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POSITION PAPER

Access to Health Care for Adolescents and Young Adults

Position Paper of the Society for Adolescent Medicine

The Society for Adolescent Medicine (SAM) is a multidisciplinary organization of professionals committed to improving the physical and psychosocial health and well-being of all adolescents. SAM believes that universal access to health care for all is a timely and essential goal and that proposals to improve access must address the unique needs and characteristics of adolescents [1].

Drawing from recommendations contained in other policy statements and position papers previously endorsed by the Society for Adolescent Medicine [1–6] and other recently published literature [7–25], this position paper outlines a range of policies and programs that should be implemented to ensure that all adolescents have access to high quality, comprehensive health care.

Health Insurance Coverage

All adolescents and young adults through age 24 should have access to affordable health insurance coverage. Insurance coverage should be continuous and not subject to exclusions based on pre-existing conditions. Eligibility for health insurance through public programs, particularly Medicaid and the State Children's Health Insurance Program (SCHIP), should be expanded to make coverage available to all uninsured adolescents and young adults who do not have access to affordable private insurance. Intensive outreach efforts should be undertaken to ensure that adolescents and young adults who are eligible for Medicaid and SCHIP actually enroll and benefit from these programs. Federal and state efforts to reduce eligibility levels, restrict benefits, or decrease funding for Medicaid and SCHIP should be opposed and, at a minimum, should not be allowed to affect adolescents disproportionately in comparison with other age groups.

Comprehensive, Coordinated Benefits

Public and private health insurance coverage and public health programs should provide timely access to comprehensive, coordinated benefits that meet the physical, psychological, and developmental needs of adolescents, including preventive, primary, and specialty care services. Public and private health insurance coverage should provide for "equity" or "parity" in coverage of services that are often limited for adolescent enrollees, such as reproductive and sexual health services (including contraceptives), dental services, mental health, and substance abuse services. The principles of equity and parity should apply both to differences in coverage between adolescents and other age groups and among specific services.

Safety Net Providers and Programs

Adolescents and young adults receive care from a variety of health professionals and sites, including private offices, academic medical centers, school-based health centers, community health centers, family planning and STD clinics, mental health and substance abuse treatment centers, and other public health clinics that rely on public funding. These safety net providers represent a critical element of health care access and the health care delivery infrastructure for adolescents and young adults, particularly those from low-income families and those with special health care needs. Adequate funding should

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be provided to ensure the sustainability and financial viability of these safety net providers and sites.

Quality of Care

Health insurance plans and public health programs should implement quality assurance plans and goals that specifically address the needs of adolescents and young adults. Performance measures should include items of particular relevance and importance to adolescents and young adults, including prevention and health promotion. Quality and performance data should be collected, analyzed, and reported by age group, and data collection methods should incorporate input from a variety of sources, including adolescents and young adults themselves.

Affordability

Health services should be affordable for adolescents and young adults and their families, and cost-sharing requirements such as premiums, co-insurance, deductibles, and co-payments should not hinder their utilization of health services. Co-payments, if required at all, should not be imposed for preventive services, family planning services, screening and treatment for sexually transmitted infections, substance abuse and mental health services, and other services that adolescents may seek on a confidential basis.

Consent and Confidentiality

Adolescents should be able to receive confidential services based on their own consent whenever limitations on confidentiality would serve as an obstacle impeding their access to care. Federal and state laws should support confidential access to health care for adolescents in these circumstances. Existing laws that provide for adolescents who are minors to give their own consent for health care and to receive services on a confidential basis should be maintained and fully implemented. Where additional protections are needed, they should be put in place. Health plans and providers should understand the relevant laws in their own jurisdictions, should implement administrative policies and procedures to maintain adolescents' confidentiality, and should inform adolescent patients and their parents about the scope and limitations of these protections. The existence of confidentiality protections for adolescents does not preclude, and sometimes helps to support, voluntary communication with parents, often with the assistance of a health care professional. Efforts to repeal minor consent laws or to place limits on the confidentiality of services for adolescents who are minors could undermine their access to essential services and should be opposed.

Compensation

Health plans and providers will be able to deliver the full range of comprehensive, age-appropriate services needed by adolescents only if capitation rates, fee schedules, and other reimbursements paid to providers are established at a level that enables them to do so. Health care financing mechanisms, including risk adjustment and other mechanisms, should be sufficient to support the range and intensity of services needed by adolescents, including those with chronic illness or disabilities and those with other intense or specialized health care needs. Reimbursement rates for specific services should account for the time required to address the specific developmental needs of adolescents.

Availability of Trained and Experienced Health Care Providers

Health care providers who are appropriately trained and experienced in adolescent and young adult health should be available in all communities. Health plans should include health care providers with training, expertise, and experience in serving this population in their provider networks, both as primary care providers and specialists for referral. Adolescents and young adults should be offered maximum choice among providers and sites within health plans.

Visibility and Flexibility of Adolescent-oriented Sites and Services

A number of features characterize adolescent-oriented sites, including locations and hours that are accessible to adolescents; age-appropriate settings; and multi-disciplinary clinical and administrative staff who are approachable and are able to address the cultural, linguistic, and developmental needs of adolescents from a variety of backgrounds. Information about adolescent-oriented providers and sites and the services they offer should be made available to adolescents and their families.

Coordination

Local, state, and national health goals and objectives should include issues of particular importance and relevance to adolescents and young adults. Public health programs, including publicly funded health insurance, should be coordinated at local, state, and national levels to ensure that health services are financed and delivered in a way that addresses the needs of underserved adolescents, particularly those who experience disparities in access and health outcomes.

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References

1. Klein JD, Slap GB, Elster AB, Schonberg SK. Access to health care for adolescents: A position paper of the Society for Adolescent Medicine. J Adolesc Health 1992;13:162–70.
2. Rosen DS, Elster A, Hedberg V, Paperny D. Clinical preventive services for adolescents: Position paper of the Society for Adolescent Medicine. J Adolesc Health 1997;21:203–14.
3. Emans SJ, Brown RT, Davis A, et al. Society for Adolescent Medicine position paper on reproductive health care for adolescents. J Adolesc Health 1991;12:649–61.
4. Pastore DR, Murray PJ, Juszczak L. School-based health center: Position paper of the Society for Adolescent Medicine. J Adolesc Health 2001;29:448–50.
5. Society for Adolescent Medicine. Confidential health care for adolescents: Position paper of the Society for Adolescent Medicine. J Adolesc Health 2004;35:160–7.
6. English A, Kapphahn C, Perkins J, Wibbelsman CJ. Meeting the needs of adolescents in managed care: A position paper of the Society for Adolescent Medicine. J Adolesc Health 1998;22:271–7.
7. Brindis CD, Morreale MC, English A. The unique health care needs of adolescents. Future Child 2003;13:117–35.
8. Morreale MC, English A. Eligibility and enrollment of adolescents in Medicaid and SCHIP: Recent progress, current challenges. J Adolesc Health 2003;32(6 Suppl):25–39.
9. Fox HB, McManus MA, Reichman MB. Private health insurance for adolescents: Is it adequate? J Adolesc Health 2003;32(6 Suppl):12–24.
10. Fox HB, McManus MA, Limb SJ. Early assessments of SCHIP's effect on access to care for adolescents. J Adolesc Health 2003;32(6 Suppl):40–52.
11. Klein JD, Sesselberg TS, Gawronski B, et al. Improving adolescent preventive services through state, managed care, and community partnerships. J Adolesc Health 2003;32(6 Suppl):91–7.
12. Brindis CD, Llewelyn L, Marie K, et al. Meeting the reproductive health care needs of adolescents: California's Family Planning Access, Care, and Treatment Program. J Adolesc Health 2003;32(6 Suppl):79–90.
13. Weist MD, Goldstein J, Evans SW, et al. Funding a full continuum of mental health promotion and intervention programs in the schools. J Adolesc Health 2003;32(6 Suppl):70–8.
14. Brindis CD, Klein J, Schlitt J, et al. School-based health centers: Accessibility and accountability. J Adolesc Health 2003;32(6 Suppl):98–107.
15. Juszczak L, Melinkovich P, Kaplan D. Use of health and mental health services by adolescents across multiple delivery sites. J Adolesc Health 2003;32(6 Suppl):108–18.
16. Newacheck PW, Wong ST, Galbraith AA, Hung Y. Adolescent health care expenditures: A descriptive profile. J Adolesc Health 2003;32(6 Suppl):3–11.
17. Youngblade LM, Col J, Schenkman EA. Health care use and charges for adolescents enrolled in a Title XXI program. J Adolesc Health 2002;30:262–72.
18. Yu SM, Bellamy HA, Schwalberg RH, Drum MA. Factors associated with the use of preventive dental and health services among US adolescents. J Adolesc Health 2001;29:395–405.
19. Park MJ, Macdonald TM, Ozer EM, et al. Investing in Clinical Preventive Health Services for Adolescents. San Francisco, CA: University of California, San Francisco, Policy Information and Analysis Center for Middle Childhood and Adolescence and National Adolescent Health Information Center, 2001.
20. American Academy of Pediatrics. Insurance coverage of mental health and substance abuse services for children and adolescents: A consensus statement. Policy Statement RE0090. Pediatrics 2000;106:860–2.
21. American Academy of Pediatrics. Section report: Improving the implementation of State Children's Health Insurance Programs for adolescents, report of an invitational conference sponsored by the American Academy of Pediatrics, Section on Adolescent Health, September 26–27, 1999. Pediatrics 2000;105:906–12.
22. Klein JD, Wilson KM, McNulty M, et al. Access to medical care for adolescents: Results from the 1997 Commonwealth Fund Survey of the Health of Adolescent Girls. J Adolesc Health 1999;25:120–30.
23. Ford C, Bearman P, Moody J. Foregone health care among adolescents. JAMA 1999;282:2227–34.
24. Ziv A, Boulet JR, Slap GB. Utilization of physician offices by adolescents in the United States. Pediatrics 1999;104:35–42.
25. Newacheck PW, Brindis CD, Cart CU, et al. Adolescent health insurance coverage: Recent changes and access to care. Pediatrics 1999;104:195–202.