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In a Time of Growing Need: State Choices Influence Health Coverage Access for Children and Families

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

Prepared by
Donna Cohen Ross
and
Laura Cox
Center on Budget and Policy Priorities

October 2005

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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Table of Contents

Executive Summary

The nation's progress in reducing the number of uninsured people suffered another setback in 2004, as the number of Americans without health insurance rose for the fourth consecutive year. However, also for the fourth consecutive year, increased enrollment in Medicaid and the State Children's Health Insurance Program (SCHIP) partially offset the decline in job-based health coverage, preventing the number of uninsured Americans from rising even faster.

Whether Medicaid and SCHIP will continue to be able to respond to growing health insurance needs depends in part on whether state policies in these programs make publicly funded coverage *more* available to those who need it, or *less* so. 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 2005. It is one of a series of surveys conducted over the last five years by the Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured.

Key Findings

The survey finds that between July 2004 and July 2005, progress on expanding health coverage was both advanced and impeded:

On the positive side:

- **Twenty (20) states took steps to increase access to health coverage for children and parents.** Twelve (12) states enacted new eligibility expansions for children, pregnant women or parents *(Colorado, Connecticut, Florida, Illinois, Montana, New Jersey, New Mexico, North Carolina, Utah, Virginia, Wisconsin and Wyoming);* eight (8) states adopted procedural simplifications *(Connecticut, Florida, New Hampshire, New Jersey, New York, North Dakota, Washington and Oklahoma);* and four (4) states either reduced premiums for children or relaxed penalties for nonpayment of premiums *(Florida, Georgia, Michigan, Texas).*

- **Nine (9) states reversed steps they had taken in prior years to restrict coverage; they reversed eligibility cuts, restored simplified procedures or relaxed financial barriers** *(Connecticut, Florida, Georgia, Michigan, Montana, New Jersey, Texas, Utah* and *Washington).* **The previous year, in contrast, no states reversed prior eligibility restrictions, and many states imposed new barriers to Medicaid and SCHIP coverage.**

On the negative side:

- **Fourteen (14) states took actions that could impede access to health coverage for children and parents.** Six (6) states either cut eligibility levels or froze enrollment for parents in their Medicaid waiver programs *(Connecticut, Ohio, Missouri, Tennessee, Oregon, and Utah)*; two (2) states adopted procedures that make enrolling or renewing

coverage more difficult *(Connecticut and Pennsylvania)*; and ten (10) states increased premiums for children (*California, Connecticut, Illinois, Maine, Maryland, Minnesota, Missouri, New Jersey, Pennsylvania, and Vermont).*

- **Eleven (11) states took steps that made it more difficult for eligible children to secure or retain coverage, such as imposing new financial or procedural barriers** *(California, Connecticut, Illinois, Maine, Maryland, Minnesota, Missouri, New Jersey, Pennsylvania, Tennessee, and Vermont).* **However, this approach to "managing caseloads" was less common than in the prior year, when nearly half the states adopted such measures.**

- **The disparity between the income level at which parents are eligible for coverage and the level at which children qualify widened. Four (4) states reduced parents' income eligibility for coverage, in some cases severely** *(Connecticut, Ohio, Missouri,* and *Tennessee).*

As these mixed results indicate, there is no guarantee that Medicaid and SCHIP will remain ready to respond in times of economic hardship to protect low-income families across the country from the health and financial risks of being uninsured. Other warning signs exist as well. Many states continue to face fiscal problems, and Medicaid continues to be a prominent target for state budget cuts. Also, Congress is considering cuts to health care entitlement programs that could result in reduced access to Medicaid for low-income families.

I. Introduction

The nation's progress on reducing the number of uninsured people suffered another setback in 2004. While the number of uninsured people in the United States declined steadily between 1998 and 2000, that trend began to reverse in 2000. Since then, weak economic conditions, rising health care costs and the further deterioration of employer-based health coverage have caused the number of people without health insurance in this country to continue to rise each year. This reversal would have been even more pronounced had it not been for the countervailing force exerted by increased enrollment in Medicaid and the State Children's Health Insurance Program (SCHIP). In each of the last four years, enrollment in these programs has expanded, partially offsetting the decline in job-based health coverage.[1] Medicaid and SCHIP continue to assure low-income people — especially children — the security of affordable health coverage that provides a benefit package designed to meet their needs.

At a time when states have been confronted by both the mounting health insurance needs of families and serious fiscal pressures, what steps have they taken to ensure that Medicaid and SCHIP are able to respond? Using the flexibility they have under federal law, state policymakers can employ a host of strategies to determine the extent to which their programs are available, affordable and easy to obtain. Their decisions are described in this report, which 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 2005. It is one of a series of surveys conducted over the last five years by the Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured.

In the 1990s, states began placing a high priority on enrolling uninsured, low-income children — and to some extent, their parents — in health coverage. Fueled by the allocation of federal SCHIP funds in 1997, they intensified their efforts, paying more attention than ever before to designing streamlined enrollment systems. Many states imported such improvements into their existing Medicaid programs, a move that helped begin to reshape Medicaid's image from a welfare program to a health insurance program for working families. States also initiated aggressive promotional activities and made unprecedented investments in statewide and community-based outreach and enrollment projects. The convergence of these efforts resulted in a major boost in enrollment.[2]

An understanding of the strategies that work to increase or inhibit the enrollment of children and parents in Medicaid and SCHIP has developed over time through experience and research. Previous surveys in this series have highlighted states' efforts to put this knowledge into practice to boost or restrict enrollment. And, as this survey reveals, state policymakers also have used their own understanding of the dynamics of these policy choices to change course on enrollment as economic or political conditions change.

The survey finds that between July 2004 and July 2005, some states restricted eligibility, a few severely. But, at the same time, others began to restore or expand eligibility, reduce required premiums and reinstate or adopt new simplified enrollment and renewal procedures. In some cases, the actions aimed at addressing the needs of a growing uninsured population were

encouraged by improving state revenues. In other instances, however, even though budget pressures continued, states reversed restrictive policies implemented during the economic downturn after evidence showed those policies had caused an unexpectedly precipitous drop in enrollment among eligible individuals.

That states continue to turn to Medicaid and SCHIP as a critical vehicle for providing health coverage to low-income children and families attests to the pivotal role these programs have played in ensuring that preventive care, physician and dental visits, hospital care and medications are available to beneficiaries. But, will these programs remain ready to respond in times of economic hardship to protect low-income families from the health and financial risks of being uninsured? As demonstrated by these survey findings, there is no guarantee that eligible families in need of health coverage will consistently find this vital assistance to be affordable and easy to secure and retain.

While state budgets have started to emerge from the depths of the fiscal crisis, the resurgence of state revenues is less robust than experience from past economic recoveries would predict.[3] Thus, many states still have reason to worry about their fiscal health and continue to explore ways to restrict spending. With health care costs continuing to rise generally and the number of jobs with health insurance continuing to decline, Medicaid remains a prominent budget target. To compound matters, most states also are seeing a reduction in the share of their Medicaid costs they receive from the federal government, further compromising their ability to finance health coverage.

In addition, under the terms of this year's federal budget resolution, Congress may reduce health care entitlement spending by $10 billion over the next five years. In the aftermath of Hurricanes Katrina and Rita, the Administration and some Congressional leaders are pushing for even larger cuts. There is a risk that they will move to achieve savings by enacting policies that could limit access to essential services or make coverage unaffordable for the low-income families Medicaid is designed to serve.

II. Key Survey Findings

Between July 2004 and July 2005:

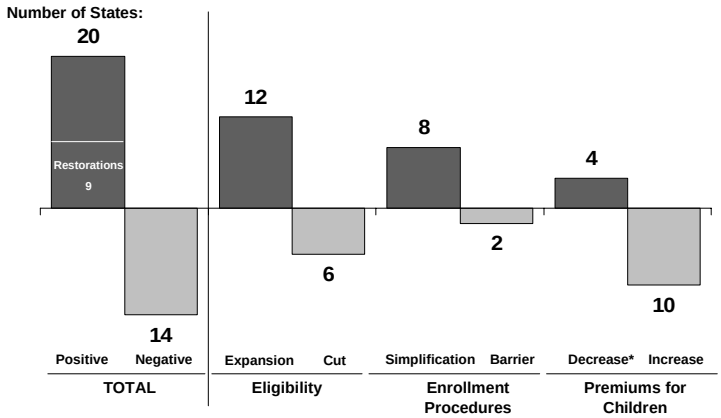
Twenty (20) states took steps to increase access to health coverage. (Figure 1) Twelve (12) states enacted new eligibility expansions for children, pregnant women or parents *(Colorado, Connecticut, Florida, Illinois, Montana, New Jersey, New Mexico, North Carolina, Utah, Virginia, Wisconsin and Wyoming);* eight (8) states adopted procedural simplifications *(Connecticut, Florida, New Hampshire, New Jersey, New York, North Dakota, Washington and Oklahoma);* and four (4) states *(Florida, Georgia, Michigan and Texas)* either reduced premiums for children or relaxed penalties for nonpayment of premiums.

In some states, tax increases or strong revenue growth helped finance health coverage expansions, but other states gave coverage expansions priority despite a difficult fiscal environment. In Colorado, voters approved a new tobacco tax to pay for a Medicaid eligibility

expansion for pregnant women and also for the elimination of the asset test in determining eligibility for children in Medicaid. Colorado had been one of only six states that still barred low-income children from Medicaid because their family's assets exceeded the state limit, which was just $1,000. Wyoming, which has seen oil and mineral tax revenues grow, expanded health coverage for children for the second year in a row. On the other hand, Illinois — which still is experiencing fiscal constraints — enacted the second phase of its parent expansion; parents with income up to 185 percent of the federal poverty line will be eligible for coverage, effective January 2006.

Figure 1

State Policy Decisions on Eligibility, Enrollment Procedures, and Premiums for Children and Families in Medicaid and SCHIP, July 2005



*Decreases include one state which reduced premiums for children and three states which reduced or eliminated their lock-out periods for non-payment of premiums.
SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for KCMU, 2005.

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States also continued to simplify procedures and, during the survey period, this activity focused on improving the renewal process more than it has in the past. Ensuring that eligible individuals keep their coverage for as long as they qualify is key to reducing the number of uninsured people. Easy renewal also reduces the chances that individuals will experience gaps in coverage, which can cause serious health and financial hardship, such as having to skip or delay medical care or having to deplete savings to pay medical bills.[4] Perhaps the most effective technique for preventing coverage gaps is the adoption of 12-month continuous eligibility, an option under which children can retain their health coverage for a full year, regardless of any changes in family income or other circumstances. Washington State restored 12-month continuous eligibility, and New Jersey and New York have adopted this option in both their Medicaid and SCHIP programs for children. In addition, Florida lengthened its SCHIP enrollment period from six to 12 months, and Oklahoma did the same in Medicaid for children and parents. In each of these states, families now are relieved of the burdens associated with having to renew their coverage frequently, which research has shown does much to deter eligible individuals from retaining coverage and also has administrative cost implications for states.[5]

Finally, a few states eased financial barriers to coverage for children by either reducing premiums or relaxing the penalties imposed on families for non-payment of premiums.

Nine (9) states took steps to re-open doors to health coverage that previously had been closed. They reversed eligibility cuts, restored simplified procedures or relaxed premium payment policies *(Connecticut, Florida, Georgia, Michigan, Montana, New Jersey, Texas, Utah and Washington).* **This progress is in contrast to the previous year, during which there were no restorations of eligibility and newly imposed barriers appeared to be undermining the advances that had been made on simplifying and streamlining Medicaid and SCHIP enrollment and renewal procedures in many states.**

The reversal of cuts previously made to Medicaid and SCHIP is a significant development. As a result, tens of thousands of low-income parents in New Jersey and Connecticut will gain renewed access to health coverage, and eligible children in three states that had frozen SCHIP enrollment will find they are again able to apply for and obtain the coverage for which they qualify. The SCHIP enrollment freezes had left thousands of eligible children without coverage, creating health and financial hardship for families, especially those that have children with serious medical needs.

In addition to restoring eligibility, several states revisited their earlier decisions to put in place more complicated procedures or financial barriers to coverage. After finding that the negative effects on children's enrollment were greater than had been projected, they reversed the policies. (Several examples of these actions are discussed in Section III of this report.) As a result, eligible children in a number of states will find that barriers to securing and retaining coverage have been removed. A notable example is Washington State, which reinstated its 12-month continuous eligibility policy, and once again guarantees children a full year of coverage, protecting them from the risks associated with a breach in coverage. Texas rescinded SCHIP premiums for the lowest income families and substantially reduced the amount other families are charged for their children's coverage. Michigan eliminated its "lock-out" period, which barred families from re-enrolling their children in the state's SCHIP program for six months, as a penalty for nonpayment of premiums. This state decision was motivated, in part, by the costs associated with administering the penalty period.[6]

Fourteen (14) states took actions that impeded access to health coverage for children and parents. Six (6) states either cut eligibility levels or froze enrollment for parents in their Medicaid waiver programs *(Connecticut, Ohio, Missouri, Tennessee, Oregon, and Utah)*; two (2) states adopted procedures that make enrolling or renewing coverage more difficult *(Connecticut and Pennsylvania)*; and ten (10) states increased premiums for children (*California, Connecticut, Illinois, Maine, Maryland, Minnesota, Missouri, New Jersey, Pennsylvania, and Vermont).*

Eleven (11) states took some action that will make it more difficult for eligible children to secure or retain coverage *(California, Connecticut, Illinois, Maine, Maryland, Minnesota, Missouri, New Jersey, Pennsylvania, Tennessee, and Vermont).* **Such actions include imposing financial or procedural barriers to health coverage and maintaining enrollment freezes. While the survey found that this approach to "managing caseloads" persists, it was not as prevalent this year as it was in 2004, when nearly half the states adopted such measures. (Figure 2 and Figure 3)**

Figure 2

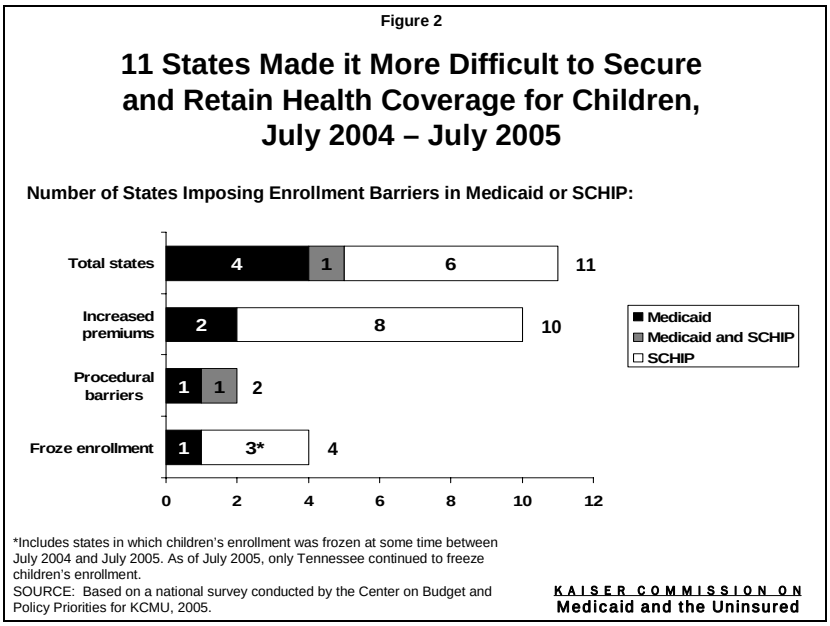
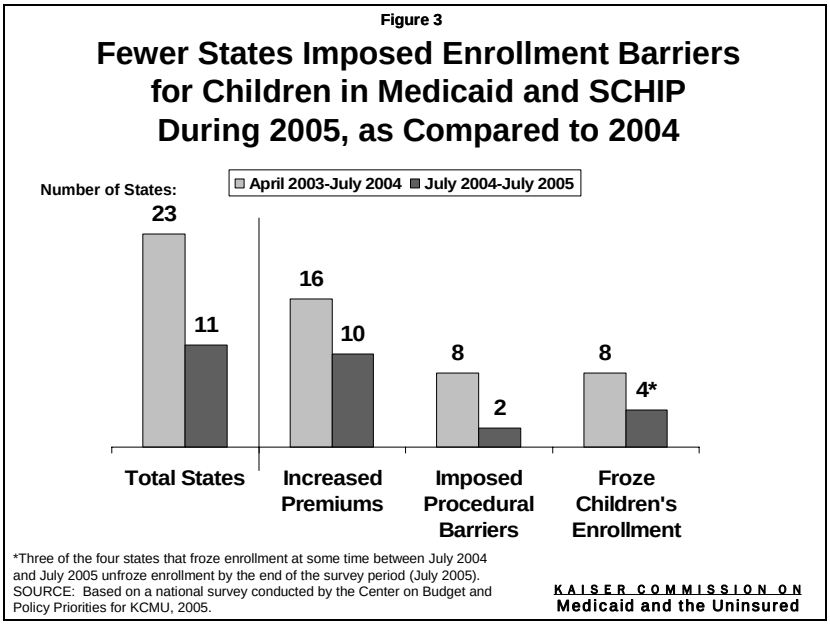


Figure 3



Most of the states that imposed barriers to enrollment and renewal in 2005 did so by increasing the premiums families are required to pay for their children to participate in the SCHIP program. Such actions generally are not taken in the Medicaid program since, under federal law, most Medicaid beneficiaries may not be charged premiums, except where states have secured Section 1115 waivers to allow them to impose cost-sharing on higher-income beneficiaries. 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.[7] Recently, the St. Louis Post-Dispatch reported that an estimated 21,500 will be dropped from Missouri's Children's Health Insurance Program since their families missed paying the newly established premium for children in families with income above 150 percent of the federal poverty line, about $29,000 per year for a family of four.[8] The

children slated to lose coverage represent about half of the children now required to pay a premium. The state is allowing families a grace period, until November 30, to give them more time to pay. Children who are disenrolled will have to wait six months before they can re-enter the program.

Two states, Connecticut and Pennsylvania, imposed procedural barriers to coverage. Connecticut will no longer accept a family's statement of its income on a children's health coverage application and will require the family to produce verification. Although states may view requiring more rigorous verification requirements as a method for ensuring "program integrity," states that have allowed families to "self-declare" their income have found it to be a reliable procedure.[9] Moreover, research indicates that burdensome verification requirements can significantly deter families with eligible children and parents from applying or being able to maintain their coverage.[10] States such as Georgia and Louisiana, that have conducted data matches with various state databases to verify income and other information, have been able to streamline the enrollment and renewal process for families, reduce the number of cases that are closed due to missing documents and simplify the work of eligibility staff.[11]

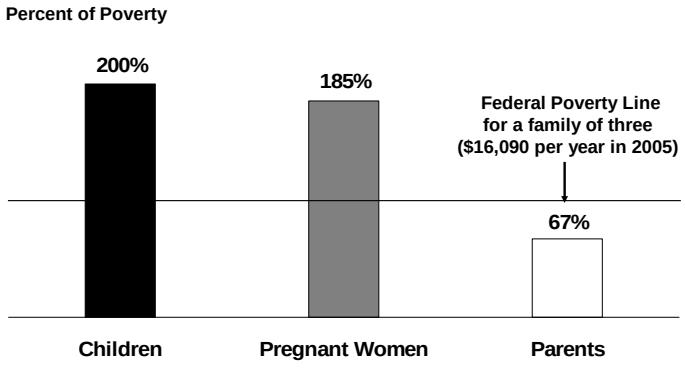
Pennsylvania has shortened the enrollment period in Medicaid for children and parents, making it necessary for families to renew their coverage twice a year instead of annually. Requiring families to comply with more frequent requests for documents increases the risk that eligible people will lose coverage. In addition, since Pennsylvania's more difficult renewal procedure applies only to Medicaid, and the state's SCHIP program still features 12-month continuous eligibility, the confusion families face at renewal will be intensified if they have children in both of the programs.

States did not impose new enrollment freezes in children's coverage programs this year, and all but one of the freezes that had been in effect in the past have now been lifted. Tennessee currently has an enrollment freeze in effect for eligible children applying for the state's Medicaid waiver program, although some children who lose their "regular" Medicaid coverage are permitted to enroll in the waiver program. (Oregon and Utah have enrollment freezes in effect for parents and other adults in their Medicaid waiver programs, and Pennsylvania and Washington have frozen enrollment in their state-funded health coverage programs for parents and other adults.)

The disparity between the income level at which parents are eligible for coverage and the level at which children qualify has widened. Despite a somewhat brighter fiscal picture in some places, parents in four (4) states *(Connecticut, Ohio, Missouri and Tennessee)* **suffered income eligibility cuts, which were severe in some instances.[12] (Figure 4)**

Figure 4

Median Medicaid/SCHIP Income Eligibility Threshold for Children, Pregnant Women, and Parents, July 2005



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, 2005.

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Among the most striking developments during the survey period were the deep reductions in Medicaid coverage enacted in Missouri and Tennessee. These cuts have adversely affected Medicaid eligibility for thousands of adults, including parents. In Missouri, over 104,000 people — including more than 68,000 low-income parents — are expected to lose health coverage.[13] The income eligibility level for parents, which endured a previous cut in 2002, will fall to just 22 percent of the federal poverty line (42 percent of the federal poverty line for working parents.) Thus, in the last three years, with respect to parent coverage, Missouri has gone from being one of the most generous states to being one of the least generous. Other cuts in Missouri will adversely affect parents and other adults who remain on the program, since they will be subject to new co-payments and a range of services previously required under Missouri law will be eliminated. In Tennessee, the cuts have already resulted in the termination of coverage for adults covered under TennCare expansion categories, that is, those not eligible under regular Medicaid rules; more than 200,000 adults — including parents — have been disenrolled. Individuals remaining on the program are subject to reduced coverage of specific benefits, particularly prescription drugs; new co-payments also are required. Significant cuts to parent coverage — though more modest than those enacted in Missouri and Tennessee — also were also implemented in Ohio and Connecticut.

Low-income parents are twice as likely as their children to be uninsured — in 2004, 36 percent of parents with income below 200 percent of the federal poverty level (FPL) were uninsured, compared to 18 percent of low-income children.[14] While chances are good that children in working families are eligible for health coverage, the prospects are dim for working parents themselves, who in most states qualify for Medicaid only if they have income far below the federal poverty line. In a typical state, a working parent in a family of three loses Medicaid eligibility when her income surpasses 67 percent of the federal poverty line, or $10,780 per year for a family of three in 2005. In half the states (25 states), a parent in a family of three working full time at the federal minimum wage earning $893 per month cannot qualify for Medicaid. The lack of coverage for parents has adverse ramifications for children's coverage. Research indicates that providing health coverage for low-income parents helps boost the number of

children enrolled in Medicaid and children in Medicaid are more likely to get well-child care if their parents also are enrolled in the program.[15]

III. Eligibility and Enrollment Policy Decisions, Revisited

After finding that certain eligibility and enrollment policies constituted significant procedural and financial barriers to coverage, during the survey period some states reevaluated previous decisions. In a number of states, restrictive policies enacted for budgetary reasons — such as requiring beneficiaries to renew their coverage more frequently than once a year, meet more rigorous verification requirements or pay premiums — resulted in greater enrollment declines than had been projected, and such policies were reversed or modified. Policy reversals took place in New Jersey, where parent coverage was re-opened after having been closed since 2002; Washington State, where 12-month continuous eligibility was restored; and Texas, where SCHIP premiums imposed on the lowest income families were rescinded and premiums for other families were reduced substantially. In Wisconsin, a new verification policy that has led to a steep decline in enrollment is being re-evaluated. In addition, in North Carolina, eligibility policy changes went into effect to help avoid a SCHIP enrollment freeze, a situation that in the past had proven seriously detrimental for eligible children unable to obtain coverage under the state's SCHIP program. A few states, including Massachusetts, have reinstated funding for outreach activities.

New Jersey Restores Eligibility for Parents
and Takes Additional Steps to Advance Health Coverage for Children and Families

New Jersey enacted several major health coverage improvements, restoring parent eligibility that had been cut three years ago and forging ahead to further simplify enrollment, foster retention of Medicaid and SCHIP, and conduct new outreach activities. Although the state experienced a late surge in revenues in fiscal year 2005, state finances continue to be tight. Nevertheless, the state legislature appropriated $20 million to fund the health care improvements. In a statement on the Family Health Care Coverage Act, the bill's prime sponsor, New Jersey Senator Joseph Vitale, said: "If we cannot provide for a high-quality health care safety net for our children and for future generations, we are shirking one of the most important responsibilities entrusted to us as leaders of the State … With these reforms we have proven that compassion and sound public policy and the concern about the bottom line are not mutually exclusive ideals…" [16]

The state's new law advances health coverage for low-income children and families by:

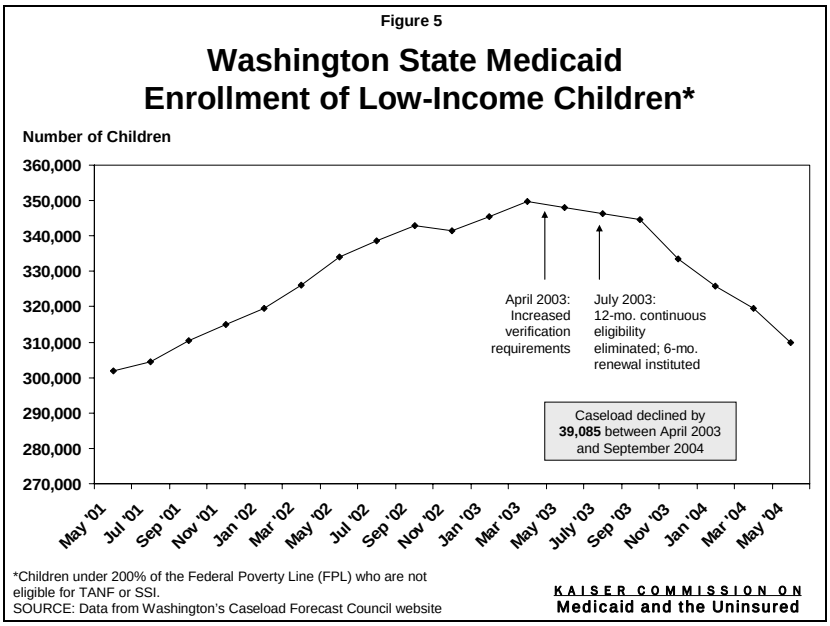
- Expanding parent coverage from 35 percent of the federal poverty line to 133 percent of the federal poverty line, over the next three years. As a result, 75,000 low-income parents will be able to secure health coverage;
- Relaxing burdensome verification requirements at enrollment and renewal;
- Creating a one-page application and streamlined renewal forms, and providing the opportunity to apply electronically;
- Enhancing the state's presumptive eligibility process, allowing a broader array of providers

to directly enroll children who appear to qualify for coverage and allowing more children to get the advantages of presumptive eligibility;
- Establishing 12-month continuous eligibility for children in Medicaid and SCHIP, guaranteeing a full year of coverage; and
- Expanding the state's outreach initiative to facilitate health coverage enrollment through schools and hospitals, and to provide information and applications to families through child care programs, schools and community-based health care providers.

According to Senator Vitale, a major reason the state re-opened the program for parents was because " we know that in some cases, the key to getting children in the health care they need is to provide a program that covers the entire family, to ensure everyone has access." The legislation also addresses critical goals by ensuring that [those who can benefit from FamilyCare] "are not scared off by an unnecessarily long and complex process."

Washington State Reinstates the Guarantee of Full-Year Coverage

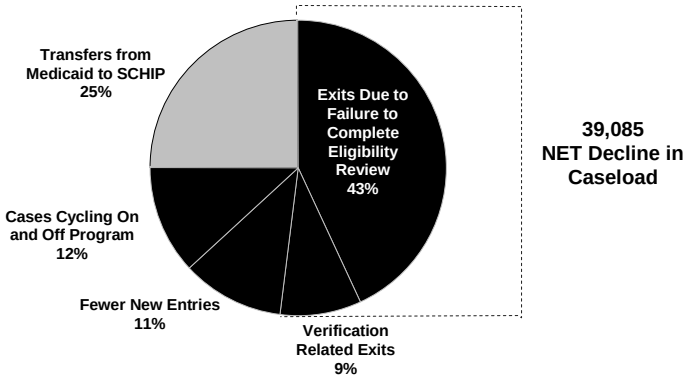
Policy changes in Washington State's children's Medicaid and SCHIP programs were reversed after state enrollment data revealed that the more stringent eligibility and procedural rules had led to 39,000 children being dropped from the programs, more than twice the number that had been projected when the changes were proposed for budgetary reasons two years ago. (Figure 5) In 2003, the state adopted more rigorous income verification requirements, switched from 12-month eligibility reviews to six-month reviews, and eliminated 12-month continuous eligibility. In January 2005, Governor Gregoire ordered several policies reversed: 12-month reviews and continuous eligibility were reinstated, meaning children once again get a full year of coverage regardless of changes in their family income or other circumstances and their eligibility will be reviewed just once, rather than twice, a year. The Governor also continued the moratorium on instituting premiums, a move authorized by the legislature but not implemented because of concerns that the costs imposed on low-income families could cause significant numbers of children to lose coverage and could deter others from entering the program.[17]



A study by the Washington State Department of Social and Health Services (DSHS), released after the Governor's order, provided insights into the consequences of the more stringent policies.[18] The study found that over half (52 percent) of the decline in enrollment was attributable to children leaving the program because their families did not complete an eligibility review or because they did not or could not verify income. It also found a sharp increase in the number of children who "cycle" off the program and then return after a gap of three months or less. About one in five children who left the program were re-enrolled after three months or less, suggesting that they were likely to have been eligible when their coverage was terminated. (Figure 6) A second DSHS study, a survey of 800 families of children who left the program, found that a large proportion of "leavers" — 40 percent — were uninsured, and the vast majority of the uninsured children — 90 percent — were likely to still qualify for Medicaid or SCHIP. Eligible but uninsured "leavers" were less likely than insured "leavers" to have had a physician or clinic visit in the previous six months (52 percent vs. 77 percent) and were twice as likely to have used the emergency room during that period (15 percent vs. 7 percent).[19]

Figure 6

More than Half of Children's Enrollment Decline in Washington State Due to Procedures



52,063 GROSS Decline in Caseload

SOURCE: Washington State Department of Social and Health Services, Research and Data Analysis Division. *Children's Medical Caseload—Why the Decline?* August 2005.

Texas Eliminates SCHIP Premiums for the Lowest Income Families and Significantly Reduces Required Premiums for Others

As reported in the Center on Budget and Policy Priorities' 2004 survey of eligibility and enrollment procedures for the Kaiser Commission on Medicaid and the Uninsured, after Texas enacted a host of budget cuts, SCHIP enrollment dropped by 149,000 children, a 29 percent decline. While several forces converged to drive the plummeting enrollment, one factor was a 12-fold increase in the SCHIP premium, which went from an *annual* $15 enrollment fee to a *monthly* $15 premium for families with income between 101 percent and 150 percent of the federal poverty line. Families worried about their ability to afford the cost of coverage were likely to have been deterred from applying or to have made the decision not to renew their children's coverage. In fact, the large decline in SCHIP enrollment did not reflect the full effect of the premium increase since the state had placed a moratorium on terminating children's coverage for unpaid premiums in August 2004. Subsequently, the state went further and suspended the collection of all premiums.[20]

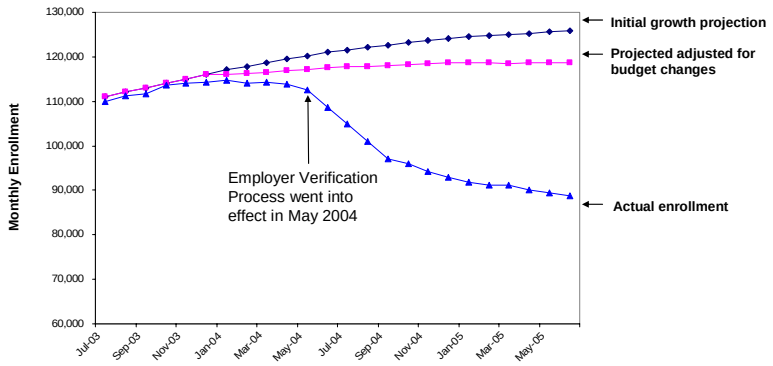
In 2005, the state's SCHIP premium structure was revised significantly, with premiums being eliminated for the lowest income families and substantially reduced for others. Effective January 2006, Texas plans eliminate SCHIP premiums for families with income at or below 133 percent of the federal poverty line, or about $21,400 for a family of three in 2005. In addition, the state plans to begin requiring semiannual premiums instead of monthly premiums. For example, the annual amount a family with income at 151 percent of the federal poverty line would be required to pay was reduced to $70 from $240; the annual amount a family with income at 200 percent of the federal poverty line would be required to pay was reduced to $100 from $300.

Wisconsin Assesses Problems with its Employer Verification Process

When Wisconsin established a new verification requirement in BadgerCare, its Medicaid expansion program, the state anticipated there would be a short-term, modest decline in the number of participants. Previously, individuals had not been required to produce documents to verify the information on their BadgerCare applications and renewal forms. However, after the new policy was implemented in May 2004, the state experienced a substantial drop in enrollment that was much larger than expected. The new verification procedure features an "Employer Verification Form (EVF)" that BadgerCare applicants and recipients are required to have their employers complete and return to the state. The form requires employers to verify the employee's income and also to verify that the employee does not have access to health insurance through the employer. By June 2005, BadgerCare enrollment had declined by 25,000 people — 22 percent. Following the introduction of the new form, an analysis of state data by the Wisconsin Council on Children and Families found that enrollment declined significantly at a time when the state had projected it would *increase*.[21] The barriers created by the new verification requirements (as well as new monthly premiums), appeared to be precipitating the denial of coverage to thousands of BadgerCare applicants and beneficiaries seeking to retain their BadgerCare coverage. (Figure 7)

Figure 7

BadgerCare Enrollment Trends: Estimated vs. Actual (July 2003 – June 2005)



SOURCE: Department of Heath and Family Strategies, Office of Strategic Finance, Program Evaluation and Audit Section. *Evaluation of BadgerCare Employer Verification Process*. September 2005; Wisconsin Council on Children & Families. *DHFS Report on BadgerCare Verification Released*. Press release issued September 14, 2005.

A study by the Wisconsin Department of Health and Family Services, released in September 2005, confirmed that the new EVF requirement was a key reason health coverage was being denied.[22] Moreover, the complications associated with the procedure — not that ineligible individuals were choosing not to return the forms — were identified as being chiefly responsible for the denials. According to the study, "it has been speculated that clients are not returning the EVF forms because they have excess income or access to insurance and therefore are not eligible for BadgerCare…[Information] from this evaluation as well as other research *does not support this* (emphasis added.) The persons denied eligibility due to the EVF requirements had been determined otherwise eligible based on their self-declared income." (A previous report by the department's Medicaid Quality Assurance Unit and by the Legislative Audit Bureau found that

the state's "self-declaration of income policy" had been reliable, with only a small percentage (5 to 6 percent) of persons found not to be eligible when their income was verified.[23]) The study of the problems caused by the EVF process found that the number of persons denied coverage because the employer health insurance form was not returned was more than five times greater than the number denied because the income verification form was not returned.

The Department examined why EVF forms were not being returned and found that most of the reasons were beyond the control of the employee. Some of the reasons included: employers lacked awareness of the consequences employees could suffer if the forms were not returned; the forms and instructions were not clear (particularly the Spanish translation); the responsibility for verifying income and health insurance may either be outsourced or assigned to different units within a company; and preaddressed business reply envelopes were not provided. A number of improvements to the forms and procedures were included in the state's 2005-07 biennial budget and some are being implemented. Since June 2005, enrollment has begun to return slowly, however, it is unclear whether the increase is because people who were deterred from BadgerCare are managing to get through the process and find their way back to the program. Requiring employers to complete and return verification forms still may be a significant barrier to children and parents obtaining health coverage.

North Carolina Takes Steps to Avert a SCHIP Enrollment Freeze

North Carolina made changes to the eligibility structure of its children's Medicaid and SCHIP programs to ensure that as many children as possible can obtain SCHIP coverage and to avoid having to freeze SCHIP enrollment, as it did in 2003. A report for the Kaiser Commission on Medicaid and the Uninsured on the consequences of North Carolina's SCHIP enrollment freeze found that, during the freeze, children's health was compromised and families suffered significant financial hardship.[24]

Effective January 2006, the state will expand Medicaid coverage so that all children under age six with family income below 200 percent of the federal poverty line will be covered in Medicaid. This means children under age six in families with income over 133 percent of the federal poverty line and less than 200 percent of the federal poverty line will be shifted from SCHIP to Medicaid. The state will accept the federal Medicaid match rate for these children — which is lower than the enhanced SCHIP match rate — and therefore will not have to draw down funds from its federal SCHIP allotment to cover these young children. In addition to the eligibility changes, the state also reduced the SCHIP provider payment rate to the level allotted to Medicaid providers, which is somewhat lower. This also will help preserve SCHIP funds. According to a Center on Budget and Policy Priorities analysis of SCHIP spending, without measures designed to preserve SCHIP funding, North Carolina would be in danger of experiencing a shortfall in federal SCHIP funds in federal fiscal year 2006.[25]

Massachusetts Restores Funding for Community-Based Outreach Activities

Massachusetts restored financial support for outreach grants this year. In the early days of SCHIP, when most states were investing heavily in outreach, Massachusetts had been one of the first to provide grants to enable community organizations to assist families in enrolling in health coverage programs. Massachusetts discontinued the grants in the fall of 2003. Around this time, many states either had scaled back their activities considerably or had eliminated their outreach budgets completely because they were concerned about their ability to pay for coverage for newly enrolled children during tight economic times. In most states outreach initiatives have not rebounded.

On October 4, 2005, the Massachusetts Department of Health and Human Services announced that it awarded $500,000 in grants to 22 organizations to increase enrollment in MassHealth, the state's Medicaid and SCHIP programs.[26] Groups receiving grants include hospitals, community health centers, child care agencies, and community action programs. According to Medicaid Deputy Director, Tom Dehner, a major goal will be to train grantees to help enroll eligible people in MassHealth using the state's electronic application.

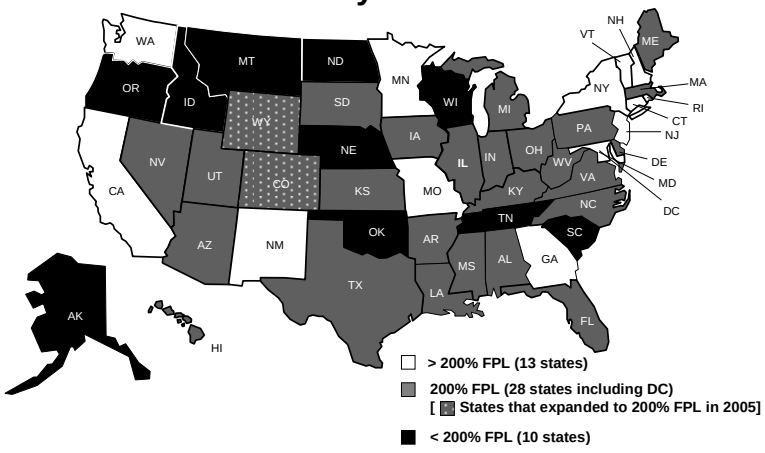
IV. Where do States Stand on Eligibility, Enrollment and Renewal Procedures and Cost-Sharing Rules and Practices?

This section provides detailed information on the status of eligibility levels, enrollment and renewal procedures, and premiums and co-payments in state Medicaid and SCHIP programs for children and parents. Changes in rules and procedures that occurred between July 2004 and July 2005 are described.

Eligibility levels in Medicaid and SCHIP for children have been relatively stable, with a few states making modest coverage expansions this year. Most states maintain eligibility at 200 percent of the federal poverty line or higher. (Figure 8) As of July 2005, 41 states including D.C. make coverage available to children in families with income at 200 percent of the federal poverty line or higher. While four (4) states had frozen enrollment for children during the survey period, enrollment in only one state remains frozen. Forty-six (46) states including D.C. disregard assets in determining children's eligibility for health coverage; and 18 states including D.C. do not require children to be uninsured for a period of time before they can enroll in Medicaid or SCHIP.

Figure 8

Children's Eligibility for Medicaid/SCHIP by Income, July 2005



*The Federal Poverty Line (FPL) for a family of three in 2005 is $16,090 per year.
SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for KCMU, 2005.

KAISER COMMISSION ON
Medicaid and the Uninsured

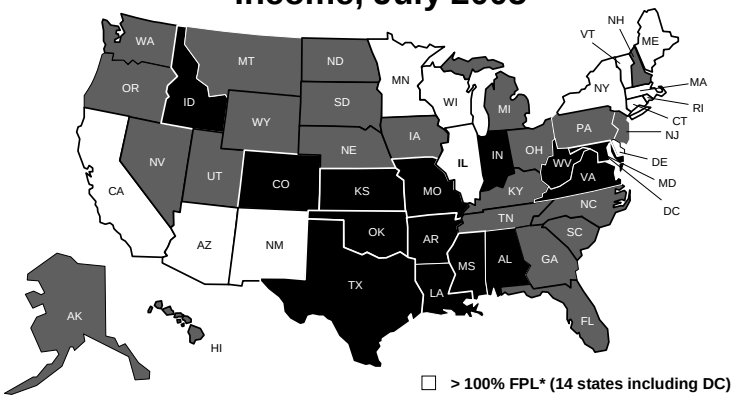
During the survey period, four (4) states expanded eligibility for children; no state reduced children's eligibility. *Colorado* increased SCHIP eligibility for children between 185 percent and 200 percent of the federal poverty line and also eliminated the asset test for children in Medicaid. For the second consecutive year, *Wyoming* increased SCHIP eligibility and now covers children in families with income up to 200 percent of the federal poverty line. *New Jersey* reduced from six months to three months the time children must be uninsured before applying for SCHIP. *North Carolina* expanded Medicaid eligibility for children under age six, and will now cover such children with income up to 200 percent of the federal poverty line in that program, rather than in SCHIP, effective January 2006.

Tennessee currently has an enrollment freeze in effect for eligible children applying for the state's Medicaid waiver program, although some children who lose their regular Medicaid coverage are permitted to enroll in the waiver program. While three (3) other states — *Florida, Montana* and *Utah* — had imposed enrollment freezes in their SCHIP programs during some portion of the survey period, all have since re-opened enrollment and continue to allow eligible children to receive coverage. Florida passed legislation to allow ongoing enrollment in SCHIP, rather than limiting access to discrete open enrollment periods. In Montana, the SCHIP program received additional funding, mainly through the state's tobacco tax, and an additional 3,000 slots were added. Utah allocated an additional $3.3 million to its SCHIP program, allowing enrollment to proceed on an on-going basis.

A few states boosted eligibility for parents, but others enacted severe reductions. The sharp disparity between the level of eligibility for children and parents persists and has widened. (Figure 9) As of July 2005, 17 states including D.C. provide health coverage to parents in families with income at or above the federal poverty line; in 14 states, working parents with income at half the federal poverty line, just $670 for a family of three, earn too much to qualify for Medicaid. And, in half the states (25 states), a parent in a family of three working full time at the federal minimum wage who earns $893 per month cannot qualify. Twenty-two (22) states including D.C. disregard assets in determining Medicaid eligibility for parents.

Figure 9

Medicaid Eligibility for Working Parents by Income, July 2005



US Median Eligibility = 67% FPL: $10,849 per year

- > 100% FPL* (14 states including DC)
- 50% - 100% FPL (23 states)
- < 50% FPL (14 states)

*The Federal Poverty Line (FPL) for a family of three in 2005 is $16,090 per year.
SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for KCMU, 2005.

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Connecticut and *New Jersey* restored eligibility for parents that had been cut in 2002. Connecticut reinstated Medicaid coverage for parents with income between 100 percent and 150 percent of the federal poverty line. New Jersey partially restored coverage, re-opening enrollment for parents with income up to 100 percent of the federal poverty line in its SCHIP waiver program. In 2002, the state had closed eligibility in this program to applicants with income above 35 percent of the federal poverty line. New Jersey plans to continue to restore coverage for the next two years, until eligibility reaches 133 percent of the federal poverty line in 2007. *Illinois* enacted the second phase of its FamilyCare expansion, bringing eligibility for parents to 185 percent of the federal poverty line, effective January 2006. *New Mexico*, through a SCHIP waiver, implemented coverage for parents (and other adults) with income up to 200 percent of the federal poverty line (over 400 percent of the federal poverty line for working adults.) Medicaid coverage in New Mexico currently covers working parents with income up to just 67 percent of the federal poverty line, so the waiver coverage constitutes a large expansion. However, there are limits on benefits and the participants are subject to significant cost-sharing. (Iowa implemented a Medicaid waiver that features a limited benefit package and premiums. The program is available to individuals over 19 and under 65 with income below 200 percent of the poverty line who are not eligible for Medicaid. Participants can receive services only at certain public hospitals and health providers.)

Tennessee and *Missouri* both made deep reductions in Medicaid eligibility for parents. In Tennessee, substantial cuts in TennCare largely repealed coverage expansions that began under the TennCare waiver in 1994. Missouri reduced income eligibility for working parents from 82 percent to 42 percent of the federal poverty line. This cut follows on the heels of an eligibility reduction from 100 percent of the federal poverty line in 2002, meaning Missouri has gone from being among the most generous states to being one of the most restrictive. Because most of these parents continue to qualify for transitional Medicaid coverage, they will not lose their insurance immediately, but the state also has cut in half the amount of time a person can receive transitional coverage (see below.) *Ohio* also dropped the eligibility level in its parent coverage program from 100 percent of the federal poverty line to 90 percent. Both *Connecticut* and

Missouri reduced the length of time parents can receive Transitional Medical Assistance (TMA), from 24 months to 12 months, the minimum required under federal law. TMA is designed to protect families as they enter the workforce after receiving public assistance and begin earning more than the allowable limit for Medicaid. Since many people begin working in low-wage jobs that do not offer health insurance, TMA provides a vital work support enabling many employees to keep their jobs. The reductions in Connecticut and Missouri erode that protection.

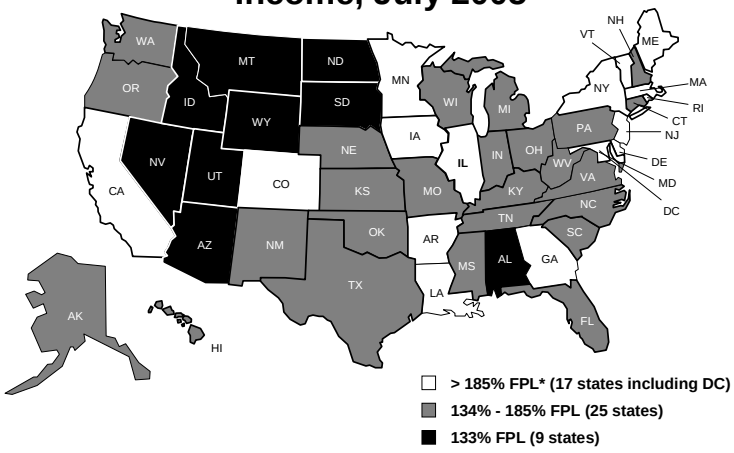
States are not permitted to freeze enrollment in their regular Medicaid programs, although several states have done so in their Medicaid waiver programs. *Oregon* and *Utah* have closed enrollment in their Medicaid waiver programs, meaning eligible parents and other adults cannot obtain coverage. (Utah's premium assistance program remains open.) Two additional states, *Pennsylvania* and *Washington*, operate health coverage programs for parents and other adults using state funds only. Pennsylvania's program, Adult Basic, has frozen enrollment except during open periods and currently has a waiting list of approximately 116,000. Of these individuals, some 3,000 have managed to buy into the program at full cost, pending the availability of subsidized coverage. In Washington State, adults who qualify for the program, called Basic Health, must wait for a space to open before they can enroll.

A few states expanded coverage, and no state reduced coverage, for pregnant women. (Figure 10) As of July 2005, 36 states including D.C. make coverage available to pregnant women with income at 185 percent of the federal poverty line or higher. Forty-five (45) states including D.C. disregard assets in determining pregnant women's eligibility for health coverage. Nine (9) states have adopted the option to cover unborn children using SCHIP funds.

During the survey period, three (3) states expanded eligibility for pregnant women. Under SCHIP waivers, *Colorado* expanded eligibility for pregnant women from 185 percent to 200 percent of the federal poverty line and *Virginia* expanded eligibility for pregnant women from 133 to 150 percent of the federal poverty line. *Wisconsin* will adopt the option to cover unborn children using SCHIP funds, effective January 2006. This will enable some pregnant women not previously eligible for Medicaid to qualify.

Figure 10

Medicaid Eligibility for Pregnant Women by Income, July 2005



*The Federal Poverty Line (FPL) for a family of three in 2005 is $16,090 per year.
SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for KCMU, 2005.

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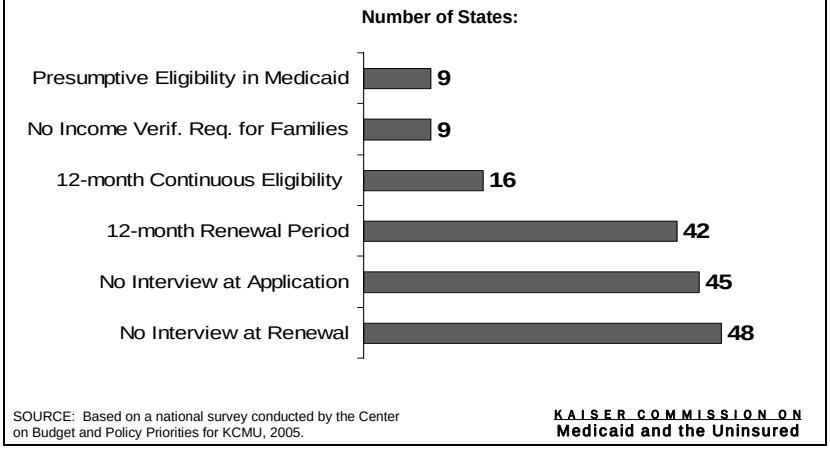
States have largely preserved the relatively simple enrollment and renewal procedures they have implemented in their children's health coverage programs. Some states reversed administrative barriers they had put in place and others adopted new simplification techniques. Efforts to simplify focused mainly on improving the renewal process in most states. (Figure 11) As of July 2005, 45 states including D.C. do not require a face-to-face interview for families applying for children's coverage; 34 of the 36 states with separate SCHIP programs use a single application for both Medicaid and SCHIP (17 of these 36 states use a joint renewal form for the two programs), and nine (9) states do not require families to provide pay stubs or other verification of their income to substantiate statements made on their applications. Also, nine (9) states have adopted presumptive eligibility for children's Medicaid, allowing a child to be temporarily enrolled pending a final eligibility determination. Some of these states also have adopted presumptive eligibility in their separate SCHIP programs and one state has the option only in its separate SCHIP program. Forty-two (42) states including D.C. allow children to renew coverage annually, as opposed to more frequently, and 16 states guarantee children a full-year of coverage regardless of changes in their family income and other circumstances.

Figure 11

Simplifying Enrollment and Renewal: Strategies States are Using in Children's Health Coverage Programs, July 2005



SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for KCMU, 2005.

KAISER COMMISSION ON Medicaid and the Uninsured

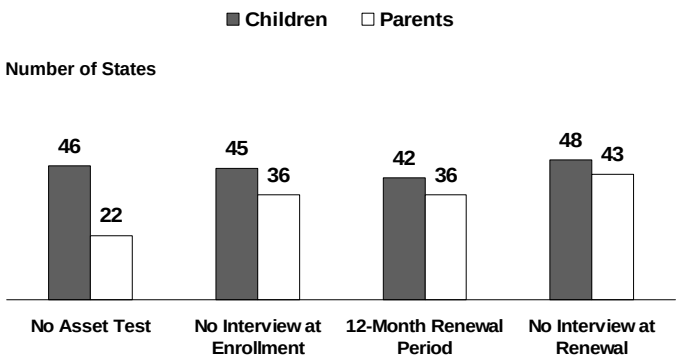
During the survey period, seven (7) states added at least one simplified procedure and three (3) states made some improvements to existing procedures. Six (6) states out of the seven states that adopted new simplifications focused their efforts on making it easier for families to retain coverage for their eligible children. After having eliminated presumptive eligibility a year ago, *Connecticut* restored the procedure for children in Medicaid. Presumptive eligibility allows certain providers to enroll children directly into the program if they appear eligible, ensuring they get needed health care right away. Children can receive benefits on a temporary basis, until the full application process is completed and eligibility is determined. *New Jersey* expanded its presumptive eligibility procedures, enabling more children to sign up for coverage this way and authorizing a broader group of providers — including hospitals, community health centers, local health departments and other primary care providers — to conduct presumptive eligibility determinations. *Colorado, New Jersey* and *Pennsylvania* reduced the amount of income verification families must provide, so that only one pay stub is required. In *North Dakota* families now can use a single form to renew Medicaid and SCHIP coverage for their children. *Florida* lengthened the enrollment period for children in its SCHIP program from six to 12 months, and *Oklahoma* will do so for its Medicaid program (effective January 2006), meaning families do not have to renew their children's coverage as frequently. *New Jersey* and *New York* have now adopted, and *Washington State* has restored, 12-month continuous eligibility in both Medicaid and SCHIP, guaranteeing children a full year of coverage. (New Jersey will implement this option in January 2006.)

Two (2) states dropped simplified procedures that had been established in the past, making it more difficult for families to keep health coverage for their children. *Connecticut* no longer allows families to attest to their income and will require them to provide verification of the statements on their application. Effective January 2006, *Pennsylvania* will require families with children enrolled in Medicaid to renew their coverage every six months instead of annually, raising the risk that eligible children will lose coverage if they cannot complete the process.

It remains more difficult for an eligible parent to secure and retain coverage than it is for an eligible child. (Figure 12) During the survey period, two (2) states adopted simplified procedures in their parent coverage programs that helped to create a somewhat more coordinated system for covering families in those states. Despite these improvements, the number of states that have adopted simplifications in their parent coverage still lags behind the number that have done so for children. There is a particularly large disparity between the number of states that disregard assets in determining eligibility for children's coverage as compared with the number that have adopted this option for parents: 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 12

States Have Not Simplified Health Coverage for Parents to the Extent They Have for Children, July 2005



SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for KCMU, 2005.

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As of July 2005, 27 states including D.C. allow parents and children to apply for coverage using a single application. A greater number of states disregard a family's assets when determining eligibility for children's health coverage (46 states, including D.C.) than do so when determining eligibility for parent coverage (22 states, including D.C.); a greater number of states have dropped the requirement that families have a face-to-face interview when applying for children's coverage (45 states, including D.C.) than when applying for parents' coverage (36 states, including D.C.); a greater number of states have dropped the face-to-face interview for renewing children's coverage (48 states, including D.C.) than for renewing parents' coverage (43 states, including D.C.); and a greater number of states allow children to renew coverage every 12 months (42 states, including D.C.) than allow parents to do so (36 states, including D.C.).

During the survey period, *New Hampshire* eliminated the face-to-face interview required for parents to renew their coverage and *Oklahoma* will lengthen the Medicaid enrollment period from six to 12 months for parents, just as it did for children, effective January 2006. Three states took steps to improve procedures: *Colorado, New Jersey* and *Pennsylvania* now allow parents (as well as children) to submit only one pay stub as verification of income. On the other hand, effective January 2006, Pennsylvania will require parents (as well as children) in Medicaid to renew their coverage every six months rather than annually.

Premiums imposed on low-income families for their children's health coverage have increased and, in some states, are targeted to lower income families than in the past.[27] In some cases, the premiums increased substantially. (Figure 13 and Figure 14) As of July 2005, 33 states impose premiums or an enrollment fee in their children's health coverage programs, with 10 of them charging families with incomes as low as 101 percent of the federal poverty line. In states with premiums, the cost for two children in a family with income of 101 percent of the federal poverty line ranges from $8 to $40 per month, and at 151 percent of the federal poverty line ranges from $5 to $70 per month. The cost for families with income at 200 percent of the federal poverty line ranges from $5 to $250 per month. Premiums charged in states with Medicaid waivers, such as Rhode Island and Wisconsin, may be considerably higher than most other states, because premiums may include coverage for a parent. In addition, 11 states impose "lock-out" periods on children in families that fail to pay their premiums, preventing such children from re-entering the program after being disenrolled. Such "lock out" periods range from 60 days to six months.

Figure 13

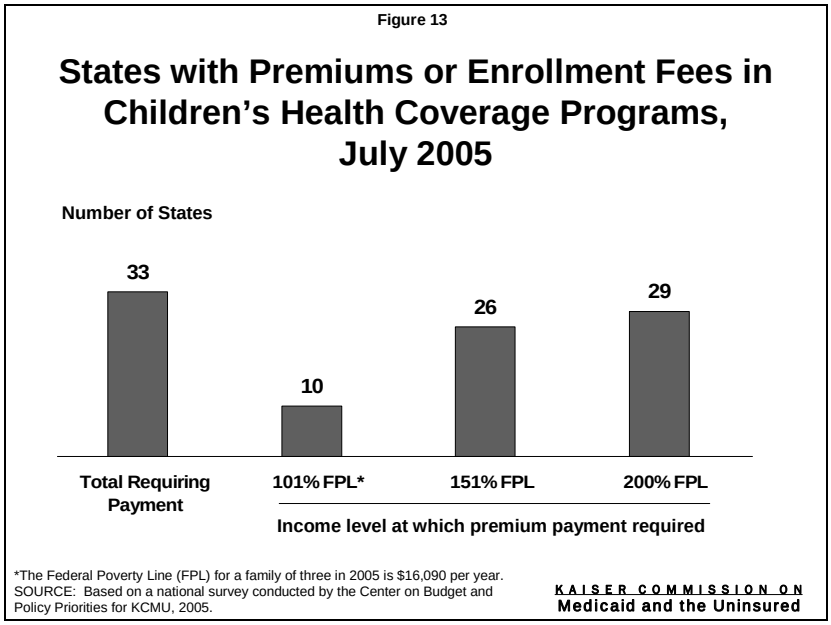
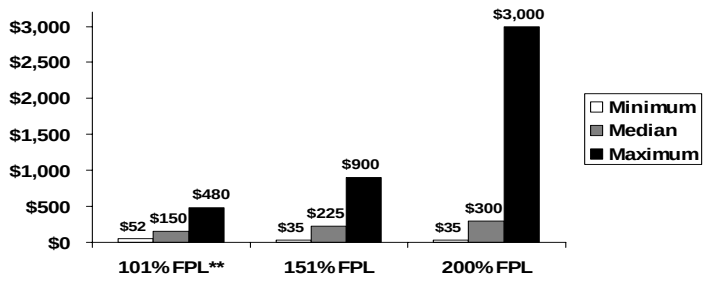


Figure 14

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



*Includes the 33 states that require premium payments for children. The remaining 18 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 2005 is $16,090 per year.
SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for KCMU, 2005.

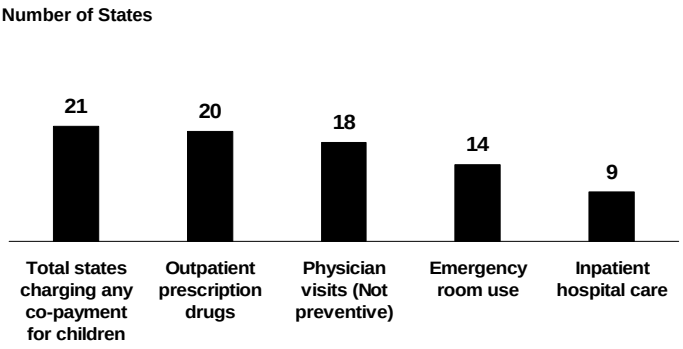
KAISER COMMISSION ON Medicaid and the Uninsured

During the survey period, 10 states either increased existing premiums or lowered the income level at which they begin charging premiums for children's coverage. These states are *California, Connecticut, Illinois, Maine, Maryland, Minnesota, Missouri, New Jersey, Pennsylvania* and *Vermont.* Both Connecticut and Missouri now target premiums to families with lower incomes than in the past; the premium for children's coverage increased most substantially in California, Connecticut, Maine and Missouri where in some cases the amount of the premiums doubled. One state —*Texas* — reduced the amount of the premiums it charges for SCHIP coverage. Texas also rescinded SCHIP premiums charged to the lowest income families. Three states — *Georgia, Florida* and *Michigan* — reduced or eliminated the penalties imposed on families for nonpayment of premiums. *New York* gave parents more time in which to pay required premiums.

The amounts families pay to obtain specific services for their children remained relatively stable. While there were a few slight downward adjustments, reductions in co-payments for children and parents were not substantial. However, a number of states increased the co-payments on specific services for parents. (Figure 15) As of July 2005, 21 states require a co-payment for non-preventive physician visits, emergency room care, inpatient hospital care, and/or prescription drugs for children. In states with co-payments for children's services, the charge for non-preventive physician visits ranges from $5 to $15, emergency room care from $5 to $50, inpatient hospital care from $5 to $200 and prescription drugs from $1 to $20. Forty (40) states require parents to share the cost of prescription drugs. The co-payments range from $.50 to $6, although New Jersey charges $10 for more than a 34-day supply, and some states charge a percentage of the full cost for a brand-name drug or one not included on the preferred list.

Figure 15

States with Co-payments for Selected Services in Children's Health Coverage Programs, July 2005



SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for KCMU, 2005.

KAISER COMMISSION ON
Medicaid and the Uninsured

[1] Leighton Ku, Matt Broaddus and Victoria Wachino, "Medicaid and SCHIP Protected Insurance Coverage for Millions of Low-Income Americans," Center on Budget and Policy Priorities, January 2005.
[2] Cindy Mann, David Rousseau, Rachel Garfield and Molly O'Malley, "Reaching Uninsured Children Through Medicaid: If You Build It Right, They Will Come," Kaiser Commission on Medicaid and the Uninsured, June 2002.
[3] Robert Zahradnik, Iris J. Lav and Elizabeth McNichol, "Framing the Choices," Center on Budget and Policy Priorities, May 2005. Although in the fourth quarter of 2004 state revenues grew by 7.8 percent, total state revenues between 2000 and 2004 were $184 billion below the amount needed to fund state services at the 2000 level. Moreover, the most recent economic downturn was both longer and deeper than the previous downturn in the early 1990s and states did much less this time to shore up their revenue systems.
[4] L. Duchon, C. Shoen, M. Dory et al., "Security Matters: How Instability in Health Insurance Puts U.S. Workers at Risk," The Commonwealth Fund, 2001.
[5] T. Riley, C. Pernice, M. Perry and S. Kannel, "Why Eligible Children Lose or Leave SCHIP: Findings From a Comprehensive Study of Retention and Disenrollment," National Academy for State Health Policy, 2002; Andrew W. Dick, R. Andrew Allison, Susan G. Haber, Cindy Brach and Elizabeth Shenkman, "Consequences of State Policies for SCHIP Disenrollment," *Health Care Financing Review* 23(3), Spring 2002; Michael Birnbaum and Danielle Holahan, "Renewing Coverage in New York's Child Health Plus B Program: Retention Rates and Enrollee Experiences," United Hospital Fund, 2003.
[6] Michigan Department of Community Health Medical Assistance Administration, "Memorandum on MIChild/ Elimination of the Six-Month Penalty for Failure to Pay the Monthly Premium," April 13, 2005.
[7] Samantha Artiga and Molly O'Malley, "Increasing Premiums and Cost Sharing in Medicaid and SCHIP: Recent State Experiences," Kaiser Commission on Medicaid and the Uninsured, May 2005.
[8] Virginia Young, "21,500 Children Are Dropped From State Health Insurance," St. Louis Post-Dispatch, October 4, 2005.
[9] Danielle Holahan and Elise Hubert, "Lessons from States with Self-Declaration of Income Policies," United Hospital Fund of New York, 2004.
[10] Michael Perry, Susan Kannel, R. Burciaga Valdez and Christina Chang, "Medicaid and Children Overcoming Barriers to Enrollment Findings from a National Survey," Kaiser Commission on Medicaid and the Uninsured, January 2000.
[11] J. Ruth Kennedy, Medicaid Deputy Director, Louisiana Department of Health and Hospitals, Presentation to South Carolina Hospital Association, April 29, 2005.
[12] This survey examined eligibility rules in Medicaid and SCHIP for children and parents. Actions affecting other Medicaid populations were not investigated. However, it is important to acknowledge that the states mentioned here that cut eligibility for parents also may have cut eligibility for other adults and people with disabilities. In addition, Florida and Mississippi enacted eligibility cuts that affected populations not studied in this survey.
[13] Joel Ferber, "Summary of Medicaid Cuts Adopted in the 2005 Legislative Session," Legal Services of Eastern Missouri, May 23, 2005.
[14] Center on Budget and Policy Priorities' analysis of the March supplement to the 2005 Current Population Survey.
[15] Lisa Dubay and Genevieve Kenney, *Covering Parents Through Medicaid and SCHIP: Potential Benefits to Low-Income Parents and Children*, Urban Institute for the Kaiser Commission on Medicaid and the Uninsured, October 2001.
[16] Senator Joseph F. Vitale Statement on FamilyCare Bill Signing, GovNetNJ.com Legislative Tracking Service, July 13, 2005.
[17] Ralph Thomas, "Gregoire Relaxes Rules on Medicaid," Seattle Times, January 20, 2005.
[18] David Mancuso, Ph.D., Katheryn Beall, M.A., Barbara Felver, M.E.S., M.P.A. in conjunction with the Washington State Department of Social and Health Services Medical Assistance Administration, "Understanding the Children's Medical Caseload Decline: A Look at the Administrative Data," Washington State Department of Social and Health Services Research & Data Analysis Division, August 2005.
[19] David Mancuso, Ph.D. et al., "Understanding the Children's Medical Caseload Decline: Part II, What the Survey Findings Tell Us," Washington State Department of Social and Health Services Research & Data Analysis Division, August 2005.
[20] Donna Cohen Ross and Laura Cox, "Beneath the Surface: Barriers Threaten to Slow Progress on Expanding Health Coverage of Children and Families," Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, October 2004.

[21] Wisconsin Council on Children and Families, "Press Release: DHFS Report on BadgerCare Verification Released Families Still Qualify; Process Too Complicated for Users and Employers," September 2005.
[22] Wisconsin Department of Health and Family Services Office of Strategic Finance Program Evaluation and Audit Section, "Evaluation of BadgerCare Employer Verification Process," September 2005.
[23] Wisconsin Department of Health and Family Services, "The State of Wisconsin's Medicaid Eligibility Quality Control 2002," November 2003.
[24] Pam Silberman, Joan Walsh, Rebecca Slifkin, and Stephanie Poley, "The North Carolina Health Choice Enrollment Freeze of 2001: Health Risks and Financial Hardships for Working Families," Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill for the Kaiser Commission on Medicaid and the Uninsured, January 2003.
[25] Based on Center on Budget and Policy Priorities' SCHIP financing model updated to reflect states most recent spending projections.
[26] Commonwealth of Massachusetts Executive Office of Health and Human Services, "Press Release: $500,000 Statewide Outreach Effort to Expand MassHealth," October 4, 2005.
[27] **Thirteen (13) states require some parents to pay premiums or enrollment fees.** In 2005, the following changes were made: **Arizona** introduced a $15, $20 or $25 enrollment fee in addition to the premium it was already charging. **Minnesota** made minor increases to its sliding scale premiums. These changes apply to waiver coverage for children and parents. **New Jersey** enacted a slight increase to premiums for parents with income above 150 percent of the federal poverty line covered under its waiver program. In 2004, the premium was $28.50 for the first adult and $11.50 for the second adult. Premiums are now $29.50 for the first adult and $12.00 for the second adult. **Vermont** increased premiums for parents and other adults covered under its waiver program for parents. Previously the premium for a parent with income of 151 percent of the federal poverty line was $45 per parent per month. The premium at this income level is now $75 per parent per month. **Oregon** eliminated the monthly premium for parents and other adults with income below 10 percent of the federal poverty line in its waiver program. **Utah** reduced premiums for parents and other adults covered under its waiver program. Previously, the premium was $15 for parents on general assistance and $50 for all other parents. The premium is now $15 for parents on general assistance, $25 for parents with income below 50 percent of the federal poverty line and $50 for all other parents. **Pennsylvania** and **Washington** increased premiums in their state-funded program for some parents and other adults.

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 2005. 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, waivers, or separate state programs)

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
    - Selected verification requirements for children (age, income, residency)

- **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

- **Cost-sharing**

    - Premiums in children's Medicaid and SCHIP
    - Use of "lock-out" periods 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

VI. Tables

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 2005

	Medicaid Infants (0-1)[2]	Medicaid Children (1-5)	Medicaid Children (6-19)	Separate State Program (0-19)[3]	Enrollment Freeze Implemented[4] (Enrollment Currently Open)
Alabama	133	133	100	200	
Alaska[5]	175	175	175		
Arizona	140	133	100	200	
Arkansas	200	200	200		
California	200	133	100	250	
Colorado ✣	133	133	100	200	
Connecticut	185	185	185	300	
Delaware	200	133	100	200	
District of Columbia	200	200	200		
Florida[6]	200	133	100	200	**(Y)**
Georgia[7]	200	133	100	235	
Hawaii[8]	200	200	200		
Idaho	150	150	150	185	
Illinois[7]	200	133	133	200	
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[7]	200	150	150	200	
Maryland	200	200	200	300	
Massachusetts[9]	200	150	150	200 (400+)	
Michigan	185	150	150	200	
Minnesota[10]	280	275	275		
Mississippi	185	133	100	200	
Missouri	300	300	300		
Montana	133	133	100	150	**(Y)**
Nebraska	185	185	185		
Nevada	133	133	100	200	
New Hampshire	300	185	185	300	
New Jersey[7]	200	133	133	350	
New Mexico	235	235	235		
New York	200	133	100	250	
North Carolina[11] ✣	200	200	100	200	
North Dakota	133	133	100	140	
Ohio	200	200	200		
Oklahoma	185	185	185		
Oregon	133	133	100	185	
Pennsylvania[9]	185	133	100	200 (235)	
Rhode Island	250	250	250		
South Carolina	185	150	150		
South Dakota	140	140	140	200	
Tennessee[4/12]	185	133	100		**Y - waiver coverage**
Texas	185	133	100	200	
Utah	133	133	100	200	**(Y)**
Vermont[13]	300	300	300	300	
Virginia	133	133	133	200	
Washington	200	200	200	250	
West Virginia	150	133	100	200	
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, 2005. 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 2004 and July 2005.
– Indicates that a state has reduced eligibility in at least one of its children's health insurance programs between July 2004 and July 2005.

Table presents rules in effect as of July 2005, 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.

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 2004 and July 2005. As of July 2005, no state has an SCHIP enrollment freeze in place. In Tennessee, enrollment under the state's waiver coverage is closed to new applicants.

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. 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.

7. **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.

8. In Hawaii, families with children enrolled in Medicaid whose income exceeds 200 percent of the federal poverty line can purchase alternative coverage by paying a monthly premium. This program, QUEST-NET, has an income eligibility guideline of 300 percent of the federal poverty line and is federally funded.

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

10. In Minnesota, the "regular" Medicaid income eligibility guideline for children ages two through 19 is 150 percent of the federal poverty line. There is a Section 1115 waiver that expands the infant eligibility category under "regular" Medicaid to include one-year-olds. There is an income cap of $50,000 regardless of family size in Minnesota's Section 1115 Medicaid expansion program.

11. North Carolina will cover children up to age six in families with income up to 200 percent of the federal poverty line under Medicaid, effective January 2006.

12. In Tennessee, the number represents the income eligibility guidelines under "regular" Medicaid. Enrollment under the state's waiver coverage is closed to all new applicants.

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

Table 2

Length of Time a Child is Required to Be Uninsured Prior to Enrolling in Children's Health Coverage* July 2005

Total Number of States Without a Waiting Period	At Implementation	July 2005
	11	18
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*	*None*
Georgia	3	6
Hawaii	*None*	*None*
Idaho	6	6
Illinois	3	*None*
Indiana	3	3
Iowa	6	*None*
Kansas	6	*None*
Kentucky	6	6
Louisiana	3	*None*
Maine	3	3
Maryland[4]	6	6
Massachusetts	*None*	*None*
Michigan	6	6
Minnesota[3]	4	4
Mississippi	6	*None*
Missouri[3]	6	6
Montana	3	3
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[5]	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, 2005. See notes on following page.

Notes for Table 2

+ Indicates that a state has shortened or eliminated this period between July 2004 and July 2005.
– Indicates that a state has lengthened this period between July 2004 and July 2005.

* 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, 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 2005, 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 expansion programs. In **Wisconsin**, the waiting period applies only to children covered under the Section 1115 waiver and SCHIP-funded Medicaid expansion.

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

5. 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 2005)

State	Income threshold for non-working parents			Income threshold for working parents			Enrollment Freeze Implemented[2]
	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	43%	$904	$10,849	67%	
AL	$164	$1,968	12%	$254	$3,048	19%	
AK	$1,260	$15,120	75%	$1,350	$16,200	81%	
AZ*	$2,682	$32,180	200%	$2,682	$32,180	200%	
AR	$204	$2,448	15%	$255	$3,060	19%	
CA	$1,341	$16,090	100%	$1,431	$17,170	107%	
CO	$421	$5,052	31%	$511	$6,132	38%	
CT	$2,011	$24,135	150%	$2,101	$25,215	157%	
DE*	$1,341	$16,090	100%	$1,431	$17,170	107%	
DC	$2,682	$32,180	200%	$2,682	$32,180	200%	
FL	$303	$3,636	23%	$806	$9,672	60%	
GA	$424	$5,088	32%	$756	$9,068	56%	
HI*[3]	$1,543	$18,510	100%	$1,543	$18,510	100%	
ID	$317	$3,804	24%	$407	$4,884	30%	
IL*[4]	$2,481	$29,772	185%	$2,571	$30,852	192%	
IN	$288	$3,456	21%	$378	$4,536	28%	
IA*[5]	$426/$2,682	$5,112/$32,180	32%/200%	$1,065/$3,352	$12,780/$40,225	79%/250%	
KS	$403	$4,836	30%	$493	$5,916	37%	
KY	$526	$6,312	39%	$909	$10,903	68%	
LA	$174	$2,088	13%	$264	$3,168	20%	
ME	$2,011	$24,135	150%	$2,101	$25,215	157%	
MD	$434	$5,208	32%	$524	$6,288	39%	
MA*	$1,783	$21,400	133%	$1,783	$21,400	133%	
MI	$459	$5,508	34%	$774	$9,285	58%	
MN*	$3,690	$44,280	275%	$3,690	$44,280	275%	
MS	$368	$4,416	27%	$458	$5,496	34%	
MO	$292	$3,504	22%	$558	$6,696	42%	
MT	$491	$5,892	37%	$855	$10,256	64%	
NE	$643	$7,716	48%	$804	$9,645	60%	
NV	$348	$4,176	26%	$1,133	$13,590	84%	
NH	$625	$7,500	47%	$781	$9,375	58%	
NJ*	$1,341	$16,090	100%	$1,341	$16,090	100%	
NM*[6]	$389/$2,682	$4,668/$32,180	29%/200%	$903/$5,488	$10,836/$65,860	67%/409%	
NY*	$2,011	$24,135	150%	$2,011	$24,135	150%	
NC	$544	$6,528	41%	$750	$9,004	56%	
ND	$523	$6,276	39%	$904	$10,849	67%	
OH	$1,207	$14,481	90%	$1,207	$14,481	90%	
OK	$471	$5,652	35%	$591	$7,092	44%	
OR*[2]	$1,341	$16,090	100%	$1,341	$16,090	100%	**Y**
PA*[2/7]	$421/$2,682	$5,052/$32,180	31%/200%	$842/$2,682	$10,104/$32,180	63%/200%	**Y (state-funded)**
RI*	$2,481	$29,767	185%	$2,571	$30,847	192%	
SC	$652	$7,824	49%	$1,304	$15,648	97%	
SD	$796	$9,552	59%	$796	$9,552	59%	
TN	$942	$11,304	70%	$1,092	$13,104	81%	
TX	$188	$2,256	14%	$401	$4,807	30%	
UT*[2/8]	$583/$2,011	$6,996/$24,135	43%/150%	$673/$2,011	$8,076/$24,135	50%/150%	**Y**

State	Income threshold for non-working parents			Income threshold for working parents			Enrollment Freeze Implemented
	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*	$2,481	$29,767	185%	$2,571	$30,847	192%	
VA	$322	$3,864	24%	$412	$4,994	31%	
WA*[2/9]	$546/$2,682	$6,552/$32,180	41%/200%	$1,092/$2,682	$13,104/$32,180	81%/200%	**Y (state-funded)**
WV	$253	$3,036	19%	$499	$5,992	37%	
WI*	$2,481	$29,767	185%	$2,571	$30,847	192%	
WY	$590	$7,080	44%	$790	$9,480	59%	

SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, 2005.

* States marked with (*) have expanded coverage for parents under waivers using Medicaid and/or SCHIP funds, while **Pennsylvania** and **Washington** have used state funds to expand coverage for parents.

Table presents rules in effect as of July 2005, unless noted otherwise.

1. This table takes relevant earnings disregards into account when determining income thresholds for working parents. These disregards may be time limited. States may also use additional disregards in determining eligibility. Some states do not allow earnings disregards at the income levels noted in the table. 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. This column indicates whether the state stopped enrolling eligible parents at any time between July 2004 and July 2005. In **Pennsylvania**'s state-funded program and **Utah**'s wavier 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 must wait for space to open in the program before being enrolled.

3. In Hawaii, enrolled families whose income exceeds 200 percent of the federal poverty line can purchase alternative coverage by paying a monthly premium. This program, QUEST-NET, has an income eligibility guideline of 300 percent of the federal poverty line and is federally funded.

4. In Illinois, coverage at the income level noted is effective January 2006.

5. In Iowa, the state's Section 1931 guidelines precede the state's waiver guidelines. The waiver coverage provides a limited benefit package and requires premiums and co-payments.

6. In New Mexico, the state's Section 1931 guidelines precede the state's waiver guidelines. The waiver coverage provides a limited benefit package and requires premiums and co-payments.

7. In Pennsylvania, the Section 1931 Medicaid eligibility levels precede the state-funded program eligibility levels.

8. In Utah, the state's Section 1931 guidelines precede the state's waiver guidelines. The waiver coverage provides a limited benefit package with enrollment fees and co-payments and is subject to an enrollment cap.

9. In Washington, the Section 1931 Medicaid eligibility levels precede the state-funded program eligibility levels.

Table 4
Selected Criteria Related to Health Coverage of Pregnant Women
July 2005

	Income Eligibility Level (Percent of Federal Poverty Line)	No Asset Test[1]	Presumptive Eligibility	Unborn Child Option[2]
Total	N/A	45	30	9
Alabama	133	Y		
Alaska[3]	175	Y		
Arizona	133	Y		
Arkansas[1]	200	($3,100)	Y	Y
California[4]	200 (300)	Y	Y	
Colorado[5] ✣	200	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[1]	133	($5,000)	Y	
Illinois	200	Y	Y	Y
Indiana	150	Y		
Iowa[1/8]	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[1]	133	($3,000)	Y	
Nebraska	185	Y	Y	Y
Nevada	133	Y		
New Hampshire	185	Y	Y	
New Jersey[9]	200	Y	Y	
New Mexico	185	Y	Y	
New York	200	Y	Y	
North Carolina	185	Y	Y	
North Dakota	133	Y		
Ohio	150	Y		
Oklahoma	185	Y	Y	
Oregon	185	Y		
Pennsylvania[10]	185	Y	Y	
Rhode Island[11]	250 (350)	Y		Y
South Carolina	185	Y		
South Dakota[1]	133	($7,500)		
Tennessee	185	Y	Y	
Texas	185	Y	Y	
Utah[1/12]	133	($5,000)	Y	
Vermont[13]	200	Y		
Virginia ✣	150	Y		
Washington	185	Y		Y
West Virginia	150	Y		
Wisconsin[14] ✣	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, 2005. 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 2004 and July 2005.
– Indicates that a state has reduced eligibility or eliminated a simplified procedure for pregnant women between July 2004 and July 2004.

Table presents rules in effect as of July 2005, 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 SCHIP-funded expansion to pregnant women is frozen at 175 percent of the 2003 federal poverty line.

4. In California, a state-funded 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 through a HIFA waiver.

6. Connecticut is in the process of implementing a presumptive-like process for pregnant women with declared income of less than 85 percent of the Medicaid income eligibility guideline for pregnant women.

7. In Hawaii, women enrolled in the program whose income exceeds 185 percent of the federal poverty line can purchase alternative coverage by paying a monthly premium. This program, QUEST-NET, has an income eligibility guideline of 300 percent of the federal poverty line and is federally funded.

8. In Iowa, 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. 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 the expanded coverage, pregnant women must be uninsured and no income deductions are allowed.

10. In Pennsylvania, the state is in the process of phasing out presumptive eligibility and replacing it with another expedited eligibility process.

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

12. 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.

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

14. Wisconsin expects to implement the SCHIP prenatal care option in January 2006.

Table 5

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

July 2005

		Program	Joint application	No Face-to-Face Interview	No Asset Test[2]	Presumptive eligibility[3]
Total		Medicaid (51)*	N/A	45	47	9
		SCHIP (36) **	N/A	33	33	6
		Aligned Medicaid and Separate SCHIP ***	34	45	46	7
Alabama[4]		Medicaid for Children	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[6]	✢	Medicaid for Children	Y	Y	Y	
		Separate SCHIP		Y	Y	
Connecticut[3]	✢	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[2]		Medicaid for Children	Y	Y	($5,000)	
		Separate SCHIP		Y	($5,000)	
Illinois		Medicaid for Children	Y	Y	Y	Y
		Separate SCHIP		Y	Y	Y
Indiana[7]		Medicaid for Children	Y	Y	Y	
		Separate SCHIP		Y	Y	
Iowa		Medicaid for Children	Y	Y	Y	
		Separate SCHIP		Y	Y	
Kansas		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[8]		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[9]		Medicaid for Children	N/A	Y	Y	Y
Montana[2/10]		Medicaid for Children	Y	Y	($3,000)	
		Separate SCHIP		Y	Y	

		Program	Joint application	No Face-to-Face Interview	No Asset Test[2]	Presumptive eligibility[3]
Nebraska		Medicaid for Children	N/A	**Y**	**Y**	
Nevada[11]		Medicaid for Children		**Y**	**Y**	
		Separate SCHIP		**Y**	**Y**	
New Hampshire		Medicaid for Children	**Y**	**Y**	**Y**	**Y**
		Separate SCHIP		**Y**	**Y**	
New Jersey[3]		Medicaid for Children	**Y**	**Y**	**Y**	**Y**
	+	Separate SCHIP		**Y**	**Y**	**Y**
New Mexico		Medicaid for Children	N/A	**Y**	**Y**	**Y**
New York[3/12]		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[2]		Medicaid for Children	**Y**	**Y**	**Y**	
		Separate SCHIP		**Y**	**($10,000)**	
Pennsylvania[13]		Medicaid for Children	**Y**	**Y**	**Y**	
		Separate SCHIP		**Y**	**Y**	
Rhode Island		Medicaid for Children	N/A	**Y**	**Y**	
South Carolina		Medicaid for Children	N/A	**Y**	**Y**	
South Dakota		Medicaid for Children	**Y**	**Y**	**Y**	
		Separate SCHIP		**Y**	**Y**	
Tennessee[14]		Medicaid for Children	N/A		**Y**	
Texas[2/15]		Medicaid for Children	**Y**	**Y**	**($2,000)**	
		Separate SCHIP		**Y**	**($5,000)**	
Utah[2/16]		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, 2005.

+ Indicates that a state has simplified one or more of its procedures between July 2004 and July 2005.
– Indicates that a state has rescinded one or more simplified procedures between July 2004 and July 2005.

* "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 2005, unless noted otherwise. See additional notes on following page.

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. **Connecticut** adopted presumptive eligibility in children's Medicaid, however procedures have not yet been implemented. The state plans to implement presumptive eligibility procedures in November 2005. In **New Jersey**, presumptive eligibility is now available to all children covered under Medicaid and SCHIP; previously, presumptive eligibility was only available to children in families with income up to 200 percent of the federal poverty line. The **New York** 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. Alabama requires an interview for families applying for Medicaid for their children, however the interview can be done by telephone.

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. Colorado will eliminate the asset test in children's Medicaid effective October 2005.

7. In Indiana, telephone interviews are used for all families that come through the centralized unit that determines eligibility for children and pregnant women.

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

9. 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.

10. Montana plans to increase the asset limit in children's Medicaid from $3,000 to $15,000 in July 2006.

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

12. In New York, a contact with a community-based "facilitated enroller" will meet the face-to-face interview requirement.

13. 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.

14. Tennessee requires an interview for families applying for Medicaid for their children, however the interview can be done by telephone.

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

16. In Utah, an interview is required for Medicaid and SCHIP, though families are permitted to do the interview by phone. Utah still counts assets in determining Medicaid eligibility for children over the age of 6. Families that use the SCHIP application, but are found to be eligible for Medicaid, must complete an addendum on other information, including information on assets, before eligibility can be determined. The SCHIP application is only available during SCHIP open enrollment periods. During SCHIP open enrollment periods, the Medicaid application can be used to apply for SCHIP.

Table 6

Selected Verification Procedures: Families are Not Required to Provide Verification of Income, Residency or Age in Children's Regular Medicaid, Children's SCHIP-funded Medicaid Expansions and Separate SCHIP Programs[1]

July 2005

	Program	Income[2]	Residency	Age
Total	Medicaid (51)*	9	44	46
	SCHIP (36) **	9	32	33
	Aligned Medicaid and Separate SCHIP ***	9	44	46
Alabama	Medicaid for Children		Y	Y
	Separate SCHIP	Y	Y	Y
Alaska	Medicaid for Children		Y	
Arizona	Medicaid for Children		Y	Y
	Separate SCHIP	Y	Y	Y
Arkansas[3]	Medicaid for Children	Y	Y	Y
California[4]	Medicaid for Children			Y
	Separate SCHIP			Y
Colorado	Medicaid for Children		Y	Y
	Separate SCHIP		Y	Y
Connecticut	Medicaid for Children		Y	Y
	Separate SCHIP		Y	Y
Delaware	Medicaid for Children		Y	Y
	Separate SCHIP		Y	Y
District of Columbia	Medicaid for Children			Y
Florida	Medicaid for Children		Y	Y
	Separate SCHIP		Y	Y
Georgia	Medicaid for Children	Y	Y	Y
	Separate SCHIP	Y	Y	Y
Hawaii	Medicaid for Children	Y	Y	Y
Idaho	Medicaid for Children	Y	Y	Y
	Separate SCHIP	Y	Y	Y
Illinois	Medicaid for Children		Y	Y
	Separate SCHIP		Y	Y
Indiana	Medicaid for Children		Y	Y
	Separate SCHIP		Y	Y
Iowa	Medicaid for Children		Y	Y
	Separate SCHIP		Y	Y
Kansas	Medicaid for Children		Y	Y
	Separate SCHIP		Y	Y
Kentucky	Medicaid for Children		Y	Y
	Separate SCHIP		Y	Y
Louisiana	Medicaid for Children		Y	Y
Maine	Medicaid for Children		Y	Y
	Separate SCHIP		Y	Y
Maryland	Medicaid for Children	Y	Y	Y
	Separate SCHIP	Y	Y	Y
Massachusetts	Medicaid for Children		Y	Y
	Separate SCHIP		Y	Y
Michigan	Medicaid for Children	Y	Y	Y
	Separate SCHIP	Y	Y	Y
Minnesota	Medicaid for Children		Y	Y
Mississippi	Medicaid for Children		Y	
	Separate SCHIP		Y	
Missouri	Medicaid for Children		Y	Y
Montana[4]	Medicaid for Children		Y	Y
	Separate SCHIP	Y	Y	Y
Nebraska	Medicaid for Children		Y	Y

	Program	Income[2]	Residency	Age
Nevada[5]	Medicaid for Children			Y
	Separate SCHIP		Y	Y
New Hampshire	Medicaid for Children			
	Separate SCHIP			
New Jersey	Medicaid for Children		Y	Y
	Separate SCHIP		Y	Y
New Mexico	Medicaid for Children		Y	
New York	Medicaid for Children			
	Separate SCHIP			
North Carolina	Medicaid for Children		Y	Y
	Separate SCHIP		Y	Y
North Dakota	Medicaid for Children		Y	Y
	Separate SCHIP		Y	Y
Ohio	Medicaid for Children		Y	Y
Oklahoma	Medicaid for Children	Y	Y	Y
Oregon[6]	Medicaid for Children			Y
	Separate SCHIP			Y
Pennsylvania	Medicaid for Children		Y	Y
	Separate SCHIP		Y	Y
Rhode Island	Medicaid for Children		Y	Y
South Carolina	Medicaid for Children		Y	Y
South Dakota	Medicaid for Children		Y	Y
	Separate SCHIP		Y	Y
Tennessee[7]	Medicaid for Children			Y
Texas	Medicaid for Children		Y	Y
	Separate SCHIP		Y	Y
Utah	Medicaid for Children		Y	Y
	Separate SCHIP		Y	Y
Vermont	Medicaid for Children	Y	Y	Y
	Separate SCHIP	Y	Y	Y
Virginia	Medicaid for Children		Y	Y
	Separate SCHIP		Y	Y
Washington	Medicaid for Children		Y	Y
	Separate SCHIP		Y	Y
West Virginia	Medicaid for Children		Y	Y
	Separate SCHIP		Y	Y
Wisconsin[8]	Medicaid for Children		Y	Y
Wyoming	Medicaid for Children	Y	Y	Y
	Separate SCHIP	Y	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, 2005.

+ Indicates that a state has eliminated a verification requirement between July 2004 and July 2005.
– Indicates that a state has instituted a verification requirement between July 2004 and July 2005.

* "Total Medicaid" indicates the number of states that have adopted a particular verification 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 verification 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 verification 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 2005, 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 by accessing data from other government agencies, such as the Social Security Administration and state Departments of Labor.

3. Arkansas has eliminated age verification for families that can provide Social Security numbers for their children.

4. In **California**, families must submit birth certificates for children applying for SCHIP. In **Montana**, families must submit birth certificates or other proof of citizenship for children applying for Medicaid. In both states, birth certificates are used to verify citizenship. In **California**, proof of income can be used as proof of residency for Medicaid; the SCHIP program does not require proof of residency.

5. In Nevada, age is generally verified for children's Medicaid using a data match with the Social Security Administration, however birth certificates are required of applicants who do not have a Social Security number.

6. In Oregon, there is no state rule requiring that residency be verified, however state workers request verification of address so that program cards can be issued.

7. In Tennessee, verification of age is required; however it is verified online by the worker for children born in Tennessee.

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

Table 7

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

July 2005

	Program	Frequency┼ (months)	12-Month Continuous Eligibility	No Face-to-Face Interview	Joint Renewal Form┼┼
Total	Medicaid (51)*	42	17	48	N/A
	SCHIP (36) **	34	24	35	N/A
	Aligned Medicaid and Separate SCHIP ***	42	16	48	17
Alabama	Medicaid for Children	12	Y	Y	
	Separate SCHIP	12	Y	Y	
Alaska	Medicaid for Children	6		Y	N/A
Arizona[2]	Medicaid for Children	12			
	Separate SCHIP	12	Y	Y	
Arkansas[3]	Medicaid for Children	12		Y	N/A
California	Medicaid for Children	12	Y	Y	
	Separate SCHIP	12	Y	Y	
Colorado	Medicaid for Children	12		Y	
	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	Medicaid for Children	12	Y	Y	
┼	Separate SCHIP	12		Y	
Georgia[4]	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		Y	N/A
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

		Program	Frequency┼ (months)	12-Month Continuous Eligibility	No Face-to-Face Interview	Joint Renewal Form┼┼
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[5]	+	Medicaid for Children	12	Y	Y	Y
	+	Separate SCHIP	12	Y	Y	
New Mexico[6]		Medicaid for Children	6		Y	N/A
New York		Medicaid for Children	12	Y	Y	
	+	Separate SCHIP	12	Y	Y	
North Carolina		Medicaid for Children	12	Y	Y	Y
		Separate SCHIP	12	Y	Y	
North Dakota[7]	+	Medicaid for Children	1		Y	Y
	+	Separate SCHIP	12	Y	Y	
Ohio		Medicaid for Children	12		Y	N/A
Oklahoma[8]	+	Medicaid for Children	12		Y	N/A
Oregon[9]		Medicaid for Children	6/12		Y	Y
		Separate SCHIP	6		Y	
Pennsylvania[10]	–	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[11]		Medicaid for Children	12		Y	
		Separate SCHIP	12	Y	Y	
Washington[12]	+	Medicaid for Children	12	Y	Y	Y
	+	Separate SCHIP	12	Y	Y	
West Virginia[13]		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, 2005.

+ Indicates that a state has simplified one or more of its procedures between July 2004 and July 2005.
– Indicates that a state has rescinded one or more simplified procedures between July 2004 and July 2005.

* "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.

┼ 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 2005, 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, there is a Medicaid interview requirement, however it can be done by telephone. Twelve-month continuous eligibility only applies to the first 12 months of coverage in SCHIP.

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**, there is an interview requirement at renewal in "regular" Medicaid, however it can be done by telephone. Reviews have been suspended in Tennessee's Section 1115 waiver program; however the state plans to begin reviewing children's eligibility in the near future.

4. 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.

5. 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 application as a renewal form. New Jersey plans to implement 12-month continuous eligibility in children's Medicaid and SCHIP effective January 2006.

6. In New Mexico, families receive a notice instructing them to call to receive a renewal form.

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

8. Oklahoma plans to implement a 12 month renewal period effective January 2006.

9. In Oregon, the renewal period for poverty-level children's Medicaid and SCHIP is 6 months. The renewal period for children covered under Section 1931 coverage is 12 months.

10. Pennsylvania plans to implement a six-month renewal period in Medicaid effective January 2006.

11. 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. A one-page renewal form is now being used for children's Medicaid. A pre-printed renewal form is used for SCHIP.

12. Washington plans to implement 12-month continuous eligibility effective fall 2005.

13. 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 2005

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	45	46
	Total Medicaid for Parents (51)**		36	22
Alabama[2]	Medicaid for Children			**Y**
	Separate SCHIP	**Y**	**Y**	**Y**
	Medicaid for Parents			**Y**
Alaska[3]	Medicaid for Children		**Y**	**Y**
	Medicaid for Parents			**($2,000)**
Arizona[4]	Medicaid for Children		**Y**	**Y**
	Separate SCHIP	**Y**	**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**
	Separate SCHIP	**Y**	**Y**	**Y**
	Medicaid for Parents		**Y**	**($2,000)**
Connecticut	Medicaid for Children		**Y**	**Y**
	Separate SCHIP	**Y**	**Y**	**Y**
	Medicaid for Parents		**Y**	**Y**
	Expanded Medicaid for Parents		**Y**	**Y**
Delaware	Medicaid for Children		**Y**	**Y**
	Separate SCHIP	**Y**	**Y**	**Y**
	Medicaid for Parents		**Y**	**Y**
	Expanded Medicaid for Parents		**Y**	**Y**
District of Columbia	Medicaid for Children		**Y**	**Y**
	Medicaid for Parents	**Y**	**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**
	Medicaid for Parents	**Y**	**Y**	**($3,250)**
	Expanded Medicaid for Parents		**Y**	**($3,250)**
Idaho[6]	Medicaid for Children		**Y**	**($5,000)**
	Separate SCHIP		**Y**	**($5,000)**
	Medicaid for Parents		**Y**	**($1,000)**
Illinois	Medicaid for Children		**Y**	**Y**
	Separate SCHIP	**Y**	**Y**	**Y**
	Medicaid for Parents		**Y**	**Y**
	Expanded Medicaid for Parents		**Y**	**Y**

	Program	Family Application┼	No Face-to-Face Interview	No Asset Test[1] (or limit for family of 3)
Indiana[6/8]	Medicaid for Children		Y	Y
	Separate SCHIP		Y	Y
	Medicaid for Parents			($1,000)
Iowa[6/9]	Medicaid for Children		Y	Y
	Separate SCHIP		Y	Y
	Medicaid for Parents			($2,000)
	Expanded Medicaid for Parents		Y	Y
Kansas	Medicaid for Children		Y	Y
	Separate SCHIP	Y	Y	Y
	Medicaid for Parents		Y	Y
Kentucky	Medicaid for Children			Y
	Separate SCHIP	Y		Y
	Medicaid for Parents			($2,000)
Louisiana	Medicaid for Children		Y	Y
	Medicaid for Parents		Y	Y
Maine[10]	Medicaid for Children		Y	Y
	Separate SCHIP	Y	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
	Separate SCHIP	Y	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
	Medicaid for Parents	Y	Y	($20,000)
	Expanded Medicaid for Parents		Y	($20,000)
Mississippi	Medicaid for Children			Y
	Separate SCHIP	Y		Y
	Medicaid for Parents			Y
Missouri[11]	Medicaid for Children	Y	Y	Y
	Medicaid for Parents		Y	Y
Montana[12]	Medicaid for Children		Y	($3,000)
	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)
New Jersey	Medicaid for Children		Y	Y
	Separate SCHIP	Y	Y	Y
	Medicaid for Parents		Y	Y
	Expanded Medicaid for Parents		Y	Y
New Mexico[13]	Medicaid for Children		Y	Y
	Medicaid for Parents	Y	Y	Y
	Expanded Medicaid for Parents		Y	Y

	Program	Family Application┼	No Face-to-Face Interview	No Asset Test[1] (or limit for family of 3)
New York[14]	Medicaid for Children			Y
	Separate SCHIP	Y	Y	Y
	Medicaid for Parents			($5,900)
	Expanded Medicaid for Parents			($17,700)
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
	Separate SCHIP	Y	Y	Y
	Medicaid for Parents		Y	Y
Ohio	Medicaid for Children		Y	Y
	Medicaid for Parents	Y	Y	Y
	Expanded Medicaid for Parents		Y	Y
Oklahoma[6]	Medicaid for Children		Y	Y
	Medicaid for Parents		Y	Y
Oregon	Medicaid for Children		Y	Y
	Separate SCHIP	Y	Y	($10,000)
	Medicaid for Parents		Y	($2,500)
	Expanded Medicaid for Parents		Y	($2,000)
Pennsylvania[15]	Medicaid for Children		Y	Y
	Separate SCHIP	Y	Y	Y
	Medicaid for Parents		Y	Y
	Expanded Coverage for Parents		Y	Y
Rhode Island	Medicaid for Children		Y	Y
	Medicaid for Parents	Y	Y	Y
	Expanded Medicaid for Parents		Y	Y
South Carolina[6]	Medicaid for Children		Y	Y
	Medicaid for Parents		Y	Y
South Dakota[6]	Medicaid for Children		Y	Y
	Separate SCHIP		Y	Y
	Medicaid for Parents		Y	($2,000)
Tennessee	Medicaid for Children	Y		Y
	Medicaid for Parents			($2,000)
Texas[16]	Medicaid for Children		Y	($2,000)
	Separate SCHIP		Y	($5,000)
	Medicaid for Parents			($2,000)
Utah[17]	Medicaid for Children			($3,025)
	Separate SCHIP			Y
	Medicaid for Parents			($3,025)
	Expanded Medicaid for Parents		Y	Y
Vermont[18]	Medicaid for Children		Y	Y
	Separate SCHIP	Y	Y	Y
	Medicaid for Parents		Y	($3,150)
	Expanded Medicaid for Parents		Y	Y
Virginia	Medicaid for Children		Y	Y
	Separate SCHIP		Y	Y
	Medicaid for Parents		Y	Y
Washington[19]	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

	Program	Family Application┼	No Face-to-Face Interview	No Asset Test[1] (or limit for family of 3)
Wyoming	Medicaid for Children	**Y**	**Y**	**Y**
	Separate SCHIP		**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, 2005.

+ Indicates that a state has simplified one or more of its procedures for parents between July 2004 and July 2005.
– Indicates that a state has rescinded one or more simplified procedures for parents between July 2004 and July 2005.

* "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. Sixteen 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.

Table presents rules in effect as of July 2005, unless noted otherwise.

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

2. Alabama requires that families applying for Medicaid complete an interview, however the interview can be done by phone.

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

4. In Arizona, families 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 an in-person or telephone interview. 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 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, parents may do a face-to-face or telephone interview. Telephone interviews are used for all families that come through the centralized unit that determines eligibility for children and pregnant women.

9. 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 would have to provide information on assets. Parents applying for "regular" Medicaid may use the Medicaid only application for the combined application for Medicaid, food stamps and TANF. The waiver program for parents has its own application.

10. Maine disregards $12,000 of savings toward its asset test for parents.

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

12. Montana plans to increase the asset limit in children's Medicaid from $3,000 to $15,000 in July 2006.

13. 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.

14. In New York, families may apply for health coverage for their children using one of two possible applications, 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.

15. 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.

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

17. In Utah, an interview is required for Medicaid and SCHIP, though families are permitted to do the interview by phone. Utah counts assets in determining Medicaid eligibility for children age 6 and older. Families that use the SCHIP application, but are found to be Medicaid-eligible, must complete a Medicaid addendum on other information, including information on assets, before eligibility can be determined. The SCHIP application is only available during SCHIP open enrollment periods. During SCHIP open enrollment periods, the Medicaid application can be used to apply for SCHIP.

18. In Vermont, families may apply for health coverage for their children using one of two possible applications, one of which can also be used to apply for parents.

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

Table 9
Renewal: Selected Simplified Procedures in Medicaid for Parents, with Comparisons to Children
July 2005

	Program	Frequency┼ (months)	No Face-to-Face Interview
Total	Aligned Medicaid for Children and Separate SCHIP *	42	48
	Total Medicaid for Parents (51)**	36	43
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	6	**Y**
	Expanded Medicaid for Parents	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**
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	

	Program	Frequency┼ (months)	No Face-to-Face Interview
Iowa	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	**Y**
	Medicaid for Parents	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[6]	Medicaid for Children	6	**Y**
	Medicaid for Parents	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**
New Jersey	Medicaid for Children	12	**Y**
	Separate SCHIP	12	**Y**
	Medicaid for Parents	12	**Y**
	Expanded Medicaid for Parents	12	**Y**
New Mexico[7]	Medicaid for Children	6	**Y**
	Medicaid for Parents	6	**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**

	Program	Frequency┼ (months)	No Face-to-Face Interview
North Carolina	Medicaid for Children	12	**Y**
	Separate SCHIP	12	**Y**
	Medicaid for Parents	6	**Y**
North Dakota[8]	Medicaid for Children	1	**Y**
	Separate SCHIP	12	**Y**
	Medicaid for Parents	1	**Y**
Ohio	Medicaid for Children	12	**Y**
	Medicaid for Parents	6	**Y**
	Expanded Medicaid for Parents	6	**Y**
Oklahoma[9] +	Medicaid for Children	12	**Y**
	Medicaid for Parents	12	**Y**
Oregon[10]	Medicaid for Children	6/12	**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	
Utah[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**
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, 2005. 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 2004 and July 2005.
– Indicates that a state has rescinded one or more simplified procedures for parents between July 2004 and July 2005.

* "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. Sixteen states and the District of Columbia have expanded Medicaid coverage for parents.

┼ 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 2005, unless noted otherwise.

1. In Arizona, the required Medicaid interview can be done by telephone.

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 occur every 6 months and eligibility reviews every 12 months.

3. In California, parents must submit a status report every 6 months. A full review of eligibility 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, the required Medicaid interview can be done by telephone.

6. In Nebraska, parents enrolled in Medicaid must report their income every three months. A full review of eligibility is done every six months. A face-to-face interview is not required, however a telephone interview is required.

7. In New Mexico, under "regular" Medicaid, families receive a notice instructing them to call to receive a renewal form.

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

9. Oklahoma plans to implement a 12 month renewal period effective January 2006.

10. In Oregon, cases maintained at the central office do not require interviews; however, local office may require interviews.

11. In Pennsylvania, expansion coverage for parents is through a state-funded program. The state plans to implement semiannual Medicaid reviews in January 2006.

12. In Tennessee, there is an interview requirement for children and parents, however it can be done by telephone.

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

14. In Washington, eligibility for the state-funded expansion program is reviewed every 12 months, unless the family's income information is not available in other state databases. If the information is not available in other state databases, eligibility is reviewed more frequently.

Table 10A

Premium Payments for Two Children in a Family of Three at Selected Income Levels[1] July 2005

	Increase or decrease[2]	Frequency of payment	Income Level at which State begins Requiring Premiums (FPL)	Amount at 101% of the Federal Poverty Line ($16,251)	Amount at 151% of the Federal Poverty Line ($24,296)	Amount at 200% of the Federal Poverty Line ($32,180)
Total	10 - Increase 1 - Decrease	33	N/A	10	26	29
Alabama		Annually	101	$100	$200	$200
Alaska		None	—	—	—	—
Arizona		Monthly	101	$15	$30	$35
Arkansas		None	—	—	—	—
California[3]	Increase	Monthly	101	$8/$14	$12/$18	$12/$18
Colorado		Annually	151	$0	$35	$35
Connecticut[4]	Increase	Monthly	185	$0	$0	$50
Delaware		Monthly	101	$10	$15	$25
Dist. of Columbia		None	—	—	—	—
Florida		Monthly	101	$15	$15	$20
Georgia[5]		Monthly	101	$15	$40	$56
Hawaii		None	—	—	—	—
Idaho		Monthly	151	$0	$30	N/A
Illinois[6]	Increase	Monthly	151	$0	$25	$25
Indiana		Monthly	150	$0	$16.50	$24.75
Iowa		Monthly	151	$0	$20	$20
Kansas		Monthly	151	$0	$20	$30
Kentucky		Monthly	151	$0	$20	$20
Louisiana		None	—	—	—	—
Maine	Increase	Monthly	151	$0	$16	$64
Maryland[7]	Increase	Monthly	201 ($42)	$0	$0	$0
Massachusetts		Monthly	101	$15	$24	$24
Michigan		Monthly	151	$0	$5	$5
Minnesota[1/8]	Increase	Monthly	151	$0	$58	$114
Mississippi		None	—	—	—	—
Missouri[9]	Increase	Monthly	150	$0	$20	$74
Montana		None	—	—	N/A	N/A
Nebraska		None	—	—	—	N/A
Nevada[10]		Quarterly	101	$15	$35	$70
New Hampshire		Monthly	186	$0	$0	$50
New Jersey[11]	Increase	Monthly	150	$0	$17.50	$35
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[12]	Increase	Monthly	201 ($91-$139)	$0	$0	$0
Rhode Island[1]		Monthly	150	$0	$61	$77
South Carolina		None	—	—	N/A	N/A
South Dakota		None	—	—	—	—
Tennessee[13]		Monthly	101	$40	$70	$250
Texas[14]	Decrease	Semiannual	134	$0	$35	$50
Utah		Quarterly	101	$13	$25	$25
Vermont[15]	Increase	Monthly	185	$0	$0	$30
Virginia		None	—	—	—	—
Washington		Monthly	201 ($30)	$0	$0	$0
West Virginia		None	—	—	—	—
Wisconsin[1/16]		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, 2005. See notes on following page.

Notes for Table 10A

Table presents rules in effect as of July 2005, unless noted otherwise.

1. Federal Medicaid law prohibits states from requiring premiums for children, unless a federal waiver has been obtained by the state. States in *italics* require the premiums noted in their children's Medicaid programs per waivers. The figures noted for the waiver programs in **Rhode Island** and **Wisconsin** may include coverage for parents. The figures noted for **Minnesota** are for two persons, which could include a parent. All other states require the premiums noted in their separate SCHIP programs. 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 added a premium, increased premiums at the income levels noted or lowered the income level at which premiums are required. "Decrease" indicates that the state has decreased premiums.

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 plan.

4. The premiums noted for Connecticut are effective October 2005.

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

6. Illinois plans to increase premiums for families with more than three children effective January 2006.

7. Maryland also increased premiums for children in families with income higher than noted in this table.

8. In Minnesota, the premiums noted apply only to children covered under the Section 1115 waiver program and are approximate. The state also increased premiums for children in families with income higher than noted in this table.

9. The premiums noted for Missouri are effective September 2005. The state also increased premiums for children in families with income higher than noted in this table.

10. 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 source of income and family composition. These families are required to pay SCHIP premiums.

11. New Jersey also increased premiums for children in families with income higher than noted in this table.

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

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

14. The premiums noted for Texas are effective January 2006.

15. Vermont also increased premiums for children in families with income higher than noted in this table.

16. 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 2005

	Effective Annual Amount at 101% of the Federal Poverty Line ($16,251)	Effective Annual Amount at 151% of the Federal Poverty Line ($24,296)	Effective Annual Amount at 200% of the Federal Poverty Line ($32,180)
Total	10	26	29
Alabama	$100	$200	$200
Alaska	—	—	—
Arizona	$180	$360	$420
Arkansas	—	—	—
California[2]	$96/$168	$144/$216	$144/$216
Colorado	$0	$35	$35
Connecticut[3]	$0	$0	$600
Delaware	$120	$180	$300
Dist. of Columbia	—	—	—
Florida	$180	$180	$240
Georgia[4]	$180	$480	$672
Hawaii	—	—	—
Idaho	$0	$360	N/A
Illinois	$0	$300	$300
Indiana	$0	$198	$297
Iowa	$0	$240	$240
Kansas	$0	$240	$360
Kentucky	$0	$240	$240
Louisiana	—	—	—
Maine	$0	$192	$768
Maryland	$0	$0	$0
Massachusetts	$180	$288	$288
Michigan	$0	$60	$60
Minnesota[1/5]	$0	$696	$1,368
Mississippi	—	—	—
Missouri[6]	$0	$240	$888
Montana	—	N/A	N/A
Nebraska	—	—	N/A
Nevada	$60	$140	$280
New Hampshire	$0	$0	$600
New Jersey	$0	$210	$420
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[7]	$480	$840	$3000
Texas[8]	$0	$70	$100
Utah	$52	$100	$100
Vermont	$0	$0	$360
Virginia	—	—	—
Washington	$0	$0	$0
West Virginia	—	—	—
Wisconsin[1/9]	$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, 2005. See notes on following page.

Notes for Table 10B

Table presents rules in effect as of July 2005, unless otherwise noted.

1. Federal Medicaid law prohibits states from requiring premiums for children, unless a federal waiver has been obtained by the state. States in *italics* require the premiums noted in their children's Medicaid programs per waivers. The figures noted for the waiver programs in **Rhode Island** and **Wisconsin** may include coverage for parents. The figures noted for **Minnesota** are for two persons, which could include a parent. All other states require the premiums noted in their separate SCHIP programs. 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 plan.

3. The premiums noted for Connecticut are effective October 2005. At that time, the state will also increase premiums for children in families with incomes higher than noted in this table.

4. In Georgia, premiums are required only of families with children age 6 and older.

5. The figures noted for Minnesota are approximate.

6. The premiums noted for Missouri are effective September 2005.

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

8. The premiums noted for Texas are effective January 2006.

9. 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 2005

	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	$0	$0	$0
Arizona[3]	$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]	$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[6] **D**	$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[7]	N/A	N/A	N/A	N/A	N/A	N/A
South Dakota	$0	$0	$0	$0	$0	$0
Tennessee[4]	$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, 2005. See notes on following page.

Notes for Table 11

D Indicates that a state has decreased the co-payment for one or more services between July 2004 and July 2005.
I Indicates that a state has increased the co-payment for one or more services between July 2004 and July 2005.

Table presents rules in effect as of July 2005, unless otherwise noted.

1. Federal Medicaid law prohibits states from requiring co-payments for children, unless a federal waiver has been obtained by the state. States in *italics* require the co-payments in their children's Medicaid programs per waivers. All other states charge the co-payments in their separate SCHIP programs. No co-payments are required of Alaska Native or American Indian children. "N/A" indicates that the state does not provide coverage at this income level.

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 in-patient 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 $.50-$3.00 co-payment for prescriptions and the co-pay of 10 percent of the cost of the first day of in-patient care. In **Kentucky**, 18-year-olds are subject to the $2 co-payment for non-preventive physician visits, the $3 co-payment for non-emergency use of the emergency room and the $50 co-payment for in-patient care.

3. In the states noted, the co-payment for emergency room use in non-emergency situations is higher than noted in the table. They are as follows: In **Alabama**, $20; In **Arizona**, $5; 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 **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. Missouri eliminated all co-payments required in children's Medicaid effective September 2005.

7. 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.

Table 12

Co-payments for Specific Services in Health Coverage Programs for Parents
July 2005

	Cost-sharing Applies for Parents in a Family of 3 at or Below the following Monthly Income Limits	Inpatient Hospital (Per admission unless otherwise noted)	Emergency Room Visit[1]
Total	N/A	26	9
Alabama[1]	$254	$50	$0
Alaska	$1,350	$50 per day for first four days	$0
Arizona[1]	$2,682	$0	$0
Arkansas	$255	10 percent of reimbursement rate for first day	$0
California	$1,431	$0	$0
Colorado	$511	$15	$0
Connecticut	$2,101	$0	$0
Delaware	$1,431	$0	$0
District of Columbia	$2,682	$0	$0
Florida[1]	$806	$3	$0
Georgia	$756	$12.50	$0
Hawaii	$1,543	$0	$0
Idaho	$407	$0	$0
Illinois[2]	$2,571	$3 per day/$2 or $5	$0/$2 or $5
Indiana[1]	$378	$0	$0
Iowa[3]	$1,065/$3,352	$0	$0
Kansas	$493	$48	$0
Kentucky[1] **I**	$909	$50	$0
Louisiana	$264	$0	$0
Maine	$2,101	$3 per day	$0
Maryland	$524	$0	$0
Massachusetts[1]	$1,783	$3	$0
Michigan	$774	$0	$0
Minnesota[1/4]	$3,690	10% of cost	$0
Mississippi	$458	$10	$0
Missouri[1] **D**	$558	$10	$0
Montana[1]	$855	$100	$0
Nebraska	$804	$0	$0
Nevada	$1,133	$0	$0
New Hampshire	$781	$0	$0
New Jersey[5]	$1,341	$0	$0/$35
New Mexico[6]	$903/$5,488	$0/$0, $25 or $30	$0/$0, $15 or $20
New York[7] **I**	$2,011	$25 per discharge	$3
North Carolina	$750	$3 per day	$0
North Dakota	$904	$75	$6
Ohio	$1,207	$0	$0
Oklahoma	$591	$3 per day	$0
Oregon	$1,341	$0	$0
Pennsylvania[8]	$842/$2,682	$3 per day (maximum of $21)/$0	$0/$25
Rhode Island	$2,571	$0	$0
South Carolina[1]	$1,304	$25	$0
South Dakota[1]	$796	$0	$0
Tennessee	$1,092	$0	$0
Texas	$401	$0	$0
Utah[1/9]	$673/$2,011	$220/no coverage	$0/$30
Vermont[10]	$2,571	$75/$0	$0/$25
Virginia	$412	$100	$0
Washington[11]	$1,092/$2,682	$0/$100 plus 20 percent coinsurance	$0/20% coinsurance
West Virginia	$499	$0	$0
Wisconsin	$2,571	$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, 2005. 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 2004 and July 2005.
I Indicates that a state has increased the co-payment for one or more services between July 2004 and July 2005.

Table presents rules in effect as of July 2005, unless otherwise noted.

1. Several states require a co-payment for non-emergency use of the emergency room. **Alabama**, **Indiana**, **Kentucky**, **Massachusetts**, **Missouri** and **South Carolina** require a $3 co-payment for this service. **Arizona** and **Montana** require a $5 co-payment for this service. **Wyoming** requires a co-payment of $6 for this service. **Minnesota** and **Utah** require a $6 co-payment for this service for parents covered under "regular" Medicaid. In **Florida**, there is a co-insurance of 5 percent up to the first $300 of cost (maximum is $15) for this service. In some cases, this co-payment is for outpatient hospital care. In **South Dakota**, the co-payment for outpatient hospital services not billed as emergencies is five percent of the allowable Medicaid reimbursement up to a maximum of $50.

2. In Illinois, the first amount shown in the table applies to parents with income below 133 percent of the federal poverty line. When the state expands coverage to 185 percent of the federal poverty line for parents in January 2006, these parents will be subject to the SCHIP co-payments. The second amounts noted, which vary by income, are the co-payments required in SCHIP.

3. In Iowa, the first monthly income limit shown applies to "regular" Medicaid. The second income limit shown applies to the state's waiver program.

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, there is no cost-sharing required of parents covered under "regular" Medicaid. Parents with income above 150 percent of the federal poverty line must pay a co-payment of $35 for emergency room visits.

6. In New Mexico, the first monthly income limit shown applies to "regular" Medicaid. The second income limit shown applies to the state's waiver program. The first co-payment amount noted is for "regular" Medicaid and the second co-payment amount noted is for the state's waiver program. The co-payments required in the state's waiver program vary by income.

7. In New York, the co-payments noted apply to "regular" Medicaid. The expansion program will begin requiring these co-payments effective September 2005.

8. In Pennsylvania, the first monthly income limit shown applies to "regular" Medicaid. The second income limit shown applies to the state-funded program. The co-payments for parents vary based on whether they are covered under Medicaid or the state-funded program. The first co-payment amount shown in the table applies to Medicaid. The second co-payment amount shown applies to the state-funded program. The co-payment for emergency room use under the state-funded program is waived if the parent is admitted.

9. In Utah, the first monthly income limit shown applies to "regular" Medicaid. The second income limit shown applies to the state's waiver program. The first co-payment amount noted is for 'regular" Medicaid and the second co-payment amount noted is for the state's waiver program.

10. In Vermont, the first amount noted is for "regular" Medicaid and the second amount noted is for the state's waiver program.

11. In Washington, the first monthly income limit shown applies to "regular" Medicaid. The second income limit shown applies to the state-funded program. The first co-payment amount noted is for "regular" Medicaid and the second co-payment amount noted is for the state-funded program. Under the state-funded program, the co-payment for emergency room care is waived if the patient is admitted to the hospital. In addition, an annual deductible applies to inpatient and emergency room care. 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 2005

	Prescription Co-payment for Children
Total	20
Alabama[2/5]	$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[2/3]	$5.00
California	$5.00
Colorado[5]	$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[4]	$5.00
Georgia	$0
Hawaii	$0
Idaho	$0
Illinois[5]	$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[2]	$0
Louisiana	$0
Maine	$0
Maryland	$0
Massachusetts	$0
Michigan	$0
Minnesota	$0
Mississippi	$0
Missouri[6] **D**	$0
Montana	$3.00 (generic) $5.00 (brand name)
Nebraska	$0
Nevada	$0
New Hampshire[7]	$5.00 (generic) $10.00 (brand name)
New Jersey[5]	$1.00 or $5.00 (generic) $5.00 or $10.00 (brand name)
New Mexico[8]	$2.00
New York	$0
North Carolina[5]	$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[3] **D**	$3.00
Texas[5]	$0 or $5.00 (generic) $3.00, $5.00 or $20.00 (brand name)
Utah[5]	$1.00 or $5.00 (approved list) $3.00 or 50 percent of cost (not on approved list)
Vermont	$0
Virginia[5]	$2.00 or $5.00
Washington	$0
West Virginia[5]	$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, 2005. See notes on following page.

Notes for Table 13

D Indicates that a state has decreased the co-payment for prescriptions between July 2004 and July 2005.
I Indicates that a state has increased the co-payment for prescriptions between July 2004 and July 2005.

Table presents rules in effect as of July 2005, unless otherwise noted.

1. Federal Medicaid law prohibits co-payments from being required of children, unless a federal waiver permitting this has been obtained by the state. States in *italics* require the co-payments noted in their children's Medicaid programs per waivers. All other states require the co-payments noted in their separate SCHIP programs.

2. In **Alabama and Arkansas**, 18-year-olds are subject to the $.50 to $3 Medicaid co-payment for adults. In **Alaska**, 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 $3 co-payment for adults. In **Wisconsin**, 18-year-olds covered under the waiver program are subject to the $1 or $3 co-payment for adults.

3. 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.

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

5. 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 are required to pay $3 for brand name prescriptions. Families with income between 101 and 150 percent of the federal poverty line are required to pay $5 for brand name prescriptions. Families with income between 151 and 200 percent of the federal poverty line are required to 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.

6. Missouri eliminated all co-payments in children's Medicaid effective September 2005.

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

8. 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 2005

		Prescription Co-payment for Parents
Total		40
Alabama		$.50-$3.00
Alaska		$2.00
Arizona		$0
Arkansas		$.50 -$3.00
California		$0
Colorado		$.75 (generic) $3.00 (brand name)
Connecticut		$0
Delaware	**I**	$.50-$3.00
District of Columbia		$0
Florida		$0
Georgia		$.50
Hawaii[1]		$0
Idaho		$0
Illinois[2]	**D**	$0 (generic) $3.00 (brand name)/$2.00 or $3.00 (generic) $2.00 or $5.00 (brand name)
Indiana		$3.00
Iowa		$.50 - $3.00
Kansas		$3.00
Kentucky	**I**	$1.00 (generic) $2.00 (brand name) $3.00 (not on preferred drug list)
Louisiana		$.50-$3.00
Maine		$2.50
Maryland		$0
Massachusetts		$1.00 (generic) $3.00 (brand name)
Michigan		$1.00
Minnesota[3]		$1.00 (generic) $3.00 (brand name)/ $3.00
Mississippi	**I**	$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[3]		$0/ $5.00, $10.00 (more than a 34 day supply)
New Mexico[4]		$0/$3.00
New York[3]	**I**	$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		$3.00 for prescriptions not on preferred drug list
Oklahoma		$1.00-$2.00
Oregon[5]		$2.00 (generic) $3.00 (brand name)
Pennsylvania[3]		$1.00 (generic) $3.00 (brand name)/$0
Rhode Island		$0
South Carolina		$3.00
South Dakota		$2.00
Tennessee	**I**	$0 (generic) $3.00 (brand name)
Texas		$0
Utah[3/6]	**I**	$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[3]		$0/$10.00 (generic) 50 percent of cost (brand name)
West Virginia	**I**	$.50-$3.00
Wisconsin[3]		$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, 2005. See notes on following page.

Notes for Table 14

D Indicates that a state has decreased the co-payment for prescriptions between July 2004 and July 2005.
I Indicates that a state has increased the co-payment for prescriptions between July 2004 and July 2005.

Table presents rules in effect as of July 2005, unless noted otherwise.

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

2. In Illinois, the first amount shown in the table applies to parents with income below 133 percent of the federal poverty line. When the state expands coverage to 185 percent of the federal poverty line for parents in January 2006, these parents will be subject to the SCHIP co-payment for prescriptions. The second amounts noted, which vary by income, are the co-payments required in SCHIP.

3. In **Minnesota**, **New Jersey, New York, Pennsylvania, Utah, Washington** and **Wisconsin,** the co-payment amounts vary depending on whether the parent is covered under pre-expansion Medicaid or the state's expanded coverage for parents. The first amount shown in the table is the amount for pre-expansion Medicaid. The second amount shown is for the Medicaid expansion program or, in the case of **Pennsylvania** and **Washington**, the state-funded separate program for parents. In **New York**, the co-payment in the state's expanded coverage for parents is effective September 2005. In **Utah**'s expansion program, there is a limit of four prescriptions per member per month. In **Wisconsin**, the co-payment only applies to parents covered under the waiver expansion with income at or above 150 percent of the federal poverty line.

4. In New Mexico, the first amount noted is for "regular" Medicaid and the second amount noted is for the state's waiver program. Under the waiver program, a co-payment is only required for the first four prescriptions each month.

5. In Oregon, the co-payment noted is only required of non-exempt Medicaid recipients. No prescription co-payment is required of parents eligible under waiver coverage.

6. In Utah, there is an out-of-pocket limit of $15 per month for prescriptions under "regular" Medicaid.

Table 15

State Changes to Premiums and "Lock-Out" Periods in Children's Health Coverage Programs
July 2005

	Changes to Premiums and "Lock-Out" Periods
Total Premium Increases	**10**
California	Increased SCHIP premiums for families with income above 200 percent of the federal poverty line. Previously, these families were required to pay $12 or $18 per month, depending on whether they chose the discounted community provider plan. They are now required to pay $24 or $30 per month.
Connecticut	Lowered the income level at which SCHIP premiums are required from 235 percent of the federal poverty line to 185 percent of the federal poverty line; the state increased the premium required of families with income above 235 percent of the federal poverty line from $50 to $75 per month.
Illinois	Plans to increase SCHIP premiums for families with more than three children effective January 2006. For example, premiums for a family with four children with income at 151 percent of the federal poverty line will go from $30 to $35 per month and premiums for a family with five children will go from $30 to $40 per month.
Maine	Increased the SCHIP premiums required at all income levels. For example, premiums for families with income at 151 percent of the federal poverty line went from $8 to $16 per month and premiums for families with income at 200 percent of the federal poverty line went from $40 to $64 per month.
Maryland	Enacted a slight increase of SCHIP premiums from $41 to $42 for families with income above 200 percent of the federal poverty line and $52 to $53 for families with income above 250 percent of the federal poverty line.
Minnesota	Increased its sliding scale premiums, however the changes at the income levels reported in this survey were minor. The current premiums are $58 at 151 percent of the federal poverty line and $114 at 200 percent of the federal poverty line. These changes apply to waiver coverage for children and parents.
Missouri	Lowered the income level at which premiums are required from 225 to 150 percent of the federal poverty level as of September 2005. Families with income at 151 percent of the federal poverty line will now be charged $20 per month. Families with income at 200 percent of the federal poverty line will be charged $74 per month.
New Jersey	Enacted a slight increase of SCHIP premiums, from $17 to $17.50 for families with income at 151 percent of the federal poverty line and $34 to $35 for families with income at 200 percent of the federal poverty line.
Pennsylvania	Increased SCHIP premiums. In 2004, the premiums, which vary by health plan, ranged from $60 to $138. Premiums now range from $91 to $139.
Vermont	Increased SCHIP premiums. For example, premiums for families with income at 200 percent of the federal poverty line went from $25 to $30.
Total Premium Reductions	**1**
Texas	Plans to reduce SCHIP premiums effective January 2006. In addition to eliminating premiums for families with income at or below 133 percent of the federal poverty line, the state plans to begin requiring semiannual premiums instead of monthly premiums. For example, the annual premium for a family with income at 151 percent of the federal poverty line went from $240 to $70 and the annual premium for a family with income at 200 percent of the federal poverty line went from $300 to $100.
Changes to Lock-Out Periods	**3**
Georgia	Reduced its "lock-out" period from three months to one month.
Florida	Reduced its "lock-out" period from six months to 60 days. This restores the state's former, less restrictive policy.
Michigan	Eliminated its six-month "lock-out" period.

SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, 2005.

Table 16

State Changes to Co-payments in Health Coverage Programs for Children and Parents
July 2005

	Changes to Co-payments
Total Co-payment Increases	**7**
Delaware	Implemented a co-payment for prescriptions for parents. The co-payment is between $.50 to $3.00, depending on the cost of the drug.
Kentucky	Increased the co-payment for prescriptions and added co-payments for inpatient care and non-emergency use of the emergency room for parents. The co-payment for prescriptions originally was $1.00 and is now $1.00, $2.00 or $3.00, depending on the type of drug. The new co-payment for in-patient care is $50.00 and the new co-payment for emergency room care in non-emergency situations is $3.00.
Mississippi	Increased the co-payment for prescriptions for parents. The co-payment for prescriptions was originally $1.00 for a generic drug and $3.00 for a brand name drug. The co-payment is now $3.00 for all drugs.
New York	Increased the co-payment for prescriptions for parents in both "regular" Medicaid and its Medicaid waiver expansion. The co-payment for prescriptions under regular Medicaid was $.50 for a generic drug and $2.00 for a brand name drug. It is now $1.00 for a generic drug and $3.00 for a brand name drug. The co-payment for prescriptions under expanded Medicaid was $1.00 for generic drug and $3.00 for a brand name drug. It is now $3.00 for a generic drug and $6.00 for a brand name drug. The state also implemented new co-payments for some other services in its Medicaid expansion for parents. These include $25.00 for inpatient hospital care and $3.00 for an emergency room visit.
Tennessee	Implemented a co-payment for prescriptions in Medicaid for parents. There is now a $3.00 co-payment for brand name drugs.
Utah	Increased the co-payment for prescriptions for parents in Medicaid from $2.00 to $3.00.
West Virginia	Increased the co-payment for prescriptions for parents. The co-payment formerly ranged from $.50 to $2.00; the new range is $.50 to $3.00.
Total Co-payment Reductions	**3**
Illinois	Eliminated the co-payment for generic prescriptions for parents.
Missouri	Will eliminate all co-payments in its children's Medicaid program, effective September 2005. (This will coincide with implementation of increased premiums targeting lower-income families). Missouri also eliminated the co-payment for emergency room use by parents.
Tennessee	Reduced the co-payment for prescriptions in its waiver program. The co-payment was reduced from $5.00 or $10.00, depending on income level, to $3.00.

SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, 2005.

Table A

Expanding Eligibility and Simplifying Enrollment: Trends in Children's Health Coverage Programs (July 1997 to July 2005)

State Strategies	July 1997[1]	Nov. 1998[2]	July 2000[2]	Jan. 2002[2]	April 2003[2]	July 2004[2]	July 2005[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**
Covered children under age 19 in families with income at or above 200 percent of FPL	6[3]	22	36	40	39	39	41
Joint application for Medicaid and SCHIP	N/A	not collected	28	33	34	34	34
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)
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)
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)
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)
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)
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)
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]

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 waiver. 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 have all reopened enrollment as of July 2005.

SOURCE: Based on a national survey conducted by the Center on Budget and Policy Priorities for the Kaiser Commission on Medicaid and the Uninsured, 2005.

Table B

Expanding Eligibility and Simplifying Enrollment: Trends in Health Coverage for Parents (January 2002 to July 2005)

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

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 must 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 the Kaiser Commission on Medicaid and the Uninsured, 2005.

1330 G Street NW, Washington, DC 20005
Phone: (202) 347-5270, *Fax:* (202) 347-5274
Website: www.kff.org/KCMU

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