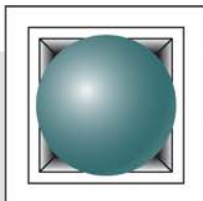


Health Reform and Adolescents

By Harriette B. Fox and Margaret A. McManus

The promise of health reform is not only that it will provide much needed health insurance for the 46 million Americans without coverage, but that it will also focus more resources on prevention and strengthen the delivery system to make it more efficient and effective. Adolescents are an ideal target for health reform. They have significant unmet physical, reproductive, and behavioral health needs associated with long-term personal and societal costs. Many low- and moderate-income adolescents are uninsured and have limited options for purchasing affordable, comprehensive coverage. Historic community-based provider arrangements, outmoded payment policies, and inadequate provider training and supply have resulted in health care delivery systems poorly structured to meet adolescents' health needs.

Health reform offers an important opportunity to provide adolescents with appropriate and affordable coverage and to support a comprehensive primary care system that can respond earlier and more effectively to their needs. The National Alliance recommends that all low-income children up to age 21 be considered a mandatory child eligibility group under Medicaid and CHIP and that all children up to age 21 have access to a benefit package that places greater emphasis on prevention and offers comprehensive physical, mental, and oral health services to enable them to achieve and maintain optimal health and functioning. Reforming the delivery system for adolescents will require a variety of payment reforms for all primary care providers and new funding mechanisms for those interested in offering enhanced models of comprehensive, interdisciplinary care. In addition, federal support is needed to improve the training and supply of medical and mental health professionals with expertise in caring for adolescents.



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Compelling Health Needs

Adolescents ages 12 to 21 are generally thought to be a healthy population -- presumably because of their low health care utilization rates -- but, in fact, they have morbidity and mortality rates twice those of younger children.¹ Today, 26% of all adolescents have a sexually transmitted disease,² 21% have a diagnosed mental health condition,³ 17% are obese,⁴ and 8% have a substance abuse or dependence disorder.⁵

In addition, adolescents have high rates of risk-taking behaviors, such as unprotected sex, drug and alcohol use, regular tobacco use, fighting, inadequate physical activity, and poor nutritional habits. For example, among high school students, 17% report that they did not use a condom at the time of their last intercourse, 17% report that they did not exercise at all during the previous week, and 28% report that they engaged in binge drinking several times during the last month or drove while under the influence of alcohol. In fact, the prevalence of multiple health risk-taking behaviors is not uncommon. Looking at responses regarding 12 significant health risk behaviors, 52% of high school students report two or more risks, 35% report three or more, and as many as 15% report five or more.⁶ Prevalence rates for health risk behaviors are even higher among those who have dropped out of high school.⁷

Further, many adolescents are subject to significant environmental risks that threaten their well-being. A recent national survey found that 67% of adolescents say they feel a lot of stress in their lives,⁸ which according to experts is made more difficult when adolescents do not have the resources to cope and can lead to anxiety, withdrawal, aggression, physical illness, and substance abuse.⁹ Also disturbing is the fact that so many adolescents today are exposed to violence. As many as 39% have witnessed violence, 17% have been physically assaulted, and 8% have been sexually assaulted, with rates of sexual assault among Black and Hispanic adolescents almost double that of Whites.¹⁰ Reports of dating violence of either a physical or sexual nature have revealed prevalence rates as high as 20%.¹¹

Health problems that emerge during adolescence, increasingly at much earlier ages, can have long-term personal and societal consequences, with associated costs reflected in the budgets of the welfare and criminal justice systems as well as in lost productivity and direct medical care expenditures.^{12,13} The link between adolescent health risk indicators and adult

morbidity and mortality, particularly in the areas of coronary heart disease,¹⁴ diabetes,¹⁵ cancer,¹⁶ and addiction¹⁷ has been well established. An increased prevalence of coronary heart disease, for example, is projected for adults as a consequence of the higher prevalence of obesity in adulthood that will result from current adolescent overweight.¹⁸

Yet, many adolescents, particularly low-income and minority adolescents, are not receiving the care they need. Research on adolescents involved in high-risk behaviors reveals that they want to talk about their lives, but seldom have the opportunity to discuss important health concerns with a health care provider. A recent RAND study found that 65% of adolescents do not receive any preventive care,¹⁹ and other research has shown that among those who do, less than half receive guidance regarding common health risks at the visit.^{20,21} National survey data reveal that almost 80% of adolescents who require a mental health evaluation do not receive one.²² Also, despite increasing rates of sexually transmitted diseases and HIV, 60% of sexually active teens have not received counseling, testing, or treatment for these conditions.²³

Lack of Coverage

Many adolescents are not receiving appropriate care because they lack insurance coverage. According to data from the Current Population Survey, 16% of adolescents ages 12 to 21 are uninsured throughout the year compared to 10% of children from birth through age 11. Among older adolescents, those ages 19 and 20, 27% are without public or private health insurance throughout the year, with the poorest in this age group, those living below the poverty level, having a full-year uninsurance rate as high as 42% -- a rate almost three times that of younger children in the same income group.²⁴

There are a number of optional Medicaid eligibility groups through which older adolescents can be covered; however, Medicaid is required only for those financially eligible older adolescents who are pregnant or parents, and CHIP excludes the participation of older adolescents completely. While 70% of adolescents ages 17 and 18 are eligible for Medicaid or CHIP but are not enrolled, the proportion of older adolescents who are eligible but not enrolled is only 20%.²⁵ Only 15 states take advantage of the option to cover all financially eligible older adolescents and most set income eligibility levels for this age group below 100% of poverty.²⁶

Even when states secure waivers to cover childless adults, most older adolescents are ineligible for coverage because they usually are still dependents.

Yet, low-income older adolescents need affordable, comprehensive health insurance coverage, especially if racial and ethnic disparities in health status are to be reduced and adolescents are to complete their education and succeed in the workplace or the military. During late adolescence chronic conditions require sustained management; new health problems, particularly serious mental health disorders, emerge;²⁷ and the prevalence of behavioral health risks rises.²⁸ Even with subsidies, low- and moderate-income families, who may already be contributing to their employer sponsored coverage, are not likely to be able to purchase comprehensive coverage for dependent older adolescents. Nor are they likely to have sufficient discretionary income to pay out of pocket for the type and intensity of health services their adolescents may require.

Delivery System Failures

In addition to the lack of insurance, an equally important problem for adolescents is that the current health care delivery system is not structured to meet their needs. At a critical point in their development, when interventions could make a significant difference, the health care delivery system is failing adolescents, many of whom seek care on their own.²⁹ Adolescents are typically left to seek care from different types of providers in different locations whose practices are primarily organized to serve either younger children or adults. One of the main conclusions of the recently released IOM report, *Adolescent Health Services: Missing Opportunities*, is that health services for adolescents are poorly equipped to meet their disease prevention, health promotion, and behavioral health needs. Health services are extremely fragmented, poorly coordinated, and delivered in multiple settings. Mental health care, sexual and reproductive health services, oral health care, and substance abuse treatment are not accessible to most adolescents. In addition, primary care services are generally ineffective in fostering health promotion and addressing risky behaviors and are inconsistent in adhering to recommended prevention and treatment guidelines.³⁰

Adolescent health providers believe that adolescents would benefit most from a comprehensive, interdisciplinary model of primary care. The model could operate in a hospital

outpatient department, a community clinic, a school, or a private practice. It would be a site where adolescents are able to receive physical health, reproductive health, and mental and behavioral health services from an interdisciplinary staff that includes, in addition to physicians, health educators, clinical social workers, nurse practitioners, and possibly psychologists, in an environment that assures confidentiality and where there is an intensive focus on health promotion, disease prevention, and behavioral health counseling.

Although they are not very common, comprehensive, interdisciplinary models of primary care for adolescents do exist in various settings. What they have in common is that they offer a wide range of health services, a team approach to care, an efficient division of provider responsibilities, a specially trained staff, a teen-friendly environment, and a positive youth development focus. The Mount Sinai Adolescent Health Center, a free-standing hospital clinic in New York City that serves more than 10,000 low-income adolescents each year, is able to offer a very broad range of integrated primary care services as well as a peer health education program, hip hop classes, legal services, neuropsychological evaluations, and tutoring. However, even an office-based practice, Wake Teen Medical Services, in Raleigh, North Carolina, is able to provide a full spectrum of primary physical, reproductive, and mental health services with a health team that includes two pediatricians, a nurse practitioner, a health educator, a clinical social worker, and on a part-time basis, a nutritionist and a child and adolescent psychiatrist.³¹

Adolescents, particularly low-income adolescents, have complex and interrelated health needs. Holistic care furnished by an interdisciplinary staff offers the most cost-efficient primary care model. It assures that health needs are identified early, that there is an efficient division of professional responsibility, and that adolescents are not lost to referral.

Weak Primary Care Arrangements

There are several reasons that more primary care providers are not offering comprehensive, interdisciplinary care. One reason is that the historic community-based provider arrangements important to adolescents are not organized to provide this enhanced model of primary care. Pediatric practices tend to focus on young children. They usually do not have adolescent-friendly waiting areas; rather they have toys for young children and reading materials for parents. And pediatric practices typically offer annual preventive exams and management of

acute and chronic medical conditions, referring adolescents elsewhere for sexual health and most mental health services.

Even community clinics, including federally qualified health centers, the usual source of care for many low-income adolescents in inner-city and rural areas, generally do not have dedicated staff or space to serve adolescents as a special population. The adolescent-focused services they offer are usually made available at school-based health centers. Community clinics almost always provide on-site reproductive health services, case management, social support services, and at least some mental health services, but they are not often delivered to adolescents by an interdisciplinary primary care team.

School-based health centers vary considerably in the services they offer to adolescents. While these clinics offer definite advantages as a convenient site for underserved, low-income adolescents, especially younger adolescents, those who are in high school are often less comfortable receiving their care at school and, in some communities, have a high likelihood of dropping out of school by age 16. In addition, school-based clinics, which now operate in about 3% of public high schools nationwide,³² typically provide limited treatment services and are accessible only when schools are open.

Inadequate Provider Training and Supply

A second reason for the scarcity of adolescent-centered models of primary care is that many pediatricians, the physician providers most likely to care for adolescents, report that they lack training and confidence in diagnosing and managing adolescents' psychosocial and reproductive health problems. A study conducted by the American Board of Pediatrics revealed that only 17% of pediatricians think that they are very well trained to care for adolescents.³³ And a recent periodic survey conducted by the American Academy of Pediatrics found that only just over a third of practicing pediatricians are very comfortable talking to adolescents about substance abuse issues, only about 40% are very comfortable talking about mental health problems, and only about half are very comfortable talking about sexual health issues.³⁴

This is due in part to the fact that pediatric residency training gives relatively little attention to the adolescent population. A recent national survey of pediatric residency program directors and adolescent medicine residency faculty found great variability across pediatric

residency programs with respect to training in the care of adolescents and significant shortcomings in many programs. For example, in most programs, numerous adolescent health topics -- particularly those related to mental health and behavioral health -- were covered only somewhat or not covered at all. In addition, throughout their three years of training, residents did not generally have enough opportunity to establish ongoing, therapeutic relationships with adolescents.³⁵

In addition, there is a severe shortage of child and adolescent psychiatrists, psychologists, and social workers that prevents adolescents from receiving needed care.^{36,37} Most importantly, there are only about 7,000 child and adolescent psychiatrists practicing in the US.³⁸ Yet, in 1990, the Council on Graduate Medical Education reported that the nation would need more than 30,000 child and adolescent psychiatrists by 2000, based on increasing rates of child mental illness and managed care staffing models.³⁹ Primary care providers treating adolescents commonly complain that they are left to address mental health conditions, such as depression, anxiety, and other mood disorders, for which they feel inadequately trained.

Outmoded Payment Policies

A third reason there are not more adolescent-centered primary care arrangements is that health insurance -- even Medicaid -- is not structured to support this care. Theoretically, Medicaid benefits are available. Medicaid's mandatory EPSDT service requires states to provide all eligible children and adolescents up to age 21 with periodic screening services to detect physical or mental health problems and to furnish them with all federally allowable Medicaid services that are determined to be medically necessary as a result of a screen. However, most states interpret the preventive component of the EPSDT benefit to consist only of screening services, a physical exam, immunizations, and brief anticipatory guidance. Still, only 33 states have policies consistent with the AAP's standard, which calls for annual preventive care for adolescents ages 10 to 21; the other 18 states do not require a preventive visit each year during adolescence.⁴⁰ Even if all states complied with the American Academy of Pediatrics' periodicity schedule for annual visits during adolescence⁴¹ and adopted *Bright Futures* as the recommended guide for the annual visit,⁴² adolescent needs for targeted and sustained health promotion and disease prevention interventions would not be met.

Probably more important is the fact that state Medicaid payment policies do not support the delivery of integrated physical, behavioral, and reproductive health services that emphasize health promotion, disease prevention, and risk reduction. The time needed to interview adolescents, identify health issues of concern, and provide age-appropriate health education and behavioral health counseling services, either as part of a comprehensive annual preventive visit or in subsequent visits, is simply not reimbursed under most fee-for-service or capitated arrangements. Only about half of state Medicaid programs allow physicians to bill for preventive counseling -- on their own behalf, or on behalf of the nurses, clinical social workers, or psychologists they may supervise -- and in virtually all cases the service cannot be furnished on the same day as the preventive care visit. Should an adolescent need to receive short-term counseling for emerging mental health problems related to stress, learning difficulties, or even physical or sexual abuse, states generally provide no mechanism for payment. Moreover, just over half of state Medicaid agencies assign responsibility for mental health to a separate capitated plan or another state agency, and in other states general managed care plans often subcontract themselves to separate behavioral health plans.⁴³ As a result, mental health staff in comprehensive primary care sites generally cannot be compensated for interventions pertaining to diagnosed mental health disorders.

A related and very important payment issue concerns confidentiality. Although all states allow minors to consent for one or more “sensitive services” such as STD screening and treatment, commercial insurers and the vast majority of state Medicaid agencies violate adolescents’ confidentiality by mailing home an explanation of benefits (EOB) statement for services billed by providers. Commercial insurers typically do so to comply with state insurance regulations; Medicaid agencies choose to do so -- randomly, for a small sample of recipients -- as a method of combating fraud. Importantly, though, managed care organizations participating in Medicaid, or in CHIP, apparently do not mail EOBs home.⁴⁴ Without the guaranteed protection of confidentiality, adolescents often forego needed care and providers elect not to submit claims for otherwise covered services.

The Value of Medicaid Benefits

Nevertheless, the importance of Medicaid protections for adolescents cannot be overstated. Medicaid’s EPSDT benefit, which applies to all children up to age 21, provides

coverage for any federally allowable diagnostic and treatment service determined to be medically necessary to address a physical or mental health condition. The intent of EPSDT is to promote health and development and to enable children to achieve and maintain age-appropriate functioning. Medicaid-enrolled adolescents, therefore, are not subject to arbitrary coverage limits, as they are under commercial or employer-sponsored plans under which condition exclusions, day and visit limits, and monetary limits typically apply.⁴⁵

Several studies have documented the restrictive coverage that commercial plans often provide, particularly for oral health and mental health and substance abuse services. For example, one study found that only half of beneficiaries of employer-sponsored plans have coverage for oral health services and that, while nearly all beneficiaries have mental health benefits, about two thirds have coverage that is limited to 30 or fewer outpatient mental health visits and 30 or fewer inpatient days.⁴⁶ Other studies found that, in addition to mental health benefit limits, private health insurance arrangements commonly exclude coverage for a number of child and adolescent behavioral health conditions, including learning disorders, impulse control disorder, relational or abuse-related problems, autism, and childhood psychosis.^{47,48} It will not be clear for some time whether the federal parity law will bring benefit reforms sufficient to provide adolescents with serious mental health disorders coverage for the amount and duration of therapeutic services they may require to manage their conditions.

Not only are Medicaid benefits for adolescents better than benefits under private coverage, they are also far better than the Medicaid benefits generally available to Medicaid-enrolled adults. Almost a quarter of states impose visit or day limits, some very restrictive, on physician visits and inpatient and outpatient hospital services.⁴⁹ Several states do not cover dental services and, of those that do, almost half exclude preventive care for non-pregnant adults.⁵⁰ Also, well over half of states fail to provide any coverage for physical therapy, speech therapy, occupational therapy, and psychologists' services outside of a hospital setting.⁵¹

Recommendations

Given the considerable effort that Congress is undertaking to achieve health reform for all Americans, it is important that the unique health needs of adolescents be given fair consideration and that the opportunity to improve their health status not be lost. We offer several

recommendations. These call for providing comprehensive and affordable coverage to all adolescents, ensuring that coverage encompasses their specific service requirements and emphasizes prevention, supporting enhanced models of comprehensive, interdisciplinary primary care that are financially sustainable, and improving the training and supply of medical and mental health professionals with expertise in caring for adolescents.

1. Ensure that all adolescents up to age 21 have affordable, appropriate, and high quality health insurance coverage.

- Mandate Medicaid coverage for all children up to age 21 in families with incomes up to 150% of poverty, and also establish 19 and 20 year olds as an eligible population in CHIP.
- At a minimum, ensure that 19 and 20 year olds who would be made eligible for Medicaid under health reform, or for premium assistance vouchers to purchase Medicaid coverage, are, like other children in the Medicaid program, given a benefit package that includes the mandatory Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit for all children up to age 21.
- In addition to adopting policies to facilitate easy enrollment, establish a policy of default coverage for all children under 21 who qualify for Medicaid or CHIP, so that in the absence of an affirmative decision by parents to enroll children, health reform will guarantee them coverage, as Medicare does for the elderly. Eligibility for Medicaid and CHIP could be determined on the basis of income tax records and eligibility records for means-tested programs.

2. Ensure that health insurance coverage for adolescents is structured to cover the services adolescents require to improve their health status, that coverage places greater emphasis on health promotion and disease prevention, and that payment policies under Medicaid and CHIP are consistent with this objective.

- Require a benefit package for children up to age 21 that not only includes benefits for primary and preventive care, medical and surgical services, hospitalization, diagnostic services, and prescription drugs, but also includes benefits for health education and behavioral health counseling services; sexual and reproductive health care; oral health care; ancillary therapies; and mental health and substance abuse treatment services sufficient to address both emerging health problems and chronic conditions. Given the erosion of dependent coverage in employer sponsored plans,⁵² require that a plan option solely for children up to age 21 be offered in the exchange.
- At least for children and adolescents in families below a certain level of income (perhaps 400% of poverty) require that all plans participating in the exchange or in Medicaid or CHIP establish medical necessity standards for coverage that include preventive, diagnostic, and treatment services to achieve and maintain optimal health and

functioning. Also require plans to ensure access to an adequate network of child and adolescent providers and to ensure the continuity of providers and services.

- Ensure that where scientific evidence is not available, coverage policies and individual medical necessity decisions for children and adolescents are based on the opinion of child and adolescent health expert clinicians and take into account differences in culture, genetics, environment, and also child, adolescent, and parental competencies.
- Require all plans participating in the exchange or in Medicaid and CHIP to compensate providers fairly for comprehensive primary care services to adolescents and to have payment policies in effect to ensure that mental health clinicians in primary care settings are able to receive payment for their services, that same-day billing is allowed, that interdisciplinary care teams are reimbursed for their time, that consultation by mental health and other specialists is reimbursed, and that confidentiality of sensitive services is guaranteed.

3. Provide federal support for comprehensive adolescent health centers, including, but not limited, to school-based clinics, and structure payment incentives to support the development of these models.

- Direct the Secretary to establish criteria for qualified comprehensive adolescent health centers for low-income adolescents ages 12-21. Specific criteria would be developed for hospital outpatient departments, community clinics, school-based health centers, and private practices, but all comprehensive adolescent health centers would be required to provide comprehensive, interdisciplinary primary care that includes physical, reproductive health, and mental and behavioral health services and gives attention to health promotion and risk reduction counseling as well as care management. Other health services, including oral health and peer health education, could be considered optional, but centers would have to have arrangements in place for consultation, referral, and follow-up to assure access and receipt of services not available at the center. Comprehensive adolescent health centers would be based in convenient locations and provide 24-hour coverage. Informational materials and waiting areas would be “adolescent friendly” and staff would have special training in the care of adolescents. Centers would be required to have strong linkages to community prevention and youth development programs.
- Provide federal grants or loans to finance capital improvements, training related to the provision of comprehensive primary care, and other infrastructure improvements needed for providers to develop and operate comprehensive adolescent health centers that meet established criteria.
- Establish new payment mechanisms under Medicaid and CHIP to incentivize interested primary care providers to redesign their practices to offer an enhanced model of primary care for adolescents. Make federal grants to state Medicaid and CHIP agencies to enable them to offer technical support for these transformations and to provide stipends both to qualified comprehensive adolescent health centers and to hospitals, clinics, and private practices with plans for the development of such centers.

- In addition, provide federal funds for a technical assistance program to furnish support for the development of comprehensive adolescent health centers in hospitals, community clinics, schools, and private practices. The program could offer technical assistance regarding staff training, delivery system reforms, quality improvement strategies, and fiscal and program management.

4. Support major reforms in pediatric training in the care of adolescents and expand the child and adolescent mental health workforce.

- Make federal funds available for the development, implementation, and dissemination of innovative pediatric residency curricula in adolescent medicine and in child and adolescent psychiatry to better prepare pediatricians to care for adolescents.
- Make federal funds available for the development and establishment of programs that provide an additional year of clinical training in adolescent medicine for pediatricians and family physicians.
- Also, make federal funds available for scholarships and loan repayment programs to dramatically increase the availability of all child and adolescent mental health professionals, particularly psychiatrists.
- For the purpose of calculating GME payments, consider residents who are training in child and adolescent psychiatry, adolescent medicine, and in the post pediatric portal project into child and adolescent psychiatry⁵³ to be board-eligible primary specialty residents that are counted as one FTE rather than as one-half FTE.

In sum, adolescents are an underserved group with real and compelling health care needs. To improve their health status, we need fundamental changes in publicly subsidized health insurance expansions and in primary and preventive care benefits, payment, delivery system arrangements, and provider training.

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The National Alliance to Advance Adolescent Health provides education, research, policy analysis, and technical assistance to achieve fundamental improvements in the way that adolescent health care is structured and delivered in the United States. Its mission is to enhance the physical and emotional well-being of adolescents, especially those who are low-income and minority, by improving the health care delivery model for adolescents and achieving the infrastructure changes needed to support it. The National Alliance seeks to promote comprehensive, interdisciplinary models of physical, mental, behavioral, and reproductive health care that incorporate a youth development philosophy and operate in collaboration with schools and other community-based programs. It also seeks to ensure that all adolescents have health insurance coverage for the services they require.

For more information about our work and available publications, contact Corinne Dreskin at The National Alliance to Advance Adolescent Health: cdreskin@TheNationalAlliance.org. Also visit our website: www.TheNationalAlliance.org.

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