



American Academy
of Family Physicians

MEDICAID TOPICS

State-By-State Comparisons
Eligibility Trends: Particularly
for Pregnant Women and Children
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Issue Summary

Medicaid eligibility tends to vary based upon the growth of state tax revenue. During periods of economic downturn such as 2001-2003, Medicaid enrollment tended to increase. At the same time, state revenue decreased. In an attempt to balance their budget (as constitutionally required by many states) Medicaid eligibility was cut. Unexpected drops in enrollment led some states to expand coverage and reverse barriers but others cut back or increased costs to families. Additionally, fewer states imposed enrollment barriers for children in Medicaid and SCHIP (State Children's Health Insurance Program) during 2005 as compared to 2004.

The economic recovery has been uneven across the nation. The Great Lakes states and Plains states have had the least recovery while the Southeast and Far West has experienced greater increases in state revenue. The trend in Medicaid spending growth has tended to decrease, however, after peaking at 12.7% in 2002-2003. The FY 2006 estimates are for an increase of 5.5%; generally less than the private health insurance market increase.

Thirty states have presumptive eligibility for pregnant women (pregnant women are presumed eligible upon application until proven otherwise when the application is processed). The intention of presumptive eligibility is to enroll pregnant women in prenatal care early in the pregnancy. Forty-five states do not require an asset test for pregnant women in order to be eligible for Medicaid coverage. Income eligibility levels for pregnant women vary considerably by states from the minimum 133% of poverty to 275% of poverty.

Children are covered through both Medicaid and the SCHIP program. States have minimum coverage levels for children under Medicaid in order to be eligible for federal participation (matching federal funds) but are permitted to have higher levels of eligibility. Some states have different eligibility levels based upon the age of the child with the most generous eligibility being for infants' ages 0-1. The other age eligible categories are children ages 1-5 and 6-18. Thirty-six states have a separate SCHIP program for children with eligibility ranging from the minimum of 140% of poverty in North Dakota to 350% of poverty in New Jersey.

In FY 2006, all fifty states plus the District of Columbia increased provider payments. Ten states increased benefits and 21 plus the District of Columbia expanded eligibility while a total of 16 states reported plans to cut or restrict benefits.

Importance to Family Physicians

Overall, the trend in states is to restore eligibility and reduce barriers to Medicaid and SCHIP enrollment for pregnant women and children. The variation among states is considerable, however, with those states with greater revenues offering more liberal eligibility. There is a general acceptance that providing Medicaid coverage to pregnant women (i.e. early enrollment in prenatal care) and children is cost effective versus the cost of treatment after the onset of serious illness. Family physicians need to monitor state developments regarding eligibility trends and testify before state legislatures regarding the importance of early detection and prevention of health problems.

State-by-State Tables

The following data tables may be found at: www.kaiser.com/medicaid

- 1). State by state SCHIP enrollment changes
- 2). Income eligibility levels for pregnant women applying for Medicaid by annual income and as a percent of federal poverty level (FPL) 2005
- 3). Positive Medicaid policy actions taken by states, FY 2006
- 4). Medicaid cost containment acts taken by states, FY 2006
- 5). Income eligibility levels for children's separate SCHIP programs by annual incomes and as a percent of federal poverty level, 2005
- 6). Income eligibility levels for children's regular Medicaid by annual incomes and as a percent of federal poverty level (FPL), 2005