

SCHIP and Adolescents: An Overview and Opportunities for States

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Over the past decade, the State Children’s Health Insurance Program (SCHIP) has made great strides in increasing health care coverage among youth under age 19. However, this overall success masks an important disparity – adolescents are more likely to be uninsured than younger children. As state policy makers and program administrators seek to build on their successes to reach more of those eligible for SCHIP, special attention should be paid to adolescents. SCHIP coverage can not only improve teens’ health, but can reduce the burdens of chronic disease in adulthood.

Adolescents have distinct service utilization and developmental health care needs, which should be addressed in the design of each state’s SCHIP program. Outreach, benefits, service providers, and

quality measurement and improvement are all program elements that can be examined and tailored to meet adolescents’ needs. This *State Health Policy Briefing* provides an overview of adolescents’ characteristics and health care needs and offers guidance on how to tailor state SCHIP programs to better target the health care needs of low-income adolescents.

Why Focus on Adolescents?

Most experts define adolescence as a period from ages 12 to 24, and further recognize two distinct groups within that age range – adolescents ages 12 to 17 and older adolescents ages 18 to 24.¹ Since youth under age 19 are eligible for SCHIP, this *Briefing* focuses on the younger of the two adolescent age groups. However, it should also be noted that older adolescents (also referred to as young adults) are more likely than any other age group to be uninsured.²

ADOLESCENTS ARE MORE LIKELY TO BE UNINSURED THAN YOUNGER CHILDREN

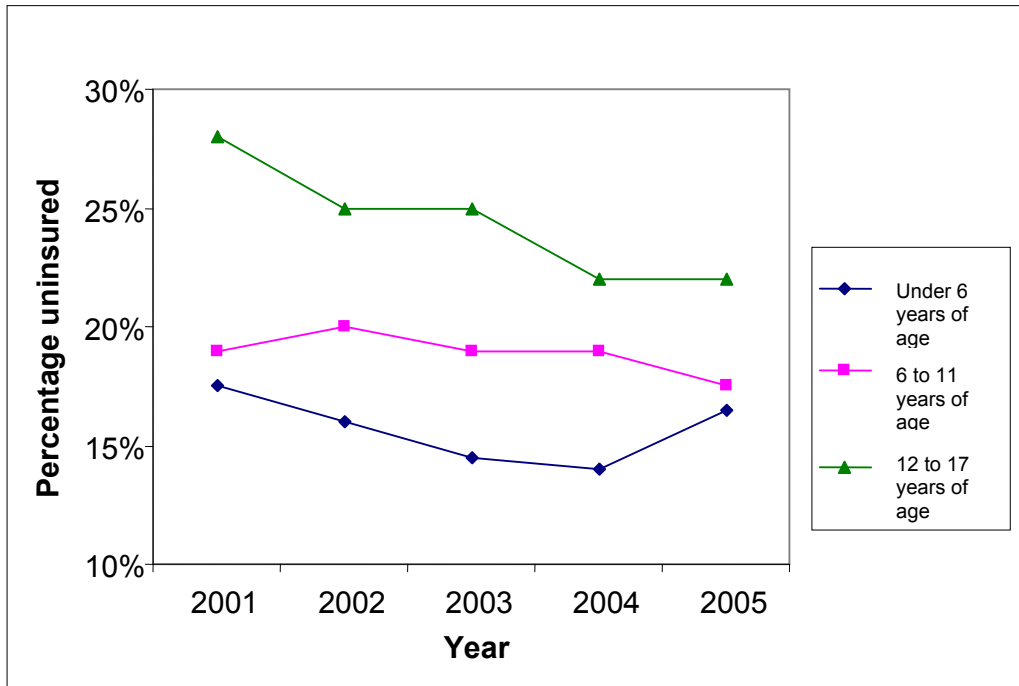
Health insurance coverage plays a key role in meeting adolescents’ health care needs; however, adolescents are more likely to lack coverage than younger children.³ According to U. S. Census Bureau statistics for 2006, approximately 13 percent of adolescents ages 12 through 17 were uninsured compared with 11 percent of children 11 years old and younger.⁴ Even more striking is the comparison for children and youth living in poverty. For these poor youth, approximately 23 percent of adolescents ages 12 through 17 lacked health coverage compared with 19 percent of children ages 6 through 11 and 17 percent of children younger than 6 years of age.⁵ Figure 1 shows that while the uninsured rate for adolescents has decreased slightly since 2001, it remains consistently higher

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FIGURE 1. CHILDREN AND ADOLESCENTS UNDER AGE 18 LIVING IN POVERTY NOT COVERED AT ANY TIME DURING THE YEAR FROM 2001 TO 2005



Source: Current Population Survey (CPS): Annual Social and Economic Supplement 2001-2006

than that of younger children.

ADOLESCENTS HAVE UNIQUE HEALTH NEEDS

Adolescence is a time of exploration and experimentation in which adolescents begin making their own decisions. Adolescents experience a natural tendency toward high-risk behaviors as they become more self-aware and search for their individual identity.⁶ Some of the normal behaviors in which teens engage can affect their health without proper attention from a range of community resources, including health care providers. An estimated \$700 billion is spent annually on preventable adolescent health problems.⁷ This estimate includes medical and social costs associated with six common adolescent health problems:

- pregnancy,
- sexually transmitted infections,
- motor vehicle injuries,
- substance use,
- unintentional injuries, and
- mental health problems.⁸

The health needs and service requirements of adolescents are distinct from those of younger children because of the difference in developmental stages. Adolescents need

care that bridges the space between pediatrics and adult internal medicine and that addresses the nonmedical factors that affect their health.⁹ Ideally, adolescent coverage should allow for an interdisciplinary approach with a comprehensive benefit package that focuses on behavioral as well as physical health.¹⁰ Different from younger children, adolescents either have or are developing a sense of autonomy and should be given the opportunity to participate and contribute to their own care.¹¹ Frequently, health care decisions are made for them and little attempt is made to engage adolescents or

encourage them to take responsibility for their own health and well-being.¹²

WE NEED MORE INFORMATION ABOUT ADOLESCENTS AND SCHIP

There has been little research done to provide a national picture of adolescents’ participation in SCHIP. We know little about adolescents enrolled in the SCHIP program, their rates of participation and retention, or whether and how they are using health care services.¹³ However, NASHP’s regular interaction with state SCHIP directors has yielded examples of how states are trying to incorporate focus on adolescents and their needs into state SCHIP programs.¹⁴

NASHP did identify one recent study addressing SCHIP and adolescents that was published in the *Journal Pediat-*

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rics.¹⁵ The study results indicate that after uninsured adolescents enrolled in SCHIP, they had increased access to care and improved quality of care, leading to fewer unmet health needs. Results also show that adolescents enrolled in SCHIP were more likely to have a usual source of care, which is crucial in obtaining preventive health care services.¹⁶ Study results also indicated that SCHIP was effective in reducing racial and ethnic disparities in access to care. The study also identified issues that require further attention, especially confidentiality. Confidentiality of care can determine whether or not a teen seeks and receives medical care.

How Can SCHIP Meet Adolescents' Needs?

States can use SCHIP's flexibility in their policy and program design to meet the unique needs of adolescents. This *Briefing* covers four areas of program design that states should consider to reach adolescents and meet their coverage needs:

1. outreach and enrollment,
2. benefit design,
3. service delivery, and
4. quality and performance measurement and improvement.

OUTREACH AND ENROLLMENT

Over the past decade, states have made substantial progress in efforts to reach and enroll uninsured children and adolescents into their SCHIP programs. As a result of these efforts, SCHIP enrollment nationally averaged 4.1 million per month in 2006, the highest average in the program's history. However, it appears that very few states have targeted adolescents in their outreach or marketing strategy. Small variations in marketing tools can make a difference. For instance, Pennsylvania's advertisements for its Cover All Kids program include billboards and other print materials, in both English and Spanish, that declare "CHIP now covers all uninsured kids and teens," acknowledging that adolescents are a distinct group. Virginia is developing plans for a marketing initiative focused on adolescents. Also, as a part of a multi-year outreach and enrollment initiative, Hawaii focused on adolescents ages 14 to 18 by working with schools' sports programs and tying the benefits of coverage into the school's health curriculum.

In 2006, NASHP brought together a select group of states and national experts to discuss recent progress and

remaining barriers for states in reducing numbers of uninsured children and adolescents. *Seven Steps Toward State Success in Covering Children Continuously*¹⁷ summarized the themes that emerged during the discussion.¹⁸ While all of the strategies are relevant to covering adolescents, one is particularly noteworthy. Experts identified the importance of community-based outreach efforts in enrolling children and youth in SCHIP and Medicaid. These types of efforts are useful in enrolling adolescents because they seek office-based health care less frequently than any other age group.¹⁹ SCHIP state program administrators should consider partnering with high schools, community centers, and other community organizations that work with teens to raise awareness of the coverage available through SCHIP for adolescents.

As states develop tailored outreach strategies for adolescents, it is important to remember that in most cases the parent or guardian of the adolescent submits the application for coverage. States may want to consider targeting outreach to parents of adolescents as well as targeting adolescents with information they can use to advocate for themselves to their parents. Experts have identified ways to focus outreach on adolescents which include:

- Working with community sites which adolescents frequent, such as schools, malls, movie theaters, and summer job programs, to display adolescent friendly promotional materials, counsel teens, and possibly provide application assistance.
- Training hotline operators as well as enrollment brokers and health care workers to answer questions posed frequently by adolescents regarding convenient enrollment sites, the availability of adolescent-oriented providers, and policies regarding confidential access to services.
- Targeting outreach activities and materials toward special populations of adolescents, such as runaways, homeless youth, immigrants, and racial and ethnic minorities who are uninsured in greater numbers.²⁰
- Streamlining enrollment procedures and coordinating them with eligibility and enrollment procedures for related programs for low-income youth, such as Food Stamps and School Lunch programs.²¹
- Highlighting coverage benefits that speak directly to adolescents' health care needs, such as reproductive, mental, dental, and preventive care.
- Tailoring outreach materials and messages to speak to the particular concerns of adolescents and parents of adolescents.

BENEFIT DESIGN

Adolescents require health care coverage with a comprehensive benefit package that can meet their particular physiological, cognitive, and emotional needs during this stage of accelerated growth. While state SCHIP benefit packages must meet minimum federal requirements, states have some flexibility in benefit design. Many state SCHIP plans already include coverage of the four types of services that teens most commonly require:²²

Preventive care

Preventive services are designed to avert or delay the onset of various health problems, or to identify these problems and reduce their impact. The most common clinical preventive services for adolescents include: immunizations for infectious diseases; screening for a wide range of health and mental health conditions such as depression, vision problems, and tuberculosis; and education and counseling regarding nutrition and diet, exercise, injury prevention, tobacco, alcohol, drugs, dental health, school, family, peers, and sexual behavior.²³

Mental health services

Adolescents experience rapid physical, emotional and social changes as they develop. Preventive mental health services, such as counseling, can help avert the onset or help to mitigate the occurrence of problems, such as depression or eating disorders that are largely associated with adolescents as they learn to cope with the changes they are experiencing. Adolescents also need coverage for mental health treatment services appropriate to their developmental stage. Approximately 20 percent of children and adolescents have a diagnosable mental health disorder,²⁴ but only 24 percent who need services receive treatment.²⁵

Dental care

Dental care, including preventive, diagnostic, restorative, and emergency treatment, is not readily available to low-income and/or uninsured adolescents. Federal officials note that poor oral health can lead to cavities, gingivitis, bleeding, rare heart damage, pain, malnutrition, and sleeplessness.²⁶ For adolescents of all races and ethnic groups who live in poverty, dental problems are particularly severe compared with higher-income youth.²⁷

Reproductive health

Adolescents learn to interact through experimentation, thus it is valuable to incorporate reproductive health education within preventive care services. Ongoing education and ser-

vices, including abstinence education, access to contraceptive services, family planning, and, if needed, comprehensive perinatal care, are critical to support young people in acting responsibly and planning effectively for their future.²⁸

To meet adolescents' unique care needs, states should review their SCHIP benefit packages for inclusion of specific benefits that adolescents need. States that provide their SCHIP coverage through a Medicaid expansion program (M-SCHIP) are required to cover comprehensive benefits as specified by the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. States that provide coverage through a separate SCHIP program (S-SCHIP) have more flexibility in determining the program's benefit package.

Adolescent health experts and advocates have expressed concern about states' use of benchmark plans for S-SCHIP benefit packages, because with the exception of Medicaid, none of the plans were developed with the child and adolescent population in mind.²⁹ It is important for states to review their benefit packages, as some may not include coverage to an adequate degree for all of the services that adolescents need. Medicaid's EPSDT program, on the other hand, was designed specifically to promote healthy development for children and youth.³⁰

Additional recommendations from adolescent health experts include limiting the cost-sharing requirements for preventive services to increase the likelihood that adolescents will seek care earlier. Experts also recommend that the same level of coverage be available for mental health and substance abuse as is available for other services because they are commonly needed services for adolescents.³¹ Including significant cost-sharing requirements and/or restricting the number of provider visits could act as barriers to adolescents accessing necessary care.

SERVICE DELIVERY

To best meet the needs of adolescents, states also should work to ensure the availability of SCHIP providers who understand adolescents' distinct care needs. For example, Vermont realized there was a gap within its provider network and actively recruited providers who specialized in substance abuse among youth.

Medicaid and SCHIP reimbursement rates may be insufficient to cover fully the time and resources required to provide adolescent-focused care.³² Therefore, beyond assuring availability of providers appropriate for adolescents, another way to help guarantee that adolescents enrolled in SCHIP have access to care is to provide adequate reimbursement to health care providers for the services they render to their teen patients. When Illinois expanded health care

coverage to all children and adolescents through age 18 regardless of family income, state leaders acknowledged that expanding coverage for all children and adolescents did not ensure they would have access to care. Therefore, the state included a provider rate increase to motivate providers to participate in the state's "All Kids" health care expansion. In addition to raising the rate for office visits, Illinois increased the rates for several other preventive care services that are specific to adolescent care, including "Healthy Adolescent Evaluation" and "Periodic Re-evaluation." Within a year of increasing the provider reimbursement rate, Illinois saw a dramatic increase of 1,600 active providers within the state's coverage network.

Confidentiality

When adolescents are discouraged from seeking health care due to concerns that the care will not be confidential, the result can be adverse health outcomes and significant social and economic costs.³³ Many adolescents will seek health care services only if they can receive services confidentially.³⁴ This is true particularly for services addressing such sensitive areas as pregnancy, sexually transmitted infections, or substance use. Providing teens with education, information, and resources about sexuality and substance use is important to their health and development.

Confidentiality protections can be found in both state and federal laws for adolescents. Federal Medicaid law includes confidentiality provisions that apply in any setting where a Medicaid beneficiary receives services.³⁵ The federal Health Insurance Portability and Accountability Act (HIPAA) includes privacy provisions, some of which are directed toward minors. The HIPAA privacy rule provides that when a minor is allowed to consent for health care and does so, the minor receives protection under the privacy rule.³⁶ However, the HIPAA privacy rule defers to "state or other applicable law" in regard to sharing of information with parents. These laws may prohibit, require, or permit the disclosure of information to parents.³⁷

To encourage adolescents to utilize necessary services, it is important to understand state specific minor consent laws. Every state has laws that allow adolescents under age 18 to give their own consent for health care in specific circumstances.³⁸ The laws can be based on the status of the adolescent (such as emancipated minor) or on the services being sought (such as contraceptive services).³⁹ States often provide confidentiality protections when minors receive contraceptive services.⁴⁰ State SCHIP officials not only need to assure adolescents of their privacy rights, but also need to ensure that the providers within their network are aware of

and comply with the confidentiality protections for minors.⁴¹

Complementary programs and networks

Working in conjunction with other public programs and forming partnerships with community organizations and networks that serve adolescents can help SCHIP programs to meet adolescents' needs. How a state's SCHIP program is coordinated or integrated with other services and programs for adolescents and their families is an important factor in its ability to improve access to care and the health of eligible youth.

Maternal and child health (MCH)⁴² and children with special health care needs (CSHCN) programs can be important partners in states' SCHIP programs' efforts to serve adolescents. These programs, authorized under the Title V MCH block grant, have limited but flexible resources, expertise, and a history of developing and administering programs and service delivery systems that meet the specific needs of women, children, adolescents, and families. State Title V programs are required by law to spend 30 percent of federal funds on preventive and primary care for children and youth from birth through age 21, and to coordinate with Title XIX (Medicaid) and other health and human services programs.

School-based health centers (SBHCs) and school-linked health centers (SLHCs) also are important programs for serving adolescents. These programs may be funded through state Title V or related state programs, by federal agencies, and by local sources. SBHCs provide a range of physical and mental health services to students at accessible and familiar locations. Multidisciplinary teams of physicians, nurses, nurse practitioners, health educators, social workers, and psychologists at many of these centers can assure that care is continuous, age-appropriate, culturally sensitive, and coordinated with other providers.⁴³ Evidence suggests that adolescents who have access to SBHCs use more outpatient primary care and mental health services, but require fewer urgent care and emergency room visits.⁴⁴

New York and Connecticut have worked to integrate school-based health centers with their Medicaid and SCHIP programs' managed care delivery system by requiring contracts with SBHCs. SBHCs are more likely to play a role in SCHIP when there is a strong state agency that requires or encourages the contracting process and an effective state SBHC association that can educate both its members and health plans about how the two can complement one another. For states that do not want to impose subcontracting requirements on managed care organizations, it might be possible to "carve out" SBHC services or a subset of these

services and reimburse SBHCs for serving SCHIP enrollees on a fee-for-service basis.⁴⁵

QUALITY AND PERFORMANCE MEASUREMENT AND IMPROVEMENT

Along with tailored outreach, benefits, and provider networks, states should include an adolescent focus when measuring their SCHIP program's quality and performance. Increasingly, states are undertaking efforts to measure, assess, and improve the quality and performance of health care programs they administer.⁴⁶ Almost all states reported in a 2006 national survey that they use some kind of policy or initiative to measure quality and performance.⁴⁷ Most states' policies for Medicaid and SCHIP require reporting on one or more of the measures within the Healthcare Effectiveness Data and Information Set (HEDIS) that focus on preventive and primary care.

The one adolescent-specific measure voluntarily reported annually by state SCHIP programs to the federal government has been access to primary care providers for those ages 12 to 19. In 2005, approximately 30 percent of states were able to provide this specific information on adolescents' access to primary care providers in their annual report to CMS.⁴⁸ Further information on how adolescents use SCHIP coverage or the quality of care adolescents receive under SCHIP coverage is less well known. This presents a challenge to state officials as they work to meet the health needs and improve the care for adolescents enrolled in the program.

To determine if adolescents enrolled in SCHIP are receiving quality health care services necessary for their development, quality measures specific to adolescents are needed. Adolescent health experts⁴⁹ suggest that the following services, which are of particular importance to adolescents, could be the focus of measurement to evaluate how the program is meeting adolescents' needs:

- Adolescent well-care visits;
- Screening for sexually transmitted infections;
- 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.⁵⁰

Conclusion

States' SCHIP programs provide coverage for a diverse population, given the range of developmental stages that occur from infancy to age 18. SCHIP includes both the program components and flexibility needed to serve this diverse population, which it has done with some success already. However, as states look to reach and better serve more eligible children and youth, public health coverage program administrators and health care policy makers should consider adolescents as a distinct group that requires age-specific policies and practices, including tailored outreach, benefit, and service delivery strategies.

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Vermont's Focus on Benefit Design and Quality

Vermont has made a focused effort to consider adolescents in both its S-SCHIP benefit package benefit design and in the establishment of a statewide quality initiative.

Dr. Dynasaur, Vermont's SCHIP program, offers coverage of comprehensive benefits that include preventive care, substance abuse, family planning, nutritional counseling, mental health services, and more. To ensure the program's providers are delivering care in an age appropriate manner, Vermont's Child Health Improvement Program (VCHIP) is coordinating an initiative that includes provider training and evaluation. VCHIP's initiative is the Vermont Youth Health Improvement Initiative (YHII), a collaborative project that includes both public and private entities, such as Blue Cross Blue Shield of Vermont, MVP Health, the Vermont Department of Health, and others. The VCHIP project team and stakeholders have worked with more than 20 Vermont family and pediatric practices that see the highest number of adolescents in the state, including school-based health centers. The goal of the initiative is to assist the providers in improving their preventive service delivery to youth ages 8 through 18 through office-based training and follow-up evaluations. Participating providers can choose one of the following four adolescent health preventive service topics:

- Strengths and Protective Factors Screening,
- Physical Activity and Nutrition Screening,
- Sexual Behavior Screening, and
- Substance Abuse Screening.

All training sessions share a core section that encourages practices to 1) use all the recommended preventive screenings during annual well-child visits; 2) assess for strengths; and 3) adopt an office-systems approach that would involve all staff in any changes made as a result of the training.⁵¹

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