

# ISSUE BRIEF

AN UPDATE ON WOMEN'S HEALTH POLICY

THE HENRY J.  
KAISER  
FAMILY  
FOUNDATION

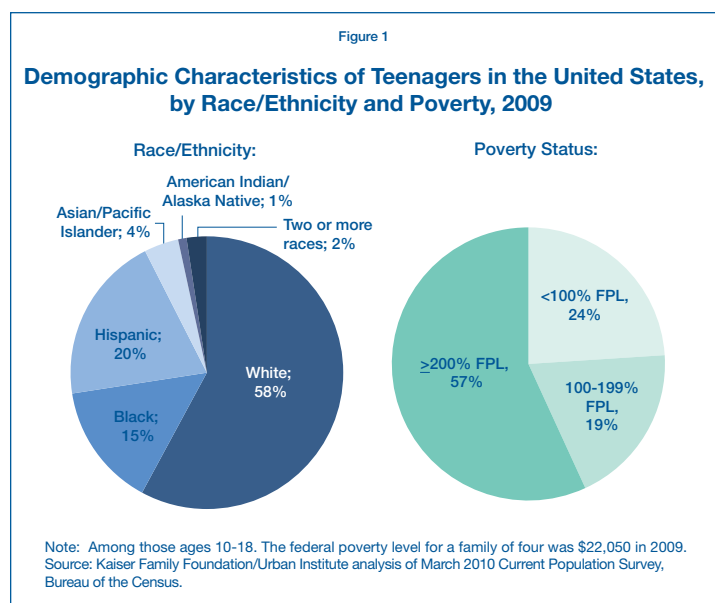
## ADOLESCENT HEALTH: COVERAGE AND ACCESS TO CARE

October 2011

Adolescents are among the healthiest populations in the nation, with relatively low rates of acute and chronic conditions and high self-reported health status.<sup>1</sup> While enjoying good health, teens face a range of physiological and developmental changes, including puberty, burgeoning independence, experimentation and risky behaviors, which shape their health decisions and needs. This period of unique physical and mental growth requires a range of tailored health services that are different from that of adults and younger children. Additionally, research suggests that adolescence is a period of opportunity for initiating and developing positive health behaviors that can last into adulthood. This issue brief examines the availability and access to health services for adolescents, their insurance coverage, as well as the role of state and federal policies in shaping access to care. It also highlights considerations for the delivery of comprehensive care to this age group and discusses how some of the provisions in the new health reform law may impact adolescent health, access, and incentives to use preventive care services.

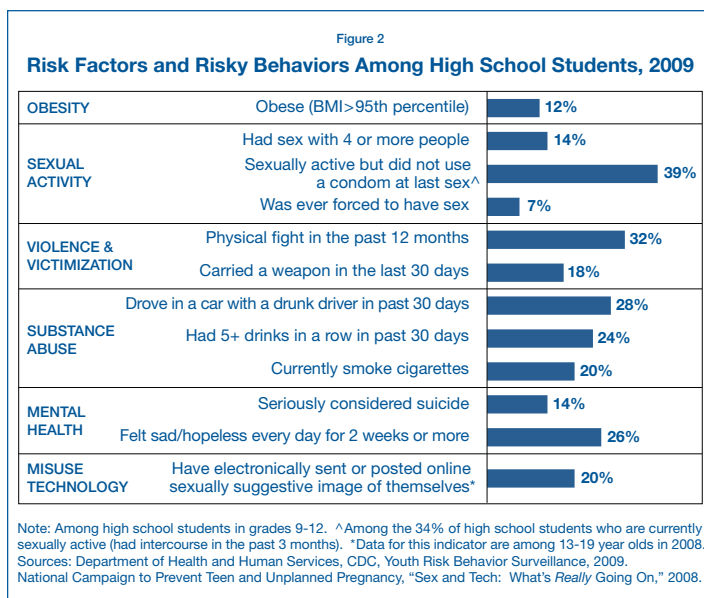
### BACKGROUND

Adolescents in the U.S. represent a demographically diverse population that has been changing over time. The proportion of teens that are racial and ethnic minorities has been increasing rapidly in this country, with Hispanics and Latinos the fastest growing group.<sup>2</sup> In 1980, 80% of young people ages 15-24



in the US were white; by 2009, this share had fallen to 58% (Figure 1).<sup>3</sup> Many adolescents are low-income; over 40% are either poor or near-poor, and those who are Black and Hispanic are twice as likely to fall into this group. Low-income youth are more likely to lack protective social support networks and financial resources, and often face more sources of stress, such as discrimination.<sup>4</sup> For adolescents who are in foster care, the justice system, and certain sexual and racial minority groups, the need for specialized services is particularly pronounced.

Developmental changes can give rise to a new set of health risk factors during adolescence, including, weight problems due to lack of physical activity or poor diet, sexual behavior, violence and victimization, abuse of substances, such as tobacco, alcohol and drugs, and mental health issues (Figure 2). These risk behaviors are often influenced by the community in which a teen lives, as well as by their race, ethnicity, family income, age, and gender.<sup>5,6</sup>



Major areas of concern during adolescence include:

- **Physical activity and nutrition:** The national rise in obesity is evident among adolescents. In 2009, 12% of all U.S. high school students were classified as obese, with significant racial and gender differences.<sup>7</sup> Eighty percent of all young people who are obese on their 18th birthday will stay obese throughout their lives, facing long term health consequences.<sup>8</sup>

Almost two-thirds (63%) of teens did not meet the basic recommendations of an hour of physical activity for at least 5 days per week.<sup>9</sup>

- **Sexual activity, STIs and pregnancy:** Despite a marked decline in adolescent pregnancy over the past three decades, the U.S. still has one of the highest rates of teen pregnancies in the developed world.<sup>10,11,12</sup> Rates of sexually transmitted infections (STIs) are high in this age group, with more reported cases of Chlamydia and Gonorrhea among women aged 15-19 than any other age group.<sup>13</sup> The CDC estimates that 1 in 4 sexually active young women are infected with an STI.<sup>14</sup>
- **Violence and victimization:** Approximately 30% of middle and high school students report being bullied during the school year and cyber-bullying is on the rise.<sup>15</sup> Teenagers aged 12-15 have the highest rate of violent crime victimization of any age group. Widespread use of technology and social media has added opportunities for new kinds of teenage bullying and victimization, some with severe psychological consequences.<sup>16</sup>
- **Substance use:** Substance use, including underage binge drinking, cigarette smoking, and illicit drugs are serious risk factors for the teenage population. One in ten 12-17 year olds in 2010 reported use of illegal drugs in the past month.<sup>17</sup> In 2009, one in four high school students reported having over five drinks in a row in the past month, and one in five high school students reported that they smoke cigarettes on a regular basis.<sup>18</sup>
- **Mental illness:** Research has shown that about half of all adults suffering from serious mental illnesses present symptoms by age 14.<sup>19</sup> Mental illness and depression are commonly faced by adolescents, who experience numerous physiological and emotional changes. The National Comorbidity Study found that 46% of 13-18 year olds have had a mental disorder at some point, which may include mild to serious symptoms of anxiety, depression, or behavioral disorders like attention deficit hyperactivity disorder (ADHD).<sup>20</sup> Around 22% of teens were found to have a mental disorder that can be classified as severe—causing impairment or distress in their daily lives.<sup>21</sup>

Treatment and stigma are major issues regarding mental illness. While 2 million adolescents aged 12-17 had a major depressive episode in 2009 (8% of the adolescent population), only 35% received treatment.<sup>22</sup>

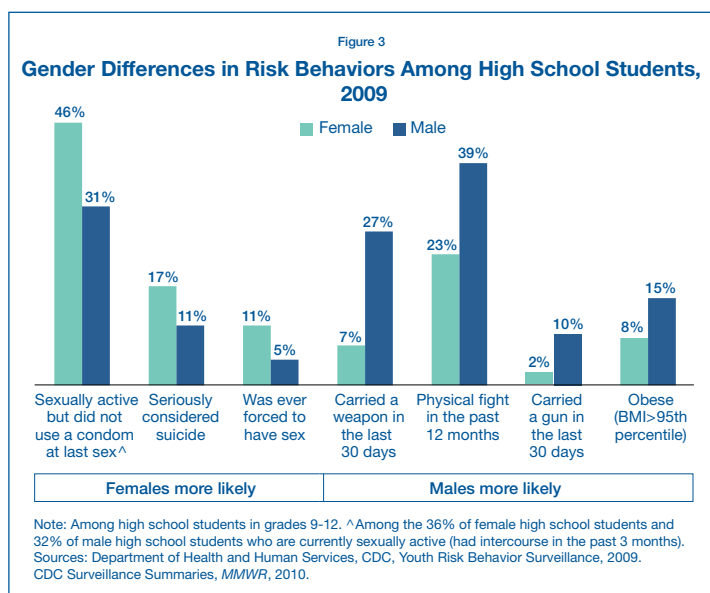
While adolescent males and females may experience some of the same health risks, there are some significant gender differences in the incidence of risky sexual behaviors, depression, and exposure to violence and victimization. These differences may influence the types of strategies needed to prevent and address these issues (Figure 3).

## PHYSICAL INJURY AND SAFETY

The top causes of death among adolescents are motor vehicle accidents, homicides, and suicide. The percentage of deaths attributed to these three causes increases dramatically through childhood into adolescence, from 47% among 10-year-olds to 77% among 15-19 year olds.<sup>23</sup> Furthermore, teens are the most likely to have a nonfatal injury attributable to a motor vehicle accident. Thus, a key area of focus in teen health is injury prevention and safety. Legislation is one measure that can affect the rates of unintentional injury. A pivotal example is the federal 1984 Drinking Age Act, which raised the drinking age to 21 and likely contributed to a stark decline (by 38% over four years) in adolescent deaths attributed to motor vehicle crashes.<sup>24</sup> State policymakers have enacted myriad laws regarding minors' motor vehicle safety and access to weapons, although these vary significantly by state. For instance, 29 states ban cell phone use for adolescent drivers, 13 have laws in place that protect high school students from being bullied or harassed on the basis of sexual orientation, and three require bicycle helmets for those under age 17.<sup>25</sup>

## CONFIDENTIALITY AND CONSENT

State policies also affect an adolescent's ability to consent to medical treatment, as well as confidentiality when they access health services. Confidentiality is linked to access to and quality of care for this age group. Research has found that some teenagers will go without care, withhold information about themselves, delay, or not seek help in order to keep their parents from finding out about a health issue.<sup>26</sup> Confidentiality and privacy issues do not only pose significant barriers to successful screening and assessment of risky behavior, but can affect patient compliance and return for follow-up visits after a diagnosis.<sup>27</sup> Teens are more likely to seek care and relay important information about their health when they perceive and are verbally assured by the provider that the information will be kept private (unless the adolescent is placing themselves or others at bodily risk).<sup>28</sup> Confidentiality is interconnected with consent to care by state laws dictating whether a minor can receive or access a health service without parental consent or notification, and whether a doctor can tell parents about



an adolescent's health visit. States also have a range of laws regarding consent for sensitive services, such as reproductive and mental health services (Table 1).<sup>29,30</sup>

Insurance billing can be a major issue for confidential services, including those that do not require parental consent. Most private insurance plans send a co-payment form or notification of use of services (Explanation Of Benefits – EOB forms) to the primary insurance holder, who is usually the parent.<sup>31</sup> This can pose a barrier to care for adolescents, resulting in adolescents forgoing needed healthcare out of fear of parental consequences.<sup>32</sup> Most Medicaid programs also send EOBs to a subset of their patients, though there is no state or federal law requiring that they do this.<sup>33</sup> In 2008, the National Alliance to Advance Adolescent Health surveyed state Medicaid programs about their use of EOBs in Fee-For-Service and Patient Care Case Management plans and found that 88% sent EOBs, with half sending it to the parent or head of household, rather than to the adolescent.<sup>34</sup> There is variability in which states exclude EOBs in Medicaid for sensitive services like family planning (24 states) or STDs (12 states). EOB requirements do not correlate and, in some cases, may conflict with states' minor consent laws.<sup>35</sup>

<b>TABLE 1: Examples of State Level Confidentiality and Consent Laws (June 2011)</b>	<b>Number of states with policy</b>
Minors (>12) can consent to contraceptive services	26 (20 more with categories of minors who can consent)
Minors can consent to STI services	All (18 allow a doctor to inform parents)
Minors may consent to abortion services on their own	2 and the District of Columbia
Minors can consent to abortion, but requires parental notification	12
Minors require parental consent for abortion	20
Minors may consent to outpatient mental health care (2010)	25
Minors may consent to care for drug or alcohol abuse (2010)	46

Sources: Guttmacher Institute, Center for Adolescent Health and the Law.

## REPRODUCTIVE HEALTH AND FAMILY PLANNING

Substantial efforts and funding in adolescent health are focused on reproductive health services to reduce the incidence of teen pregnancy and STIs. Sex education has been one avenue for intervention in this field. Federal programs for sexual education include the Teen Pregnancy Prevention Program, which was appropriated \$105 million in 2011 and supports evidence-based interventions, the Personal Responsibility Education

Program, which received \$75 million for comprehensive relationship and sex education programs in 2011, and the Abstinence-Only program which supports the promotion and education of abstinence until marriage.<sup>36</sup> Despite a lack of evidence that abstinence education delays sexual activity and studies suggesting it may deter contraceptive use among sexually active teens, the Title V Abstinence-Only Program was renewed for the next 5 years at \$50 million annually.<sup>37</sup> States also have considerable variation in the types of policies that they promulgate regarding sex education, with 20 states mandating sex and HIV education in school, 36 states requiring that abstinence be taught as part of sexual education, and 27 mandating that it be stressed as a choice. Only 18 require that contraception be included as part of sex education.<sup>38</sup>

The Title X Family planning program, enacted in 1970, is the only federal grant program specifically dedicated to providing community-based reproductive health and family planning services. More than 4,500 clinics across the country receive Title X money to provide access to contraceptive services, family planning, and comprehensive reproductive and preventive health care. These clinics often provide services to low-income and uninsured individuals and are often the only source of care for the clients they serve. In 2009, 70% of Title X users had incomes that were at or below the federal poverty level<sup>i</sup> and 66% were uninsured.<sup>39</sup>

Title X funding and family planning services play an especially important role for adolescents: 24% of all Title X users were age 19 and under.<sup>40</sup> Community clinics and sites like Planned Parenthood are an important option for low-income teens in need of reproductive health or counseling, family planning, contraceptive, and STI services who may have difficulties accessing health care services or are in need of confidential reproductive care.<sup>41</sup> It is estimated that in 2008, Title X funded health centers helped prevent nearly 2 million unintended births for women across the country, 400,000 of which were among teens.<sup>42</sup> Throughout its history, the program has been and continues to be politically controversial, and in 2011, for the first time, the House of Representatives voted to defund the program. While this did not occur, Title X funding has declined over time, and the program and the clinics it funds face future challenges that may affect access to contraceptive services for the teens who rely on these services.<sup>43</sup>

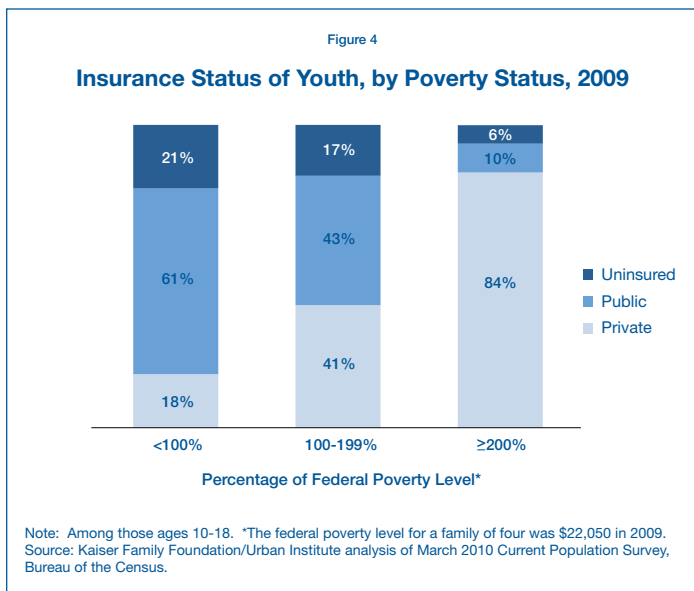
While Title X is an important source of funding for family planning services, Medicaid actually covers the majority (71%) of public funding of reproductive health services.<sup>44</sup> Family planning services have a special status under Medicaid. States are

<sup>i</sup> Federal Poverty Level was \$22,050 for a family of four in 2009. Federal Register, Vol 74, 2009.

required to cover services and the federal government pays a significant portion (90%) of the costs. Over half of the states have taken their own initiatives to expand Medicaid coverage of family planning. Twenty-eight states have received federal approval to extend Medicaid eligibility for family planning services to individuals who would otherwise not be eligible for full Medicaid benefits either because their income is too high or they do not meet Medicaid's categorical eligibility rules. Most states have expanded these family planning programs to serve women up to 200% of the poverty level. Eleven states extend benefits to both men and women, and 16 states include individuals under 19 years of age in these programs.<sup>45</sup>

## INSURANCE COVERAGE

Insurance coverage plays an important role in facilitating and shaping how teens use health care services. Adolescents ages 10-18 have the highest rate of coverage of any age group, with 88% of adolescents covered by either private or public coverage (Figure 4).

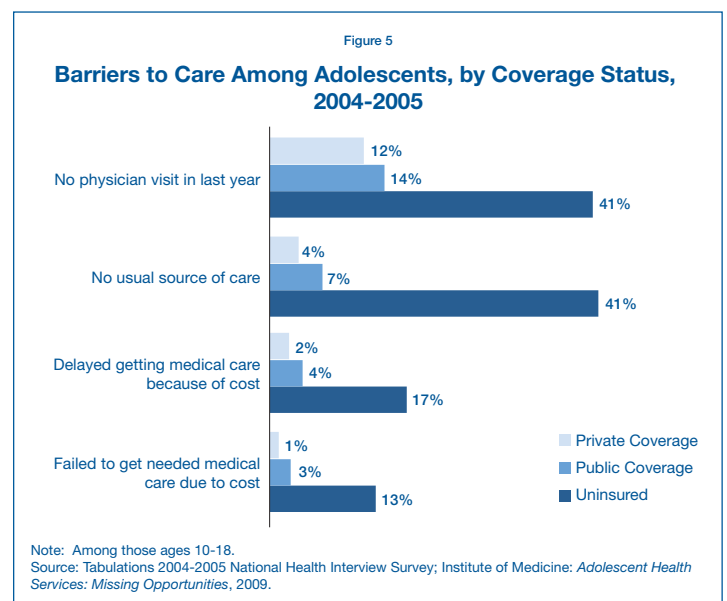


**Private insurance:** The majority of adolescents ages 10-18 are currently covered by private insurance (60%)<sup>46</sup>, with significantly higher private coverage rates among those living with both parents and in higher income groups.<sup>47</sup> Private insurance plans have traditionally varied what services they offer for this age group, but new minimum benefits established under health reform, especially around coverage of preventive services, will change the private plan landscape for many teenagers by 2014.

**Public coverage:** Medicaid and CHIP (Children's Health Insurance Program) are the major forms of public coverage for low-income teens. Adolescents with public insurance may go to private doctors or clinics that accept these types of payment. Medicaid coverage of preventive care is quite broad as a result of the Early Periodic Screening Diagnosis and Treatment (EPSDT) program which serves children and teenagers until age 21. Services covered under EPSDT include screening and diagnosis, as well as treatment, which can be expensive for states to cover for children with very complex health needs. While EPSDT services are mandated under Medicaid, many states have avoided meeting recommendations by taking advantage of their discretion over specific details, such as periodicity (number of screenings required per age group).<sup>48</sup> Access can also be limited due to a shortage of providers that accept Medicaid, stemming in part from the program's low reimbursement rates.<sup>49,50</sup>

The CHIP program provides insurance to children from low-income families whose incomes exceed Medicaid eligibility levels. To operate CHIP programs, states may either expand their Medicaid eligibility levels or establish separate programs (not bound by the EPSDT requirements). CHIP is funded by a federal block grant to states, and in recent years, some states have had to limit enrollment in their programs due to budget shortfalls.<sup>51</sup>

**Uninsured:** Approximately 4 million adolescents ages 10-18 lack health insurance; however, it is estimated that 65% of these adolescents are eligible for Medicaid/CHIP, but not enrolled. Adolescents without healthcare insurance or with gaps in coverage have worse access to needed health services, and half of uninsured adolescents have at least one unmet health need.<sup>52</sup> Uninsured teens skip care because of cost and lack a usual source of care more often than insured teens (Figure 5). The Patient Protection and Affordable Care Act (ACA) is expected to help many of these remaining uninsured teens and their families qualify for public coverage or receive subsidies for private coverage by 2014.





## DELIVERY OF CARE

In addition to insurance coverage, delivery and site of care are important to adolescents' health care access and quality. Nine in ten (92%) adolescents report having a usual source of care—often a pediatrician, family practice physician, internist, or nurse practitioner at a private doctor's office or health maintenance organization (HMO).<sup>53</sup> While a high share of teens have a usual source of care, teenagers are more likely to use the ER for non-urgent, routine health services than any other age group.<sup>54</sup>

Despite being at significant risk for many behavioral and psychological issues, adolescents rarely receive recommended levels of developmental and behavioral services, including preventive care, through annual primary care visits.<sup>55,56</sup> The benchmarks for adolescent care and screening in the primary care setting are the *Bright Futures Guidelines for Health Supervision of Infants, Children, and Adolescents*, an extensive set of recommendations issued by experts through the American Academy of Pediatrics and Health Resources and Services Administration (HRSA).<sup>57</sup> The section detailing *Adolescent Preventive Services (GAPS)* focuses on recommended well-care visits, diagnostic tests, vision and hearing screening, vaccines, and counseling specific to different stages of adolescence.<sup>58</sup> These guidelines are intended to standardize delivery

The ACA mandates that all private health insurance plans not grandfathered<sup>ii</sup> after September 2010 provide coverage without cost-sharing for several groups of federally-recommended clinical services, particularly preventive services that receive A and B grades from the U.S. Preventive Services Task Force (USPSTF), *Bright Futures* recommendations for children up until age 21, and immunizations recommended by the federal Advisory Committee on Immunization Practices (ACIP).

Many of the risk factors and conditions that are detected through adolescent screenings often require more than a single well-visit to diagnose and treat. Long-term follow-up care and management of these risk factors can be time consuming and challenging as some teenagers may have poor compliance with follow-up appointments.<sup>59</sup> Like adults, adolescents encounter a number of non-financial barriers to care, such as inadequate time with a provider, lack of transportation, lack of continuity with a physician or place of care, racial, ethnic, gender and language-related barriers, concerns regarding whether their visits are confidential, or inconvenient office location.<sup>60</sup>

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<sup>ii</sup> "Grandfathered" plans are those that existed prior to the passing of the Affordable Care Act and have not changed major provisions as stated in the ACA. Although almost half the plans are still grandfathered in 2011, and are exempt from some of the ACA mandates, it is expected only a third of plans will be grandfathered by 2014 and over time these plans will lose their grandfathered status (<http://docs.house.gov/energycommerce/ppacacon.pdf>).

On the provider side, many healthcare professionals serving teenagers in primary care settings report feeling unprepared to address an adolescent patient after a positive screening for drugs, behavioral, reproductive, or developmental issues.<sup>61</sup> They often also feel unprepared to introduce preventive health content, such as tobacco and injury prevention. Traditionally, there have been few incentives to include such content because providers may not be reimbursed for time spent on prevention education, nor has there been professional training aimed at primary prevention. Primary care settings most adolescents use, such as pediatrician offices, are often focused on serving young children and their parents. Many offices will accept adolescents for annual well-visits, but direct them elsewhere for sexual health or risk behavior screenings.<sup>62</sup> A sizable share of teens rely on Obstetrician/Gynecologists, family medicine, and adult internal medicine clinicians who also may not have expertise in the special needs of teens.<sup>63</sup> Much of the counseling for risk factors in adolescent patients is complex, requires sensitivity, and is difficult to reimburse, leaving many primary care doctors without incentives to offer comprehensive adolescent services. It is estimated that meeting the recommendations for adolescent screenings outlined by the USPSTF would require at least 40 minutes of counseling time – much longer than a typical office visit.<sup>64</sup>

The supply of specialists in the field of adolescent health also falls short of the need. Between 1996 and 2005 only 466 certificates in adolescent medicine were obtained, far fewer than what is needed to meet the needs of 40 million adolescents. Despite efforts in the field of pediatrics to incorporate specialized training in adolescent health, only 12% of pediatric residency training programs have an approved fellowship in Adolescent Medicine. The American Board of Pediatrics found only 17% of pediatricians think they are very well trained to care for adolescents.<sup>65</sup>

Many experts have suggested broadening the healthcare workforce serving teens to include other professionals with expertise in adolescent health to work alongside clinicians in teams. This may include nurses, school-based therapists, social workers, psychologists, and counselors with training in adolescent-specific needs, among others. To improve access and confidentiality, new sites and approaches for delivery of care outside of the doctor's office are being explored around the country. These models include a diverse range of non-health services to support teenagers in their community and environment, including close physical proximity to ensure follow-up care and supplemental health education. Some of these models go beyond the scope of treating an acute condition, to focus on quality of life, well-being, and protective factors in teenagers' communities that impact health. While some of these models have been used for years, they are not yet wide spread throughout the nation and can be difficult to finance and

## MODELS OF HEALTH CARE TO TEENS

### Adolescent Health Clinics & Centers

These centers consist of mobile clinics or drop-in centers where specialists in adolescent health serve patients alongside a diverse staff of professionals. Most centers have combined social support programs in local communities, and many provide comprehensive medical and behavioral health services to adolescents at high risk, including the homeless, immigrants, and those living in rural settings. The funding structure is different for each center depending on its size and capacity, and the professionals it can employ depend on available resources. They are often supported by both federal and state funding, as well as a cascade of private donors and foundation, but development of these centers is usually limited by available resources. Some of the most prominent models have been closely tied to a teaching hospital (Mount Sinai Adolescent Health Center in New York, Johns Hopkins Center for Adolescent Health in Baltimore) where they can access needed diverse financial and medical support.

Source: Strozer, J., & Juszczak L. (2010). *2007-2008 National School-Based Health Care Census*, Washington, D.C.: National Assembly on School-Based Health.

### School-based Health Centers

These clinics operate inside or near a school setting, usually staffed with a mix of health professionals with varied training — nurse practitioners, social workers, psychologists, counselors, physicians, nutritionists, educators, case managers, dentists, and medical assistants — commonly rotating at these sites. The benefits of being situated in a school enable them to serve many uninsured teens who may not have a usual source of care, as well as teens with transportation barriers. These centers are typically operated and funded by a patchwork of state and private funders and providers, including hospitals, health departments, federally funded community health centers, school districts, and community-based non-profits. Most receive funding from the state (76%) or local government (37%), and half receive funding from private foundations. Because funding sources are limited and inconsistently available and supported, many face challenges to stay open. The ACA appropriates \$50 million a year from 2010 to 2013 to over 1,100 qualifying centers serving more than 2 million children.

sustain (Box 1). In addition, web-based health information sources and social networking among young adults has grown, creating a number of opportunities for health education and counseling on the internet regarding a range of health concerns. Internet campaigns such as MTV's "It's Your (Sex) Life" and "Get Yourself Tested" help teens and young adults find centers for reproductive health services and obtain accurate information, while social networking platforms allow teenagers to anonymously voice their health concerns and seek information about care.

## HEALTH REFORM & FUTURE POLICY

The new health reform law includes many provisions that will likely affect coverage and access to care for adolescents, including access to and affordability of coverage, scope of benefits, and new incentives to change the health care delivery system.<sup>66</sup> Some of these new rules have already been implemented, and others are being phased in overtime, such as the State Health Benefits Exchanges, which will be operational in 2014. Some of the provisions that are notable for adolescents and young adults include:

- **Ban on denial of insurance coverage to children with pre-existing conditions** – For teens with private plans, insurance companies are no longer able to exclude children based on pre-existing conditions (2010).

- **Age extension of dependent coverage** – Adolescents and young adults can remain on their parents' insurance plan as a dependent until age 26, assuring coverage during important transition years as young adults (2010).
- **Coverage of preventive services without cost-sharing** – All private plans must cover the services recommended by the *Bright Futures Guidelines*, *USPTSF*, and *ACIP* without cost sharing. Adolescents enrolled in Medicaid will get these services through the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program through age 21 (2010). New preventive services for women and girls will be offered in qualifying new private plans after August 2012. These new services include coverage of FDA-approved contraceptives that are prescribed, counseling and testing for STIs, and screening for intimate partner violence.
- **Extended eligibility for Medicaid and access to private coverage through state exchanges** – The ACA will extend Medicaid coverage to all children in families with incomes below 138%<sup>iii</sup> of the poverty threshold. Currently, there are approximately 6 million uninsured children who qualify for coverage through Medicaid or CHIP but are not enrolled in either program.<sup>67</sup> The ACA includes incentives for states to recruit uninsured children eligible for Medicaid and CHIP and ease the enrollment process. New subsidies will be made

<sup>iii</sup> Note: The ACA extends Medicaid coverage to all individuals with incomes up to 133% of the poverty level and includes a provision to disregard first 5% of income, effectively extending Medicaid to all individuals with incomes up to 138% FPL.

available to obtain private health insurance coverage through State Exchanges for modest and moderate income families who do not qualify for Medicaid (2014).

- **Increasing Medicaid reimbursement rates** – Recognizing the role that the program’s generally low reimbursement rates have on access to providers, the ACA includes federal funding to raise Medicaid payment rates to Medicare levels for primary care providers, including pediatricians (2013).

In addition, the ACA includes authorization of grants to states and local organizations for the following adolescent health priorities:<sup>68</sup>

- **Obesity prevention** – \$25 million is appropriated over the next five years to the CDC’s demonstration project to study and combat childhood obesity.
- **Teen pregnancy prevention** – \$75 million per year between 2010 and 2014 is authorized for state programs educating adolescents about sexual health, abstinence, contraception, STDs, and HIV. An additional \$50 million was appropriated for Abstinence Education and \$25 million was appropriated for the Pregnancy Assistance Fund which aids pregnant and parenting teens.
- **Family planning** – ACA includes a provision allowing states to expand Medicaid coverage of family planning using a state plan amendment (SPA), rather than a Medicaid waiver, which may extend services offered to adolescents.
- **Home visiting** – The ACA authorizes funding to implement new evidence-based home visiting programs to improve health and developmental outcomes for families in at-risk communities, many of whom may be adolescents.
- **Community health centers** – Community Health Center expansions across the country will be funded under the ACA with an additional \$11 billion over 5 years. These community health centers are expected to increase access of medical and behavioral health services to a total of 24 million patients, particularly in low-income communities.
- **School-based health centers** – \$50 million has been allocated specifically for School-Based Health Center expansions.
- **Primary care** – \$1.3 billion in new funds has been allotted to bolster primary care services, including \$315 million in mandatory funding to enhance the primary care health workforce.

The ACA will lay the groundwork for coverage expansions, but additional efforts will be needed to translate coverage expansions into meaningful changes in the use of health care and the quality of services targeted at teens.<sup>69</sup> Programs, such as preventive healthcare counseling in the areas of tobacco, alcohol and drug abuse, and screening and counseling for intimate partner violence which will be included in public and private plans, will need to have adequately trained providers to deliver these services to teens. Similarly, the 40+ minutes of counseling that is estimated to meet guidelines for well child screenings recommended by the USPSTF will face the test of feasibility and adequate provider reimbursements. Furthermore, the issue of confidentiality of care is a salient challenge. How plans handle EOBs and notification to parents and guardians regarding care will have a large impact on how teens use care moving forward.

Adolescents face numerous challenges in the health care system, and they remain one of the most vulnerable populations for several reasons. The implementation of the ACA and its provisions is a unique opportunity to further expand integrative models of care to this population, including development of school-based health centers, adolescent community health clinics, and numerous innovative community-level programs. With increased attention to the importance of medical homes and the value of integrating often fragmented care, there are greater opportunities to provide teens and young adults with a broad range of services that will meet their unique needs. Many teenagers will, for the first time, have the opportunity to experience continuous coverage from childhood into adulthood and will have full coverage for preventive care. While improving the health of adolescents will include the expansion of access to health care at the community and school level, new education about health promotion and use of preventive health services will be equally important. Many teen populations, including the undocumented, will lack access to coverage and newly supported services in the ACA, and will continue to rely on a wide range of safety nets. Ensuring that there are adequate resources to support these safety nets, as well as resources for health care delivery, programs, training, and research addressing the needs of the diverse adolescent population will be key to addressing their health needs.

## ENDNOTES

<sup>1</sup> Public Policy Analysis and Education Center for Middle Childhood. (2006). *Adolescent and young adult health; National health interview survey, 2006*.

<sup>2</sup> Mulya T. et al. (2009). Trends in adolescent and young adult health in the United States. *Journal of Adolescent Health* 45: 8-24.

<sup>3</sup> Ibid.

<sup>4</sup> Institute of Medicine. (2011). *The science of adolescent risk taking: workshop report, 2011*. Washington, D.C.

<sup>5</sup> Mulya T. et al. (2009). Trends in adolescent and young adult health in the United States. *Journal of Adolescent Health* 45: 8-24.

<sup>6</sup> Pleck, J. & O’Donnell, L. (2001). Gender attitudes and health risk behaviors in urban African American and Latino early adolescents. *Maternal and Child Health Journal* 4: 265-272.

<sup>7</sup> Centers for Disease Control and Prevention. (2010). *Youth risk behavior surveillance, United States 2009*. Atlanta, GA: U.S. Department of Health and Human Services.

<sup>8</sup> Institute of Medicine. (2010). *The science of adolescent risk taking: workshop report*. Washington, D.C.

<sup>9</sup> Centers for Disease Control and Prevention. (2010). *Youth risk behavior surveillance, United States 2009*. Atlanta, GA: U.S. Department of Health and Human Services.

<sup>10</sup> Guttmacher Institute, (2010). *U.S. teenage pregnancies, births, and abortions: National and state trends and trends by race and ethnicity*. Washington, D.C.: Kost, K., Henshaw, S., & Carlin, L.

<sup>11</sup> Boonstra, H. (2002). Teen pregnancy: Trends and lessons learned. *The Guttmacher Report on Public Policy* 5(1).

<sup>12</sup> Singh S. (2000). Adolescent pregnancy and childbearing: Levels and trends in developed countries. *Family Planning Perspectives* 32(1):14-23.

<sup>13</sup> Centers for Disease Control and Prevention. (2010). *Sexually transmitted disease surveillance 2009*. Atlanta, GA: U.S. Department of Health and Human Services.

<sup>14</sup> Ibid.



## ENDNOTES (continued)

- <sup>15</sup> Institute of Education Sciences. (2010). *Indicators of school crime and safety: 2010*. Washington, D.C.: U.S. Department of Education.
- <sup>16</sup> Hinduja S., & Patchin, J.W. (2010). Bullying cyber-bullying, and suicide. *Archives of Suicides Research* 14 (3):206-221.
- <sup>17</sup> Substance Abuse and Mental Health Services Administration. (2011). *Results from the 2010 National Survey on Drug Use and Health: Summary of National Findings*. Rockville, MD: U.S. Department of Health and Human Services.
- <sup>18</sup> Centers for Disease Control and Prevention. (2010). *Youth risk behavior surveillance, United States 2009*. Atlanta, GA: U.S. Department of Health and Human Services.
- <sup>19</sup> Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the national co-morbidity survey replication. *Archives of General Psychiatry* 62:593-602.
- <sup>20</sup> Ibid.
- <sup>21</sup> Merikangas, K.R., He, J., Burstein, M. et al. (2010). Lifetime prevalence of mental disorders in US adolescents: Results of the national co-morbidity adolescent supplement (NCS-A). *Journal of Academic Child and Adolescent Psychiatry* 49 (10): 980-989.
- <sup>22</sup> Substance Abuse and Mental Health Services Administration. (2009). *The NSDUH report: Major depressive episode and treatment among adolescents*. Rockville, MD: U.S. Department of Health and Human Services.
- <sup>23</sup> Centers for Disease Control and Prevention. (2011). *National vital statistics reports, deaths: Leading causes for 2007*. Atlanta, GA: Heron, M.
- <sup>24</sup> Clemente, R.J., Santelli, J.S., & Crosby, R.A. (Eds.). (2009). *Adolescent health: Understanding and preventing risk behaviors*. San Francisco, CA: Jossey-Bass.
- <sup>25</sup> National Center for Children in Poverty, Mailman School of Public Health, Columbia University, 2010.
- <sup>26</sup> Akinbami, L., Gandhi, H., & Chen, T. (2009). Availability of adolescent health services and confidentiality in primary care practices. *Pediatrics* 111(2)394-400.
- <sup>27</sup> Ford, C., English, A., & Sigman, G. (2004). Confidential health care for adolescents: Position paper for the Society for Adolescent Medicine. *Journal of Adolescent Health* 35:160.
- <sup>28</sup> Thrall, J.S., McCloskey, L. et al. (2000). Confidentiality and adolescents' use of providers for health information and for pelvic examinations. *Archives of Pediatric and Adolescent Medicine* 154 (9): 885-892.
- <sup>29</sup> Guttmacher Institute. (2011). *An overview of minors' consent laws, state policies in brief*. Washington, D.C.
- <sup>30</sup> Center for Adolescent Health and the Law. (2010). *State minor consent laws: A summary (3rd Ed.)*. Chapel Hill, NC: English, A., Bass, L., et al.
- <sup>31</sup> National Institute for Health Care Management Foundation. (2011). *Protecting confidential health services for adolescents & young adults: Strategies & considerations for health plans*. Washington, D.C.: Santoro, K.L.
- <sup>32</sup> Guttmacher Institute. (2009) *Unintended consequences: How insurance processes inadvertently abrogate patient confidentiality*. Washington, D.C.: Gold, R.B.
- <sup>33</sup> National Alliance to Advance Adolescent Health. (2008). *State policies affecting the assurance of confidential care for adolescents, Fact sheet No5*. Washington, D.C.: Fox, H.B., & Limb, S.J.
- <sup>34</sup> Ibid.
- <sup>35</sup> Ibid.
- <sup>36</sup> The National Campaign. (2011). *Federal funding streams for teen pregnancy prevention*. Washington, D.C.
- <sup>37</sup> Boonstra, H. (2010) Sex education: another big step forward—and a step back, *Guttmacher Policy Review* 13(2):27-28.
- <sup>38</sup> Guttmacher Institute. (2011). *Sex and STD/HIV education: State policies in brief*. Washington, D.C.
- <sup>39</sup> Fowler, C.I., Gable, J., Wang, J., & Lloyd, S.W. (2010). *Family planning annual report: 2009 national summary*. Research Triangle Park, NC: RTI International.
- <sup>40</sup> Ibid.
- <sup>41</sup> Gold, R. (2008). An enduring role: The continuing need for a robust family planning clinic system. *Guttmacher Policy Review* 11:1.
- <sup>42</sup> Guttmacher Institute. (2010). *Facts on publicly funded contraceptive services in the United States*. Washington, D.C.
- <sup>43</sup> National Family Planning and Reproductive Health Association, Policy Action Center, online at [www.nfprha.org](http://www.nfprha.org).
- <sup>44</sup> Guttmacher Institute. (2008). *Public funding for family planning, sterilization and abortion services, FY 1980–2006, Occasional Report*. New York: Sonfield, A., Alrich, C., & Gold, R.B.
- <sup>45</sup> Guttmacher Institute. (2011). *Medicaid family planning eligibility expansions*. Washington, D.C.
- <sup>46</sup> Kaiser Family Foundation/Urban Institute analysis of March 2010 Current Population Survey.
- <sup>47</sup> Newacheck, P., Park, J., & Brindis, C. (2004). Trends in private and public health insurance for adolescents. *Journal of the American Medical Association* 291(10):1231-1237.
- <sup>48</sup> Centers for Medicaid and Medicare Services. (2010). The annual EPSDT report. Washington, D.C.: US Department of Health and Human.
- <sup>49</sup> Cunningham, P.J., & Nichols, L.M. (2005). The effects of Medicaid reimbursement on the access to care of Medicaid enrollees: A community perspective. *Medical Care Research and Review* 62(6).
- <sup>50</sup> Bisgaier, J., & Rhodes, K. (2011). Auditing access to specialty care for children with public insurance. *New England Journal of Medicine* 364: 2324-2333.
- <sup>51</sup> Kaiser Commission on Medicaid and the Uninsured. (2003). *Out in the cold: Enrollment freezes in six state Children's Health Insurance Programs withhold coverage from eligible children*, Washington, D.C.: Cohen Ross, D. & Cox, L.
- <sup>52</sup> Callahan, S., & Cooper, W. (2005). Uninsurance and health care among young adults in the United States. *Pediatrics* 116: 88-95.
- <sup>53</sup> Child Policy Research Center. (2008). *Health services utilization among adolescents: results from the 2005 NHIS*. Cincinnati, OH: Schuchter, J. & Fairbrother, G.
- <sup>54</sup> Centers for Disease Control and Prevention. (2007). *National hospital ambulatory medical care survey: 2005 emergency department summary*. Atlanta, GA: Nawar, E., Niska, R., & Xu, J.
- <sup>55</sup> Coker, T.R., Sareen, H.G., et al. (2010). Improving access to and utilization of adolescent preventive health care: The perspectives of adolescents and parents. *Journal of Adolescent Health* 47: 133-142.
- <sup>56</sup> Chung, P., et al. (2006). Preventive care for children in the US: Quality and barriers. *Annual Review of Public Health* 27: 491-515.
- <sup>57</sup> National Center for Education in Maternal and Child Health, Georgetown University. (2002). *Bright Futures: Guidelines for health supervision of infants, children, and adolescents* (2nd ed). Washington, D.C.: Green, M. & Palfrey, J.
- <sup>58</sup> Ibid.
- <sup>59</sup> Hassan, A. (2009). Primary care follow-up plans for adolescents with substance use problems. *Journal of Pediatrics* 124(1): 144-150.
- <sup>60</sup> National Alliance to Advance Adolescent Health. (2010). *Strengthening preventive care to better address multiple health risks among adolescents; Report No 5*. Washington, D.C.: Fox, H.B., McManus, M.A., et al.
- <sup>61</sup> Horwitz, S., Kelleher, K., et al. (2007). Barriers to the identification and management of psychosocial issues in children and maternal depression. *Pediatrics* 119: 208-218.
- <sup>62</sup> National Alliance to Advance Adolescent Health. (2009). *Health reform and adolescents*. Washington, D.C.: Fox, H. & McManus, M.
- <sup>63</sup> Hoover, K.W., Tao, G., Berman, S., & Kent, C.K. (2010). Utilization of health services in physician offices and outpatient clinics by adolescents and young women in the United States: Implications for improving access to reproductive health services. *Journal of Adolescent Health* 46: 324-330.
- <sup>64</sup> Yarnall, K.S., Pollak, K.I., et al. (2003). Primary care: Is there enough time for prevention? *American Journal of Public Health* 93: 635-41.
- <sup>65</sup> Freed, G.L. (2006) Research Advisory Committee of the American Board of Pediatrics: Comparing perceptions of training for medicine-pediatrics and categorically trained physicians. *Pediatrics* 118: 1104-1108.
- <sup>66</sup> Center for Adolescent Health & the Law. (2010). *The Patient Protection and Affordable Care Act of 2010: How does it help adolescents and young adults?* Chapel Hill, NC: English, A.
- <sup>67</sup> Kaiser Commission on Medicaid and the Uninsured. (2009). *Children's Health Insurance Program Reauthorization Act of 2009*.
- <sup>68</sup> U.S. Department of Health and Human Services. (2011). HHS 2012 budget in brief. Washington, D.C.: U.S. Government.
- <sup>69</sup> Institute of Medicine. (2011). *Child and adolescent health and health care quality: Measuring what matters*. Washington, D.C.

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**The Henry J. Kaiser Family Foundation:** 2400 Sand Hill Road, Menlo Park, CA 94025 (650) 854-9400 Facsimile: (650) 854-4800

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