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Resuming the Path to Health Coverage for Children and Parents:

A 50 State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2006

Prepared by
Donna Cohen Ross and Laura Cox
Center on Budget and Policy Priorities
and
Caryn Marks
Kaiser Commission on Medicaid and the Uninsured

January 2007

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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Acknowledgments

The authors would like to express our appreciation to Barbara Lyons and Robin Rudowitz of the Kaiser Commission on Medicaid and the Uninsured for the guidance and technical assistance they provided throughout this project. Victoria Wachino of Wachino Health Policy Consulting and Jocelyn Guyer of the Center on Children and Families at the Georgetown University Health Policy Institute reviewed sections of this report and provided helpful suggestions, as well. Thanks also to our colleagues at the Center on Budget and Policy Priorities for their support and guidance: Andy Schneider, Edwin Park, Leighton Ku, Judy Solomon, Melanie Nathanson, Matthew Broaddus, John Springer and Elizabeth McNichol. This report would not have been possible without the cooperation and the seemingly endless patience of the many state Medicaid and SCHIP officials and health advocates with whom we conferred over the course of many months. We are deeply grateful for their willingness to work with us and we recognize their important contribution in the lives of children and families.

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Executive Summary

Providing health coverage for low-income, uninsured children and parents continues to challenge the nation. This challenge becomes ever more pressing as health care costs remain on the rise and employer-sponsored insurance becomes less available and less affordable. Over the past decade, Medicaid and the State Children's Health Insurance Program (SCHIP) have successfully provided the health coverage that millions of children and parents rely upon when they cannot afford insurance on their own. These programs have worked effectively because state and federal financing has supported coverage expansions and because states have made policy choices that have significantly simplified enrollment and renewal procedures, thereby increasing access to coverage.

With states in generally better financial shape than they have been since the fiscal crisis of 2001, many are exhibiting renewed enthusiasm for moving forward. Several states have announced fundamental coverage expansions and a significant number have allocated funds to reactivate outreach activities. A pressing issue is whether the federal government's decisions will help advance such efforts or place obstacles in their way.

Many states appear ready to resume their efforts to reduce the number of uninsured people, particularly children — the path they were pursuing in the late 1990s. These efforts got somewhat off-track when states experienced fiscal pressure between 2001 and 2004. During that period, some states reduced income eligibility in their health programs and others retracted simplified procedures. As a result, enrollment suffered substantial declines in some states. A number of states have now restored simplified procedures, which has helped enrollment recover, and others are undertaking major children's coverage expansions that build on the success of Medicaid and SCHIP.

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 in effect in the 50 states and District of Columbia in July 2006. It is the sixth in a series of annual surveys conducted by the Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured.

Between July 2005 and July 2006, one-third of the states made efforts to cover more of their uninsured residents. A few states broke new ground by setting in motion plans to provide health coverage for all children. States continued to adopt proven strategies to simplify enrollment and renewal, and to reinstate simplified procedures that were retracted when their budgets were tight. However, a new federal law, the Deficit Reduction Act (DRA) of 2005, requires U.S. citizens applying for Medicaid or seeking to renew their Medicaid coverage to present proof of their citizenship and identity. This new federal requirement restricts state flexibility to establish simple and efficient procedures and appears to be compromising efforts to cover eligible individuals.

The survey found that:

One-third of states (17) increased access to health coverage. *Hawaii, Illinois* and *Massachusetts* initiated significant expansions to cover children, while a number of other states undertook more incremental expansions for children, parents, and pregnant women. Some states also removed or mitigated paperwork, procedural, or financial barriers to health coverage. Two of these states, *Connecticut* and *New Mexico,* restored (fully or in part) previous simplification initiatives they had retracted due to state budget pressures.

For the first time in four years, no state cut income eligibility in Medicaid or SCHIP. Some states, however, restricted eligibility by imposing asset tests (*South Carolina)* or "waiting periods" during which children must be uninsured before they can apply for coverage *(Florida*). *Utah* reinstated its SCHIP freeze, making it the only state in 2006 to do so.

A sharp disparity persists between the income levels at which parents and children qualify for health coverage programs. In 35 states, family income must be below the federal poverty line for a parent to qualify for coverage; in 14 states, parents with income of *half* the federal poverty line — just $692 per month for a family of three — earn too much to qualify for Medicaid. In contrast, most states cover children whose family income is up to 200 percent of the poverty line or higher. In addition, it remains harder for eligible parents than eligible children to secure and retain coverage. Numerous studies show that expanding parents' coverage not only reduces the number of uninsured parents, but also increases enrollment by eligible children.

A new federal law (the Deficit Reduction Act of 2005) requires U.S. citizens to present proof of their citizenship and identity when they apply for or seek to renew their Medicaid coverage, which could undercut the progress states have made on increasing access to health coverage for eligible individuals. Families now have to submit more documentation, rather than less and they must present original documents which are likely to take time and money to obtain. Although states are using a variety of approaches available to them to lessen the burden on eligible families, since the new rule was implemented in July 2006, a growing number of states are reporting enrollment declines and large backlogs of applications that are not being processed in a timely manner because they are incomplete or because eligibility workers need to spend more time on each case.

Several states raised premiums for children's health coverage or targeted them to lower-income families, although these changes were less substantial than in recent years. *Idaho, Indiana, Maryland, Minnesota, New Jersey* and *Pennsylvania* took at least one of these steps. Although *Indiana* doubled its premium and *Idaho* targets premiums to families with lower incomes than in the past, most premium increases were modest. Research has shown that premiums depress participation in Medicaid. *Connecticut* and *Missouri* went in the opposite direction, lowering premiums for children's coverage.

Federal law now gives states new options for imposing cost-sharing on Medicaid beneficiaries, however, only Kentucky applied this new authority to children in 2006. Under the Deficit Reduction Act of 2005, for the first time, states can require cost-sharing for some children in Medicaid, and beneficiaries with income above the federal poverty line can be denied care if they cannot afford to pay the co-payment. *Kentucky* was the only state to use the new option to impose co-payments on some children. (Kentucky also imposed co-payments in its SCHIP program.)

Looking forward, federal policies will significantly influence the progress states will be able to make. As Congress prepares to reauthorize SCHIP in 2007, the level of federal funding allocated will be critical to ensuring that children who are now enrolled do not lose coverage and that states can cover additional children in the future. Sustaining Medicaid also will be of the utmost importance, since most children eligible for publicly financed health coverage are covered by Medicaid. The new Medicaid citizenship documentation requirement appears to be undercutting the

simplified enrollment and renewal systems states have built over the past decade. A growing number of states are reporting enrollment declines and large backlogs of applications since the requirement took effect in July 2006.

Over the past decade, Medicaid and SCHIP have helped offset the erosion of employer-based coverage and significantly reduced the share of low-income children who are uninsured. This progress has been fueled by state and federal investments in health coverage and by efforts to design simple enrollment and renewal procedures. As increased emphasis is placed on extending coverage to the many children who are eligible but not enrolled, both state and federal investments in extending coverage and continued efforts to design simple enrollment and renewal procedures that are family-friendly are clearly critical to further progress.

I. Introduction

Providing health coverage for low-income, uninsured children and parents continues to challenge the nation. This challenge becomes ever more pressing as health care costs remain on the rise and employer-sponsored insurance becomes less available and less affordable. Over the past decade, Medicaid and the State Children's Health Insurance Program (SCHIP) have stepped up to the job, successfully providing the health coverage that millions of children and parents rely upon when they cannot afford insurance on their own. For children, the gains in Medicaid and SCHIP coverage have outpaced the gradual erosion of employer-sponsored coverage, so the percentage of low-income children who are uninsured declined significantly — by one-third – between 1997 and 2004. That trend reversed in 2005 when the loss of employer sponsored coverage was not fully offset and the uninsured rate increased for children for the first time since 1998. Although Medicaid enrollment has also helped stem the loss of coverage for low-income parents who have lost employer-sponsored insurance, eligibility is more limited compared to children, so the number of uninsured adults has increased steadily over this period.[1] For both children and parents, the increase in the number of uninsured would have been greater had it not been for the critical role of Medicaid and SCHIP.

These trends add urgency to discussions on bolstering coverage of uninsured children and families. Medicaid and SCHIP have worked effectively because state and federal financing has been available to support coverage expansions, and because states have made a host of affirmative policy choices that have significantly simplified enrollment and renewal procedures. Experience and research have shown that both expanding income eligibility and simplifying procedures are key to reducing the number of uninsured people, and that increasing eligibility by itself is not enough.[2]

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 in effect in the 50 states and District of Columbia in July 2006. It is the sixth in a series of annual surveys conducted by the Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured. These surveys have tracked the shifts in policies and procedures that influence the ability of Medicaid and SCHIP to accomplish the job they are charged with: ensuring that eligible people get the health coverage they need.

During the course of this survey a new federal law became effective which significantly restricts state flexibility to adopt simplified procedures. This new law, the Deficit Reduction Act (DRA) of 2005, requires U.S. citizens applying for Medicaid or seeking to renew their Medicaid coverage to present proof of their citizenship and identity. By mandating that applicants and beneficiaries provide such documentation, this change runs counter to the longstanding trend toward removing barriers to health coverage and has the potential to undermine the progress states have made on streamlining their programs. As a result, the new law stands to impede access to health coverage for eligible children and parents. While the timing of the current survey did not allow for systematic collection of the procedures states are using to implement the Medicaid citizenship documentation requirement, a set of follow-up questions posed to state officials shed light on the ways in which the new rule is complicating the enrollment process. Early evidence that the rule is having an adverse effect on enrollment is also presented in this report.

The nation has seen nearly ten years of progress on covering low-income, uninsured children and, with states in better financial shape generally than they have been since the fiscal crisis of 2001, many are exhibiting renewed enthusiasm for moving forward.[3] Several states have announced fundamental coverage expansions and a significant number have allocated funds to reactivate outreach activities. The question is how changes at the federal level will affect the goal of covering children who remain uninsured. As Congress prepares to reauthorize SCHIP in 2007, the level of federal funding allocated will be critical to ensuring that children who are now enrolled do not lose coverage and that states can cover additional children in the future. Sustaining Medicaid also will be of the utmost importance, since most children eligible for publicly financed health coverage are covered by Medicaid. As states are developing strategies to insure more children, a key component will be whether they continue to have at their disposal the tools necessary to establish simple and effective enrollment and renewal procedures.

II. Key Survey Findings

Between July 2005 and July 2006, one-third of the states made efforts to cover more of their uninsured residents. A few states broke new ground by setting in motion plans to provide health coverage for all children. States continued to adopt proven strategies to simplify enrollment and renewal, and to reinstate simplified procedures they had retracted when their budgets were tight. However, a new federal requirement — under which U.S. citizens must present proof of their citizenship and identity when they apply for or renew their Medicaid coverage — restricts state flexibility to establish simple and efficient procedures and appears to be undermining efforts to cover eligible children and others. (For a summary of the number of states that have adopted various options on eligibility, enrollment and renewal procedures, and cost-sharing rules, see Table A).

The survey found that:

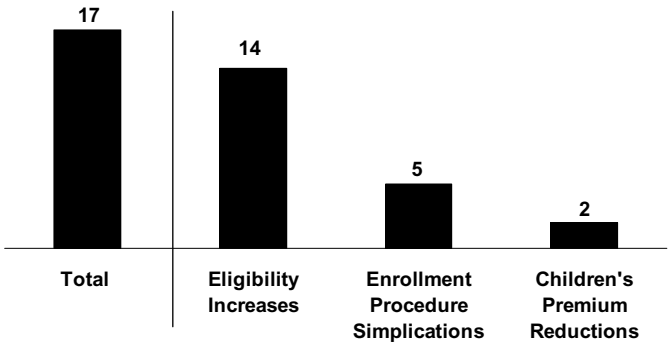
One-third of states (17) took steps to increase access to health coverage (Figure 1). A few states *(Hawaii, Illinois and Massachusetts)* initiated significant expansions to cover children. Other expansions were more incremental *(California, Colorado, Maine, Nevada, New Jersey, New Mexico, Texas, Virginia and West Virginia)*, featuring modest increases in income eligibility for parents, provisions making it easier for young children in working families to qualify for Medicaid and coverage of pregnant women under SCHIP. *Idaho* eliminated its asset test used in determining children's eligibility for Medicaid and SCHIP. *Montana* increased its asset limit, making it easier for children in families with assets to qualify for Medicaid, and also reduced (from three months to one month) the amount of time a child is required to be uninsured before he or she can apply for SCHIP.

Some states removed or mitigated paperwork, procedural or financial barriers. For example, *Texas* eliminated its face-to-face interview requirement for parents; *Connecticut* no longer requires families to produce documentation of their income and conducts electronic verification; and *Colorado* allows families to renew their children's Medicaid or SCHIP coverage using a single form. Efforts to improve retention occurred in *New Mexico*, where the frequency for renewing children's coverage was reduced, and in *Florida*, where children in the state's SCHIP program are now guaranteed 12 months of coverage regardless of changes in their family's income or other circumstances. The changes in *Connecticut* and *New Mexico* were full or partial restorations of previous policies that had been retracted due to state budget pressures. These restorations show that a significant

development first identified in last year's survey is continuing. States that restore simplifications can expect enrollment to recover from declines sustained when the simplified procedures were withdrawn. *Connecticut* and *Missouri* made minor reductions to premiums for children in SCHIP, somewhat alleviating the financial obstacle to coverage.

Figure 1

One-Third of States Expanded Access to Medicaid and SCHIP, July 2005-2006



SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for KCMU, 2006.

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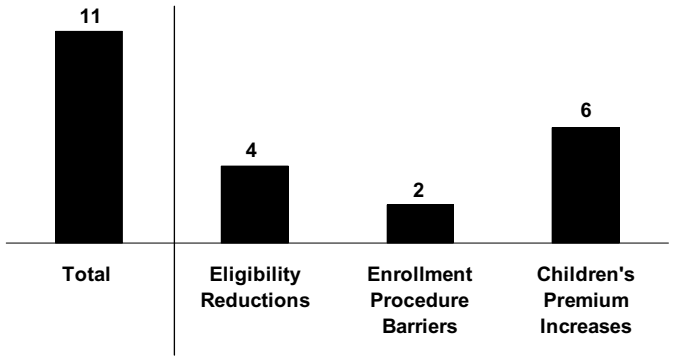
For the first time in four years, no state cut income eligibility in Medicaid or SCHIP. Although some states took steps to reduce access to health coverage, in general, changes to their programs were less severe than in prior years (Figure 2). Although all states preserved *income eligibility* in their health coverage programs, some states restricted eligibility by imposing less overt barriers to enrollment. For example: they established asset tests (*South Carolina)*; switched children from Medicaid to SCHIP where they are subject to premiums (*Idaho)*, and initiated "waiting periods" during which children must be uninsured before they can apply for coverage *(Florida*). Maintaining income limits conveys the message that health coverage remains available, however other measures to restrict eligibility have the same consequences as explicit reductions in income eligibility: Children and parents remain uninsured and are subject to health risks and financial hardship. In contrast to actions that reduce eligibility, enrollment freezes bar access to coverage for people who qualify. Parent enrollment has been frozen in Medicaid waiver programs in Oregon and Utah for the past few years (and some children in Tennessee have been subject to a freeze under the state's Medicaid waiver.) This year, *Utah* reinstated its SCHIP freeze, making it the only state in 2006 to do so. Six states increased premiums for children *(Idaho, Indiana, Maryland, Minnesota, New Jersey and Pennsylvania)*; in Idaho and Indiana these changes were substantial. *Georgia* and *Montana* imposed procedural barriers that make it more difficult to enroll or renew coverage.

Figure 2

Restrictive State Policy Decisions in Medicaid and SCHIP, July 2005-2006



SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for KCMU, 2006.

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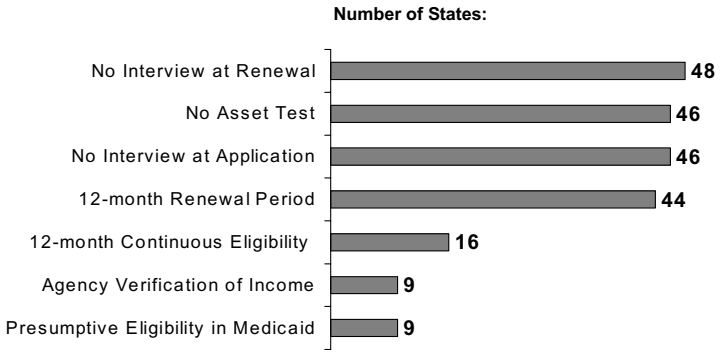
With respect to enrollment and renewal procedures for children, most states do not require face-to-face interviews at application or at renewal. In addition, most states allow families to renew coverage for their children every 12 months, although they must report changes in income and other family circumstances that occur in the interim. Just less than one-third of the states provide children 12-month continuous eligibility, which guarantees a full year of coverage regardless of changes in the family situation. While many states have reduced the amount of income documentation families are required to submit with their child's health coverage application, only nine (9) states require no income documentation and verify the family's statements about their income using available state databases. Only nine (9) states have adopted the option to allow certain qualified entities (health care providers, schools, Head Start programs, WIC agencies, etc.) to conduct presumptive eligibility determinations, allowing children to be temporarily enrolled in coverage if they appear eligible and enabling them to obtain health services while the family completes the eligibility process (Figure 3).

Figure 3

Simplifying Enrollment and Renewal: Strategies States are Using in Children's Health Coverage Programs, July 2006



SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for KCMU, 2006.

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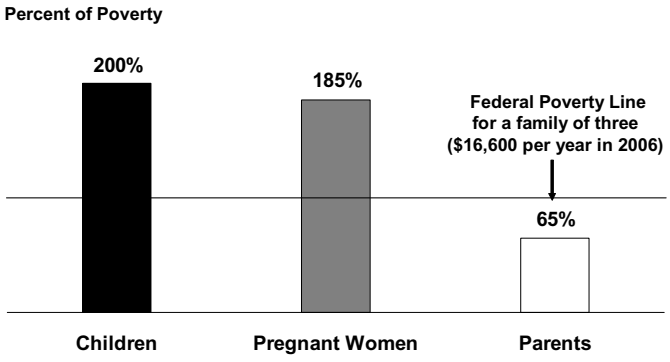
A sharp disparity persists between the income levels at which parents and children qualify for health coverage programs (Figure 4)**. In addition, it remains more difficult for an eligible parent to secure and retain coverage.** Most states maintain income eligibility for children at 200 percent of the federal poverty line or higher, and a growing number of states have expanded to 300 percent of the federal poverty line (Figure 5). In addition, most states maintain income eligibility for pregnant women at 185 percent of the federal poverty line or higher (Figure 6). But, in 35 states family income must be below 100 percent of the federal poverty line for a parent to qualify for coverage; in 14 states, working parents with income at half the federal poverty line — just $692 for a family of three — earn too much to qualify for Medicaid. And, in nearly half the states (24 states), a parent in a family of three, working full time at the federal minimum wage earning $893 per month, cannot qualify (Figure 7 and 8).

Figure 4

Median Medicaid/SCHIP Income Eligibility Threshold for Children, Pregnant Women, and Working Parents, July 2006



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, 2006.

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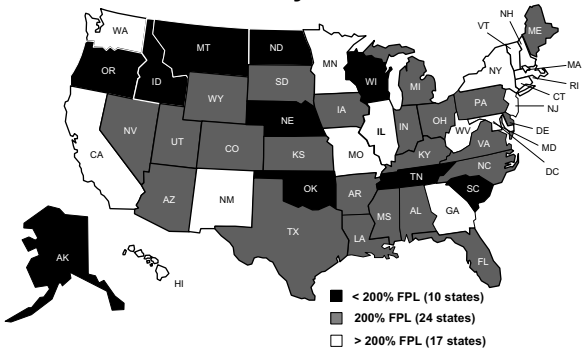
Figure 5

Children's Eligibility for Medicaid/SCHIP by Income, July 2006



*The Federal Poverty Line (FPL) for a family of three in 2006 is $16,600 per year.
SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for KCMU, 2006.

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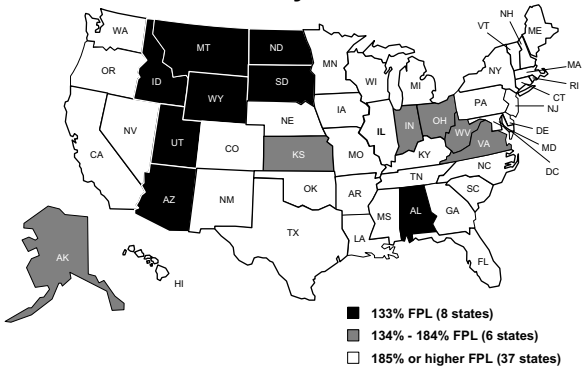
Figure 6

Medicaid Eligibility for Pregnant Women by Income, July 2006



*The Federal Poverty Line (FPL) for a family of three in 2006 is $16,600 per year.
SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for KCMU, 2006.

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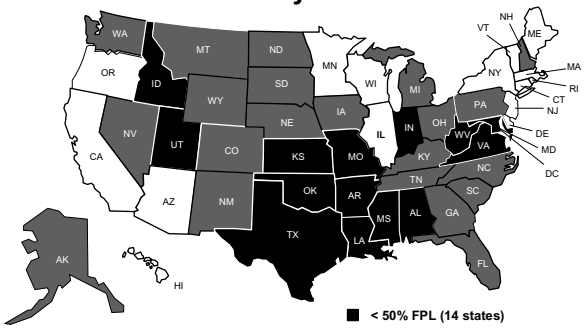
Figure 7

Medicaid Eligibility for Working Parents by Income, July 2006



US Median Eligibility = 65% FPL: $10,849 per year

■ < 50% FPL (14 states)
■ 50% - 99% FPL (21 states)
□ 100% or higher FPL (16 states)

*The Federal Poverty Line (FPL) for a family of three in 2006 is $16,600 per year.
SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for KCMU, 2006.

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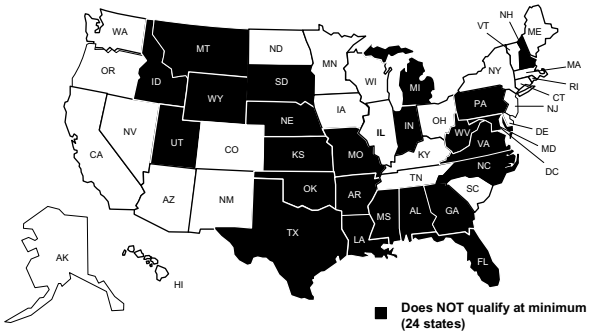
Figure 8

Medicaid Eligibility for Working Parents by Federal Minimum Wage, July 2006



■ Does NOT qualify at minimum wage (24 states)
□ Qualifies at minimum wage (27 states)

*A parent in a family of three working full time at federal minimum wage earns $893 per month
SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for KCMU, 2006.

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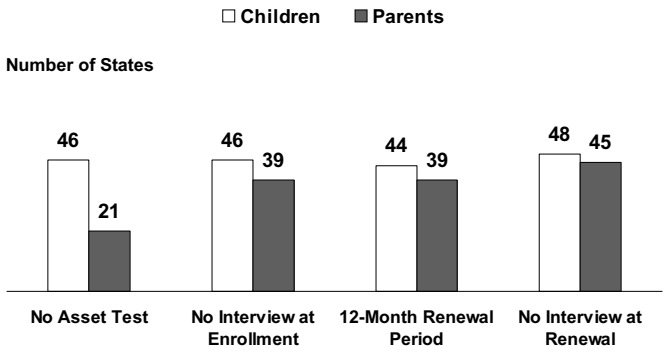
Unlike the previous two years, no state cut parent eligibility during the survey period. A few states *(Colorado, Maine and New Jersey)* expanded parent income eligibility modestly. Others have initiatives to cover parents, but they fall short of what is needed to bring parent coverage in line with the coverage available for their children. For example, states such as Iowa, New Mexico, Oklahoma, and Utah are offering programs to parents under waivers, but they have featured reduced benefit packages, high cost sharing and, in some cases, enrollment is frozen.

During the survey period, *Connecticut, New Mexico* and *Texas* adopted simplified procedures in their parent coverage programs. Despite these improvements, the number of states that have adopted simplifications in their parent coverage programs still lags behind the number that have done so for children. For example, more than twice as many states have eliminated the asset test in their children's coverage programs than have done so in their parent coverage programs (Figure 9).

Figure 9

States Have Not Simplified Health Coverage for Parents to the Extent They Have for Children, July 2006



SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for KCMU, 2006.

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In addition to reducing the number of low-income parents who are uninsured and improving their access to health care, expanding coverage for parents has additional advantages: An extensive body of research demonstrates that covering low-income parents in programs such as Medicaid and SCHIP increases enrollment by eligible children.[4] For example, one study found that public insurance (Medicaid or SCHIP) participation rates among eligible children were about 20 percentage points higher in states that had raised the Medicaid income limit for parents above the state's welfare income limit than in states that had not done so.[5] Another found that parent expansions led the percentage of eligible children who enroll in Medicaid to rise by 5.3 percentage points and caused the percentage of children who are uninsured to fall by 4.1 percentage points.[6] A California study compared insured children whose parents were *uninsured* to insured children whose parents were *insured* and found that children with uninsured parents were more likely to experience breaks in their insurance coverage, while children whose parents were insured were more likely to have continuous coverage.[7] In addition, when their parents are insured, children gain better access to health care and improve their use of preventive health services.[8]

A new federal law (the Deficit Reduction Act of 2005) requires U.S. citizens to present proof of their citizenship and identity when they apply for or seek to renew their Medicaid coverage, which threatens to undermine the simplified systems states have built over the past decade to facilitate enrollment and renewal of eligible individuals. Nearly all states have designed mail-in enrollment and renewal systems and many have made significant efforts to reduce verification requirements in their Medicaid programs. The Centers for Medicare and Medicaid Services (CMS) has encouraged states to pursue such efforts and has explained that such techniques do not jeopardize program integrity.[9] The new Medicaid citizenship documentation law, however, could undercut the progress states have made on increasing access to health coverage by creating procedural and financial barriers. Families now have to submit more documentation, rather than less and they must present original documents which are likely to take time and money to obtain. The new requirement could discourage working families from applying since they may now need to make a trip to a Medicaid office rather than use mail-in or on-line systems.

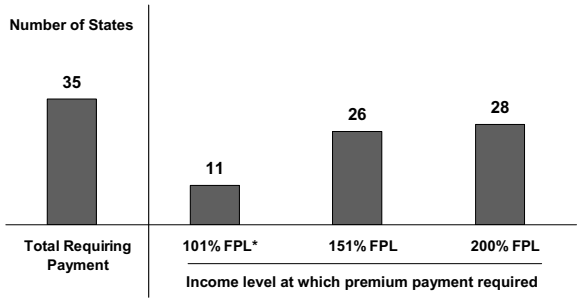
States are using a variety of approaches available to them to try to lessen the burden of the new requirement on applicants, beneficiaries and eligibility workers. For example, they are conducting data matches with state Vital Records agencies to obtain birth certificates for people born in the state, rather than requiring families to produce certified paper documents. Such strategies are helpful, but imperfect, and since the new rule was implemented in July 2006, a growing number of states are reporting enrollment declines and large backlogs of applications that are not being processed in a timely manner because they are incomplete or because eligibility workers need to spend more time on each case.

Premiums for children's health coverage have increased or are targeted to lower income families than in the past; however, in general these premium increases were less substantial than in prior years (Figures 10 and 11). During the survey period, *Idaho, Indiana, Maryland, Minnesota, New Jersey* and *Pennsylvania* either increased existing premiums or lowered the income level at which they begin charging premiums for children's coverage. Most premium increases were modest, with the exception of *Indiana*, where the amount of the premium doubled. One state — *Idaho* — now targets premiums to families with lower incomes than in the past. Two

states —*Connecticut* and *Missouri* — reduced the amount of the premiums it charges for children's coverage. *Connecticut* now charges premiums for children in families with income above 235 percent of the federal poverty line, as opposed to 185 percent of the federal poverty line. Studies from Maryland, Oregon, Rhode Island and Vermont have illustrated that premiums reduce participation in Medicaid and make it harder for individuals to maintain stable and continuous enrollment.[10]

Figure 10

States with Premiums or Enrollment Fees in Children's Health Coverage Programs, July 2006



*The Federal Poverty Line (FPL) for a family of three in 2006 is $16,600 per year.
SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for KCMU, 2006.

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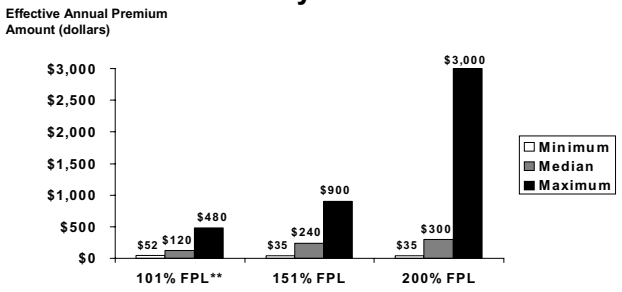
Figure 11

Range of Premiums Across States* for Two Children in a Family of Three, July 2006



*Includes the 35 states that require premium payments for children. The remaining 16 states (including DC) do not charge premiums for children's coverage. Some Medicaid waiver programs requiring premiums may include coverage for a parent.
**The Federal Poverty Line (FPL) for a family of three in 2006 is $16,600 per year.
SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for KCMU, 2006.

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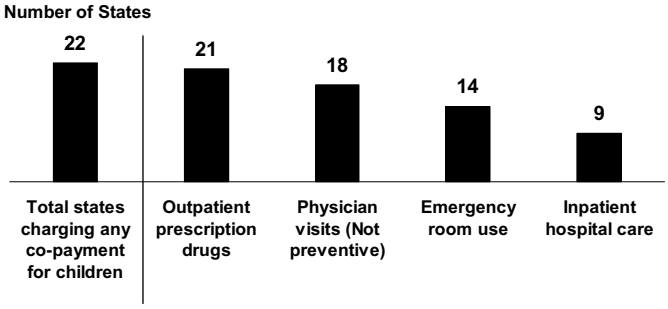
Federal law now gives states new options for imposing cost-sharing on Medicaid beneficiaries, however, only one state — Kentucky — applied this new authority to children in 2006 (Figure 12). Under the Deficit Reduction Act of 2005, for the first time, states can require cost-sharing for some children in Medicaid and beneficiaries with income above the federal poverty line can be denied care when they cannot afford to pay. During the survey period, *Kentucky* was the only state to use the new option to impose co-payments on some children. (In addition, Kentucky also imposed co-payments in its separate SCHIP program.)

Figure 12

States with Co-payments for Selected Services in Children's Health Coverage Programs, July 2006



*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, 2006.

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III. State Profiles Illustrate How Funding and Policy Choices Affect Progress on Children's Health Coverage

Developments at the state and federal levels in 2006 have set the stage for dramatic changes in publicly financed health insurance programs in the coming year and into the future, but whether those changes will push health coverage in a positive or negative direction is uncertain. Several factors are essential to promoting progress on covering more of the uninsured. Chief among them are a commitment to sustaining the successful financial partnership between the federal and state governments so that sufficient funding will be available to advance and strengthen Medicaid and SCHIP, and a continuation of efforts to improve access to the programs for eligible children and parents.

The state profiles presented below illustrate how choices on funding and on establishing simplified procedures have helped or hindered health coverage during 2006. On funding choices, the profiles include a discussion of the **Illinois** initiative to provide health coverage for all children and perspectives on the SCHIP enrollment freeze in **Utah**; With respect to activities related to administrative procedures, the profiles look at enrollment trends in **Connecticut** when simplified procedures were retracted and then reinstated, and a presentation of early evidence from **Iowa, Louisiana, New Hampshire, Virginia** and **Wisconsin** that the federal Medicaid citizenship documentation requirement is undermining simplification and outreach efforts — and having an adverse effect on enrollment.

Universal Coverage for Children in Illinois

In October 2005, Governor Blagojevich announced his vision for providing health coverage to the children of Illinois. Legislation was quickly introduced and approved, and *All Kids* was implemented on July 1, 2006. The program was built upon the state's existing Medicaid and SCHIP-funded health coverage program, KidCare. *All Kids* now covers children who would have previously qualified for KidCare, as well as children who did not qualify based on their immigration status. The *All Kids* initiative is funded with a mix of federal and state funds, as well as premiums and copayments paid by families of children in the expansion group, with income between 200 percent and 400 percent of the federal poverty line. In addition, families with incomes above 400 percent of the federal poverty line have the opportunity to purchase health coverage through *All Kids*.

In its first year, the state projects that it will spend $44 million in state funds and $37 million in federal funds (a total of $81 million) on the *All Kids* initiative. A substantial share of the first-year costs is expected to be offset by savings generated by implementing a disease management program in Medicaid and a primary care case management program, designed to assure that every family has a medical home where its primary care is coordinated, thereby reducing costs for services such as unnecessary emergency room visits and duplicated tests. With the savings realized through these two programs, as well as the premiums and copayments families pay, the state expects to fully cover the costs of *All Kids*.

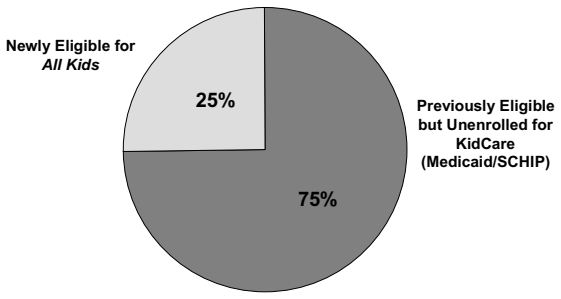
Since *All Kids* was unveiled, the state has been alerting the public to the new health coverage opportunity. The message that coverage is available for *all children* is proving to be a powerful one, and outreach efforts have attracted a substantial number of children who already qualified for existing programs, in addition to newly eligible children. The program has been heavily advertised in

the media, through a major Back-to-School campaign and a "Stand Up For *All Kids*" Faith Initiative in 100 cities. The same simple application and renewal procedures that have been integral to the success of KidCare are being used to enroll children in *All Kids*, and families will be able to find application assistance from trained, community-based *All Kids* Application Agents (AKAAs).

Even before *All Kids* officially opened, thousands of families preregistered their children. Between November 2005 and June 2006, when coverage was not yet available for newly eligible children, *All Kids* enrolled 50,471 children who were previously eligible for KidCare but not enrolled. Once *All Kids* began in July 2006, another 40,020 children were enrolled. In total, between November 2005 and November 2006, All Kids has enrolled 94,703 children: Three quarters of these children (71,171) were eligible for KidCare but not enrolled and 24,020 were newly eligible (Figure 13).[11] These figures underscore the vital role Medicaid and SCHIP play in efforts to ensure that all children have the health coverage they need. According to Anne Marie Murphy, Medicaid Director, reaching out to middle income families through the state's *All Kids* initiative has "significantly enhanced enrollment in both Medicaid and SCHIP... This is a clear case of "lifting all boats."

Figure 13

Increase in Children's Enrollment with Implementation of Illinois' *All Kids*



Increase in Total Enrollment November 2005 – November 2006: 94,703

SOURCE: Illinois Department of Healthcare and Family Services

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The Illinois' *All Kids* program has sparked what appears to be a new movement to provide universal health coverage for children. Either independently or inspired by the bold step in Illinois, a number of other states, including Massachusetts and Pennsylvania, also have embarked on their own brands of health coverage expansions. These states, like Illinois, will build on the foundation laid by Medicaid and SCHIP, using both state and federal funds to accomplish their goals.

Inadequate Investment of State Funds Triggers SCHIP Enrollment Freeze in Utah

In September 2006, Utah froze enrollment in its SCHIP program, making it the only state to do so this year. Enrollment freezes have been imposed on a recurring basis in Utah: Since the inception of the program in 1998, Utah's SCHIP program has been closed more than 40 percent of the time.[12] Unlike 17 other states that are facing a shortfall in federal SCHIP funding in federal fiscal year 2007, Utah has sufficient *federal* funds to sustain and even expand enrollment. However, the

state has closed enrollment because it capped the amount of *state* funds it allocates to the program, even though sufficient state resources appear to be available through the state's tobacco settlement fund, which supports the state's SCHIP program. Although there is a state budget surplus, the state does not use state general revenues to fund SCHIP. In 2005, the state legislature provided an additional $3.5 million, allowing the state to cover up to 40,000 children, but this is not sufficient to meet the needs of all children eligible for the program. Since Utah's federal matching rate for SCHIP is 79.1 percent, for every dollar the state spends on SCHIP the federal government contributes $3.78. Thus, by not investing more state funds in SCHIP, Utah is forgoing a significant amount of federal funding that could be used to cover more children.

Currently, no date is set for re-opening SCHIP enrollment, but the earliest new state dollars could be made available would be July 2007, if approved during the 2007 General Session of the legislature. That suggests that children who are currently eligible for SCHIP may have to go without health coverage at least until then. Because Utah does not maintain a waiting list of children who apply but cannot be enrolled, there is no way to tell precisely how many children are at risk.

Although Utah has made specific efforts to protect some children formerly eligible for Medicaid from being harmed by the SCHIP freeze, there is reason to be concerned that children in families that are turned away from the SCHIP application process during the freeze may not discover that their children are actually Medicaid-eligible and could be enrolled in Medicaid which is not frozen. In Utah, families may apply for SCHIP on-line via an electronic application, which normally is screened to assess whether the applicant can be enrolled in Medicaid. During periods when SCHIP enrollment is closed, families that log onto the website receive the following message: "CHIP enrollment is closed and we are not accepting applications at this time. Please check back often for updates on when the next open enrollment period will be held." A family that reads this message, and consequently cannot submit an application, loses an avenue for applying for Medicaid. The website does not advise families that they still can apply for Medicaid through their local health department or the Department of Workforce Services. During Utah's most recent open enrollment period, 42 percent of families applied using the on-line application.

During an enrollment freeze, children who are eligible for coverage are likely to remain uninsured. Studies reveal that being uninsured can have severe ramifications, and Utah families have experienced such situations. In 2003, parents of children in Utah who had been without coverage in the past year participated in a series of focus groups.[13] They described having serious difficulties during this period. Of the strategies to which parents had to resort, the most significant was that they "had to prioritize which [of their children] needed the most immediate care." They also said that as a result of not having health insurance they "skipped [children's] regular check-ups, preventative exams or immunizations," and "delayed seeking treatment." They also said that not having insurance "created financial hardships" and that they were "forced to make fundamental trade-offs, such as between food and medical expenses." The hardships described were similar to those confronting North Carolina families during the 2003 SCHIP freeze in that state.[14]

Governor Huntsman Recommends Funds for Utah's SCHIP Program

As this report goes to print, Governor Huntsman of Utah released his FY2008 Budget which includes a recommendation to provide an additional $4.2 million for children's health insurance, a move that would enable the state to reverse the freeze on SCHIP enrollment that closed the program in 2006. This is a significant development for two reasons: First, eligible children who have been denied access to SCHIP will now be able to obtain the health services they need. Secondly, the Governor's proposal would mark the first time the program would receive an ongoing allocation from the General Fund. According to children's health advocates, the amount of money in the proposed budget would cover an estimated 14,000 additional children and would allow enrollment to remain open for a considerable period of time. For this change to occur, the state legislature would have to approve these funds in a final appropriations bill.

Policy and Procedural Changes Cause Children's Enrollment in Connecticut to Fluctuate[15]

Under federal law, states have had the discretion to design and implement most enrollment and renewal procedures in Medicaid and SCHIP, and over the past ten years states have adopted an array of simplified procedures to encourage enrollment and retention of health coverage. During the economic downturn a few years ago, however, in response to severe budget pressures, several states retracted their simplified procedures as a way to curb spending. Such restrictions produced declines in enrollment, sometimes deeper than had been expected. Moreover, state officials recognized that, rather than barring access to Medicaid and SCHIP for *ineligible* people, burdensome procedures tend to restrict access to coverage for those who qualify. To prevent eligible children from losing health coverage, a number of states have reversed restrictive policies over the past two years.

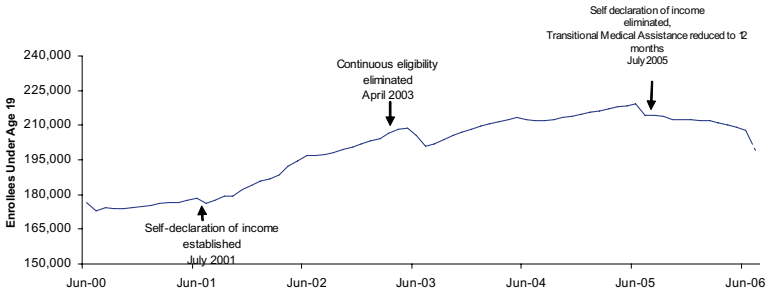
When Connecticut established HUSKY — its children's health coverage program — in 1998, it adopted a raft of federal options aimed at making it easy for families to enroll their children in either Medicaid (HUSKY A) or SCHIP (HUSKY B). These included a simple application, a guarantee of 12 months of coverage regardless of changes in family circumstances, and a state-funded outreach initiative. Later, Connecticut added other simplifications, such as "self-declaration of income," under which the state verifies a family's income electronically rather than by requiring the family to submit pay stubs or other documents, thereby reducing the paperwork burden and facilitating children's enrollment. The state also increased parent coverage to 150 percent of the federal poverty line, which boosted enrollment among children as well.[16] As a result of all these measures, enrollment of children climbed steadily during the first five years of the program.

When the economic downturn placed budget pressures on the state between 2001 and 2003, Connecticut held children's income eligibility steady, but made procedural changes that reduced children's enrollment: The state retracted the guarantee of 12-month continuous coverage, cut outreach efforts and reduced parent coverage. (In addition, financial barriers to coverage were erected and then — because a profound drop in enrollment was predicted — the premiums were either not enforced or removed: Between February 2004 and November 2005 premiums for some groups of children were raised, lowered, raised again, and then lowered again. While the potentially devastating effect on enrollment was averted, the on-again, off-again situation caused significant confusion.)[17] In 2005, the state did away with self-declaration (electronic verification) of income, and enrollment declined. The state also pared back parent coverage and then reduced, from 24

months to 12 months, the amount of time families could receive Transitional Medical Assistance when their earnings rise. As a result, enrollment of children dropped a precipitous 10,000 in July 2005 and then by an additional 15,000 in July 2006 (Figure 14).

Figure 14

Effect of Administrative Changes on Children's Enrollment in Connecticut's HUSKY A Program



SOURCE: Connecticut Department of Social Services

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To counteract some of this decline, Connecticut recently reconsidered some of its previous actions. It restored self-declaration of income and allocated $1 million to reactivate outreach efforts aimed, in part, at finding children who lost coverage when Transitional Medical Assistance ended for their parents. Advocates are pushing to reverse other cutbacks, such as the elimination of 12-month continuous coverage. While these restorations are meant to restore enrollment, the degree to which it will rebound will be influenced by any deterrent effect the new Medicaid citizenship documentation requirement may have.

This constantly shifting set of program rules has caused a roller-coaster effect on children's enrollment. One lesson is that changing administrative procedures frequently can be problematic if such changes send conflicting messages to prospective and current program participants, but the bottom line is that simplifying procedures can be a powerful strategy for facilitating progress on covering the uninsured. According to David Parella, Director of the Medical Care Administration for the Connecticut Department of Social Services, commitment and consistency matter. "It's as simple as keeping your eyes on the prize," he stated. "We say we want to cover all children, and once you've made that commitment … you want families to view the programs as easy to understand and easy to access … you want people to feel vested in the program and welcome. Otherwise you jeopardize confidence in the program and you drive people away."[18]

New Medicaid Citizenship Documentation Requirement Could Unravel Progress on Covering the Uninsured

States have long understood the tension between designing program procedures that facilitate enrollment and ensuring that only eligible individuals obtain access to health coverage programs. In the past, states have had the flexibility to balance these two goals as they deemed appropriate. The Deficit Reduction Act of 2005 now removes much of this discretion by significantly restricting states' ability to establish simplified procedures in their Medicaid programs. Under the new law, as of July 1, 2006, U.S. citizens applying for Medicaid or seeking to renew their Medicaid coverage (except Medicare beneficiaries, people receiving Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) and children in state foster care systems) are required to present proof of their citizenship and identity.* This law emerged from a concern that undocumented immigrants falsely claiming to be citizens were obtaining access to Medicaid. However, in response to a study of state practices conducted by the U.S. Department of Health and Human Services, Office of the Inspector General, then-CMS Administrator, Mark McClellan stated: "The report does not find particular problems regarding false allegations of citizenship, nor are we aware of any."[19] Prior to the new law, U.S. citizens in the vast majority of states were allowed to attest to their citizenship, under penalty of perjury, on the Medicaid application. Only four states — Georgia, Montana, New Hampshire and New York — required proof of citizenship and their rules were significantly easier to meet than the new federal requirement since a greater variety of documents were acceptable and photocopies, rather than originals or certified copies, were permitted.

In implementing the new requirement, states are having to establish procedures that run counter to what they have learned over time about successful strategies: The new requirement adds to, rather than lessens, the amount of documentation applicants and beneficiaries are required to produce and it undercuts the value of the mail-in application process — which almost all states have implemented — since families will be reluctant to part with birth certificates and other documents that have cost them time and money to obtain. This could be especially discouraging to working families and families in rural areas. The experiences of the states described below indicate that the requirement already is having a deterrent effect and other states may be encountering similar trends. In addition, the new requirement is likely to frustrate the efforts of states like Illinois, Massachusetts and Pennsylvania that are making concerted efforts to increase the number of children with health coverage.

Many states have been making efforts to reduce the burden of the new Medicaid Citizenship Documentation Requirement on children and families using an array of strategies available to them. A number of states have been conducting data matches with Vital Records agencies to obtain birth records for people born in the state; some have included with the Medicaid application an affidavit form parents can use to swear to the identity of their children under age 16, and others have deputized community-based application assistors to confirm they have viewed original documents. While helpful, these strategies are often imperfect. For example, states may not have the

* Just before the 109th Congress ended, it passed the Tax Relief and Health Care Act of 2006 (TRHCA), which included a clarification that citizens who are receiving Medicare, Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI), children for whom child welfare services are made available under Title IV-B and children who receive foster care and adoption assistance payments under Title IV-E are exempt from citizenship documentation requirements.

technological capacity to conduct effective Vital Records matches and there is no system for obtaining birth records for individuals born in another state.[20] Community-based groups may wish to assist people but may be dissuaded by the complicated rules or by the lack of funding to take on a more intensive role in application assistance. States such as Iowa, Louisiana, New Hampshire, Virginia and Wisconsin – all of which have made some effort to take the weight of the requirement off families with children – are reporting enrollment declines and processing backlogs; many states also are reporting that they are incurring significant new administrative costs.

- **Iowa —** Iowa has identified an unprecedented decline in Medicaid enrollment which state officials are attributing to the Medicaid citizenship documentation requirement. Prior to July 1, 2006, overall Medicaid enrollment had steadily increased for the past several years. While sporadic declines occurred in rural counties, no county in the state's larger population centers experienced a decline in the months leading up to the implementation of the new requirement. However, between July and September 2006, Medicaid enrollment sustained the largest decrease in the past five years; this also was the first time in five years that the state has experienced an enrollment decline for three consecutive months.

  Although other factors may be partially responsible for the recent decrease in enrollment, state officials point out the state is now experiencing a more severe effect on enrollment than it has following any of the Medicaid changes that have occurred over the past several years. The supposition that the citizenship documentation requirement is behind the decline is supported by the fact that enrollment has dropped among the populations subject to the requirement (children and families), but has remained steady among groups not affected by the requirement (individuals receiving Medicare and SSI). According to Anita Smith, Chief of the Bureau of Medical Supports for the Iowa Department of Human Services, "There is no evidence that the [enrollment] decline is due to undocumented aliens leaving the program. Rather, we believe that these new requirements are keeping otherwise eligible citizens from receiving Medicaid because they cannot provide the documents required to prove their citizenship or identity."[21]

- **Louisiana —** Louisiana is another state that has experienced marked declines in enrollment since implementing the Medicaid citizenship documentation requirement in July 2006. The state had always experienced a Back-to-School spike in net enrollment in prior years, with September increases of almost 13,000 for Medicaid and LaCHIP, the state's SCHIP-funded Medicaid expansion. In September 2006, however, despite the usual outreach effort and a sharp increase in applications, the state experienced a net decline in enrollment of 3,332 children. This decline continued, with enrollment declining another 4,231 in October, for a net loss of more than 7,500 children in just two months. According to Deputy Medicaid Director, Ruth Kennedy, these numbers are not driven primarily by the loss of population from New Orleans and other parishes affected by Hurricane Katrina. In addition, she stated: "We are quite confident that the overwhelming majority of these children are citizens – born right here in Louisiana – and not ineligible alien children."

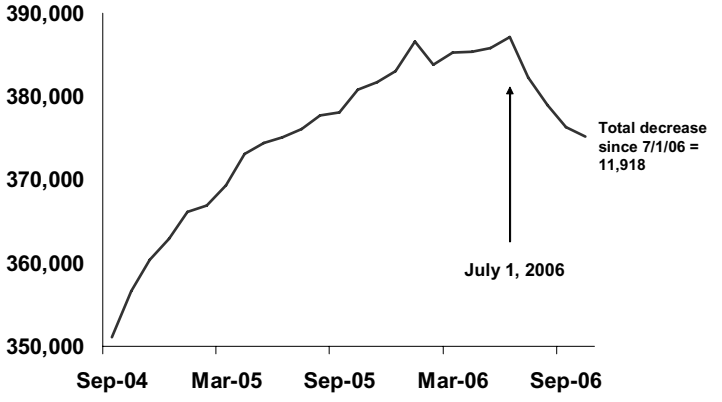
  Of great concern is the dramatic increase in procedural closures at renewal which has more than tripled, from under 5 percent to about 16 to 17 percent, since the Medicaid citizenship documentation requirement has been implemented. The state has been tracking closures for procedural reasons for several years and has taken aggressive steps to reduce such events, in which people lose Medicaid not because they don't qualify, but because they do not provide all the documents needed to process the renewal. Several years ago the state pursued an all-out

internal campaign to reduce the incidence of such closures by requiring eligibility workers to increase their use of *ex parte* renewal procedures (for example, using data from recent food stamp eligibility determinations to affirm Medicaid eligibility, rather than requiring families to provide the same information a second time) and to conduct rigorous follow-up when families do not respond to renewal notices. The follow-up procedures were suspended in July 2006 as a tradeoff for the additional workload imposed by the new citizenship documentation requirement. These procedures were restored in early November 2006 — and other methods are being introduced — to try to stem the loss of enrollment of eligible U.S. citizens in Medicaid and LaCHIP. According to Kennedy, "Louisiana is fully committed to enrolling only those children who are eligible for the program and we are trying to balance that goal with reasonable policies that do not cause undue hardship to either families or caseworkers."[22]

- **New Hampshire —** The New Hampshire Healthy Kids program processes mail-in applications for the state's Medicaid and separate SCHIP programs — called Healthy Kids Gold and Healthy Kids Silver, respectively. Despite a steady volume of applications, which has traditionally surged in September, data from New Hampshire Healthy Kids shows that the percentage of applications that were submitted complete dropped by almost half in September 2006 (16 percent), as compared with September 2005 (29 percent). In addition, while the percentage of applications previously closed due to missing documents was between 9 percent and 11 percent in 2005, in July 2006 it was 16 percent and in August 2006 it rose to 20 percent.[23] In New Hampshire, applications are closed within 28 days if the applicant does not provide all the documentation, although the case can be reactivated if documents are submitted within the following 10 days. It is noteworthy that New Hampshire is one of only four states that had a citizenship documentation requirement prior to July 1 when the federal requirement took effect. This suggests that the problems have to do with the difficulty families have in obtaining identity documents for their children. New Hampshire Healthy Kids reports that the state is not accepting affidavits from parents of children under age 16 attesting to their child's identity.

- **Virginia —** In Virginia, children can be enrolled in Medicaid (called FAMIS PLUS) either through a county social services office or through the Central Processing Unit (CPU) which processes applications for the state's separate SCHIP program (FAMIS) and FAMIS PLUS According to Linda Nablo, Director of the Division of Maternal and Child Health for the Department of Medical Assistance Services, CPU enrollment trends reflect what is going on statewide. Since July 2006, when the state began implementing the new Medicaid citizenship documentation requirement, enrollment of children in FAMIS PLUS (children subject to the new requirement) has declined steadily each month and by November 2006, the total net decline for the state neared 12,000. During this same period of time, enrollment of children in FAMIS, the separate SCHIP program not subject to the new requirement, increased steadily (Figure 15).

Figure 15



SOURCE: Virginia Department of Medical Assistance Services

Prior to the new requirement, the CPU processed 1,100 applications per month. However, in August and September only about 400 per month could clear the system — the remaining 700 per month were being held up solely because citizenship documentation for those applicants was missing. Normally, the CPU would never end a month with more than 50 applications pending. By the end of September, 2,600 cases were pending.

Of significant interest is the state's experience between October and November, when an enrollment surge usually occurs following an aggressive Back-to-School outreach campaign. This year, FAMIS, the separate SCHIP program experienced a particularly strong increase — 384 new enrollments — but overall, FAMIS PLUS showed a net decline of 1,158.[24]

- **Wisconsin —** Wisconsin has been tracking the number of individuals whose Medicaid has been denied or terminated since the state began implementing the Medicaid citizenship documentation requirement. A total of 8,799 individuals either were denied Medicaid or had their Medicaid terminated between August and October 2006. A large majority of people were denied or terminated — 70 percent — solely because they did not present documentation of identity, as compared to 17 percent who did not provide citizenship documentation and 14 percent who were missing both citizenship and identity documents.[25] This suggests that the state's efforts to obtain birth records electronically is meeting with success, but that it has been more difficult to obtain identity documents.

IV. Conclusion

State activities aimed at advancing children's health coverage demonstrate that many states appear ready to resume their efforts to reduce the number of uninsured people, particularly children – the path they were pursuing in the late 1990s. These efforts got somewhat off-track during the economic downturn that put significant pressure on state budgets between 2001 and 2004. During that period, some states reduced income eligibility in their health coverage programs and others retracted simplified procedures as a means of managing their caseloads. As a result, enrollment suffered substantial declines in some states, and without the federal fiscal relief legislation enacted in 2003, under which the federal government took on a greater share of Medicaid costs in exchange for states maintaining eligibility levels, the state cuts to the program would have been deeper. Now, with a more promising fiscal outlook, many states have been restoring simplified procedures, which have helped their enrollments recover, and others are undertaking significant children's coverage expansions that build on the success of Medicaid and SCHIP.

With many states headed in a positive direction, a pressing issue is whether federal policy with respect to both funding and simplification, will promote states' forward movement on children's health coverage. As Congress prepares to reauthorize SCHIP in 2007, the level of federal funding it allocates for states will determine whether children who are now enrolled do not lose coverage and whether additional children can be covered in the future. Since most children eligible for publicly financed health coverage are covered by Medicaid, sustaining coverage through that program also will be critical to children's coverage.

New federal policies that restrict states' ability to establish simple and efficient enrollment procedures are undermining progress on reducing the number of uninsured people. The Medicaid citizenship documentation requirement included in the Deficit Reduction Act of 2005 requires states to act in opposition to the lessons they have learned about effective ways to enroll and retain eligible people in health coverage programs. For example, they are having to add, rather than lessen, documentation requirements, and rely less on mail-in application systems. As a result, the requirement appears to be obstructing access to health coverage by eligible U.S. citizens, and could place a considerable burden on working families in particular. Eligible children and others whose coverage is delayed or denied are likely to bear health and financial risks as a result.

Policymakers can draw from a decade of state experience to understand how federal policies on funding and simplification can play a pivotal role in future efforts to provide health coverage to uninsured children and their families. Effective enrollment procedures are a critical component of any effort to reduce the number of uninsured children.

V. Survey Methodology

This report presents the findings of a survey of eligibility, enrollment and renewal procedures, and cost-sharing rules in Medicaid and SCHIP for children and parents in the 50 states and District of Columbia. It is part of a series of such surveys conducted by the Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured. The survey findings reflect policies and procedures in effect in the states in July 2006. The survey was conducted through extensive telephone interviews with state program administrators.

Findings are presented for:

- pregnant women and children in 51 Medicaid programs (including Section 1115 waivers and SCHIP-funded Medicaid expansions) and children in 36 separate SCHIP programs

- parents in 51 "regular" Medicaid programs and programs that have expanded coverage to parents (under Section 1931 or waivers)

Program elements investigated:

- **Eligibility Criteria**

    - Income eligibility for pregnant women, children, and parents
    - Use of asset tests, including asset limits
    - Length of "waiting period" in Medicaid (under waivers) and separate SCHIP programs (required period without insurance before child can enroll)
    - Implementation of enrollment freezes
    - Use of the SCHIP option to cover unborn children

- **Application Procedures**

    - Use of joint Medicaid/SCHIP application form for children; use of single family coverage form for children and parents
    - Face-to-face interview requirements at initial application for children and parents
    - Use of presumptive eligibility procedures for children and pregnant women
    - Income verification requirements at initial application for children

- **Renewal Procedures**

    - Length of enrollment periods for children and parents
    - Adoption of 12-month continuous eligibility for children
    - Use of joint Medicaid/SCHIP renewal form for children
    - Face-to-face interview requirements at renewal for children and parents
    - Income verification requirements at renewal for children

- **Cost-sharing**

    - Premiums in children's Medicaid and SCHIP
    - Use of "lock-out" periods as a penalty for nonpayment of premiums
    - Co-payments for physician visits (non-preventive), emergency room care and inpatient hospital stays for children
    - Co-payments for emergency room care and inpatient hospital stays for parents
    - Co-payments for prescription drugs for parents and children

While the timing of the current survey did not allow for systematic collection of the procedures states are using to implement the Medicaid citizenship documentation requirement, a set of follow-up questions posed to state officials shed light on the ways in which the new rule is complicating the enrollment process. State-by-state findings are not presented in this report, although information gleaned from the follow-up questionnaire and subsequent conversations with state officials is discussed.

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[22] Communication with Ruth Kennedy, Deputy Medicaid Director, Louisiana Department of Health and Hospitals, November 13, 2006.
[23] Communication with Tricia Brooks, President and CEO, New Hampshire Healthy Kids, November 14, 2006.
[24] Communication with Linda Nablo, Director, Division of Maternal and Child Health, Department of Medical Assistance Services, November 13, 2006.
[25] Communication with James Jones, Director, Bureau of Eligibility Management, Wisconsin Department of Health and Family Services, December 4, 2006.

VI. List of Tables

Table A
Where Do States Stand: Eligibility, Enrollment and Renewal Procedures and Cost-Sharing Rules
(July 2006)

Eligibility

Children

- 41 states, including DC, cover children in families with income 200% FPL or higher
- 46 states, including DC, disregard assets in determining children's eligibility for health coverage
- 16 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

- 37 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
- 31 states, including DC, have adopted presumptive eligibility for pregnant women
- 11 states have adopted the option to cover unborn children using SCHIP funds

Parents

- 16 states, including DC, cover parents in families with income at 100% FPL or higher
- 21 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 36 states with separate SCHIP programs use a single application for both Medicaid and SCHIP (Half of these 36 states use a joint renewal form for the two programs.)
- 9 states do not require families to provide pay stubs or other verification of their income
- 9 states have adopted presumptive eligibility for children's Medicaid
- 44 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 regardless of changes in family circumstances

Parents

- 27 states, including DC, allow parents and children to apply for health coverage using a single, simplified application
- 39 states, including DC, do not require a face-to-face interview when applying for a parent; 45 states, including DC, do not require an interview for renewing a parent's coverage
- 39 states, including DC, allow parents to renew coverage annually, as opposed to more often

Premiums and Copayments

Children

- 35 states impose premiums or an enrollment fee in their children's health coverage programs; 11 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 at 151% FPL ranges from $5 to $75 per month.
  - + the cost for families with income at 200% FPL ranges from $5 to $250 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.
- 11 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 copayments 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 copayment for prescription drugs for children

Table B
Expanding Eligibility and Simplifying Enrollment:
Trends in Children's Health Coverage Programs
(July 1997 to July 2006)

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]
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**
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
Joint application for Medicaid and SCHIP	N/A	not collected	28	33	34	34	34	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)
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)
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)
Family not required to verify income	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) 10 (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)
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)
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]

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.

SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for KCMU, 2006.

Table C
Expanding Eligibility and Simplifying Enrollment:
Trends in Health Coverage for Parents
(January 2002 to July 2006)

State Strategies	January 2002	April 2003	July 2004	July 2005	July 2006
Total number of health coverage programs for parents	**51**	**51**	**51**	**51**	**51**
Covered parents with income at or above 100 percent of FPL	20	16	17	17	16
Family application	23	25	27	27	27
Eliminated asset test	19	21	22	22	21
Eliminated face-to-face interview at enrollment	35	36	36	36	39
12-month eligibility period	38	38	36	36	39
Eliminated face-to-face interview at renewal	35	42	42	43	45
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]

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.

SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for KCMU, 2006.

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)
July 2006

	Medicaid Infants (0-1)[2]	Medicaid Children (1-5)[2]	Medicaid Children (6-19)[2]	Separate State Program (0-19)[3]	Enrollment Freeze Implemented[4]
Alabama	133	133	100	200	
Alaska[5]	175	175	175		
Arizona	140	133	100	200	
Arkansas	200	200	200		
California[6]	200	133	100	250	
Colorado	133	133	100	200	
Connecticut	185	185	185	300	
Delaware	200	133	100	200	
District of Columbia[7]	200	200	200		
Florida[8]	200	133	100	200	
Georgia[9]	200	133	100	235	
Hawaii[10] +	300	300	300		
Idaho –	133	133	100	185	
Illinois[9/11] +	200	133	133	200 (No limit)	
Indiana	150	150	150	200	
Iowa	200	133	133	200	
Kansas	150	133	100	200	
Kentucky	185	150	150	200	
Louisiana	200	200	200		
Maine[9]	200	150	150	200	
Maryland	200	200	200	300	
Massachusetts[11] +	200	150	150	300 (400+)	
Michigan	185	150	150	200	
Minnesota[12]	280	275	275		
Mississippi	185	133	100	200	
Missouri	300	300	300		
Montana	133	133	100	150	
Nebraska	185	185	185		
Nevada	133	133	100	200	
New Hampshire	300	185	185	300	
New Jersey[9]	200	133	133	350	
New Mexico[13] +	235	235	235		
New York	200	133	100	250	
North Carolina	200	200	100	200	
North Dakota	133	133	100	140	
Ohio	200	200	200		
Oklahoma	185	185	185		
Oregon	133	133	100	185	
Pennsylvania[11/14]	185	133	100	200 (235)	
Rhode Island	250	250	250		
South Carolina	185	150	150		
South Dakota	140	140	140	200	
Tennessee[4/15]	185	133	100		**Y** - waiver coverage
Texas	185	133	100	200	
Utah[4]	133	133	100	200	**Y**
Vermont[16]	300	300	300	300	
Virginia	133	133	133	200	
Washington	200	200	200	250	
West Virginia[17] +	150	133	100	220	
Wisconsin	185	185	185		
Wyoming	133	133	100	200	

SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, 2006. 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 2005 and July 2006.
– Indicates that a state has reduced eligibility in at least one of its children's health insurance programs between July 2005 and July 2006.

Table presents rules in effect as of July 2006, 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 stopped enrolling eligible children in SCHIP at any time between July 2005 and July 2006. In Tennessee, enrollment under the state's waiver coverage is closed to new applicants. Utah stopped enrolling eligible children in its SCHIP program in September 2006.

5. In Alaska, the income eligibility guideline for the SCHIP-funded Medicaid expansion is frozen at 175 percent of the 2003 federal poverty line.

6. In California, infants born to women on the Access for Infants and Mothers (AIM) program are automatically enrolled in SCHIP. The income guideline for these infants, through their second birthday, is 300 percent of the federal poverty line.

7. The District of Columbia plans to increase income eligibility for children to 300 percent of the federal poverty line in early 2007.

8. 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.

9. **Georgia, Illinois, Maine 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**, **Maine** 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.

10. Hawaii implemented a SCHIP-funded expansion of Medicaid to 300 percent of the federal poverty line in October 2006.

11. **Illinois**, **Massachusetts** and **Pennsylvania** provide state-financed coverage to children with incomes above SCHIP levels. Eligibility is shown in parentheses.

12. In Minnesota, the Section 1115 waiver program provides coverage up to age 21. This waiver also expands the infant eligibility category under "regular" Medicaid to include one-year-olds. The "regular" Medicaid income eligibility guideline for children ages two through 19 is 150 percent of the federal poverty line. There is an income cap of $50,000 regardless of family size in the waiver program.

13. New Mexico expanded eligibility for children under age six by significantly increasing allowable earnings and childcare disregards.

14. Pennsylvania plans to enact a broad expansion of coverage for children in 2007. This coverage will not have an upper income eligibility limit; however, there will be no premium subsidy for families with income above 300 percent of the federal poverty line.

15. In Tennessee, the figures represent the income eligibility guidelines under "regular" Medicaid. Enrollment under the state's waiver coverage is closed to new applicants. The state is awaiting CMS approval of a separate SCHIP program for children in families with income up to 250 percent of the federal poverty line.

16. 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.

17. West Virginia plans to expand SCHIP eligibility to 220 percent of the federal poverty line effective January 2007.

Table 2
Length of Time a Child is Required to Be Uninsured Prior to Enrolling in Children's Health Coverage*
July 2006

Total Number of States Without a Waiting Period	At Implementation	July 2006
	11	16
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* (SCHIP) 6-12/12 (state-funded)
Indiana	3	3
Iowa	6	*None*
Kansas	6	*None*
Kentucky	6	6
Louisiana	3	*None*
Maine	3	3
Maryland[5]	6	6
Massachusetts[6]	*None*	6
Michigan	6	6
Minnesota[3]	4	4
Mississippi	6	*None*
Missouri[3]	6	6
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	*None*	*None*
Rhode Island	4	*None*
South Carolina	*None*	*None*
South Dakota	3	3
Tennessee	*None*	*None*
Texas[1]	3	3
Utah[1]	3	3
Vermont[7]	1	1
Virginia	12	4
Washington	4	4
West Virginia	6	6
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, 2006. See notes on following page.

Notes for Table 2

+ Indicates that a state has shortened this period between July 2005 and July 2006.
– Indicates that a state has lengthened this period between July 2005 and July 2006.

* 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 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 not in bold**, the waiting period applies to SCHIP-funded Medicaid expansions.

Table presents rules in effect as of July 2006, unless noted otherwise.

1. In **Alabama**, **Texas** and **Utah** the waiting period is 90 days. In **Texas**, families are subject to the waiting period *after* eligibility has been determined.

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

3. In **Arkansas**, **Minnesota** and **Missouri**, 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. To obtain coverage in 2006 (coverage became available in July 2006), children must have been without coverage since January 1, 2006. Beginning in 2007, the required waiting period will be 12 months.

5. In Maryland, the waiting period is required in both the SCHIP-funded Medicaid expansion and the SCHIP-funded separate program.

6. In Massachusetts, the waiting period applies only to families with income above 200 percent of the federal poverty line.

7. 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 July 2006)

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	42%	$904	$10,849	65%	
AL	$164	$1,968	12%	$366	$4,391	26%	
AK	$1,311	$15,732	76%	$1,401	$16,812	81%	
AZ	$2,767	$33,200	200%	$2,767	$33,200	200%	
AR[4]	$204	$2,448	15%	$255	$3,060	18%	
CA	$1,383	$16,600	100%	$1,473	$17,680	107%	
CO	$830	$9,960	60%	$920	$11,040	67%	
CT	$2,076	$24,912	150%	$2,166	$25,992	157%	
DE	$1,383	$16,600	100%	$1,473	$17,680	107%	
DC	$2,767	$33,200	200%	$2,867	$34,400	207%	
FL	$303	$3,636	22%	$806	$9,672	58%	
GA	$424	$5,088	31%	$756	$9,068	55%	
HI[5]	$1,591	$19,090	100%	$1,591	$19,090	100%	
ID	$317	$3,804	23%	$595	$7,143	43%	
IL	$2,559	$30,708	185%	$2,649	$31,788	192%	
IN	$288	$3,456	21%	$378	$4,536	27%	
IA[2]	$426/$2,767	$5,112/$33,200	31%/200%	$1,065/$3,458	$12,780/$41,500	77%/250%	
KS	$403	$4,836	29%	$493	$5,916	36%	
KY	$526	$6,312	38%	$909	$10,903	66%	
LA	$190	$2,280	14%	$280	$3,360	20%	
ME	$2,767	$33,200	200%	$2,857	$34,280	207%	
MD	$434	$5,208	31%	$524	$6,288	38%	
MA	$1,840	$22,078	133%	$1,840	$22,078	133%	
MI	$519	$6,225	38%	$848	$10,181	61%	
MN	$3,806	$45,672	275%	$3,806	$45,672	275%	
MS	$368	$4,416	27%	$458	$5,496	33%	
MO	$292	$3,504	21%	$556	$6,670	40%	
MT	$491	$5,892	35%	$854	$10,248	62%	
NE	$643	$7,716	46%	$804	$9,645	58%	
NV[6]	$348	$4,176	25%	$1,185	$14,220	86%	
NH	$625	$7,500	45%	$781	$9,375	56%	
NJ	$1,591	$19,090	115%	$1,591	$19,090	115%	
NM[2]	$389/$2,767	$4,668/$33,200	28%/200%	$903/$5,658	$10,836/$67,900	65%/409%	
NY	$2,075	$24,900	150%	$2,075	$24,900	150%	
NC	$544	$6,528	39%	$750	$9,004	54%	
ND	$523	$6,276	38%	$904	$10,849	65%	
OH[7]	$1,245	$14,940	90%	$1,245	$14,940	90%	
OK[2/8]	$471/$2,559	$5,652/$30,710	34%/185%	$591/$2,559	$7,092/$30,710	43%/185%	
OR[3]	$1,383	$16,600	100%	$1,383	$16,600	100%	Y
PA[2/3]	$421/$2,767	$5,052/$33,200	30%/200%	$842/$2,767	$10,104/$33,200	61%/200%	Y (state-funded)
RI	$2,559	$30,710	185%	$2,649	$31,790	192%	
SC	$670	$8,040	48%	$1,340	$16,080	97%	
SD	$796	$9,552	58%	$796	$9,552	58%	
TN	$963	$11,556	70%	$1,113	$13,356	80%	
TX	$188	$2,256	14%	$402	$4,822	29%	
UT[2/3]	$583/$2,075	$6,996/$24,900	42%/150%	$673/$2,075	$8,076/$24,900	49%/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	$2,559	$30,710	185%	$2,649	$31,790	192%	
VA	$337	$4,044	24%	$427	$5,124	31%	
WA[2/3]	$546/$2,767	$6,552/$33,200	39%/200%	$1,092/$2,767	$13,104/$33,200	79%/200%	Y (state-funded)
WV	$253	$3,036	18%	$499	$5,992	36%	
WI	$2,559	$30,710	185%	$2,649	$31,790	192%	
WY[9]	$590	$7,080	43%	$790	$9,480	57%	

SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, 2006.

┼ 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.

Table presents rules in effect as of July 2006, 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.

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 stopped enrolling eligible parents at any time between July 2005 and July 2006. In **Pennsylvania**'s state-funded program and **Utah**'s waiver program, parents may only enroll during open enrollment periods. Enrollment is currently closed in **Oregon**'s waiver program. **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 plans to implement waiver coverage, which will only be available to parents and childless adults employed by a participating employer, in January 2007.

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 guideline of 300 percent of the federal poverty line.

6. Nevada plans to implement waiver coverage, which will provide up to $100 per month in premium assistance for employer-sponsored coverage, by April 2007.

7. The income eligibility guideline noted for Ohio is only available for 24 months.

8. Oklahoma obtained a waiver to create a health plan for employees of small employers and other individuals. Coverage for employees of participating employers is currently available. The state plans to open enrollment to other individuals by the end of 2006.

9. 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 threshold for unmarried parents with one earner.

Table 4
Selected Criteria Related to Health Coverage of Pregnant Women
July 2006

	Income Eligibility Level (Percent of Federal Poverty Line)	No Asset Test[1]	Presumptive Eligibility	Unborn Child Option[2]
Total	N/A	44	31	11
Alabama	133	Y		
Alaska[3]	175	Y		
Arizona	133	Y		
Arkansas[1]	200	($3,100)	Y	Y
California[4] +	200 (300)	Y	Y	Y
Colorado[5]	200	Y	Y	
Connecticut[6]	185	Y	Y	
Delaware	200	Y	Y	
District of Columbia	200	Y	Y	
Florida	185	Y	Y	
Georgia	200	Y	Y	
Hawaii[7]	185	Y		
Idaho	133	($5,000)	Y	
Illinois	200	Y	Y	Y
Indiana	150	Y		
Iowa[8]	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	133	($3,000)	Y	
Nebraska	185	Y	Y	Y
Nevada[9] +	185	Y		
New Hampshire	185	Y	Y	
New Jersey[10]	200	Y	Y	
New Mexico	185	Y	Y	
New York	200	Y	Y	
North Carolina	185	Y	Y	
North Dakota	133	Y		
Ohio[11]	150	Y		
Oklahoma	185	Y	Y	
Oregon	185	Y		
Pennsylvania[12]	185	Y	Y	
Rhode Island[13]	250 (350)	Y		Y
South Carolina[14] –	185	($30,000)		
South Dakota	133	($7,500)		
Tennessee[15]	185	Y	Y	
Texas[16] +	185	Y	Y	Y
Utah[17]	133	($5,000)	Y	
Vermont[18]	200	Y		
Virginia[19] +	166	Y		
Washington	185	Y		Y
West Virginia	150	Y		
Wisconsin	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, 2006. 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 2005 and July 2006.
– Indicates that a state has reduced eligibility or eliminated a simplified procedure for pregnant women between July 2005 and July 2006.

Table presents rules in effect as of July 2006, 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 Alaska, the income eligibility guideline for the expanded coverage for pregnant women is frozen at 175 percent of the 2003 federal poverty line.

4. 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.

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

6. Connecticut has a presumptive-like eligibility process for pregnant women known as expedited eligibility.

7. In Hawaii, pregnant women enrolled in Medicaid whose income exceeds 185 percent of the federal poverty line can purchase alternative coverage by paying a monthly premium. This coverage has an income eligibility guideline of 300 percent of the federal poverty line.

8. 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.

9. Nevada plans to implement coverage for pregnant women with income between 133 and 185 percent of the federal poverty line under a HIFA waiver in December 2006.

10. 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.

11. 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.

12. 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.

13. In Rhode Island, the Medicaid income eligibility guideline 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.

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

15. Tennessee plans to adopt the SCHIP unborn child option in 2007.

16. Texas will implement the SCHIP unborn child option effective January 2007.

17. 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.

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

19. Virginia expanded its SCHIP-funded coverage for pregnant women from 150 to 166 percent of the federal poverty line in September 2006.

Table 5

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

July 2006

	Program	Joint application	No Face-to-Face Interview	No Asset Test[2]	Presumptive eligibility[3]
Total	Medicaid (51)*	N/A	46	47	9
	SCHIP (36) **	N/A	33	34	6
	Aligned Medicaid and Separate SCHIP ***	33	46	46	7
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	Medicaid for Children	Y	Y	Y	
	Separate SCHIP		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	
	Separate SCHIP		Y	Y	
Kentucky	Medicaid for Children	Y		Y	
	Separate SCHIP			Y	
Louisiana	Medicaid for Children	N/A	Y	Y	
Maine	Medicaid for Children	Y	Y	Y	
	Separate SCHIP		Y	Y	
Maryland[7]	Medicaid for Children	Y	Y	Y	
	Separate SCHIP		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	N/A	Y	Y	Y

		Program	Joint application	No Face-to-Face Interview	No Asset Test[2]	Presumptive eligibility[3]
Montana[9]	+/–	Medicaid for Children		Y	($15,000)	
		Separate SCHIP		Y	Y	
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	
		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[12]		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[13]		Medicaid for Children	N/A		Y	
Texas[14]		Medicaid for Children	Y	Y	($2,000)	
		Separate SCHIP		Y	($5,000)	
Utah[9/15]		Medicaid for Children			($3,025)	
		Separate SCHIP			Y	
Vermont		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		Medicaid for Children	N/A	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, 2006.

+ Indicates that a state has simplified one or more of its procedures between July 2005 and July 2006.

– Indicates that a state has rescinded one or more simplified procedures between July 2005 and July 2006.

* "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-six states operate such programs. The remaining 14 states and the District of Columbia used their SCHIP funds to expand Medicaid, exclusively.

*** “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 2006, 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 only available through the Child Health and Disability Prevention program provider. In **Illinois**, presumptive eligibility is available in children’s Medicaid and SCHIP but not in the state-funded expansion program. **Kansas** has adopted presumptive eligibility in children's Medicaid and SCHIP but does not plan to implement procedures until spring 2007. **New York's** SCHIP program has a presumptive-like process in which health plans can provide coverage for a temporary period while the family submits necessary documentation.

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, telephone interviews are used for all families that come through the centralized unit that determines eligibility for children and pregnant women. 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. Missouri has eliminated the asset test for children’s “regular” Medicaid. Children in the Medicaid expansion group 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. Rhode Island has adopted a $10,000 asset limit, however no implementation date has been set.

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

14. In Texas, the SCHIP asset test applies only to families with income above 150 percent of the federal poverty line.

15. In Utah, an 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.

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]
July 2006

	Program	Income Verification Not Required at Enrollment[2]	Income Verification Not Required at Renewal[2]	Income Verification Not Required at Renewal Unless Income has Changed[2]
Total	Medicaid (51)*	9	9	2
	SCHIP (36) **	9	10	4
	Aligned Medicaid and Separate SCHIP ***	9	9	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	Y	Y	
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	
	Separate SCHIP	Y	Y	
Massachusetts	Medicaid for Children			
	Separate SCHIP			
Michigan	Medicaid for Children	Y	Y	
	Separate SCHIP	Y	Y	

	Program	Income Verification Not Required at Enrollment[2]	Income Verification Not Required at Renewal[2]	Income Verification Not Required at Renewal Unless Income has Changed[2]
Minnesota	Medicaid for Children			
Mississippi	Medicaid for Children			
	Separate SCHIP			
Missouri	Medicaid for Children			
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[5]	Medicaid for Children			
	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			
Texas	Medicaid for Children			
	Separate SCHIP			Y
Utah[6]	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[7]	Medicaid for Children			
	Separate SCHIP			Y
Wisconsin[8]	Medicaid for Children			
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, 2006.

+ Indicates that a state has eliminated an income verification requirement between July 2005 and July 2006.
– Indicates that a state has instituted an income verification requirement between July 2005 and July 2006.

* "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-six states operate such programs. The remaining 14 states and the District of Columbia used their SCHIP funds to expand Medicaid, exclusively.

*** "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 2006, 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 the self-attested 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 New York, income verification is not required at SCHIP renewals if a Social Security number (s) is provided for the parent(s).

6. 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.

7. 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.

8. In Wisconsin, verification of income is required only of families with children who qualify under the state's Section 1115 waiver program.

Table 7
Renewal: Selected Simplified Procedures in Children's Regular Medicaid, Children's SCHIP-funded Medicaid Expansions and Separate SCHIP Programs[1]
July 2006

	Program	Frequency┼ (months)	12-Month Continuous Eligibility	No Face-to-Face Interview	Joint Renewal Form┼┼
Total	Medicaid (51)*	44	16	48	N/A
	SCHIP (36) **	34	25	35	N/A
	Aligned Medicaid and Separate SCHIP ***	44	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[4] ┼	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[5]	Medicaid for Children	12		Y	
┼	Separate SCHIP	12	Y	Y	
Georgia[6]	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	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	Y
	Separate SCHIP	12		Y	
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 (6)		Y	N/A

	Program	Frequency┼ (months)	12-Month Continuous Eligibility	No Face-to-Face Interview	Joint Renewal Form┼┼
Mississippi	Medicaid for Children	12	**Y**		**Y**
	Separate SCHIP	12	**Y**		
Missouri	Medicaid for Children	12		**Y**	N/A
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[7]	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[8]	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[9]	Medicaid for Children	6		**Y**	**Y**
	Separate SCHIP	6		**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			N/A
Texas	Medicaid for Children	6		**Y**	
	Separate SCHIP	6		**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, 2006.

┼ Indicates that a state has simplified one or more of its procedures between July 2005 and July 2006.
– Indicates that a state has rescinded one or more simplified procedures between July 2005 and July 2006.

* "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-six states operate such programs. The remaining 14 states and the District of Columbia used their SCHIP funds to expand Medicaid, exclusively.

*** "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 2006, 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**, **Minnesota** and **Tennessee**, 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 6 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. Colorado implemented a joint renewal form in August 2006.

5. 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.

6. In Georgia, families with children on Medicaid and SCHIP receive different renewal forms. However, families that have their child's Medicaid case maintained by the SCHIP office, as the result of a previous process, will continue to receive the same renewal form as families with children on SCHIP.

7. 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.

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

9. In Oregon, the renewal period for poverty-level children's Medicaid and SCHIP 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.

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
July 2006

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 *	27	46	46
	Total Medicaid for Parents (51)**		39	21
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]	Medicaid for Children		**Y**	**Y**
	Medicaid for Parents			**($1,000)**
California[6]	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**	**($2,000)**
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[7]	Medicaid for Children		**Y**	**Y**
	Separate SCHIP		**Y**	**Y**
	Medicaid for Parents		**Y**	**($2,000)**
Georgia[6]	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[6]	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[6/8]	Medicaid for Children		**Y**	**Y**
	Separate SCHIP		**Y**	**Y**
	Medicaid for Parents		**Y**	**($1,000)**
Iowa[6/9/10]	Medicaid for Children		**Y**	**Y**
	Separate SCHIP		**Y**	**Y**
	Medicaid for Parents		**Y**	**($2,000)**
	Expanded Medicaid for Parents			**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**
	Separate SCHIP		**Y**	**Y**
	Medicaid for Parents			**($3,000)**
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**
	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	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[9/15]	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	Y
	Separate SCHIP			Y
	Medicaid for Parents			($6,100)
	Expanded Medicaid for Parents			($18,300)
North Carolina[6]	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[6/9]	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[6] –	Medicaid for Children		Y	($30,000)
–	Medicaid for Parents		Y	($30,000)
South Dakota[6]	Medicaid for Children		Y	Y
	Separate SCHIP		Y	Y
	Medicaid for Parents		Y	($2,000)
Tennessee[19]	Medicaid for Children	Y		Y
	Medicaid for Parents			($2,000)
Texas[20]	Medicaid for Children		Y	($2,000)
	Separate SCHIP		Y	($5,000)
+	Medicaid for Parents		Y	($2,000)
Utah[9/21]	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, 2006.

+ Indicates that a state has simplified one or more of its procedures for parents between July 2005 and July 2006.
– Indicates that a state has rescinded one or more simplified procedures for parents between July 2005 and July 2006.

* "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 2006, 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 Arkansas, county offices have the option of requiring either a face-to-face or telephone interview for Medicaid. Applicants that 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.

6. 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.

7. 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.

8. In Indiana, a telephone interview will meet the interview requirement if the parent is applying for Medicaid only. Telephone interviews also are used for all families that come through the centralized unit that determines eligibility for children and pregnant women.

9. In these states, "Expanded Medicaid for Parents" 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. **Oklahoma** obtained a waiver to create a state health plan for employees of small employers and other individuals. Coverage for employees of participating employers is currently available. The state plans to open enrollment to other individuals by the end of 2006.

10. In Iowa, a parent who is added to a case initiated with an SCHIP application does not have to do a face-to-face interview, however they do have to provide information on assets. 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 disregards $12,000 of liquid assets toward its asset test for parents.

13. In Missouri, children covered under the Section 1115 waiver expansion are subject to a “net worth” test of $250,000.

14. Montana implemented a Medicaid-only application that can be used for children and parents in the fall of 2006.

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.

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.

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

Table 9
Renewal: Selected Simplified Procedures in Medicaid for Parents, with Comparisons to Children
July 2006

Program		Frequency┼ (months)	No Face-to-Face Interview
Total	Aligned Medicaid for Children and Separate SCHIP *	44	48
	Total Medicaid for Parents (51)**	39	45
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]	Medicaid for Children	12	**Y**
	Medicaid for Parents	12	**Y**
California[3]	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[4]	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[5]	Medicaid for Children	12	Y
	Separate SCHIP	12	Y
	Medicaid for Parents	12	Y
Iowa[6]	Medicaid for Children	12	Y
	Separate SCHIP	12	Y
	Medicaid for Parents	12	
	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
	Separate SCHIP	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[2]	Medicaid for Children	6/12 (6)	Y
	Medicaid for Parents	6/12 (6)	Y
	Expanded Medicaid for Parents	6	Y
Mississippi	Medicaid for Children	12	
	Separate SCHIP	12	
	Medicaid for Parents	12	
Missouri	Medicaid for Children	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[7]	Medicaid for Children	6	Y
	Medicaid for Parents	6 (3)	Y
Nevada	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	12	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[6/8]	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[9]	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[6]	Medicaid for Children	12	**Y**
	Medicaid for Parents	12	**Y**
	Expanded Medicaid for Parents	12	**Y**
Oregon[10]	Medicaid for Children	6	**Y**
	Separate SCHIP	6	**Y**
	Medicaid for Parents	12	**Y**
	Expanded Medicaid for Parents	6	**Y**
Pennsylvania[11]	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[12]	Medicaid for Children	12	
	Medicaid for Parents	12	
Texas	Medicaid for Children	6	**Y**
	Separate SCHIP	6	**Y**
†	Medicaid for Parents	6	**Y**
Utah[6/13]	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	6	**Y**
	Expanded Medicaid for Parents	6	**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[14]	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, 2006. 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 2005 and July 2006.
– Indicates that a state has rescinded one or more simplified procedures for parents between July 2005 and July 2006.

* "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 2006, unless noted otherwise.

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

2. 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 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**, individuals who qualify under the state's Section 1115 expansion program have eligibility reviewed every 6 months. In the "regular" Medicaid program, income reviews are required every 6 months and eligibility reviews are required annually.

3. 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.

4. 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.

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

6. In these states, "Expanded Medicaid for Parents" 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. **Oklahoma** obtained a waiver to create a state health plan for employees of small employers and other individuals. Coverage for employees of participating employers is currently available. The state plans to open enrollment to other individuals by the end of 2006.

7. 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.

8. 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.

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

10. In Oregon, interviews are not required of families receiving Section 1931 Medicaid only. 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.

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

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

13. 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.

14. 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]
July 2006

	Increase or decrease[2]	Frequency of payment	Income Level at which State begins Requiring Premiums (FPL)	Amount at 101% of the Federal Poverty Line ($16,766)	Amount at 151% of the Federal Poverty Line ($25,066)	Amount at 200% of the Federal Poverty Line ($33,200)
Total	6 - Increase 2 - Decrease	35	N/A	11	26	28
Alabama		Annually	101	$100	$200	$200
Alaska		None	—	—	—	—
Arizona		Monthly	101	$15	$30	$35
Arkansas		None	—	—	—	—
California[3]		Monthly	101	$8/$14	$12/$18	$12/$18
Colorado		Annually	151	$0	$35	$35
Connecticut	Decrease	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[1]		Monthly	251 ($30)	$0	$0	$0
Idaho[5]	Increase	Monthly	134	$0	$30	N/A
Illinois		Monthly	151	$0	$25	$25
Indiana	Increase	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	Increase	Monthly	201 ($44)	$0	$0	$0
Massachusetts[1]		Monthly	101	$15	$24	$24
Michigan		Monthly	151	$0	$5	$5
Minnesota[1/6]	Increase	Monthly	All waiver families	$8	$60	$118
Mississippi		None	—	—	—	—
Missouri[1]	Decrease	Monthly	150	$0	$19	$63
Montana		None	—	—	N/A	N/A
Nebraska		None	—	—	—	N/A
Nevada[7]		Quarterly	101	$15	$35	$70
New Hampshire		Monthly	186	$0	$0	$50
New Jersey	Increase	Monthly	150	$0	$18	$36
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	—	—	—	—
Oregon		None	—	—	—	N/A
Pennsylvania[8]	Increase	Monthly	201 ($95 to $145)	$0	$0	$0
Rhode Island[1]		Monthly	150	$0	$61	$77
South Carolina		None	—	—	N/A	N/A
South Dakota		None	—	—	—	—
Tennessee[1/9]		Monthly	101	$40	$70	$250
Texas		Semiannual	134	$0	$35	$50
Utah		Quarterly	101	$13	$25	$25
Vermont[1]		Monthly	185	$0	$0	$30
Virginia		None	—	—	—	—
Washington		Monthly	201 ($30)	$0	$0	$0
West Virginia[10]		Monthly	201 (TBD)	$0	$0	$0
Wisconsin[1/11]		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, 2006. See notes on following page.

Notes for Table 10A

Table presents rules in effect as of July 2006, 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.

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

5. In Idaho, premiums are required at the income level noted in the table as of October 2006. Families with children covered under the state's new "enhanced" plan are not required to pay premiums.

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

7. 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.

8. In Pennsylvania, the premium varies by health plan.

9. In Tennessee, recipients may have income up to 200 percent of the federal poverty line.

10. West Virginia plans to implement premiums when coverage for children is expanded in January 2007. Premium amounts have not yet been determined.

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

Table 10B
Effective Annual Premium Payments for Two Children in a Family of Three at Selected Income Levels[1]
July 2006

	Effective Annual Amount at 101% of the Federal Poverty Line ($16,766)	Effective Annual Amount at 151% of the Federal Poverty Line ($25,066)	Effective Annual Amount at 200% of the Federal Poverty Line ($33,200)
Total	11	26	28
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
Delaware	$120	$180	$300
Dist. of Columbia	—	—	—
Florida	$180	$240	$240
Georgia[3]	$180	$480	$672
Hawaii[1]	$0	$0	$0
Idaho[4]	$0	$360	N/A
Illinois	$0	$300	$300
Indiana	$0	$396	$600
Iowa	$0	$240	$240
Kansas	$0	$240	$360
Kentucky	$0	$240	$240
Louisiana	—	—	—
Maine	$0	$192	$768
Maryland	$0	$0	$0
Massachusetts[1]	$180	$288	$288
Michigan	$0	$60	$60
Minnesota[1/5]	$96	$720	$1,416
Mississippi	—	—	—
Missouri[1]	$0	$228	$756
Montana	—	N/A	N/A
Nebraska	—	—	N/A
Nevada	$60	$140	$280
New Hampshire	$0	$0	$600
New Jersey	$0	$216	$432
New Mexico	—	—	—
New York	$0	$0	$216
North Carolina	$0	$100	$100
North Dakota	—	N/A	N/A
Ohio	—	—	—
Oklahoma	—	—	—
Oregon	—	—	N/A
Pennsylvania	$0	$0	$0
Rhode Island[1]	$0	$732	$924
South Carolina	—	N/A	N/A
South Dakota	—	—	—
Tennessee[1/6]	$480	$840	$3,000
Texas	$0	$70	$100
Utah	$52	$100	$100
Vermont[1]	$0	$0	$360
Virginia	—	—	—
Washington	$0	$0	$0
West Virginia	$0	$0	$0
Wisconsin[1/7]	$0	$900	$1500
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, 2006. See notes on following page.

Notes for Table 10B

Table presents rules in effect as of July 2006, 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, the premiums noted are required as of October 2006. 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 Tennessee, recipients may have income up to 200 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]
July 2006

	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	15	12	8	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	$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[3]	$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	N/A	N/A	N/A	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	$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	$25	$100	$10	$50	$200
Texas	$7	$50	$50	$10	$50	$100
Utah	$15	$35	10% of daily reimbursement rate	$15	$35	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]	$15	$35	$25	$15	$35	$25
Wisconsin	$0	$0	$0	$0	$0	$0
Wyoming[4]	$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, 2006. See notes on following page.

Notes for Table 11

Table presents rules in effect as of July 2006, 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. During the survey period, **Kentucky** added a co-payment for emergency room use in non-emergency situations. 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 **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 **Massachusetts**, $3; 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**, **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. The co-payments shown for Tennessee are only required in the state's waiver program, which is closed to new applicants.

Table 12
Co-payments for Specific Services in Health Coverage Programs for Parents
July 2006

	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	8
Alabama[1]	$366	$50	$0
Alaska	$1,401	$50 per day for first four days	$0
Arizona[1]	$2,767	$0	$0
Arkansas	$255	10 percent of reimbursement rate for first day	$0
California	$1,473	$0	$0
Colorado	$920	$10	$0
Connecticut	$2,166	$0	$0
Delaware	$1,473	$0	$0
District of Columbia	$2,867	$0	$0
Florida[1]	$806	$3	$0
Georgia	$756	$12.50	$0
Hawaii	$1,591	$0	$0
Idaho	$595	$0	$0
Illinois[1/3]	$2,649	$3 per day/$2 or $5	$0/$0 or $5
Indiana[1]	$378	$0	$0
Iowa[2]	$1,065/$3,458	$0	$0
Kansas	$493	$48	$0
Kentucky[1]	$909	$50	$0
Louisiana	$280	$0	$0
Maine	$2,857	$3 per day	$0
Maryland	$524	$0	$0
Massachusetts[1]	$1,840	$3	$0
Michigan	$848	$0	$0
Minnesota[1/4]	$3,806	$0	$0
Mississippi	$458	$10	$0
Missouri[1]	$556	$10	$0
Montana[1]	$854	$100	$0
Nebraska	$804	$0	$0
Nevada	$1,185	$0	$0
New Hampshire	$781	$0	$0
New Jersey[5]	$1,591	$0	$0/$35
New Mexico[2/6]	$903/$5,658	$0/$0, $25 or $30	$0/$0, $15 or $20
New York	$2,075	$25 per discharge	$3
North Carolina	$750	$3 per day	$0
North Dakota[1]	$904	$75	$0
Ohio[1]	$1,245	$0	$0
Oklahoma[2/7]	$591/$2,559	$3 per day/$50	$0/$30
Oregon	$1,383	$0	$0
Pennsylvania[1/2/8]	$842/$2,767	$3 per day (maximum of $21)/$0	$0/$25
Rhode Island	$2,649	$0	$0
South Carolina[1]	$1,340	$25	$0
South Dakota[1]	$796	$50	$0
Tennessee	$1,113	$0	$0
Texas	$402	$0	$0
Utah[1/2]	$673/$2,075	$220/no coverage	$0/$30
Vermont	$2,649	$75/$0	$0/$25
Virginia	$427	$100	$0
Washington[2/9]	$1,092/$2,767	$0/20 percent coinsurance	$0/$100
West Virginia	$499	$0	$0
Wisconsin	$2,649	$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, 2006. 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 2005 and July 2006.
I Indicates that a state has increased the co-payment for one or more services between July 2005 and July 2006.

Table presents rules in effect as of July 2006, 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. During the survey period, **Kentucky**, **Minnesota** and **Ohio** either added or increased the co-payment for this service. **Alabama**, **Massachusetts**, **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 at or above 133 percent of the federal poverty line.

4. In Minnesota, the inpatient hospital co-insurance noted in the table applies only to parents eligible under the Section 1115 waiver expansion with income above 175 percent of the federal poverty line. The maximum co-insurance a family can be required to pay annually for inpatient care is $1,000 per adult or $3,000 per family.

5. 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.

6. 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.

7. Oklahoma plans to open enrollment in its waiver program by the end of 2006. Coverage for employees of participating employers is already available.

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

9. 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.

Table 13
Co-payments for Prescriptions in Children's Health Coverage Programs[1]
July 2006

	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] I	$1.00 (generic), $2.00 (preferred brand name), $3.00 (non-preferred brand name)
Louisiana	$0
Maine	$0
Maryland	$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) $10.00 (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	$0
Rhode Island	$0
South Carolina	$0
South Dakota	$0
Tennessee[1/4]	$3.00
Texas[3]	$0 or $5.00 (generic) $3.00, $5.00 or $20.00 (brand name)
Utah[3]	$1.00 or $5.00 (approved list) $3.00 or 50 percent of cost (not on approved list)
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, 2006. See notes on following page.

Notes for Table 13

D Indicates that a state has decreased the co-payment for prescriptions between July 2005 and July 2006.
I Indicates that a state has increased the co-payment for prescriptions between July 2005 and July 2006.

Table presents rules in effect as of July 2006, 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 the $1 or $3 co-payment for adults.

3. In **Alabama**, **Colorado**, **Illinois, New Jersey, North Carolina, 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 **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 below 150 percent of the federal poverty line pay $1 for prescriptions on the approved list and $3 for prescriptions not on the approved list. Families with income above 150 percent of the federal poverty line pay $5 for prescriptions on the approved list and 50 percent of cost for prescriptions not on the approved list.
- 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-payment noted is required only of children covered under the state's Section 1115 expansion component.

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.

Table 14
Co-payments for Prescriptions in Health Coverage Programs for Parents
July 2006

	Prescription Co-payment for Parents
Total	40
Alabama	$.50-$3.00
Alaska	$2.00
Arizona	$0
Arkansas	$.50 -$3.00
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[2]	$0
Idaho	$0
Illinois[3]	$0 (generic) $3.00 (brand name)/$2.00 or $3.00 (generic) $2.00 or $5.00 (brand name)
Indiana	$3.00
Iowa[4]	$.50 - $3.00
Kansas	$3.00
Kentucky I	$1.00 (generic) $2.00 (preferred brand name) 5 percent of cost (non-preferred brand name)
Louisiana	$.50-$3.00
Maine	$2.50
Maryland	$0
Massachusetts	$1.00 (generic) $3.00 (brand name)
Michigan	$1.00
Minnesota[5]	$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	$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 I	$2.00 for brand name prescriptions on preferred drug list $3.00 for brand name prescriptions not on preferred drug list
Oklahoma[1]	$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 I	$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	$2.00

SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, 2006. See notes on following page.

Notes for Table 14

D Indicates that a state has decreased the co-payment for prescriptions between July 2005 and July 2006.
I Indicates that a state has increased the co-payment for prescriptions between July 2005 and July 2006.

Table presents rules in effect as of July 2006, 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. **Oklahoma** plans to open enrollment in its waiver program by the end of 2006. Coverage for employees of participating employers is already available.

2. In Hawaii, self-employed parents are required to pay $2 for generic prescriptions and $5 for brand name prescriptions.

3. 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.

4. 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.

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

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-payment only applies to parents covered under the state's expansion coverage who are not in managed care, with income at or above 150 percent of the federal poverty line.

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