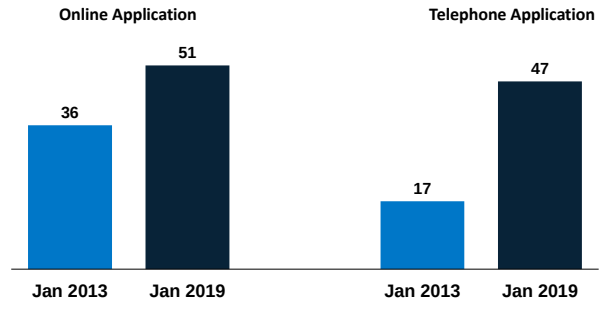
more of these aspects of operations were worse, but a number of those states were in the process of implementing a new system, which is often associated with short-term challenges.

Applications, Online Accounts, and Mobile Access

With Tennessee's launch of a new eligibility system and accompanying web-based application in 2018, individuals can apply online for Medicaid in every state as of January 2019.[39] In contrast, online applications were only available in 36 states in January 2013, the year prior to the implementation of the ACA coverage provisions (Figure 11). In 38 states, individuals can complete the online application using a mobile device, and 20 states have made the online application mobile-friendly and/or developed a mobile "app" for the application. In 2018, Indiana and Tennessee developed the capacity for individuals to apply using a mobile device, New Hampshire and Nevada added a mobile-friendly design to their application, and Wisconsin launched a mobile "app" for its online application. Additional states plan to enhance mobile functionality in 2019 or later. All states also offer the ability for individuals to apply via telephone, but four states have not enabled telephonic signatures and require a follow-up paper form or electronic signature to complete the application. The broad availability of telephone applications also represents a significant increase compared to prior to the ACA, when telephone applications were accepted in only 17 states.

Figure 11

Number of States with Online and Telephone Medicaid Applications, January 2013 and 2019

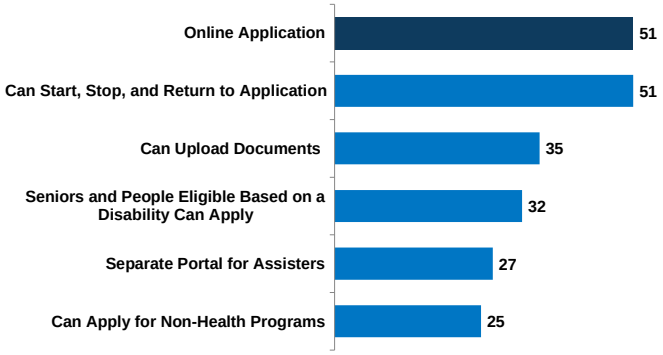


NOTE: In additional states, individuals can complete the application by phone but must provide a follow-up paper form or signature to complete the application process.
SOURCE: Based on results from national surveys conducted by the Kaiser Family Foundation and the Georgetown University Center for Children and Families in 2013 and 2019.

All states have designed their online applications so that individuals may start, stop, and return to the application (Figure 12). In addition, two-thirds of states (35) provide the option for individuals to scan and upload documents that may be needed to verify eligibility, and 27 states have separate portals for application assisters to submit facilitated applications. In 32 states, all Medicaid eligibility groups (children, pregnant women, adults, seniors, and individuals eligible based on a disability) can apply through a combined online application. Half of the states (25) offer a multi-benefit online application that also allows individuals to apply for at least one non-health program such as the Supplemental Nutrition Assistance Program (SNAP),

Figure 12

Number of States with Selected Features and Functions for Online Medicaid Applications, January 2019



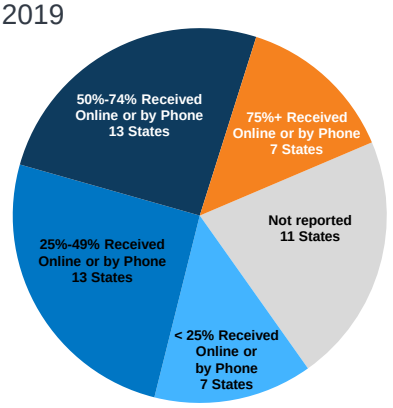
SOURCE: Based on results from a national survey conducted by the Kaiser Family Foundation and the Georgetown University Center for Children and Families, 2019.

Temporary Assistance for Needy Families (TANF), or child care assistance. These combined applications can facilitate individuals' access to a broader array of services, but also may increase the length and complexity of the application.

Although online applications offer potential benefits to individuals and states, other application pathways remain important. Online applications can make applying for coverage more convenient and accessible for some individuals, and can facilitate faster processing of determinations, limit data entry errors, and reduce state administrative burdens. However, other application pathways remain important for individuals who may not have easy access to a computer or the internet or who feel more comfortable applying in-person or through a paper form. Among the 40 states able to report data on modes of application, the median share of applications received online was 50%. The remaining half came via phone, in-person, or mail, although the share of telephone applications was very small in many states. Of these 40 states, 20 reported receiving half or more of applications online, including 7 states that reported receiving at least 75% of applications online (Figure 13). However, the share varied widely across states, ranging from 4% in Mississippi to 90% or higher in Florida, New York and Texas.

Figure 13

Share of Medicaid Applications Received Online, January 2019

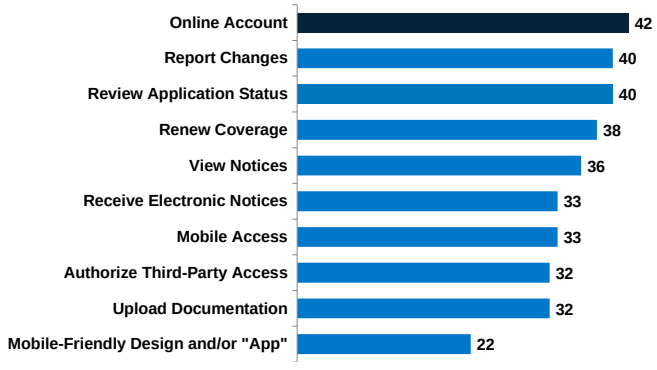


SOURCE: Based on results from a national survey conducted by the Kaiser Family Foundation and the Georgetown University Center for Children and Families, 2019.

States continued to advance the use of electronic accounts for enrollees to review or submit information. Online accounts add convenience for enrollees to access and update their information and efficiencies for states by eliminating the need for caseworkers to manually enter information like address changes. With New Jersey and Tennessee implementing electronic accounts, 42 states provided electronic accounts as of January 2019. During 2018, states also continued to expand the functions and features of existing accounts. As of January 2019, most states offer a broad array of functions through their accounts (Figure 14). In 33 of the 42 states with an electronic account, enrollees can access the account through a mobile device. Additionally, 21 states indicate that the online account has been designed with mobile-friendly formatting and six report

Figure 14

Number of States with Selected Features for Online Accounts, January 2019



SOURCE: Based on results from a national survey conducted by the Kaiser Family Foundation and the Georgetown University Center for Children and Families, 2019.

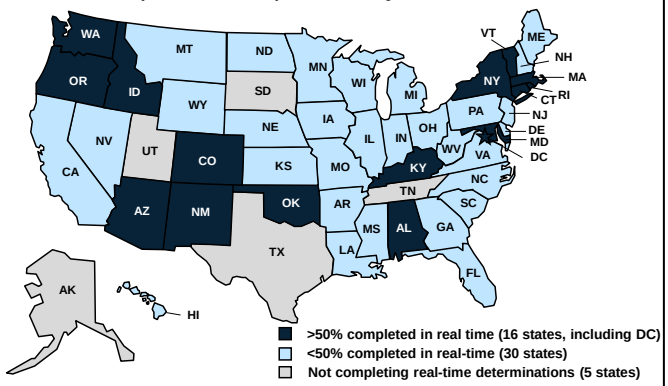
that they have created a mobile “app” through which individuals can access their account. Several states reported plans to enhance mobile access to online accounts during or after 2019.

Eligibility Determinations

With new or upgraded eligibility systems, states are increasingly able to make real-time eligibility determinations (within 24 hours) by using electronic data matches to verify eligibility criteria. As of January 2019, 46 states are able to make real-time eligibility determinations. However, the share of determinations completed in real-time varies widely across states. A total of 16 states report conducting at least half of MAGI-based determinations in real-time, including 9 states which make three-quarters or more of determinations in under 24 hours (Figure 15). States processing the majority of their applications in real-time are more likely to report that most are made by the eligibility system automatically without caseworker action, while those processing a lower share in real-time are more likely to require caseworker interaction to complete the determination. Automated determinations are more efficient and can reduce data entry errors and administrative burden, but systems and links to trusted data sources must be well-tested and subject to ongoing quality assurance to ensure accuracy.

Figure 15

Share of Medicaid Determinations Conducted in Real-Time (<24 Hours), January 2019



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, 2019.

The majority of states do not report any problems or delays in their eligibility determinations. However, ten states indicated problems or delays as of January 2019**.** About half of these states are continuing to make changes to systems and processes, which may be contributing to these challenges. Other reasons for backlogs include gaps in staffing and resources or increased volume of applications resulting from recent implementation of the Medicaid expansion.

All states verify citizenship or qualified immigration status, as well as income, when determining eligibility for Medicaid and CHIP. States are able to electronically verify citizenship or immigration status either directly with the Social Security Administration or Department of Homeland Security or through the federal data services hub that consolidates access to these sources. These verifications must be conducted prior to determining eligibility, however, individuals who attest to a qualified status must be given a reasonable amount of time to provide documentation if eligibility cannot be confirmed electronically. While states must also verify income, they have the option to do so prior to enrollment, which 45 states do, or to enroll based on the applicant’s reported income and verify post-enrollment. Verification policies for other eligibility criteria, including age/date of birth, state residency, and household size, vary across states, reflecting state options to verify this information before or after enrollment or to accept the individual’s self-attestation.

Just over half of states (28) report that they conduct data matches on a periodic basis to identify changes in circumstances between annual redetermination periods. States may disenroll individuals if these data checks reveal changes in income or other information that affect eligibility and the individual is unable to resolve the discrepancy within specified timeframes (often within ten days from the date of the notice). These data checks can lead to coverage losses among eligible individuals if they do not receive the notice or are not able to provide documentation within the required timeframe. States vary in the frequency of these checks. For example, some conduct them quarterly, while others conduct only one check between annual renewals. In 2018, Minnesota and Tennessee implemented routine data checks to verify eligibility. Several additional states have recently passed legislation or are considering legislation to require stricter and more frequent data checks.[40,41]

The need for presumptive eligibility has decreased as states are increasingly able to process determinations quickly, but it remains an avenue in some states for people to access temporary coverage when they are unable to receive a real-time determination. Presumptive eligibility is a long-standing policy option that allows states to train and authorize qualified entities such as federally qualified health centers or prenatal clinics to make a temporary eligibility determination so that individuals can quickly access temporary coverage while their final eligibility determination is processed. The ACA expanded the use of presumptive eligibility to allow hospitals in all states to presumptively enroll MAGI-based groups including parents and expansion adults, although Arkansas obtained an exemption from this requirement through a Section 1115 waiver. As of January 2019, 30 states use presumptive eligibility for pregnant women and 20 states have adopted the policy for children. Fifteen states also have extended the policy to parents, adults, family planning services, and/or former foster youth.

System Integration

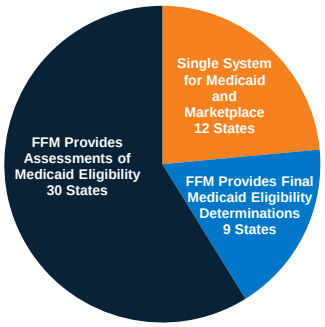
States continue to reintegrate Medicaid eligibility determinations for seniors, individuals eligible based on a disability, and non-health programs into their upgraded Medicaid systems. Prior to the ACA, state systems generally determined eligibility for all Medicaid groups and most included non-health programs, such as TANF and SNAP.[42] The ACA required states to use new financial eligibility rules and streamlined enrollment policies for MAGI-based groups. However, states continue to apply their pre-ACA financial eligibility rules to non-MAGI groups (seniors and individuals eligible based on a disability). As a result, some states separated MAGI eligibility determinations from non-MAGI groups and non-health programs when they implemented the ACA. As their new systems have matured, states have increasingly reintegrated non-MAGI groups and non-health programs into the upgraded systems. This trend continued in 2018, with Iowa and Tennessee integrating non-MAGI groups into their systems. As of January 2019, 32 states determine eligibility for all Medicaid groups through a single system, and, in 24 states, the MAGI-based Medicaid eligibility system determines eligibility for at least one non-health program. This integration can facilitate access to services for individuals and offer efficiencies to states but requires more complex system implementation. States also have realized progress integrating Medicaid and CHIP eligibility determinations. Prior to the ACA, less than half of states with separate CHIP programs (16 of 38) used a single system for Medicaid and CHIP, but, as of January 2019, all but 1 of the 36 states with separate CHIP programs determine eligibility through a single system. Looking ahead, states remain

focused on reintegration with nearly half indicating plans to integrate non-MAGI groups and/or additional non-health programs into their MAGI-based system in 2019 or beyond.

All states coordinate Medicaid and Marketplace coverage, as required under the ACA. However, how states coordinate this coverage depends on the structure of its Marketplace. Most states (39) rely on the Federally Facilitated Marketplace (FFM) system, known as Healthcare.gov, for Marketplace eligibility determinations and enrollment. These states must electronically transfer data back and forth with the FFM to coordinate Medicaid and Marketplace coverage. States report that these transfers generally are going smoothly without any significant delays or problems. Of the 39 states relying on the FFM platform, 30 states use the FFM only to assess Medicaid eligibility, and then make a final determination after the case is transferred to the state. In 2018, Arkansas shifted to receiving assessments from the FFM. Nine states allow the FFM to make final Medicaid or CHIP determinations, including Virginia, which switched from an assessment to a determination state in 2018 to facilitate its implementation of the Medicaid adult expansion. In the remaining 12 states that use their own State-based Marketplace system, Medicaid, CHIP, and Marketplace determinations are conducted through a single integrated system (Figure 16).

Figure 16

Relationship of Marketplace and Medicaid Eligibility Systems, January 2019



SOURCE: Based on results from a national survey conducted by the Kaiser Family Foundation and the Georgetown University Center for Children and Families, 2019.

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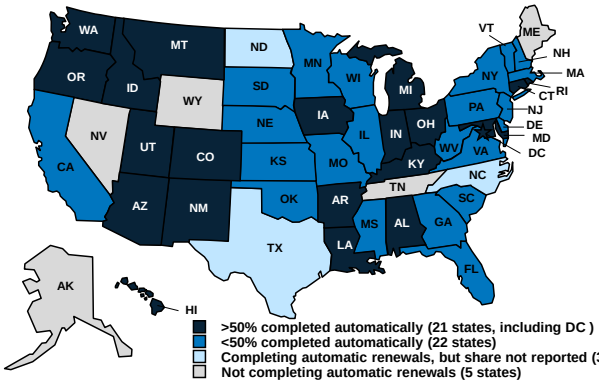
Renewals

Streamlined renewal policies can facilitate continuous coverage among eligible individuals, which helps prevent gaps in care and protects individuals from medical costs that might occur if they experience breaks in coverage. Under ACA policies, states are required to use available data to determine ongoing eligibility before requesting the enrollee to complete a renewal form or provide documentation. If a state is unable to determine ongoing eligibility based on available data, it may then request additional information from the individual and must provide the individual multiple avenues to renew, including online, by phone, in-person, or via mail. The move to automatic renewals can help reduce “churn” or short gaps in coverage, contribute to efficiencies and cost savings, and reduce data entry errors and administrative burden. However, eligible individuals may remain at risk for losing coverage at renewal if the state is unable to determine ongoing eligibility based on available data and they do not receive or understand notices or forms requesting additional information and respond to requests within required timeframes, which are often limited to 10 days.

As of January 2019, 46 states were completing automatic or "ex parte" renewals, through which the state renews coverage based on available eligibility-related data. Among the 43 states able to report the share of renewals completed through automated processes, 21 states reported at least half of MAGI renewals are conducted automatically, including 10 states that complete three-quarters or more of renewals automatically (Figure 17). States with a high share of automatic renewals are more likely to have a system that can complete the renewals without requiring caseworker action. Conversely, states that rely on manual action by a caseworker—for example, to look up data to verify ongoing eligibility—generally report a smaller share of renewals completed automatically.

Figure 17

Share of Medicaid Renewals Completed Using Automated Processes, January 2019

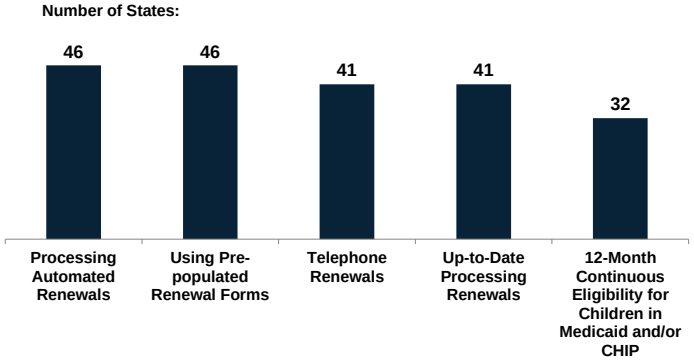


NOTE: Share of renewals for non-disabled children, pregnant women, parents and expansion adults.
SOURCE: Based on results from a national survey conducted by the Kaiser Family Foundation and the Georgetown University Center for Children and Families, 2019.

When unable to renew coverage based on available data, 46 states send pre-populated forms to enrollees to facilitate the renewal process (Figure 18). This count includes Tennessee and Vermont which began sending pre-populated forms in 2018. Idaho stopped mailing pre-populated forms in 2018, and like Florida and Oklahoma, sends a notice to the individual requesting that they log into their online account or call to confirm their information and/or report any changes. Most states (41), allow individuals to renew by phone; and four additional states allow individuals to complete most of the renewal process by phone, but still require a paper form or electronic signature to complete the process.

Figure 18

Medicaid Renewal Processes and Status of Renewals, January 2019



SOURCE: Based on results from a national survey conducted by the Kaiser Family Foundation and the Georgetown University Center for Children and Families, 2019.

As of January 2019, the majority of states were up-to-date in processing Medicaid and CHIP renewals. However, ten states reported delays with most of these states overlapping with the ten states that reported delays in application processing. Causes of renewal delays were similar to those contributing to backlogs in eligibility determinations, including issues related to system upgrades or challenges related to staffing and volume of renewals.

Nearly two-thirds of the states (32) minimize gaps in coverage for children by providing 12-month continuous eligibility in either Medicaid and/or CHIP. All states are required to renew coverage every 12 months for children, pregnant women, parents and expansion adults. However, during that 12-month

period, individuals may lose coverage if they experience a change in circumstance that makes them ineligible, such as an increase in income. For children, states can opt to provide 12-month continuous eligibility, which allows a child to remain enrolled for a full year unless the child ages out of coverage, moves out of state, voluntarily withdraws, or does not make required premium payments. Continuous eligibility promotes stable access to care by reducing "churn" or individuals moving on and off coverage due to modest, and often temporary, changes in circumstances such as overtime or extra seasonal work. Continuous eligibility also facilitates a more accurate assessment of the quality of health care children receive in Medicaid and CHIP because most quality measures require minimum periods of enrollment. As of January 2019, 24 states have adopted continuous eligibility for children in Medicaid and CHIP, and eight additional states have implemented the policy only in their separate CHIP programs. Montana and New York also provide 12-month continuous coverage for adults through a Section 1115 waiver.

Premiums and Cost Sharing

Research shows that premiums serve as a barrier to enrollment for low-income families and copayments can limit utilization of needed health care.[43] Federal regulations establish parameters for premiums and cost sharing for Medicaid and CHIP enrollees that reflect their limited ability to pay out-of-pocket health care costs due to their modest incomes. Under these rules, states may not charge premiums in Medicaid for enrollees with incomes less than 150% FPL. However, some states have obtained waivers to impose charges in Medicaid that are not otherwise allowed. Maximum allowable cost sharing varies by type of service and income in Medicaid (Table 1). CHIP programs have more flexibility in regard to premiums and cost sharing, but both Medicaid and CHIP limit total family out-of-pocket costs to no more than 5% of family income.

Box 1: 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.

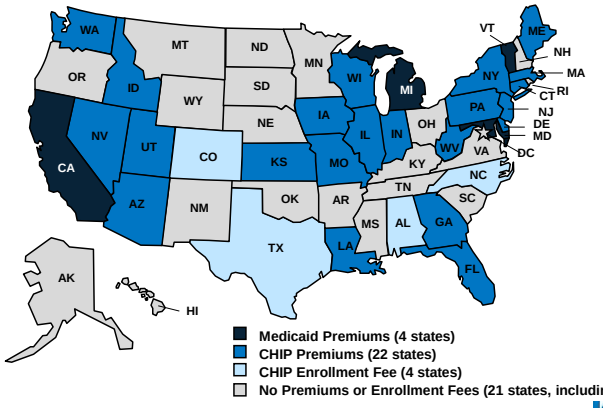
Table 1: Allowable Cost Sharing Amounts for Adults in Medicaid by Income			
	<100% FPL	**100% – 150% FPL**	**>150% FPL**
Outpatient Services	up to $4	up to 10% of state cost	up to 20% of state cost
Non-Emergency use of ER	up to $8	up to $8	No limit
Prescription Drugs	Preferred: up to $4 Non-Preferred: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

The number of states (30) charging premiums or enrollment fees to children in Medicaid/CHIP held steady in 2018 (Figure 19). The stability of premiums, in part, reflects that the extension of CHIP funding also extended the MOE provision for children's eligibility and enrollment policies. Under the MOE, states may not implement new premiums or increase premiums outside of routine increases that were approved in the state's plan as of 2010. Premiums and cost sharing are much more prevalent in CHIP than Medicaid, reflecting that the program covers families with more moderate income levels. Only four states charge premiums for children in Medicaid. These premiums are limited to children in CHIP-funded Medicaid expansions and the lowest income level at which they are charged is 160% FPL. Among the 36 separate CHIP programs, four charge annual enrollment fees and 22 impose monthly or quarterly premiums for children; the lowest income at which these charges begin is 133% FPL.

Figure 19

Premiums or Enrollment Fees for Children in Medicaid and CHIP, January 2019



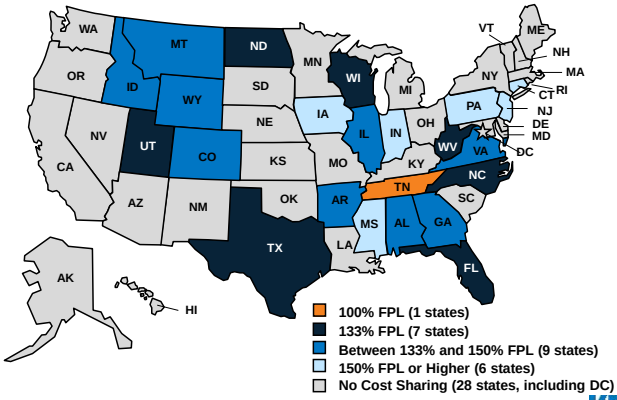
SOURCE: Based on results from a national survey conducted by the Kaiser Family Foundation and the Georgetown University Center for Children and Families, 2019.

States vary in disenrollment policies related to non-payment of premiums within federal rules designed to minimize gaps in coverage for children. The minimum grace period before canceling coverage for non-payment of premiums is 60 days in Medicaid and 30 days in CHIP. However, 16 of the 22 states charging monthly or quarterly premiums in CHIP provide at least a 60 day grace period. Children who are disenrolled from Medicaid for non-payment of premiums cannot be locked-out of coverage for a period of time as a penalty for non-payment, while separate CHIP programs may establish a lockout period of up to 90 days. Among the 22 states charging monthly or quarterly premiums in CHIP, eight states do not impose lockout periods, including Georgia, which eliminated the practice in 2018. As of January 2019, 14 states maintain lockout periods in CHIP ranging from 1 month to 90 days.

As of January 2019, less than half of the states (23) charge copayments to children in Medicaid and CHIP after Kentucky and New Mexico eliminated children's copayments. In 2018, New Mexico eliminated its copayments for children, leaving only two states (Tennessee and Wisconsin) that require copayments for children in Medicaid. Kentucky also eliminated copayments for children in its separate CHIP program in 2018, reducing the number of states that impose copayments on children to 23 of 36 states with separate CHIP programs (Figure 20). Only one state (Tennessee) imposes cost sharing below 133% FPL due to long-standing waiver authority. Cost sharing varies by state and service. At 151% FPL, 18 states charge cost sharing for non-preventive physician visits, 14 states charge for an inpatient hospital visit, and 14 charge for generic drugs.

Figure 20

Income at Which Cost Sharing for Children in Medicaid and/or CHIP Begins, January 2019



SOURCE: Based on results from a national survey conducted by the Kaiser Family Foundation and the Georgetown University Center for Children and Families, 2019.

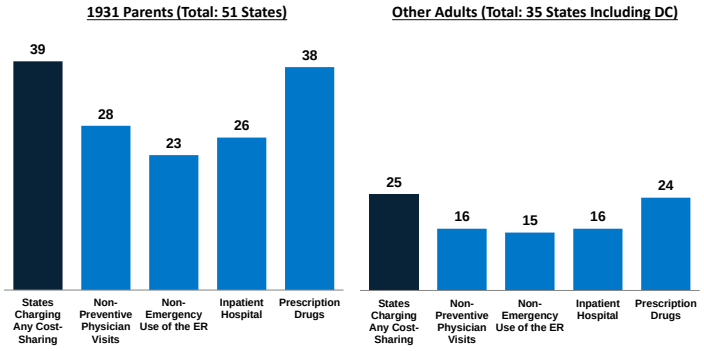
Premiums and Cost Sharing for Parents and Other Adults

Some states have obtained waivers to charge premiums or monthly contributions for adults in Medicaid that would not otherwise be allowed under federal rules. As of January 2019, five states (Arkansas, Indiana, Iowa, Michigan, and Montana) have implemented premiums or monthly contributions for expansion adults, and, in Indiana, the charges also apply to parents. In 2018, Indiana used waiver authority to add a tobacco surcharge of 50% of the normal monthly contribution if the enrollee has been a tobacco user for the past year. Some of these waivers also allow individuals to be locked out of coverage for a period of time if they are disenrolled due to non-payment and to delay coverage until after the first premium is paid. An additional four states (Arizona, Kentucky, New Mexico, and Wisconsin) have obtained waiver approval to charge premiums or monthly contributions to adults and, in some cases, impose lockout periods or delay coverage, but they were not yet implemented as of January 2019. New Mexico is no longer planning to implement the premiums following a change in state leadership and implementation was on hold in Arizona and Wisconsin, while Kentucky is in the process of preparing for implementation.

As of January 2019, most states charge cost sharing for parents and other adults. A total of 39 states charge copayments for parents eligible for Medicaid under traditional pathways that existed before the ACA (Figure 21). In addition, of the 35 states that cover other adults (including the 34 states that have implemented the ACA Medicaid expansion and Wisconsin, which covers other adults but has not adopted the expansion), 25 charge copayments. The number of states charging copayments to traditional parents has remained generally consistent for several years. Although many states impose the charges on all adult beneficiaries, regardless of income, cost sharing amounts in Medicaid are limited by federal law. Two states made minor adjustments to copayments in 2018, including New Hampshire, which lowered cost sharing amounts for expansion adults to match levels charged for 1931 parents, and Indiana which dropped its copayment of subsequent non-emergency use of the emergency room from $25 to $8.

Figure 21

Number of States with Cost Sharing for Selected Services for Adults, January 2019



Note: Wisconsin covers other adults up to 100% FPL, but has not adopted the ACA Medicaid expansion.
SOURCE: Based on results from a national survey conducted by the Kaiser Family Foundation and the Georgetown University Center for Children and Families, 2019.

Looking Ahead

Looking ahead, one key question is whether there will be continued advances to expand coverage and streamline enrollment processes or whether emerging policy changes will erode coverage gains and enrollment simplifications realized under the ACA.

Additional states may expand Medicaid, which would increase access to coverage for low-income adults and have positive effects on care and state budgets and economies.[44] Several new governors who were elected in 2018 ran on platforms to expand Medicaid. Further, the success of recent ballot initiatives to expand could spark similar action in other states. However, voter-approved ballot measures may face barriers to implementation based on state law requirements, efforts to block or amend the policies by legislators or governors, or legal challenges.[45] Ongoing litigation related to the constitutionality of the ACA also could influence state decisions to expand. However, if states attach waiver provisions such as work requirements or other restrictions to expansion, the positive reach and impact would be limited. Recently, some states have indicated interest in a partial expansion to an income level below 138% FPL with the ACA enhanced federal match rate.[46] Relative to full expansion, partial expansions could limit coverage and potentially increase federal costs. While states can pursue waivers to extend coverage to a lower income level without access to the enhanced federal match, no waivers to allow an enhanced match for a partial expansion have been approved to date, and guidance from the previous administration prohibited the use of the enhanced match for "partial expansions."

Renewed CHIP funding protects children's eligibility levels through 2027, but states that extend eligibility above 300% FPL will have the option to reduce eligibility starting in October 2019. When

Congress continued funding for CHIP in 2018, it retained the MOE provision that requires states to preserve Medicaid and CHIP eligibility and enrollment policies for children. However, starting in October 2019, the MOE only applies to children's coverage up to 300% FPL. At that time, states can maintain coverage for children above this income level and still receive federal matching funds, but will newly have the option to reduce eligibility to 300% FPL. This change in the scope of the MOE coincides with the beginning of the phase-out of the 23-percentage point temporary boost in federal CHIP matching rates available between 2016 and 2019. This boost will be reduced by half (11.5 percentage points) in 2020 and then rates revert to the traditional enhanced CHIP match rate in 2021, leaving states to resume paying a larger share of CHIP costs.

Emerging state and federal policies to add Medicaid eligibility requirements could erode the coverage gains and enrollment simplifications realized under the ACA. The Trump Administration is promoting new Medicaid eligibility requirements through waivers and its proposed budget and has approved a growing number of waiver requests from states, including work requirements, which have never previously been approved for the program. Some states are no longer moving forward with implementing waiver provisions following a change in leadership in the 2018 elections,[47,48] while other states are considering adding waiver provisions.[49,50,51,52] Research shows that these types of requirements create barriers for eligible individuals to obtain and maintain coverage and increase administrative burdens and costs for states.[53,54] As such, they will likely dampen potential coverage gains and lead to coverage losses that would erode the coverage increases realized under the ACA. States' implementation of waiver provisions could be affected by ongoing legal challenges to the Administration's authority to approve work requirements and other restrictive measures in Arkansas and Kentucky.

Other policy changes may lead to coverage losses among eligible low-income families and growing burdens on states. In 2017, coverage gains stalled and began to reverse for the first time since the implementation of the ACA and Medicaid enrollment of adults and children declined in 2018.[55,56,57] Some of the decline in Medicaid enrollment could reflect the improving economy. However, some factors may be leading to enrollment declines among eligible individuals. While states' growing use of technology and automation has led to improvements for individuals and states, there are concerns emerging in some states that eligible individuals may be losing coverage due to process-related issues.[58,59,60] Further, other policy changes outside of Medicaid could be dampening enrollment. For example, the Trump administration substantially decreased funding for outreach and enrollment assistance, which is pivotal for helping eligible individuals get and stay enrolled in coverage. In addition, shifting immigration policies, including the proposed rule to make changes to public charge policy, will likely lead to broad decreases in participation in Medicaid among legal immigrant families and their primarily U.S.-born children and increase administrative burdens on states.[61] Twenty states reported they would need to change applications, forms, or other guidance, conduct additional staff training, and/or increase outreach and education to immigrant families if the public charge rule is finalized, while most of the remaining states indicated they could not yet determine how the rule would impact their operations.

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[26] Some immigrants with qualified status, such as refugees and asylees, do not have to wait five years before enrolling. Some immigrants, such as those with temporary protected status, are lawfully present but do not have a qualified status and are not eligible to enroll in Medicaid or CHIP regardless of their length of time in the country

[27] This option also extends coverage to lawfully present immigrants without a qualified status.

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Trend and State-by-State Tables

Table A: Trends in State Medicaid and CHIP Eligibility, Enrollment, and Renewal Policies, July 2000-January 2019[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	January 2019
ELIGIBILITY																		
Cover children >200% FPL	**N/A**	36	40	39	39	41	41	45	44	47	47	47	47	48	48	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
Cover lawfully-residing immigrant children without five-year wait	**Medicaid**	Option Not Available								17	21	24	25	28	29	31	33	34
	CHIP														19	21	22	23
Cover pregnant women >200% FPL	**N/A**	NC		17	16	17	17	20	21	24	25	25	25	33	33	34	34	34
Cover lawfully-residing immigrant pregnant women without five-year wait	**Medicaid**	Option Not Available								14	17	18	20	23	23	23	25	25
	CHIP														4	3	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	35
Cover other adults[2, 3]	**N/A**	NC									7	8	25	29	32	33	33	35
Asset test not required[4]	**Medicaid Children**	42	45	45	46	47	47	47	47	48	48	48	48	51	51	51	51	51
	CHIP	31	34	34	33	33	34	35	36	37	36	37	36					
	Parents	NC	19	21	22	22	21	22	23	24	24	24	24					
STREAMLINED ENROLLMENT PROCESSES																		
Real-time eligibility determinations	**N/A**	NC													37	39	40	46
Online Medicaid application[4]	**Medicaid**	NC									32	34	36	50	50	50	50	51
Telephone Medicaid application[4]	**Medicaid**	NC											17	47	49	49	49	47
Presumptive eligibility for children	**Medicaid**	8	9	7	8	9	9	14	14	14	16	16	17	15	18	20	20	20
	CHIP	4	5	4	6	6	6	9	9	9	10	11	12	9	10	11	11	11
Presumptive eligibility for pregnant women	**Medicaid**	NC		29	29	30	31	30	30	30	31	31	32	27	29	30	30	30
	CHIP														2	3	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	51
	CHIP	31	34	33	33	33	33	34	38	38	37	38	37					
	Parents	NC	35	36	36	36	39	40	41	41	44	45	45					
STREAMLINED RENEWAL PROCESSES																		
Processing automated renewals	**N/A**	NC													34	42	46	46
Telephone Medicaid renewal	**N/A**	NC													41	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	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	51
	CHIP	23	33	33	32	34	34	37	39	39	38	28	38					
	Parents		38	38	36	36	39	40	40	43	45	46	46					
12-month continuous eligibility for children	**Medicaid**	14	18	15	15	17	16	16	18	22	23	23	23	21	24	24	24	24
	CHIP	22	23	21	21	24	25	27	30	30	28	28	27	25	26	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, 2011-2019.

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 2019[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%**	**218%**	**149%**	**216%**	**138%**	**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[5]	324%	324%	206%-324%	324%	146%-324%	324%	112%-324%	
Florida[7]	215%	211%	192%-211%	145%		138%	112%-138%	215%
Georgia	252%	210%		154%		138%	113%-138%	252%
Hawaii	313%	191%	191%-313%	139%	139%-313%	133%	105%-313%	
Idaho	190%	147%		147%		138%	107%-138%	190%
Illinois	318%	147%		147%		147%	108%-147%	318%
Indiana[8]	262%	218%	157%-218%	165%	141%-165%	165%	106%-165%	262%
Iowa	380%	380%	240%-380%	172%		172%	122%-172%	307%
Kansas[9]	240%	171%		154%		138%	113%-138%	240%
Kentucky	218%	200%		142%	142%-164%	133%	109%-164%	218%
Louisiana	255%	142%	142%-217%	142%	142%-217%	142%	108%-217%	255%
Maine	213%	196%		162%	140%-162%	162%	132%-162%	213%
Maryland	322%	194%	194%-322%	138%	138%-322%	133%	109%-322%	
Massachusetts[10]	305%	205%	185%-205%	155%	133%-155%	155%	114%-155%	305%
Michigan[11]	217%	195%	195%-217%	160%	143%-217%	160%	109%-217%	
Minnesota[12]	288%	275%	275%-288%	280%		280%		
Mississippi	214%	199%		148%		138%	107%-138%	214%
Missouri	305%	201%		148%	148%-155%	148%	110%-155%	305%
Montana	266%	148%		148%		138%	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[5,14]	210%	210%	169%-210%	210%	151%-210%	210%	115%-210%	
Oregon	305%	190%	133%-190%	138%		138%	100%-133%	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%	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 KFF with the Georgetown University Center for Children and Families, 2019.
Table presents rules in effect as of January 1, 2019.

Table 1 Notes

1. January 2019 income limits are reported as a percentage of the federal poverty level (FPL). The 2019 FPL for a family of three was $21,330. 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 five percentage point disregard is applied, which is not reflected in the table. Eligibility levels are reported as a 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. 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 Services Managed Care Plan serves children with special health care needs from birth through age 18. In Florida, families can buy-in to Healthy Kids for children ages 5-19 and to MediKids for children ages 1 to 4.

8. Indiana uses a state-specific income disregard that is equal to five percent of the highest income eligibility threshold for the group.
9. In Kansas, eligibility for children in the separate CHIP program is a dollar-based income level equal to 238% FPL in 2008. This amount increased in 2014 for the MAGI conversion, but as a fixed dollar amount, the equivalent FPL level may erode over time.
10. Massachusetts also covers insured children in its separate CHIP program with Title XIX Medicaid funds under its Section 1115 waiver. Massachusetts also covers uninsured 18-year-olds with incomes up to 150% FPL under its Medicaid expansion.
11. Michigan also provides CHIP-funded Medicaid expansion coverage to children with incomes between 212% and 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.
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 incomes 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 a 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 2019		
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	No
California	None	
Colorado	None	
Connecticut	None	
Delaware	None	
District of Columbia	None	
Florida	2 months	No
Georgia	None	
Hawaii	None	
Idaho	None	
Illinois	90 days	Below 209%
Indiana	90 days	No
Iowa	1 month	Below 200%
Kansas	90 days	Below 219%
Kentucky	None	
Louisiana	90 days	Below 212%
Maine	90 Days	No
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	No
Ohio	None	
Oklahoma	None	
Oregon	None	
Pennsylvania	None	
Rhode Island	None	
South Carolina	None	
South Dakota	90 days	No
Tennessee	None	
Texas	90 days	No
Utah	90 days	No
Vermont	None	
Virginia	None	
Washington	None	
West Virginia	None	
Wisconsin	None	
Wyoming	1 month	No

SOURCE: Based on a national survey conducted by KFF with the Georgetown University Center for Children and Families, 2019.

Table presents rules in effect as of January 1, 2019.

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 2019						
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]	EPSDT for Children Enrolled in Separate CHIP[5] (Total =36)	Health Services Initiative[6]
		Medicaid	CHIP (Total =36)			
Total	**18**	**34**	**23**	**11**	**16**	**22**
Alabama	Y					
Alaska	N/A (M-CHIP)		N/A (M-CHIP)		N/A (M-CHIP)	
Arizona					Y	
Arkansas	Y	Y	Y		Y	
California[7,8]	N/A (M-CHIP)	Y	N/A (M-CHIP)	Y	N/A (M-CHIP)	Y
Colorado	Y	Y	Y		Y	
Connecticut	Y	Y	Y			
Delaware[9]		Y	Y	Y	Y	Y
District of Columbia[7]	N/A (M-CHIP)	Y	N/A (M-CHIP)		N/A (M-CHIP)	
Florida[10]	Y	Y	Y			Y
Georgia	Y			Y	Y	
Hawaii	N/A (M-CHIP)	Y	N/A (M-CHIP)		N/A (M-CHIP)	
Idaho[10]					Y	Y
Illinois[7,11,12]		Y	Y		Y	Y
Indiana[8,13]						Y
Iowa[8,11]		Y	Y			Y
Kansas	Y				Y	
Kentucky	Y	Y	Y	Y		
Louisiana					Y	
Maine	Y	Y	Y		Y	
Maryland[8,14]	N/A (M-CHIP)	Y	N/A (M-CHIP)		N/A (M-CHIP)	Y
Massachusetts[7,10,15]		Y	Y	Y		Y
Michigan[8,14,16]	N/A (M-CHIP)		N/A (M-CHIP)		N/A (M-CHIP)	Y
Minnesota[12]	N/A (M-CHIP)	Y	N/A (M-CHIP)		N/A (M-CHIP)	Y
Mississippi	Y					
Missouri[10,14,17,18]						Y
Montana	Y	Y	Y			
Nebraska[8]	N/A (M-CHIP)	Y	N/A (M-CHIP)		N/A (M-CHIP)	Y
Nevada[10,17,19]	Y	Y	Y		Y	Y
New Hampshire	N/A (M-CHIP)		N/A (M-CHIP)		N/A (M-CHIP)	
New Jersey[8,10,20]		Y	Y		Y	Y
New Mexico	N/A (M-CHIP)	Y	N/A (M-CHIP)	Y	N/A (M-CHIP)	
New York[7,8,10,21]		Y	Y			Y
North Carolina	Y	Y	Y			
North Dakota						
Ohio[14]	N/A (M-CHIP)	Y	N/A (M-CHIP)		N/A (M-CHIP)	Y
Oklahoma[22]	N/A (M-CHIP)		N/A (M-CHIP)		N/A (M-CHIP)	Y
Oregon[7,8]		Y	Y			Y
Pennsylvania[23]	Y	Y	Y	Y		
Rhode Island	N/A (M-CHIP)	Y	N/A (M-CHIP)		N/A (M-CHIP)	
South Carolina	N/A (M-CHIP)	Y	N/A (M-CHIP)		N/A (M-CHIP)	
South Dakota				Y	Y	
Tennessee	Y					
Texas	Y	Y	Y			
Utah		Y	Y	Y		
Vermont	N/A (M-CHIP)	Y	N/A (M-CHIP)		N/A (M-CHIP)	
Virginia	Y	Y	Y	Y		
Washington[7,8]		Y	Y		Y	Y
West Virginia[10,24]	Y	Y	Y		Y	Y
Wisconsin[8,14]		Y	Y	Y	Y	Y
Wyoming						

SOURCE: Based on a national survey conducted by KFF with the Georgetown University Center for Children and Families, 2019.
Table presents rules in effect as of January 1, 2019.

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. The column indicates whether states with separate CHIP provide the full array of EPSDT (or Early Periodic Screening Diagnosis and Treatment Services). EPSDT is the pediatric benefit standard in Medicaid. All Medicaid programs, including M-CHIP programs, must provide EPSDT services to all children but separate CHIP programs have more flexibility within federal parameters with regard to CHIP benefits.
6. States may use CHIP funds to support a state-designed health services initiative (HSI) to improve the health of low-income children, as long as overall CHIP administrative costs combined with HSI services do not exceed 10% of total CHIP expenditures. HSIs must directly improve the health of low-income children who are eligible for CHIP and/or Medicaid but may serve children regardless of income.
7. 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.
8. California, Indiana, Iowa, Maryland, Michigan, Nebraska, New Jersey, New York, Oregon, Washington, and Wisconsin use CHIP health service initiative funding to support the state's Poison Control Center.
9. Delaware's HSI provides vision exams and glasses to uninsured children in schools with a large share of children receiving free or reduced-cost school meals.
10. Florida, Idaho, Massachusetts, Missouri, Nevada, New Jersey, New York, and West Virginia use CHIP HSIs to fund various school-based health services programs.
11. Illinois and Iowa use HSI funds to automatically cover children who apply for Medicaid/CHIP through presumptive eligibility until the final determination is made.
12. Illinois and Minnesota use HSI funds to cover post-partum services for women covered under the CHIP unborn child option.
13. Indiana covers EPSDT benefits for children in separate CHIP subject to certain limitations.

14. Maryland, Michigan, Missouri, Ohio, and Wisconsin use HSI funds to support lead abatement programs.
15. Massachusetts has 18 different HSI programs with the overall goal of improving the health of children that are at least partially funded by CHIP. Due to the number of programs and the 10% cap of administrative services, the state does not currently claim federal funds under all programs.
16. Michigan eliminated coverage for former foster children from other states up to age 26 as of December 2018.
17. In Missouri and Nevada, most EPSDT services are provided for children in separate CHIP coverage; however, non-emergency medical transportation (NEMT) services are not covered.
18. Missouri uses its HSI to fund different health projects for children ranging from immunizations to newborn home visiting.
19. Nevada began using federal funds to cover lawfully residing immigrant children without the five-year wait in Medicaid and CHIP as of January 1, 2019. Nevada uses HSI funds for a prevention program to target and address behavioral health issues early in after school programs.
20. In addition to poison control and school-based health services, New Jersey uses HSI funds for a number of different health projects for children (seven total) ranging from respite care for children with developmental disabilities to a pediatric psychiatry collaborative to support children with mental health issues to a birth defects registry.
21. In addition to poison control and school-based services, New York uses HSI funds for a hunger prevention and assistance program and offers sickle cell screening for children.
22. Oklahoma uses HSI funding to support 18 different health projects for children and youth, including increasing access to long-acting reversible contraceptives (LARC), distributing Naloxone rescue kits in high-need counties, improving evidence-based prescribing of antipsychotic medications in counties with high utilization, and providing newborns with safe sleep kits.
23. In Pennsylvania, dependents of state employees are eligible for CHIP 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.
24. West Virginia's HSI pays for well-child visits for uninsured children.

Table 4: Medicaid and CHIP Coverage for Pregnant Women and Medicaid Family Planning Expansion Programs, January 2019									
State	Income Eligibility Limits for Pregnant Women (% of the FPL)			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 (% of the FPL)[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**	**206%**
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
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	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[10]	218%				N/A	Y	N/A	N/A	148%
Iowa[11]	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		Y	N/A	N/A	214%
Maryland[12]	264%			Y	N/A	Y	N/A	N/A	264%
Massachusetts[8]	205%		205%	Y	N/A	Y	N/A	Y	N/A
Michigan[13]	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[14]	255%			Y	N/A		N/A	N/A	255%
New York[8]	223%			Y	N/A	Y	N/A	N/A	223%
North Carolina[15]	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[16]	138%		210%		N/A	Y	N/A		138%
Oregon[8]	190%		190%		N/A	Y	N/A	Y	255%
Pennsylvania	220%			Y	N/A	Y	N/A	N/A	220%
Rhode Island[17]	195%	258%	258%			Y	Y	Y	258%
South Carolina	199%			Y	N/A	Y	N/A	N/A	199%
South Dakota[18]	138%				N/A		N/A	N/A	N/A
Tennessee[19]	200%		255%		N/A	Y	N/A		N/A
Texas[11]	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	200%
Virginia	148%	205%		Y	Y	Y	Y	N/A	205%
Washington[8]	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[17]	159%			Y	N/A	Y	N/A	N/A	164%

SOURCE: Based on a national survey conducted by KFF with the Georgetown University Center for Children and Families, 2019.
Table presents rules in effect as of January 1, 2019.

Table 4 Notes

1. January 2019 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 2019, the FPL for a family of three was $21,330.
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 2019 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 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, 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 post-partum period 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. Indiana uses a state-specific income disregard that is equal to five percent of the highest income eligibility threshold for the group.
11. Iowa and Texas established family planning programs with state-only funds.
12. In July 2018, Maryland expanded family planning eligibility to match the pregnant women eligibility level and include men.
13. Michigan also provides coverage to pregnant women with incomes over 400% FPL affected by the Flint water crisis.
14. New Mexico limited family planning coverage to individuals age 50 and under without health insurance and under age 65 with Medicare effective January 1, 2019.

15. 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.
16. 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.
17. Rhode Island and Wyoming limit eligibility for their family planning expansion programs to those losing Medicaid at the end of their post-partum period.
18. 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.
19. 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.
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 2019[1]			
State	Parents (in a family of three)		Other Adults (for an individual)
	Section 1931 Limit	Upper Limit	
Median	**49%**	**138%**	**138%**
Alabama	18%	18%	0%
Alaska	135%	138%	138%
Arizona	106%	138%	138%
Arkansas	15%	138%	138%
California	109%	138%	138%
Colorado	68%	138%	138%
Connecticut	155%	155%	138%
Delaware	87%	138%	138%
District of Columbia[2]	221%	221%	215%
Florida	32%	32%	0%
Georgia	35%	35%	0%
Hawaii[2]	100%	138%	138%
Idaho[3]	25%	25%	0%
Illinois[4]	29%	138%	138%
Indiana[5]	17%	139%	139%
Iowa	49%	138%	138%
Kansas	38%	38%	0%
Kentucky	19%	138%	138%
Louisiana	19%	138%	138%
Maine[6]	100%	138%	138%
Maryland	123%	138%	138%
Massachusetts[2,7]	138%	138%	138%
Michigan	54%	138%	138%
Minnesota[9]	138%	138%	138%
Mississippi	26%	26%	0%
Missouri	21%	21%	0%
Montana[8]	24%	138%	138%
Nebraska[10]	63%	63%	0%
Nevada	27%	138%	138%
New Hampshire	54%	138%	138%
New Jersey	28%	138%	138%
New Mexico[2]	43%	138%	138%
New York[2,9]	89%	138%	138%
North Carolina	42%	42%	0%
North Dakota	49%	138%	138%
Ohio	90%	138%	138%
Oklahoma[11]	42%	42%	0%
Oregon	34%	138%	138%
Pennsylvania[2]	33%	138%	138%
Rhode Island	116%	138%	138%
South Carolina	67%	67%	0%
South Dakota	49%	49%	0%
Tennessee	95%	95%	0%
Texas[12]	17%	17%	0%
Utah[13]	60%	60%	0%
Vermont[14]	42%	138%	138%
Virginia[6,15]	33%	138%	138%
Washington	46%	138%	138%
West Virginia	17%	138%	138%
Wisconsin[16]	100%	100%	100%
Wyoming	54%	54%	0%

SOURCE: Based on a national survey conducted by KFF with the Georgetown University Center for Children and Families, 2019.

Table presents rules in effect as of January 1, 2019.

Table 5 Notes

1. January 2019 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 2019 FPL for a family of three, which is $21,330. Eligibility limits for other adults are presented as a percentage of the 2019 FPL for an individual, which is $12,490.
2. The District of Columbia, Hawaii, Massachusetts, New Mexico, New York, and Pennsylvania cover some income-eligible adults who are not otherwise eligible due to immigration status using state-only funds. In some cases, the coverage is limited to targeted groups, such as lawfully present immigrants who are in the five-year waiting period for Medicaid coverage.
3. Idaho voters approved a ballot measure in November 2018 that requires the state to submit a state plan amendment to CMS to implement the Medicaid expansion. The expansion has not yet been implemented as of January 2019.
4. In Illinois, traditional 1931 Medicaid coverage is based on a dollar threshold tied to TANF levels. Parents are also covered up to 133% FPL based on prior waiver eligibility and are not considered Section VIII expansion adults.
5. Indiana uses a state-specific income disregard that is equal to five percent of the highest income eligibility threshold for the group.
6. Maine and Virginia began coverage for expansion adults in January 2019.
7. 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.
8. In Montana, the Medicaid expansion to adults will end at the end of June 2019 in the absence of state legislative action.
9. Minnesota and New York have implemented Basic Health Programs (BHPs) established by the Affordable Care Act (ACA) for adults with incomes between 138%-200% FPL.
10. Nebraska voters approved a ballot measure on November 6, 2018 to expand Medicaid coverage to low-income adults. The initiative requires the state to file all paperwork to the federal government by April 1, 2019.
11. In Oklahoma, individuals without a qualifying employer with incomes up to 100% FPL are eligible for more limited subsidized insurance through the Insure Oklahoma Section 1115 waiver program.

Individuals working for certain qualified employers with incomes at or below 222% FPL are eligible for premium assistance for employer-sponsored insurance.

12. In Texas, the income limit for parents and other caretaker relatives is based on monthly dollar amounts which differ depending on family size and whether there are one or two parents in the family. The eligibility level shown is for a single parent household and a family size of three.
13. In November 2018, Utah voters approved a ballot initiative to expand Medicaid under the ACA. It has not been implemented as of January 2019. Certain 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 2019			
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 Online[3]
Total or Median	**51**	**47**	**50%**
Alabama	Y	Y	24%
Alaska[4,5]	Y	Y	10%
Arizona	Y	Y	72%
Arkansas	Y	Y	Not reported
California	Y	Y	23%
Colorado	Y	Y	62%
Connecticut	Y	Y	27%
Delaware	Y	Y	64%
District of Columbia	Y	Y	56%
Florida	Y	Y	90%
Georgia	Y	Y	Not reported
Hawaii[6]	Y	Y	59%
Idaho	Y	Y	30%
Illinois	Y	Y	57%
Indiana	Y	Y	89%
Iowa	Y	Y	44%
Kansas	Y	Y	60%
Kentucky	Y	Y	Not reported
Louisiana	Y	Y	31%
Maine[4]	Y		26%
Maryland	Y	Y	Not reported
Massachusetts	Y	Y	16%
Michigan	Y	Y	63%
Minnesota	Y		61%
Mississippi[7]	Y	Y	4%
Missouri	Y	Y	85%
Montana	Y	Y	40%
Nebraska[5]	Y	Y	48%
Nevada	Y	Y	30-40%
New Hampshire	Y	Y	89%
New Jersey	Y	Y	51%
New Mexico	Y	Y	65%
New York	Y	Y	95%
North Carolina[4]	Y		Not reported
North Dakota	Y	Y	25%
Ohio	Y	Y	Not reported
Oklahoma	Y	Y	89%
Oregon	Y	Y	Not reported
Pennsylvania	Y	Y	40%
Rhode Island	Y	Y	Not reported
South Carolina	Y	Y	44%
South Dakota	Y	Y	10%
Tennessee[8]	Y	Y	Not reported
Texas	Y	Y	91%
Utah[4]	Y		66%
Vermont	Y	Y	62%
Virginia	Y	Y	Not reported
Washington	Y	Y	Not reported
West Virginia	Y	Y	48%
Wisconsin	Y	Y	37%
Wyoming	Y	Y	20%

SOURCE: Based on a national survey conducted by KFF with the Georgetown University Center for Children and Families, 2019.

Table presents rules in effect as of January 1, 2019.

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 without being required to send a follow-up paper form or electronic signature to complete the application.
3. This column indicates the share of total applications for non-disabled groups (children, pregnant women, parents, and expansion adults) that are submitted online.
4. In Alaska, Maine, North Carolina, and Utah, a follow-up signature form is required to complete a telephone application. Maine is currently in the process of designing a method to accept a telephonic signature.
5. In Alaska and Nebraska, the share of applications submitted online includes MAGI and non-MAGI based Medicaid applications.
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. In 2018, Tennessee launched an online application with its new eligibility system. It is available in select counties on a pilot basis as of January 2019 and is expected to be expanded statewide in Spring 2019.

Table 7: Functions of Online Medicaid Applications for Children, Pregnant Women, Parents, and Expansion Adults, January 2019					
State	Individuals Can Start, Stop, and Return to Application	Individuals Can Scan and Upload Documents	Online Portal for Application Assisters[1]	Application Can be Used for: Seniors and Individuals Eligible Based on Disability	Application Can be Used for: At Least One Non-Health Program[2]
Total	**51**	**35**	**27**	**32**	**25**
Alabama	Y				
Alaska	Y			Y	
Arizona	Y	Y	Y	Y	Y
Arkansas	Y				
California[3]	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[4]	Y	Y	Y	Y	Y
Louisiana	Y		Y	Y	
Maine	Y			Y	Y
Maryland	Y	Y			
Massachusetts	Y		Y		
Michigan	Y	Y		Y	Y
Minnesota	Y		Y		
Mississippi	Y	Y			
Missouri	Y				
Montana	Y	Y		Y	Y
Nebraska[5]	Y	Y		Y	
Nevada[6]	Y	Y		Y	Y
New Hampshire	Y	Y		Y	Y
New Jersey	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	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
Tennessee	Y	Y		Y	
Texas	Y	Y	Y	Y	Y
Utah	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 KFF with the Georgetown University Center for Children and Families, 2019.
Table presents rules in effect as of January 1, 2019.

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 the Supplemental Nutrition Assistance Program (SNAP; food stamps) or cash assistance.
3. In California, a multi-benefit application is submitted at the county level, not through the integrated application and Marketplace system CALHEERS.
4. Kentucky added eligibility for child care assistance into its integrated eligibility system in 2018.
5. In Nebraska, applicants can return to and complete an application for 30 days only.
6. In Nevada, child care assistance was added to the multi-benefit online application in 2018, but the data is transferred to the child care unit to determine eligibility.

Table 8: Features of Online Medicaid Accounts, January 2019								
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**	**40**	**40**	**38**	**36**	**32**	**32**	**33**
Alabama	Y	Y	Y	Y		Y		
Alaska								
Arizona	Y	Y	Y	Y	Y	Y	Y	Y
Arkansas								
California[2]	Y	Y	Y	Y	Y	Y	Y	Y
Colorado	Y	Y	Y	Y	Y	Y	Y	Y
Connecticut	Y	Y	Y	Y	Y	Y	Y	Y
Delaware	Y	Y	Y	Y	Y	Y		Y
District of Columbia	Y	Y	Y	Y	Y	Y	Y	Y
Florida	Y	Y	Y	Y	Y		Y	Y
Georgia	Y	Y	Y	Y	Y	Y	Y	Y
Hawaii	Y	Y	Y	Y	Y	Y	Y	Y
Idaho	Y	Y	Y	Y	Y	Y	Y	
Illinois	Y	Y	Y	Y	Y	Y	Y	Y
Indiana	Y	Y	Y			Y		
Iowa								
Kansas								
Kentucky	Y	Y	Y	Y	Y	Y	Y	Y
Louisiana	Y	Y		Y				
Maine	Y	Y	Y	Y	Y			Y
Maryland	Y	Y	Y	Y	Y	Y	Y	Y
Massachusetts	Y	Y	Y	Y				
Michigan	Y	Y	Y	Y	Y	Y	Y	Y
Minnesota[3]								
Mississippi								
Missouri[4]								
Montana	Y	Y	Y	Y	Y	Y	Y	Y
Nebraska	Y	Y	Y	Y	Y	Y	Y	Y
Nevada[5]	Y	Y	Y	Y	Y	Y	Y	Y
New Hampshire	Y	Y	Y	Y	Y	Y	Y	Y
New Jersey	Y		Y		Y			Y
New Mexico	Y	Y	Y	Y	Y		Y	
New York	Y	Y	Y	Y	Y	Y	Y	Y
North Carolina								
North Dakota	Y	Y	Y	Y	Y	Y	Y	Y
Ohio	Y	Y	Y	Y	Y	Y	Y	
Oklahoma	Y	Y	Y	Y	Y	Y	Y	Y
Oregon	Y	Y	Y	Y	Y		Y	Y
Pennsylvania	Y	Y	Y	Y	Y		Y	Y
Rhode Island	Y	Y	Y	Y	Y	Y	Y	Y
South Carolina[5]	Y	Y	Y					
South Dakota								
Tennessee[6]	Y		Y		Y	Y	Y	Y
Texas[7]	Y	Y	Y	Y		Y	Y	Y
Utah	Y	Y	Y	Y	Y	Y	Y	Y
Vermont	Y	Y	Y	Y	Y	Y		
Virginia	Y	Y	Y	Y	Y	Y	Y	Y
Washington	Y	Y	Y	Y	Y	Y	Y	Y
West Virginia	Y	Y	Y	Y	Y			Y
Wisconsin	Y	Y	Y	Y	Y	Y	Y	Y
Wyoming	Y	Y		Y	Y	Y	Y	Y

SOURCE: Based on a national survey conducted by KFF with the Georgetown University Center for Children and Families, 2019.
Table presents rules in effect as of January 1, 2019.

Table 8 Notes

1. This column indicates whether individuals can create an online account to review, update, or submit information at the state level, either through the Medicaid case management system or the integrated State-based Marketplace (SBM) system.
2. In California, Medicaid applicants can access certain eligibility notices if they applied through CALHEERS, the state's integrated Medicaid and Marketplace system. However, cases for all Medicaid enrollees are transferred to and managed at the county level. The ability to view notices and go paperless varies by county.
3. In Minnesota, not all notices can be viewed online. All notices are always mailed.
4. Missouri does not offer online accounts but applicants who apply online are able to return to the application to check its status.
5. Nevada and South Carolina added new features to their online accounts in 2018.
6. In 2018, Tennessee launched an online account with its new eligibility system. It is available in select counties on a pilot basis as of January 2019 and is expected to be expanded statewide in Spring 2019.
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.

Table 9: Mobile Access to Online Medicaid Applications and Accounts, January 2019						
State	Online Application (Total = 51)			Online Account[1] (Total = 42)		
	Can Submit using Mobile Device	Mobile-Friendly Design	Mobile App Available	Can Access using Mobile Device	Mobile-Friendly Design	Mobile App Available
Total	**38**	**18**	**4**	**33**	**21**	**6**
Alabama	Y					
Alaska	Y			N/A		N/A
Arizona						
Arkansas				N/A		N/A
California[2]	Y	Y				
Colorado				Y	Y	Y
Connecticut	Y	Y		Y	Y	
Delaware	Y			Y		
District of Columbia						
Florida						
Georgia	Y			Y		
Hawaii	Y			Y		
Idaho	Y			Y		
Illinois	Y			Y		
Indiana[3]	Y			Y		
Iowa	Y		Y	N/A		N/A
Kansas	Y			N/A		N/A
Kentucky	Y	Y		Y	Y	
Louisiana	Y	Y		Y	Y	
Maine	Y			Y		
Maryland	Y	Y	Y	Y	Y	Y
Massachusetts						
Michigan	Y	Y		Y	Y	
Minnesota	Y			Y		
Mississippi				N/A		N/A
Missouri	Y	Y		N/A		N/A
Montana				Y	Y	
Nebraska	Y	Y		Y	Y	
Nevada[4]	Y	Y		Y	Y	
New Hampshire[4]	Y	Y		Y	Y	
New Jersey[5]	Y	Y		Y	Y	
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				N/A		N/A
Tennessee[6]	Y			Y	Y	
Texas	Y	Y		Y	Y	Y
Utah	Y			Y	Y	
Vermont						
Virginia	Y			Y		
Washington	Y	Y	Y	Y	Y	Y
West Virginia	Y	Y		Y	Y	
Wisconsin[7]	Y		Y			Y
Wyoming	Y	Y		Y	Y	

SOURCE: Based on a national survey conducted by KFF with the Georgetown University Center for Children and Families, 2019.
Table presents rules in effect as of January 1, 2019.

Table 9 Notes

1. N/A responses indicate that the state does not have an online account.
2. In California, individuals can apply for MAGI-Medicaid only through the CALHEERS online application and user account, which are mobile-friendly.
3. Indiana added functionality for individuals to apply through a mobile device in 2018.
4. Nevada and New Hampshire implemented a mobile-friendly design for their online applications in 2018. Nevada also implemented a mobile-friendly design for its online account in 2018.
5. New Jersey added functionality for individuals to access the online account through a mobile device and to provide a mobile-friendly design for the account in 2018.
6. In 2018, Tennessee launched an online application with its new eligibility system. Individuals can apply using a mobile device. It is available in select counties on a pilot basis as of January 2019 and is expected to be expanded statewide in Spring 2019.
7. Wisconsin launched an “app” for individuals to apply and to access their online account. Wisconsin’s Medicaid account “app” has more limited features than the web-based online account. It allows individuals to check benefits, get reminders of actions needed, and submit documents.

Table 10: Medicaid Eligibility Systems for Children, Pregnant Women, Parents, and Expansion Adults, January 2019						
State	Able to Make Real-Time Determinations[1] (<24 Hours)	Share of Determinations Completed in Real-Time[2]				State Checks Databases for Changes in Circumstances[3]
		<25%	25%-50%	50%-75%	75%+	
Total	**46**	**22**	**8**	**7**	**9**	**28**
Alabama	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	Y	Y				
Hawaii	Y		Y			Y
Idaho	Y				Y	
Illinois	Y	Y				Y
Indiana	Y	Y				Y
Iowa	Y	Y				Y
Kansas	Y	Y				
Kentucky	Y			Y		Y
Louisiana	Y	Y				
Maine	Y	Y				Y
Maryland	Y				Y	
Massachusetts	Y			Y		Y
Michigan	Y		Y			Y
Minnesota	Y		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	Y				Y
New Mexico	Y			Y		
New York	Y				Y	
North Carolina	Y	Y				
North Dakota	Y	Y				
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						Y
Texas						Y
Utah						Y
Vermont	Y				Y	
Virginia	Y	Y				
Washington	Y				Y	
West Virginia	Y	Y				Y
Wisconsin	Y		Y			Y
Wyoming	Y		Y			

SOURCE: Based on a national survey conducted by KFF with the Georgetown University Center for Children and Families, 2019. Table presents rules in effect as of January 1, 2019.

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. This column reflects whether the state system is able to make real-time eligibility determinations, defined as within 24 hours. Not all states have programmed their eligibility systems to make real-time determinations without worker interaction. In some states, only a small share of applications completed in person or over the phone that can be verified by an eligibility worker immediately are processed in real time.
2. These columns indicate the share of applications for non-disabled groups (children, pregnant women, parents, and expansion adults) that are determined eligible in real-time.
3. This column indicates whether the state checks against other databases on a routine basis for changes in circumstances that would affect eligibility for enrollees.

Table 11: Coordination between Medicaid and Other Systems, January 2019					
State	System Determines Eligibility For:			Marketplace Structure[3]	FFM Conducts Assessment or Final Determination for Medicaid Eligibility[4] (Total Using FFM = 39)
	CHIP[1,2] (Total = 36)	Seniors and Individuals Eligible Based on a Disability[1]	At Least One Non-Health Program[1]		
Total	**35**	**32**	**24**	**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[5]	Y			SBM-FP	Assessment
California[6]	N/A (M-CHIP)			SBM	N/A (SBM)
Colorado	Y	Y	Y	SBM	N/A (SBM)
Connecticut	Y			SBM	N/A (SBM)
Delaware	Y	Y	Y	Partnership	Assessment
District of Columbia	N/A (M-CHIP)			SBM	N/A (SBM)
Florida	Y	Y	Y	FFM	Assessment
Georgia	Y	Y	Y	FFM	Assessment
Hawaii	N/A (M-CHIP)	Y		FFM	Assessment
Idaho	Y	Y	Y	SBM	N/A (SBM)
Illinois	Y	Y	Y	Partnership	Assessment
Indiana	Y	Y	Y	FFM	Assessment
Iowa[7]	Y	Y		Partnership	Assessment
Kansas	Y	Y	Y	FFM	Assessment
Kentucky	Y	Y	Y	SBM-FP	Assessment
Louisiana	Y	Y		FFM	Determination
Maine	Y	Y	Y	FFM	Assessment
Maryland	N/A (M-CHIP)			SBM	N/A (SBM)
Massachusetts	Y			SBM	N/A (SBM)
Michigan	N/A (M-CHIP)			Partnership	Assessment
Minnesota	N/A (M-CHIP)			SBM	N/A (SBM)
Mississippi	Y	Y		FFM	Assessment
Missouri	Y			FFM	Assessment
Montana	Y	Y	Y	FFM	Determination
Nebraska	N/A (M-CHIP)	Y	Y	FFM	Assessment
Nevada	Y	Y	Y	SBM-FP	Assessment
New Hampshire	N/A (M-CHIP)	Y	Y	Partnership	Assessment
New Jersey	Y	Y		FFM	Determination
New Mexico	N/A (M-CHIP)	Y	Y	SBM-FP	Assessment
New York	Y			SBM	N/A (SBM)
North Carolina	Y	Y	Y	FFM	Assessment
North Dakota	Y			FFM	Assessment
Ohio	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[8]	Y	Y		FFM	Determination
Texas	Y	Y	Y	FFM	Assessment
Utah	Y	Y	Y	FFM	Assessment
Vermont	N/A (M-CHIP)			SBM	N/A (SBM)
Virginia[9]	Y	Y	Y	FFM	Determination
Washington	Y			SBM	N/A (SBM)
West Virginia	Y	Y	Y	Partnership	Determination
Wisconsin	Y	Y	Y	FFM	Assessment
Wyoming[10]	Y	Y		FFM	Determination

SOURCE: Based on a national survey conducted by KFF with the Georgetown University Center for Children and Families, 2019. Table presents rules in effect as of January 1, 2019.

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 eligible based on a disability, or at least one non-health program, such as Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), or 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 U.S. 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 an 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. Arkansas began receiving assessments rather than final determinations of Medicaid and CHIP eligibility from the FFM in 2018.
6. California's statewide-integrated Marketplace and Medicaid system, CALHEERS is not integrated with other programs. However, cases for all Medicaid enrollees are transferred to and managed at the county level where systems are integrated for all Medicaid groups, including seniors and people eligible based on a disability and non-health programs.
7. Iowa integrated eligibility determinations for seniors and people eligible based on a disability with other Medicaid groups in 2018.
8. Tennessee integrated eligibility determinations for seniors and people eligible based on a disability and CHIP with other Medicaid groups with the launch of its new eligibility system. It is available in select counties on a pilot basis as of January 2019 and is expected to be expanded statewide in Spring 2019.
9. Virginia began receiving final determinations rather than assessments of Medicaid and CHIP eligibility from the FFM in 2018.
10. In Wyoming, the FFM conducts assessments rather than final determinations of CHIP eligibility.

Table 12: Presumptive Eligibility in Medicaid and CHIP, January 2019[1]								
State	Children		Pregnant Women		Parents	Adults[2] (Total = 35)	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	Y	Y	Y	N/A		N/A	N/A	
Kentucky			Y	N/A				
Louisiana				N/A				
Maine			Y	N/A				
Maryland[3]		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								
Washington				N/A				
West Virginia	Y		Y	N/A	Y	Y	N/A	Y
Wisconsin	Y		Y	N/A			Y	
Wyoming	Y		Y	N/A	Y	N/A		Y

SOURCE: Based on a national survey conducted by KFF with the Georgetown University Center for Children and Families, 2019.
Table presents rules in effect as of January 1, 2019.

Table 12 Notes

1. These columns indicate whether a state has elected to implement presumptive eligibility, under which a state can authorize qualified entities such as hospitals, community health centers, and schools to make presumptive eligibility determinations for Medicaid and/or CHIP and extend temporary coverage to individuals until a full eligibility determination is made. The ACA also gave hospitals nationwide the authority to conduct presumptive eligibility determinations regardless of whether a state has otherwise adopted presumptive eligibility.
2. N/A (M-CHIP) responses indicate that the state does not 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. Maryland utilizes presumptive eligibility for individuals leaving correctional facilities if an application cannot be submitted prior to release.
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 2019										
State	Processing Automated Renewals[1]	Percentage of Renewals that are Automated[1]				Pre-populated 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**	**10**	**12**	**11**	**10**	**46**	**13**	**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	Y				Y	Y	Y	Y		N/A (M-CHIP)
Florida[6,7]	Y		Y					Y		Y
Georgia	Y	Y				Y				
Hawaii	Y			Y		Y	Y	Y		N/A (M-CHIP)
Idaho[7]	Y				Y			Y	Y	Y
Illinois	Y	Y				Y			Y	Y
Indiana[8]	Y			Y		Y	Y	Y		
Iowa	Y			Y		Y	Y	Y	Y	Y
Kansas[9]	Y		Y			Y			Y	Y
Kentucky	Y			Y		Y		Y		
Louisiana	Y				Y			Y	Y	Y
Maine[9]						Y			Y	Y
Maryland	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[10]	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[10]	Y		Y			Y		Y	Y	Y
North Carolina	Y		Not Reported			Y		Y	Y	Y
North Dakota	Y		Not Reported			Y		Y	Y	Y
Ohio	Y				Y	Y		Y	Y	N/A (M-CHIP)
Oklahoma[7]	Y		Y					Y		N/A (M-CHIP)
Oregon	Y				Y	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[11]						Y	Y	Y		Y
Texas[12]	Y		Not Reported			Y	Y	Y		Y
Utah[9]	Y			Y		Y				Y
Vermont[13]	Y		Y			Y		Y		N/A (M-CHIP)
Virginia	Y		Y			Y		Y		
Washington	Y			Y		Y		Y	Y	Y
West Virginia[9]	Y	Y				Y			Y	Y
Wisconsin	Y	Y				Y		Y		
Wyoming						Y		Y	Y	Y

SOURCE: Based on a national survey conducted by KFF with the Georgetown University Center for Children and Families, 2019.
Table presents rules in effect as of January 1, 2019.

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 without requiring a paper form or electronic signature.
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. Florida's renewal form for Medicaid is pre-populated when the enrollee completes an online renewal, but the state does not mail prepopulated forms. However, Florida Healthy Kids does use prepopulated renewals forms for children enrolled in the separate CHIP program. 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.
7. Florida, Idaho, and Oklahoma do not mail a renewal form to individuals, instead, the state sends a notice directing the enrollees to go online or call to update their information as needed. Idaho switched from mailing prepopulated renewal forms to sending notices in 2018.
8. In Indiana, 12-month continuous eligibility is provided only to children under age 3.
9. In Kansas, Maine, Utah, and West Virginia, families may report changes by telephone but still need to sign and return the pre-populated renewal form.
10. Montana and New York provide 12-month continuous eligibility to parents and expansion adults through a Section 1115 waiver.
11. Tennessee added prepopulated renewal forms and telephone renewals with its new system.
12. In Texas, a child in CHIP with income below 185% FPL receives 12-month continuous eligibility; at or above 185% FPL, a child in CHIP receives 12-month continuous eligibility unless there is an indication of a change at a six-month income check that would make the child ineligible for CHIP.
13. Vermont began sending pre-populated renewal forms in 2018.

Table 14: Premium, Enrollment Fee, and Cost Sharing Requirements for Children, January 2019						
State	Premiums/Enrollment Fees			Cost Sharing		
	Medicaid	CHIP (Total = 36)[1]	Lowest Income at Which Premiums Begin (% of the FPL)[2]	Medicaid	CHIP (Total = 36)[1]	Lowest Income at Which Cost Sharing Begins (% of the FPL)[2]
Total	**4**	**26**		**2**	**23**	
Alabama		Y	141%		Y	141%
Alaska		N/A (M-CHIP)			N/A (M-CHIP)	
Arizona		Y	133%			
Arkansas					Y	142%
California	Y	N/A (M-CHIP)	160%		N/A (M-CHIP)	
Colorado		Y	157%		Y	143%
Connecticut		Y	249%		Y	196%
Delaware		Y	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	143%		Y	143%
Illinois		Y	157%		Y	142%
Indiana		Y	158%		Y	158%
Iowa		Y	182%		Y	182%
Kansas		Y	167%			
Kentucky[5]						
Louisiana		Y	213%			
Maine		Y	157%			
Maryland	Y	N/A (M-CHIP)	211%		N/A (M-CHIP)	
Massachusetts		Y	150%			
Michigan	Y	N/A (M-CHIP)	160%		N/A (M-CHIP)	
Minnesota		N/A (M-CHIP)			N/A (M-CHIP)	
Mississippi					Y	150%
Missouri		Y	150%			
Montana					Y	143%
Nebraska		N/A (M-CHIP)			N/A (M-CHIP)	
Nevada		Y	133%			
New Hampshire		N/A (M-CHIP)			N/A (M-CHIP)	
New Jersey		Y	200%		Y	151%
New Mexico[5]		N/A (M-CHIP)			N/A (M-CHIP)	
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[6]				Y	Y	100%
Texas		Y	151%		Y	133%
Utah		Y	133%		Y	133%
Vermont	Y	N/A (M-CHIP)	195%		N/A (M-CHIP)	
Virginia					Y	143%
Washington		Y	210%			
West Virginia		Y	211%		Y	133%
Wisconsin		Y	201%	Y	Y	133%
Wyoming					Y	134%

SOURCE: Based on a national survey conducted by KFF with the Georgetown University Center for Children and Families, 2019.
Table presents rules in effect as of January 1, 2019.

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. Kentucky and New Mexico eliminated copayments for children effective January 1, 2019.
6. 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 2019[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[3,4]
Monthly Payments (24 states)						
Arizona[5]	$40	$50	N/A	N/A	N/A	Yes
California[6]	$0	$13	$13	N/A	N/A	
Connecticut[7]	$0	$0	$30	$30	N/A	Yes
Delaware[8]	$10	$25	N/A	N/A	N/A	Family Based Premium
Florida[9]	$15	$20	N/A	N/A	N/A	Family Based Premium
Georgia[10]	$11	$29	N/A	N/A	N/A	No
Idaho[11]	$15	N/A	N/A	N/A	N/A	No
Illinois[12]	$0	$15	$40	$40	N/A	Yes
Indiana[13]	$0	$33	$53	N/A	N/A	Yes
Iowa[14]	$0	$10	$20	$20	N/A	Yes
Kansas[15]	$0	$30	N/A	N/A	N/A	Family Based Premium
Louisiana	$0	$0	$50	N/A	N/A	Family Based Premium
Maine[16]	$0	$32/$64	N/A	N/A	N/A	Yes
Maryland	$0	$0	$54	$68	N/A	Family Based Premium
Michigan	$0	$10	N/A	N/A	N/A	Family Based Premium
Massachusetts[17]	$12	$20	$28	$28	N/A	Yes
Missouri[18]	$19 I $24 I $29	$63 I $79 I $96	$154 I $195 I $235	$154 I $195 I $235	N/A	
New Jersey[19]	$0	$45	$90	$152	$152	Family Based Premium
New York[20]	$0	$9 | $27	$30 | $90	$45 | $135	$60 | $180	Yes
Pennsylvania[21]	$0	$0	$53	$84	N/A	
Vermont[22]	$0	$15	$20/$60	$20/$60	N/A	Family Based Premium
Washington[23]	$0	$0	$20 | $40	$20 | $40	N/A	Yes
West Virginia[24]	$0	$0	$35	$35	N/A	Yes
Wisconsin	$0	$10	$34	$98	N/A	
Quarterly Payments (2 states)						
Nevada	$50	$80	N/A	N/A	N/A	Family Based Premium
Utah	$75	$75	N/A	N/A	N/A	Family Based Premium
Annual Payments (4 states)						
Alabama[25]	$104	$104	$104	$104	N/A	Yes
Colorado[26]	$0	$25	$75	N/A	N/A	Yes
North Carolina[27]	$0	$50	N/A	N/A	N/A	Yes
Texas[28]	$35	$50	N/A	N/A	N/A	Family Based Premium
No Premiums or Enrollment Fees (21 states)						
Alaska	--	--	--	--	--	--
Arkansas	--	--	--	--	--	--
District of Columbia	--	--	--	--	--	--
Hawaii	--	--	--	--	--	--
Kentucky	--	--	--	--	--	--
Minnesota	--	--	--	--	--	--
Mississippi	--	--	--	--	--	--
Montana	--	--	--	--	--	--
Nebraska	--	--	--	--	--	--
New Hampshire	--	--	--	--	--	--
New Mexico	--	--	--	--	--	--
North Dakota	--	--	--	--	--	--
Ohio	--	--	--	--	--	--
Oklahoma	--	--	--	--	--	--
Oregon	--	--	--	--	--	--
Rhode Island	--	--	--	--	--	--
South Carolina	--	--	--	--	--	--
South Dakota	--	--	--	--	--	--
Tennessee	--	--	--	--	--	--
Virginia	--	--	--	--	--	--
Wyoming	--	--	--	--	--	--

SOURCE: Based on a national survey conducted by KFF with the Georgetown University Center for Children and Families, 2019.
Table presents rules in effect as of January 1, 2019.

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. Family Based Premium indicates that the premium amount listed in the table is per family rather than per child.
4. Federal rules limit total premiums and cost sharing for all household members enrolled in Medicaid or CHIP to five percent of family income. States have the option to apply the cap on a monthly or quarterly basis. States are also required to have a mechanism in place to track family-based cost sharing and waive cost sharing for the remainder of the cost sharing period selected by the state.
5. In Arizona, there is a maximum premium of $60 for families with incomes at 151% FPL and $70 for families with incomes at 200% FPL.
6. In California, the family maximum premium is $39.
7. In Connecticut, the family maximum premium is $50.
8. Delaware has an incentive system for premiums where families can pay three months and get one premium-free month, pay six months and get two premium-free months, and pay nine months and get three premium-free months.
9. Florida charges premiums to children enrolled in its three separate CHIP programs, but it only charges cost sharing for children in its separate CHIP program, HealthyKids.
10. In Georgia, the lockout period for children was eliminated.
11. In Idaho, if a child is up to date on wellness checks the premiums are waived.
12. In Illinois, CHIP premiums are $15 per child, $25 for two children, and $5 for each additional child up to a $40 maximum for families with incomes below 208% FPL. Above 208% FPL, families pay $40 per child or $80 for two or more children.
13. In Indiana, there is a maximum premium of $33 for families with incomes between 175% and 200% FPL, $50 for families with incomes between 200% and 225% FPL, $53 for families with incomes between 225% and 250% FPL, and $70 for families with incomes at or above 250% FPL.
14. In Iowa, there is a maximum premium of $20 for families with incomes at 201% FPL and $40 for families with incomes at 251% FPL or 301% FPL.
15. In Kansas, there is a maximum premium of $20 for families with incomes up to 191% FPL, $30 for families with incomes up to 218% FPL, and $50 for families with incomes up to 241% FPL.
16. In Maine, families with incomes between 157%-166% FPL pay $8 for one child and $16 for two or more children. Families with incomes between 166%-177% FPL pay $16 for one child and $32 for two or more children. Families with incomes between 177%-192% FPL pay $24 for one child and $48

for two or more children. Families with incomes between 192% -208% FPL pay $32 for one child and $64 for two or more children. The family maximum premium is $64.

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

Table 16: Disenrollment Policies for Non-Payment of Premiums in Children's Coverage, January 2019		
State	**Grace Period (Amount of Time) Before a Child Loses Coverage for Nonpayment[1]**	**Lockout Period in Separate CHIP Program[2]**
Monthly Payments (24 states)		
Arizona	60 days	2 months
California	60 Days	N/A (M-CHIP)
Connecticut[3]	Until Renewal	None
Delaware	60 days	None
Florida	1 month	1 month
Georgia	60 days	None
Idaho[3]	Until renewal	None
Illinois	60 days	None
Indiana	60 days	90 days
Iowa	44 days	None
Kansas	60 days	90 days
Louisiana	30 days	90 days
Maine[4]	12 Months	90 days
Maryland	60 Days	N/A (M-CHIP)
Massachusetts[5]	60 days	90 days
Michigan	60 days	N/A (M-CHIP)
Missouri[6]	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]	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 KFF with the Georgetown University Center for Children and Families, 2019.
Table presents rules in effect as of January 1, 2019.

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 canceling 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 Massachusetts, if the premium payment is not paid within 60 days of the due date, a final notice is sent giving the family 15 days to pay before the case is closed. After the 90-day lockout period children may re-enroll for prospective coverage without paying the past due premiums. Children may re-enroll for prospective coverage during the 90-day lockout period if the past due premiums are paid, if a payment plan is set up, or if the family is determined eligible for a premium waiver. Premiums that are more than 24 months overdue are waived.
6. In Missouri, only children in families with incomes above 225% FPL are subject to the lockout period.
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; after that time they will be disenrolled for non-payment.
8. Colorado’s annual enrollment fee is required before a child enrolls in coverage. Applications remain pending until the enrollment fee is paid. Once individuals pay the enrollment fee, their eligibility is effective retroactively to the first of the month of application.
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 2019[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	**18**	**13**	**16**	**14**	**18**	**13**	**16**	**13**
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]	--	--	--	--	--	--	--	--
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[3]	--	--	--	--	--	--	--	--
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[2,4]	$0	$0	$0	$0	$0	$0	$0	$0
Rhode Island	--	--	--	--	--	--	--	--
South Carolina	--	--	--	--	--	--	--	--
South Dakota	--	--	--	--	--	--	--	--
Tennessee[2,5]	$5	$10 | $50	$10 | $50	$5 | $100	$5 | $15/$20	$50	$50	$100
Texas	$5	$0	$5	$35	$25	$0	$75	$125
Utah[6]	$25/$40	$300	$100-$200	20% daily reimbursement rate	$25/$40	$300	$100-$200	20% daily reimbursement rate
Vermont	--	--	--	--	--	--	--	--
Virginia	$5	$5	$25	$25	$5	$5	$25	$25
Washington	--	--	--	--	--	--	--	--
West Virginia[2,7]	$15	$35	$35	$25	$20	$35	$35	$25
Wisconsin[8]	$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 KFF with the Georgetown University Center for Children and Families, 2019.
Table presents rules in effect as of January 1, 2019.

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, Tennessee, West Virginia, and Wyoming, the emergency room copayment is waived if the child is admitted.
3. Kentucky and New Mexico eliminated copayments for children in 2018.
4. Pennsylvania charges cost sharing starting at >208% of the federal poverty level (FPL), so no charges are reported in the table.
5. Tennessee covers children in its regular Medicaid program, called TennCare, with incomes up to 195% 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.
6. Utah has a $40 deductible for all hospital services for families with incomes up to 150% FPL. Families with incomes above 150% FPL have a $500 per child or $1,500 per family deductible for hospital services. In Utah, for a non-preventive physician visit, the value before the “/” is the copayment amount for a visit with a primary care doctor, the value after the “/” is the copayment for a visit with a specialist.
7. In West Virginia, the copayment for a non-preventive physician visit is waived if the child goes to his or her medical home.
8. 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 2019[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	**14**	**16**	**13**	**16**	**17**	**14**
Alabama	$5	$25	$28	$5	$25	$28
Alaska	--	--	--	--	--	--
Arizona	--	--	--	--	--	--
Arkansas	$5	$5	$5	$5	$5	$5
California	--	--	--	--	--	--
Colorado	$3	$10	N/C	$5	$15	N/C
Connecticut	$0	$0	$0	$5	$10	$10
Delaware	--	--	--	--	--	--
District of Columbia	--	--	--	--	--	--
Florida	$5	$5	$5	$5	$5	$5
Georgia	$0.50	$0.50-$3	$0.50-$3	$1	$0.50-$3	$0.50-$3
Hawaii	--	--	--	--	--	--
Idaho	$0	$0	$0	N/A	N/A	N/A
Illinois	$2	$3.90	$3.90	$3	$5	$5
Indiana	$0	$0	$0	$3	$10	$10
Iowa	$0	$0	$0	$0	$0	$0
Kansas	--	--	--	--	--	--
Kentucky[2]	--	--	--	--	--	--
Louisiana	--	--	--	--	--	--
Maine	--	--	--	--	--	--
Maryland	--	--	--	--	--	--
Massachusetts	--	--	--	--	--	--
Michigan	--	--	--	--	--	--
Minnesota	--	--	--	--	--	--
Mississippi	$0	$0	$0	$0	$0	$0
Missouri	--	--	--	--	--	--
Montana[3]	$0	$0	$0	$0	$0	$0
Nebraska	--	--	--	--	--	--
Nevada	--	--	--	--	--	--
New Hampshire	--	--	--	--	--	--
New Jersey	$1	$5	$5	$5	$5	$5
New Mexico[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[4]	$0	$0	N/C	$0	$0	N/C
Rhode Island	--	--	--	--	--	--
South Carolina	--	--	--	--	--	--
South Dakota	--	--	--	--	--	--
Tennessee[5]	$1.50 | $1	$3	$3 | $5	$1.50 | $5	$3 | $20	$3 | $40
Texas	$0	$5	N/C	$10	$35	N/C
Utah	$15	25% of cost	50% of cost	$15	25% of cost	50% of cost
Vermont	--	--	--	--	--	--
Virginia	$5	$5	$5	$5	$5	$5
Washington	--	--	--	--	--	--
West Virginia	$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 KFF with the Georgetown University Center for Children and Families, 2019. Table presents rules in effect as of January 1, 2019.

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 recoded as a $0; if a state does not provide coverage at a particular income level, it is noted as “N/A;” if a state does not charge copayments at all, it is noted as “- -“; if a state does not cover a type of drug, it is noted as “N/C”. Some states require 18-year-olds to meet the copayments of adults in Medicaid. These data are not shown.
2. Kentucky and New Mexico eliminated copayments in 2018.
3. In Montana, if families order prescriptions through the mail, they pay $6 for a three-month supply of a generic drug.
4. Pennsylvania charges cost sharing starting at >208% of the federal poverty level (FPL), so no charges are reported in the table.
5. Tennessee covers children in its regular Medicaid program, called TennCare, with incomes up to 195% FPL for infants, 142% for children ages 1 – 5, and 133% FPL for children 6 – 18. Children who lose eligibility in TennCare qualify for coverage under a Medicaid expansion program, called TennCare Standard, if they are uninsured, have no access to insurance, and have family incomes below 211% FPL. Tennessee also operates a separate CHIP program, called Cover Kids, which covers uninsured children of all ages who do not qualify for TennCare or TennCare Standard and have incomes below 250% FPL. Children enrolled in TennCare have no copayments. The values shown before the “|” represent copayments for children enrolled in TennCare Standard, whereas the values after the “|” represent copayments for children enrolled in Cover Kids.

Table 19: Premium and Cost Sharing Requirements for Selected Services for Section 1931 Parents, January 2019[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**	**23**	**26**	**34**	**38**	**37**
Alabama		Yes	0%	$1.30-$3.90	$3.90	$50	$.65-$3.90	$.65-$3.90	$.65-$3.90
Alaska		Yes	0%	$10	$0	$50/day	$3	$3	$3
Arizona		Yes	0%	$3.4	$0	$0	$2.30	$2.30	$2.30
Arkansas[2]		Yes	0%	$0	$0	10% cost of first day	$0.50-$3.90	$0.50-$3.90	$0.50-$3.90
California		Yes	0%	$1	$5	$0	$1	$1	$1
Colorado		Yes	101%	$2	$6	$4	$3	$3	$3
Connecticut		No	--	--	--	--	--	--	--
Delaware[3]		Yes	0%	$0	$0	$0	$.50-$3	$.50-$3	$.50-$3
District of Columbia		No	--	--	--	--	--	--	--
Florida		Yes	0%	$2	5% of first $300	$0	$0	$0	$0
Georgia		Yes	0%	$0	$0	$12.50	$.50-$3	$.50-$3	$.50-$3
Hawaii		No	--	--	--	--	--	--	--
Idaho		No	--	--	--	--	--	--	--
Illinois		Yes	0%	$3.90	$3.90	$3.90/day	$2	$3.90	$3.90
Indiana[4]	Yes, >0%	Yes	0%	$4	$8	$75	$4	$4	$8
Iowa[5]		Yes	0%	$3	$3	$0	$1	$1	$2-3
Kansas		No	--	--	--	--	--	--	--
Kentucky[6]		Yes	0%	$3	$8	$50	$1	$4	5% cost ($8 min/ $20 max)
Louisiana		Yes	0%	$0	$0	$0	$.50-$3	$.50-$3	$.50-$3
Maine[7]		Yes	0%	$0	$3	Up to $3/day	$3	$3	$3
Maryland		Yes	0%	$0	$0	$0	$1-$3	$1-$3	$1-$3
Massachusetts[8]		Yes	0%	$0	$0	$3	$3.65	$3.65	$3.65
Michigan[9]		Yes	0%	$2 | $4	$3 | $8	$50 | $100	$1 | $4	$1 | $4	$3 | $8
Minnesota		Yes	0%	$3	$3.50	$0	$1	$3	$3
Mississippi		Yes	0%	$3	$0.00	$10	$3	$3	$3
Missouri		Yes	0%	$1	$3	$10	$.50-$2	$.50-$2	$.50-$2
Montana		Yes	0%	$4	$8	$75	$0	$4	$8
Nebraska[10]		Yes	0%	$2	$0	$15	$2	$3	$3
Nevada		No	--	--	--	--	--	--	--
New Hampshire		Yes	100%	$0	$0	$0	$0	$1	$2
New Jersey		No	--	--	--	--	--	--	--
New Mexico		No	--	--	--	--	--	--	--
New York		Yes	100%	$0	$3	$25/discharge	$1	$3	$3
North Carolina[11]		Yes	0%	$3	$3	$3/day	$3	$3	$3
North Dakota		Yes	0%	$2	$0	$75	$0	$3	$3
Ohio		Yes	0%	$0	$3	$0	$0	$2	$3
Oklahoma		Yes	0%	$4	$4	$10/day; $90 max	$4	$4	$4
Oregon		No	--	--	--	--	--	--	--
Pennsylvania[12]		Yes	0%	$0.65-$3.80	$0.50-$3	$3/day	$1	$3	$3
Rhode Island		No	--	--	--	--	--	--	--
South Carolina		Yes	0%	$3.30	$0	$25	$3.40	$3.40	$3.40
South Dakota		Yes	0%	$3	Full amount	$50	$1	$3.30	N/C
Tennessee		Yes	0%	$0	$0	$0	$1.50	$3	$3
Texas		No	--	--	--	--	--	--	--
Utah[13]		Yes	20%	$4	$8	$75	$4	$4	$4
Vermont		Yes	0%	$3	$0	$0	$1-$3	$1-$3	$1-$3
Virginia		Yes	0%	$1	$75	$75	$1	$3	$3
Washington		No	--	--	--	--	--	--	--
West Virginia[14]		Yes	0%	$0-$4	$8	$0-$75	$0-$3	$0-$3	$0-$3
Wisconsin[7]		Yes	0%	$0.50-$3	$0	$3	$1	$3	$3
Wyoming		Yes	0%	$2.45	$3.65	$0	$0.65	$3.65	$3.65

SOURCE: Based on a national survey conducted by KFF with the Georgetown University Center for Children and Families, 2019.
Table presents rules in effect as of January 1, 2019.

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. In Arkansas, drug copayments for 1931 parents vary based on the cost of drug ranging from $0.50 to $3.00.
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 non-emergency use of the emergency room. Indiana changed its monthly payments to a tiered structure instead of a flat 2% of income, added a tobacco surcharge of 50% of the normal monthly contribution if the member has been a tobacco user for the past year, and removed the $25 copay for subsequent non-emergency use of the emergency room in 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. In Michigan, copayments vary by income levels. The values shown before the “|” represent copayments for individuals with incomes less than or equal to 100% FPL, whereas the values after the “|” represent copayments for individuals with incomes above 100% FPL.
10. In Nebraska, as long as all 1931 parents are enrolled in Managed Care, that MCO has waived all copayments regardless of income level.
11. North Carolina added a copayment for non-emergency use of the emergency room of $3.
12. In Pennsylvania, the inpatient hospital copayment is subject to a maximum of $21 per stay.
13. In Utah, enrollees under the Temporary Aid to Needy Families (TANF) payment limit are exempt from paying copayments.
14. 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 2019[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
Implemented Medicaid Expansion (34 states)									
Total	**5**	**24**		**15**	**15**	**15**	**19**	**23**	**23**
Alaska		Yes	0%	$10	$0	$50/day	$3	$3	$3
Arizona			--	--	--	--	--	--	--
Arkansas[2]	Yes, >100%	Yes	100%	$8/$10	$0	$140/day	$4	$4	$8
California		Yes	0%	$1	$5	$0	$1	$1	$1
Colorado		Yes	0%	$2	$6	$10/day	$1	$3	$3
Connecticut			--						
Delaware[3]		Yes	0%	$0	$0	$0	$0.50-$3	$0.50-$3	$0.50-$3
District of Columbia			--	--	--	--	--	--	--
Hawaii			--	--	--	--	--	--	--
Illinois		Yes	0%	$3.90	$3.90	$3.90/day	$2	$3.90	$3.90
Indiana[4]	Yes, >0%	Yes	0%	$4	$8	$75	$4	$4	$8
Iowa[5]	Yes, >50%	Yes	0%	$0	$8	$0	$0	$0	$0
Kentucky		Yes	0%	$3	$8	$50	$1	$4	5% cost ($8 min/ $20 max)
Louisiana		Yes	0%	$0	$0	$0	$.50-$3	$.50-$3	$.50-$3
Maine		Yes	0%	$0	$3	Up to $3 per day	$3	$3	$3
Maryland		Yes	0%	$0	$0	$0	$1-$3	$1-$3	$1-$3
Massachusetts[6]		Yes	0%	$0	$0	$3	$3.65	$3.65	$3.65
Michigan[7,8]	Yes, >100%	Yes	0%	$2 | $4	$3 | $8	$50 | $100	$1 | $4	$1 | $4	$3 | $8
Minnesota		Yes	0%	$3	$3.50	$0	$1	$3	$3
Montana[8,9]	Yes, >51%	Yes	0%	$4/10% of state payment	$8	$75/10% of state payment	$0	$4	$8
Nevada			--	--	--	--	--	--	--
New Hampshire[10]		Yes	100%	$0	$0	$0	$0	$1	$2
New Jersey			--	--	--	--	--	--	--
New Mexico			--	--	--	--	--	--	--
New York		Yes	100%	$0	$3	$25/ discharge	$1	$3	$3
North Dakota		Yes	0%	$2	$0	$75	$0	$3	$3
Ohio		Yes	0%	$0	$3	$0	$0	$2	$3
Oregon			--	--	--	--	--	--	--
Pennsylvania[11]		Yes	0%	$0.65-$3.80	$0.50-$3	$3/day	$1	$3	$3
Rhode Island			--	--	--	--	--	--	--
Vermont		Yes	0%	$3	$0	$0	$1-$3	$1-$3	$1-$3
Virginia		Yes	0%	$1	$75	$75	$1	$3	$3
Washington			--	--	--	--	--	--	--
West Virginia[12]		Yes	0%	$0-$4	$8	$0-$75	$0-$3	$0-$3	$0-$3
Expansion Not Yet Implemented (17 states)									
Total	**0**	**1**	**1**	**1**	**0**	**1**	**1**	**1**	**1**
Alabama									
Florida									
Georgia									
Idaho									
Kansas									
Mississippi									
Missouri									
Nebraska									
North Carolina									
Oklahoma									
South Carolina									
South Dakota									
Tennessee									
Texas									
Utah									
Wisconsin[13]		Yes	>0%	$0.50-$3	$0	$3	$1	$3	$3
Wyoming									

SOURCE: Based on a national survey conducted by KFF with the Georgetown University Center for Children and Families, 2019.
Table presents rules in effect as of January 1, 2019.

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 incomes above 100% of the federal poverty level (FPL) a monthly premium of up to 2% of income. Expansion adults with incomes 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 re-enrolling 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. Indiana changed its monthly payments to a tiered structure instead of a flat 2% of income, added a tobacco surcharge of 50% of the normal monthly contribution if the member has been a tobacco user for the past year, and removed the $25 copay for subsequent non-emergency use of the emergency room in 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, premiums are also charged for some adults with incomes above 150% FPL covered through waiver programs. In Massachusetts, generic drugs for diabetes, high blood pressure, and high cholesterol have a $1 copayment. There is a $36 annual cap for non-pharmacy copayments and a $250 annual cap for pharmacy copayments.
7. In Michigan, under Section 1115 waiver authority, expansion adults with incomes above 100% FPL are charged monthly premiums that are equal to 2% of income. Expansion adults 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 Michigan and Montana, copayments vary by income levels. The values shown before the "|" represent copayments for individuals with incomes less than or equal to 100% FPL, whereas the values after the "|" represent copayments for individuals with incomes above 100% FPL.
9. 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 (the 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.
10. Effective January 2019, New Hampshire decreased cost sharing for expansion adults to match those charged to 1931 parents.
11. In Pennsylvania, the inpatient hospital copayment is subject to a maximum of $21 per stay.
12. 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%.
13. Wisconsin offers Medicaid coverage to childless adults up to 100% FPL but has not adopted the ACA Medicaid expansion. Copayments begin above 0% FPL.

Filling the need for trusted information on national health issues.

THE HENRY J. KAISER FAMILY FOUNDATION

Headquarters

185 Berry Street Suite 2000
San Francisco CA 94107
650 854 9400

Washington Offices and Conference Center

1330 G Street NW
Washington DC 20005
202 347 5270

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