The Unique Health Care Needs of Adolescents

Claire D. Brindis, Madlyn C. Morreale, and Abigail English

Health insurance coverage plays a key role in meeting adolescents’ needs by increasing their access to health care, yet adolescents are more likely to lack coverage than younger children. One in seven adolescents ages 10 to 18 has no form of public or private insurance. Even higher rates of uninsurance are found among low-income, black, and Hispanic adolescents. For low-income adolescents, insurance through public programs such as Medicaid and the State Children’s Health Insurance Program (SCHIP) is particularly important. Like younger children without coverage, adolescents without insurance use fewer health services, receive care less frequently, return for fewer follow-up appointments, and are more likely to seek care in an emergency room.

While most adolescents are healthy by traditional medical standards, a significant number of young people experience some serious physical or mental health problems or concerns. For example, approximately one in five adolescents suffers from at least one serious health problem, such as chronic conditions, asthma, or depression; and about one in four is believed to be at risk for early unprotected sexual intercourse or substance abuse. Moreover, many health problems occur disproportionately among adolescents who are Medicaid and SCHIP eligible. Low-income adolescents, especially those of color, have higher rates of death, illness, and health risk behaviors in almost every category studied. In addition, other subgroups of adolescents face special, heightened health risks and are more likely to have acute and complex health care needs. These groups include youth who have chronic physical or mental health conditions; live in foster or group homes; are homeless or have run away from home; are undocumented, migrant, or new immigrants; have limited English language skills; are incarcerated or involved in the juvenile justice system; or are pregnant or parenting.

Making adolescent health a priority is especially timely because significant demographic changes are occurring in the United States. While adolescents will represent a smaller proportion of the overall population, the number of adolescents ages 10 through 19 is expected to grow from 39.8 million in 2000 to 42.3 million in 2020, a 6.4% increase. Moreover, adolescent population projections anticipate far greater numbers of young people of color, who are more likely to live in poverty, be uninsured, and underutilize primary and preventive health care services.

This article describes the particular health care needs of adolescents and explores the extent to which public

Claire D. Brindis, Dr.P.H., is a professor of pediatrics and health policy with the Division of Adolescent Medicine and the Institute for Health Policy Studies at the University of California, San Francisco.

Madlyn C. Morreale, M.P.H., is deputy director of the Center for Adolescent Health & the Law.

Abigail English, J.D., is director of the Center for Adolescent Health & the Law.
health insurance programs are meeting those needs. It includes an overview of the coverage available to adolescents through Medicaid and SCHIP, how that coverage has evolved, the importance of providing comprehensive benefits to adolescents, and the need to adopt age-appropriate quality and performance measures to track progress over time. Throughout the article, recommendations are provided to strengthen health care services for adolescents, informed by the work of several national health care and policy organizations.

Special Health Care Needs of Adolescents

Adolescence is a unique developmental stage of accelerated growth, when a number of physiological, cognitive, social, and emotional changes occur simultaneously. Despite the lack of a formally established age range to define this developmental period, health professionals generally consider adolescence to include young people ages 10 through 19, or those ages 10 through 24. During the transition from childhood into adolescence and again from adolescence into adulthood, youth have complex and important health care needs. Also, adolescence is a critical time to avoid the onset of health-damaging, risky behaviors such as smoking and unsafe sexual activity that can lead to lifelong health problems. Thus, health care services for adolescents need to emphasize prevention, early intervention, and education.

Risk-Taking Behavior

Seven categories of risk-taking behavior account for 70% of adolescent illness, injury, and death: drug and alcohol abuse; unsafe sexual activity; violence; injury-related behavior; tobacco use; inadequate physical activity; and poor dietary habits. Many of these same health-damaging behaviors are related to the majority of adult death and illness. Furthermore, adolescents’ perception and assessment of risk seem to differ from adults’. For example, studies suggest that while teens understand the risks involved with engaging in certain behaviors such as smoking, they believe that negative consequences associated with those risks are more likely to affect other people than themselves.

Overall, there is a lack of consensus about the factors underlying adolescents’ risk-taking behaviors. Nevertheless, to reduce the prevalence of such behaviors, a range of responses—including preventive health services, legislative and regulatory initiatives (such as those meant to reduce access to cigarettes), and other strategies—likely will be needed.

Preventive and Primary Care

Prevention and primary care services are particularly critical for adolescents because many of the most serious, costly, and widespread adolescent health problems—including unintended pregnancy, sexually transmitted infections, and substance use—are potentially preventable. Early intervention and preventive care could improve adolescents’ physical and mental health and reduce death and illness. Through education, screening, anticipatory guidance, counseling, early intervention, and treatment, preventive care can help establish healthy habits that last a lifetime. However, insurance coverage of these services has been uneven and limited. Many adolescents, both those covered in Medicaid and SCHIP as well as those with private insurance coverage, do not receive necessary and appropriate preventive care.

Medicaid and SCHIP both offer a basis for providing low-income adolescents with some essential preventive services, such as regular comprehensive health assessments. For low-income adolescents who are entitled to receive Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services through Medicaid, many prevention components are included as required elements of a screening visit, and many SCHIP programs also include well-adolescent visits as a benefit. To increase the likelihood that adolescents will actually receive these benefits, purchasers could track them using the Health Plan Employer Data and Information Set (HEDIS) or other quality-measurement tools.

Improving Access to Publicly Subsidized Health Insurance for Adolescents

Medicaid and SCHIP represent the two most significant sources of publicly funded health insurance for low-income children and adolescents. Several researchers and organizations have examined the unique challenges of and opportunities for serving adolescents in Medicaid and SCHIP. These studies have found that Medicaid and SCHIP offer the potential to provide comprehensive health insurance coverage to millions of adolescents, and that states have made progress toward covering adoles-
In recent years. Nevertheless, the extent to which states implement these programs so that eligible adolescents fully benefit has yet to be determined, and several challenges to serving this population remain.

**Adolescents’ Eligibility**

Historically, adolescents were less likely than younger children to be eligible for public coverage under Medicaid, but program expansions adopted in the late 1980s and early 1990s and the creation of SCHIP in 1997 significantly increased adolescents’ eligibility for public coverage.  

Medicaid is jointly financed and administered by states and the federal government. States may vary program guidelines as long as they adhere to federal standards or receive federal permission (in the form of a waiver) to depart from those standards. Thus, adolescents’ eligibility for Medicaid—along with benefits, provider reimbursement, and many other issues of critical importance to youth and their families—varies by state.

Federal Medicaid law specifies a number of groups that must be covered in every state (referred to as “mandatory eligibility categories”) and groups that may be covered if the state chooses to do so (referred to as “optional eligibility categories”). Before 1988, Medicaid eligibility for children and adolescents essentially was limited to those who qualified on a “categorical” basis, such as those whose parents received cash assistance, Supplemental Security Income for disabilities, or federal foster care or adoption assistance.

Between 1988 and 1990, Congress enacted several laws that required states to expand coverage to children and adolescents based on family income. Among these, the Omnibus Budget Reconciliation Act of 1990 was most important for adolescents. It required states to gradually phase in Medicaid coverage (one year at a time) for poor children and adolescents ages 6 through 18, so that by October 1, 2002, all poor adolescents under age 19 would be eligible.

Beyond the mandatory phase-in of coverage for poor adolescents, two optional Medicaid expansions of the 1990s were of particular importance: an option that allows states to disregard certain income and assets and to provide coverage for children and adolescents beyond the age or income levels set as minimums under federal law.
Despite these expansions, progress across the states has varied, and Medicaid still serves significantly more infants and younger children than adolescents. During Fiscal Year 1999, the latest year for which data are available, Medicaid served more than twice as many children under age 6 and children and adolescents ages 6 through 14 as it served older adolescents ages 15 through 20.\(^{34}\) (See Figure 1.)

The creation of SCHIP in 1997 expanded the potential for states to provide public health insurance coverage to adolescents in two significant ways. First, the population eligible for SCHIP (called “targeted low-income children”) includes children and adolescents under age 19 in families with incomes less than or equal to 200% of the federal poverty level (FPL) in most states.\(^{35}\) In addition, the definition of “targeted low-income children” excludes children and adolescents who are eligible for Medicaid, based on eligibility standards in effect on March 31, 1997, and those who do not have access to other insurance.\(^{36}\) This definition particularly benefited adolescents because they were both less likely than younger children to have been eligible for Medicaid before SCHIP and less likely to have private insurance coverage. By September 30, 2001, only five states did not provide Medicaid coverage to all poor adolescents under age 19: Colorado, Montana, Nevada, Pennsylvania, and Utah did not accelerate the mandatory Medicaid phase-in schedule to cover poor adolescents to a higher age than federal law requires.

Second, because the federal match for SCHIP is more generous than the match for Medicaid, Congress essentially provided states with a financial incentive to use SCHIP funds to accelerate the phase-in of Medicaid eligibility for poor adolescents.\(^{37}\) As a result, while only 14 states provided Medicaid coverage to all poor adolescents under age 19 as of March 31, 1997, by September 30, 2001, 46 states (including the District of Columbia) provided Medicaid or SCHIP coverage to all poor adolescents under age 19.\(^{38}\)

When looking at the highest income level at which adolescents are eligible for public insurance (either SCHIP or Medicaid), states’ progress is similarly impressive (see Figure 2). On March 31, 1997, only 6 states provided Medicaid coverage to all adolescents under age 19 in families with incomes above 100% of the FPL.\(^{39}\) By September 30, 2001, all but 12 states provided SCHIP or Medicaid eligibility to all children and adolescents under age 19 with family incomes up to at least 200% of the FPL.\(^{40}\)

### Progress in Expanding Coverage

During Fiscal Year 2001, nearly 4.5 million children and adolescents under age 19 were enrolled in SCHIP, and nearly one-third (32%) of these enrollees were between ages 13 and 18.\(^{41}\) An interesting picture emerges when SCHIP enrollment data are analyzed by both age group and program type. First, older adolescents were more likely than younger children to have been enrolled in Medicaid expansion SCHIP—36% of adolescents ages 13 to 18 were enrolled in Medicaid expansion SCHIP, compared with 22% of children and adolescents ages 6 through 12 and 16% of children under age 6.\(^{42}\) Second,
although more children and adolescents of all ages were enrolled in state-designed SCHIP programs than in Medicaid expansion SCHIP, adolescents ages 13 through 18 represented nearly one-half (46%) of all Medicaid expansion SCHIP enrollees, but only 28% of enrollees in state-designed SCHIP programs during Fiscal Year 2001.43 (See Figure 3.)

The distinction of enrollment by program type is important because it has implications for the benefits that enrollees may receive, and for whether or not eligibility is an entitlement. For example, because Medicaid is an entitlement program, children and adolescents covered by Medicaid expansion SCHIP will remain eligible for Medicaid even if a state has used up its allotment of SCHIP funds.44,45 By contrast, there is no entitlement to eligibility in a separate (non-Medicaid) SCHIP program, which means that states can limit services to eligible children and youth by placing them on waiting lists or by capping enrollment.

The proportion of SCHIP enrollees who are adolescents varies considerably by state. During Fiscal Year 2001, for example, adolescents ages 13 through 18 represented anywhere from less than 25% of total SCHIP enrollment (in four states) to 100% of total SCHIP enrollment (in two states). Among the five states that reported a majority of total SCHIP enrollees being ages 13 through 18, four were Medicaid-expansion-only states.46
Benefits Available to Adolescents

Once adolescents enroll in Medicaid or SCHIP, their access to particular benefits may vary, depending on the state in which they live and the type of program for which they are eligible. The Medicaid benefit package includes a broad range of mandatory and optional services. However, for children and adolescents under age 21, all mandatory and optional Medicaid services must be made available by a state if medically necessary. Nevertheless, states are allowed to impose initial limits on the amount, duration, and scope of a particular benefit—such as mental health services—and adolescents may have to overcome such limits to obtain all the services they need. Also, states may be less generous to adolescents than to younger children, such as in establishing the frequency of required comprehensive health assessments, or screenings, in Medicaid.

The scope of benefits available in a state’s SCHIP program depends on the type of program that was created—that is, Medicaid expansion, combination, or separate SCHIP program (see the article by Wysen, Pernice, and Riley in this journal issue). Benefits for adolescents in Medicaid expansion SCHIP must meet the requirements for Medicaid. Benefits for adolescents in a state-designed SCHIP program must meet minimum criteria, but they can be more generous. Uniform data about the range of services offered to adolescents under state-designed SCHIP programs are not readily available, although some state-by-state data about specific benefits suggest that states vary with respect to preventive health services, reproductive health services, substance-abuse and mental health services, dental services, and the breadth and depth of the benefit package for adolescents with special health care needs.
Improving Health Care for Adolescents through Public Health Insurance Programs

Even though health insurance—whether private or public—plays a critical role in adolescents’ access to health care services, it does not guarantee that adolescents will actually receive the services they need to assure their overall health. A number of significant barriers, both financial and nonfinancial, prevent young people from receiving needed care (see Box 1).

Box 1

Barriers to Health Care for Adolescents

- **Shortage of providers trained in adolescent health.** Few clinicians specialize in adolescent health, and most medical staff are inadequately trained to recognize health problems whose symptoms may be primarily psychosocial instead of physical. Although most adolescent medicine specialists are trained as pediatricians, internists and family physicians reflect the most common pathways to care for adolescents.

- **Inadequate provider reimbursement/low provider participation.** Reimbursement and capitation rates for providers serving children and adolescents are significantly lower for public insurance than for private insurance. In addition, delays in receiving payment from public insurance create a strong disincentive for health care providers to serve publicly insured adolescents.

- **Limited insurance coverage.** Health insurance policies (both public and private) often sharply limit or do not cover visits for preventive care, mental health services, substance-abuse treatment, dental health, and other needed care.

- **Focus on acute, medical care.** The health care system has traditionally emphasized the treatment of physical problems rather than health promotion and disease prevention, including mental health care. Adolescents could benefit significantly from preventive and primary care services that integrate their physical and psychosocial needs, such as screening, education, and anticipatory guidance to prevent and/or ameliorate risk-taking behaviors that place adolescents at risk for poor health.

- **Fragmentation.** Most teenagers and their families find navigating the complex and rapidly changing health care system difficult. Most young people are ill-prepared to understand how to access health services, have limited knowledge regarding their eligibility for diverse programs, and have few skills with which to recognize and anticipate their own needs for health services or to advocate for their own needs.

- **Confidentiality.** Without confidentiality protections, some adolescents will forgo care for such issues as pregnancy, sexually transmitted diseases, or substance abuse. Assurances of confidentiality have been found to increase adolescents’ willingness to disclose information, report truthfully, and consider a return visit.

- **Transportation/inconvenient hours.** Most teenagers have to rely on their parents and/or public transportation to reach health care providers, yet few physicians and community health clinics have scheduled their locations or hours of service to accommodate adolescents’ needs. Long waits to obtain an appointment and/or long waiting times at the provider site may deter adolescents even more than adults.

- **Cost.** Even very low co-payments may discourage adolescents and their families from initiating preventive or primary care visits. Families with low incomes may also struggle with premiums and deductibles required by employers, state-sponsored/subsidized programs, and/or private insurance policies.

To improve adolescent health, states must respond to adolescents’ barriers to care and establish systems and provider networks that are available, accessible, and appropriate for this population. To aid states in such efforts, the Society for Adolescent Medicine has compiled a list of criteria for evaluating access to quality care for adolescents (see Box 2).

Insurance coverage is an essential part of access to care, and Medicaid and SCHIP provide states with an
unprecedented opportunity to improve health care for adolescents. Yet, much work remains to ensure that adolescents actually enroll in and benefit from public insurance programs. This work includes addressing gaps in eligibility, improving outreach and enrollment, offering a broad range of services, and assuring confidentiality.

Addressing Gaps in Eligibility

Despite recent progress in making more adolescents eligible for public health coverage, gaps in eligibility remain. Some groups of adolescents, including many legal immigrant youth, adolescents who are exiting state custody, and older adolescents, are particularly vulnerable, either because they are not eligible for public health coverage under current federal or state rules or because they are not identified or screened for eligibility.

Coverage for Legal Immigrants

As described in the article by Lessard and Ku in this journal issue, numerous studies have shown that immigrant families have significant health care needs, yet are more likely than others to lack health insurance and face numerous barriers to accessing health services. For example, the 1996 federal welfare law (the Personal Responsibility and Work Opportunity Reconciliation Act of 1996) substantially restricted many immigrants’ eligibility for public benefits, including Medicaid and later SCHIP.56 While efforts to address the unique health care needs of immigrant families must include a diverse array of strategies, addressing legal and policy barriers to care and coverage is of critical importance in serving adolescents within this population.

At a minimum, to help ensure coverage for legal immigrant adolescents:

Congress should enact legislation that permits states to expand eligibility for Medicaid and SCHIP to immigrants who are lawfully present in this country.

Coverage for Adolescents Leaving State Custody

Each year, as many as 20,000 young people age 16 or older leave the foster care system and are expected to live independently.51,52 Most of these young people lack familial, financial, and other support, and many have seri-
ous unmet physical and mental health needs. Although relatively small in number, this is an unusually vulnerable group of young people in terms of health status, likelihood of having insurance, and access to care. As described previously, the Foster Care Independence Act of 1999 (FCIA) included a new option for states to expand Medicaid coverage to age 21 for young people who were in foster care on their eighteenth birthdays. Unfortunately, by July 2002, only eight states had enacted or implemented this option, although several others had at least considered doing so.

While the new FCIA Medicaid expansion option is critically important, it does have limitations. For example, it does not provide the opportunity to expand coverage to adolescents who leave the foster care system before age 18, even though they, too, may be expected to live independently. In addition, approximately 42,000 adolescents age 16 and older depart the foster care system every year and either reunite with their parents, go to live with other relatives, are transferred to the custody of another agency, or run away. Significant numbers of these adolescents are likely to be eligible for Medicaid or SCHIP on the basis of income, but are not systematically screened for eligibility when they leave the foster care system.

Young people transitioning from the juvenile justice system also have significant health problems and face numerous barriers to obtaining health care. Each year in the United States, hundreds of thousands of youth are held in the custody of the juvenile justice system at the state and local levels. For example, the National Center for Juvenile Justice reported that nearly 106,000 juvenile offenders were held in residential placement facilities during a one-day census count in 1997. These youth included juveniles who were under age 21, had been charged with or adjudicated by a court for committing an offense, and were in residential placement because of that offense. Annual numbers reveal that in 1993, more than 800,000 youth were held in short- and long-term facilities in the United States and that these young people were disproportionately members of racial and ethnic minority groups.

The juvenile population is characterized by a wide variety of pressing health problems, including behavioral health...
problems and acute and chronic medical conditions. In particular, youth in the juvenile justice system experience significant mental health problems. These young people often receive inadequate health care, especially mental health care, in juvenile justice custody and their health problems are likely to persist when they leave state custody. Although while they are incarcerated, many of them cannot receive Medicaid or SCHIP coverage; when they exit state custody, most would be eligible for one of these programs.

To help ensure coverage for vulnerable adolescents leaving state custody:

- States that have not already done so should expand Medicaid eligibility to include young people who exit the foster care system at age 18 or thereafter.
- States should screen all young people exiting the juvenile justice and child welfare systems for Medicaid and SCHIP eligibility.

Coverage Based on Age and Income

Despite the recent expansions of Medicaid and SCHIP coverage, millions of poor and low-income adolescents remain uninsured. Many of these adolescents are already eligible for one of these programs, but simply are not enrolled. Others live in states that have not raised their SCHIP eligibility levels as high as permitted under the federal statute, and others do not qualify because they are in families with incomes that exceed the federal limits, or they are older than age 18.

According to the latest data available from the U.S. Census Bureau, more than 5.7 million children and adolescents under age 19 in families with incomes at or below 200% of the FPL were uninsured during 2001, even though based on family income, virtually all of these individuals could have been eligible for Medicaid or SCHIP. (See the article by Holahan, Dubay, and Kenney in this journal issue.)

Older adolescents, those age 18 through 24, are less likely to have health insurance than those in any other age group. According to the U.S. Census Bureau, 28% of youth age 18 through 24 were uninsured during 2001 (compared with 12% of children and adolescents under age 18, 17% of persons age 25 through 64, and less than 1% of persons age 65 and older). As with other age groups, rates of uninsurance are higher among older adolescents who are poor—nearly one-half (46%) of poor adolescents age 18 through 24 were uninsured during 2001. The 107th Congress considered several bills that would have begun to address the eligibility gaps that remain for older adolescents and those in families with incomes above 200% of the FPL, but did not enact any of these bills before it adjourned.

To help ensure coverage for low-income adolescents:

- States that have not already done so should expand Medicaid and SCHIP to all children and adolescents in families with incomes up to 200% of the FPL, or the highest level permitted (given their pre-SCHIP eligibility rules).
- The federal government should permit states to expand Medicaid and SCHIP eligibility to older adolescents (under age 24) and to children and adolescents in families with incomes above 200% of the FPL.

Outreach and Enrollment

To increase the enrollment of eligible children in public health insurance programs, a wide variety of outreach strategies have been implemented. (See the article by Cohen Ross and Hill in this journal issue.) Little of this activity has specifically targeted adolescents, however. There is a critical need to evaluate which approaches are most likely to reach adolescents generally and which are most likely to reach particular subpopulations of youth who are at increased risk of health problems and access barriers. Meanwhile, a number of outreach and enrollment strategies have been recommended for adolescents. These include:

- Providing outreach and adolescent-oriented written materials at sites frequented by young people, such as school-based health centers, family planning and sexually transmitted infection clinics, adolescent medicine clinics, county health departments, high schools, Job Corps sites, summer job programs, recreation centers and after-school programs, movie theaters, and malls.
- Developing outreach materials and strategies to reach special populations of adolescents, such as runaway and homeless youth, pregnant and parenting adolescents, adolescents in immigrant families, adolescents with spe-
Many adolescents will seek health care services—particularly for such issues as pregnancy, sexually transmitted infections, or substance abuse—only if they can receive services confidentially.

Offering a Broad Range of Services
Adolescents require a broad range of health care services to address their multiple needs. Services of particular importance include preventive services, family planning and reproductive health services, mental health and substance-abuse services, dental care, and services related to chronic illnesses or disabilities. Medicaid and SCHIP both offer opportunities to ensure the provision of these services for adolescents.

Preventive Services
Preventive services represent a key set of benefits in Medicaid and SCHIP, because many common health problems faced by adolescents are preventable. The rapid developmental changes that occur in adolescence necessitate frequent health assessments in order to identify new health issues and risk behaviors early. Medicaid requires states to establish a schedule for comprehensive health assessments in consultation with professional medical and dental organizations involved in child health care; and there is broad consensus among professional groups that annual health assessments for adolescents are needed.

In Medicaid, EPSDT is the cornerstone of preventive care for children and could result in the provision of comprehensive care for adolescents. Yet, full implementation of EPSDT has not been achieved. (See Box 3 for one example of a state’s effort to enhance delivery of EPSDT services.) Also, not all states have provided for annual well-adolescent exams in their state-designed SCHIP programs.

To provide for annual well-adolescent visits consistent with the most current recommendations for adolescent care:

• States should update their EPSDT periodicity schedules and ensure that all health plans and providers are using the updated schedules.

• States with separate (non-Medicaid) SCHIP programs should incorporate requirements for annual comprehensive well-adolescent evaluations into their benefit packages.

• States should ensure that their Medicaid and SCHIP programs cover appropriate preventive services for adolescents in accordance with the most current guidelines.

Family Planning and Reproductive Health Services
Among adolescents, high rates of unintended pregnancy and sexually transmitted infection (including HIV) make access to family planning and reproductive health services critical. A broad range of federal programs, including Medicaid and SCHIP, can help states meet adolescents’ needs for reproductive health services. In Medicaid and Medicaid expansion SCHIP, family-planning services are a mandatory and confidential benefit. In state-designed SCHIP programs, states may include family-planning services as a benefit. Recent data indicate that although most states have provided coverage for reproductive health services for adolescents in their SCHIP programs, fewer require providing adolescents with information about the full range of reproductive health services or
how to access care. In addition, although many laws protect the confidentiality of adolescents (as discussed later), few states report guaranteeing confidentiality.

To ensure adolescents’ access to essential family-planning services:

- States should ensure that adolescents enrolled in Medicaid and SCHIP are informed of the family-planning services available to them and how to access them.

**Mental Health and Substance-Abuse Services**

High rates of suicide, depression, and substance abuse in adolescents suggest that many teens need access to mental health and substance-abuse services. Although Medicaid and SCHIP provide the possibility of broad coverage for mental health and substance-abuse services, numerous limitations exist, such as high cost sharing and restrictions on numbers of outpatient visits per year, numbers of inpatient days permitted, and the types of providers who can deliver services and be reimbursed. While these limitations generally also apply to younger children and adults, they are likely to have greater significance for adolescents: During this developmental period, many behaviors and illnesses that require mental health services—such as drug use, depression, and eating disorders—have their onset.

Many adolescents could be helped by receiving preventive mental health services before emotional or behavioral problems become severe. But often, services are not available through Medicaid, SCHIP, or private insurance without a diagnosis. Nevertheless, some states are beginning to adopt innovative approaches to increase adolescents’ access to mental health and substance-abuse services and at least one state, North Carolina, has made a significant effort to address these problems (see Box 4).
To address the mental health and substance-abuse problems of adolescents:

- States should include coverage in their Medicaid and SCHIP programs for a limited number of preventive mental health visits without a diagnosis being required.

- States should include coverage in their Medicaid and SCHIP programs for care coordination to help families and primary care providers integrate medical care, mental health care, substance-abuse treatment, and social services for adolescents.

**Dental Care**

Dental and oral health problems are particularly severe for adolescents of all races and ethnic groups who live in poverty, compared with higher-income youth. For youth who smoke, tobacco use contributes to significant oral health problems, and adult gum disease may have its onset at this time. Nonetheless, access to dental care for adolescents is particularly limited, with lack of insurance and low family income being major barriers to adolescents’ use of preventive dental care.

Medicaid provides dental coverage for children and adolescents, and most non-Medicaid SCHIP programs provide dental coverage, but many limitations exist with respect to scope of coverage and cost sharing. As with younger children, even adolescents with insurance coverage often have difficulty finding providers who accept Medicaid payments, and they encounter long waiting lists.

To help ensure that adolescents receive adequate dental care:

- States should implement comprehensive strategies to increase adolescents’ access to dental services in Medicaid and SCHIP.

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**Box 4**

**Spotlight on Mental Health Benefits—North Carolina**

In 2000, North Carolina expanded access to mental health benefits for children and adolescents covered by its public health insurance programs by improving the coverage of preventive mental health services and broadening the scope of providers who may bill Medicaid for their services.

North Carolina now allows up to six visits to specified mental health and substance-abuse providers without a diagnosis of mental illness. This policy allows adolescents to receive preventive mental health and substance-abuse services without being formally “labeled” or diagnosed with a psychiatric disorder. This policy applies to Health Choice, North Carolina’s state-designed non-Medicaid SCHIP program; Health Check, the state’s Medicaid program for children; and the state employees benefit program, on which the Health Choice benefit package is based.

In addition, Medicaid policy in North Carolina has been subsequently amended to expand opportunities for a broader range of health care professionals—such as licensed clinical social workers, master’s-level psychologists, and nurse practitioners with specialized training—to bill for their services. North Carolina now permits these mental health professionals who are practicing independently to enroll directly as Medicaid providers and to bill for services delivered in their offices.

Like many other states, North Carolina is experiencing severe budgetary crises, including crises in Medicaid and SCHIP. The extent to which these crises will impede implementation of North Carolina’s preventive mental health expansion is not yet known.

Services for Chronic Illness or Disability

Approximately 1.8 million adolescents ages 12 to 17 experience some degree of limitation due to chronic conditions, a prevalence rate that is higher than the rate for younger children. The breadth and depth of the benefit package is particularly critical for adolescents with chronic illnesses or disabilities, who often require services of greater variety, intensity, and duration than do other youth. For example, these adolescents may need physical, occupational, or speech therapy, for which benefit limitations are often imposed.

While Medicaid and SCHIP offer the potential to provide comprehensive care to adolescents with special health care needs, services are not always accessible, and important benefits for this population are sometimes limited.

Assessing the relative effectiveness of Medicaid and state-designed SCHIP programs in meeting the needs of adolescents with chronic illnesses or disabilities is difficult. State-designed SCHIP programs have greater latitude in shaping their benefit packages, and the effect varies among the programs: Some states have elected to limit the types of benefits important for adolescents with chronic conditions, but some have chosen to offer an enriched benefit package for children and adolescents with special health care needs that is equivalent to the breadth of the Medicaid benefit package. (See the article by Szilagyi in this journal issue for a more complete discussion of children with special health care needs.)

To address the needs of adolescents with chronic illnesses or disabilities:

- States should offer an expanded benefit package in state-designed SCHIP programs for children and adolescents with chronic illnesses or disabilities.

Assuring Confidentiality

Many adolescents will seek health care services—particularly for such issues as pregnancy, sexually transmitted infections, or substance abuse—only if they can receive services confidentially. Studies show that assurances of confidentiality increase adolescents’ willingness to disclose information, report truthfully, and consider a return visit, and that without confidentiality protection, some adolescents will forgo care.

Numerous federal and state laws affect the confidentiality of adolescents’ health care information, addressing issues such as when adolescents may give their own consent for care and when information is shared with parents. At the federal level, new medical privacy regulations, initially issued in late 2000, contain specific requirements regarding the confidentiality of medical records and information pertaining to the care of minors, including adolescents who are under age 18. These rules, which went into effect in 2001 and were modified in August 2002, stipulate that when minors can receive health care based on their own consent—that is, without parental consent—they can exercise most of the privacy rights provided under the federal privacy regulations. However, the rules give states greater latitude to determine the extent of privacy protections for minors than for adults and defer to “state or other law” on the question of when otherwise protected information may or must be disclosed to parents. The federal Title X Family Planning Program and the federal confidentiality regulations for drug and alcohol programs also include strong confidentiality protections for adolescents who seek treatment on their own. Finally, both Medicaid and SCHIP include some confidentiality protections that should extend to adolescents receiving services.

At the state level, every state has laws that control the confidentiality of medical information and records and allow minors to give their own consent for health care in specific circumstances. The minor consent laws generally are based either on the status of the adolescent minor or on the services being sought. Overall, every state offers some confidentiality protections to adolescents who are minors (under age 18), while adolescents age 18 or older generally receive the same confidentiality protections as other adults.

To ensure that adolescents who are served in Medicaid and SCHIP are able to access essential services on a confidential basis:

- The federal government and states should ensure that health plans and health care providers adopt medical record, billing, and laboratory procedures that protect the confidentiality of services provided to adolescents.

- States and health plans should provide health care providers and enrollees with specific information about minor consent and confidentiality protections that exist for adolescents.
Quality and Performance Measurement

Policymakers, purchasers, researchers, health care providers, and consumers have become increasingly concerned about the quality of health care provided through both commercial and publicly funded insurance programs. Considerable progress has been made in recent years toward developing and testing quality-measurement strategies and tools related to the care received by children and adolescents. For example, some quality-measurement tools include items of particular importance to adolescents, such as adolescent well-care visits; screening for chlamydia; utilization of mental health services; screening, counseling, and treatment for substance abuse and chemical dependency; immunization status; and counseling for risk behaviors and other issues such as diet, exercise, and emotional health.

Nevertheless, only a small number of states have adopted these measures or items for their Medicaid and SCHIP programs, and little is currently known about how adolescents use services in Medicaid and SCHIP or the quality of services that these programs provide. For example, while every state is collecting quality or performance data related to SCHIP enrollees’ use of health care services, few states have established performance goals or strategic objectives for SCHIP that address issues of particular importance to adolescents. Of the 33 states that included performance measures related to immunization status in their Fiscal Year 2001 annual reports for SCHIP, only 10 reported measuring the immunization status of adolescents. Similarly, while 32 states are collecting data related to annual well-child visits, only 14 states specifically report collecting data related to annual well-adolescent visits. Even for measures that are relevant for all enrollees regardless of age, such as access to a usual source of care, improving EPSDT screening rates, or increasing Medicaid and SCHIP enrollment, only a small number of states are collecting or reporting these findings by age group, making it impossible to determine if the programs are serving children and adolescents equally well or poorly.

To promote a better understanding of how adolescents use services in Medicaid and SCHIP, and the quality of services that these programs provide:

- The federal government and states should collect, analyze, and report quality and performance data in a consistent and uniform way, by appropriate categories including age group, gender, race, ethnicity, and primary language.
- States working with consumers (including adolescents), purchasers, health plans, and health care professionals with expertise in caring for adolescents should adopt adolescent-specific performance measures designed to monitor clinical effectiveness, use of services, access, and satisfaction with care.
- Quality assurance and performance assessment should include measures that focus on health promotion and prevention, including counseling and screening related to health-compromising behaviors, unwanted pregnancy and sexually transmitted infections, diet, weight, asthma, exercise, depression, and mental health.
- States should require that all purchasers, including Medicaid and SCHIP plans, adhere to the HEDIS guidelines that are specific to or relevant to the care of adolescents.

Conclusion

All adolescents, including those with private insurance, face significant barriers to accessing the care they need. Whether through insurance or other programs, enhancing adolescents’ access to health care will require the dedication of a broad array of policymakers, health care providers, researchers, advocates, and consumers, including adolescents and their families. While Medicaid and SCHIP have made a significant impact on adolescents’ access to health services, much remains to be done to ensure that these programs reach their potential.

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1. See the article by Holahan, Dubay, and Kenney in this journal issue.
10. These organizations include the American Academy of Pediatrics; the Association of Maternal and Child Health Programs; the Center for Adolescent Health and the Law; the Maternal and Child Health Policy Research Center; and the National Adolescent Health Information Center and Policy Information and Analysis Center for Middle Childhood and Adolescence of the University of California, San Francisco.
18. See note 9, Ozer, et al.
20. The Health Plan Employer Data and Information Set (HEDIS) was developed by the National Committee for Quality Assurance (NCQA). For information about HEDIS, see the NCQA Web site at http://www.ncqa.org/Programs/HEDIS/index.htm.
25. See the article by Holahan, Dubay, and Kenney in this journal issue.
26. See the article by Mann, Rowland, and Garfield in this journal issue.
29. The Medicare Catastrophic Coverage Act of 1988 (Public Law
mandated coverage of pregnant women and infants in families with incomes up to 100% of the FPL. The Omnibus Budget Reconciliation Act of 1989 (Public Law 101-239) mandated coverage for pregnant women and children under age 6 in families with incomes up to 133% of the FPL. The Omnibus Reconciliation Act of 1990 (Public Law 101-508) mandated that states phase in eligibility for children ages 6 through 18 in families with incomes up to 100% of the FPL.

30. For the purposes of Medicaid and SCHIP eligibility, family income is measured as a percentage of FPL, where “poor” is defined as 100% of the FPL. FPL refers to the federal poverty guidelines that the Department of Health and Human Services issues each year and publishes in the Federal Register. The guidelines vary by family size and jurisdiction. In 2002, for example, 100% of the FPL for a family of four living in the 48 contiguous states and the District of Columbia was $18,100. See Office of the Assistant Secretary for Planning and Evaluation, U.S. Department of Health and Human Services. The 2002 HHS poverty guidelines. 2002. Available online at http://www.aspe.hhs.gov/poverty/02poverty.htm.

31. Social Security Act, Title XIX, 42 U.S.C. § 1396a(l)(D) and 42 U.S.C. § 1396a(l)(2)(C) (LEXIS 2002), requires states to phase in eligibility to children in families with incomes less than or equal to 100% of the FPL who were born after September 30, 1983 (or, at the option of a state, after any earlier date), and are between ages 6 and 18.

32. The Foster Care Independence Act of 1999 (Public Law 106-169) increased federal funds for programs to assist youths in the transition from foster care to independence and created a new option for states to expand Medicaid to this vulnerable population.

33. This option, commonly called the “1902(r)(2) option,” allows states to use less-restrictive income and resource methodologies to determine Medicaid eligibility for certain groups. For additional information, see Center for Medicare and Medicaid Services. Medicaid eligibility groups and less restrictive methods of determining countable income and resources: May 11, 2001. Available online at http://www.cms.gov/medicaid/eligibility/elig0501.pdf.


35. Social Security Act, Title XXI, 42 U.S.C. § 1397jj(b)(1)(B)(i) and (ii)(1) (LEXIS 2002), permit states that had previously raised their Medicaid eligibility levels above 150% of the FPL to extend SCHIP eligibility to children and adolescents in families with incomes up to 50 percentage points higher than the state’s Medicaid eligibility cutoff as of March 31, 1997, for children of the same age.


37. Social Security Act, Title XIX, 42 U.S.C. § 1396d(b) (LEXIS 2002).


39. See note 38, Morreale and English.

40. See note 38, Morreale and English.

41. See note 38, Morreale and English.

42. Calculation based on data provided by the Center for Medicare and Medicaid Services (CMS), Center for Medicaid and State Operations, Family and Children’s Health Program Group, August 2002. Data do not include missing data (not reported to CMS) from Alabama and Illinois.

43. See note 38, Morreale and English.


45. Once a state’s SCHIP allotment is exhausted, the state receives payments at the regular Medicaid matching rate. Centers for Medicare and Medicaid Services. The administration’s response to questions about the State Children’s Health Insurance Program. 2002. Available online at http://www.cms.hhs.gov/schip/qandaintro.asp.

46. See note 42, Center for Medicare and Medicaid Services.


49. See the article by Szilagyi in this journal issue.


56. See note 54, English, et al.
58. See note 57, Snyder, et al.
60. See note 57, Snyder, et al.
64. See note 61, Soler.
65. See note 62, Council on Scientific Affairs.
66. See note 63, Society for Adolescent Medicine.
67. See note 61, Soler.
70. For example, several bills would allow states to provide Medicaid and SCHIP coverage through age 22 or 24 (rather than 19) and/or to extend coverage to children and adolescents in families with incomes up to 250% or 300% of the FPL. See the Start Healthy, Stay Healthy Act of 2001, S. 1016; the SCHIP Enhancement Act of 2001, S. 1266; the Family Care Act of 2001, H.R. 2630/S. 1244; the Leave No Child Behind Act of 2001, H.R. 1990/S. 940; the Dylan Lee James Act, H.R. 600/S. 321; and the MediKids Health Insurance Act of 2002, H.R. 1753/S. 827.
71. See note 22, English, et al.
73. See note 22, English, et al.
74. See note 48, Social Security Act.
75. See note 17, Park, et al. However, although professional guidelines for clinical preventive services recommend annual health assessments for adolescents, only 16 of 47 states responding to a recent survey specify the recommended annual visits for adolescents in their EPSDT periodicity schedules. See McNulty, M. Medicaid, managed care and adolescent health: State prevention policies. Rochester, NY: University of Rochester. Monograph in press.
82. See note 24, Fox, et al.
86. See note 85, U.S. Department of Health and Human Services.
89. See note 24, Fox, et al.


95. See note 92, Fox, et al.


103. 45 Code of Federal Regulations § 164.502(g).


107. English, A., Morreale, M.C., Stinnett, A., et al. State minor consent laws: A summary, 2d ed. Chapel Hill, NC: Center for Adolescent Health and the Law, 2003. Depending on the state, minors may be allowed to give their own consent if they are mature minors, legally emancipated minors, married minors, minors in the armed forces, minors living apart from their parents, minors over a certain age, high school graduates, pregnant minors, or minor parents. Also, depending on the state, they may be able to consent to one or more services, such as emergency care, pregnancy-related care, contraceptive services, diagnosis and treatment of venereal or sexually transmitted infections, HIV/AIDS testing and/or treatment, treatment or counseling for drug or alcohol problems, collection of medical evidence or treatment for sexual assault, inpatient mental health services, or outpatient mental health services.

108. See note 107, English, et al.


110. See, for example, the Health Plan Employer Data and Information Set (HEDIS), developed by the National Committee for Quality Assurance (see the NCQA Web site at http://www.ncqa.org/Programs/HEDIS/index.htm); the Young Adults Health Care Survey developed by the Foundation for Accountability (see the FACCT Web site at http://facct.org); and Bethell C., Klein J., and Peck C. Assessing health system provision of adolescent preventive services: The Young Adults Health Care Survey. Medical Care (2002) 39(5):478–90.

111. One study, conducted by the American Public Human Services Association (APHSA), found that among enrollees of nearly 170 Medicaid managed care plans in 31 states and Puerto Rico, surveyed in 1999, approximately 29% of adolescents received an annual well-care visit, compared with 51% of children ages 3 through 6, and that only a little more than half (51%) of 13-year-old adolescents received the recommended second dose of measles/mumps/rubella immunization. See Partridge, L. The APHSA Medicaid HEDIS database project, report for the third project year (data for 1999). American Public Human Services Association, December 2001. Available online at http://www.cmwf.org/programs/quality/partridge_aphsa_hedis_1999.pdf.