Addressing Adolescent Health: The Role of Medicaid, CHIP, and the ACA

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The 2010 National Health Interview Survey reported that most U.S. children age 17 years and under had excellent or very good health and the adolescent death rate has declined steadily over the last decade.[2] Despite these encouraging trends, major disparities still exist among the population. Moreover, the health care needs of adolescents are numerous and complex. The health of young people must be continuously evaluated with continued support for programs that seek to improve their health and well-being. This issue brief will describe how the Affordable Care Act (ACA) and public programs like Medicaid and the Children's Health Insurance Program (CHIP) can best meet the health needs of low-income adolescents.

Background

Major health problems and concerns

All adolescents need regular check-ups, and most need contraceptive services and STD screenings. Many adolescents need treatment and monitoring for chronic health conditions, including asthma, or behavioral health care services. Adolescents are far less likely than adults to suffer from cardiovascular disease or cancers, but instead have their own problems, some of them life-threatening, from which they suffer disproportionately. These problems, which include poor nutrition, mental and emotional illness, suicide, chronic illness, pregnancy, STDs, and substance use, have been described as "preventable health conditions with predominantly behavioral and environmental etiologies."[3]

Income level and race also play a role in adolescent health status. For example, poor youth tend to have higher rates of pregnancy, STDs, HIV, and substance use than their wealthier counterparts. Health problems are particularly acute for minority youth. Across

[1] Thanks to Esther Earbin, 2L at the University of North Carolina at Chapel Hill School of Law, for assistance with this Issue Brief.
[2] Barbara Bloom et al., *Summary health statistics for U.S. children: National Health Interview Survey, 2010; Nat'l Center for Health Statistics*, 10 Vital Health Stat. 250 (2011); Nan Jiang et al., *Health of Adolescents and Young Adults: Trends in Achieving the 21 Critical National Health Objectives by 2010*, 49 J. Adolescent Health 124 (2011).
[3] David S. Rosen et al., *Clinical Preventive Services for Adolescents: Position Paper of the Society for Adolescent Medicine*, 21 J. Adolescent Health 203 (1997).

all adolescent health problem measures, Black and Latino adolescents are disproportionately affected.[4]

In terms of chronic disease and disability, approximately 2.8 million school-aged children suffer from physical disabilities that limit their ability to do regular schoolwork, create problems in personal care or activities of daily living, and/or require them to use assistive aids.[5] Black adolescents are much more likely to suffer serious consequences, including death, from chronic conditions like asthma as compared to White adolescents.[6] Furthermore, five times as many foster children (30 percent) as children in the general population suffer from chronic disorders.[7]

Mental disorders account for approximately 32 percent of all adolescent disabilities, making them the single largest cause of disability among adolescents.[8] Approximately 20 percent of adolescents have a diagnosable mental disorder, and major depression affects 5 percent of youth aged 9 to 17 years.[9]

Understanding the sexual activity and reproductive health of adolescents is crucial to ensuring overall health and well-being. Approximately 47 percent of teenagers report having had sexual intercourse, and 15.3 percent report having had sex with four or more people during their life.[10] Nearly half of the 19 million new STDs each year are among young people aged 15-24 years.[11]

Some notable improvements have occurred in recent years. Between 2006 and 2010, for example, approximately 86 percent of female teens and 93 percent of male teens reported using contraceptives at last sex (up from 71 percent and 82 percent

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[4] Tracy A. Lieu et al., *Race, Ethnicity, and Access to Ambulatory Care among U.S. Adolescents*, 83 Am. J. Pub. Health 960 (1993); Laurie Emmer, *The Impact of Poverty on Adolescent Health*, 3 Adolescent Health 2 (2003).

[5] Elizabeth M. Ozer et al., Nat'l Adolescent Health Info. Ctr., *America's Adolescents: Are they Healthy?* 13 (1998) [hereinafter NAHIC]; Centers for Disease Control & Prevention, *Disabilities Among Children Aged less than or equal to 17 Years - United States 1991-1992*, 44 MMWR 609 (1995).

[6] American Lung Association, *Trends in Asthma Morbidity and Mortality* (July 2011), *available at* http://www.lung.org/finding-cures/our-research/trend-reports/asthma-trend-report.pdf.

[7] Center for Health Policy Research, *Children in Foster Care: A Vulnerable Population in Health Care Reform*, 1 Health Pol'y & Child Health 1, 3 (1994).

[8] NAHIC, *supra* note 5, at 14.

[9] Susan Wile Schwarz, Nat'l Ctr. for Children in Poverty, *Adolescent Mental Health in the United States* (2009); Arlene Rubin Stiffman et al., *Adolescents' and Provider Perspectives on the Need for and Use of Mental Health Services*, 21 J. Adolescent Health 335 (1997); Shashi K. Bhatia et al., *Childhood and Adolescent Depression*, 75 Am. Fam. Physician 73 (2007).

[10] Centers for Disease Control and Prevention, *Sexual Risk Behavior: HIV, STD, & Teen Pregnancy Prevention* (2012)*, available at* http://www.cdc.gov/HealthyYouth/sexualbehaviors/.

[11] *Id.*

respectively in 1995).[12] On the other hand, in 2008, young people aged 13-24 made up about 17 percent of all individuals diagnosed with HIV/AIDS.[13]

In terms of adolescent pregnancy, each year nearly 750,000 women aged 15-19 become pregnant, with two-thirds of all teen pregnancies occuring among women aged 18-19.[14] Although the teen pregnancy rate in the U.S. has declined in the past several years, it is still one of the highest in the developed world. In 2005, New Mexico had the highest teenage pregnancy rate (93 per 1,000), followed by Nevada, Arizona, Texas and Mississippi.[15] Approximately 82 percent of teen pregnancies are unplanned, accounting for one-fifth of all unintended pregnancies per year in the United States. In 2008, 59 percent of pregnancies among 15-19 year olds ended in birth, and 26 percent in abortion.[16]

Adolescents and young adults without health insurance are more likely to have unmet medical needs, to have no usual source of care, and to report fair or poor health.[17] Public insurance rates for adolescents are highest for those aged 13 to 14 years, with the rate declining sharply between the ages of 17 and 20 years, likely a result of aging out of public coverage programs like Medicaid.[18] Studies have shown that racial and ethnic disparities in coverage are present in adolescents and continue into young adulthood.[19] While uninsured rates for children have fallen, eight million children remained uninsured in 2010.[20] Poor and low-income children are more likely to be uninsured than their higher income counterparts, as are racial and ethnic minorities as compared to White children.[21] Approximately 74 percent of uninsured children live in households below 200 percent of the FPL, and 65 percent of these children are in

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[12] Gladys Martinez et al., *Teenagers in the United States: Sexual Activity, Contraceptive Use, and Childbearing, 2006-2010 National Survey of Family Growth*, 23 Vital & Health Stat. 31 (2011).
[13] Centers for Disease Control and Prevention, *HIV Surveillance Report, 2008* (2010), *available at* http://www.cdc.gov/hiv/topics/surveillance/resources/reports>.
[14] Guttmacher Inst., *U.S. Teenage Pregnancies, Births and Abortions, 2008: National Trends by Race and Ethnicity, 2010* (2012), *available at* http://www.guttmacher.org/pubs/USTPtrends08.pdf.
[15] *Id.*
[16] Guttmacher, *supra* note 14; Lawrence B. Finer & Mia R. Zolna, *Unintended pregnancy in the United States: incidence and disparities, 2006*, 84 Contraception 478 (2011).
[17] Todd Callahan & William Cooper, *Uninsurance and Health Care Access Among Young Adults in the United States,* 116 Pediatrics 88 (2005); Margaret McManus et al., *Health insurance Status of Young Adults in the United States*, 84 Pediatrics 709 (1989).
[18] Sally Adams et al., *Health Insurance Across Vulnerable Ages: Patterns and Disparities From Adolescence to the Early 30s*, 119 Pediatrics 1033 (2007).
[19] *Id.*
[20] Kaiser Comm'n on Medicaid & Uninsured, *Health Coverage of Children: The Role of Medicaid and CHIP* (July 2012), *available at* http://www.kff.org/uninsured/upload/7698-06.pdf [hereinafter *Health Coverage of Children*].
[21] *Id.*

families with at least one full-time worker but, due to lack of employer coverage or unaffordability, are not able to access employer-sponsored family coverage.[22]

Legal Provisions Regarding Coverage of Adolescent Health Needs

Medicaid

Medicaid is a medical assistance program financed jointly by the state and federal governments. Participation in Medicaid is optional, but if a state chooses to accept Federal funding for the program--payment for half or more of total expenditures on services and administrative costs in the state--the state must provide health insurance coverage for specific groups of people (additional groups at state option) for a specific set of services (additional services at state option). All states participate in the Medicaid program. Medicaid is the largest single source of federal funding for health care for low income individuals in the United States, including for adolescents.[23] Medicaid covers approximately 31 million children, and 4.6 million children gained coverage through either Medicaid or the Children's Health Insurance Program (CHIP) between 2007 and 2010.[24]

Medicaid eligibility and enrollment: Medicaid operates as an entitlement program, with individuals who satisfy the financial and other eligibility requirements entitled to receive the services covered by the state's program. Under existing rules, certain adolescents must be covered under Medicaid as "mandatory categorically needy", including:

- adolescents younger than age 19, whose family income is at or below 100 percent of the federal poverty level (FPL);[25]
- pregnant adolescents with family incomes at or below 133 percent of the FPL;[26]
- adolescents living in families who met the state Aid to Families with Dependent Children (AFDC) eligibility criteria that were in effect on July 16, 1996;[27]
- adolescents receiving SSI because they are blind or disabled;[28]
- adolescents who receive federal foster care maintenance payments under Title IV-E of the Social Security Act;[29] and

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[22] *Id.*

[23] For a detail discussion of the requirements of federal Medicaid law related to administration, eligibility, and services, including citations to all pertinent Medicaid statutory and regulatory provisions and cases, see National Health Law Program, *The Advocate's Guide to the Medicaid Program* (May 2011, revised Sept. 2012) (available from the National Health Law Program, Los Angeles, CA).

[24] *See Health Coverage of Children, supra* note 20. The CHIP program is discussed further infra.

[25] 42 U.S.C. § 1396(l)(1)(D).

[26] *Id.* § 1396a(a)(10)(A)(i)(IV).

[27] *Id.* § 1396a(a)(10)(A)(i)(I).

[28] *Id.* § 1396a(a)(10)(A)(i)(II).

[29] *Id.* §§ 672(h), 1396a(a)(10)(A)(i)(I); 42 C.F.R. § 435.145.

- adolescents who receive federal adoption assistance payments or for whom an adoption assistance agreement is in effect under Title IV-E of the Social Security Act.[30]

Beginning in January 2014 as a result of the ACA, Medicaid programs are required to cover all non-pregnant individuals under age 65 with no creditable coverage if their income is below 138 percent of the FPL.[31] The Supreme Court's recent Affordable Care Act decision, however, held that states cannot have their federal Medicaid funding terminated if they refuse to make this expansion.[32]

Other groups of adolescents may be covered at state option including:[33]

- pregnant adolescents living in families with incomes between 133 percent and 185 percent of the FPL;[34]
- adolescents who meet the definition of "optional targeted low-income child" and may therefore be covered by Medicaid using funds under the CHIP program;[35]
- adolescents who would have been eligible for AFDC under the rules in place on July 16, 1996 except that they do not meet the definition of "dependent child" (known as "Ribicoff children");[36]
- "medically needy" adolescents meeting the criteria for SSI (disability) or the criteria for AFDC July 16, 1996 rules, but for excess income levels;[37]
- adolescents with disabilities age 18 or younger living at home who do not qualify for SSI because of income and/or resources being "deemed" to them from a parent;[38]
- adolescents with special needs for whom adoption assistance agreements are in effect under state-funded adoption subsidy programs;[39] or
- adolescents with tuberculosis who meet the income and resources test for individuals with disabilities.[40]

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[30] *Id.* §§ 673(b), 1396a(a)(10)(A)(i)(I); 42 C.F.R. § 435.145.
[31] *Id.* § 1396a(a)(10)(A)(i)(VIII) (added by Patient Protection and Affordable Care Act, Pub. L. No. 111-148 § 2001(a)(1) (Mar. 23, 2010) [hereinafter ACA]. *See Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566 (2012) [hereinafter *NFIB*] (upholding constitutionality of most of the ACA, but finding that states have flexibility to expand Medicaid, and must comply with all of the Medicaid Act if they do so, but they will not lose all federal Medicaid funding if they choose not to expand Medicaid).
[32] *See NFIB* at 2607.
[33] For a complete list of optional Medicaid eligibility categories, *see The Advocate's Guide to the Medicaid Program*, *supra* note 23, Chapter III, Eligibility.
[34] *Id.* §§ 1396a(a)(10)(A)(ii)(IX), 1396a(l)(1).
[35] *Id.* § 1396d(u)(2)(C).
[36] *Id.* § 1396a(a)(10)(A)(ii).
[37] *Id.* § 1396a(a)(10)(C).
[38] *Id.* § 1396a(e)(3).
[39] *Id.* § 1396a(a)(10)(A)(ii)(VIII).
[40] *Id.* § 1396a(a)(10)(A)(ii)(XII).

Provisions of the Medicaid Act also seek to ensure that adolescents are enrolled in the Medicaid program. States must create "outstations" accepting short form applications at sites other than welfare offices, in particular focusing on places where children and youth seek their health care (e.g. clinics outpatient hospitals). States may also eliminate asset tests, expediting applications for pregnant women, and allow certain "qualified" providers or entities to make presumptive eligibility determinations for pregnant women, children, and adolescents pending a formal determination of eligibility.[41] States may also rely on eligibility findings made by an "Express Lane agency."[42] An Express Lane agency is a public agency the state decides is capable of making determinations of one or more eligibility requirements, including Medicaid, CHIP, TANF, WIC, school lunch or public housing programs, and the Indian Health Service, and Indian tribes and tribal organizations.[43] This option allows a state to initiate and determine an adolescents' eligibility without a program application form, but the adolescent or caregiver must affirmatively consent to enrollment before they are automatically enrolled.

Medicaid Services*:* The Medicaid Early and Periodic Screening, Diagnostic and Treatment (EPSDT) service represents a broad benefit package offering comprehensive coverage to children and adolescents.[44] EPSDT is a mandatory Medicaid service that must be provided for Medicaid-eligible children and youth up to age 21. Added to the Medicaid Act in 1967, EPSDT has the potential to dramatically improve the overall health and well-being of adolescents in the United States. The robust benefits package was created based on the understanding that low socioeconomic status carries with it numerous by-products, as noted in the previous section of this issue brief. Moreover, growing evidence shows that lifelong patterns of health and well-being are established during childhood.[45] Access to EPSDT comprehensive and coordinated care with a focus on early detection and prevention is therefore of paramount importance.

Four separate types of screens are required: medical, vision, hearing, and dental.[46] Medical screens must be provided according to a "periodicity schedule" set by the state according to the standards of recognized medical organizations involved in child health care. The medical screens must include at least:

- a comprehensive health and development history;

[41] *Id.* §§ 1396a(a)(47), (55), 1396a(l)(3)(A), 1396r-1, 1396r-1a.
[42] *Id.* §§ 1396a(e)(13), 1397gg(e)(1)(F).
[43] *Id.* § 1396a(e)(13)(F).
[44] 42 U.S.C. §§ 1396a(a)(10), (43), 1396d(a)(4)(B), 1396d(r); 42 C.F.R. §§ 441.50-441.62; CMS STATE MEDICAID MANUAL §§ 5010-5360. For a comprehensive guide to the EPSDT program, *see* NHeLP, *Toward a Healthy Future: Medicaid Early and Periodic Screening, Diagnostic, and Treatment Services for Poor Children and Youth* (April 2003) (available from NHeLP's Los Angeles office).
[45] *See* Edward L. Schor et al., *Medicaid: Health Promotion and Disease Prevention for School Readiness*, 26 Health Affairs 420, 423 (2007); Paul Newacheck et al., *The Effect on Children of Curtailing Medicaid Spending*, 274 JAMA 1468 (1995).
[46] *See* 42 U.S.C. §§ 1396a(a)(43)(B), 1396d(r)(1)-(4). *See* CMS, *Dear State Medicaid Director* (Dec. 14, 2004) (SMDL #04-008) (discussing procedures to assure Medicaid children in vaccine for children program receive influenza shots). *See also* 42 U.S.C. §§ 1396a(a)(62), 1396s.

- a comprehensive unclothed physical exam;
- immunizations;
- laboratory testing when appropriate including, e.g., STD testing and hepatitis B immunizations; and
- health education and anticipatory guidance, concerning, e.g., smoking cessation, drug therapy, and counseling programs.[47]

The Bright Futures guidance developed by the American Academy of Pediatrics is a useful guide for states in addressing adolescent health needs, including for practice guides on oral health, nutrition, mental health, and physical activity.[48] It also recommends annual health check-ups for adolescents. However, the periodicity schedule for adolescents in many states lags behind the annual checkups recommended by virtually every professional group and compliance with screening requirements is far from adequate.

Vision services must include vision screens and diagnosis and treatment of vision defects, including eyeglasses.[49] Hearing services must include hearing screens and diagnosis and treatment for defects in hearing, including hearing aids.[50] And finally, dental services must include dental screens, relief of pain and infections, restoration of teeth, and maintenance of dental health.[51]

Pursuant to federal requirements, states must provide for comprehensive coverage of services necessary to "correct or ameliorate" health conditions identified by a screen, even if those services otherwise are not covered under the state's Medicaid plan for

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[47] *See* CMS STATE MEDICAID MANUAL § 2700.4. *See* HCFA, *Dear State Medicaid Director* (Jan. 19, 2001) (SMDL #01-011) (discussing asthma services); HCFA, *Dear State Medicaid Director* (Jan. 5, 2001) (discussing smoking cessation, drug therapy, and counseling programs). *See also* CMS, *Guide for States Interested in Transitioning to Targeted Blood Lead Screening for Medicaid-Eligible Children* (May 2012), *available at* http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Downloads/TargetedLeadScreening.pdf.

[48] Bright Futures Project & Am. Acad. of Pediatrics, *Recommendations for Preventive Pediatric Health Care* (2008), *available at* http://brightfutures.aap.org/pdfs/AAP%20Bright%20Futures%20Periodicity%20Sched%20101107.pdf.

[49] 42 U.S.C. § 1396d(r)(2).

[50] *Id.* § 1396d(r)(4).

[51] *Id.* § 1396d(r)(3); HCFA, *Dear State Medicaid Director* (Jan. 18, 2001) (discussing dental services). Orthodontia has generally been considered medically necessary only when the child or adolescent exhibits malocclusion (poor alignment of the teeth) that is considered extreme and thus "handicapping." *See* CMS, U.S. Dep't of Health and Human Servs., *A Guide to Children's Dental Care in Medicaid*, app. 14 (Oct. 2004), *available at* http://www.cms.hhs.gov/medicaid/epsdt/dentalguide.pdf. *See also* NHeLP, *Fact Sheet: Medicaid Coverage of Orthodontia for Children* (Mar. 2005), *available at* http://healthlaw.org/images/stories/epsdt/10-200503-medicaidandorthodontia.pdf.

adults.[52] States can require prior authorization for treatment services (not screens), but they cannot place quantitative limits (e.g. 5 visits) or monetary (e.g. $1000) caps on EPSDT treatment needed to correct or ameliorate an individual child's condition.[53] Medicaid plays a large role in financing mental health services, with the program supporting nearly a third of community-based mental health services and often serving as the only source of funding for rehabilitative services.[54] Through the EPSDT benefit, a number of mandatory Medicaid services can be used to address adolescents' mental health and substance abuse needs, including inpatient and outpatient hospital services, physician services, home health care, rehabilitative services, and case management. Rehabilitative services, for example, are mandatory when necessary to "correct or ameliorate" mental illnesses and conditions and are defined as services, including any medical or remedial services, recommended for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level.[55] Thus, a range of services can be offered to adolescents through EPSDT, including:

- basic living skills to restore independent function in the community, including food preparation, maintenance of living environment, and mobility skills;
- social skills to develop skills needed to enable and maintain community living, including communication and socialization skills and techniques;
- counseling and therapy to eliminate psychological barriers that impede development of community living skills;[56] and
- rehabilitative equipment, including daily living aids.[57]

Family planning services and supplies are also mandatory Medicaid services for adolescents.[58] To the extent that other mandatory Medicaid services, like physician services, hospital services, clinic services, laboratory, and X-ray services, can meet the reproductive needs of adolescents, even if not explicitly designated as "reproductive" health services, they can ensure necessary coverage for adolescent reproductive health needs.

Cost-sharing may not be applied to family planning services, and beneficiaries have the right to select the provider of their choice for family planning services, whether or not

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[52] *Id.* §§ 1396a(a)(43)(C), 1396d(r)(5); 42 C.F.R. §§ 441.50-441.62; CMS STATE MEDICAID MANUAL § 5124; CMS, *Dear State Medicaid Director* (Sept. 9, 2010) (noting services may include pain and symptom management and family counseling).
[53] 42 C.F.R. § 440.230(d).
[54] Carl Taube et al., *Medical Coverage of Mental Illness*, 9 Health Affairs 5 (1990); American Managed Behavioral Health Association, *Behavioral Health Care Tomorrow* 63 (1995).
[55] 42 U.S.C. §§ 1396d(r)(5), 1396d(a)(13).
[56] *See* HCFA, Medicaid Regional Memorandum No. 92-80 (Region IX) (Aug. 10, 1992).
[57] *See* Letter from A.W. Schnellbacher, Jr., Chief, Program Operations Branch, Division of Medicaid (Region VIII) to Richard Allen, Medicaid Director, Colorado Department of Health Care Policy and Financing (March 7, 1996) (stating that daily living aids such as specialized utensils "can be vital in allowing a beneficiary to achieve/reach/maintain his or her best visible functional level").
[58] 42 U.S.C. § 1396d(a)(4)(C); 42 C.F.R. §§ 440.40(c), 441.20; CMS STATE MEDICAID MANUAL §§ 2088.5, 4270.

they are enrolled in a managed care plan.[59] To encourage the provision of family planning services and supplies, the federal government reimburses these services at a 90 percent matching rate rather than the typical service rate.

Medicaid offers only limited coverage of abortion coverage. Abortion coverage is limited to cases of life endangerment, rape, or incest, unless a state has chosen to cover abortion with state funds more broadly than federal law allows.[60]

Federal law allows states to require copayments for certain services, but they may not be imposed on services provided to individuals under age 18 (or at state option under age 19, 20, or 21).[61] Certain services, such as emergency services, pregnancy-related care and family planning services and supplies also may not include copayments, except that copayments can be imposed on services to pregnant women with incomes above 150 percent of the FPL.[62]

Federal law also requires that all adolescents eligible for Medicaid be informed of the availability of EPSDT services.[63] The state Medicaid agency must aggressively seek out eligible adolescents and inform them, using a combination of oral and written methods.[64]

State Medicaid agencies must also offer EPSDT eligible individuals "necessary assistance" with transportation and scheduling appointments for services and to provide such assistance if requested.[65] Federal regulations require that each stage of the service delivery system assure that adolescents and their families are informed about their right to transportation and scheduling assistance; that such assistance is offered; and that it is provided upon request.[66] This assistance must be made available with respect to diagnostic and treatment services, as well as periodic health assessments.[67]

To ensure that eligible beneficiaries, including adolescents, can access required services, federal law requires a range of "due process" protections that apply when eligibility or services are denied, reduced, or terminated. These include adequate written notice and an opportunity for a fair hearing for any individual whose claim for medical

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[59] 42 U.S.C. §§ 1396a(a)(23), 1396o; 42 C.F.R. §§ 431.51(a)(3), 447.53(b); Rachel Benson Gold, *State Efforts to Expand Medicaid-funded Family Planning Show Promise*, 2 Guttmacher Report on Public Policy 2 (1999); CMS STATE MEDICAID MANUAL § 2088.5.
[60] This restriction, commonly known as the Hyde Amendment, has been attached to appropriations bills on an annual basis since 1976. The most recent reauthorization of the Hyde Amendment can be found in the Consolidated Appropriations Act, 2010, Pub. L. No. 111-117, §§ 507, 508, 123 Stat. 3034, 3150 (2010).
[61] 42 U.S.C. § 1396o(b)(2)(A); 42 C.F.R. § 447.53.
[62] 42 U.S.C. §§ 1396o(b)(2)(A), 1396o(c).
[63] *Id.* § 1396a(a)(43).
[64] 42 C.F.R. § 441.56(a)(1); CMS STATE MEDICAID MANUAL § 5010.
[65] 42 U.S.C. § 1396a(a)(43); 42 C.F.R. § 441.62.
[66] 42 C.F.R. § 441.62; CMS STATE MEDICAID MANUAL § 5121(C).
[67] CMS, STATE MEDICAID MANUAL § 5150.

assistance is denied or is not acted upon with reasonable promptness.[68] Rights to due process apply equally to individuals enrolled in a Medicaid managed care plan.[69]

Confidentiality and Medicaid*:* Federal and state laws explicitly guarantee confidential access to services, including Medicaid and Title X of the Public Health Service Act services. Title X is a federal program dedicated to providing family planning services to low-income women and teenagers. The Medicaid statute also requires confidentiality in the provision of family planning services to sexually active minors who seek them. Many state laws also allow minors to consent to a range of reproductive health services beyond family planning (including prenatal care and delivery), as well as to treatment for substance abuse disorders and mental health care; in addition, all states allow minors to consent to testing and treatment services for STDs.[70] By contrast, minors' access to abortion services is often quite restricted, with 34 states requiring parental notification or consent prior to obtaining an abortion.[71] Each of these states has in place a procedure for minors to obtain approval from a court or to allow another adult relative to be notified or consent to the procedure, and most laws allow doctors to forego parental involvement in cases of medical emergency or abuse, assault, incest or neglect.[72] The Medicaid Act's confidentiality protections should apply in both Medicaid managed care as well as fee-for-service plans.[73]

Medicaid Managed Care*:* A full review of the legal framework governing managed care, including Medicaid managed care, is beyond the scope of this paper, particularly as the laws, for the most part, do not focus on adolescent health care. Rather, they regulate the managed care organizations, financing, and quality in ways that affect consumers generally. This discussion will instead highlight some of the direct implications for adolescents of a few key managed care features.[74]

States have broad authority to allow voluntary enrollment in managed care and may also establish state plans that require many covered population groups to enrolle in a managed care plan. However, states must obtain specific federal approval to require mandatory enrollment of children under age 19 with special needs, individuals who are dually eligible for Medicare and Medicaid or Qualified Medicare Beneficiaries, and certain Native Americans.[75]

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[68] 42 U.S.C. § 1396a(a)(3); 42 C.F.R. §§ 431.206(b) 431.210, 435.912, 435.919. *See* CMS STATE MEDICAID MANUAL §§ 2040, 2900. The right to a fair hearing is also required by the due process clause of the United States Constitution. *Goldberg v. Kelly*, 397 U.S. 254 (1970).
[69] 42 U.S.C. §§ 1396u-2(a)(1)(A)(i), (b)(4); 42 C.F.R. §§ 438.400-438.424.
[70] Cynthia Dailard & Chinue Turner Richardson, *Teenagers' Access to Confidential Reproductive Health Services*, 8 Guttmacher Report on Public Policy 4 (2005).
[71] *Id.*
[72] *Id.*
[73] 42 U.S.C. § 1396a(a)(7); 42 C.F.R. §§ 431.300-431.306; 431.940-432.965.
[74] It is important for advocates to have a general understanding of the general legal requirements for managed care organizations. NHeLP has numerous publications available on this topic, *available at* www.healthlaw.org.
[75] 42 U.S.C. §§ 1396u-2(a)(2)(A)-(C) (requiring states to obtain permission from federal government for the following: children under age 19 who are eligible for SSI, described in

Some of the standards related to adolescent health care that managed care entities must follow include:

- they must provide all enrollment notices and informational materials in a manner and form which can be easily understood by enrollees and potential enrollees;[76]
- beneficiaries have the freedom to obtain services from any qualified, Medicaid-participating provider;[77]
- beneficiaries must have the right to disenroll at any time for cause, but without cause can be required to remain in the plan for a state-imposed period of up to one year;
- there can be no discrimination on the basis of health status or needs;
- emergency services must be covered;
- states must assure that each managed care organization establishes an internal grievance procedure that allows challenges of denials of coverage or payment;
- managed care health plans must cover inpatient hospital stays of 48 hours for normal deliveries and 96 hours for cesareans;
- subject to a moral or religious exception, managed care plans cannot prohibit or restrict in-plan health care professionals from advising patients about their health status or need for medical treatment, regardless of whether benefits for that treatment are covered under the contract; and
- managed care plans must not impose more restrictive lifetime or dollar limits on mental health benefits than on medical and surgical benefits.[78]

The Medicaid program is a critical safety net for poor and vulnerable adolescents. Opportunities to expand eligibility to additional adolescents, combined with the promising reforms created by the Affordable Care Act (ACA), discussed below, mean that Medicaid is poised now more than ever to best meet adolescents' health needs.

Children's Health Insurance Program (CHIP)

The Children's Health Insurance Program (CHIP) provides health coverage to approximately eight million low-income children in families with incomes too high to qualify for Medicaid, but who cannot afford private coverage. As with Medicaid, CHIP is administered by the states but is jointly financed by the federal government and states. The federal matching rate for CHIP programs is generally 15 percentage points higher than the Medicaid matching rate for that state. Unlike Medicaid, however, CHIP is a capped program, with each state receiving an annual CHIP allotment.

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community-based coordinated care programs under Title V, living at home under the Katie Becket option, receiving foster care or adoption assistance under title IV-E, or living in foster care or other out-of-home placements).

[76] 42 U.S.C. § 1396u-2(a)(5)(A); 42 C.F.R. §§ 438.10(b)-(d); HCFA, *Dear State Medicaid Director* (Feb. 20, 1998) (provision of information and effective date).

[77] 42 U.S.C. § 1396a(a)(23). This is referred to as the "freedom of choice" rule.

[78] 42 U.S.C. §§ 1396d(t)(3), 1396b(m)(2)(A)(iii), (vi), (vii), 1396v(a)(4); *see* 42 C.F.R. §§ 434.25(b), 434.27(a)(2), 434.30, 438.6(d), (f), (k), (l), & (m) (regarding enrollment discrimination, hours of operation, network adequacy, right to disenroll, and choice of provider).

CHIP Eligibility: CHIP programs can operate as a program separate from Medicaid, as an expansion of the Medicaid program, or as a combination of both program types. The program serves uninsured children up to age 19. Forty-six states and the District of Columbia cover children up to or above 200 percent of the FPL, and 24 of these states cover children in families with incomes at 250 percent of FPL or higher. States that expand coverage above 300 percent of the FPL get the Medicaid matching rate rather than the CHIP enhanced match. The ACA maintains CHIP eligibility standards in place as of March 23, 2010 through 2019.

On February 5, 2009, President Obama signed into law the Children's Health Insurance Program Reauthorization Act (CHIPRA). The purpose of this legislation was to "provide dependable and stable funding for children's health insurance" under CHIP and Medicaid.[79] CHIPRA eliminated the federal requirement that eligible children and pregnant women who are legal immigrants must wait five years before enrolling in Medicaid or CHIP.[80] As a result, many states have elected to include coverage for children and pregnant women lawfully residing in the U.S. in their CHIP and Medicaid programs, as well as for certain other pregnant women.[81]

CHIP Services*:* Medicaid Expansion CHIP must provide the standard Medicaid benefit package, including all EPSDT services. States with separate CHIP can choose to provide benchmark, benchmark-equivalent, or Secretary-approved coverage. These Medicaid benchmark plans have existed since the Deficit Reduction Act of 2005 and allow states the option of developing alternative Medicaid benefits packages for certain Medicaid-eligible individuals. [82] Separate CHIP must also ensure coverage for dental services "necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions."[83]

Since its implementation in 1998, CHIP has reduced the number of uninsured adolescents in the U.S., particularly for adolescents of color.[84] Adolescents of color are more likely to be eligible for, but not enrolled, in these programs. CHIPRA creates an opportunity to increase enrollment of eligible adolescents as well as address the underlying barriers they face when trying to enroll for coverage, for example language

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[79] *See* CHIPRA, Pub. L. No. 111-3, § 2.
[80] *Id.* § 214.
[81] *See* CMS, *Dear State Health Official* (July 1, 2010) (describing implementation of Medicaid and CHIP coverage of "Lawfully Residing" Children and Pregnant Women); CMS, *Dear State Health Official* (May 11, 2009) (describing state option to provide necessary prenatal, delivery, and postpartum care to low-income uninsured pregnant women through an amendment to the state's CHIP plan).
[82] For more information on Medicaid benchmarks and the ACA, *see* NHeLP, *Health Advocate* (June 2012), *available at* http://healthlaw.org/images/stories/2012_06_Vol_2_Health_Advocate.pdf.
[83] CHIPRA § 501 (amending 42 U.S.C. § 1397cc).
[84] Families USA, *SCHIP and Children's Health Coverage: Leveling the Playing Field for Children of Color* (Dec. 2006, updated June 2007), *available at* http://www.familiesusa.org/assets/pdfs/schip-leveling-the-playing.pdf.

and cultural barriers when applying and misinformation regarding eligibility rules. Notably, CHIPRA provides outreach and education grants to increase enrollment in Medicaid and CHIP, targeting minority communities.[85] These grants promote and support activities using technology to facilitate enrollment and renewal, keeping adolescents covered for as long as they qualify, engaging schools in outreach, enrollment and renewal activities, and reaching out to eligible teens that are more likely to experience gaps in coverage. CHIPRA also creates new quality measures designed to track child and adolescent health outcomes.[86]

The Affordable Care Act

The ACA contains several provisions that will affect access to and quality of care for adolescents and young adults. Previously, health plans were permitted to exclude individuals, including children and adolescents, from coverage due to their existing illnesses (pre-existing conditions). Under ACA § 2704, health plans or issuers offering group or individual health insurance coverage may not exclude individuals because of pre-existing conditions or discriminate against them due to a history of illness. Health plans or issuers are also prohibited from establishing lifetime or annual limits for any plan participant on the monetary value of benefits (limited to EHB).[87] This is especially important for adolescents with disabilities and chronic health conditions.

The ACA also requires most health plans offering group or individual health coverage to provide, at minimum, certain preventive health services with no cost-sharing. These services include the evidenced-based items and services recognized by the U.S. Preventive Services Task Force (USPSTF), immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and evidence-informed preventive care and screenings for infants, children, and adolescents.[88] Recommendations by the USPSTF that are particularly relevant for adolescents include screening and high-intensity behavioral counseling to prevent STI and HIV transmission for all sexually active adolescents, screening adolescents for major depressive disorder and follow-up, and screening children 6 years and older for obesity, including offering or referring them to comprehensive, intensive behavioral interventions to promote improve weight status.[89]

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[85] Glenn Flores et al., *A Randomized, Controlled Trial of the Effectiveness of Community-Based Case Management in Insuring Uninsured Latino Children*, 116 Pediatrics 1433 (Dec. 2005).
[86] CHIPRA §§ 201(b), 401 (amending 42 U.S.C. §§ 1397ee, 1320b-9a respectively).
[87] *Id.* § 1001.
[88] *Id.* For more information on the USPSTF recommendations, see http://www.ahrq.gov/clinic/uspstfix.htm#Recommendations. For more on the women's health provisions related to preventive care requirements, see NHeLP, *Q&A on Preventive Services for Women Coverage Requirements* (Aug. 2012), *available at* http://www.healthlaw.org/images/stories/Implementation_of_Preventive_Services_for_Women_Q&A.pdf.
[89] *See* U.S. Preventive Services Task Force, *USPSTF A and B Recommendations* (Aug. 2010), *available at* http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm.

Health plans offering group or individual health coverage that also provide dependent coverage must extend that coverage until the dependent turns 26 years old. The plan does not, however, have to extend coverage to any child of a covered dependent.[90]

For those with low to moderate family incomes who are uninsured but ineligible for Medicaid because their household income is above 133 percent FPL, the ACA provides for tax subsidies to help these individuals obtain private health insurance coverage through State Exchanges. Individuals between 100-400 percent FPL are eligible for these tax subsidies. This coverage must minimally include "essential health benefits" (EHB), which in turn must include categories of coverage such as preventive and wellness services and chronic disease management, mental health and substance use disorder services, maternity and newborn care, pediatric oral and vision services, and rehabilitative and habilitative services.[91]

The most expansive reform to the Medicaid program created by the ACA is the coverage expansion to all individuals, including adolescents, in households with incomes below 138 percent FPL.[92] These newly eligible individuals will receive, at minimum, Medicaid benchmark coverage and EHB services mentioned above. This coverage expansion is effective January 1, 2014, although the Supreme Court's recent decision, discussed above, means that some states may decide against expanding their Medicaid programs.

Beginning January 1, 2014, states must provide Medicaid coverage until age 26 to individuals who were in foster care and under the responsibility of the state for more than six months.[93] To be eligible, these individuals must have been enrolled in the state Medicaid plan while in foster care.[94]

Additional Medicaid reforms that will benefit low-income adolescents include:

- requiring Medicaid coverage for services provided in freestanding birth centers;[95]
- clarifying that terminally ill children electing to receive hospice care do not waive the right to any treatment for the child's terminal condition;[96]
- increasing federal funding for states to raise Medicaid payment rates to primary care physicians, including pediatricians, for two years beginning in 2013;[97]
- requiring Medicaid coverage of products, drugs, and therapies to help pregnant women, including pregnant adolescents, to stop smoking (including coverage of diagnostic services, therapy and counseling, and prescription and non-

[90] *See* ACA § 1001.
[91] *See* ACA § 1301.
[92] *Id.* § 2001.
[93] *Id.* § 2004.
[94] *Id.*
[95] *Id.* § 2301.
[96] *Id.* § 2302.
[97] *Id.* § 2303.

prescription drugs covered by the Food and Drug Administration for smoking cessation;[98]

- appropriating $100 million for grants to states that create innovative Medicaid programs that will incentivize Medicaid beneficiaries, including adolescents, to improve their health and avoid certain chronic conditions (including tobacco product use, being overweight, lowering cholesterol or blood pressure, and avoiding the onset or better managing diabetes);[99]
- and removing barriers to states providing Medicaid-funded, home and community-based, long-term care services.[100]

The ACA also increased federal funding for a number of public programs that will benefit adolescents in particular. For example, the ACA adds a new provision to the Maternal and Child Health Services Block Grant requiring the allocation of funding to states for programs that work to reduce teen pregnancy and birth rates by educating adolescents aged 10-19 on contraception, abstinence, prevention of pregnancy and sexually transmitted infections and HIV, and preparation for adulthood.[101] States must apply for this funding, and the minimum state allocation (based on the state's proportion of residents aged 10-19 relative to the population of the state) is $250,000 per year. These programs must be evidence-based, age appropriate, culturally competent and include skill development such as healthy relationships, financial literacy, career skills, and healthy living skills.[102] For states that do not apply for this funding in 2010 and 2011, the Secretary of the Department of Health and Human Services must solicit proposals from non-profit organizations that may include faith-based organizations in the state. Congress allocated $75 million per year for this program through 2014, with $10 million reserved for innovative pregnancy prevention programs that target at-risk youth and five percent reserved for Indian tribes.

The ACA also restores funding for abstinence-only education.[103] Notably, significant research and evidence have shown that abstinence-only-until-marriage education is not effective in delaying adolescent sexual activity and postponing teen pregnancy, and may cause higher rates of STIs among adolescents.[104] Congress allocated $50 million per year through 2014 for this abstinence-only-until-marriage education program.

Other ACA public health initiatives benefiting adolescents include:

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[98] *Id.* § 4107.
[99] *Id.* § 4108.
[100] *Id.* § 2402.
[101] *Id.* § 2953.
[102] *Id.*
[103] *Id.* § 2954.
[104] John Santelli, et al., *Abstinence and abstinence-only education: A review of U.S. policies and programs*, 38 J. Adolescent Health 72 (2006); Hazel Beh & Milton Diamond, *The Failure of Abstinence-Only Education: Minors Have the Right to Honest Talk about Sex*, 15 Colum. J. Gender & L. 12 (2006).

- authorization for the Secretary to award grants supporting the operation of school-based health centers, with preference allowed to schools serving a large population of children eligible for Medicaid or CHIP;[105]
- establishment of a five-year national, public education campaign that focuses on oral health prevention and education, including prevention of oral disease such as early childhood and other caries, periodontal disease and oral cancer, with special focus on populations such as children, pregnant women, parents, the elderly, individuals with disabilities, and Native Americans and Native Alaskans;[106]
- requirement for HHS to issue competitive community transformation grants to implement and evaluate community preventive programs that promote healthy living and reduce health disparities, with activities that may include creating healthier school environments; developing programs that advance nutritional, social, and emotional wellness; and assisting special populations including persons with disabilities;[107] and
- requiring large employers to provide accommodations for nursing mothers in workplace settings by providing a reasonable break time for employees to express breast milk in a private area (other than a bathroom) free from intrusion.[108]

Conclusion

Health insurance aimed at improving the health and well-being of adolescents should prioritize coverage that is comprehensive in meeting the physical and mental health needs of children and adolescents, as well as effectively managing health problems such as chronic conditions and/or disabilities, with emphasis on eliminating or reducing existing health disparities. The current EPSDT provisions embody this principle, and advocates should encourage reliance on these provisions as states offer coverage under the ACA and CHIP.

[105] *Id.* § 4101.
[106] *Id.* § 4102.
[107] *Id.* § 4201.
[108] *Id.* § 4207.