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# Reproductive Health Services for Adolescents Under the State Children's Health Insurance Program

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**Context:** The federal government enacted the State Children's Health Insurance Program (CHIP) in 1997 to provide insurance coverage to uninsured, low-income children up to age 19. Individual states' decisions when designing their CHIP efforts will in large part determine the extent to which the program will help the nation's nearly three million low-income uninsured adolescents get needed reproductive health services.

**Methods:** CHIP administrators in all states and the District of Columbia were sent a survey concerning reproductive health services for adolescents aged 13-18 provided under their state's CHIP effort. The questionnaire asked about services covered, information provided to adolescents, confidentiality, outreach and enrollment activities, managed care and performance measures.

**Results:** Of the 46 respondents to the survey, 29 states and the District of Columbia included a Medicaid component to their CHIP effort, and 28 states included a state-designed component. Overall, states provided relatively comprehensive coverage of reproductive health services, with all 58 CHIP programs covering routine gynecologic care, screening for sexually transmitted diseases and pregnancy testing. Fifty-four covered the full range of the most commonly used prescription contraceptive methods, although only 43 covered emergency contraception. Twenty of 58 CHIP programs required that adolescents be provided with information about coverage for the full range of reproductive health services, and 18 required that information be provided about accessing care. Seventeen programs reported guarantees of confidentiality before and after receipt of reproductive health care. In 26 programs, enrollees in managed care were guaranteed access to contraceptive services through out-of-network providers. Twenty-six states and the District of Columbia reported targeting outreach activities specifically to adolescents, and 41 states and the District of Columbia stated that they provide outreach materials at middle schools, high schools and community-based organizations serving teenagers.

**Conclusions:** Despite their nearly comprehensive coverage of reproductive health services, programs were inconsistent in guaranteeing the information, confidentiality and flexibility in choosing providers that is critical to adolescents' ability to access care. In addition, many states failed to creatively use strategies to target uninsured adolescents for enrollment, although new initiatives are under way to correct this problem.

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» article in pdf
» table of contents
» search the FPP archive
» guidelines for authors

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The State Children's Health Insurance Program, known as CHIP or SCHIP (Title XXI

of the Social Security Act), was enacted as part of the Balanced Budget Act of 1997. The program is one of the most significant moves taken by Congress to incrementally reduce the number of uninsured Americans after the collapse of plans for large-scale health care reform in the early 1990s.

Congress allocated up to $40 billion in federal funds over 10 years to CHIP to provide health insurance coverage to many of the nation's uninsured children. Although the political rhetoric surrounding its creation focused on the need to cover young children, CHIP targeted children up to age 19 in families with incomes below 200% of the federal poverty level, a group that in 1997 included 12% of the country's adolescents (1.3 million females and 1.4 million males).[1]

In practice, states had the option of setting age and income ceilings for their individual CHIP efforts. Nevertheless, a 1998 analysis by The Alan Guttmacher Institute (AGI) of the plans approved by the Health Care Financing Administration (HCFA), which oversees the CHIP program, found that all but a few states opted to cover adolescents up to age 19. And while 14 states did plan to cut off eligibility at 150% of poverty or below, the rest had ceilings near, at or—in the case of seven states—above 200%.[2]

All of the teenagers eligible for enrollment in CHIP require a range of educational and medical services related to reproductive health. According to several widely accepted guidelines of care for preventive services to adolescents that have been developed by major health organizations—including the American College of Obstetricians and Gynecologists, the American Medical Association and the Department of Health and Human Services—all adolescents need routine preventive care, including health guidance about sexual development and responsible sexual decision-making.[3] According to these guidelines, sexually experienced teenagers—a group that includes half of all U.S. adolescents and more than 75% of females and 85% of males at age 19—should also be screened for cervical cancer and sexually transmitted diseases (STDs) and should have access to family planning services and supplies.

The degree to which CHIP can help adolescents meet these reproductive health needs depends largely on the decisions that individual states make in designing their efforts. The federal statute gives states three options for their CHIP effort's overall design: expanding eligibility for its Medicaid program; creating or expanding a state-designed program not based on Medicaid; or using a combination of the two approaches.

States have utilized all three approaches. Generally, states that have taken the combination approach provide Medicaid coverage to poorer or younger enrollees and provide state-designed (and often less comprehensive) coverage to higher-income or older enrollees. Under this approach, the state effectively implements two separate programs for two different groups of children.

Enrollees in the Medicaid expansion programs and in the Medicaid components of the combination efforts are, under federal law, entitled to the same benefits as other Medicaid enrollees. These include family planning services, which are specifically mandated by the federal Medicaid statute for "individuals of childbearing age," including "minors who can be considered to be sexually active."[4] Medicaid law also requires that enrollees have the option to obtain family planning services and supplies from any provider, even one who is not part of the enrollee's managed care network—a

requirement often referred to as "freedom of choice." Even though not specifically mandated to do so under federal law, all states have chosen to cover a broad range of other reproductive health services under Medicaid (such as routine gynecologic care, STD and HIV screening, and pregnancy testing); these services should be available in Medicaid-based CHIP programs as well.

States choosing to use a separate, state-designed program for all or part of their CHIP effort, on the other hand, have many more options in choosing the benefits provided to enrollees. The federal CHIP statute and regulations require coverage of only a minimum set of services, such as physician and hospital care, laboratory and X-ray services, well-child care and immunizations. While the statute explicitly gives states the option to cover "prepregnancy family planning services,"[5] these and other reproductive health services are not required, and the scope of such services is not defined. Even if a state chooses to cover family planning services, it is not required to provide freedom of choice.

Separately, the statute allows federal payment for abortion services under state-designed CHIP programs only in cases of life endangerment, rape or incest, although states may cover abortion in other circumstances with their own funds.[6] A similar restriction applies to coverage of abortion under Medicaid and therefore to Medicaid-based CHIP efforts.

Critical to the program's success are the various outreach efforts that states have adopted to boost enrollment, estimated by HCFA at 3.3 million children during FY 2000.[7] Outreach is a required component of all CHIP programs,[8] in part because of the need to overcome the stigma of its connection to Medicaid. Until 1996, Medicaid was linked to welfare, which has traditionally attempted to limit enrollment through strict eligibility criteria and processes rather than to actively seek out new clients.

States have some well-tested options for easing the enrollment processes. These options were pioneered in the late 1980s, when Medicaid was expanded to cover pregnant women and young children in families with incomes higher than states' traditional Medicaid ceilings. Implemented to help states enroll a population that had no connection to welfare, such options include mail-in applications and wide distribution of information and application forms. Additionally, personnel authorized to determine eligibility may be assigned to nongovernmental sites (called "outstationing"), and health care providers may be certified to grant temporary eligibility while waiting for a formal application to be processed (known as "presumptive eligibility"). States are required to use outstationing under Medicaid at community health centers and at hospitals that serve a disproportionate share of low-income and high-cost patients.[9]

Similarly, states are required to establish "objective, independently verifiable" performance measures to gauge the success of the CHIP program in meeting overall program objectives for improving health coverage among the targeted group of children.[10] The statute, however, leaves both the specific measures to be used and the underlying objectives entirely to the states' discretion. As a result, each state will determine on its own whether any of its measures or objectives will be related to coverage of reproductive health care.

## METHODOLOGY

In May 1999, we sent questionnaires regarding the coverage and delivery of reproductive health services under CHIP to the offices listed by HCFA as having been designated to administer the CHIP effort in 47 states and the District of Columbia, all of which had plans approved by HCFA. We asked that all responses pertain to adolescents aged 13-18 and be current as of April 1, 1999. Three states—Tennessee, Washington and Wyoming—did not have CHIP plans approved by HCFA when we initially fielded the survey; we sent surveys to these states upon HCFA approval of their plans. We received responses from 47 states and the District of Columbia; New Mexico, South Dakota and Virginia declined to complete the survey. Additionally, Hawaii and Minnesota indicated that their CHIP efforts did not cover adolescents and, therefore, were not applicable to our survey. As a result, we compiled responses from a total of 45 states and the District of Columbia.

Of the 46 responses that we used, 30 CHIP efforts (in 29 states and the District of Columbia) included a Medicaid component,* while 28 had a state-designed component. (The 12 states that took a combination approach for adolescents are included in both tallies.) Because so many states had combined Medicaid and state-designed approaches, and because federal requirements differed for these two types of components, most of this article actually addresses 58 different programs—30 Medicaid programs and 28 state-designed ones.

We asked CHIP administrators to complete the questionnaire, which was divided into four sections, based on the design of their state's CHIP effort. The first section applied to Medicaid components, while the second applied to state-designed elements. The two sections were otherwise identical. We requested states that took a combination approach to complete both sections. All administrators were asked to complete the last two sections of the questionnaire regarding outreach activities and performance measures; these sections asked about the jurisdictions' CHIP effort as a whole and did not distinguish between Medicaid and state-designed components.

In the first two sections, we asked administrators to indicate whether their state's CHIP components covered specific reproductive health services, including six main categories of services: routine gynecologic care, STD and HIV screening and testing, contraceptive services, abortion, pregnancy testing and obstetric care. We also asked whether the state required that adolescents enrolled in CHIP routinely be informed of whether these six categories of services were covered and, if so, how to access this care.

Furthermore, we asked administrators whether the state required that adolescents be able to obtain confidential reproductive health services without parental notification, both before and after care, and about the use of outstationing and presumptive eligibility. Finally, we posed a series of questions to document the extent to which adolescents were enrolled in managed care organizations, the degree of reproductive health care coverage under these contracts, the extent to which managed care organizations were required to demonstrate that their networks are adequate to provide "reasonable access" to these services and the prevalence of freedom-of-choice protections for these services.

The outreach section of the questionnaire asked about activities tailored specifically to

encourage enrollment of teenagers in CHIP and about distribution of outreach materials and enrollment forms at various locations. In addition, the performance measures section asked about the use of six specific measures on reproductive health-related screening and counseling.

The findings of the survey, while for the most part reflecting actual (as opposed to planned) CHIP policy, cannot be taken as a precise picture of efforts across the country as of April 1, 1999. For the three states that received approval of their CHIP plans from HCFA after we initially fielded the survey, the findings are as of the specific plan's approval date. For these three programs and for two other components that were not operational as of the cutoff date,[‡] the findings reflect states' plans rather than operational policy.

In addition, we do not know the extent to which the various features of states' CHIP programs are fully implemented, enforced and followed. Clearly, the range of services available to enrollees depends not only on what is offered and required under a program, but also on how well-informed enrollees, providers and administrators are about these requirements and on how willing they are to use, recommend, prescribe or facilitate these services. Similarly, even when a state reports that it requires complete confidentiality for adolescents' reproductive health care, this confidentiality can be negated, on purpose or by accident, by the actions or ignorance of a wide range of individuals or by inadequate systems or technology. This limitation, however, is no more significant here than in any other top-down survey of state policy; a reliable study of how CHIP policies are being put into practice would require a survey of providers or enrollees and was beyond the scope of this project.

Finally, many administrators had considerable difficulty providing the number of female and male adolescent enrollees in CHIP as of April 1, 1999. Administrators were, for the most part, unable to provide accurate numbers for the specific population or the specific date, and many expressed concerns about their ability to provide numbers without counting individual enrollees multiple times. As a result, we excluded this question from the analysis.

## FINDINGS

### Services Covered

All of the Medicaid-based CHIP components covered nearly the full range of reproductive health care services about which we asked (Table 1). All 30 covered routine gynecologic care (including annual examinations and Pap tests); screening and testing for the full range of STDs we listed (gonorrhea, chlamydia, syphilis, human papillomavirus, genital herpes and HIV); all five major prescription contraceptive methods and related services (oral contraceptives, the injectable, the IUD, the diaphragm and the implant); abortion in cases of life endangerment, rape or incest; pregnancy testing; and obstetric care. Only three of the reproductive health services we asked about were covered less frequently: Twenty-six Medicaid components covered instruction on natural family planning, 21 covered emergency contraception and only six covered abortions in broader circumstances, such as for health reasons (not shown).

Several state-designed components provided less comprehensive coverage (Table 1). All 28 state-designed components covered routine gynecologic care, STD and HIV screening and testing, and pregnancy testing. However, three state-designed components (North Carolina, Pennsylvania and West Virginia) excluded obstetric care. Two did not cover abortion at the level mandated by Medicaid: Alabama did not cover abortion under any circumstances in its state-designed component, and Utah covered abortion only to preserve the woman's life.

Four of the 28 programs did not cover the full range of the most commonly used prescription contraceptive methods (Table 2, page 84). Two states, Montana and Pennsylvania, excluded all forms of contraceptive services; in addition, New Hampshire excluded diaphragms, the implant and IUDs, and Utah excluded the implant. Some state-designed components did not cover natural family planning and emergency contraception; only seven covered abortions in cases other than life endangerment, rape or incest (not shown).

## Information Provided to Adolescents

Eight of the 30 Medicaid components required that adolescents be routinely provided with information about the coverage of all six categories of reproductive health services (Table 1). All but one of these eight (Maryland) also required the provision of information about how to access this care. States required information about the coverage of contraceptive services more often—in 12 Medicaid programs—than any other service about which we asked.

Twelve of the state-designed components reported that they required information for adolescents on coverage of all six categories of care. All but one of these programs (Colorado) also required information on how to access this care. In all cases, more state-designed components than Medicaid components reported requiring provision of each type of information.

## Confidentiality for Adolescents

Nine of the 30 Medicaid programs required confidentiality in providing reproductive health services to adolescents both before and after care has been obtained, including through the receipt of an explanation of benefits form (Table 1). Medicaid programs in California, Connecticut, New Jersey and Texas required confidentiality before such care, but only required it afterwards when specifically requested by the enrolled adolescent (Table 2). A total of 20 Medicaid programs required at least some degree of confidentiality for adolescents, either before or after care is obtained.

Eight of the 28 state-designed programs required complete confidentiality for adolescents' reproductive health care (Table 1). One additional program (New Jersey) required it before and, upon request, after (Table 2). Eighteen state-designed programs required at least some confidentiality.

## Facilitating Enrollment

Of the various locations about which we queried, prenatal care clinics were the most common sites for outstationed eligibility workers under CHIP—in eight Medicaid programs and six state-designed programs (Table 1). Nine Medicaid components and nine state-designed components reported using outstationing at any of the locations we

listed.

A total of seven Medicaid-based CHIP programs and three state-designed programs reported using presumptive eligibility (Table 1). Again, of the seven possibilities listed, prenatal care clinics were the sites most often cited as presumptive eligibility providers. None of the programs reported certifying middle schools or high schools as presumptive eligibility pro-viders. One of the seven Medicaid programs and two of the three state-designed programs that used presumptive eligibility reported certifying none of the specific types of providers we listed.

## Managed Care

A total of 26 Medicaid components and 22 state-designed components reported that at least some adolescents were enrolled in managed care organizations under their CHIP efforts. Just about all of the managed care contracts for adolescents under CHIP included most, if not all, of the seven categories of reproductive care about which we asked (Table 3). Only abortion was excluded from managed care contracts in more than a few programs.‡ Moreover, almost all of the CHIP programs required participating managed care organizations to demonstrate to the state that their networks are able to provide reasonable access to each category of reproductive health care included in their contracts for adolescents.

However, programs did not consistently allow access to out-of-network providers for reproductive health care services. Freedom of choice under the Medicaid programs ranged from 18 programs for pregnancy testing to only seven programs for abortion; 17 permitted freedom of choice for contraceptive services and supplies. Among the state-designed programs, freedom of choice was even less common, ranging from nine programs for contraceptive services to five programs for abortion and obstetric care. All but two of the 19 Medicaid programs and all but one of the nine state-designed programs requiring freedom of choice for any reproductive health care service also required that adolescents be informed of the specific services they may obtain from providers outside the network (not shown).

## Outreach Activities

Of the 46 jurisdictions that responded to the survey, 26 states and the District of Columbia reported tailoring some outreach activities specifically to encourage enrollment of adolescents (Table 4). Of the four types of activities we listed, the most popular choices employed were printed materials and media campaigns, reported by 24 and 22 jurisdictions, respectively. States used hotlines and the Internet less often. Eight of the 27 jurisdictions reported using all four of these tactics (not shown).

Forty-two states and the District of Columbia provided outreach materials at one or more of the eight types of locations we listed (Table 4). Middle schools, high schools and community-based organizations serving teenagers were the most commonly cited locations, at 42 jurisdictions each; fast-food outlets and shopping malls were included least often, in 25 and 22 jurisdictions, respectively. All but three of these 43 jurisdictions provided enrollment forms at one or more of the locations about which we asked (not shown). In 13 states, the range of locations at which enrollment forms were provided was narrower than the range at which outreach materials were offered.

## Performance Measures

Nine states out of the 46 jurisdictions reported using screening for cervical cancer as a performance measure for their CHIP efforts (not shown). Only four states, each of which was among the nine, reported using any of the other five performance measures we specified (screening and testing for chlamydia; screening and testing for gonorrhea; counseling for pregnancy prevention; counseling for HIV and STD prevention; and counseling for breast self-examination): New Jersey and Texas reported using all five of the other measures, Indiana answered "yes" for the two STD screening measures and Nebraska included a measure for HIV and STD prevention counseling.

## DISCUSSION

From its inception, CHIP had the potential for helping large numbers of America's uninsured adolescents get the reproductive health services they need. The plans approved by HCFA for states' CHIP efforts seemed to indicate that this potential might become a reality. According to the 1998 AGI review of state plans, 21 states and the District of Columbia were opting to expand their Medicaid program, and 13 additional states had chosen a combination approach.[§] All of the adolescents enrolled in these Medicaid efforts would be provided with a broad range of reproductive health benefits.

However, the state plans only partially answered the question of whether and to what extent, when operational, the state-designed CHIP efforts would cover reproductive health services. According to the 1998 AGI study of state plans, 16 of the 29 state plans with a state-designed component specified that family planning services and supplies would be covered for adolescents, while 12 indicated coverage of the general category "prenatal care and prepregnancy family planning services" without further explanation. Only one state, Pennsylvania, declared its intention to exclude coverage of that general category. In addition, all of the state-designed programs were to cover prescription drugs in general, and 15 state plans specifically included prescription contraceptives. Only two states declared their intention to limit coverage of contraceptives: Georgia, for all contraceptive devices, and Utah, for the contraceptive implant. Thus, for many states, which (if any) reproductive health services would be covered once CHIP was up and running was uncertain.

A 12-state survey of CHIP officials, conducted in fall 1998 by researchers at the Association of Maternal and Child Health Programs, the Policy Information and Analysis Center for Middle Childhood and Adolescence, and the National Adolescent Health Information Center, indicated that coverage of at least some reproductive health services was likely the norm. In fact, all 12 states reported some coverage of family planning services and preventive gynecologic care. Moreover, five of the states cited reproductive health services as "one of the most pressing issues for adolescents under CHIP."[11]

Our study confirms the results of these earlier efforts. With few exceptions, even the states that had only included "prenatal care and prepregnancy family planning services" in their plans were in fact covering a nearly complete range of reproductive health care services and contraceptive drugs and devices. Furthermore, states that had included definite answers on reproductive health care in their plans almost universally stuck to those decisions. Only Montana reversed course completely and decided not to

cover contraceptives, while Georgia, in the end, decided to cover contraceptive devices.

We did uncover a few deficiencies in the range of covered services, both for Medicaid-based and state-designed CHIP programs. Only 43 of the 58 programs (21 Medicaid-based and 22 state-designed) reported coverage of emergency contraception. This is a disappointing but unsurprising finding. Despite recent publicity campaigns, emergency contraception—high-dose regimens of oral contra- ceptives that can prevent pregnancy if taken within 72 hours of unprotected intercourse or known or suspected contraceptive failure—is still a relatively unknown method. Some policymakers (and providers, even) confuse it with the medical abortion drug, mifepristone, and others insist that it is an abortifacient because it, like other hormonal contraceptive methods, may prevent implantation of a fertilized egg in the uterus.**

Beyond the extent of coverage, we identified three serious problems that could impede adolescents' access to covered reproductive health services. First, only about half of the programs provided information to adolescents (even about whether contraceptive services were covered), and only 18 of 58 offered information about coverage and accessing care for the full range of reproductive health services. In particular, few of the Medicaid programs provided this type of information, although that situation could change significantly if regulations on Medicaid managed care that were promulgated by the Clinton administration are ultimately implemented.

These findings echo a 1996-1997 AGI study on contraceptive services in managed care that found that only one-half of commercial plans and one-third of Medicaid plans in the regions studied reported that they routinely provided any enrollees with information about specific contraceptive methods covered, and that most did not give information directly to dependents younger than age 18.[12] Particularly because of the sensitive nature of contraceptive, STD and similar services, adolescents need to be made fully aware of the extent of their coverage and need to be given such information directly.

A second major flaw identified by this study was the dearth of protections for adolescents' confidentiality. Only 17 programs reported the maximum level of confidentiality (both before and after the provision of care). A larger number of programs required only a limited degree of confidentiality, demonstrating a failure to understand that the potential for even accidental notification of a teenager's parents—through routine insurance billing practices, for example—can delay or dissuade a teenager from seeking critical, sensitive care and put her at risk for unintended pregnancy, STDs and future infertility. These findings echo those of the 1998 12-state study, which found that while five of the states cited confidentiality as a priority issue for adolescents under CHIP, most states had not developed specific provisions to address the issue (such as prohibiting managed care plans from sending explanation of benefits forms to the homes of adolescent enrollees).[13]

The third problem highlighted by this study is that only a small number of programs allowed access to out-of-network providers, even for contraceptive services and supplies, and much less for other reproductive health services. In fact, six Medicaid components did not provide enrollees the freedom to choose to obtain contraceptive services and supplies from a provider not affiliated with their managed care plan,

despite a clear federal mandate that enrollees be able to do so.[††] Freedom of choice was even less available under state-designed components, as would be expected because there is no comparable federal requirement. While Medicaid managed care enrollees overwhelmingly seek contraceptive services from providers within their own managed care plans,[14] the freedom of choice provisions in the overall Medicaid program have been important for providing access over the years to women who, for a variety of reasons, need to obtain care elsewhere. Because of the heightened importance of confidentiality to teenagers, this option is particularly critical for enrollees in all CHIP efforts.

Aside from concerns related directly to reproductive health care, CHIP programs overall (despite significant achievements in such areas as simplifying enrollment procedures) have experienced problems with outreach and enrollment, particularly for adolescents. Our results demonstrate that most states were not making the most of activities targeted specifically at adolescents and the places that regularly serve them. For example, only 27 of the 46 jurisdictions reported having any type of adolescent-specific outreach activity. And although most states reported using schools and community-based organizations that serve teenagers for providing outreach materials, fewer stated that they used these locations for distributing enrollment forms and far fewer still used them for outstationing. If anything, the findings that 27 jurisdictions conducted adolescent-specific outreach efforts may be an overstatement, reflecting some efforts only minimally tailored for adolescents. The 1998 12-state survey, for example, found that while seven states reported targeting outreach activities to adolescents, many also targeted younger children.[15]

Our results, however, indicate that some states were already providing important examples of what can be done. Nine states, for example, were using Internet-based campaigns targeted at outreach to adolescents. And more than half were providing at least some outreach materials at such adolescent gathering places as fast-food outlets. It must be noted, moreover, that we conducted this study in early 1999, shortly before disappointing enrollment numbers for CHIP overall led the Clinton administration to unveil a multifaceted effort to boost enrollment. It included a nationwide request by the Department of Education that educators link CHIP enrollment with registration for school, distribute information at school functions and screen for CHIP enrollment using applications for reduced-price school lunches.

Even more recently, policymakers have finally begun to focus on adolescents and CHIP. The October 2000 meeting of the National Association of State Medicaid Directors was devoted largely to a discussion of ways to reach out to adolescents who are eligible but not yet enrolled in the program.[16] Doing so, according to Cynthia Mann, director of family and children's health programs at HCFA, will require targeted outreach activities, appropriate benefit packages and improved confidentiality. In moving down this road, policymakers may find useful models upon which to build among the steps already being taken by some states. As this effort moves forward, further research may be called for to keep track of states' efforts to refine their outreach and enrollment tactics, as well as to gauge progress (in policy and in practice) in guaranteeing that adolescents are given the information, confidentiality and freedom in choosing providers that is necessary for their full access to reproductive health services.

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**4.** U.S. Social Security Act 1905(a)(4)(C)

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**8.** U.S. Social Security Act 2102(c)(1)

**9.** U.S. Social Security Act 1902(a)(55)(A)

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**14.** Gold RB, Darroch JE and Frost JJ, 1998, op. cit. (see reference 12).

**15.** Brindis CD et al., 1999, op. cit. (see reference 11).

**16.** Reuters Health, States to cover teens eligible for Medicaid, CHIP, <http://www.reutershealth.com/archives/2000/10/18/eline/links/20001018elin063 .html>, Oct. 18, 2000.


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*The efforts in two additional states—New Hampshire and West Virginia—included Medicaid components that only enrolled young children and were ignored for the purposes of this study. The state-designed components in these two states covered adolescents and therefore have been included in this analysis.

†The state-designed components of combination efforts in Kentucky and Mississippi were not operational as of the cutoff date.

‡One Medicaid program (Alabama) consistently provided reproductive health services only under some managed care contracts, and several additional programs included selected reproductive health services (particularly abortion) only under some contracts. The remainder of this section and the corresponding portions of **Table 3** address the services that are included under all managed care contracts.

§These numbers continue to change as states submit and implement revisions to their CHIP plans. As of August 2000, Illinois, Indiana, North Dakota and Texas had had revised plans approved by HCFA to implement a second component in what are now combination approaches.

**Another deficiency in the range of covered services is that medically necessary abortion was rarely covered; this was entirely expected, however, because the federal government will not help to pay for abortion in cases other than life endangerment, rape or incest. States choosing to pay for medically necessary abortions must do so entirely with their own funds, and few states choose to do so even under their basic Medicaid programs, let alone for adolescents under CHIP.

†† These include five programs (in Florida, Iowa, Mississippi, Rhode Island and Tennessee) that stated they do

not allow access to contraceptive services through out-of-network providers. Additionally, Alabama's Medicaid component included contraceptive services and supplies in only some of its managed care contracts, and only allowed access to out-of-network providers when contraception was not included in the contract. In contrast, the Illinois and New York Medicaid components, which like Alabama also included contraceptive services and supplies in only some contracts, nevertheless always allowed out-of-network access to contraceptives.