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# Medicaid and SCHIP:

## Essential programs that benefit adolescents

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### Overview

Medicaid and the State Children's Health Insurance Program (SCHIP) have played a key role in supporting adolescents' health and their access to essential health care. This has been increasingly true of Medicaid since it was established four decades ago, and of Medicaid and SCHIP together for the past 10 years. To understand the past and current significance of these programs, and their future potential for adolescents, it is helpful to consider a series of questions:

- What is the health status of adolescents?
- What are the health care needs of adolescents?
- What is the status of health insurance coverage for adolescents?
- Have Medicaid and SCHIP improved health insurance coverage for adolescents?
- Have Medicaid and SCHIP improved adolescents' access to health care?
- Have Medicaid and SCHIP improved adolescents' health outcomes?
- Can Medicaid and SCHIP help redress health disparities among adolescents?
- How might policy developments in Medicaid and SCHIP affect adolescents?
- What Medicaid and SCHIP policies would provide the greatest benefits for adolescents?

### Health status of adolescents

Adolescents are often perceived as “healthy,” and many are healthy. However, they also experience significant health concerns, which have been extensively documented. Moreover, even healthy adolescents need access to preventive services, such as immunizations, and routine care, such as health checkups.

*Medicaid and SCHIP have played a key role in supporting adolescents' health and their access to essential health care.*

The major health problems faced by adolescents have been described as “preventable health conditions with predominantly behavioral, environmental and social etiologies.”<sup>1</sup> They include injury, homicide, suicide, mental and emotional illness, chronic illness and disability, poor nutrition, eating disorders, dental problems, pregnancy, sexually transmitted disease (STD), human immunodeficiency virus (HIV) infection, and substance abuse.<sup>2</sup>

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The health problems and concerns of adolescents are more prevalent and more severe among those who are characterized as “vulnerable” or members of “special populations.” Such groups include adolescents with a chronic illness or disability; pregnant and parenting teens; immigrant and migrant youth; gay, lesbian, bisexual and transgender adolescents; homeless, runaway and street youth; and adolescents living in state custody or out-of-home care.<sup>3</sup> Adolescents in these vulnerable groups are likely to need more intensive health services than other adolescents and to have greater difficulty accessing traditional sources of care.<sup>3</sup> Young adults also experience significant health concerns and encounter access barriers.<sup>4</sup> In addition, adolescents who are members of racial and ethnic minority groups are particularly affected by significant health disparities.<sup>5</sup>

### Health care needs of adolescents

The health concerns and problems of adolescents mean that this age group has a pressing need for a wide variety of health care and related services.<sup>3,6</sup> Many health care professional organizations and governmental agencies have issued recommendations on the health care services needed by adolescents.<sup>7–11</sup> Essential services include:

- Comprehensive health assessments
- Immunizations
- Dental examinations and treatment
- Family planning and other reproductive health services



- Pregnancy-related care, including prenatal and maternity care
- STD and HIV prevention, diagnosis, and treatment
- Mental health services
- Substance abuse assessment, counseling and treatment
- Treatment for acute and chronic illnesses and conditions
- Case management and coordination of care

## Health insurance coverage for adolescents

Adolescents have long been uninsured and underinsured at higher rates than many other groups in the population. The term “adolescents” in this context includes some young people who are legally minors (under age 18 years) and other young people who are officially adults (age 18 years or older). The term “adolescents” often will be used to refer to both, especially when concerns or characteristics span the 18th birthday demarcation. Older adolescents and young adults are among those most likely to lack any type of health insurance coverage, private or public. Those who are living in poverty or are members of racial or ethnic minority groups are even more likely to be uninsured.

Older adolescents are at significantly greater risk than younger adolescents of going without health insurance, with 13.7 percent of 15- to 18-year-olds uninsured in 2002, compared with 11 percent of 10- to 14-year-olds (Table A).<sup>12</sup>

*Older adolescents, young adults and those who are living in poverty or members of racial or ethnic minority groups are most likely to lack health insurance.*

Race and ethnicity play a major role both for adolescents and for the population as a whole. In 2002, 27.7 percent of Hispanic, 12 percent of Black and 8.4 percent of White adolescents aged 10–18 years were uninsured (Table B).<sup>12</sup> In 2005, for all age groups, 32.7 percent of Hispanics, 19.6 percent of Blacks, 17.9 percent of Asians and 11.3 percent of Whites were uninsured.<sup>13</sup>

Income also plays a highly significant role. In 2002, 19.7 percent of adolescents aged 10–18 years with family incomes below 100 percent of the federal poverty level (FPL),<sup>14</sup> and 19.2 percent of adolescents with family incomes ranging from 100 percent to 199 percent FPL, were uninsured, compared with just 6.3 percent of adolescents with family incomes at or above 200 percent FPL who were uninsured (Table C).<sup>12</sup>

Young adults are in even worse straits than older adolescents.<sup>15,16</sup> Overall, the U.S. Census Bureau reported for 2005 that a total of 3.2 million adolescents aged 12–17 years (12.5 percent) and 8.6 million young adults aged 18–24 years (30.6 percent) lacked health insurance (Table D).<sup>17</sup> In 2005, 45.9 percent of young adults aged 18–24 years who were living in poverty lacked insurance, and 22.8 percent of poor adolescents aged 12–17 years were without coverage (Table D).<sup>18</sup>

## Effect of Medicaid and SCHIP on health insurance coverage for adolescents

Throughout Medicaid’s four-decade history, numerous policy developments have increased the program’s capacity to meet the needs of adolescents for health insurance coverage with a broad benefit package. With the enactment of SCHIP in 1997, the beneficial reach of public health insurance programs was extended to children and adolescents with family incomes that were higher than would have allowed them to qualify for Medicaid, but still too low for private health insurance to be affordable.<sup>19,20</sup>

In the past two decades, one development of particular significance for adolescents was the expansion of eligibility based on income rather than receipt of cash assistance. Another was the expansion of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) component of Medicaid to ensure coverage of all medically necessary Medicaid services to diagnose or treat children’s and adolescents’ identified health problems.<sup>21</sup>

**Table A**  
Uninsured adolescents by age, 2002

Age	Percent of uninsured adolescents
Aged 10–14 years	11.0%
Aged 15–18 years	13.7%

Source: Newacheck PW, Park MJ, Brindis CD, Biehl M, Irwin CE, 2004.<sup>12</sup>

**Table B**  
Uninsured adolescents by race and ethnicity, 2002

Race/ethnicity	Percent of uninsured adolescents, aged 10–18 years
Hispanic	27.7%
Black (not Hispanic)	12.0%
White (not Hispanic)	8.4%

Source: Newacheck PW, Park MJ, Brindis CD, Biehl M, Irwin CE, 2004.<sup>12</sup>

**Table C**  
Uninsured adolescent by family income, 2002

Family income	Percent of uninsured adolescents, aged 10–18 years
< 100% FPL	19.7%
100% to 199% FPL	19.2%
≥ 200% FPL	6.3%

Source: Newacheck PW, Park MJ, Brindis CD, Biehl M, Irwin CE, 2004.<sup>12</sup>

**Table D**  
Uninsured adolescent and young adults, 2005

Age and income	Family income	Percent uninsured	Number uninsured
Aged 12–17 years	All income levels	12.5%	3.2 million
	≤ 100% FPL	22.8%	0.9 million
Aged 18–24 years	All income levels	30.6%	8.6 million
	≤ 100% FPL	45.9%	2.3 million

Source: U.S. Census Bureau, 2006.<sup>17,18</sup>

## Eligibility of adolescents for Medicaid and SCHIP

Originally, Medicaid eligibility for adolescents was generally limited to “categories” of individuals who received cash assistance from the former welfare program, Aid to Families with Dependent Children (AFDC), the Supplemental Security Income (SSI) program for individuals who are blind or disabled, or the federal foster care or adoption assistance program under Title IV-E of the Social Security Act. By the early 1990s, however, states were required to provide Medicaid eligibility independent of cash assistance for certain groups of pregnant women, children and adolescents. In particular, states were required to phase in, one year at a time, eligibility for all adolescents with family incomes at or below 100 percent of the FPL through age 18 years until they were all covered by 2002.<sup>20</sup>

In 1997, Congress created the State Children’s Health Insurance Program (SCHIP) and authorized approximately \$40 billion in federal funds over 10 years to assist the states in providing health insurance to children and adolescents on the basis of family income. States were given the option of using the funds to expand Medicaid, to implement a separate state-designed SCHIP program or to employ a combination of the two; about one-third of the states chose each of these options. States also were offered fiscal incentives—in the form of federal funds at higher matching rates—to accelerate their Medicaid coverage of poor adolescents and to be generous with their eligibility criteria in SCHIP programs.<sup>20</sup>

*The enactment of SCHIP, and the financial incentives it offered to states, served as a catalyst to improve adolescents’ eligibility for both Medicaid and SCHIP.*

The enactment of SCHIP, and the financial incentives it offered to states, served as a catalyst to improve adolescents’ eligibility for public health insurance through both Medicaid and the new SCHIP programs. In the years following SCHIP’s enactment, states made significant progress in expanding eligibility and increasing adolescents’ enrollment in both programs.

Eligibility for adolescents in Medicaid and SCHIP improved significantly soon after SCHIP’s enactment. For example, between 1997, when SCHIP was enacted, and 2001, the number of states that provided Medicaid eligibility for all poor adolescents up to their 19th birthday doubled from 23 to 46. As a result, many of the states allowed poor adolescents through the age of 18 to enroll in Medicaid or SCHIP well before the 2002 deadline that required the states to do so (Figure 1).<sup>20</sup>

In all states that established separate SCHIP programs or combined a separate SCHIP program with an expansion of Medicaid (rather than using SCHIP solely to expand Medicaid), the maximum eligibility level is higher for SCHIP than for Medicaid, although Medicaid eligibility levels were raised

in most states as well. As of 2006, 24 states and the District of Columbia had established their maximum eligibility level (in either Medicaid or SCHIP) at 200 percent FPL.<sup>22</sup> In seven states it was between 200 percent and 250 percent FPL, and in nine states it was between 250 percent and 350 percent FPL (Figure 2).<sup>22</sup> However, in 10 states the maximum level was either 185 percent FPL or lower (Figure 2).<sup>22</sup>

The clear conclusion to be drawn from these findings is that, in recent years, the combined effect of Medicaid and SCHIP policies established by the states within federally set parameters has been to expand the possibility of public health insurance coverage for adolescents. Indeed, the fact that the vast majority of states, when given the opportunity to do so, chose to expand public health insurance eligibility for children and adolescents to higher levels illustrates that state flexibility can lead to the adoption of generous policies.

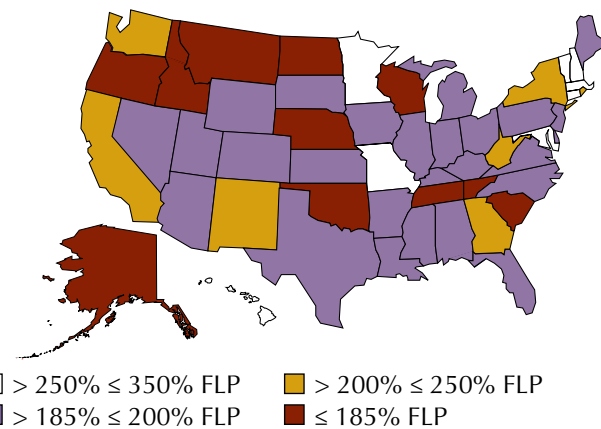
Nevertheless, the rate of health insurance coverage of adolescents has not changed much overall. One of the main reasons for this is that during the same period that the availability of public health insurance coverage increased, coverage for adolescents in private, employer-sponsored health insurance decreased.<sup>12</sup> Thus, public health insurance programs have become more important over time as a means of ensuring that adolescents living in poverty or with low family incomes have access to the coverage that is essential to protect their health.

**Figure 1**  
State Medicaid coverage of poor adolescents up to age 19



Source: Morreale MC, English A, 2003.<sup>20</sup>

**Figure 2**  
Maximum eligibility for adolescents under age 19 years in Medicaid and/or SCHIP, 2006



Source: Ross DC, Cox L, Marks C, 2007.<sup>22</sup>

## Enrollment of adolescents in Medicaid and SCHIP

In addition to expanded eligibility, the years following SCHIP's enactment saw increased enrollment of adolescents in public health insurance, not only in SCHIP but also in Medicaid (Figure 3). Direct comparisons over time across the two programs are generally difficult because the federal Centers for Medicare & Medicaid Services (CMS) reports data for the two programs in different age groupings (6–14 and 15–20 in Medicaid; 13–18 in SCHIP). Nonetheless, numerous points are noteworthy.

Before the enactment of SCHIP in 1997, Medicaid served a substantial portion of children and younger adolescents (19 percent of those aged 6–14 years), but a much smaller proportion of older adolescents (9 percent of those aged 15–20 years).<sup>20</sup> After SCHIP's enactment, however, the enrollment of adolescents in Medicaid increased.<sup>20</sup>

Looking at a single year, 2001, and specifically at adolescents aged 13–18 years, it is clear that Medicaid serves *three times as many* adolescents as SCHIP: 4.7 million in “traditional” Medicaid and 1.5 million in SCHIP (counting both Medicaid SCHIP expansions and state-designed SCHIP programs).<sup>20</sup> By 2001, the enrollment of adolescents in traditional Medicaid had increased in large part as a result of the mandatory “phase-in” of eligibility for poor adolescents under age 19 years, which was implemented on an accelerated basis by many states as a result of the financial incentives created by SCHIP.<sup>20</sup> Traditional Medicaid mostly serves the poorest adolescents, while those with slightly higher family incomes are mostly covered in SCHIP Medicaid expansions above 100 percent FPL and in state-designed SCHIP programs. In 2002, the congressionally mandated evaluation of SCHIP found that in the 10 states it had reviewed, one-third of SCHIP enrollees were adolescents aged 13–18 years.<sup>19</sup>

*Medicaid serves three times as many adolescents as SCHIP does: 4.7 million in Medicaid and 1.5 million in SCHIP in 2001.*

## Medicaid and SCHIP services for adolescents

Medicaid and SCHIP each have the potential to meet the multiple and challenging health needs of adolescents. The Medicaid benefit package is comprehensive and specifically includes the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) requirements for Medicaid recipients who are under age 21 years.<sup>23</sup> For most Medicaid beneficiaries in this age group, EPSDT means that states are required to make available periodic comprehensive assessments of their health, inter-periodic health screens, and follow-up diagnosis and treatment for identified problems. However, not all states have gone far enough in doing this. For example, only 33 states require annual comprehensive health

assessments in EPSDT as recommended by professional guidelines.<sup>11,24</sup> The breadth of the benefit package is virtually unequalled in other private and public health plans.

The SCHIP benefit package is potentially as broad as Medicaid's, although states have greater discretion in determining which services to offer, and considerable variation exists among states with respect to the benefit packages in their state-designed SCHIP programs.<sup>6</sup> Moreover, at least as a matter of federal law, SCHIP does not confer any entitlement to covered services, in contrast to Medicaid.<sup>25–27</sup>

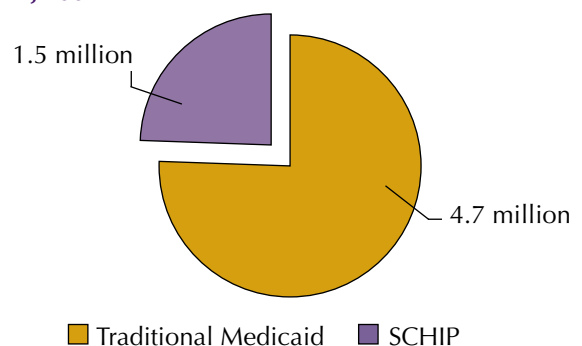
Early reviews of SCHIP in several states found that the states have not focused special attention on the unique service needs of adolescents. These reviews also suggested that access limitations for adolescents with respect to important services such as dental care and mental health services had more to do with reimbursement rates for providers and other policy issues than with the actual scope of the benefits covered.<sup>6</sup>

In evaluating the potential cost of offering a broad benefit package, it is noteworthy that the cost of health care is relatively low for adolescents compared with other age groups. For example, in 1997, the total average per capita annual expenditure was \$621 per adolescent (aged 10–18 years) with public health insurance coverage (at that time primarily Medicaid), and \$799 for all adolescents in that age group, while for adults it was nearly three times that amount, \$2343.<sup>28</sup> Other studies have estimated the annual per capita cost of providing clinical preventive services to adolescents at between \$78 and \$304.<sup>11</sup>

There is broad consensus in the health care professional community on the importance of providing adolescents with a comprehensive range of clinical preventive services.<sup>11</sup> Medicaid and SCHIP have the potential to make this possible for the adolescent beneficiaries in these programs.

*The Medicaid benefit package is comprehensive ... The SCHIP benefit package is potentially as broad as Medicaid's.*

**Figure 3**  
Enrollment of adolescents aged 13–18 in Medicaid and SCHIP, 2001



Source: Morreale MC, English A, 2003.<sup>20</sup>

## Effect of Medicaid and SCHIP on adolescents' access to health care

Health insurance coverage—or its absence—has significant effects on access to and utilization of health care.<sup>29–31</sup> This is true for adolescents as well as other age groups. Therefore, the expansion of eligibility and enrollment for adolescents in Medicaid and SCHIP, combined with the breadth of the benefit packages offered by these programs, has had a positive effect on access to health care for poor and low-income adolescents.<sup>19</sup> Although many adolescents receive quality care with private insurance coverage and in the private sector, and there is some evidence that publicly insured children and adolescents are more likely to have unmet medical or dental needs than privately insured children and adolescents, public coverage has led to significant improvements in access for low-income adolescents.

Compared with adolescents who have health insurance, uninsured adolescents are five times as likely to lack a usual source of health care, four times as likely to have an unmet health need and twice as likely to go without a physician visit during the year.<sup>12</sup> They also encounter increased barriers to the preventive health care that is so critical at their developmental stage<sup>33</sup> and are more likely to have an unmet mental health need than their insured peers.<sup>34</sup>

Medicaid and SCHIP have addressed these access problems for adolescents in two important ways: first, by enabling those with low family incomes to have health insurance coverage; and second, by offering a benefit package that includes some of the key services needed by this age group. The increased access has been associated with increased utilization of needed services.

For example, Medicaid and SCHIP offer coverage for preventive care, an essential element of comprehensive care for adolescents. Although participation levels are not as high as they should be, recent data show improvements in the rates at which older adolescents (aged 15–20 years) enrolled in Medicaid are receiving the comprehensive health assessments that must be made available to them as part of EPSDT.<sup>35</sup> An earlier study found that 74 percent of children in Medicaid had at least one preventive or well-child visit within the past year, compared to 41 percent of uninsured children.

Moreover, low-income children and adolescents who are covered by Medicaid are more likely than those with private insurance to have well-child and dental visits.<sup>30</sup> Preliminary studies also show increased utilization of preventive services, particularly by Black and Hispanic adolescents, many of whom had no access to preventive care prior to SCHIP.<sup>36,37</sup>

Both Medicaid and SCHIP have been linked with generally increased access and service use. For example, SCHIP enrollment has been associated with a perceived increase in access to a wide range of services, increases in health service utilization and decreases in unmet need,<sup>38</sup> as well as improved use of a usual source of care.<sup>39–41</sup> Medicaid enrollment has been

associated with decreases in the use of emergency departments for enrollees under age 18 years<sup>42</sup> and with higher utilization of mental health services by children and adolescents.<sup>34</sup>

Eligibility for health insurance and even health insurance coverage—public or private—does not guarantee access to care, and access problems have been documented in both Medicaid and SCHIP.<sup>43,44</sup> For example, shortcomings occurring in SCHIP programs have included difficulties experienced by adolescents in accessing dental care and mental health services, with limitations often being related to reimbursement rates for providers.<sup>6</sup> Nevertheless, in spite of some access limitations, SCHIP and Medicaid coverage demonstrably do improve access to care, particularly when compared with access for uninsured adolescents.<sup>19</sup>

Although much of the currently available data on the beneficial effects of Medicaid and SCHIP group children and adolescents together, some studies have looked specifically at adolescents. Taken together, the data strongly suggest a positive impact.

Limited data are available that directly address the effect of Medicaid and SCHIP on adolescents' health outcomes. Nevertheless, studies that have examined the impact of these insurance programs on health outcomes for children and adolescents generally demonstrated their potential to improve the health status of beneficiaries.<sup>31</sup> An analysis of data from the Centers for Disease Control and Prevention suggests that about one-fourth of children and adolescents enrolled in Medicaid and SCHIP have better health than one year ago.<sup>45</sup>

Medicaid has been shown to reduce childhood deaths<sup>46</sup> and infant mortality.<sup>47</sup> Medicaid also has been shown to improve health outcomes for enrolled children and adolescents with asthma.<sup>48</sup> Broader positive effects on the lives of enrolled children and adolescents also have been found.<sup>31</sup> For example, at least one study using national data found that children and adolescents with either Medicaid or private insurance missed fewer school days due to illness and had fewer days of restricted activity, even after controlling for factors such as income, parental education and location.<sup>31</sup> Other analyses have demonstrated similar benefits from health coverage—through Medicaid, SCHIP or private insurance—or increased access to health care in terms of fewer missed school days and improved school performance.<sup>49,50</sup>

Further study is needed to fully document the effects of improved health insurance coverage and health care access on the health status and outcomes of adolescents who are enrolled in Medicaid and SCHIP. Nevertheless, clear evidence already exists that both programs make a difference for adolescents.

*Both Medicaid and SCHIP have been linked with generally increased access and service use.*

*Studies have demonstrated Medicaid and SCHIP's potential to improve the health status of beneficiaries.*

Not only do Medicaid and SCHIP have the potential to improve the health status of adolescent beneficiaries enrolled in these programs, but they also have the potential to reduce health care disparities for adolescents who are members of racial and ethnic minority groups.<sup>19</sup> These disparities are well documented,<sup>5,51</sup> and leading health care professional organizations recognize the urgent need to reduce them through improved health care access and other means.<sup>52</sup>

In almost every area in which racial and ethnic health care disparities affect adolescents, Medicaid and SCHIP either already have made or could make a significant difference. For example, racial and ethnic minority youth are uninsured at higher rates than their white counterparts,<sup>12,53</sup> but many of these uninsured youth are eligible for, but not yet enrolled in, Medicaid or SCHIP, suggesting that more targeted outreach to minorities is required. Minority youth also use preventive services infrequently,<sup>36</sup> in spite of high rates of preventable diseases and health concerns.<sup>54</sup> Specific health concerns that affect minority youth at high rates, and which could be addressed by services that are covered in Medicaid and SCHIP, include mental health problems,<sup>34</sup> dental care,<sup>55</sup> STD,<sup>56,57</sup> and chronic illnesses and disabilities.<sup>58</sup>

Medicaid and SCHIP could make an important difference in reducing health disparities for minority adolescents in several distinct ways. Many of these are strategies that are needed to benefit poor and low-income adolescents generally, such as further increasing health insurance coverage for poor and minority youth and maintaining access to a broad benefit package. However, some necessary strategies are specific to racial and ethnic minority youth, such as conducting direct outreach to these young people to encourage utilization of essential services and increasing the cultural competence of health care providers and systems. In addition, generating and monitoring data on the progress being made to reduce health disparities is an essential element of any effective strategy in this arena.

## **Implications for adolescents of policy developments in Medicaid and SCHIP**

Important legislative developments and policy changes—some proposed, others enacted or implemented—have had or could have major implications for adolescents, particularly for low-income adolescents and their health care access. Key developments at the federal level in 2007 with major significance for adolescents include implementation of the Deficit Reduction Act of 2005, proposals for health insurance expansion and reforms, and SCHIP reauthorization. The outcome of these policy developments and others, in 2007 and beyond, will almost certainly affect adolescents' access to health care for the foreseeable future.

## **Significance of the Deficit Reduction Act for medical coverage of adolescents**

The Deficit Reduction Act of 2005 (DRA) was signed into law Feb. 8, 2006. It contained substantial cuts to the Medicaid budget, new opportunities for states to exercise flexibility with regard to key elements of Medicaid, and new requirements for citizenship documentation for Medicaid beneficiaries.<sup>59</sup>

Specifically, for the first time since Medicaid was created, the DRA gave states the option of limiting the scope of mandatory benefits, including EPSDT, for children and adolescents in mandatory eligibility categories, and for whom the full range of EPSDT services have long been an entitlement.<sup>60</sup> At the federal level, over many years, proposals were made to convert Medicaid to a block grant.<sup>21</sup> By giving states the option of limiting mandatory benefits for children and adolescents, the DRA achieved, at least in part, one of the goals of a block grant—the possibility of eliminating the entitlement guarantee of Medicaid services—without converting the entire program.

The guarantee of comprehensive services that has characterized EPSDT is a key element of Medicaid's potential to meet the service needs of low-income and vulnerable adolescents. Its loss could have serious adverse consequences for the adolescent age group, particularly if the weakened service requirements were those of great importance to adolescents, such as mental health services, substance abuse counseling and treatment, or family planning services. Under the DRA, states are, at minimum, supposed to arrange for EPSDT but can offer it as a wraparound benefit, rather than part of the standard benefit package. It is not clear whether federal oversight will ensure that these services are actually available to children and adolescents, or whether Congress will alter this requirement.

The DRA gave states the option of increasing cost sharing for beneficiaries, in the form of both premiums and copayments for services.<sup>60</sup> Prior to the DRA, all children and adolescents in Medicaid were exempt from cost sharing; however, the DRA retained this protection only for those children and adolescents whom states are mandated to cover (for adolescents this includes those younger than age 19 years with family incomes at or below 100 percent FPL). Thus, cost sharing could be imposed for the first time for any adolescent in Medicaid whose family income exceeds 100 percent FPL, even though such families have limited ability to meet cost-sharing requirements.

Increases in cost sharing have been shown to harm beneficiaries by reducing the likelihood that they will enroll initially and retain coverage if they do, and by reducing their utilization of services.<sup>61</sup> Both of these effects would have adverse consequences for adolescent beneficiaries, particularly members of minority groups or especially vulnerable populations, who already are at risk for more limited enrollment, access and utilization of services.

The DRA also imposed complex citizenship documentation requirements, which have already been found to reduce or delay the enrollment of citizen children in Medicaid, including one particularly vulnerable group, foster children.<sup>62,63</sup> In certain arenas, the implications for adolescents are particularly significant. For example, California serves 1.5 million individuals annually through its Medicaid family planning waiver, and one-fifth of them are adolescents for whom timely enrollment and receipt of services is critical.<sup>64</sup>

## Significance of diverse health care reform proposals for adolescents

During 2007, numerous health care reform proposals have been introduced in Congress that could benefit adolescents and young adults by increasing the number of young people with access to health insurance coverage and by improving access to benefits of critical importance for this age group. Such proposals include efforts to establish universal health insurance coverage for children, adolescents and young adults<sup>65,66</sup>; to reach vulnerable populations such as legal immigrants<sup>67</sup> and former foster youth<sup>68</sup>; and to improve access to certain services that are particularly important for adolescents, such as extending Medicaid coverage of family planning services<sup>69</sup> and expanding mental health parity requirements.<sup>70</sup> Any of these measures, if enacted, would be of significant value to adolescents.

## Significance of SCHIP reauthorization for adolescents

SCHIP is due for reauthorization in 2007. This provides the opportunity to build on past achievements in both SCHIP and Medicaid toward reaching the goal of ensuring that all low-income children and adolescents have the health insurance coverage they need.<sup>71,72</sup> Ten years after its initial enactment, SCHIP will need increased funding to maintain the levels of coverage it has been able to provide thus far.<sup>72</sup> An even larger increase in funding will be required to enroll all of the more than 5 million children and adolescents who are eligible for, but unenrolled in, Medicaid and SCHIP.<sup>72</sup> Both the Congressional Budget Resolution for FY 2008 and legislation being acted upon by Congress in mid-2007 provide for such increases.<sup>72</sup>

Originally enacted with bipartisan support, the State Children's Health Insurance Program has continued to enjoy broad support from many different stakeholders. Governors,<sup>73</sup> state-level SCHIP directors,<sup>74</sup> opinion leaders in health policy,<sup>75</sup> child and adolescent health advocates, and the public<sup>76</sup> have all expressed their support for SCHIP and its reauthorization. While not every group supports every issue, there is strong support across different sectors for proposals such as maintaining SCHIP and Medicaid coverage for existing enrollees and expanding coverage to additional children and adolescents; simplifying enrollment; reducing some burdens of the citizen documentation requirements; allowing states to cover legal immigrant pregnant women and children; and giving states the flexibility to provide coverage up to 300 percent FPL and to older adolescents and young adults. All of these proposals would be of significant benefit to adolescents.

## Conclusion

Healthy People 2010 articulated a series of national objectives designed to improve the health of the population in the United States in furtherance of two overarching goals: to increase the quality and years of life and to eliminate health disparities.<sup>77</sup> Adolescents in general and vulnerable groups of adolescents in particular are subject to disparities in comparison with other segments of the population in terms of their health status, insurance status and access to health care.<sup>78</sup> Medicaid and SCHIP have made important gains in addressing these disparities and can continue to benefit adolescents in the future if they are supported and safeguarded. SCHIP reauthorization measures and other bills currently pending in Congress provide an important opportunity to do this in significant ways that enjoy broad bipartisan support among policymakers, advocates and the public.

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## About the ACPM-AMA National Coalition for Adolescent Health

This issue brief was prepared for the American College of Preventive Medicine (ACPM)–American Medical Association (AMA) National Coalition for Adolescent Health. The coalition is a unique consortium of national medical, nursing, public health, health care, research and public interest organizations that share an interest in promoting participation in and distributing resources for professionals who want to improve the health status of adolescents. From 2004 to 2006, the ACPM and the AMA co-chaired the coalition with support from the Maternal and Child Health Bureau (MCHB) in the Health Resources and Services Administration (HRSA) in the U.S. Department of Health and Human Services. Prior to 2004, the coalition was chaired by the AMA with support from MCHB and HRSA.

The membership of the ACPM-AMA National Coalition for Adolescent Health includes the following organizations:

American Academy of Child and Adolescent Psychiatry  
American Academy of Family Physicians  
American Academy of Pediatrics  
American Academy of Physician Assistants  
American Association of Health Plans  
American Association of Public Health Physicians  
American College of Allergy, Asthma and Immunology  
American College of Emergency Physicians  
American College Health Association  
American College of Obstetricians and Gynecologists  
American College of Physicians  
American College of Preventive Medicine  
American Institutes for Research  
American Medical Association  
American Medical Women's Association  
American Osteopathic Association  
American Psychiatric Association  
American Society for Adolescent Psychiatry  
American Social Health Association  
American Society of Addiction Medicine  
Association of State and Territorial Health Officials  
Center for Adolescent Health & the Law  
Center for Science in the Public Interest  
National Association of County and City Health Officials  
National Association of School Nurses

National Association of State Alcohol and Drug Abuse Directors

National Hispanic Medical Association

National Medical Association

Society for Adolescent Medicine

## About the Center for Adolescent Health & the Law

The Center for Adolescent Health & the Law supports laws and policies that promote the health of adolescents and their access to comprehensive health care. Established in 1999, the center is a nonprofit 501(c)(3) organization. Working nationally, the center clarifies the complex legal and policy issues that affect access to health care for the most vulnerable youth in the United States. The center provides information and analysis, publications, consultation, and training to health professionals, policymakers, researchers and advocates who are working to protect the health of adolescents. For additional information, contact Abigail English, JD, director, Center for Adolescent Health & the Law.

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