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Health Coverage for Children and Families in Medicaid and SCHIP: State Efforts Face New Hurdles

A 50-State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2008

Prepared By
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and

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Kaiser Commission on Medicaid and the Uninsured

January 2008

THE HENRY J. KAISER FAMILY FOUNDATION

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The Kaiser Commission on Medicaid and the Uninsured provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured. Begun in 1991 and based in the Kaiser Family Foundation's Washington, DC office, the Commission is the largest operating program of the Foundation. The Commission's work is conducted by Foundation staff under the guidance of a bi-partisan group of national leaders and experts in health care and public policy.

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Executive Summary

States have been revitalizing their efforts to expand health coverage for low-income, uninsured individuals, particularly children. During 2007, states were bolstered by a positive fiscal outlook and the anticipation that strong SCHIP reauthorization legislation would be passed, conditions that led them to take affirmative steps towards improving access to health coverage through Medicaid and the State Children's Health Coverage Program (SCHIP). Successes at the state level mark 2007 as a pivotal year, with eligibility increases for children representing the most aggressive push forward since the early years of SCHIP.

Despite states' recent bold initiatives to advance children's health coverage, a string of federal developments is dampening the prospects for making real progress. First, states were counting on a strong SCHIP reauthorization that has not yet materialized. Although two bills were passed with large bipartisan majorities in Congress that would have enabled states to expand and strengthen their programs, they were vetoed twice by President Bush. Congress has since enacted a temporary extension of SCHIP that will be in place until the end of March 2009.

During the SCHIP debate, the Centers for Medicare and Medicaid Services (CMS) issued a new federal directive on August 17, 2007, that restricts states' ability to use SCHIP funds to cover children in families with gross incomes above 250 percent of the federal poverty line. CMS has also issued new federal regulations curtailing Medicaid funding, including one that eliminates administrative funding for outreach and enrollment activities conducted by school personnel. In addition, implementation of the Medicaid citizenship documentation requirement, a provision of the Deficit Reduction Act (DRA) enacted in early 2006 that requires new applicants and current enrollees to provide original documents to prove citizenship and identity has resulted in eligible U.S. citizens having their Medicaid benefits delayed, denied or terminated. These developments are impeding states' efforts to cover children made eligible through newly authorized expansions, as well as their efforts to enroll children who are already eligible for coverage but who remain uninsured.

This report presents the findings of a survey of eligibility rules, enrollment and renewal procedures, and cost-sharing practices in Medicaid and SCHIP for children and families that were implemented or authorized between July 2006 and January 2008 in the 50 states and the District of Columbia. These policies are the driving forces behind efforts to reduce the number of low-income people who lack adequate insurance but cannot afford to pay for it on their own. The survey documents the steps states took to advance coverage, and also the impact of new hurdles that are constraining their efforts to reduce the number of low-income uninsured children, pregnant women and parents.

The survey's major findings are presented below.

Changes in Health Coverage Programs for Children

- **Nearly two-thirds of the states (32 states, including DC) took actions to increase access to health coverage for low-income children, pregnant women, and parents.** Twenty-six states authorized or adopted income eligibility expansions, 11 states reduced procedural barriers, and seven states reduced financial barriers to Medicaid and SCHIP. While the most vigorous activity was focused on children, modest improvements for pregnant women and parents also occurred.

- **Twenty-six states improved access to children's health coverage.** Twenty states expanded eligibility, the most aggressive step forward since the early years of the SCHIP program. Of those 20 states, 12 raised (or authorized raising) SCHIP income limits to 300 percent of the poverty line or higher, more than doubling the number of states with eligibility at this level. Nine states simplified enrollment procedures, and seven states reduced financial barriers to coverage.

- **Over the next year, children's health coverage in nearly half the states (23 states) will be hampered by the August 17th directive.** Just as states are pushing forward, a new federal directive issued by CMS on August 17, 2007 restricts states from using SCHIP funds to cover children in families with gross incomes above 250 percent of the federal poverty line, thus limiting states' ability to reach uninsured children above this income level. The directive currently affects 23 states, including 10 states that passed eligibility expansions but had not obtained federal approval before the directive was issued and 14 states that had implemented coverage expansions above this level but will have to comply with the directive by August 2008. (Washington is counted in both sets of states.) In response to the directive, several states have scaled back or postponed their expansion plans or have decided to absorb the full cost of covering children with income above the CMS limit. As a result, thousands of children already have lost the opportunity to obtain health coverage. Many more may be adversely affected as states make decisions about going forward.

- **Fourteen states enacted children's coverage expansions that were moderate in scope but focused on particularly vulnerable populations, such as infants or children discharged from foster care at age 18.** These changes include modest income eligibility expansions, increasing the SCHIP asset limit, and allowing children who are discharged from foster care at age 18 to retain Medicaid through age 21.

- **No state cut back income eligibility for children, but a few states took other actions to restrict eligibility.** Three states froze children's enrollment; two states imposed or lengthened waiting periods. Experience from states that have endured enrollment freezes indicates that most children who are closed out of coverage have no alternatives and remain uninsured, missing out on needed health care including prompt medical treatment, medication, preventive exams and immunizations.

- **States have made progress in adopting simplified enrollment and renewal procedures in children's Medicaid and SCHIP, with particular emphasis on strategies that reduce paperwork and jump-start enrollment.** Nine states took steps to simplify enrollment and renewal procedures for children. Several basic simplified strategies — disregarding assets in determining eligibility, allowing enrollment and renewal without an in-person interview, and limiting the frequency of renewal to once a year— have been adopted for children almost universally. Only one state, Georgia, retracted a simplified procedure in its children's health coverage program during the survey period.

- **The Medicaid Citizenship Documentation Requirement included in the DRA enacted in 2006, continues to impede states' simplification efforts by complicating enrollment, especially for children.** The requirement that U.S. citizens applying for Medicaid or renewing their coverage present original documents to prove their citizenship and identity has contributed to significant enrollment declines in states. These adverse effects have persisted even when states have employed strategies aimed at minimizing the loss of coverage, such as

conducting data matches with Vital Records agencies to obtain birth records. While many states find such systems helpful, others note that database constraints and technological challenges limit the effectiveness of the strategy.

- **Seven states reduced or eliminated premiums for children's health coverage, but another seven either imposed new premiums or increased the amount of existing premiums.** Numerous studies find that premiums for low-income individuals can depress enrollment in health coverage programs.

Changes in Health Coverage Programs for Pregnant Women and Parents

- **One-quarter of the states (13 states, including DC) enacted modest coverage expansions for pregnant women and parents.** No state retracted income eligibility for these adults. Nine states increased eligibility for pregnant women, either by expanding income eligibility or by adopting the option to cover unborn children in SCHIP. Six states took steps to expand health coverage for parents.

- **Income eligibility for parents still lags behind eligibility for children.** The stark disparity between the availability of coverage for parents and children persists, although the situation improved slightly in 2007.

- **Efforts to simplify enrollment and renewal procedures for parents edged forward, but it remains harder for an eligible parent than for an eligible child to obtain and keep coverage.** A substantial body of research demonstrates that efforts to cover low-income parents in programs like Medicaid and SCHIP increases the enrollment of eligible children. In addition, when their parents are insured, children gain better access to health care and improve their use of preventive health services. Efforts to expand parent coverage will help advance enrollment of children as well, while limits on parent coverage could pose a barrier to enrollment of more children.

Several elements are critical if states are to realize the advances achieved in 2007. SCHIP reauthorization that provides support from the federal government to undergird states' efforts to furnish health coverage for children is essential to continued progress in reducing the number of uninsured children. The concern that federal action will curtail longstanding federal financial support for children's health coverage and states' flexibility to design and operate their programs has created considerable tension at the state level. In addition, emerging state budget deficits and potential pressure to cut state spending is placing the hard-won progress on children's health coverage at further risk. These conditions present new hurdles for states and will make it even more challenging to identify steps to maintain and promote coverage, especially if the economy and state revenue situation worsens.

I. Introduction

State efforts to improve access to health coverage for low-income children and their families began in earnest with the enactment of the State Children's Health Insurance Program (SCHIP) in 1997 and continued to advance throughout the succeeding decade. Even when economic pressures led some states to restrict enrollment in Medicaid and SCHIP, most states subsequently reversed those decisions. Leading into 2007, state revenues were on the rise and a positive fiscal outlook revitalized interest in expanding coverage. At the same time, states' anticipation that strong SCHIP reauthorization legislation would be passed fed a growing enthusiasm for investing in "Cover All Kids" initiatives and rededicating resources to enrolling children who are eligible but remain uninsured.

This survey examined steps that states took between July 2006 and January 2008 regarding access to health coverage for children and families in Medicaid and SCHIP. The findings document strong forward momentum in 2007. Nearly two-thirds of the states increased access to health coverage, with 20 states expanding eligibility for children, and the number of states authorizing children's coverage up to 300 percent of the federal poverty line ($51,510 for a family of three in 2007) or higher more than doubled. These successes mark 2007 as a pivotal year, with eligibility increases for children representing the most aggressive push forward since the early years of SCHIP.

This resurgence of purpose comes at a critical time. The latest Census data found that the number of uninsured children had increased for the second year in a row, going up by more than 700,000 (from 2005 to 2006) to 9.4 million uninsured children, a new high."[1] Between 1998 and 2005, the steady reduction in the number of uninsured children was driven mainly by rising enrollment in Medicaid and SCHIP, which was enough to outpace the erosion of employer-based coverage. This trend began to reverse in 2005, when slowed enrollment in public health insurance programs was overshadowed by the loss of private coverage.[2] Since most uninsured children are eligible for Medicaid or SCHIP, concerted efforts to get more of these children enrolled in public coverage programs could help restore the trend toward reducing the number of uninsured children.

However, despite states' recent bold steps to advance children's health coverage, a string of federal developments is dampening the prospects for making real progress. One troubling issue that continues to challenge states is the Medicaid citizenship documentation requirement, a provision of the Deficit Reduction Act enacted in early 2006, which requires U.S. citizens applying for Medicaid to present original documents proving their citizenship and identity. The consequences of a rule that proponents said was designed to keep ineligible immigrants from gaining access to the program has been to delay, deny and terminate Medicaid coverage for thousands of eligible U.S. citizens.

A second source of concern is a new policy issued by the Centers for Medicare and Medicaid Services (CMS) on August 17, 2007, while Congress was in the midst of work on SCHIP reauthorization legislation. This policy effectively places a gross income cap of 250 percent of the federal poverty line ($42,925 for a family of three in 2007) on SCHIP eligibility, undercutting states' ability to go forward with planned expansions and threatening continued federal support for states that have covered children with incomes above this level for years.

Compounding these concerns are additional new roadblocks to enrolling children who are already eligible but remain uninsured. A host of federal regulations that would curtail Medicaid funding have recently been issued, including one that eliminates administrative funding for outreach and enrollment activities conducted by school personnel.[3] Such activities are thriving in school

districts across the country and are considered to be among the most effective ways of ensuring that families of eligible children get the help they need to secure and renew their child's health coverage. Congress placed a moratorium on the implementation of this regulation that lasts until the start of the 2008/09 school year, but unless it extends the moratorium or passes legislation that expressly allows Medicaid funding for school-based outreach and enrollment assistance, schools will have to find other sources of financial support or end these activities altogether. As a result, families may lose the opportunity to get enrollment assistance in a familiar place and with the help of school staff they know and trust.

Finally, there is the overriding concern that a strong SCHIP reauthorization has not yet materialized. While states anticipated that legislation would be enacted before the program expired on September 30, 2007, two bills that passed Congress with large bipartisan majorities were vetoed by President Bush. These bills would have enabled states to sustain their existing programs and would have provided significantly greater financial support and incentives for enrolling more of the eligible children who remain uninsured. Since the SCHIP reauthorization legislation was stopped, Congress enacted a temporary extension of SCHIP that will be in place until the end of March 2009. The extension included additional funds to avert shortfalls some states are projected to face under their current SCHIP programs, but did not incorporate provisions from the SCHIP legislation to ease the impact of the Medicaid citizenship documentation requirement, to address the eligibility limitations raised by the August 17th directive, or to provide financial incentives to allow states to enroll more eligible low-income children.

The concern that federal action will curtail longstanding federal financial support for children's health coverage and states' flexibility to design and operate their programs has created considerable tension at the state level. In addition, emerging state budget deficits and potential pressure to cut state spending is placing the hard-won progress on children's health coverage at further risk. These conditions present new hurdles for states and will make it even more challenging to identify steps to maintain and promote coverage, especially if the economy and state revenue situation worsens.

II. About This Survey

This report presents the findings of a survey of eligibility rules, enrollment and renewal procedures, and cost-sharing practices in Medicaid and SCHIP for children and families that were implemented or authorized between July 2006 and January 2008 in the 50 states and the District of Columbia. These policies have a large influence on how effectively Medicaid and SCHIP can deliver health coverage to the eligible children, pregnant women and parents who rely on the vital services these programs provide, and are the driving forces behind efforts to reduce the number of low-income people who lack adequate insurance but cannot afford to pay for it on their own.

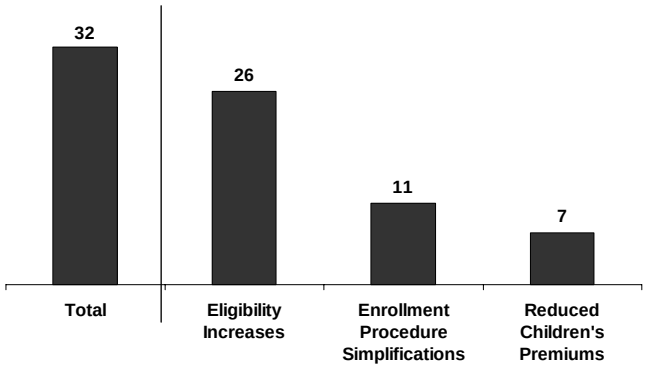
This study, the seventh annual survey conducted by the Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, was carried out in the summer and early fall of 2007 through extensive telephone interviews with state Medicaid and SCHIP program administrators. Detailed follow-up interviews proceeded through the end of the year. The findings reflect policies and procedures in effect in the states in January 2008, as well as coverage expansions that were authorized by states during the survey period but were not implemented.

III. Key Survey Findings

Nearly two-thirds of the states (32 states, including DC) took actions to increase access to health coverage for low-income children, pregnant women and parents (Figure 1). Twenty-six states authorized or adopted income eligibility expansions, 11 states reduced procedural barriers, and seven states reduced financial barriers to Medicaid and SCHIP. While the most vigorous activity was focused on children, modest improvements for pregnant women and parents also occurred.

Figure 1

Nearly Two-Thirds of States Expanded Access to Medicaid and SCHIP, July 06 – January 08



SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for KCMU, 2008.

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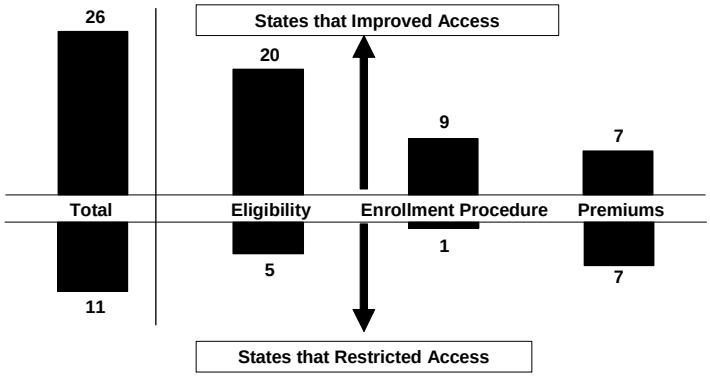
Changes in Health Coverage Programs for Children

Twenty-six states improved access to children's health coverage. Twenty states expanded eligibility, nine states simplified enrollment procedures and seven states reduced financial barriers to coverage for children (Figure 2).

Figure 2

Number of States Improving Access to Children's Health Coverage Exceeded the Number that Restricted, Jul 06 – Jan 08



SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for KCMU, 2008.

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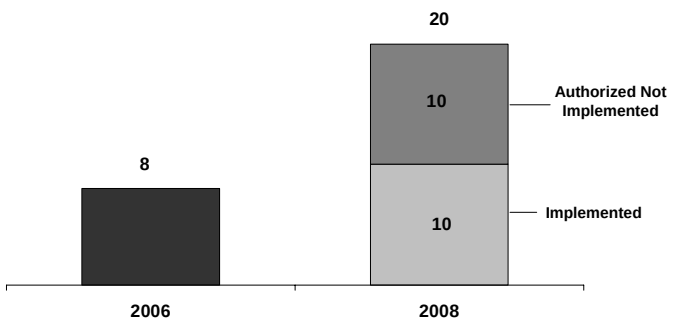
Eligibility for Children

States' efforts to expand children's health coverage represented the most aggressive steps forward since the early years of the SCHIP program. Of the 20 states that expanded eligibility for children, 12 raised or authorized raising SCHIP income limits to 300 percent of the federal poverty line or higher, more than doubling the number of states that previously had eligibility set at this level. States that expanded income eligibility to 300 percent of the poverty line include *Pennsylvania* and the *District of Columbia*, which implemented coverage during the survey period, and *Indiana, Louisiana, North Carolina, New York, Ohio, Oklahoma, Washington, West Virginia* and *Wisconsin,* which authorized coverage expansions during that time. *Illinois* currently uses state funds to cover children in families with incomes above 200 percent of the federal poverty line, but planned to request SCHIP funds for its expansion. These states join eight states (*Connecticut, Hawaii, Maryland, Massachusetts, Missouri, New Hampshire, New Jersey* and *Vermont)* that previously implemented coverage to 300 percent of the federal poverty line or higher (Figure 3).

Figure 3

Number of States with Children's Health Coverage Eligibility at 300% FPL or Higher



SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for KCMU, 2008.

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Impact of the August 17h CMS Directive

States that have authorized health coverage expansions for children and families with incomes above 250 percent of the federal poverty line, and states that have implemented such expansions in the past, will be affected by a new directive issued by CMS on August 17, 2007. The directive restricts states from using SCHIP funds to cover children in families with gross incomes above this level. To obtain approval for such expansions, states will have to demonstrate that they have enrolled 95 percent of children under 200 percent of the federal poverty line who are eligible for SCHIP or Medicaid, and that private employer-based coverage for lower income children has not declined by more than two percentage points over the past five years. States that meet these conditions will be required to impose specific cost sharing policies, and will have to require children to be uninsured for at least 12 months before enrolling (see Exhibit A).[4]

Exhibit A
The August 17th SCHIP Directive

What the August 17th Directive Requires. On August 17, 2007, CMS issued a new policy that the agency said is intended to ensure that SCHIP coverage does not substitute for coverage under group plans (a phenomenon known as "crowd out.") While in the past states were permitted to decide on "reasonable procedures" to prevent crowd-out, the directive sets forth the procedures CMS now expects states to follow.[i] Referred to as the "August 17th directive," the new CMS policy bars states from using SCHIP funds to cover children in families with gross incomes above 250 percent of the federal poverty line, or $42,925 per year for a family of three in 2007, unless they meet certain conditions. States must show that they have enrolled 95 percent of the children under 200 percent of the federal poverty line who are eligible for SCHIP or Medicaid, and that private employer-based coverage for lower income children has not declined by more than two percentage points in the prior five years. If states can meet these conditions, there are additional stipulations: States will have to require children with incomes above 250 percent of the federal poverty line to be uninsured for at least 12 months before they can enroll in SCHIP. In addition, the families' cost-sharing under SCHIP "compared to the cost-sharing required by competing private plans must not be more favorable to the public plan by more than 1 percent of the family income, unless the public plan's cost sharing is set at the 5 percent family cap." In other words, the state's cost-sharing could not be substantially below that of private plans unless the state is already charging the maximum amount allowed under SCHIP.

Implementation of the August 17th Directive Raises Several Issues. States that wish to expand their children's health coverage programs to children with incomes above 250 percent of the federal poverty line will face challenges meeting the conditions of the August 17th directive. Assuring that they have enrolled 95 percent of the eligible children under 200 percent of the federal poverty line will be difficult since reliable data sources to accurately determine participation rates are not available.[ii] Moreover, the 95 percent enrollment goal may be unrealistic, considering the take-up rates for other means-tested public benefit programs are typically much lower. For example, a GAO report found that for twelve federal programs supporting low-income people, participation rates range from about 50 percent to more than 70 percent.[iii] A recent estimate found that the participation in Medicaid and SCHIP nationally was 63 percent and 79 percent, respectively. The condition that employer-based coverage may not have dropped significantly also will present problems for states. The erosion of employer coverage has been driven by factors, such as the rising costs of health care in general and overall economic conditions, that are not in the state's control and may be unrelated to whether or not public health coverage programs are available.

Further, if a state managed to meet the conditions, the mandated 12-month waiting period would place children at risk, especially those with serious health conditions who would be left without a way to pay for needed medicine and care. Preventive and other routine services would also be out of reach for children left uninsured. In addition, the level of cost sharing required under the directive could present a substantial barrier. Numerous studies show that premiums in SCHIP can depress participation.[iv] High premiums can also increase "churning," which occurs when children are disenrolled from coverage (for missing a premium payment, for instance), but actually remain eligible and re-enroll within a short period of time.[v]

Sources:

i. Letter from Dennis Smith, Director of the Center for Medicaid and State Operations at the Centers for Medicare and Medicaid Services, to State Health Officials, August 17, 2007.

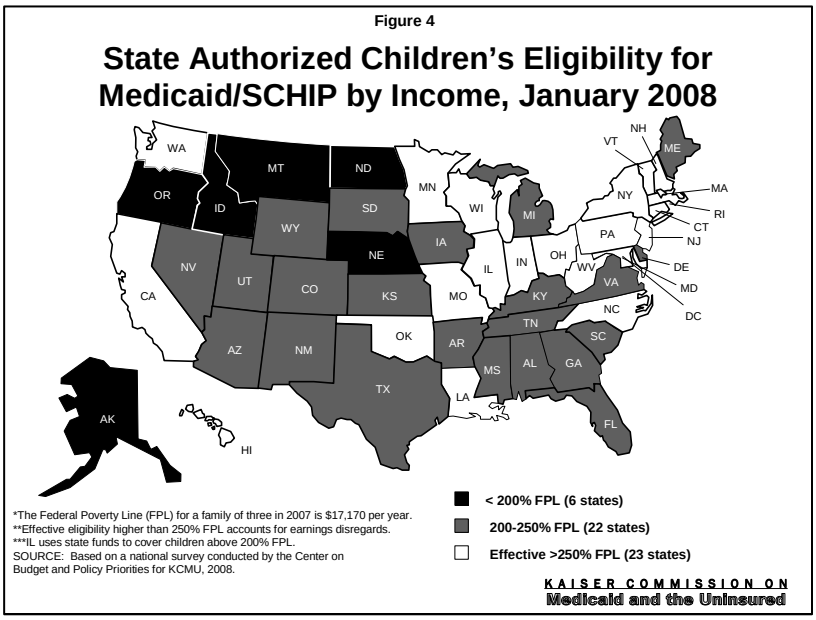
ii. Cindy Mann and Michael Odeh, "Moving Backward: Status Report on the Impact of the August 17 SCHIP Directive To Impose New Limits on States' Ability to Cover Uninsured Children," Georgetown University Health Policy Institute, Center for Children and Families, December 2007.
Genevieve Kenney, "Medicaid and SCHIP Participation Rates: Implications for New CMS Directive," The Urban Institute, September 2007.

iii. Means-tested Programs: Information on Program Access Can Be an Important Management Tool (programs studied include TANF, Head Start, Medicaid, SCHIP, Food Stamps, WIC, EITC, SSI), GAO, March 2005.

iv. Samantha Artiga and Molly O'Malley, "Increasing Premiums and Cost Sharing in Medicaid and SCHIP: Recent State Experiences," Kaiser Commission on Medicaid and the Uninsured, May 2005.

v. Laura Summer and Cindy Mann, "Instability of Public Health Insurance Coverage fro Children and Their Families: Causes, Consequences and Remedies," The Commonwealth Fund, June 16, 2006.

Nearly half the states (23 states) will be affected by the new directive over the next year. Just as states are pushing forward, the new federal directive issued by CMS is compromising their ability to expand health coverage. Having to meet the August 17th conditions impedes the ability of states to proceed with new expansions and hinders the viability of previously approved expansions. The directive currently affects a total of 23 states, including 10 states that passed eligibility expansions but had not obtained federal approval before the directive was issued, and 14 states that had enacted coverage expansions above 250 percent of the federal poverty line before the directive was issued and will have to comply with it by August 2008 (Figure 4 and Exhibit B). *Washington* is counted in both sets of states.



In response to the directive, several states have scaled back or postponed their plans to expand or have decided to absorb the full cost of covering children with income above the CMS limit. *Indiana, Louisiana* and *Oklahoma* have decided to expand to only 250 percent of the federal poverty line and *New York* and *Wisconsin* have decided to use state funds to pay the full cost of covering children above the CMS limit. *Illinois* is continuing to finance its children's coverage expansion solely with state dollars. Other states with new expansions, and states that expanded prior to the directive, have not yet determined how they will proceed. As a result of the directive, thousands of children already have lost the opportunity to obtain health coverage and many more may be adversely affected as states make decisions about going forward.[5]

States affected by the directive vary with respect to their cost sharing policies and the length of the waiting periods they impose. Many of these states would have to make significant adjustments to come into compliance with the August 17th directive. Of the 23 states affected by the August 17th directive, all except the *District of Columbia* and *Hawaii* currently impose cost sharing (or plan to do so if their expansions are allowed to go forward) for children under their expansion. However, it appears that none of these states plans to charge amounts that are as high as those that would be required by the directive. In addition, all of the affected states, except the *District of Columbia*, *Hawaii* and *Rhode Island,* require or plan to require children to be uninsured for a period of time before they can enroll in SCHIP. However, they generally would not mandate that children be without insurance for a full year, as the August 17th directive would stipulate. While *Illinois, Louisiana*

and *West Virginia* would impose year-long waiting periods, these states would allow certain exceptions – such as when the cost sharing for the private plan exceeds a certain percentage of family income – which may or may not comport with the CMS policy.

Exhibit B
Children's Coverage in States Currently Affected by the August 17, 2007 Directive

State	Current Eligibility	Proposed Expansion	Action Post Directive	Proposed or Current Premium[3]	Proposed or Current Waiting Period[3]
Authorized At State Level - Not Implemented					
Illinois	200	300	State funded above 200	Y	Y[1]
Indiana	200	300	Reduced to 250	Y	Y
Louisiana	200	300	Reduced to 250	Y	Y[1]
New York	250	400	State funded above 250	Y	Y
N. Carolina	200	300	Plan not submitted	Y	Undecided
Ohio	200	300	Plan not submitted	Y	Undecided
Oklahoma	185	300	Reduced to 250	Y	Y
Washington	250	300	Plan not submitted	Y	Y
West Virginia	220	300	Plan not submitted	Y	Y[1]
Wisconsin	185	300	State funded above 250	Y	Y
Implemented Prior to Directive					
California[2]	250			Y	Y
Connecticut	300			Y	Y
D.C.	300			-	-
Hawaii	300			-	-
Maryland	300			Y	Y
Massachusetts	300			Y	Y
Minnesota[2]	275			Y	Y
Missouri	300			Y	Y
N. Hampshire	300			Y	Y
New Jersey	350			Y	Y
Pennsylvania	300			Y	Y
Rhode Island[2]	250			Y	Y
Vermont	300			Y	Y

NOTES:
1. IL, LA and WV are the only states that have a 12-month waiting period for children with income above 250% FPL.
2. Each of these states has effective eligibility higher than 250% FPL when accounting for earnings disregards.
3. Premium amounts and length of waiting periods appear in Table 1A.

Additional Eligibility Changes for Children

Fourteen states enacted children's coverage expansions that were moderate in scope, but focused on particularly vulnerable populations such as infants or children discharged from foster care at age 18. Modest income eligibility expansions were implemented or passed by *Indiana (for infants), Montana, South Carolina* and *Tennessee.* Nine states *(Colorado, Florida, Massachusetts, Michigan, Missouri, North Carolina, Ohio, Washington* and *Wisconsin)* now allow children who are discharged from foster care at age 18 to retain their Medicaid coverage through age 21, extending benefits to a relatively small, but especially needy, group of young people. In addition, *Texas* increased its asset limit in SCHIP, making it easier for children to qualify, and the state no longer requires those already determined eligible to wait 90 days before receiving benefits (although a child still must be uninsured for 90 days before enrolling in SCHIP). *Missouri* no longer requires some children to be uninsured for a period of time before enrolling in coverage.

No state cut back income eligibility for children, but a few states took other actions to restrict eligibility. Three states froze children's enrollment and two imposed or lengthened waiting periods. In three states (*Utah, Georgia* and *Tennessee*), eligible children found the doors to coverage closed for some length of time during the survey period. *Utah* closed enrollment in its separate SCHIP program due to a shortage of state funds, but re-opened enrollment in July 2007 when newly allocated funds became available. *Georgia* faced a shortfall of federal SCHIP funding and closed enrollment in PeachCare, the state's separate SCHIP program. The state reopened enrollment in July 2007 once Congress passed legislation averting the shortfalls. *Tennessee* created a separate SCHIP program in 2007 which offers health coverage to many of the children who formerly would have depended on the state's waiver program, TennCare Standard, for coverage. TennCare Standard, continues to be closed to some children and adults.

Experience from states that have endured SCHIP freezes in the past indicates that most children who are closed out of coverage have no alternatives and remain uninsured, missing out on needed health care including prompt medical treatment, medication, preventive exams and immunizations. Families also report facing significant financial hardships requiring them to make fundamental trade-offs, between paying for food and other necessities or medical expenses. The consequences of a SCHIP freeze can be long-term. Without aggressive outreach efforts, families may believe the program remains closed and forego opportunities to apply. Additionally, they may have lost faith in the program and may be reluctant to enroll their child in a program that appears to be unstable.[6]

Since states began implementing their SCHIP programs, a number of states have reduced or eliminated waiting periods, but others have imposed or expanded them, particularly when they initiate coverage for higher income children. In 2007, children in *West Virginia*, whose family incomes are between 200 percent and 220 percent of the federal poverty line must now be uninsured for a full year, rather than six months, before they can enroll in SCHIP. Under *Pennsylvania*'s new expansion, children in families with income between 200 percent and 300 percent of the federal poverty line must be uninsured for six months before they can obtain coverage. *Tennessee*'s new separate SCHIP program imposes a waiting period of three months on all eligible children. Although waiting periods have been imposed as a way to discourage the substitution of public coverage for private coverage, a recent report on the "crowd out" phenomenon found that "requiring a waiting period lowers take-up yet does not increase the degree of private coverage."[7]

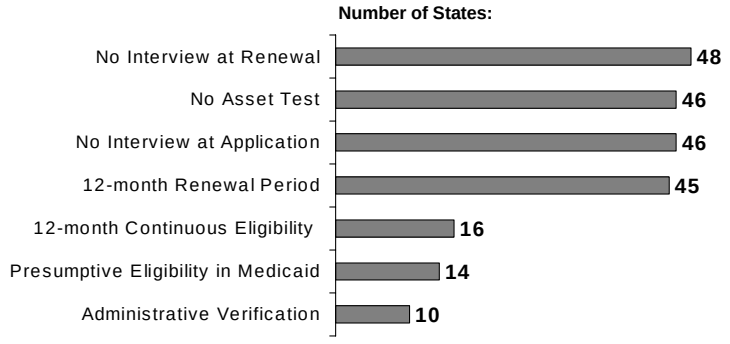
Enrollment and Renewal Procedures for Children

States have made progress on adopting simplified enrollment and renewal procedures in their children's Medicaid and SCHIP programs, with particular emphasis on strategies that reduce paperwork and jump-start enrollment. Nine (9) states took steps to simplify enrollment and renewal procedures for children. Several basic simplified strategies — disregarding assets in determining eligibility, allowing enrollment and renewal without an in-person interview, and limiting the frequency of renewal to once a year— have been adopted for children almost universally (Figure 5). While a few states added one of these widely accepted procedures *(Minnesota, Oregon, Tennessee* and *Texas*), simplification advancements mainly focused on other strategies: Both *Tennessee* and *Texas* adopted 12-month continuous eligibility for children in their separate SCHIP programs, an effective method for minimizing gaps in coverage since it guarantees children a full year of benefits. Three states *(New York, Tennessee* and *Wisconsin)* no longer require families to present documentation of their income when they are either enrolling or renewing Medicaid or SCHIP coverage for their child. When using such procedures, called administrative verification and renewal, states generally consult state data bases or available case records to verify income.

Five states *(Colorado, Kansas, Louisiana, New York,* and *Wisconsin)* adopted the presumptive eligibility option, which allows "qualified entities" such as clinics, hospitals, schools, WIC agencies, Head Start programs, and the agencies that determine eligibility for some public benefits including the Medicaid and SCHIP agencies themselves, to temporarily enroll a child who appears eligible while the family completes the process for ongoing eligibility.

Figure 5

Simplifying Enrollment and Renewal: Strategies States are Using in Children's Health Coverage Programs, Jan 08



SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for KCMU, 2008.

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Only one state retracted a simplified procedure in its children's health coverage program in 2007 affecting *eligible* individuals. Although *Georgia* was one of the first states to employ an "administrative verification and renewal" process in its separate SCHIP program, it now requires families to provide proof of income when they apply for SCHIP and when they renew their child's coverage. While numerous factors influenced *Georgia's* decision to retract administrative verification and renewal, state officials say that the integrity of the program was not compromised while this simplified procedure was in place.

When states impose restrictive procedures, enrollment responds by declining, in the same way it would if the state pared back income eligibility. However, while a cut in income limits would render some potential applicants ineligible, procedural barriers often result in individuals being denied or losing coverage even though they are eligible. In such situations, individuals who lose coverage may return to the program within a short period of time when they have been able to comply with the process. This situation, known as "churning" results in unnecessary coverage gaps for children and increased administrative costs for states.[8]

The experience in a number of states demonstrates that enrollment is sensitive to changes in procedures. In *Washington*, the children's health coverage programs suffered a precipitous drop in enrollment when the state replaced 12-month continuous eligibility with a requirement that children renew their coverage every six months. Enrollment bounced back when the state restored the original policy.[9] Enrollment in *Connecticut*'s program fluctuated when the state removed, then reinstated, several simplified procedures, including administrative verification of income.[10] *Mississippi* provides the latest illustration of how enrollment responds to restrictive procedures. In 2005, the state rescinded its mail-in application process, and began requiring families to enroll and renew their coverage in person. In 2006, at least 62,000 fewer children and adults were enrolled in Medicaid and SCHIP as compared with 2004. According to a report released in 2007 by the Mississippi Center for Justice and Mississippi Health Advocates, Medicaid offices are inaccessible, and roughly 80 percent of Medicaid outstations are open one day a week or less, with some open only one day a month, sometimes for only a few hours. This makes it extremely difficult for working families and for those without transportation. State data show that nearly 60 percent of individuals due for renewal do not appear for their face-to-face meeting and close to 90 percent of "new" approved applications are for children or adults whose coverage had lapsed.[11]

Impact of the Medicaid Citizenship Documentation Requirement

The Medicaid Citizenship Documentation Requirement, a provision of the 2005 Deficit Reduction Act, continued to impede states' simplification efforts by complicating enrollment, especially for children. The federal rule requiring that U.S. citizens applying for Medicaid or renewing their coverage present original documents to prove their citizenship and identity has contributed to significant enrollment declines in states (see Exhibit C).[12] Adverse effects have persisted even when states have tried to employ strategies aimed at minimizing the loss of coverage. For example, at least 39 states say they now conduct data matching with their Vital Records agencies to obtain birth records. While many states find such systems helpful, others note that database constraints and technological challenges limit the effectiveness of the strategy. An overriding problem reported by many states is that securing birth records for individuals born in other states is difficult or impossible, and when individuals attempt to secure out-of-state records on their own, the time and costs are daunting.

At least 12 states allow the use of affidavits in which parents attest to the identity of their children under age 16, but this does not cover everyone affected by the requirement, and identity documentation still constitutes a significant barrier. *Wisconsin* continues to report that it has birth records, but not identity documentation, for the majority of people who have been denied coverage, proving that they are in fact citizens but have not been able to comply with the requirement. The latest data from that state show that between August 1, 2006 and January 1, 2008, 32,907 people were denied or terminated from Medical Assistance or BadgerCare because of the documentation requirements, and in 62 percent of those cases it was for lack of identification alone.[13]

Under the federal requirement, states are not allowed to provide Medicaid benefits to applicants who otherwise appear eligible unless and until they produce the required documents. The only mechanism under which states can do this is the presumptive eligibility option, discussed earlier. Several of the states that adopted presumptive eligibility during the survey period stated that they did so, in part, to ease the negative consequences of the citizenship documentation requirement.

Exhibit C
Medicaid Citizenship Documentation Requirement

What is the Medicaid Citizenship Documentation Requirement? U.S. citizenship or legal immigration status has always been a requirement in Medicaid, however in the past, applicants could attest to their status. The new documentation requirement included in the DRA "is intended to ensure that Medicaid beneficiaries are citizens without imposing undue burdens on them and the states." This federal requirement stipulates that state programs require that U.S. citizens applying for Medicaid or renewing their coverage prove their citizenship and identity by presenting an original birth certificate, passport or similar documents.

Issues Raised by the Requirement. States have reported that, as a result of the requirement, thousands of *eligible U.S. citizens*, most of whom are children, have either lost Medicaid or have had their benefits delayed or denied. While the intent of the legislation was to ensure that undocumented immigrants do not enroll fraudulently, the requirement appears to mostly retard enrollment of eligible citizens. According to a recent study by the Kaiser Commission on Medicaid and the Uninsured, state officials in 37 states reported that application processing delays brought on by the requirement are the main reason Medicaid enrollment dropped in 2007 for the first time in a decade. The Kaiser report also found that 45 states have incurred increased administrative costs as a result of the requirement. A study by the House Oversight and Government Reform Committee, found that the six states that have examined the issue in greatest detail spent $17 million to administer the requirement and had denied health coverage to tens of thousands of eligible people, only to identify eight individuals who incorrectly claimed to be citizens. The bipartisan SCHIP reauthorization legislation, passed twice by Congress but vetoed twice by President Bush, would have provided states with new options to mitigate these problems.

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Donna Cohen Ross, "Medicaid Requirement Disproportionately Harms Non-Hispanics, State Data Show," Center on Budget and Policy Priorities, July 10, 2007.

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States Constrained on Two Fronts

A number of states are now facing limitations on their efforts to expand coverage and enroll currently eligible children. States such as *Ohio, Oklahoma, Wisconsin* and others are directly affected by the August 17th directive and also have reported enrollment declines or delays in determining eligibility as a result of the Medicaid citizenship documentation requirement. Such states are facing federal obstacles on two fronts: Their ability to move forward with new coverage expansions is hampered, as is their ability to enroll individuals who have been determined to be eligible under existing eligibility criteria (see Exhibit D).

Exhibit D
Oklahoma Faces a Two-Front Challenge to Covering Uninsured Children

The Oklahoma story illustrates the serious challenges it and other states are facing as federal rules make it more difficult to cover uninsured children. The CMS August 17th directive is curtailing the state's efforts to make *new* children eligible for health coverage, and at the same time, the Medicaid citizenship documentation requirement is making it difficult to keep *already enrolled* children and others from losing their Medicaid (called SoonerCare) benefits.

Effect of the August 17th Directive. *W*ith strong backing from the Governor and broad bipartisan support, Oklahoma passed legislation to expand health coverage to children in families with income up to 300 percent of the federal poverty line. After being advised that the new federal policy set forth in the August 17th directive would prevent approval of the plan, the state scaled back its vision and will now limit eligibility to 250 percent of the federal poverty line. The goal of insuring 40,000 new children has been trimmed by about 20 to 25 percent, leaving behind between 7,500 and 10,000 uninsured children.

Michael Fogarty, Chief Executive Officer of the Oklahoma Health Care Authority, explained how decision-makers in his conservative state came to support reaching out to families with more moderate incomes: "You ask why people are showing up in emergency rooms and you discover it's because health insurance is just unaffordable," he said. "Then reasonable minds started shifting … It's not about giving families a handout. [Our analysis] showed that 300 percent of the federal poverty line [is] where you need to be in Oklahoma to make private coverage affordable … and insure virtually every child. And then to pull up short — to get almost there — well, that's very discouraging."

Effect of the Medicaid Citizenship Documentation Requirement. Despite significant efforts to minimize the impact of the citizenship documentation rule, Oklahoma was compelled to end coverage on December 1, 2007 for more than 5,800 beneficiaries who had not presented proof of their U.S. citizenship. On January 1, 2008, another 7,300 beneficiaries lost coverage. Since the demographics of those who lost coverage closely mirror those of the total caseload, state officials believe those adversely affected had been correctly enrolled. An aggressive effort has helped 55 percent of the December group to prove their citizenship and re-enroll. State officials say this number is growing, underscoring that the majority of people hurt were, in fact, U.S. citizens.

The majority (62 percent) of those disenrolled in December were children. Ten percent of those who lost coverage were Hispanic; over half (58 percent) were white; and 18 percent were African American. In addition, 13 percent were Native American.

Bill Lance, Administrator for the Division of Health for the Chickasaw Nation, expressed frustration that Native Americans are losing coverage. "Probing for all this additional documentation from people who are indigenous to this country is very demeaning," he said. "These are people who are Chickasaw tribal citizens who have all types of tribal records which clearly indicate that they are established citizens but are totally disregarded by the current CMS regulations." Tribal members may be from Arkansas and Texas, or they may be moving back to be within the tribal boundary. Although vital records matches can be help in obtaining birth records for people born in Oklahoma, getting birth certificates from other states can be very difficult.

> In Southern Oklahoma, a 39 year-old Native American Woman diagnosed with cervical cancer was enrolled in the state's Breast and Cervical Cancer program. She has been in and out of the hospital in active chemotherapy and radiation treatment. She failed to produce citizenship documentation and coverage was cancelled on 12/31/07. She indicated that she does not have a driver's license or other I.D. card; An approved photo I.D. is required to apply for a copy of a birth certificate from the Oklahoma State Department of Health.

States, including Oklahoma, say the requirement diverted enormous resources that could have been spent on program priorities. Fogarty added that it took his state "180 degrees from the direction [it] was headed" in terms of simplifying the program and reducing stigma.

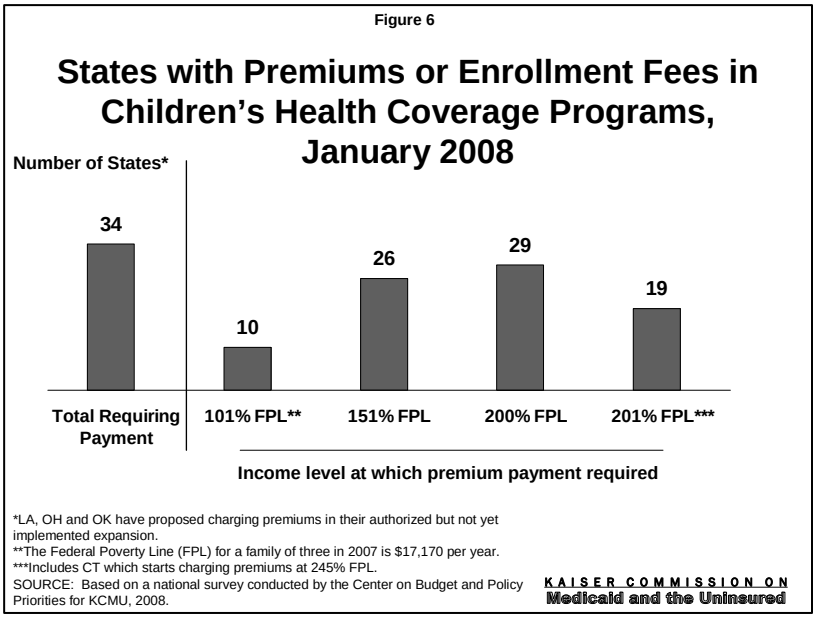
Source: Interviews with Michael Fogarty, Chief Executive Officer of the Oklahoma Health Care Authority and Bill Lance, Administrator for the Division of Health for the Chickasaw Nation, January 2008.

Cost Sharing for Children

Premiums

During the survey period, seven states reduced or eliminated premiums, but another seven imposed or increased financial barriers. Of the 34 states that charge premiums, most do so in their separate SCHIP programs (Figure 6). Ten states begin requiring premiums for children in families with income at 101 percent of the federal poverty line, meaning the lowest income children must contribute to the cost of coverage. In 2007, five states (*Hawaii, Pennsylvania, Texas, Wisconsin* and *Vermont)* reduced the amount families are required to pay for children's health coverage or eliminated premiums altogether. *Massachusetts* and *Wisconsin* raised the income level at which they begin charging premiums. *California* no longer requires families to submit a premium payment with their application.

Figure 6



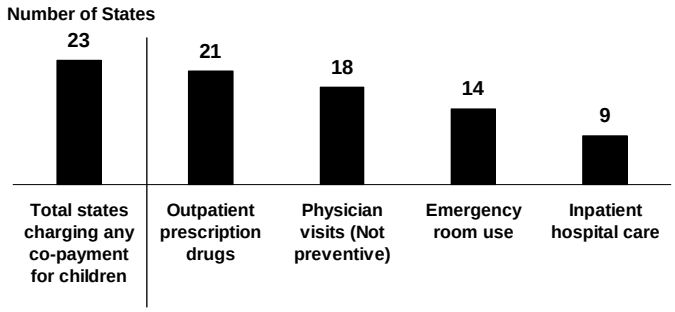
On the other hand, during the survey period, seven states either imposed new premiums or increased the amount of existing premiums *(Michigan, Minnesota, Missouri, New Jersey, Pennsylvania, Utah* and *West Virginia).* For some states *(Minnesota, Missouri* and *New Jersey)* the premium changes were small. *Michigan* doubled its SCHIP premiums from $5 to $10 per month, an amount that is still modest in comparison to many other states. *Utah* more than doubled its SCHIP premiums, however, and the resulting amounts are among the highest charged, especially for children in families at the lower income levels. *Pennsylvania* and *West Virginia* initiated premium requirements for children covered under their new SCHIP expansions, meaning children in families with income above 200 percent of the federal poverty line will be required to contribute to the cost of coverage. Numerous studies find that premiums for low-income individuals can depress enrollment in health coverage programs.[14]

Co-payments

Twenty-three states currently charge co-payments for children's health services (Figure 7). During the survey period, co-payments generally held steady and no additional states adopted co-payments in their children's health coverage programs.

Figure 7

States with Co-payments for Selected Services in Children's Health Coverage Programs, January 2008



*Based on the number of states charging co-payments for children in families with income at 200% of the FPL, with the exception of outpatient prescription drugs which is unrelated to a specific income level.
SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for KCMU, 2008.

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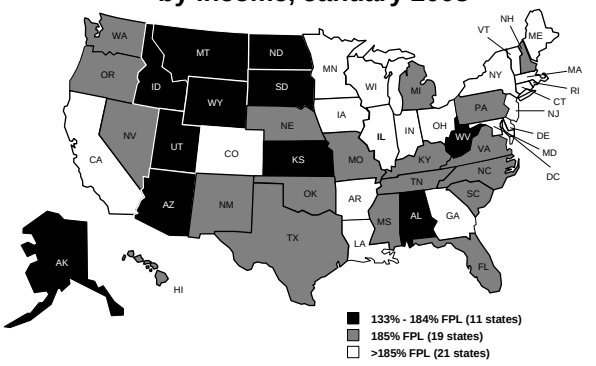
Changes in Health Coverage for Pregnant Women and Parents

One quarter of the states (13 states, including DC) enacted modest coverage expansions for pregnant women and parents. No state retracted income eligibility for these adults. Nine states *(Arizona, Connecticut, District of Columbia, Indiana, Louisiana, Montana, Tennessee, Virginia* and *Wisconsin)* increased eligibility for pregnant women either by expanding income eligibility or by adopting the option to cover unborn children in SCHIP. Six states *(Connecticut, Iowa, Maryland, New Jersey, Oklahoma* and *Wisconsin)* took steps to expand health coverage for parents (Figures 8 and 9).

Figure 8

Authorized Medicaid Eligibility for Pregnant Women by Income, January 2008



*The Federal Poverty Line (FPL) for a family of three in 2007 is $17,170 per year.
SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for KCMU, 2008.

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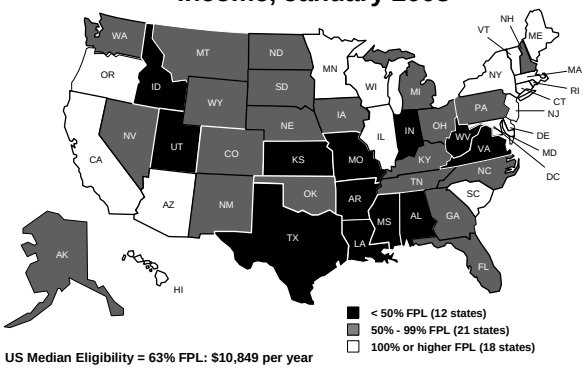
Figure 9

Authorized Medicaid Eligibility for Working Parents by Income, January 2008



US Median Eligibility = 63% FPL: $10,849 per year

*The Federal Poverty Line (FPL) for a family of three in 2007 is $17,170 per year.
SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for KCMU, 2008.

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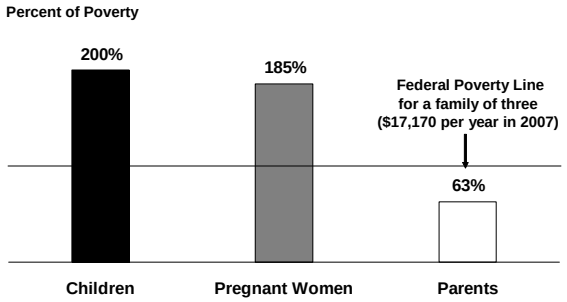
In recent years, some states have obtained federal waivers to establish programs to cover parents, but their plans feature reduced benefit packages and high cost-sharing with more limited coverage than Medicaid. Two such initiatives were implemented in 2007. The ARHealth Net program in *Arkansas* provides benefits that are much less comprehensive than those available through Medicaid and there is significant cost sharing. Although adults can be eligible with incomes up to 200 percent of the federal poverty line, participation is limited to those who work for participating employers. *Indiana's* "Healthy Indiana Plan," approved by CMS in December 2007, provides coverage to uninsured parents and adults with income up to 200 percent of the federal poverty line who are not eligible for Medicaid. (To qualify for Medicaid, *Indiana* requires a working parent's income to be less than 26 percent of the federal poverty line.) However, the benefits are significantly less than those available through *Indiana's* Medicaid program and participants must make monthly contributions to an $1,100 POWER Account, which is similar to a Health Savings Account. Even those with family income well below the poverty line are required to contribute. In addition, unlike Medicaid which does not have a waiting period, a parent must be uninsured for six months before enrolling in the Healthy Indiana Plan.[15]

Income eligibility for parents still lags behind eligibility for children's coverage (Figure 10). The stark disparity between the availability of coverage for parents and children persists, although the situation improved slightly in 2007. All but a handful of states maintain income eligibility for children's health coverage at 200 percent of the federal poverty line or higher, or have plans to come up to at least that level in 2008. In addition, most states cover pregnant women with incomes up to 185 percent of the federal poverty line or higher. By contrast, in 33 states families must have incomes below the poverty line for parents to qualify for Medicaid, and in 12 states, working parents with income at half the federal poverty line – $715 per month for a family of three – earn too much to qualify for Medicaid. And in over half of the states (29 states), a parent in a family of three, working full time at the state's minimum wage, earning on average $1,107 per month, cannot qualify (Figure 11).

Figure 10

Median Medicaid/SCHIP Income Eligibility Threshold for Children, Pregnant Women, and Working Parents, January 2008



Note: Eligibility levels for parents based on the income threshold applied to a working parent in a family of three.
SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for KCMU, 2008.

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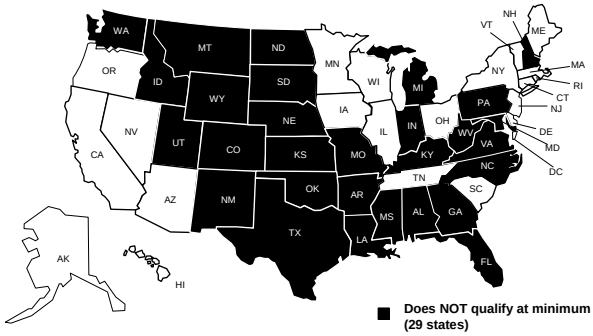
Figure 11

Medicaid Eligibility for Working Parents by State Minimum Wage, Jan 2008



*A parent in a family of three working full time at federal minimum wage ($5.85 per hour) earns $975 per month. In 32 states, the state minimum wage is higher than the federal level.
SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for KCMU, 2008.

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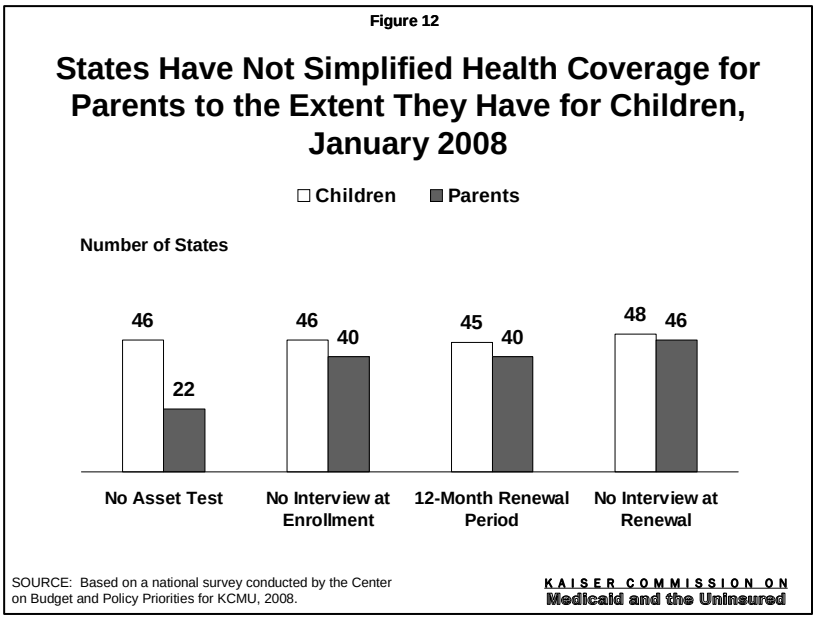
During the survey period, efforts to simplify enrollment and renewal procedures for parents edged forward, but it remains harder for an eligible parent than for an eligible child to obtain and keep coverage. *Iowa* eliminated the face-to-face interview requirement at enrollment, and both *Minnesota* and *Vermont* reduced the frequency with which parents are required to renew their coverage (Figure 12).

Figure 12



A substantial body of research demonstrates that efforts to cover low-income parents in programs like Medicaid and SCHIP increases the enrollment of eligible children. In addition, when their parents are insured, children gain better access to health care and improve their use of preventive health services.[16] Efforts to expand parent coverage will help advance enrollment of children as well, while limits on parent coverage could pose a barrier to enrollment of more children.

IV. Will States Be Able to Realize the Advances Achieved in 2007?

During the survey period, states made impressive progress in their efforts to improve access to health coverage for low-income children and families. State policymakers, encouraged by reports of the growing need to reduce the number of uninsured children and the evidence that Medicaid and SCHIP provide an effective vehicle for meeting this goal, took bold action in the past year to expand coverage, particularly for children. They also continued to simplify enrollment and renewal procedures and reduce financial barriers, recognizing the importance of removing unnecessary obstacles that block eligible individuals from securing coverage.

Several elements are critical if states are to realize the advances achieved in 2007. SCHIP reauthorization that provides support from the federal government to undergird states' efforts to furnish health coverage for children is essential to continued progress in reducing the number of uninsured children. Features of the legislation already passed by the Congress are key. They include sufficient federal funding, as well as new tools and financial incentives to enable states to expand coverage and conduct aggressive outreach and enrollment activities. It also will be essential to address recent federal policies that are obstructing state efforts to move forward on health coverage, including the August, 17, 2007 SCHIP directive, the Medicaid citizenship documentation requirement, and Medicaid regulations that would prevent states from supporting school-based outreach and enrollment activities.

Finally, but perhaps most urgently, it will be critical to take steps to protect Medicaid and SCHIP as states start to grapple with serious economic pressures. A growing number of states are beginning to report that they are facing budget shortfalls for state fiscal year 2009 (which begins for most states on July 1, 2008).[17] Seventeen states have already quantified their projected shortfalls, which total at least $31 billion. Because virtually all states must balance their budgets each year, the drop in revenues that results from an economic slowdown compels them to make spending cuts or increase taxes or both, and places the Medicaid and SCHIP programs at potential risk for cuts just at the time families are most likely to need the health coverage these programs offer. During the last economic downturn, Congress and the President provided state fiscal relief in the form of a temporary increase in the federal Medicaid matching rate (as well as general aid) to help avert or moderate state cuts in health coverage.[18] During the last recession, although state cutbacks eliminated public health coverage for more than 1 million Americans, many more would have lost coverage if federal fiscal relief had not been provided. As another recession looms, comparable action may be needed to stave off deep cuts in coverage when public coverage is most needed.

The advances made in 2007 could go a long way towards reducing the number of uninsured children, and providing coverage for more pregnant women and low-income parents. The high level of activity that produced a significant number of substantial coverage expansions and procedural improvements was extremely promising. Whether these efforts will continue will depend in large measure on actions that are in the hands of federal policymakers and Congress.

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VI. List of Tables

Table A
Where Do States Stand: Eligibility, Enrollment and Renewal Procedures and Cost-Sharing Rules
(January 2008)

Eligibility

Children

- 45 states, including DC, cover children in families with income 200% FPL or higher
- 20 states, including DC, have authorized or implemented coverage for children in families with income 300% FPL or higher
- 46 states, including DC, disregard assets in determining children's eligibility for health coverage
- 14 states, including DC, do not require children to be uninsured for a period of time before they can enroll in Medicaid or SCHIP

Pregnant Women

- 40 states, including DC, cover pregnant women with income at 185% FPL or higher
- 44 states, including DC, disregard assets in determining eligibility for a pregnant woman
- 30 states, including DC, have adopted presumptive eligibility for pregnant women
- 13 states have adopted the option to cover unborn children using SCHIP funds

Parents

- 18 states, including DC, cover working parents in families with income at 100% FPL or higher
- 22 states, including DC, disregard assets in determining Medicaid eligibility for parents

Simplified Procedures

Children

- 46 states, including DC, do not require a face-to-face interview to apply for children's coverage
- 33 of the 37 states with separate SCHIP programs use a single application for both Medicaid and SCHIP (18 of these 37 states use a joint renewal form for the two programs.)
- 10 states do not require families to provide verification of their income at enrollment (11 states do not require families to verify income at renewal).
- 14 states have adopted presumptive eligibility for children's Medicaid
- 45 states, including DC, allow children to renew coverage annually, as opposed to more often
- 16 states have adopted 12-month continuous eligibility, guaranteeing children a full year of coverage.

Parents

- 28 states, including DC, allow parents and children to apply for health coverage using a single, simplified application
- 40 states, including DC, do not require a face-to-face interview when applying for a parent; 46 states, including DC, do not require an interview for renewing a parent's coverage
- 40 states, including DC, allow parents to renew coverage annually, as opposed to more often

Premiums and Copayments

Children

- 34 states impose premiums or an enrollment fee in their children's health coverage programs; 10 charge families with income as low as 101% FPL
- In states with premiums:
  - + the cost for two children in a family with income of 101% FPL ranges from $8 to $40 per month
  - + the cost for families with income at 151% FPL ranges from $10 to $75 per month.
  - + the cost for families with income at 200% FPL ranges from $10 to $250 per month.
  - + the cost for families with income at 250% FPL ranges from $20 to $235 per month.
  - + the cost for families with income at 300% FPL ranges from $20 to $181 per month.
  - + the cost for families with income at 350% FPL ranges from $60 to $152 per month.
  - + premiums charged in states with Medicaid waivers, i.e. Rhode Island and Wisconsin, may be considerably higher than most other states because premiums may include coverage for a parent.
- 12 states impose "lock-out" periods on children in families that do not pay the required premium, preventing such children from re-entering the program after being disenrolled
- 18 states require co-payments for non-preventive physician visits, emergency room care, and/or in-patient hospital care for children (at income levels specified in the survey)
- 21 states require a co-payment for prescription drugs for children

Table B
Expanding Eligibility and Simplifying Enrollment:
Trends in Children's Health Coverage Programs
(July 1997 to January 2008)

State Strategies	July 1997[1]	Nov. 1998[2]	July 2000[2]	Jan. 2002[2]	April 2003[2]	July 2004[2]	July 2005[2]	July 2006[2]	Jan 2008[1]
Total number of children's health coverage programs	**51 MCD**	**51 MCD 19 SCHIP**	**51 MCD 32 SCHIP**	**51 MCD 35 SCHIP**	**51 MCD 35 SCHIP**	**51 MCD 36 SCHIP**	**51 MCD 36 SCHIP**	**51 MCD 36 SCHIP**	**51 MCD 37 SCHIP[10]**
Covered children under age 19 in families with income at or above 200 percent of FPL	6[3]	22	36	40	39	39	41	41	45
Joint application for Medicaid and SCHIP	N/A	not collected	28	33	34	34	34	33	33
Eliminated asset test	36	40 (M) 17 (S)	42 (M) 31 (S)	45 (M) 34 (S)	45 (M) 34 (S)	46 (M) 33 (S)	47 (M) 33 (S)	47 (M) 34 (S)	47 (M) 35 (S)
Eliminated face-to-face interview at enrollment	22[4]	33[5] (M) not collected (S)	40 (M) 31 (S)	47 (M) 34 (S)	46 (M) 33 (S)	45 (M) 33 (S)	45 (M) 33 (S)	46 (M) 33 (S)	46 (M) 34 (S)
Adopted presumptive eligibility for children	option not available	6 (M)	8 (M) 4 (S)	9 (M) 5 (S)	7 (M) 4 (S)	8 (M) 6 (S)	9 (M) 6 (S)	9 (M) 6 (S)	14 (M) 9 (S)
Family not required to verify income at enrollment	not collected	not collected	10 (M) 7 (S)	13 (M) 11 (S)	12 (M) 11 (S)	10 (M) 10 (S)	9 (M) 9 (S)	9 (M) 9 (S)	10(M) 8 (S)

State Strategies	July 1997[1]	Nov. 1998[2]	July 2000[2]	Jan. 2002[2]	April 2003[2]	July 2004[2]	July 2005[2]	July 2006[2]	Jan 2008[1]
Family not required to verify income at renewal	not collected	not collected	not collected	not collected	not collected	not collected	not collected	9 (M) 10 (S)	11(M) 9 (S)
Eliminated face-to-face interview at renewal	not collected	not collected	43 (M) 32 (S)	48 (M) 34 (S)	49 (M) 35 (S)	48 (M) 35 (S)	48 (M) 35 (S)	48 (M) 35 (S)	48 (M) 36 (S)
Adopted 12-month continuous eligibility for children	option not available	10 (M) not collected (S)	14 (M) 22 (S)	18 (M) 23 (S)	15 (M) 21 (S)	15 (M) 21 (S)	17 (M) 24 (S)	16 (M) 25 (S)	16 (M) 27 (S)
Implemented enrollment freeze	not collected	not collected	not collected	3 (S)	1 (M)[6] 2 (S)	1 (M)[7] 7 (S)	1 (M) 3 (S)[8]	1 (M) 1 (S)[9]	1 (M) 2 (S)[9]

SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for KCMU, 2008.

Notes for Table B

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. (M) indicates Medicaid; (S) indicates SCHIP.

1. These data reflect states' eligibility expansions and use of simplification strategies for children's Medicaid (poverty level groups).
2. These data reflect states' eligibility expansions and use of simplification strategies for children's Medicaid (poverty level groups) and SCHIP-funded separate programs, as indicated.
3. In addition, two (2) states, **Massachusetts** and **New York**, financed children's health coverage to this income level using state funds only.
4. Seven (7) states still required telephone interviews; face-to-face interviews were left to county discretion in one state.
5. Thirty-three (33) states had eliminated the face-to-face interview for children applying for Medicaid. Six (6) states eliminated the face-to-face interview only for families using the joint Medicaid/SCHIP application to apply for coverage. No data was collected specifically about separate SCHIP programs.
6. In **Tennessee**, enrollment was closed to some but not all children eligible under the state's Medicaid waiver program.
7. In **Tennessee**, enrollment was closed to some but not all children eligible under the state's Medicaid waiver program. In **Massachusetts**, there was a waiting list for state-financed coverage.
8. The three (3) states that froze enrollment in SCHIP at some time between July 2004 and July 2005 had all reopened enrollment by July 2005.
9. **Utah** froze enrollment in SCHIP as of September 2006. The state reopened enrollment in SCHIP in July 2007. **Georgia** stopped enrolling eligible children in its SCHIP program in March 2007. The state reopened enrollment in July 2007.
10. **Tennessee** and **Missouri** created separate SCHIP-funded programs. **Maryland** eliminated its separate SCHIP-funded program.

Table C
Expanding Eligibility and Simplifying Enrollment:
Trends in Health Coverage for Parents
(January 2002 to January 2008)

State Strategies	January 2002	April 2003	July 2004	July 2005	July 2006	January 2008
Total number of health coverage programs for parents	**51**	**51**	**51**	**51**	**51**	**51**
Covered working parents with income at or above 100 percent of FPL	20	16	17	17	16	18
Family application	23	25	27	27	27	28
Eliminated asset test	19	21	22	22	21	22
Eliminated face-to-face interview at enrollment	35	36	36	36	39	40
12-month eligibility period	38	38	36	36	39	40
Eliminated face-to-face interview at renewal	35	42	42	43	45	46
Implemented enrollment freeze	not collected	1 (Medicaid)[1] 2 (state-funded program)	3 (Medicaid)[2] 2 (state-funded program)[3]	2 (Medicaid)[4] 2 (state-funded program)[5]	2 (Medicaid)[4] 2 (state-funded program)[5]	2 (Medicaid)[4] 2 (state-funded program)[5]

SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for KCMU, 2008.

The numbers in the 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.

1. In **Tennessee**, enrollment was closed to some but not all parents eligible under the state's Medicaid waiver program.
2. In **Tennessee**, enrollment was closed to some but not all parents eligible under the state's Medicaid waiver program. Enrollment was closed in the Medicaid waiver programs in **Oregon** and **Utah** as well.
3. In **Washington**, enrollment was closed under the state-funded program during the survey period, but was open as of July 2004. Enrollment was also closed in **Pennsylvania's** state-funded program.
4. Enrollment is closed in **Oregon's** Medicaid waiver program. In **Utah**, parents may only enroll in the state's waiver program during open enrollment periods.
5. In **Pennsylvania**, parents may only enroll in the state-funded program during open enrollment periods. **Washington** relies on a system of "managed enrollment" though which parents who are determined eligible for the program may be required to wait for space to open in the program before being enrolled.

Table 1
State Income Eligibility Guidelines for Children's Regular Medicaid, Children's SCHIP-funded Medicaid Expansions and Separate SCHIP Programs[1]
(Percent of the Federal Poverty Line)
January 2008

			Medicaid Infants (0-1)[2]	Medicaid Children (1-5)[2]	Medicaid Children (6-19)[2]	Separate State Program (0-19)[3]	Enrollment Freeze During 2007[4]	Foster Children 18+[5]
	Alabama		133	133	100	200		
	Alaska		175	175	175			
	Arizona		140	133	100	200		Y
	Arkansas		200	200	200			
	California[6]		200	133	100	250		Y
	Colorado	+	133	133	100	200		Y
	Connecticut		185	185	185	300		Y
	Delaware		200	133	100	200		
	District of Columbia	+	300	300	300			
	Florida[5/7]	+	200	133	100	200		Y
	Georgia[4/8]	–	200	133	100	235	Y	
	Hawaii		300	300	300			
	Idaho		133	133	133	185		
*	Illinois[8/9]		200	133	133	200 (No limit)		
*	Indiana	+	200	150	150	200		Y
	Iowa		200	133	133	200		Y
	Kansas		150	133	100	200		Y
	Kentucky		185	150	150	200		
*	Louisiana		200	200	200			
	Maine		200	150	150	200		
	Maryland[10]		300	300	300			
	Massachusetts[9]	+	200	150	150	300 (400+)		Y
	Michigan[5]	+	185	150	150	200		Y
	Minnesota[11]		280	275	275			
	Mississippi		185	133	100	200		Y
	Missouri[12]	+	185	150	150	300		Y
	Montana	+	133	133	100	175		
	Nebraska		185	185	185			
	Nevada		133	133	100	200		Y
	New Hampshire		300	185	185	300		
	New Jersey[8]		200	133	133	350		Y
	New Mexico		235	235	235			Y
*	New York		200	133	100	250		
*	North Carolina[5]	+	200	200	100	200		Y
	North Dakota		133	133	100	140		
*	Ohio[5]	+	200	200	200			Y
*	Oklahoma		185	185	185			Y
	Oregon		133	133	100	185		
	Pennsylvania	+	185	133	100	300		
	Rhode Island		250	250	250			
	South Carolina[13]	+	185	150	150			Y
	South Dakota		140	140	140	200		Y
	Tennessee[4/14]	+	185	133	100	250	Y – waiver coverage	
	Texas		185	133	100	200		Y
	Utah[4]	–	133	133	100	200	Y	Y
	Vermont[15]		300	300	300	300		
	Virginia		133	133	133	200		
*	Washington	+	200	200	200	250		Y
*	West Virginia		150	133	100	220		Y
*	Wisconsin[5]	+	185	185	185			Y
	Wyoming		133	133	100	200		Y

SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, 2008. See notes on following page.

Notes for Table 1

+ Indicates that a state has expanded eligibility in at least one of its children's health insurance programs between July 2006 and July 2007, unless noted otherwise.
– Indicates that a state has reduced eligibility in at least one of its children's health insurance programs between July 2006 and July 2007, unless noted otherwise.

* An asterisk (*) indicates that the state has passed legislation to use SCHIP funds to expand its children's health coverage program to 300 percent of the federal poverty line. Due to a federal directive issued August 17, 2007 several of these states have scaled back their expansion, postponed the implementation of the expansion or have changed the way in which the state will fund the expansion. Information about these expansions can be found in Table IA.

Table presents rules in effect as of July 2007, unless noted otherwise.

1. The income eligibility levels noted may refer to gross or net income depending on the state. "Regular" Medicaid refers to coverage under Medicaid eligibility standards for children in place prior to SCHIP; states receive "regular" Medicaid matching payments as opposed to enhanced SCHIP matching payments for these children.

2. 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. To be eligible in the 6-19 category, the child is age six or older, but has not yet reached his or her 19th birthday.

3. The states noted use federal SCHIP funds to operate separate child health insurance programs for children not eligible for Medicaid. Such programs may provide benefits similar to Medicaid or they may provide a 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 through the 19th birthday.

4. This column indicates whether the state was not enrolling eligible children in SCHIP at any time between July 2006 and July 2007. **Georgia** stopped enrolling eligible children in its SCHIP program in March 2007. The state reopened enrollment in July 2007. In **Tennessee**, enrollment under the state's waiver program, called TennCare Standard, is closed to new applicants. The only children currently receiving TennCare Standard are children losing Medicaid who have no access to insurance and have income below 200 percent of federal poverty line, or who are medically eligible (have a health problem that prevents them from getting health insurance). In 2007 the state created a separate SCHIP program for children in families with income up to 250 percent of the federal poverty line. Eligible children may have access to health insurance but must be uninsured. **Utah** stopped enrolling children in its SCHIP program in September 2006 and re-opened enrollment in July 2007.

5. This column indicates whether the state has adopted the Medicaid option to cover children aging out of foster care, referred to as the Chafee option. In **Florida**, the state amended its state law to extend Medicaid coverage to children aging out of foster care until their 21st birthday. Previously, the state only covered children aging out of foster care until their 20th birthday. **Michigan** and **North Carolina** adopted this option in October 2007. **Ohio** and **Wisconsin** adopted this option in January 2008.

6. In **California**, infants born to women on the Access for Infants and Mothers (AIM) program are automatically enrolled in SCHIP unless the child is enrolled in employer-sponsored insurance or no-cost full scope Medi-Cal. The income guideline for these infants, through their second birthday, is 300 percent of the federal poverty line.

7. **Florida** operates two SCHIP-funded separate programs. Healthy Kids covers children ages five through 19, as well as younger siblings in some locations. Medi-Kids covers children ages one through four.

8. **Georgia, Illinois,** and **New Jersey** cover infants in families with income at or below 200 percent of the federal poverty line who are born to mothers enrolled in Medicaid. **Georgia** and **New Jersey** cover infants not born to Medicaid enrolled mothers in families with income at or below 185 percent of the federal poverty line. **Illinois** covers infants not born to Medicaid-enrolled mothers in families with income at or below 133 percent of the federal poverty line.

9. **Illinois** and **Massachusetts** provide state-financed coverage to children with incomes above SCHIP levels. Eligibility is shown in parenthesis

10. **Maryland** eliminated it separate SCHIP program in 2007. All children are now covered under Medicaid.

11. In **Minnesota**, the infant category under "regular" Medicaid includes children up to age 2. Under "regular" Medicaid, income eligibility for infants is up to 275 percent of the federal poverty line, and under SCHIP, eligibility for infants is between 275 percent and 280 percent of the federal poverty line. Under "regular" Medicaid, income eligibility for children ages 2-19 is up to 150 percent of the federal poverty line, and under the Section 1115 waiver, income eligibility for children in this age group is between 150 and 275 percent of the federal poverty line. The Section 1115 waiver provides coverage for children up to age 21.

12. **Missouri** created a separate SCHIP program in 2007.

13. **South Carolina** plans to create a separate SCHIP program for children with income between 150 and 200 percent of the federal poverty line in early 2008.

14. For **Tennessee**, the Medicaid figures shown represent the income eligibility guidelines under "regular" Medicaid. Enrollment under the state's waiver program is closed to new applicants; some children losing Medicaid can enroll (see footnote 4). In 2007 the state created a separate SCHIP program for children in families with income up to 250 percent of the federal poverty line. Children not eligible for regular Medicaid and children closed out of TennCare Standard who meet the SCHIP income guidelines can enroll in the separate SCHIP program.

15. In **Vermont**, Medicaid covers uninsured children in families with income at or below 225 percent of the federal poverty line; uninsured children in families with income between 226 and 300 percent of the federal poverty line are covered under a separate SCHIP program. Underinsured children are covered under Medicaid up to 300 percent of the federal poverty line. This expansion of coverage for underinsured children was achieved through an amendment to the state's Medicaid Section 1115 waiver.

Table 1A
Children's Medicaid and SCHIP: States with Income Eligibility 250 Percent of the Federal Poverty Line and Higher
Income Eligibility Levels, Waiting Periods, and Premium Payments for Two Children in a Family of Three[1]
January 2008

	Income Eligibility (Percent of Federal Poverty Line)				Premiums Current or Proposed for Expansion Population				
	Current Income Eligibility	Eligibility Authorized by State	Current Waiting Period	Waiting Period for the Expansion Population[2]	Frequency of payment	Income Level at which State begins Requiring Premiums (FPL)	Amount at 250% of the Federal Poverty Line ($42,925)	Amount at 300% of the Federal Poverty Line ($51,510)	Amount at 350% of the Federal Poverty Line ($60,095)
California[3]	250		3	3	Monthly	101	$24/$30	N/A	N/A
Connecticut	300		2	2	Monthly	235	$50	$50	N/A
District of Columbia[1]	300		None	None	None	—	—	—	N/A
Hawaii[1/4]	300		None	None	None	—	—	—	N/A
Illinois[5]	200 (No limit)		None	12	Monthly	151	$80	$80	$140
Indiana[6]	200	300/250	3	3 (proposed)	Monthly	150	TBA	TBA	N/A
Louisiana[1/7]	200	300/250	None	12 (proposed)	Monthly	201	$50	$50	N/A
Maryland[1]	300		6	6	Monthly	201	$45	$57	N/A
Massachusetts[8]	300 (400+)		6 (200-300% FPL)	6 (200-300% FPL)	Monthly	150	$40	$56	$152
Minnesota[1/9]	275		4	4	Monthly	All waiver families	$235	N/A	N/A
Missouri	300		6 (150-300% FPL)	6 (150-300% FPL)	Monthly	150	$161	$161	N/A
New Hampshire	300		6	6	Monthly	186	$50	$90	N/A
New Jersey	350		3	3	Monthly	150	$37.50	$74.50	$125
New York[10]	250	400/250, state-funded to 400	None	6 (proposed)	Monthly	160	$30	$40	$60
North Carolina[2/6]	200	300/plan not yet submitted	None	Undecided	Annually	151	TBA	TBA	N/A
Ohio[1/2/11]	200	300/plan not yet submitted	None	Undecided	Monthly	201	$80	$80	N/A
Oklahoma[1/7]	185	300/250	None	6 (proposed)	Monthly	186	$31.32	$31.32	N/A
Pennsylvania[12]	300		6 (200-300% FPL)	6 (200-300% FPL)	Monthly	201	$77.24	$124.84	N/A
Rhode Island[1/13]	250		None	None	Monthly	150	$92	N/A	N/A
Vermont[14]	300		1	1	Monthly	186	$20/$40	$20/$40	N/A
Washington[15]	250	300/plan not yet submitted	4	4	Monthly	201	$30	TBA	N/A
West Virginia[6]	220	300/plan not yet submitted	6 (below 200% FPL) 12 (>200% FPL)	12 (proposed)	Monthly	200	TBA	TBA	N/A
Wisconsin[1/16]	185	300/250, state-funded to 300	3	3 (proposed)	Monthly	200	$62	$181.48	N/A

SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, 2008.

Notes for Table IA

Table presents rules in effect as of July 2007, unless noted otherwise.

1. States noted in this table have passed legislation to expand their children's coverage programs using SCHIP funds to 300 percent of the federal poverty line and higher. Due to the August 17th CMS directive several of these states have scaled back their expansions, postponed the implementation of the expansion or have changed the way in which the state will fund the expansion. For states in *italics* in this table, the income eligibility limit, waiting period, and premiums noted apply to SCHIP-funded Medicaid expansions, unless noted otherwise. To Be Announced (TBA) indicates that premiums are planned for the state's expansion, however the amount has not yet been determined. A dash (—) indicates that no premiums are required in the program; "N/A" indicates that subsidized coverage will not be available at this income level.

2. This column indicates the length of time a child will be required to be uninsured prior to enrolling in health coverage under the state's expansion, sometimes referred to as the waiting period. For **North Carolina** and **Ohio,** this information is currently undecided.

3. In **California**, premiums vary based on whether the family uses the discounted community provider health plan. The first amount noted is the premium required under the community provider health plan.

4. **Hawaii** eliminated the premium requirement for children with income between 250 and 300 percent of the federal poverty line in January 2008.

5. **Illinois** implemented its expansion above 200 percent of the federal poverty line with state funds, however prior to the August 17th directive the state planned to use SCHIP funds to cover those children. It is unclear how **Illinois** will proceed. The waiting period applies only to children covered under the state-funded expansion.

6. **Indiana**, **North Carolina**, and **West Virginia** have passed legislation to expand their SCHIP programs to 300 percent of the federal poverty line, however these states have not moved forward with their expansions. Premiums are planned for the states' expansions, however the amount has not yet been determined.

7. In response to the August 17th directive, **Louisiana** and **Oklahoma** scaled back their expansions and will implement expansions to 250 percent of the federal poverty line in 2008. **Louisiana** plans to create a separate SCHIP program for children covered under the expansion. In **Oklahoma**, families without employer-sponsored insurance that are enrolled in the state's "Individual Plan", will pay 20% of the full cost of the premium, based on income, family size, and family composition.

8. **Massachusetts** provides state-financed coverage to children with incomes above SCHIP levels. Eligibility is shown in parentheses. **Massachusetts** requires premiums in children's Medicaid (children under six are exempt) and SCHIP.

9. In **Minnesota**, the infant category under "regular" Medicaid includes children up to age 2. Under "regular" Medicaid, income eligibility for infants is up to 275 percent of the federal poverty line, and under SCHIP, eligibility for infants is between 275 percent and 280 percent of the federal poverty line. Under "regular" Medicaid, income eligibility for children ages 2-19 is up to 150 percent of the federal poverty line, and under the Section 1115 waiver, income eligibility for children in this age group is between 150 and 275 percent of the federal poverty line. The Section 1115 waiver provides coverage for children up to age 21. In **Minnesota**, the waiting period and premiums apply only to children covered under the Medicaid Section 1115 waiver program. The premiums noted are for two persons, which could include a parent, and are approximate.

10. **New York** passed legislation to increase SCHIP coverage to 400 percent of the federal poverty line. This plan has been rejected by CMS. Pending approval from their state legislature, **New York** plans to use SCHIP funds for children in families with income up to 250 percent of the federal poverty line and use state funds for children with family incomes between 250 percent and 400 percent of the federal poverty line. The premiums noted for families with incomes 251 percent of the federal poverty line and above are proposed amounts.

11. **Ohio** passed legislation to increase children's coverage to 300 percent of the federal poverty line. This plan has been rejected by CMS. It is unclear how **Ohio** will proceed.

12. In **Pennsylvania**, children under 2 years old are exempt from the 6-month waiting period. In **Pennsylvania**, the premium varies by health plan. The amount noted is an average of the monthly premiums required by the various health plans.

13. The figures noted for **Rhode Island** may include coverage for parents.

14. In **Vermont**, Medicaid covers uninsured children in families with income at or below 225 percent of the federal poverty line; uninsured children in families with income between 226 and 300 percent of the federal poverty line are covered under a separate SCHIP program. Underinsured children are covered under Medicaid up to 300 percent of the federal poverty line. This expansion of coverage for underinsured children was achieved through an amendment to the state's Medicaid Section 1115 waiver. In **Vermont**, the waiting period is 30 days. **Vermont** requires premiums in children's Medicaid and its separate SCHIP program. For children in families with income between 225 and 300 percent of the federal poverty line there are different premium amounts depending on whether the family has other insurance or does not have other insurance. The first amount noted is for families with other insurance and the second is for families without other insurance.

15. **Washington** passed legislation to increase SCHIP to 300 percent of the federal poverty line in January 2009. Premiums are planned for this expansion, however the amounts have not yet been determined.

16. **Wisconsin** passed legislation to increase children's health coverage to 300 percent of the federal poverty line. In response to the August 17th directive, Wisconsin will use SCHIP funds for children in families with income up to 250 percent of the federal poverty line and use state funds for children with family incomes between 250 percent and 300 percent of the federal poverty line. The waiting period planned under the expansion only applies to children in families with income above 150 percent of the federal poverty line.

Table 2
Length of Time a Child is Required to Be Uninsured Prior to Enrolling in Children's Health Coverage[+]
January 2008

		At Implementation	January 08
	Total Number of States Without a Waiting Period	11	14
	Alabama[1]	3	3
	Alaska[2]	12	12
	Arizona	6	3
	Arkansas[3]	12	6
	California	3	3
	Colorado	3	3
	Connecticut	6	2
	Delaware	6	6
	District of Columbia	*None*	*None*
	Florida	*None*	*6*
	Georgia	3	6
	Hawaii	*None*	*None*
	Idaho	6	6
*	**Illinois**[4]	3	None (12)
*	**Indiana**	3	3
	Iowa	6	*None*
	Kansas	6	*None*
	Kentucky	6	6
*	**Louisiana**	3	None
	Maine	3	3
	Maryland	6	6
	Massachusetts	*None*	6 (200-300% FPL)
	Michigan	6	6
	Minnesota[3]	4	4
	Mississippi	6	*None*
	Missouri +	6	6 (150-300% FPL)
	Montana	3	1
	Nebraska	*None*	*None*
	Nevada	6	6
	New Hampshire	6	6
	New Jersey	12	3
	New Mexico	12	6
*	**New York**	None	None
*	**North Carolina**	6	None
	North Dakota	6	6
*	**Ohio**	None	None
*	**Oklahoma**	None	None
	Oregon	6	6
	Pennsylvania[5] –	None	6 (200-300% FPL)
	Rhode Island	4	*None*
	South Carolina	*None*	*None*
	South Dakota	3	3
	Tennessee –	None	3
	Texas[1] +	3	3
	Utah[1]	3	3
	Vermont[6]	1	1
	Virginia	12	4
*	**Washington**	4	4
*	**West Virginia** –	6	6 (<200% FPL) 12 (200-220% FPL)
*	**Wisconsin**[3]	3	3
	Wyoming	1	1

SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, 2008. See notes on following page.

Notes for Table 2

+ Indicates that a state has shortened this period between July 2006 and July 2007, unless noted otherwise.
– Indicates that a state has lengthened this period between July 2006 and July 2007, unless noted otherwise.

┼ The length of time a child is required to be uninsured prior to enrolling in health coverage is sometimes referred to as the waiting period**.** Exceptions to the waiting periods vary by state. **For states represented in the table in bold,** the waiting period applies to the separate SCHIP program only, unless noted otherwise**.** States are not permitted to have a waiting period in SCHIP-funded Medicaid expansions without a waiver. **For states represented in the table not in bold**, the waiting period applies to SCHIP-funded Medicaid expansions.

***** Several states have passed legislation to use SCHIP funds to expand their children's health coverage programs to children in families with income up to 300 percent of the federal poverty line or higher. These states are noted with an asterisk (*). Information about the waiting periods associated with these expansions can be found in Table IA.

Table presents rules in effect as of July 2007, unless noted otherwise.

1. In **Alabama**, **Texas** and **Utah** the waiting period is 90 days.

2. In **Alaska**, the waiting period applies only to children covered under the SCHIP-funded Medicaid expansion.

3. In **Arkansas** and **Minnesota**, the waiting period applies only to children covered under Medicaid Section 1115 waiver programs. In **Wisconsin**, the waiting period applies only to children covered under the Section 1115 waiver and the SCHIP-funded Medicaid expansion.

4. In **Illinois**, the waiting period applies only to children covered under the state-funded expansion.

5. In **Pennsylvania**, children under 2 years old are exempt from the 6-month waiting period.

6. In **Vermont**, the waiting period is 30 days.

Table 3
Income Threshold for Parents Applying for Medicaid[1]
(Based on a Family of Three as of January 2008)

State	Income threshold for non-working parents			Income threshold for working parents			Enrollment Freeze Implemented[3]
	Monthly Dollar Amount	Annual Dollar Amount	As a percent of poverty line	Monthly Dollar Amount	Annual Dollar Amount	As a percent of poverty line	
US Median	$583	$6,996	41%	$904	$10,849	63%	
AL	$164	$1,968	11%	$366	$4,391	26%	
AK	$1,354	$16,248	76%	$1,444	$17,328	81%	
AZ	$2,862	$34,340	200%	$2,862	$34,340	200%	
AR[2,4]	$204/$2,862	$2448/$34,340	14%/200%	$255/$2,862	$3,060/$34,340	18%/200%	
CA	$1,431	$17,170	100%	$1,521	$18,250	106%	
CO	$859	$10,302	60%	$949	$11,382	66%	
CT	$2,647	$31,764	185%	$2,737	$32,844	191%	
DE	$1,431	$17,170	100%	$1,521	$18,250	106%	
DC	$2,862	$34,340	200%	$2,962	$35,540	207%	
FL	$303	$3,636	21%	$806	$9,672	56%	
GA	$424	$5,088	30%	$756	$9,068	53%	
HI[5]	$1,646	$19,750	100%	$1,646	$19,750	100%	
ID	$317	$3,804	22%	$595	$7,143	42%	
IL	$2,647	$31,765	185%	$2,737	$32,845	191%	
IN[2,6]	$288/$2,862	$3,456/$34,340	20%/200%	$378/$2,862	$4,536/$34,340	26%/200%	
IA[2]	$426/$2,862	$5,112/$34,340	30%/200%	$1,268/$3,557	$15,214/$42,925	89%/250%	
KS	$403	$4,836	28%	$493	$5,916	34%	
KY	$526	$6,312	37%	$909	$10,903	64%	
LA	$190	$2,280	13%	$280	$3,360	20%	
ME	$2,862	$34,340	200%	$2,952	$35,420	206%	
MD[7]	$434	$5,208	30%	$524	$6,288	37%	
MA	$1,903	$22,836	133%	$1,903	$22,836	133%	
MI	$537	$6,439	38%	$871	$10,448	61%	
MN	$3,936	$47,232	275%	$3,936	$47,232	275%	
MS	$368	$4,416	26%	$458	$5,496	32%	
MO	$292	$3,504	20%	$556	$6,670	39%	
MT	$491	$5,892	34%	$855	$10,256	60%	
NE	$681	$8,172	48%	$851	$10,215	59%	
NV	$383	$4,596	27%	$1,341	$16,095	94%	
NH	$625	$7,500	44%	$781	$9,375	55%	
NJ	$1,904	$22,837	133%	$1,904	$22,837	133%	
NM[2]	$389/$2,862	$4,668/$34,340	27%/200%	$903/$5,848	$10,836/$70,180	63%/409%	
NY	$2,146	$25,755	150%	$2,146	$25,755	150%	
NC	$544	$6,528	38%	$750	$9,004	52%	
ND	$523	$6,276	37%	$904	$10,849	63%	
OH[8]	$1,288	$15,453	90%	$1,288	$15,453	90%	
OK[2/9]	$471/$2,862	$5,652/$34,340	33%/200%	$711/$2,862	$8,532/$34,340	50%/200%	
OR[3]	$1,431	$17,170	100%	$1,431	$17,170	100%	Y
PA[2/3]	$421/$2,862	$5,052/$34,340	29%/200%	$842/$2,862	$10,104/$34,340	59%/200%	Y (state-funded)
RI	$2,647	$31,765	185%	$2,737	$32,845	191%	
SC	$715	$8,580	50%	$1,430	$17,160	100%	
SD	$796	$9,552	56%	$796	$9,552	56%	
TN[3]	$993	$11,916	69%	$1,143	$13,716	80%	Y
TX	$188	$2,256	13%	$402	$4,824	28%	
UT[2/3]	$583/$2,146	$6,996/$25,755	41%/150%	$673/$2,146	$8,076/$25,755	47%/150%	Y

	Income threshold for non-working parents			Income threshold for working parents			Enrollment Freeze Implemented[3]
State	Monthly Dollar Amount	Annual Dollar Amount	As a percent of poverty line	Monthly Dollar Amount	Annual Dollar Amount	As a percent of poverty line	
VT	$2,647	$31,765	185%	$2,737	$32,845	191%	
VA	$348	$4,176	24%	$438	$5,256	31%	
WA[2/3]	$546/$2,862	$6,552/$34,340	38%/200%	$1,092/$2,862	$13,104/$34,340	76%/200%	Y (state-funded)
WV	$253	$3,036	18%	$499	$5,992	35%	
WI[10]	$2,647	$31,765	185%	$2,737	$32,845	191%	
WY[11]	$590	$7,080	41%	$790	$9,480	55%	

SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, 2008.

┼ The median threshold was computed using the income threshold for each state at which parents can obtain comprehensive coverage that meets federal Medicaid guidelines. In states with two thresholds listed, the first figure is the income threshold at which parents can obtain such coverage. With the exception of **Pennsylvania** and **Washington**, the second figure refers to coverage established through waivers. The coverage offered through waivers generally provides fewer benefits and has higher cost-sharing than allowed in Medicaid. In **Pennsylvania** and **Washington**, the second figure refers to coverage available to parents under a state-funded program.

+ Indicates that a state has expanded eligibility in at least one of its parent's insurance programs between July 2006 and July 2007, unless noted otherwise.
– Indicates that a state has reduced eligibility in at least one of its parent's health insurance programs between July 2006 and July 2007, unless noted otherwise.

Table presents rules in effect as of July 2007, unless noted otherwise.

1. This table takes earnings disregards, when applicable, into account when determining income thresholds for working parents. Computations are based on a family of three with one earner. In some cases, earnings disregards may be time limited. States may use additional disregards in determining eligibility. In some states, the income eligibility guidelines vary by region. In this situation, the income guideline in the most populous region of the state is used.
Time-limited disregards: In some states, the earnings disregards used to determine eligibility are applied only for the first few months of coverage. Thus, the eligibility limits for most beneficiaries would be lower than the levels that appear in this stable. States with "time-limited disregards" include, but are not limited to, **Kentucky**, **Missouri** and **Texas**.

2. With the exception of **Pennsylvania** and **Washington**, when two thresholds are noted, the first is for "regular" Medicaid programs that provide comprehensive coverage that meets federal Medicaid guidelines and the second refers to coverage established through waivers. The coverage offered through these waivers generally provides fewer benefits and has higher cost-sharing than allowed in Medicaid. In **Pennsylvania** and **Washington**, the second figure refers to coverage available to parents under a state-funded program.

3. This column indicates whether the state was not enrolling eligible parents at any time between July 2006 and July 2007. In **Pennsylvania**'s state-funded program and **Utah**'s waiver program, parents may only enroll during open enrollment periods. In **Utah,** enrollment is currently open in the waiver program for parents with children. Enrollment is currently closed in **Oregon**'s waiver program. In **Tennessee**, enrollment under the state's waiver program is closed to new applicants. **Washington**'s state-funded program relies on a system of "managed enrollment" through which persons who are determined eligible may have to wait for space to open in the program before being enrolled.

4. **Arkansas** implemented waiver coverage for parents and childless adults with income up to 200 percent of the federal poverty line in January 2007. This coverage has a more limited benefit package than Medicaid and requires monthly premiums.

5. In **Hawaii**, parents enrolled in Medicaid whose income exceeds 200 percent of the federal poverty line can purchase alternative coverage by paying a monthly premium. This coverage has an income eligibility limit of 300 percent of the federal poverty line.

6. **Indiana** implemented waiver coverage for parents and childless adults with income up to 200 percent of the federal poverty line in January 2008. This coverage has a more limited benefit package than Medicaid and requires monthly premiums.

7. **Maryland** plans to expand coverage for parents to 116 percent of the federal poverty line in 2008.

8. The income eligibility limit noted for **Ohio** is only available for 24 months.

9. **Oklahoma** increased its income eligibility limit for employees of small employers covered under its waiver from 185 percent to 200 percent of the federal poverty line in November 2007. The state plans to expand its waiver coverage to employers with 250 or more workers. The state also plans to expand the income eligibility limit under the waiver coverage to 250 percent of the federal poverty line.

10. **Wisconsin** will expand coverage for parents to 200 percent of the federal poverty line in February 2008.

11. In **Wyoming**, the earnings disregard is based on marital status and whether one or both parents are employed. The figures in this table represent the income thresholds for families with unmarried parents with one earner.

Table 4
Selected Criteria Related to Health Coverage of Pregnant Women
January 2008

		Income Eligibility Level (Percent of Federal Poverty Line)	No Asset Test[1]	Presumptive Eligibility	Unborn Child Option[2]
Total		N/A	44	30	13
Alabama		133	**Y**		
Alaska		175	**Y**		
Arizona	+	150	**Y**		
Arkansas[1]		200	($3,100)	**Y**	**Y**
California[3]		200 (300)	**Y**	**Y**	**Y**
Colorado[4]		200	**Y**	**Y**	
Connecticut[5]	+	250	**Y**	**Y**	
Delaware		200	**Y**	**Y**	
District of Columbia	+	300	**Y**	**Y**	
Florida		185	**Y**	**Y**	
Georgia		200	**Y**	**Y**	
Hawaii[6]		185	**Y**		
Idaho		133	($5,000)	**Y**	
Illinois		200	**Y**	**Y**	**Y**
Indiana	+	200	**Y**		
Iowa[7]		200 (300)	($10,000)	**Y**	
Kansas		150	**Y**		
Kentucky		185	**Y**	**Y**	
Louisiana	+/-	200	**Y**		**Y**
Maine		200	**Y**	**Y**	
Maryland		250	**Y**		
Massachusetts		200	**Y**	**Y**	**Y**
Michigan		185	**Y**	**Y**	**Y**
Minnesota		275	**Y**		**Y**
Mississippi		185	**Y**		
Missouri		185	**Y**	**Y**	
Montana	+	150	($3,000)	**Y**	
Nebraska		185	**Y**	**Y**	**Y**
Nevada		185	**Y**		
New Hampshire		185	**Y**	**Y**	
New Jersey[8]		200	**Y**	**Y**	
New Mexico		185	**Y**	**Y**	
New York		200	**Y**	**Y**	
North Carolina		185	**Y**	**Y**	
North Dakota		133	**Y**		
Ohio[9]	+	200	**Y**		
Oklahoma		185	**Y**	**Y**	
Oregon		185	**Y**		
Pennsylvania[10]		185	**Y**	**Y**	
Rhode Island[11]		250 (350)	**Y**		**Y**
South Carolina[12]		185	($30,000)		
South Dakota		133	($7,500)		
Tennessee	+	185	**Y**	**Y**	**Y**
Texas		185	**Y**	**Y**	**Y**
Utah[13]		133	($5,000)	**Y**	
Vermont[14]		200	**Y**		
Virginia	+	185	**Y**		
Washington		185	**Y**		**Y**
West Virginia		150	**Y**		
Wisconsin[15]		185	**Y**	**Y**	**Y**
Wyoming		133	**Y**	**Y**	

SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, 2008. See notes on following page.

Notes for Table 4

+ Indicates that a state has expanded eligibility or adopted a simplified procedure for pregnant women between July 2006 and July 2007, unless noted otherwise.
– Indicates that a state has reduced eligibility or eliminated a simplified procedure for pregnant women between July 2006 and July 2007, unless noted otherwise.

Table presents rules in effect as of July 2007, unless noted otherwise.

1. With the exception of **Arkansas**, all states with an asset test for pregnancy coverage rely on a standard limit regardless of family size. In **Arkansas**, the asset limit shown is for a family of three.

2. The unborn child option permits states to provide SCHIP coverage to the unborn children of pregnant women.

3. In **California**, the Access for Infants and Mothers (AIM) program is available to pregnant women with income between 201 and 300 percent of the federal poverty line. This program is funded using Title XXI (Unborn Child Amendment).

4. In **Colorado**, coverage for pregnant women with income between 134 and 200 percent of the federal poverty line is provided under a HIFA waiver.

5. **Connecticut** has a presumptive-like eligibility process for pregnant women known as expedited eligibility. The state expanded eligibility for pregnant women from 185 percent to 250 percent of the federal poverty line in January 2008.

6. In **Hawaii**, pregnant women enrolled in Medicaid whose income exceeds 185 percent of the federal poverty line can purchase Quest-Net coverage by paying a monthly premium. This coverage has an income eligibility limit of 300 percent of the federal poverty line. Limited coverage is available to persons already receiving Medicaid.

7. In **Iowa**, the asset limit applies to "regular" Medicaid only and only considers liquid assets. Pregnant women with income between 200 and 300 percent of the federal poverty line with high medical expenses can "spend down" to qualify for the state's waiver program.

8. In **New Jersey**, coverage for women with income between 186 and 200 percent of the federal poverty line is provided under a Medicaid Section 1115 waiver. Under this coverage, pregnant women must be uninsured and no income deductions are allowed.

9. **Ohio** has an "expedited eligibility" process through which pregnant women can obtain 60 days of partial coverage pending documentation of eligibility factors. Inpatient coverage is not available during this period. The state expanded eligibility for pregnant women to 200 percent of the federal poverty line in January 2008.

10. In **Pennsylvania**, presumptive eligibility is available in most of the state, however an alternate expedited procedure is being piloted in Philadelphia and four surrounding counties.

11. In **Rhode Island**, the Medicaid income eligibility limit for pregnant women is 250 percent of the federal poverty line. There is also a state-funded program for women with income between 251 and 350 percent of the federal poverty line. Under this program, which requires a premium, the state funds the cost of labor and delivery only.

12. **South Carolina** has an "assumptive" eligibility process through which pregnant women can obtain 30 days of coverage pending documentation of eligibility factors.

13. In **Utah**, women who exceed the asset limit may still qualify for coverage if they make a one-time payment of four percent of the value of their assets or $3,367, whichever is less.

14. In **Vermont**, a premium is required of women with income above 185 percent of the federal poverty line.

15. In **Wisconsin**, the Medicaid income eligibility limit for pregnant women will be expanded to 250 percent of the federal poverty line in February 2008. The state will provide coverage for women with income between 251 and 300 percent of the federal poverty line with state funds.

Table 5

Enrollment: Selected Simplified Procedures in Children's Regular Medicaid, Children's SCHIP-funded Medicaid Expansions and Separate SCHIP Programs[1]

January 2008

		Program	Joint application	No Face-to-Face Interview	No Asset Test[2]	Presumptive eligibility[3]
Total		Medicaid (51)*	N/A	46	47	14
		SCHIP (37) **	N/A	34	35	9
		Aligned Medicaid and Separate SCHIP ***	33	46	46	12
Alabama[4]		Medicaid for Children	**Y**	**Y**	**Y**	
		Separate SCHIP		**Y**	**Y**	
Alaska		Medicaid for Children	N/A	**Y**	**Y**	
Arizona[5]		Medicaid for Children	**Y**	**Y**	**Y**	
		Separate SCHIP		**Y**	**Y**	
Arkansas		Medicaid for Children	N/A	**Y**	**Y**	
California[3]		Medicaid for Children	**Y**	**Y**	**Y**	**Y**
		Separate SCHIP		**Y**	**Y**	**Y**
Colorado[3]	✣	Medicaid for Children	**Y**	**Y**	**Y**	**Y**
	✣	Separate SCHIP		**Y**	**Y**	**Y**
Connecticut		Medicaid for Children	**Y**	**Y**	**Y**	**Y**
		Separate SCHIP		**Y**	**Y**	
Delaware		Medicaid for Children	**Y**	**Y**	**Y**	
		Separate SCHIP		**Y**	**Y**	
District of Columbia		Medicaid for Children	N/A	**Y**	**Y**	
Florida		Medicaid for Children	**Y**	**Y**	**Y**	
		Separate SCHIP		**Y**	**Y**	
Georgia		Medicaid for Children	**Y**	**Y**	**Y**	
		Separate SCHIP		**Y**	**Y**	
Hawaii		Medicaid for Children	N/A	**Y**	**Y**	
Idaho		Medicaid for Children	**Y**	**Y**	**Y**	
		Separate SCHIP		**Y**	**Y**	
Illinois[3]		Medicaid for Children	**Y**	**Y**	**Y**	**Y**
		Separate SCHIP		**Y**	**Y**	**Y**
Indiana[6]		Medicaid for Children	**Y**	**Y**	**Y**	
		Separate SCHIP		**Y**	**Y**	
Iowa		Medicaid for Children	**Y**	**Y**	**Y**	
		Separate SCHIP		**Y**	**Y**	
Kansas[3]	✣	Medicaid for Children	**Y**	**Y**	**Y**	**Y**
	✣	Separate SCHIP		**Y**	**Y**	**Y**
Kentucky		Medicaid for Children	**Y**		**Y**	
		Separate SCHIP			**Y**	
Louisiana[3]	✣	Medicaid for Children	N/A	**Y**	**Y**	**Y**
Maine		Medicaid for Children	**Y**	**Y**	**Y**	
		Separate SCHIP		**Y**	**Y**	
Maryland[7]		Medicaid for Children	N/A	**Y**	**Y**	
Massachusetts		Medicaid for Children	**Y**	**Y**	**Y**	**Y**
		Separate SCHIP		**Y**	**Y**	**Y**
Michigan		Medicaid for Children	**Y**	**Y**	**Y**	**Y**
		Separate SCHIP		**Y**	**Y**	**Y**
Minnesota		Medicaid for Children	N/A	**Y**	**Y**	
Mississippi		Medicaid for Children	**Y**		**Y**	
		Separate SCHIP			**Y**	
Missouri[8]		Medicaid for Children	**Y**	**Y**	**Y**	**Y**
		Separate SCHIP		**Y**	**Y**	**Y**
Montana[9]		Medicaid for Children		**Y**	**($15,000)**	
		Separate SCHIP		**Y**	**Y**	

		Program	Joint application	No Face-to-Face Interview	No Asset Test[2]	Presumptive eligibility[3]
Nebraska		Medicaid for Children	N/A	**Y**	**Y**	
Nevada[9]		Medicaid for Children		**Y**	**Y**	
		Separate SCHIP		**Y**	**Y**	
New Hampshire		Medicaid for Children	**Y**	**Y**	**Y**	**Y**
		Separate SCHIP		**Y**	**Y**	
New Jersey		Medicaid for Children	**Y**	**Y**	**Y**	**Y**
		Separate SCHIP		**Y**	**Y**	**Y**
New Mexico		Medicaid for Children	N/A	**Y**	**Y**	**Y**
New York[3/10]	+	Medicaid for Children	**Y**		**Y**	**Y**
		Separate SCHIP		**Y**	**Y**	**Y**
North Carolina		Medicaid for Children	**Y**	**Y**	**Y**	
		Separate SCHIP		**Y**	**Y**	
North Dakota		Medicaid for Children	**Y**	**Y**	**Y**	
		Separate SCHIP		**Y**	**Y**	
Ohio		Medicaid for Children	N/A	**Y**	**Y**	
Oklahoma		Medicaid for Children	N/A	**Y**	**Y**	
Oregon		Medicaid for Children	**Y**	**Y**	**Y**	
		Separate SCHIP		**Y**	**($10,000)**	
Pennsylvania[11]		Medicaid for Children	**Y**	**Y**	**Y**	
		Separate SCHIP		**Y**	**Y**	
Rhode Island		Medicaid for Children	N/A	**Y**	**Y**	
South Carolina		Medicaid for Children	N/A	**Y**	**($30,000)**	
South Dakota		Medicaid for Children	**Y**	**Y**	**Y**	
		Separate SCHIP		**Y**	**Y**	
Tennessee[12]		Medicaid for Children			**Y**	
	+	Separate SCHIP		**Y**	**Y**	
Texas[13]		Medicaid for Children	**Y**	**Y**	**($2,000)**	
	+	Separate SCHIP		**Y**	**($10,000)**	
Utah[9/14]		Medicaid for Children			**($3,025)**	
		Separate SCHIP			**Y**	
Vermont[15]		Medicaid for Children	**Y**	**Y**	**Y**	
		Separate SCHIP		**Y**	**Y**	
Virginia		Medicaid for Children	**Y**	**Y**	**Y**	
		Separate SCHIP		**Y**	**Y**	
Washington		Medicaid for Children	**Y**	**Y**	**Y**	
		Separate SCHIP		**Y**	**Y**	
West Virginia		Medicaid for Children	**Y**	**Y**	**Y**	
		Separate SCHIP		**Y**	**Y**	
Wisconsin[3]	+	Medicaid for Children	N/A	**Y**	**Y**	**Y**
Wyoming		Medicaid for Children	**Y**	**Y**	**Y**	
		Separate SCHIP		**Y**	**Y**	

SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, 2008.

+ Indicates that a state has simplified one or more of its procedures between July 2006 and July 2007, unless noted otherwise.
– Indicates that a state has rescinded one or more simplified procedures between July 2006 and July 2007, unless noted otherwise.

* "Total Medicaid" indicates the number of states that have adopted a particular enrollment simplification strategy for their children's Medicaid program. All 50 states and the District of Columbia operate such programs.

** "Total SCHIP" indicates number of states that have adopted a particular enrollment simplification strategy for their SCHIP-funded separate program. Thirty-seven states operate such programs. The remaining 13 states and the District of Columbia used their SCHIP funds to expand Medicaid, exclusively. During the survey period **Tennessee** and **Missouri** created separate SCHIP-funded programs and **Maryland** eliminated its separate SCHIP-funded program.

*** “Aligned Medicaid and Separate SCHIP” indicates the number of states that have adopted a particular enrollment simplification strategy and have applied the procedure to both their children’s Medicaid program and their SCHIP-funded separate program. States that have used SCHIP funds to expand Medicaid exclusively are considered “aligned” if the simplified procedure applies to children in the “regular” Medicaid program and the SCHIP-funded expansion program.

Table presents rules in effect as of July 2007, unless noted otherwise.

1. "Regular" Medicaid refers to coverage under Medicaid eligibility standards for children in place prior to SCHIP; states receive "regular" Medicaid matching payments as opposed to enhanced SCHIP matching payments for these children.

2. In states with asset limits, the limit noted is for a family of three.

3. Under federal law, states may implement presumptive eligibility procedures in Medicaid and SCHIP. In **California**, the SCHIP program has a presumptive eligibility process available to families with income up to 200 percent of the federal poverty line. This process is available through the Child Health and Disability Prevention program provider and the accelerated enrollment process, which provides temporary full scope no cost medical coverage. In **Illinois**, presumptive eligibility is available in children’s Medicaid and SCHIP but not in the state-funded expansion program. In **Kansas,** presumptive eligibility is being piloted. **New York's** SCHIP program has a presumptive-like process in which health plans can provide coverage for a 60-day period while the family submits necessary documentation. **Colorado**, **Louisiana**, **New York**, and **Wisconsin** have adopted presumptive eligibility, but plan to implement the procedure in 2008. **Colorado** will implement presumptive eligibility in children’s Medicaid and SCHIP programs. **Louisiana** will implement presumptive eligibility in its children’s coverage program. **New York** will implement presumptive eligibility in its children’s Medicaid program. **Wisconsin** will implement presumptive eligibility for children in families with income up to 150 percent of the federal poverty line.

4. In **Alabama**, a telephone interview is required in children's Medicaid.

5. In **Arizona**, families that apply for Medicaid for their children using the SCHIP paper or electronic application do not have to do a face-to-face interview.

6. In **Indiana**, county offices may require telephone interview but not face-to-face interviews.

7. In **Maryland**, there is an accelerated eligibility process that is available to children who already have an open case for other benefits at a local eligibility office. These children can receive up to three months of temporary eligibility pending a final eligibility determination.

8. In **Missouri**, children in families with income above 150 percent of the federal poverty line are subject to a “net worth” test of $250,000.

9. In **Montana**, **Nevada,** and **Utah**, families that use the SCHIP application but are found to be eligible for Medicaid must complete a Medicaid addendum before eligibility can be determined.

10. In **New York**, a contact with a community-based “facilitated enroller” will meet the face-to-face interview requirement.

11. **Pennsylvania** uses Medicaid and SCHIP applications that solicit “common data elements” in collecting information for Medicaid and SCHIP, thus making Medicaid and SCHIP applications interchangeable.

12. In **Tennessee**, a face-to-face or telephone interview is required in children's Medicaid.

13. In **Texas**, the SCHIP asset test applies only to families with income above 150 percent of the federal poverty line. Texas increased its SCHIP asset limit in September 2007.

14. In **Utah**, a face-to-face or telephone interview is required for Medicaid and SCHIP. **Utah** counts assets in determining Medicaid eligibility for children over the age of six. The SCHIP application is only available during SCHIP open enrollment periods. During these periods, the Medicaid application can be used to apply for SCHIP.

15. In **Vermont**, there is an asset test for children’s Medicaid and SCHIP, however if the countable assets exceed the asset limit the children are eligible under the 1115 waiver, which has no asset test.

Table 6
Income Verification: Families are Not Required to Provide Verification of Income in Children's Regular Medicaid, Children's SCHIP-funded Medicaid Expansions and Separate SCHIP Programs[1]
January 2008

	Program	Administrative Verification at Enrollment[2]	Administrative Renewal[2]	Administrative Renewal Unless Income has Changed[2]
Total	Medicaid (51)*	10	11	2
	SCHIP (37) **	8	9	3
	Aligned Medicaid and Separate SCHIP ***	10	11	1
Alabama	Medicaid for Children			
	Separate SCHIP	**Y**	**Y**	
Alaska	Medicaid for Children			
Arizona[3]	Medicaid for Children			
	Separate SCHIP			
Arkansas	Medicaid for Children	**Y**	**Y**	
California	Medicaid for Children			
	Separate SCHIP			
Colorado	Medicaid for Children			
	Separate SCHIP			
Connecticut	Medicaid for Children	**Y**	**Y**	
	Separate SCHIP	**Y**	**Y**	
Delaware	Medicaid for Children			
	Separate SCHIP			
District of Columbia	Medicaid for Children			
Florida[4]	Medicaid for Children			**Y**
	Separate SCHIP			
Georgia	Medicaid for Children			
	Separate SCHIP			
Hawaii	Medicaid for Children	**Y**	**Y**	
Idaho	Medicaid for Children	**Y**	**Y**	
	Separate SCHIP	**Y**	**Y**	
Illinois	Medicaid for Children			**Y**
	Separate SCHIP			**Y**
Indiana	Medicaid for Children			
	Separate SCHIP			
Iowa	Medicaid for Children			
	Separate SCHIP			
Kansas	Medicaid for Children			
	Separate SCHIP			
Kentucky	Medicaid for Children			
	Separate SCHIP			
Louisiana	Medicaid for Children			
Maine	Medicaid for Children			
	Separate SCHIP			
Maryland	Medicaid for Children	**Y**	**Y**	
Massachusetts	Medicaid for Children			
	Separate SCHIP			
Michigan	Medicaid for Children	**Y**	**Y**	
	Separate SCHIP	**Y**	**Y**	
Minnesota[5]	Medicaid for Children			

		Program	Administrative Verification at Enrollment[2]	Administrative Renewal[2]	Administrative Renewal Unless Income has Changed[2]
Mississippi		Medicaid for Children			
		Separate SCHIP			
Missouri		Medicaid for Children			
		Separate SCHIP			
Montana		Medicaid for Children			
		Separate SCHIP	**Y**	**Y**	
Nebraska		Medicaid for Children			
Nevada		Medicaid for Children			
		Separate SCHIP			
New Hampshire		Medicaid for Children			
		Separate SCHIP			
New Jersey		Medicaid for Children			
		Separate SCHIP			
New Mexico		Medicaid for Children			
New York[6]	✣	Medicaid for Children		**Y**	
		Separate SCHIP		**Y**	
North Carolina		Medicaid for Children			
		Separate SCHIP			
North Dakota		Medicaid for Children			
		Separate SCHIP			
Ohio		Medicaid for Children			
Oklahoma		Medicaid for Children	**Y**	**Y**	
Oregon		Medicaid for Children			
		Separate SCHIP			
Pennsylvania		Medicaid for Children			
		Separate SCHIP			
Rhode Island		Medicaid for Children			
South Carolina		Medicaid for Children			
South Dakota		Medicaid for Children			
		Separate SCHIP			
Tennessee		Medicaid for Children			
	✣	Separate SCHIP	**Y**	**Y**	
Texas		Medicaid for Children			
		Separate SCHIP			
Utah[7]		Medicaid for Children			
		Separate SCHIP			**Y**
Vermont		Medicaid for Children	**Y**	**Y**	
		Separate SCHIP	**Y**	**Y**	
Virginia		Medicaid for Children			
		Separate SCHIP			
Washington		Medicaid for Children			
		Separate SCHIP			
West Virginia[8]		Medicaid for Children			
		Separate SCHIP			**Y**
Wisconsin	✣	Medicaid for Children	**Y**	**Y**	
Wyoming		Medicaid for Children	**Y**	**Y**	
		Separate SCHIP	**Y**	**Y**	

SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, 2008.

Notes for Table 4

+ Indicates that a state has eliminated an income verification requirement between July 2006 and July 2007, unless noted otherwise.
– Indicates that a state has instituted an income verification requirement between July 2006 and July 2007, unless noted otherwise.

* "Total Medicaid" indicates the number of states that do not ask for verification of income for their children's Medicaid program. All 50 states and the District of Columbia operate such programs.

** "Total SCHIP" indicates number of states that do not ask for verification of income for their SCHIP-funded separate program. Thirty-seven states operate such programs. The remaining 13 states and the District of Columbia used their SCHIP funds to expand Medicaid, exclusively. During the survey period **Tennessee** and **Missouri** created separate SCHIP-funded program and **Maryland** eliminated its separate SCHIP-funded program.

*** "Aligned Medicaid and Separate SCHIP" indicates the number of states that do not ask for verification of income and have applied the procedure to both their children's Medicaid program and their SCHIP-funded separate program. States that have used SCHIP funds to expand Medicaid exclusively are considered "aligned" if the simplified procedure applies to children in the "regular" Medicaid program and the SCHIP-funded expansion program.

Table presents rules in effect as of July 2007, unless noted otherwise.

1. "Regular" Medicaid refers to coverage under Medicaid eligibility standards for children in place prior to SCHIP; states receive "regular" Medicaid matching payments as opposed to enhanced SCHIP matching payments for these children.

2. While families do not have to provide verification of income in the states noted, such states generally verify this information through data matches with other government agencies, such as the Social Security Administration and state departments of labor.

3. In **Arizona's** SCHIP program, income verification is requested from all applicants but is not required if income can be verified through a data match.

4. In **Florida**, families with children on Medicaid who were enrolled through the SCHIP process are only required to verify new sources of income at renewal. Families with children on Medicaid who were enrolled through a local office must provide verification of income at renewal.

5. In **Minnesota**, the income verification requirement at enrollment and renewal was eliminated in the state's waiver coverage program in July 2007.

6. In **New York**, income verification is not required at SCHIP renewal if a Social Security number (s) is provided for the parent(s). The state implemented this procedure in its children's Medicaid program in January 2008.

7. In **Utah**, families with children on SCHIP receive one of two renewal forms. One of the renewal forms requires families to provide verification of income only if income has changed. The other form, which is sent to families that have had a change in income during the previous year, requests income verification.

8. In **West Virginia,** a simplified renewal form is used at every other SCHIP renewal. The simplified renewal form requires families to provide verification of income only if income has changed.

Table 7
Renewal: Selected Simplified Procedures in Children's Regular Medicaid, Children's SCHIP-funded Medicaid Expansions and Separate SCHIP Programs[1]
January 2008

	Program	Frequency┼ (months)	12-Month Continuous Eligibility	No Face-to-Face Interview	Joint Renewal Form┼┼
Total	Medicaid (51)*	45	16	48	N/A
	SCHIP (37) **	37	27	36	N/A
	Aligned Medicaid and Separate SCHIP ***	45	16	48	18
Alabama	Medicaid for Children	12	**Y**	**Y**	
	Separate SCHIP	12	**Y**	**Y**	
Alaska	Medicaid for Children	6		**Y**	N/A
Arizona[2]	Medicaid for Children	12			
	Separate SCHIP	12	**Y**	**Y**	
Arkansas[3]	Medicaid for Children	12		**Y**	N/A
California	Medicaid for Children	12	**Y**	**Y**	
	Separate SCHIP	12	**Y**	**Y**	
Colorado	Medicaid for Children	12		**Y**	**Y**
	Separate SCHIP	12	**Y**	**Y**	
Connecticut	Medicaid for Children	12		**Y**	
	Separate SCHIP	12		**Y**	
Delaware	Medicaid for Children	12		**Y**	**Y**
	Separate SCHIP	12	**Y**	**Y**	
District of Columbia	Medicaid for Children	12		**Y**	N/A
Florida[4]	Medicaid for Children	12		**Y**	
	Separate SCHIP	12	**Y**	**Y**	
Georgia	Medicaid for Children	6		**Y**	
	Separate SCHIP	12		**Y**	
Hawaii	Medicaid for Children	12		**Y**	N/A
Idaho	Medicaid for Children	12	**Y**	**Y**	**Y**
	Separate SCHIP	12	**Y**	**Y**	
Illinois	Medicaid for Children	12	**Y**	**Y**	
	Separate SCHIP	12	**Y**	**Y**	
Indiana [5]	Medicaid for Children	12		**Y**	**Y**
	Separate SCHIP	12		**Y**	
Iowa	Medicaid for Children	12		**Y**	
	Separate SCHIP	12	**Y**	**Y**	
Kansas	Medicaid for Children	12	**Y**	**Y**	**Y**
	Separate SCHIP	12	**Y**	**Y**	
Kentucky	Medicaid for Children	12		**Y**	**Y**
	Separate SCHIP	12		**Y**	
Louisiana	Medicaid for Children	12	**Y**	**Y**	N/A
Maine	Medicaid for Children	12	**Y**	**Y**	**Y**
	Separate SCHIP	12	**Y**	**Y**	
Maryland	Medicaid for Children	12		**Y**	N/A
Massachusetts	Medicaid for Children	12		**Y**	**Y**
	Separate SCHIP	12		**Y**	
Michigan	Medicaid for Children	12	**Y**	**Y**	
	Separate SCHIP	12	**Y**	**Y**	
Minnesota[3] ┼	Medicaid for Children	6/12 (12)		**Y**	N/A
Mississippi	Medicaid for Children	12	**Y**		**Y**
	Separate SCHIP	12	**Y**		
Missouri	Medicaid for Children	12		**Y**	**Y**
	Separate SCHIP	12		**Y**	

	Program	Frequency+ (months)	12-Month Continuous Eligibility	No Face-to-Face Interview	Joint Renewal Form++
Montana	Medicaid for Children	12		**Y**	
	Separate SCHIP	12	**Y**	**Y**	
Nebraska	Medicaid for Children	6		**Y**	N/A
Nevada	Medicaid for Children	12		**Y**	
	Separate SCHIP	12	**Y**	**Y**	
New Hampshire	Medicaid for Children	12		**Y**	**Y**
	Separate SCHIP	12		**Y**	
New Jersey[6]	Medicaid for Children	12	**Y**	**Y**	**Y**
	Separate SCHIP	12	**Y**	**Y**	
New Mexico	Medicaid for Children	12		**Y**	N/A
New York	Medicaid for Children	12	**Y**	**Y**	
	Separate SCHIP	12	**Y**	**Y**	
North Carolina	Medicaid for Children	12	**Y**	**Y**	**Y**
	Separate SCHIP	12	**Y**	**Y**	
North Dakota[7]	Medicaid for Children	12 (1)		**Y**	**Y**
	Separate SCHIP	12	**Y**	**Y**	
Ohio	Medicaid for Children	12		**Y**	N/A
Oklahoma	Medicaid for Children	12		**Y**	N/A
Oregon[8]	Medicaid for Children	6		**Y**	**Y**
+	Separate SCHIP	12		**Y**	
Pennsylvania	Medicaid for Children	6		**Y**	
	Separate SCHIP	12	**Y**	**Y**	
Rhode Island	Medicaid for Children	12		**Y**	N/A
South Carolina	Medicaid for Children	12	**Y**	**Y**	N/A
South Dakota	Medicaid for Children	12		**Y**	**Y**
	Separate SCHIP	12		**Y**	
Tennessee[3]	Medicaid for Children	12			
+	Separate SCHIP	12	**Y**	**Y**	
Texas[9]	Medicaid for Children	6		**Y**	
+	Separate SCHIP	12	**Y**	**Y**	
Utah	Medicaid for Children	12		**Y**	
	Separate SCHIP	12	**Y**	**Y**	
Vermont	Medicaid for Children	12		**Y**	**Y**
	Separate SCHIP	12		**Y**	
Virginia[10]	Medicaid for Children	12		**Y**	
	Separate SCHIP	12	**Y**	**Y**	
Washington	Medicaid for Children	12	**Y**	**Y**	**Y**
	Separate SCHIP	12	**Y**	**Y**	
West Virginia[11]	Medicaid for Children	12	**Y**	**Y**	
	Separate SCHIP	12	**Y**	**Y**	
Wisconsin	Medicaid for Children	12		**Y**	N/A
Wyoming	Medicaid for Children	12	**Y**	**Y**	
	Separate SCHIP	12	**Y**	**Y**	

SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, 2008.

+ Indicates that a state has simplified one or more of its procedures between July 2006 and July 2007, unless noted otherwise.
– Indicates that a state has rescinded one or more simplified procedures between July 2006 and July 2007, unless noted otherwise.

* "Total Medicaid" indicates the number of states that have adopted a particular renewal simplification strategy for their children's Medicaid program. All 50 states and the District of Columbia operate such programs.

** "Total SCHIP" indicates number of states that have adopted a particular renewal simplification strategy for their SCHIP-funded separate program. Thirty-seven states operate such programs. The remaining 13 states and the District of Columbia used

their SCHIP funds to expand Medicaid, exclusively. During the survey period **Tennessee** and **Missouri** created separate SCHIP-funded program and **Maryland** eliminated its separate SCHIP-funded program.

*** "Aligned Medicaid and Separate SCHIP" indicates the number of states that have adopted a particular renewal simplification strategy and have applied the procedure to both their children's Medicaid program and their SCHIP-funded separate program. States that have used SCHIP funds to expand Medicaid exclusively are considered "aligned" if the simplified procedure applies to children in the "regular" Medicaid program and the SCHIP-funded expansion program.

┼ This column shows the frequency of renewals. If monthly, quarterly or semi-annual income reporting is also required, this frequency is noted in parentheses. Some states require change reporting, which is not addressed in this table. If the frequency of renewal is every 12 months, as opposed to six months or more frequently, the procedure is considered "simplified" for the purposes of this table.

┼┼ "Joint renewal" indicates that the same renewal form is used for children's Medicaid and SCHIP. In a number of states, separate Medicaid and SCHIP renewal forms can be used to determine eligibility for both programs, however for the purposes of this table, "joint renewal" indicates that the *same form* is used for both programs.

Table presents rules in effect as of July 2007, unless noted otherwise.

1. "Regular" Medicaid refers to coverage under Medicaid eligibility standards for children in place prior to SCHIP; states receive "regular" Medicaid matching payments as opposed to enhanced SCHIP matching payments for these children.

2. In **Arizona,** a face-to-face or telephone interview is required in Medicaid. The 12-month continuous eligibility policy in SCHIP only applies to the first 12 months of coverage.

3. In **Arkansas** and **Minnesota**, renewal procedures differ for children and/or families with children enrolled in Medicaid, depending on whether they are eligible under "regular" Medicaid or under expansions pursuant to Medicaid Section 1115 waivers or SCHIP-funded Medicaid expansions. In **Arkansas**, children who qualify under expansion rules receive 12 months of continuous eligibility, as opposed to a 12-month renewal period in "regular" Medicaid. In **Minnesota**, children and parents who qualify under the state's Section 1115 expansion program have eligibility reviewed every 12 months. In the "regular" Medicaid program, income reviews occur every 6 months and eligibility reviews every 12 months. In **Tennessee**, a face-to-face or telephone interview is required at renewal in "regular" Medicaid. Reviews remain suspended in **Tennessee's** Section 1115 waiver program; however the state plans to begin reviewing children's eligibility in the near future.

4. In **Florida's** Medicaid program, children under age five receive 12 months of continuous eligibility and children age five and older receive 6 months of continuous eligibility.

5. **Indiana** adopted 12 months of continuous eligibility for children up to age three in its Medicaid and SCHIP programs in November 2007.

6. In **New Jersey**, families of children who have their Medicaid case maintained by the central SCHIP office receive a pre-printed joint renewal form. Families of children with Medicaid cases maintained at a county office do not receive this form. Forms used by county office vary, however several offices use the joint Medicaid/SCHIP application as a renewal form.

7. In **North Dakota**, families with children enrolled in Medicaid must report their income monthly. A full review of eligibility is done annually.

8. In **Oregon**, the renewal period for poverty-level children's Medicaid is six months. The renewal period for children covered under Section 1931 coverage is "up to 12 months" though most families not receiving other benefits have a six-month eligibility period.

9. In **Texas**, children covered under SCHIP get 12 months of continuous coverage beginning in September 2007. The state will conduct administrative renewal for children in families with income between 185 and 200 percent of the federal poverty line at 6 months to determine whether income has exceeded 200 percent of the federal poverty line.

10. In **Virginia**, children covered under SCHIP get 12 months of continuous coverage unless the family's income exceeds the program's income eligibility guideline or the family leaves the state.

11. In **West Virginia**, a simplified renewal form is used at every other SCHIP renewal. The joint application form printed in a different color is used for all other SCHIP and Medicaid renewals.

Table 8
Enrollment: Selected Simplified Procedures in Medicaid for Parents, with Comparisons to Children
January 2008

Program		Family Application┼	No Face-to-Face Interview	No Asset Test[1] (or limit for family of 3)
Total	Aligned Medicaid for Children and Separate SCHIP *	28	46	46
	Total Medicaid for Parents (51)**		40	22
Alabama[2]	Medicaid for Children	**Y**	**Y**	**Y**
	Separate SCHIP		**Y**	**Y**
	Medicaid for Parents		**Y**	**Y**
Alaska[3]	Medicaid for Children		**Y**	**Y**
	Medicaid for Parents			**($2,000)**
Arizona[4]	Medicaid for Children	**Y**	**Y**	**Y**
	Separate SCHIP		**Y**	**Y**
	Medicaid for Parents		**Y**	**Y**
	Expanded Medicaid for Parents		**Y**	**Y**
Arkansas[5/6]	Medicaid for Children		**Y**	**Y**
	Medicaid for Parents			**($1,000)**
	Expanded Medicaid for Parents		**Y**	**Y**
California[7]	Medicaid for Children		**Y**	**Y**
	Separate SCHIP		**Y**	**Y**
	Medicaid for Parents		**Y**	**($3,150)**
	Expanded Medicaid for Parents		**Y**	**($3,150)**
Colorado	Medicaid for Children	**Y**	**Y**	**Y**
	Separate SCHIP		**Y**	**Y**
	Medicaid for Parents		**Y**	**Y**
Connecticut	Medicaid for Children	**Y**	**Y**	**Y**
	Separate SCHIP		**Y**	**Y**
	Medicaid for Parents		**Y**	**Y**
	Expanded Medicaid for Parents		**Y**	**Y**
Delaware	Medicaid for Children	**Y**	**Y**	**Y**
	Separate SCHIP		**Y**	**Y**
	Medicaid for Parents		**Y**	**Y**
	Expanded Medicaid for Parents		**Y**	**Y**
District of Columbia	Medicaid for Children	**Y**	**Y**	**Y**
	Medicaid for Parents		**Y**	**Y**
	Expanded Medicaid for Parents		**Y**	**Y**
Florida[8]	Medicaid for Children		**Y**	**Y**
	Separate SCHIP		**Y**	**Y**
	Medicaid for Parents		**Y**	**($2,000)**
Georgia[7]	Medicaid for Children		**Y**	**Y**
	Separate SCHIP		**Y**	**Y**
	Medicaid for Parents		**Y**	**($1,000)**
Hawaii	Medicaid for Children	**Y**	**Y**	**Y**
	Medicaid for Parents		**Y**	**($3,250)**
	Expanded Medicaid for Parents		**Y**	**($3,250)**
Idaho[7]	Medicaid for Children		**Y**	**Y**
	Separate SCHIP		**Y**	**Y**
	Medicaid for Parents		**Y**	**($1,000)**

	Program	Family Application┼	No Face-to-Face Interview	No Asset Test[1] (or limit for family of 3)
Illinois	Medicaid for Children	**Y**	**Y**	**Y**
	Separate SCHIP		**Y**	**Y**
	Medicaid for Parents		**Y**	**Y**
	Expanded Medicaid for Parents		**Y**	**Y**
Indiana[7/9]	Medicaid for Children		**Y**	**Y**
	Separate SCHIP		**Y**	**Y**
	Medicaid for Parents		**Y**	**($1,000)**
	Expanded Medicaid for Parents		**Y**	**Y**
Iowa[5/7/10]	Medicaid for Children		**Y**	**Y**
	Separate SCHIP		**Y**	**Y**
÷	Medicaid for Parents		**Y**	**($2,000)**
	Expanded Medicaid for Parents		**Y**	**Y**
Kansas[11]	Medicaid for Children	**Y**	**Y**	**Y**
	Separate SCHIP		**Y**	**Y**
	Medicaid for Parents		**Y**	**Y**
Kentucky	Medicaid for Children	**Y**		**Y**
	Separate SCHIP			**Y**
	Medicaid for Parents			**($2,000)**
Louisiana	Medicaid for Children		**Y**	**Y**
	Medicaid for Parents		**Y**	**Y**
Maine[12]	Medicaid for Children	**Y**	**Y**	**Y**
	Separate SCHIP		**Y**	**Y**
	Medicaid for Parents		**Y**	**($2,000)**
	Expanded Medicaid for Parents		**Y**	**($2,000)**
Maryland	Medicaid for Children		**Y**	**Y**
	Medicaid for Parents			**($3,100)**
Massachusetts	Medicaid for Children	**Y**	**Y**	**Y**
	Separate SCHIP		**Y**	**Y**
	Medicaid for Parents		**Y**	**Y**
	Expanded Medicaid for Parents		**Y**	**Y**
Michigan	Medicaid for Children		**Y**	**Y**
	Separate SCHIP		**Y**	**Y**
	Medicaid for Parents		**Y**	**($3,000)**
Minnesota	Medicaid for Children	**Y**	**Y**	**Y**
	Medicaid for Parents		**Y**	**($20,000)**
	Expanded Medicaid for Parents		**Y**	**($20,000)**
Mississippi	Medicaid for Children	**Y**		**Y**
	Separate SCHIP			**Y**
	Medicaid for Parents			**Y**
Missouri[13]	Medicaid for Children	**Y**	**Y**	**Y**
	Separate SCHIP		**Y**	**Y**
	Medicaid for Parents		**Y**	**Y**
Montana[14]	Medicaid for Children		**Y**	**($15,000)**
	Separate SCHIP		**Y**	**Y**
	Medicaid for Parents		**Y**	**($3,000)**
Nebraska	Medicaid for Children		**Y**	**Y**
	Medicaid for Parents			**($6,000)**
Nevada[5]	Medicaid for Children		**Y**	**Y**
	Separate SCHIP		**Y**	**Y**
	Medicaid for Parents		**Y**	**($2,000)**
New Hampshire	Medicaid for Children		**Y**	**Y**
	Separate SCHIP		**Y**	**Y**
	Medicaid for Parents			**($1,000)**

	Program	Family Application┼	No Face-to-Face Interview	No Asset Test[1] (or limit for family of 3)
New Jersey	Medicaid for Children	**Y**	**Y**	**Y**
	Separate SCHIP		**Y**	**Y**
	Medicaid for Parents		**Y**	**Y**
	Expanded Medicaid for Parents		**Y**	**Y**
New Mexico[5/15]	Medicaid for Children	**Y**	**Y**	**Y**
	Medicaid for Parents		**Y**	**Y**
	Expanded Medicaid for Parents		**Y**	**Y**
New York[16]	Medicaid for Children	**Y**		**Y**
	Separate SCHIP		**Y**	**Y**
	Medicaid for Parents			**($6,600)**
	Expanded Medicaid for Parents			**($19,800)**
North Carolina[7]	Medicaid for Children		**Y**	**Y**
	Separate SCHIP		**Y**	**Y**
	Medicaid for Parents		**Y**	**($3,000)**
North Dakota	Medicaid for Children	**Y**	**Y**	**Y**
	Separate SCHIP		**Y**	**Y**
	Medicaid for Parents		**Y**	**Y**
Ohio	Medicaid for Children	**Y**	**Y**	**Y**
	Medicaid for Parents		**Y**	**Y**
Oklahoma[5/7]	Medicaid for Children		**Y**	**Y**
	Medicaid for Parents		**Y**	**Y**
	Expanded Medicaid for Parents		**Y**	**Y**
Oregon	Medicaid for Children	**Y**	**Y**	**Y**
	Separate SCHIP		**Y**	**($10,000)**
	Medicaid for Parents		**Y**	**($2,500)**
	Expanded Medicaid for Parents		**Y**	**($2,000)**
Pennsylvania[17]	Medicaid for Children	**Y**	**Y**	**Y**
	Separate SCHIP		**Y**	**Y**
	Medicaid for Parents		**Y**	**Y**
	Expanded Coverage for Parents		**Y**	**Y**
Rhode Island[18]	Medicaid for Children	**Y**	**Y**	**Y**
	Medicaid for Parents		**Y**	**Y**
	Expanded Medicaid for Parents		**Y**	**Y**
South Carolina[7]	Medicaid for Children		**Y**	**($30,000)**
	Medicaid for Parents		**Y**	**($30,000)**
South Dakota[7]	Medicaid for Children		**Y**	**Y**
	Separate SCHIP		**Y**	**Y**
	Medicaid for Parents		**Y**	**($2,000)**
Tennessee[19]	Medicaid for Children	**Y**		**Y**
┼	Separate SCHIP		**Y**	**Y**
	Medicaid for Parents			**($2,000)**
Texas[20]	Medicaid for Children	**Y**	**Y**	**($2,000)**
┼	Separate SCHIP		**Y**	**($10,000)**
	Medicaid for Parents		**Y**	**($2,000)**
Utah[5/21]	Medicaid for Children			**($3,025)**
	Separate SCHIP			**Y**
	Medicaid for Parents			**($3,025)**
	Expanded Medicaid for Parents		**Y**	**Y**
Vermont[22]	Medicaid for Children	**Y**	**Y**	**Y**
	Separate SCHIP		**Y**	**Y**
	Medicaid for Parents		**Y**	**($3,150)**
	Expanded Medicaid for Parents		**Y**	**Y**

	Program	Family Application┼	No Face-to-Face Interview	No Asset Test[1] (or limit for family of 3)
Virginia	Medicaid for Children		**Y**	**Y**
	Separate SCHIP		**Y**	**Y**
	Medicaid for Parents		**Y**	**Y**
Washington[23]	Medicaid for Children		**Y**	**Y**
	Separate SCHIP		**Y**	**Y**
	Medicaid for Parents		**Y**	**($1,000)**
	Expanded Coverage for Parents		**Y**	**Y**
West Virginia	Medicaid for Children		**Y**	**Y**
	Separate SCHIP		**Y**	**Y**
	Medicaid for Parents			**($1,000)**
Wisconsin	Medicaid for Children		**Y**	**Y**
	Medicaid for Parents	**Y**	**Y**	**Y**
	Expanded Medicaid for Parents		**Y**	**Y**
Wyoming	Medicaid for Children		**Y**	**Y**
	Separate SCHIP	**Y**	**Y**	**Y**
	Medicaid for Parents		**Y**	**Y**

SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, 2008.

+ Indicates that a state has simplified one or more of its procedures for parents between July 2006 and July 2007, unless noted otherwise.
– Indicates that a state has rescinded one or more simplified procedures for parents between July 2006 and July 2007, unless noted otherwise.

* "Aligned Medicaid for Children and Separate SCHIP" indicates the number of states that have adopted a particular enrollment simplification strategy and have applied the procedure to both their children's Medicaid and their SCHIP-funded separate program. States that have used SCHIP funds to expand Medicaid exclusively are considered "aligned" if the simplified procedure applies to children in the "regular" Medicaid program and the SCHIP-funded Medicaid expansion program. "Regular" Medicaid refers to coverage under Medicaid eligibility standards for children in place prior to SCHIP; states receive "regular" Medicaid matching payments as opposed to enhanced SCHIP matching payments for these children.

** "Total Medicaid for Parents" indicates the number of states that have adopted a particular enrollment simplification strategy and have applied the procedure to both pre-expansion Medicaid for parents and expanded coverage for parents, if the state has expanded coverage for parents. All 50 states and the District of Columbia operate a Medicaid program for parents. Fifteen states and the District of Columbia have expanded Medicaid coverage for parents up to 100 percent of the federal poverty line or higher.

┼ This column indicates whether the simplest application that can be used to apply for children's coverage can also be used to apply for coverage for parents. In states with "family" applications, parents are not required to complete additional forms or provide additional information to obtain coverage for themselves and the family application can be used to apply for all parents and children, whether they are eligible for Medicaid or a separate SCHIP program.

Table presents rules in effect as of July 2007, unless noted otherwise.

1. In states with asset limits, the limit noted is for a family of three.

2. In **Alabama**, a telephone interview is required for Medicaid.

3. In **Alaska**, the asset limit for parents is $3,000 if the household includes a person age 60 or older.

4. In **Arizona**, parents who apply for Medicaid using the SCHIP paper or electronic application do not have to do a face-to-face interview.

5. In these states, "Expanded Medicaid for Parents" refers to coverage established through waivers. The coverage offered generally provides fewer benefits and has higher cost-sharing than allowed in Medicaid.

6. In **Arkansas**, county offices have the option of requiring either a face-to-face or telephone interview for Medicaid. Applicants who have had an active Medicaid case within the past year are not required to do an interview. The joint Medicaid/SCHIP application in **Arkansas** has a place for parents to indicate they are interested in health coverage for themselves. Parents that indicate an interest in coverage for themselves are required to complete a separate Medicaid application.

7. In **California**, **Georgia**, **Idaho**, **Indiana**, **Iowa**, **North Carolina**, **Oklahoma**, **South Carolina,** and **South Dakota**, the same simplified application can be used to apply for coverage for children and parents. However, parents must complete additional forms or take additional steps (such as to provide information on assets or absent parents) prior to an eligibility determination for themselves.

8. In **Florida**, families that submit applications that don't appear to be prone to error or fraud, known as "green track" applications, are not required to do an interview.

9. In **Indiana**, a telephone interview will meet the interview requirement if the parent is applying for Medicaid only.

10. In **Iowa**, the face-to-face interview requirement was eliminated in August 2007. The waiver program for parents requires a separate application.

11. In **Kansas**, there is no asset limit for parents unless there is a trust involved. Trusts are evaluated on a case by case basis and if countable, there is a limit of $2,000 for one person or $3,000 for a family of two or more.

12. **Maine's** asset rules exempt $8,000 for an individual and $12,000 for a household of 2 or more in certain savings, including retirement savings.

13. In **Missouri**, children in families with income above 150 percent of the federal poverty line are subject to a "net worth" test of $250,000.

14. In **Montana**, there is a Medicaid-only application that can be used for children and parents.

15. In **New Mexico**, there is a single application that can be used to apply for Medicaid for children and parents. The state's waiver coverage for parents has its own application.

16. In **New York**, there are two applications families may use to apply for health coverage for their children, one of which can also be used to apply for parents. A contact with a community-based "facilitated enroller" will meet the Medicaid face-to-face interview requirement.

17. **Pennsylvania** uses Medicaid and SCHIP applications that solicit "common data elements" in collecting information for Medicaid and SCHIP, thus making Medicaid and SCHIP applications interchangeable. **Pennsylvania's** expanded coverage for parents is state-funded.

18. **Rhode Island** has adopted a $10,000 asset limit for children and parents, however no implementation date has been set.

19. In **Tennessee**, a face-to-face or telephone interview is required.

20. In **Texas**, the SCHIP asset test only applies to families with income above 150 percent of the federal poverty line. **Texas** increased its asset limit in September 2007.

21. In **Utah**, a face-to-face or telephone interview is required for Medicaid. **Utah** counts assets in determining Medicaid eligibility for children age 6 and older.

22. In **Vermont**, there are two applications families may use to apply for health coverage for their children, one of which can also be used to apply for parents. The state has an asset test for children's Medicaid and SCHIP, however if the countable assets exceed the asset limit the children are eligible under the 1115 waiver, which has no asset test.

23. In **Washington**, expanded coverage for parents is state-funded.

Table 9
Renewal: Selected Simplified Procedures in Medicaid for Parents, with Comparisons to Children
January 2008

Program		Frequency┼ (months)	No Face-to-Face Interview
Total	Aligned Medicaid for Children and Separate SCHIP *	45	48
	Total Medicaid for Parents (51)**	40	46
Alabama	Medicaid for Children	12	**Y**
	Separate SCHIP	12	**Y**
	Medicaid for Parents	12	**Y**
Alaska	Medicaid for Children	6	**Y**
	Medicaid for Parents	6	**Y**
Arizona[1]	Medicaid for Children	12	
	Separate SCHIP	12	**Y**
	Medicaid for Parents	12	
	Expanded Medicaid for Parents	12	**Y**
Arkansas[2/3]	Medicaid for Children	12	**Y**
	Medicaid for Parents	12	**Y**
	Expanded Medicaid for Parents	12	**Y**
California[4]	Medicaid for Children	12	**Y**
	Separate SCHIP	12	**Y**
	Medicaid for Parents	12 (6)	**Y**
	Expanded Medicaid for Parents	12 (6)	**Y**
Colorado	Medicaid for Children	12	**Y**
	Separate SCHIP	12	**Y**
	Medicaid for Parents	12	**Y**
Connecticut	Medicaid for Children	12	**Y**
	Separate SCHIP	12	**Y**
	Medicaid for Parents	12	**Y**
	Expanded Medicaid for Parents	12	**Y**
Delaware	Medicaid for Children	12	**Y**
	Separate SCHIP	12	**Y**
	Medicaid for Parents	12	**Y**
	Expanded Medicaid for Parents	12	**Y**
District of Columbia	Medicaid for Children	12	**Y**
	Medicaid for Parents	12	**Y**
	Expanded Medicaid for Parents	12	**Y**
Florida[5]	Medicaid for Children	12	**Y**
	Separate SCHIP	12	**Y**
	Medicaid for Parents	12	**Y**
Georgia	Medicaid for Children	6	**Y**
	Separate SCHIP	12	**Y**
	Medicaid for Parents	6	**Y**
Hawaii	Medicaid for Children	12	**Y**
	Medicaid for Parents	12	**Y**
	Expanded Medicaid for Parents	12	**Y**
Idaho	Medicaid for Children	12	**Y**
	Separate SCHIP	12	**Y**
	Medicaid for Parents	12	**Y**

	Program	Frequency┼ (months)	No Face-to-Face Interview
Illinois	Medicaid for Children	12	**Y**
	Separate SCHIP	12	**Y**
	Medicaid for Parents	12	**Y**
	Expanded Medicaid for Parents	12	**Y**
Indiana[6]	Medicaid for Children	12	**Y**
	Separate SCHIP	12	**Y**
	Medicaid for Parents	12	**Y**
	Expanded Medicaid for Parents	12	**Y**
Iowa[2/7]	Medicaid for Children	12	**Y**
	Separate SCHIP	12	**Y**
╪	Medicaid for Parents	12	**Y**
	Expanded Medicaid for Parents	12	**Y**
Kansas	Medicaid for Children	12	**Y**
	Separate SCHIP	12	**Y**
	Medicaid for Parents	12	**Y**
Kentucky	Medicaid for Children	12	**Y**
	Separate SCHIP	12	**Y**
	Medicaid for Parents	12	
Louisiana	Medicaid for Children	12	**Y**
	Medicaid for Parents	12	**Y**
Maine	Medicaid for Children	12	**Y**
	Separate SCHIP	12	**Y**
	Medicaid for Parents	12	**Y**
	Expanded Medicaid for Parents	12	**Y**
Maryland	Medicaid for Children	12	**Y**
	Medicaid for Parents	12	**Y**
Massachusetts	Medicaid for Children	12	**Y**
	Separate SCHIP	12	**Y**
	Medicaid for Parents	12	**Y**
	Expanded Medicaid for Parents	12	**Y**
Michigan	Medicaid for Children	12	**Y**
	Separate SCHIP	12	**Y**
	Medicaid for Parents	12	**Y**
Minnesota[3] ╪	Medicaid for Children	6/12 (12)	**Y**
╪	Medicaid for Parents	6/12 (12)	**Y**
╪	Expanded Medicaid for Parents	12	**Y**
Mississippi	Medicaid for Children	12	
	Separate SCHIP	12	
	Medicaid for Parents	12	
Missouri	Medicaid for Children	12	**Y**
	Separate SCHIP	12	**Y**
	Medicaid for Parents	12	**Y**
	Expanded Medicaid for Parents	12	**Y**
Montana	Medicaid for Children	12	**Y**
	Separate SCHIP	12	**Y**
	Medicaid for Parents	12	**Y**
Nebraska[8]	Medicaid for Children	6	**Y**
	Medicaid for Parents	6 (3)	**Y**
Nevada[2]	Medicaid for Children	12	**Y**
	Separate SCHIP	12	**Y**
	Medicaid for Parents	12	**Y**
New Hampshire	Medicaid for Children	12	**Y**
	Separate SCHIP	12	**Y**
	Medicaid for Parents	6	**Y**

		Program	Frequency┼ (months)	No Face-to-Face Interview
New Jersey		Medicaid for Children	12	**Y**
		Separate SCHIP	12	**Y**
		Medicaid for Parents	12	**Y**
		Expanded Medicaid for Parents	12	**Y**
New Mexico[2/9]		Medicaid for Children	12	**Y**
		Medicaid for Parents	12	**Y**
		Expanded Medicaid for Parents	12	**Y**
New York		Medicaid for Children	12	**Y**
		Separate SCHIP	12	**Y**
		Medicaid for Parents	12	**Y**
		Expanded Medicaid for Parents	12	**Y**
North Carolina		Medicaid for Children	12	**Y**
		Separate SCHIP	12	**Y**
		Medicaid for Parents	6	**Y**
North Dakota[10]		Medicaid for Children	12 (1)	**Y**
		Separate SCHIP	12	**Y**
		Medicaid for Parents	12 (1)	**Y**
Ohio		Medicaid for Children	12	**Y**
		Medicaid for Parents	6	**Y**
Oklahoma[2]		Medicaid for Children	12	**Y**
		Medicaid for Parents	12	**Y**
		Expanded Medicaid for Parents	12	**Y**
Oregon[11]		Medicaid for Children	6	**Y**
	✣	Separate SCHIP	12	**Y**
		Medicaid for Parents	12	**Y**
		Expanded Medicaid for Parents	6	**Y**
Pennsylvania[12]		Medicaid for Children	6	**Y**
		Separate SCHIP	12	**Y**
		Medicaid for Parents	6	**Y**
		Expanded Coverage for Parents	12	**Y**
Rhode Island		Medicaid for Children	12	**Y**
		Medicaid for Parents	12	**Y**
		Expanded Medicaid for Parents	12	**Y**
South Carolina		Medicaid for Children	12	**Y**
		Medicaid for Parents	12	**Y**
South Dakota		Medicaid for Children	12	**Y**
		Separate SCHIP	12	**Y**
		Medicaid for Parents	12	**Y**
Tennessee[13]		Medicaid for Children	12	
	✣	Separate SCHIP	12	**Y**
		Medicaid for Parents	12	
Texas[14]		Medicaid for Children	6	**Y**
	✣	Separate SCHIP	12	**Y**
		Medicaid for Parents	6	**Y**
Utah[2/15]		Medicaid for Children	12	**Y**
		Separate SCHIP	12	**Y**
		Medicaid for Parents	4-12	**Y**
		Expanded Medicaid for Parents	12	**Y**
Vermont		Medicaid for Children	12	**Y**
		Separate SCHIP	12	**Y**
	✣	Medicaid for Parents	12	**Y**
	✣	Expanded Medicaid for Parents	12	**Y**
Virginia		Medicaid for Children	12	**Y**
		Separate SCHIP	12	**Y**
		Medicaid for Parents	12	**Y**

	Program	Frequency┼ (months)	No Face-to-Face Interview
Washington[16]	Medicaid for Children	12	**Y**
	Separate SCHIP	12	**Y**
	Medicaid for Parents	6	**Y**
	Expanded Coverage for Parents	12	**Y**
West Virginia	Medicaid for Children	12	**Y**
	Separate SCHIP	12	**Y**
	Medicaid for Parents	12	
Wisconsin	Medicaid for Children	12	**Y**
	Medicaid for Parents	12	**Y**
	Expanded Medicaid for Parents	12	**Y**
Wyoming	Medicaid for Children	12	**Y**
	Separate SCHIP	12	**Y**
	Medicaid for Parents	12	**Y**

SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, 2008. See notes on following page.

Notes for Table 9

+ Indicates that a state has simplified one or more of its procedures for parents between July 2006 and July 2007, unless noted otherwise.
– Indicates that a state has rescinded one or more simplified procedures for parents between July 2006 and July 2007, unless noted otherwise.

* "Aligned Medicaid for Children and Separate SCHIP" indicates the number of states that have adopted a particular renewal simplification strategy and have applied the procedure to both their children's Medicaid and their SCHIP-funded separate program. States that have used SCHIP funds to expand Medicaid exclusively are considered "aligned" if the simplified procedure applies to children in the "regular" Medicaid program and the SCHIP-funded Medicaid expansion program. "Regular" Medicaid refers to coverage under Medicaid eligibility standards for children in place prior to SCHIP; states receive "regular" Medicaid matching payments as opposed to enhanced SCHIP matching payments for these children.

** "Total Medicaid for Parents" indicates the number of states that have adopted a particular renewal simplification strategy and have applied the procedure to both pre-expansion Medicaid for parents and expanded coverage for parents, if the state has expanded coverage for parents. All 50 states and the District of Columbia operate a Medicaid program for parents. Fifteen states and the District of Columbia have expanded Medicaid coverage for parents up to 100 percent of the federal poverty line or higher.

† This column shows the frequency of renewals. If monthly, quarterly or semi-annual income reporting is also required, this frequency is noted in parentheses. Some states require change reporting, which is not addressed in this table. If the frequency of renewal is every 12 months, as opposed to six months or more frequently, the procedure is considered "simplified" for the purposes of this table.

Table presents rules in effect as of July 2007, unless noted otherwise.

1. In **Arizona**, a face-to-face or telephone interview is required in Medicaid.

2. In these states, "Expanded Medicaid for Parents" refers to coverage established through waivers. The coverage offered generally provides fewer benefits and has higher cost-sharing than allowed in Medicaid.

3. In **Arkansas** and **Minnesota**, renewal procedures differ for families with children enrolled in Medicaid, depending on whether they are eligible under "regular" Medicaid or under Section 1115 waivers or SCHIP-funded Medicaid expansions. In **Arkansas**, children who qualify under expansion rules receive 12 months of continuous eligibility, as opposed to a 12-month renewal period in "regular" Medicaid. In **Minnesota**, individuals who qualify under the state's Section 1115 expansion program have eligibility reviewed every 12 months. In the "regular" Medicaid program, income reviews are required every 6 months and eligibility reviews are required annually.

4. In **California**, parents must submit a status report at six month intervals when a full eligibility review is not required. A full eligibility review is done annually.

5. In **Florida**, parents who are enrolled in Medicaid, and who do not receive other benefits such as food stamps or TANF, have a 12 month renewal period. Parents that submit applications that don't appear to be prone to error or fraud, known as "green track" applications, are not required to do an interview.

6. In **Indiana**, county offices may require telephone interviews but not face-to-face interviews.

7. In **Iowa**, the face-to-face interview requirement was eliminated in August 2007.

8. In **Nebraska**, parents enrolled in Medicaid must report their income every three months. A full review of eligibility is done every six months. A telephone interview is required at the six month review.

9. Under **New Mexico's** waiver program, families receive a notice instructing them to call to receive a new application, which is used as a renewal form.

10. In **North Dakota**, children and parents enrolled in Medicaid must report their income monthly. A full review of eligibility is done annually.

11. In **Oregon**, interviews are not required of families receiving Section 1931 Medicaid. The renewal period for families covered under Section 1931 is "up to 12 months" though most families not receiving other benefits have a six-month eligibility period.

12. In **Pennsylvania**, expanded coverage for parents is state-funded.

13. In **Tennessee**, a face-to-face or telephone interview is required at renewal in Medicaid.

14. In **Texas**, children covered under SCHIP get 12 months of continuous coverage beginning in September 2007. The state will conduct administrative renewal for children in families with income between 185 and 200 percent of the federal poverty line at 6 months to determine whether income has exceeded 200 percent of the federal poverty line.

15. In **Utah**, renewal periods for parent coverage vary from four months to 12 months, based on the stability of their income. More frequent renewals are required if income fluctuates.

16. In **Washington**, expanded coverage for parents is state-funded. Under this coverage, eligibility is reviewed every 12 months if the family's income information can be verified through data matches with the Employment Security Department. If income information can not be verified through a data match, eligibility must be reviewed at least twice a year.

Table 10A
Premium Payments for Two Children in a Family of Three at Selected Income Levels[1]
January 2008

	Increase or decrease[2]	Frequency of payment	Income Level at which State begins Requiring Premiums (FPL)	Amount at 101% of the Federal Poverty Line ($17,342)	Amount at 151% of the Federal Poverty Line ($25,927)	Amount at 200% of the Federal Poverty Line ($34,340)
Total	7 - Increase 7 - Decrease	34	N/A	10	26	29
Alabama		Annually	101	$100	$200	$200
Alaska		None	—	—	—	—
Arizona		Monthly	101	$15	$30	$35
Arkansas		None	—	—	—	—
California[3]	Decrease	Monthly	101	$8/$14	$12/$18	$12/$18
Colorado		Annually	151	$0	$35	$35
Connecticut		Monthly	235 ($50)	$0	$0	$0
Delaware		Monthly	101	$10	$15	$25
Dist. of Columbia		None	—	—	—	—
Florida		Monthly	101	$15	$20	$20
Georgia[4]		Monthly	101	$15	$40	$56
Hawaii[5]	Decrease	None	—	—	—	—
Idaho[6]		Monthly	134	$0	$30	N/A
* **Illinois**		Monthly	151	$0	$25	$25
* **Indiana**		Monthly	150	$0	$33	$50
Iowa		Monthly	151	$0	$20	$20
Kansas		Monthly	151	$0	$20	$30
Kentucky		Monthly	151	$0	$20	$20
* **Louisiana**		None	—	—	—	—
Maine		Monthly	151	$0	$16	$64
Maryland[1]	Increase	Monthly	201 ($45)	$0	$0	$0
Massachusetts[1]	Decrease	Monthly	150	$0	$24	$24
Michigan	Increase	Monthly	151	$0	$10	$10
Minnesota[1/7]	Increase	Monthly	All waiver families	$8	$63	$122
Mississippi		None	—	—	—	—
Missouri[1]	Increase	Monthly	150	$0	$20	$66
Montana		None	—	—	N/A	N/A
Nebraska		None	—	—	—	N/A
Nevada[8]		Quarterly	101	$15	$35	$70
New Hampshire		Monthly	186	$0	$0	$50
New Jersey	Increase	Monthly	150	$0	$18.50	$18.50
New Mexico		None	—	—	—	—
* **New York**		Monthly	160	$0	$0	$18
* **North Carolina**		Annually	151	$0	$100	$100
North Dakota		None	—	—	N/A	N/A
* **Ohio**		None	—	—	—	—
* **Oklahoma**		None	—	—	—	N/A
Oregon		None	—	—	—	N/A
Pennsylvania[9]	Decrease	Monthly	201 ($77.24)	$0	$0	$0
Rhode Island[1]		Monthly	150	$0	$61	$77
South Carolina		None	—	—	N/A	N/A
South Dakota		None	—	—	—	—
Tennessee[1]		Monthly	101	$40	$70	$250
Texas	Decrease	Annually	150	$0	$35	$50
Utah	Increase	Quarterly	101	$30	$60	$60
Vermont[1]	Decrease	Monthly	186	$0	$0	$15
Virginia		None	—	—	—	—
Washington		Monthly	201 ($30)	$0	$0	$0
* **West Virginia**[10]	Increase	Monthly	200	$0	$0	$71
* ***Wisconsin***[1/11]	Decrease	Monthly	151	$0	$75	$125
Wyoming		None	—	—	—	—

SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, 2008. See notes on following page.

Notes for Table 10A

***** Several states have passed legislation to use SCHIP funds to expand their children's health coverage programs to children in families with income up to 300 percent of the federal poverty line or higher. These states are noted with an asterisk (*). Information about the premiums associated with these expansions can be found in Table 1A.

Table presents rules in effect as of July 2007, unless noted otherwise.

1. States in *italics* require the premiums noted in their children's Medicaid programs. **Massachusetts** requires premiums in children's Medicaid (children under six are exempt) and SCHIP. The figures noted for **Minnesota** are for two persons, which could include a parent. The figures noted for **Rhode Island** and **Wisconsin** also may include coverage for parents. **Vermont** requires premiums in children's Medicaid and its separate SCHIP program. All other states require premiums in their separate SCHIP programs only. A dash (—) indicates that no premiums are required in the program; $0 indicates that no premium is required at this income level; "N/A" indicates that coverage is not available at this income level.

2. "Increase" indicates that the state has increased premiums or lowered the income level at which premiums are required. "Decrease" indicates that the state has decreased premiums or raised the income level at which premiums are required.

3. In **California**, premiums vary based on whether the family uses the discounted community provider health plan. The first amount noted is the premium required under the community provider health plan. **California** removed the requirement that families must pay the first month's premium when they submit their application for children's heath coverage. In addition, in the past, children were denied coverage if the family did not pick a health plan when the application was submitted. The state now has a default enrollment procedure.

4. In **Georgia**, premiums are required only of families with children age six and older.

5. **Hawaii** eliminated the premium requirement for children with income between 250 and 300 percent of the federal poverty line in January 2008.

6. In **Idaho**, families with children covered under the state's new "enhanced" plan are not required to pay premiums.

7. In **Minnesota**, the premiums noted apply only to children covered under the Section 1115 waiver program and are approximate.

8. In **Nevada**, although Medicaid covers children in families with income up to 100 or 133 percent of the federal poverty line (depending on age), some children with incomes below this level may qualify instead for SCHIP based on the source of income and family composition. Such families with income of 36 percent of the federal poverty line or higher are required to pay premiums.

9. In **Pennsylvania**, the premium varies by health plan. The amount noted is an average of the monthly premiums required by the various health plans.

10. In **West Virginia**, the premiums noted apply only to children in families with income between 200 and 220 percent of the federal poverty line.

11. In **Wisconsin**, the income level at which premiums are required will be raised under the state's February 2008 expansion. The required premium amounts will also be lower under this expansion. This information can be found on Table IA.

Table 10B
Effective Annual Premium Payments for Two Children in a Family of Three at Selected Income Levels[1]
January 2008

	Effective Annual Amount at 101% of the Federal Poverty Line ($17,342)	Effective Annual Amount at 151% of the Federal Poverty Line ($25,927)	Effective Annual Amount at 200% of the Federal Poverty Line ($34,340)	Lock-out Period
Total	10	26	29	12
Alabama	$100	$200	$200	
Alaska	—	—	—	
Arizona	$180	$360	$420	
Arkansas	—	—	—	
California[2]	$96/$168	$144/$216	$144/$216	
Colorado	$0	$35	$35	
Connecticut	$0	$0	$0	3 months
Delaware	$120	$180	$300	
Dist. of Columbia	—	—	—	
Florida	$180	$240	$240	60 days
Georgia[3]	$180	$480	$672	1month
Hawaii	—	—	—	
Idaho[4]	$0	$360	N/A	
Illinois	$0	$300	$300	3 months
Indiana	$0	$396	$600	
Iowa	$0	$240	$240	
Kansas	$0	$240	$360	
Kentucky	$0	$240	$240	
Louisiana	—	—	—	
Maine	$0	$192	$768	1 months
Maryland	$0	$0	$0	
Massachusetts[1]	$0	$288	$288	
Michigan	$0	$120	$120	
Minnesota[1/5]	$96	$756	$1,464	4 months
Mississippi	—	—	—	
Missouri[1]	$0	$240	$792	6 months
Montana	—	N/A	N/A	
Nebraska	—	—	N/A	
Nevada	$60	$140	$280	
New Hampshire	$0	$0	$600	3 months
New Jersey	$0	$222	$222	
New Mexico	—	—	—	
New York	$0	$0	$216	
North Carolina	$0	$100	$100	
North Dakota	—	N/A	N/A	
Ohio	—	—	—	
Oklahoma	—	—	N/A	
Oregon	—	—	N/A	
Pennsylvania	$0	$0	$0	
Rhode Island[1]	$0	$732	$924	4 months
South Carolina	—	N/A	N/A	
South Dakota	—	—	—	
Tennessee[1]	$480	$840	$3,000	
Texas	$0	$35	$50	
Utah	$120	$240	$240	
Vermont[1]	$0	$0	$180	
Virginia	—	—	—	
Washington	$0	$0	$0	4 months
West Virginia[6]	$0	$0	$852	6 months
Wisconsin[1/7]	$0	$900	$1500	6 months
Wyoming	—	—	—	

SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, 2008. See notes on following page.

Notes for Table 10B

Table presents rules in effect as of July 2007, unless otherwise noted.

1. States in *italics* require the premiums noted in their children's Medicaid programs. **Massachusetts** requires premiums in children's Medicaid (children under six are exempt) and SCHIP. The figures noted for **Minnesota** are for two persons, which could include a parent. The figures noted for **Rhode Island** and **Wisconsin** also may include coverage for parents. **Vermont** requires premiums in children's Medicaid and its separate SCHIP program. All other states require premiums in their separate SCHIP programs only. A dash (—) indicates that no premiums are required in the program; $0 indicates that no premium is required at this income level; "N/A" indicates that coverage is not available at this income level.

2. In **California**, premiums vary based on whether the family uses the discounted community provider health plan. The first amount noted is the premium required under the community provider health plan.

3. In **Georgia**, premiums are only required of families with children age six and older.

4. In **Idaho**, families with children covered under the state's new "enhanced" plan are not required to pay premiums.

5. In **Minnesota**, premiums apply only to children covered under the Section 1115 waiver program. The figures noted are approximate.

6. In **West Virginia**, the premiums noted apply only to children covered with income between 200 and 220 percent of the federal poverty line.

7. In **Wisconsin**, recipients may have income up to 200 percent of the federal poverty line.

Table 11
Co-payments for Specific Services in Children's Health Coverage Programs at Selected Income Levels[1]
January 2008

	Family Income is 151% of the Federal Poverty Line			Family Income is 200% of the Federal Poverty Line		
	Non-preventive Physician Visit	Emergency Room Visit	Inpatient Hospital Visit	Non-preventive Physician Visit	Emergency Room Visit	Inpatient Hospital Visit
Total	16	13	9	18	14	9
Alabama[2/3]	$5	$15	$10	$5	$15	$10
Alaska[2]	$0	$0	$0	N/A	N/A	N/A
Arizona	$0	$0	$0	$0	$0	$0
Arkansas[2]	$10	$10	20% of the reimbursement rate for first day	$10	$10	20% of the reimbursement rate for first day
California[4]	$5	$5	$0	$5	$5	$0
Colorado	$5	$15	$0	$5	$15	$0
Connecticut[3/4]	$0	$0	$0	$5	$0	$0
Delaware[3]	$0	$0	$0	$0	$0	$0
District of Columbia	$0	$0	$0	$0	$0	$0
Florida[3/5]	$5	$0	$0	$5	$0	$0
Georgia	$0	$0	$0	$0	$0	$0
Hawaii	$0	$0	$0	$0	$0	$0
Idaho[3]	$0	$0	$0	N/A	N/A	N/A
Illinois[3]	$5	$5	$5	$5	$5	$5
Indiana	$0	$0	$0	$0	$0	$0
Iowa[3]	$0	$0	$0	$0	$0	$0
Kansas	$0	$0	$0	$0	$0	$0
Kentucky[2/3]	$0	$0	$0	$0	$0	$0
Louisiana	$0	$0	$0	$0	$0	$0
Maine	$0	$0	$0	$0	$0	$0
Maryland	$0	$0	$0	$0	$0	$0
Massachusetts	$0	$0	$0	$0	$0	$0
Michigan	$0	$0	$0	$0	$0	$0
Minnesota	$0	$0	$0	$0	$0	$0
Mississippi	$5	$15	$0	$5	$15	$0
Missouri	$0	$0	$0	$0	$0	$0
Montana I	$3	$5	$25	N/A	N/A	N/A
Nebraska	$0	$0	$0	N/A	N/A	N/A
Nevada	$0	$0	$0	$0	$0	$0
New Hampshire[4]	$0	$0	$0	$10	$50	$0
New Jersey	$5	$10	$0	$5	$35	$0
New Mexico	$0	$0	$0	$5	$15	$25
New York	$0	$0	$0	$0	$0	$0
North Carolina[3]	$5	$0	$0	$5	$0	$0
North Dakota	N/A	N/A	N/A	N/A	N/A	N/A
Ohio	$0	$0	$0	$0	$0	$0
Oklahoma[4]	$0	$0	$0	N/A	N/A	N/A
Oregon	$0	$0	$0	N/A	N/A	N/A
Pennsylvania	$0	$0	$0	$0	$0	$0
Rhode Island	$0	$0	$0	$0	$0	$0
South Carolina[6]	N/A	N/A	N/A	N/A	N/A	N/A
South Dakota	$0	$0	$0	$0	$0	$0
Tennessee[4/7]	$5/$5	$25/$5	$100/$5	$10/$15	$50/$50	$100/$100
Texas	$7	$50	$50	$10	$50	$100
Utah I	$20	$75	10% of daily reimbursement rate	$20	$75	10% of daily reimbursement rate
Vermont	$0	$0	$0	$0	$0	$0
Virginia[3]	$5	$0	$25	$5	$0	$25
Washington	$0	$0	$0	$0	$0	$0
West Virginia[4/8]	$15	$35	$25	$15	$35	$25
Wisconsin[9]	$0	$0	$0	$0	$0	$0
Wyoming	$5	$5	$0	$5	$5	$0

SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, 2008. See notes on following page.

Notes for Table 11

D Indicates that a state has decreased the co-payment for one or more services between July 2006 and July 2007, unless noted otherwise.
I Indicates that a state has increased the co-payment for one or more services between July 2006 and July 2007, unless noted otherwise.

Table presents rules in effect as of July 2007, unless otherwise noted.

"N/A" indicates that the state does not provide coverage at this income level.

1. States in *italics* require these co-payments in their children's Medicaid programs. With the exception of **Kentucky**, all of these states obtained federal waivers to impose cost-sharing in children's Medicaid. **Kentucky** used the flexibility in the Deficit Reduction Act of 2005 to impose cost-sharing in its SCHIP-funded Medicaid expansion. **Kentucky** also requires cost-sharing in its separate SCHIP program. All other states charge these co-payments in their separate SCHIP programs only. Per federal law, no state can impose co-payments on Alaska Native or American Indian children.

2. Some states require 18-year-olds to meet the co-payment requirements of adults on Medicaid. In **Alabama**, 18-year-olds are subject to the $1 non-preventive physician visit co-payment as well as the $50 co-payment for inpatient care. In **Alaska**, 18-year-olds are subject to the co-payment of $50 a day for the first four days of inpatient care as well as the $3 co-payment for non-preventive physician visits. In **Arkansas**, 18- year-olds are subject to the co-payment of 10 percent of the cost of the first day of inpatient care. In **Kentucky**, 18-year-olds are subject to the $2 co-payment for non-preventive physician visits, the 5 percent co-payment for non-emergency use of the emergency room and the $50 co-payment for inpatient care.

3. In these states, the co-payment for emergency room use in non-emergency situations is higher than noted in the table. This co-payment applies to all children covered under the state's SCHIP-funded Medicaid expansion and separate SCHIP program. The co-payment amounts for emergency room use in non-emergency situations are as follows: in **Alabama**, $20; in **Connecticut**, $25; in **Delaware** and **Florida**, $10; in **Idaho**, $3; in **Illinois**, $2 for families with income between 133 and 150 percent of the federal poverty line and $25 for families with income above 150 percent of the federal poverty line; in **Iowa**, $25 for families with income above 150 percent of the federal poverty line; in **Kentucky**, a five percent co-insurance is required; in **North Carolina**, $20 for families with income above 150 percent of the federal poverty line; in **Virginia**, $25.

4. In **California**, **Connecticut**, **New Hampshire**, **Oklahoma, Tennessee**, **West Virginia** and **Wyoming**, the co-payment for emergency room use is waived if the child is admitted to the hospital. In **California**, no coverage is provided if the services received are not for an emergency condition.

5. In **Florida**, co-payments apply only to children age five and older.

6. In **South Carolina**, infants are eligible up to 185 percent of the federal poverty line; however, no co-payments are required of this coverage group.

7. In **Tennessee** co-payments are required in the state's waiver program, which is closed to new applicants and the separate SCHIP program. The first amount noted is the premium required under the state's waiver program and the second is for the separate SCHIP program.

8. In **West Virginia**, the co-payments for non-preventive physician visits are waived if the child goes to his or her medical home.

9. **Wisconsin** will require co-payments for the non-preventive physician visits and inpatient hospital visits under its February 2008 expansion. Families with income above 150 percent of the federal poverty line will be required to pay a co-pay for non-preventive physician visits, which will range from $0.50- $3.00 depending on the cost of the services provided. The co-payment required for inpatient hospital stays will be $3.00.

Table 12
Co-payments for Specific Services in Health Coverage Programs for Parents
January 2008

	Cost-sharing Applies for Parents in a Family of 3 at or Below the following Monthly Income Limits	Inpatient Hospital (Per admission unless otherwise noted)	Emergency Room Visit [1]
Total	N/A	26	9
Alabama[1]	$366	$50	$0
Alaska	$1,444	$50 per day for first four days	$0
Arizona[1]	$2,862	$0	$0
Arkansas[2]	$255/$2,862	10 percent of reimbursement rate for first day/15 percent co-insurance	$0
California	$1,521	$0	$0
Colorado	$949	$10	$0
Connecticut	$2,737	$0	$0
Delaware	$1,521	$0	$0
District of Columbia	$2,962	$0	$0
Florida[1]	$806	$3	$0
Georgia	$756	$12.50	$0
Hawaii	$1,646	$0	$0
Idaho	$595	$0	$0
Illinois[1/3]	$2,737	$3 per day/$2 or $5	$0/$0 or $5
Indiana[1/2]	$378/$2862	$0	$0
Iowa[2]	$1,268/$3,557	$0	$0
Kansas	$493	$48	$0
Kentucky[1]	$909	$50	$0
Louisiana	$280	$0	$0
Maine	$2,952	$3 per day	$0
Maryland	$524	$0	$0
Massachusetts	$1,903	$3	$0
Michigan	$871	$0	$0
Minnesota[1]	$3,936	$0	$0
Mississippi	$458	$10	$0
Missouri[1]	$556	$10	$0
Montana[1]	$855	$100	$0
Nebraska	$851	$0	$0
Nevada	$1,341	$0	$0
New Hampshire	$781	$0	$0
New Jersey[4]	$1,904	$0	$0/$35
New Mexico[2/5]	$903/$5,848	$0/$0, $25 or $30	$0/$0, $15 or $20
New York	$2,146	$25 per discharge	$3
North Carolina	$750	$3 per day	$0
North Dakota[1]	$904	$75	$0
Ohio[1]	$1,288	$0	$0
Oklahoma[2/6]	$711/$2,862	$3 per day/$50	$0/$30
Oregon	$1,431	$0	$0
Pennsylvania[1/2/7]	$842/$2,862	$3 per day (maximum of $21)/$0	$0/$25
Rhode Island	$2,737	$0	$0
South Carolina[1]	$1,430	$25	$0
South Dakota[1]	$796	$50	$0
Tennessee	$1,143	$0	$0
Texas	$402	$0	$0
Utah[1/2]	$673/$2,146	$220/no coverage	$0/$30
Vermont	$2,737	$75/$0	$0/$25
Virginia	$438	$100	$0
Washington[2/8]	$1,092/$2,862	$0/20 percent coinsurance	$0/$100
West Virginia	$499	$0	$0
Wisconsin[9]	$2,737	$0	$0
Wyoming[1]	$790	$0	$0

SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, 2008. See notes on following page.

Notes for Table 12

D Indicates that a state has decreased the co-payment for one or more services between July 2006 and July 2007, unless noted otherwise.
I Indicates that a state has increased the co-payment for one or more services between July 2006 and July 2007, unless noted otherwise.

Table presents rules in effect as of July 2007, unless otherwise noted.

1. In these states, the co-payment for emergency room use in non-emergency situations is higher than noted in this table. **Alabama**, **Missouri, Ohio** and **South Carolina** require a $3 co-payment for this service. **Arizona** requires a $1 co-payment for this service. In **Florida**, there is a co-insurance of 5 percent up to the first $300 of cost (maximum co-insurance is $15) for this service. In some cases, this co-payment is for outpatient hospital care. In **Illinois**, a co-payment is required for parents with income above 133 percent of the federal poverty line. The co-payment is $2 or $25, depending on income. In **Indiana**, the co-payment varies based on whether or not the individual is covered under the Primary Care Case Management system. If covered under PCCM, the co-payment is $1 or $2. If not covered under PCCM, the co-payment is $3. In **Kentucky**, the co-payment is five percent of the cost. **Minnesota** requires a $6 co-payment for this service for parents covered under "regular" Medicaid and its waiver program. **Montana** requires a $5 co-payment for this service. **North Dakota** requires a $6 co-payment for this service. In **Pennsylvania**, the co-payment for this service under "regular" Medicaid is $.50 to $3.00 depending on the cost of the visit. In **South Dakota**, the co-payment for this service is five percent of the allowable Medicaid reimbursement up to a maximum of $50. **Utah** requires a $6 co-payment for this service for parents covered under "regular" Medicaid. **Wyoming** requires a co-payment of $6 for this service.

2. With the exception of **Pennsylvania** and **Washington**, when two income thresholds are noted, the first is for "regular" Medicaid programs that provide comprehensive coverage that meets federal Medicaid guidelines and the second refers to coverage established through waivers. In Pennsylvania and Washington, the second threshold noted refers to coverage available to parents under a state-funded program.

3. In **Illinois**, the second amounts noted, which vary by income, are the co-payments required of parents with income above 133 percent of the federal poverty line.

4. In **New Jersey**, parents with income above 150 percent of the federal poverty line are required to pay a co-payment of $35 for emergency room visits.

5. In **New Mexico**, the co-payments required in the state's waiver program vary by income and the co-payment for emergency room use is waived if the person is admitted to the hospital.

6. In **Oklahoma**, co-payment for emergency room care is waived if the patient is admitted to the hospital.

7. In **Pennsylvania**, the co-payment for emergency room use under the state-funded program is waived if the parent is admitted.

8. In **Washington's** state-funded program, the co-payment for emergency room care is waived if the patient is admitted to the hospital. If the patient is not admitted to the hospital, a $100 co-payment applies. If the patient is admitted, whether or not it is through the emergency room, they are subject to a 20 percent co-insurance after a $150 annual deductible is met. The maximum facility charge per admittance for inpatient care is $300.

9. **Wisconsin** will require co-payments for the non-preventive physician visits and inpatient hospital visits under its February 2008 expansion. Families with income above 150 percent of the federal poverty line will be required to pay a co-pay for non-preventive physician visits which will range from $0.50- $3.00 depending on the cost of the services provided. The co-payment required for inpatient hospital stays will be $3.00.

Table 13
Co-payments for Prescriptions in Children's Health Coverage Programs[1]
January 2008

	Prescription Co-payment for Children
Total	21
Alabama[2/3]	$1.00 or $2.00 (generic) $3.00 or $5.00 (preferred brand name) $5.00 or $10.00 (non-preferred brand name)
Alaska[2]	$0
Arizona	$0
Arkansas[1/2/4]	$5.00
California	$5.00
Colorado[3]	$1.00 or $3.00 (generic) $1.00 or $5.00 (brand name)
Connecticut	$3.00 (generic) $6.00 (brand name and formularies)
Delaware	$0
District of Columbia	$0
Florida[5]	$5.00
Georgia	$0
Hawaii	$0
Idaho	$0
Illinois[3]	$2.00 or $3.00 (generic) $2.00 or $5.00 (brand name)
Indiana	$3.00 (generic) $10.00 (brand name)
Iowa	$0
Kansas	$0
Kentucky[1/2]	$1.00 (generic), $2.00 (preferred brand name), $3.00 (non-preferred brand name)
Louisiana	$0
Maine	$0
Maryland[1]	$0
Massachusetts	$0
Michigan	$0
Minnesota	$0
Mississippi	$0
Missouri[1]	$0
Montana	$3.00 (generic) $5.00 (brand name)
Nebraska	$0
Nevada	$0
New Hampshire[6]	$5.00 (generic) $15.00 (formulary brand name) $25 (non- formulary brand name)
New Jersey[3]	$1.00 or $5.00 (generic) $5.00 or $10.00 (brand name)
New Mexico[1/7]	$2.00
New York	$0
North Carolina[3]	$1.00 (generic) $3.00 or $10.00 (brand name)
North Dakota	$2.00
Ohio	$0
Oklahoma	$0
Oregon	$0
Pennsylvania[8]	$0
Rhode Island	$0
South Carolina	$0
South Dakota	$0
Tennessee[1/3]	$3.00/$1.00 or $5.00 (generic) $3.00 or $20.00 (preferred brand name) $5.00 or $40.00 (non-preferred brand name)
Texas[3]	$0 or $5.00 (generic) $3.00, $5.00 or $20.00 (brand name)
Utah[3/9]	$1.00-$3.00 or $5.00 or $10 (generic) $1.00-3.00 or $5.00 or 25% (brand name) 5% or 50% (non-preferred)
Vermont	$0
Virginia[3]	$2.00 or $5.00
Washington	$0
West Virginia[3]	$0 (generic) $5.00 or $10.00 (brand name) $5.00 or $15.00 (preferred)
Wisconsin[2]	$0
Wyoming	$3.00 (generic) $5.00 (brand name)

SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, 2008. See notes on following page.

Notes for Table 13

D Indicates that a state has decreased the co-payment for prescriptions between July 2006 and July 2007, unless noted otherwise.
I Indicates that a state has increased the co-payment for prescriptions between July 2006 and July 2007, unless noted otherwise.

Table presents rules in effect as of July 2007, unless otherwise noted.

1. States in *italics* require these co-payments in their children's Medicaid programs. With the exception of **Kentucky**, all of these states obtained federal waivers to impose cost-sharing in children's Medicaid. **Kentucky** used the flexibility in the Deficit Reduction Act of 2005 to impose cost-sharing in its SCHIP-funded Medicaid expansion. **Kentucky** also requires cost-sharing in its separate SCHIP program. All other states charge these co-payments in their separate SCHIP programs only. Per federal law, no state can impose co-payments on Alaska Native or American Indian children.

2. In **Alabama** and **Arkansas**, 18-year-olds are subject to the $.50 to $3 Medicaid co-payment for adults. In **Alask**a, 18-year-olds are subject to the $2 Medicaid co-payment for adults. In **Kentucky**, 18-year-olds are subject to the $1, $2 or 5 percent co-payment for adults. In **Wisconsin**, 18-year-olds covered under the waiver program who are not in managed care are subject to $1 or $3 co-payments for adults. Under its expansion planned for February 2008, children under 18 years old with income above 100 percent of the federal poverty line are subject to a $1, $3 or $5 co-payment.

3. In **Alabama**, **Colorado**, **Illinois, New Jersey, North Carolina, Tennessee, Texas, Utah, Virginia,** and **West Virginia**, the co-payment amounts for children depend on the family's income:

- In **Alabama**, families with children with income up to 150 percent of the federal poverty line pay $1 for generic prescriptions, $3 for preferred brand name prescriptions and $5 for non-preferred brand name prescriptions. Families with income above 150 percent pay $2 for generic prescriptions, $5 for preferred brand name prescriptions and $10 for non-preferred brand name prescriptions.
- In **Colorado**, families with children with income between 101 and 150 percent of the federal poverty line are subject to a $1 co-payment for all prescriptions. Families with income above 150 percent of the federal poverty line pay $3 for generic prescriptions and $5 for brand name prescriptions.
- In **Illinois**, families with children with income up to 150 percent of the federal poverty line pay $2 for all prescriptions. Families with income above 150 percent pay $3 for generic prescriptions and $5 for brand name prescriptions.
- In **New Jersey**, families with children with income between 150 and 200 percent of the federal poverty line pay $1 for generic prescriptions and $5 for brand name prescriptions. Families with income above 200 percent of the federal poverty line pay $5 for generic and brand name prescriptions and $10 for prescriptions for more than a 34 day supply of medication.
- In **North Carolina**, families with children with income up to 150 percent of the federal poverty line pay $1 for generic prescriptions and brand name prescriptions for which no generic version is available and $3 for brand name prescriptions. Families with income above 150 percent pay $1 for generic prescriptions and brand name prescriptions for which no generic version is available and $10 for brand name prescriptions.
- In **Tennessee**, families with children in the separate SCHIP program with income up to 150 percent of the federal poverty line pay $1 for generic, $3 for preferred brand name and $5 non-preferred brand name. Families with children with income above 150 percent of the federal poverty line pay $5 for generic, $20 for preferred brand name and $40 for non-preferred brand name.
- In **Texas**, families with children with income at or below 100 percent of the federal poverty line pay $3 for brand name prescriptions. Families with income between 101 and 150 percent of the federal poverty line pay $5 for brand name prescriptions. Families with income between 151 and 200 percent of the federal poverty line pay $5 for generic prescriptions and $20 for brand name prescriptions.
- In **Utah**, families with children with income up to 100 percent of the federal poverty line pay $1 for prescriptions under $50 and $3 for prescriptions over $50 for generic and brand name prescriptions and 5 percent of the cost for non-preferred prescriptions. Families with children with income between 101 and 150 percent of the federal poverty line pay $5 for generic and brand name prescriptions and 5 percent of the cost for non-preferred prescriptions. Families with income above 150 percent of the federal poverty line pay $10 for generic prescriptions and 25 percent of the cost for brand name prescriptions and 50 percent of the cost non-preferred prescriptions.
- In **Virginia**, families with children with income up to 150 percent of the federal poverty line pay $2 for prescriptions. Families with income above 150 percent of the federal poverty line pay $5 per prescription.
- In **West Virginia**, families with children with income below 150 percent of the federal poverty line pay $0 for generic prescriptions and $5 for brand name or preferred prescriptions. Families with income above 150 percent of the federal poverty line pay $0 for generic prescriptions, $10 for brand name prescriptions and $15 for preferred prescriptions.

4. In **Arkansas**, the co-payment noted only applies to children covered under the state's Section 1115 expansion component. In **Tennessee**, the co-payments noted are required of children covered under the state's Section 1115 expansion component and the separate SCHIP program.

5. In **Florida**, co-payments apply only to children age five and older.

6. In **New Hampshire**, brand name prescriptions for children are $5 if no generic version is available.

7. In **New Mexico**, the co-payment applies only to children in families with income above 185 percent of the federal poverty line.

8. In **Pennsylvania**, co-payments are required for families with children with income above 200 percent of the federal poverty line. The co-payments are $9 for brand name prescriptions and $6 for generic prescriptions.

9. In **Utah**, the co-payment structure changed. As a result, at some income levels there was an increase in the required co-payment amounts.

Table 14
Co-payments for Prescriptions in Health Coverage Programs for Parents
January 2008

	Prescription Co-payment for Parents
Total	40
Alabama	$.50-$3.00
Alaska	$2.00
Arizona	$0
Arkansas[1]	$.50 -$3.00/$5.00 (generic) $15.00 (brand name) $30 (non-formulary brand name)
California	$0
Colorado	$1.00 (generic) $3.00 (brand name)
Connecticut	$0
Delaware	$.50-$3.00
District of Columbia	$0
Florida	$0
Georgia	$.50
Hawaii	$0
Idaho	$0
Illinois[2]	$0 (generic) $3.00 (brand name)/$2.00 or $3.00 (generic) $2.00 or $5.00 (brand name)
Indiana	$3.00
Iowa[3]	$.50 - $3.00
Kansas	$3.00
Kentucky	$1.00 (generic) $2.00 (preferred brand name) 5 percent of cost (non-preferred brand name)
Louisiana	$.50-$3.00
Maine I	$3.00
Maryland	$0
Massachusetts	$1.00 (generic) $3.00 (brand name)
Michigan	$1.00
Minnesota[4]	$1.00 (generic) $3.00 (brand name)/$3.00
Mississippi	$3.00
Missouri	$.50-$2.00
Montana	$1.00-$5.00
Nebraska	$2.00
Nevada[5]	$0
New Hampshire	$1.00 (generic) $2.00 (brand name or compounded)
New Jersey[6]	$0/ $5.00, $10.00 (more than a 34 day supply)
New Mexico[1/7]	$0/$3.00 for first four prescriptions
New York[8]	$1.00 (generic) $3.00 (brand name)/$3.00 (generic) $6.00 (brand name)
North Carolina	$1.00 (generic) $3.00 (brand name)
North Dakota	$0 (generic) $3.00 (brand name)
Ohio	$2.00 for brand name prescriptions on preferred drug list $3.00 for brand name prescriptions not on preferred drug list
Oklahoma	$1.00-$2.00/$5.00-$10.00
Oregon	$0
Pennsylvania[9]	$1.00 (generic) $3.00 (brand name)
Rhode Island	$0
South Carolina	$3.00
South Dakota	$0 (generic) $3.00 (brand name)
Tennessee	$0 (generic) $3.00 (brand name)
Texas	$0
Utah[1]	$3.00/$5.00 (generic and brand name on preferred list) 25 percent of cost (not on preferred list)
Vermont	$1.00-$3.00
Virginia	$1.00 (generic) $3.00 (brand)
Washington[1]	$0/$10.00 (generic) 50 percent of cost (brand name)
West Virginia	$.50-$3.00
Wisconsin[10]	$0/$1.00 (generic) $3.00 (brand name)
Wyoming	$1.00 (generic) $2.00 (preferred brand name) $3 (non-preferred brand name)

SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, 2008. See notes on following page.

Notes for Table 14

D Indicates that a state has decreased the co-payment for prescriptions between July 2006 and July 2007, unless noted otherwise.
I Indicates that a state has increased the co-payment for prescriptions between July 2006 and July 2007, unless noted otherwise.

Table presents rules in effect as of July 2007, unless noted otherwise.

1. In these states, when two amounts are noted, the first is for "regular" Medicaid programs that provide comprehensive coverage that meets federal Medicaid guidelines and the second refers to coverage established through waivers, or in the case of **Washington**, state-funded coverage.

2. In **Illinois**, the first amount shown in the table applies to parents with income below 133 percent of the federal poverty line. The second amounts noted, which vary by income, are the co-payments required of parents with higher incomes.

3. In **Iowa**, the prescription co-payment noted in the table applies to “regular” Medicaid only. There is no prescription coverage in the state's waiver program.

4. In **Minnesota**, the second amount noted is the co-payment required in the state's expansion program for parents.

5. In **Nevada**, the amounts noted apply to parents covered under “regular” Medicaid. Parents enrolled in the waiver coverage are subject to the co-payments required by their employer-sponsored plan.

6. In **New Jersey**, the second amounts noted are the co-payments required in the state's expansion program for parents.

7. Under **New Mexico's** waiver program, co-payments are only required for the first four prescriptions each month.

8. In **New York**, the second amounts noted are the co-payments required in the state's expansion program for parents.

9. In **Pennsylvania**, the prescription co-payment noted in the table applies to “regular” Medicaid only. There is no prescription coverage in the state-funded program.

10. In **Wisconsin**, the co-payments currently only applies to parents covered under the state’s expansion coverage who are not in managed care with incomes at or above 150 percent of the federal poverty line. Under its expansion planned for February 2008, the co-payment will only apply to parents with income at or above 150 percent of the federal poverty line.

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