Expanding Eligibility And Improving Outreach Under CHIP

Members of Congress are beginning to discuss proposals that would expand the State Children's Health Insurance Program (CHIP) to cover previously ineligible individuals—19- and 20-year olds, pregnant women and parents of eligible children—as well as additional low-income children. Any of these expansions have the potential to provide reproductive health services to large numbers of currently uninsured women and men. While pursuing efforts to expand CHIP eligibility, however, policymakers also should be mindful that without parallel efforts to reach out to and enroll newly eligible individuals, CHIP will fail those very people for whom the program holds so much promise.

By Rachel Benson Gold and Adam Sonfield

As part of the Balanced Budget Act of 1997, Congress enacted the State Children's Health Insurance Program (CHIP), allocating $40 billion in federal funds over a 10-year period to cover low-income, uninsured individuals through age 18. The legislation gives states discretion in how to design their CHIP programs and benefit packages. Children enrolled in programs that expand on Medicaid are entitled to the same array of benefits as other Medicaid enrollees in the state, including reproductive health services. Children enrolled in state-designed programs are entitled to a benefit package designed by the state within broad parameters included in the federal statute, which allow but do not require coverage of reproductive health services. Thus, through CHIP, states have an enormous opportunity to provide reproductive health services to many of the nation's uninsured teenagers, a group with a range of critical reproductive health needs ("Adolescent Care Standards Provide Guidance for State CHIP Programs," *TGR*, June 2000, page 5).

A recent survey of state CHIP administrators by The Alan Guttmacher Institute (AGI) found that most programs cover a broad range of reproductive health services that teenagers need (see box, page 7). With proposals in Congress to expand CHIP eligibility beyond age 18, the program could have even greater potential to provide reproductive health services to large numbers of uninsured people.

Expanding CHIP

Because CHIP was enacted following the demise of broad-based national health care reform, its proponents have always seen the program as a first step in a broader strategy to reduce disparities in health insurance coverage among Americans. Proponents viewed covering low-income children, an issue with obvious political appeal, as a first—but by no means final—step in that direction. Now, armed with the knowledge that 42.5 million Americans remain uninsured, advocates and policymakers have offered a variety of proposals to expand CHIP, and an expansion appears to be politically feasible. As part of the recently approved budget agreement, Congress set aside $28 billion over the next three years for expanding health care coverage through CHIP and other programs.

Some of these proposals are designed to remove barriers in the current CHIP program that prevent or discourage states from covering specific groups of children. For example, policymakers have proposed raising income eligibility levels for the program to allow additional children to enroll. Other, less expansive proposals would modify CHIP to include children who are legal immigrants, many of whom were excluded from public health benefits as a result of 1996 legislation overhauling the nation's welfare system ("Implications for Family Planning of Post-Welfare Reform Insurance Trends," *TGR*, December 1999, page 6).

However, policymakers appear to be focusing the bulk of their attention on efforts that would extend CHIP eligibility to specific groups of people older than 18: pregnant women, parents of eligible children, and people aged 19 and 20. According to an AGI analysis of recent Census Bureau data, nationally, 12.2 million women of reproductive age (13–44) were uninsured in 1999.* Of these, 10.4 million were older than 18, the current age limit for CHIP eligibility in most states; this represents 20% of adult women of reproductive age nationwide. In 18 states, more than one in five women 19–44 were uninsured for the three-year period 1997–1999 (see table, page 8).Current proposals to expand CHIP would not cover all of these women, but several hold out the possibility of reaching significant subgroups that have substantial reproductive health care needs.

*For the purposes of AGI's analysis, individuals who had any type of private or state-sponsored health insurance at any point in the previous year were classified as insured, even if they were only covered for part of the year. Therefore, AGI's estimates of uninsured women are conservative.

One group to which policymakers are considering extending CHIP eligibility is pregnant women. This initiative would build directly on efforts of both Congress and the states in the 1980s to expand Medicaid to pregnant women whose income is well above the traditional state-determined income ceiling for the program. As with these past expansions, most of the pending CHIP expansion proposals would cover women not only throughout pregnancy—with important health benefits for both women and their newborns—but also through 60 days postpartum, including coverage for family planning services and supplies.

States are taking the lead in advocating for, and even implementing, an expansion of CHIP to include pregnant women. In January, New Jersey and Rhode Island obtained federal approval of a waiver to cover pregnant women through CHIP, and several other states have waiver requests pending with the Health Care Financing Administration (HCFA), the federal agency that administers CHIP.

In addition, congressional leaders have introduced several major proposals that would expand CHIP nationally to include pregnant women. The proposals span a wide range. The more narrow proposals, including measures introduced by Sens. Christopher S. "Kit" Bond (R-MO) and John Breaux (D-LA) and by Sen. Jeff Bingaman (D-NM), center on covering pregnant women and improving enrollment among eligible children. More expansive measures, such as the FamilyCare Act introduced by Sen. Edward M. Kennedy (D-MA), would expand the program to include pregnant women as part of a major overhaul of the entire program.

Policymakers also often mention uninsured parents of eligible children as a key group to which CHIP coverage should be expanded. Again, states appear to be leading the way on this issue. Both the Rhode Island and New Jersey waivers that were approved in January allow the states to cover parents of children who are eligible for CHIP. On the same day, Wisconsin also received federal approval for a proposal to cover parents, developed under the leadership of then-Governor Tommy Thompson (R). As Secretary of the U.S. Department of Health and Human Services, Thompson will play a key role in shaping the future of CHIP, including any expansions to it. Coverage of parents also is the focus of congressional proposals, including FamilyCare.

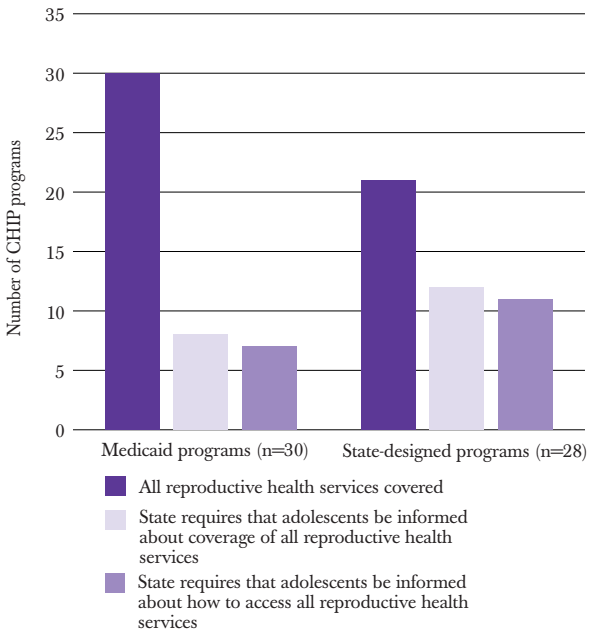
Several of the proposals pending in Congress, including the Bingaman and Kennedy measures, would allow states to expand their CHIP efforts to cover 19- and 20-year-olds as well. Older adolescents and young adults, a

Reproductive Health Services For Adolescents Under CHIP

AGI sent a survey to CHIP administrators in all states and the District of Columbia concerning reproductive health services for adolescents aged 13–18 provided under their state's CHIP effort. Questions centered on services covered, information provided to adolescents and outreach and enrollment activities.

The federal legislation gives states three options for designing and administering their CHIP programs: to expand their Medicaid programs to include the newly eligible children; to develop their own programs; or to implement a combination of both strategies. 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. All 58 programs covered routine gynecologic care, screening for sexually transmitted diseases and pregnancy testing. All but four programs covered the full range of the most commonly used prescription contraceptive methods, and 43 programs covered emergency contraception. Despite their nearly comprehensive coverage of reproductive health services, programs were inconsistent in requiring that adolescents be provided with information about coverage of the full range of reproductive health services or how to access those services (see chart).

While states provide extensive coverage of reproductive health services under CHIP, efforts to provide information to teens lag.



Note: "All reproductive health services" includes coverage of routine gynecologic exam and Pap test; screening/testing for sexually transmitted diseases, including HIV; all five leading contraceptive methods (some did not cover natural family planning or emergency contraception); abortion (in cases of life endangerment, rape or incest); pregnancy testing; and obstetric care.
Source: Gold RB and Sonfield A, Reproductive health services for adolescents under the State Children's Health Insurance Program, *Family Planning Perspectives,* 2001, 33(2):81–87.

Women of Reproductive Age Who Were Uninsured, by Age, 1997–1999

State	Age 13–44		Age 13–18		Age 19–44	
	%	Number	%	Number	%	Number
Alabama	21.4	221,009	20.6	39,754	21.6	181,254
Alaska	15.0	24,006	14.9	4,934	15.0	19,072
Arizona	27.2	305,102	27.1	51,234	27.2	253,868
Arkansas	22.1	129,389	21.4	24,981	22.3	104,409
California	25.6	2,086,648	21.8	305,515	26.3	1,781,132
Colorado	18.7	185,829	17.3	28,552	19.0	157,277
Connecticut	15.7	117,610	15.9	21,494	15.6	96,116
Delaware	16.0	28,475	13.5	4,353	16.5	24,122
District of Columbia	17.0	21,421	15.2	2,430	17.2	18,991
Florida	22.8	737,027	20.0	109,026	23.4	628,001
Georgia	19.8	383,206	15.7	57,047	20.7	326,159
Hawaii	10.4	29,350	11.1	5,392	10.2	23,958
Idaho	22.3	65,550	18.6	12,721	23.4	52,828
Illinois	15.8	475,472	12.9	73,349	16.5	402,123
Indiana	16.2	222,709	16.4	39,544	16.2	183,165
Iowa	11.0	70,732	9.9	12,119	11.2	58,613
Kansas	13.7	85,231	10.1	13,366	14.7	71,864
Kentucky	18.0	167,129	13.1	21,466	19.1	145,663
Louisiana	23.8	253,382	22.1	42,509	24.1	210,873
Maine	17.0	48,828	17.4	9,114	16.9	39,713
Maryland	15.9	187,550	11.3	21,628	16.8	165,922
Massachusetts	13.0	191,131	10.4	24,497	13.5	166,635
Michigan	15.4	362,226	11.4	52,667	16.4	309,559
Minnesota	9.5	110,146	10.5	24,645	9.3	85,501
Mississippi	23.9	167,403	23.1	31,824	24.1	135,579
Missouri	11.2	145,601	7.0	14,775	12.0	130,826
Montana	20.9	44,860	20.1	9,237	21.1	35,623
Nebraska	11.1	43,958	8.1	5,900	11.8	38,057
Nevada	22.4	92,831	25.1	17,728	21.9	75,103
New Hampshire	12.0	34,463	7.7	4,459	13.1	30,004
New Jersey	18.4	362,229	15.2	51,547	19.1	310,682
New Mexico	27.6	110,151	22.7	18,518	28.8	91,633
New York	20.8	908,607	16.1	122,602	21.7	786,005
North Carolina	18.3	321,197	16.5	47,132	18.7	274,065
North Dakota	13.6	20,404	10.8	3,547	14.3	16,857
Ohio	13.0	347,968	11.4	61,040	13.3	286,928
Oklahoma	20.2	151,757	18.4	27,530	20.7	124,227
Oregon	16.1	121,317	14.4	17,554	16.4	103,763
Pennsylvania	12.2	329,487	8.0	37,331	13.1	292,156
Rhode Island	10.2	22,212	8.5	2,933	10.5	19,279
South Carolina	22.0	197,953	19.0	30,562	22.6	167,391
South Dakota	14.2	23,741	11.3	3,962	15.0	19,779
Tennessee	16.1	214,631	18.9	47,261	15.4	167,370
Texas	27.4	1,340,984	28.0	243,825	27.2	1,097,159
Utah	15.9	85,468	11.0	12,849	17.2	72,620
Vermont	11.0	16,217	6.6	1,855	12.0	14,362
Virginia	16.3	259,059	11.8	31,147	17.2	227,912
Washington	16.6	231,613	14.0	31,919	17.1	199,694
West Virginia	23.7	93,140	13.3	8,860	25.8	84,280
Wisconsin	12.4	150,225	9.5	22,038	13.1	128,187
Wyoming	19.7	22,637	15.3	3,976	21.0	18,662

Note: Three years of survey data were combined to obtain stable estimates for individual states. *Source:* The Alan Guttmacher Institute (AGI), special tabulations from U.S. Census Bureau Current Population Surveys, March 1988–2000.

group with significant reproductive health care needs, are the least likely of any age-group to have health insurance coverage, according to Census Bureau data.

Maximizing Enrollment

Many advocates of expanding CHIP, while clearly interested in reducing the number of uninsured adults, also believe that their proposals will help CHIP to overcome one of its most persistent challenges: enrolling individuals who are eligible for the program. Advocates of expanding coverage to pregnant women, for example, view it as a way of ensuring that infants, too, will be covered. In fact, several of the proposals include language specifically requiring that an infant born to a covered woman be automatically enrolled in CHIP and presumed eligible for the first year of life.

In addition, many policymakers assert that parents are more likely to enroll their child in the program if the entire family can be covered. The results of a September 2000 study by the Center on Budget and Policy Priorities bolster this argument: States with broad family expansions under Medicaid experienced significantly higher growth in enrollment of young, low-income children than did states without such expansions. Similarly, a study published in May by the Commonwealth Fund found that 25% of low-income children were uninsured in states with limited coverage of parents, compared with 14% in states with broader coverage of parents.

These arguments resonate because CHIP got off to a slow start. An estimated 12 million children aged 18 and younger were uninsured when CHIP was enacted in 1997. Although states moved quickly to submit plans to HCFA for approval, and HCFA acted on them, and for the most part approved them, expeditiously, enrollment lagged. Only one million children were enrolled in the first year. By FY 2000 (October 1, 1999, through September 30, 2000), however, enrollment had picked up considerably, with 3.3 million children enrolled at any point during the course of the year, according to HCFA.

The Need for Outreach

As originally enacted, CHIP had severe limitations that constrained states' ability to fund outreach activities, and proponents of the program have long cited this as a major reason for the gap in enrollment. Congress has made some recent moves that may finally provide some badly needed additional funding. Late last year, Congress permitted states that had not spent all of their initial funding under CHIP to allocate a portion of their remaining funds to outreach activities. The provision's effect may not be quite as extensive as intended: A report published in April by the Center on Budget and Policy Priorities predicts that a wrinkle in CHIP's accounting rules may prevent 16 of the 39 states with left-over money from taking advantage of the option. Even so, this provision should allow states to funnel more than $100 million toward outreach activities.

The challenges of conducting outreach and enrolling the uninsured are particularly important as they relate to teenagers. HCFA's statistics do not provide information on the age of CHIP enrollees. However, AGI's analysis of census data on women of reproductive age shows that despite the progress CHIP has made in enrolling children, large numbers of teenage girls remain uninsured. In 1999, 1.85 million, or 16%, of all 13–18-year-old girls in the United States were uninsured, regardless of income. State-level data are equally distressing. In 11 states, at least one in five teenage girls was uninsured in the three-year period 1997–1999, led by Texas at 28% (see table). The data reveal some good news, however: In eight states, fewer than one in 10 teenage girls was uninsured.

These data are not totally surprising. Added to the myriad outreach and enrollment problems that beset CHIP's early days is the challenge of reaching out to teens. According to AGI's survey of CHIP administrators, most states were not targeting teenagers and the places that regularly serve them. For example, only 27 of 46 states reported having any type of adolescent-specific outreach activity. And although most states reported reaching out to teenagers through information materials provided at schools and community-based organizations that serve teens, fewer said that they distributed enrollment forms at these locations.

Attention to the need for outreach to teenagers appears to be increasing. Nine states reported to AGI that they were using Internet-based campaigns, and more than half reported providing at least some outreach materials at such common teen gathering places as fast-food outlets. Moreover, the October 2000 meeting of the National Association of State Medicaid Directors was devoted largely to a discussion of ways to reach out to teenagers who are eligible but not yet enrolled in the program.

This renewed emphasis on outreach is welcome. As history amply demonstrates, outreach efforts are vitally important to teenagers and to all groups of individuals covered by CHIP. As they consider various expansion proposals, policymakers must be mindful that it is not sufficient merely to declare categories of people eligible for coverage—they must also take the steps necessary to reach out to and enroll these individuals.

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