A LEGAL AND POLICY FRAMEWORK FOR ADOLESCENT HEALTH CARE:
PAST, PRESENT, AND FUTURE

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INTRODUCTION

Adolescents have numerous health concerns that need to be addressed, at least in part, through the health care system. Whether adolescents receive the health care they need depends on a variety of factors. At a minimum, for adolescents' needs to be met: (1) providers with the training, experience, and interest in caring for this age group must be accessible; (2) an opportunity must exist for adole-

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cents' individual needs to be accurately assessed and identified; (3) the confidentiality of information related to adolescents' care must be protected; and (4) a source of financing for the comprehensive range of necessary services must be available. Whether these factors are present depends, to a significant degree, on the laws and policies related to health care in general and health care of adolescents in particular.

In the middle of the twentieth century, none of these criteria had been met. Over the past five decades, however, important changes in laws and policies, together with other developments in the health care arena, have increased the likelihood that the particular health care needs of adolescents can be appropriately addressed. Nevertheless, many of these changes have not been fully implemented and the very existence of some is precarious or directly threatened. Thus there is reason to review the current legal and policy framework, how it came into existence, and the challenges that exist for maintenance and improvement.

The twentieth century witnessed the recognition of adolescence as a distinct phase in human development and the health care of adolescents as a specific field in the health care professions. These changes were paralleled by a similar evolution in the legal and policy arena, from an era in which the health needs of adolescents received virtually no attention from policymakers to one in which those needs have been the subject of hundreds of policy recommendations by diverse groups and of numerous legal developments in courts, legislatures, and governmental agencies. What we do not yet know is how the health of adolescents and their health care will fare in the legal and policy arena in the twenty-first century.

This article explores the legal and policy framework for adolescent health care past, present, and future. Part I briefly summarizes the current health care status and needs of adolescents. Part II looks back at the early years, which encompassed the recognition of adolescence, the creation of adolescent medicine, the expansion of health insurance, and the establishment of Medicaid and other publicly-funded health programs as means of financing health care. Part III examines the expansion of adolescent medicine and the creation of new models of service delivery for adolescents, the recognition of adolescents' constitutional rights, and the sharpening focus of Medicaid and other funding programs on the needs of adolescents as well as younger children. Part IV looks at developments in the last decade of the twentieth century, which saw increased clinical emphasis on prevention of adolescent health problems, greater at-

**I. The Health Status and Health Care Needs of Adolescents**

Adolescents experience many health concerns and problems, in spite of a widespread perception that they are healthy.1 The health issues of adolescence have been extensively documented.2 The major health problems faced by adolescents, including injury,3 homicide,4 suicide,5 mental and emotional illness,6 other chronic ill-

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1 See, e.g., Susan G. Millstein, *A View of Health from the Adolescent’s Perspective, in Promoting the Health of Adolescents: New Directions for the Twenty-First Century* (79, 79 (Susan G. Millstein et al., ed., 1993) (explaining that while adolescents generally report themselves as being healthy, they also view their health as poorer than their physicians or parents perceive it to be).


3 ADOLESCENT HEALTH CHARTBOOK, supra note 2, at 58 (documenting that motor vehicle traffic-related injuries and firearm-related injuries are the two leading causes of death among adolescents ten to nineteen years of age).


5 ADOLESCENT HEALTH CHARTBOOK, supra note 2, at 38 (documenting that in 1997 suicide was the third leading cause of injury death for adolescents ages thirteen to nineteen and that in 1999 one-fifth of all high school students reported having seriously considered or attempted suicide during the previous twelve months).

6 Ozer et al., supra note 2, at 14 (documenting that mental disorders represent nearly one-third of all adolescent disabilities, making them the single largest cause of disability among adolescents).
ness and disability, poor nutrition, eating disorders, dental problems, pregnancy, sexually transmitted disease (STD), Human Immunodeficiency Virus (HIV), and substance abuse, have been described as "preventable health conditions with predominantly behavioral, environmental, and social etiologies." Regardless of their causes, these health problems among adolescents mean that this age group has a pressing need for a wide variety of health care and related services. Essential services include: preventive services; sexual and reproductive health care; mental health and substance abuse services; dental services; treatment for acute conditions; and chronic illness and disability services.

The health problems and concerns of adolescents are more prevalent and more severe among those adolescents who are char-

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7 Adolescent Health Chartbook, supra note 2, at 36 (documenting that in 1997 approximately eight percent of all adolescents ten to seventeen years of age were reported to have some activity limitation due to one or more chronic physical, mental, or emotional health condition).


10 Adolescent Health Chartbook, supra note 2, at 36 (documenting that during 1988-1994 one-fifth of adolescents ages ten to nineteen years of age had at least one untreated cavity diagnosis or active tooth infection).

11 Id. at 62 (documenting that annually more than 900,000 adolescents become pregnant).

12 The Hidden Epidemic: Confronting Sexually Transmitted Diseases, INSTITUTE OF MEDICINE 36 (Thomas R. Bieg & William T. Butler eds., 1997), citing Centers for Disease Control and Prevention, Division of STD/HIV, Annual Report 1992 (1993) (documenting that of the twelve million new cases of STDs occurring each year, approximately three million of them are among teenagers).


14 Adolescent Health Chartbook, supra note 2, at 78, 80 (documenting that in 1999 one-half of high school students reported drinking alcohol in the previous thirty days, approximately twenty-eight percent of females and thirty-five percent of males reported binge drinking, and one-half had used marijuana during their lifetime).


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acterized as "special populations." While the term does not have a precise definition, it is often used to refer to a wide range of groups, such as adolescents with a chronic illness or disability; pregnant and parenting teens; immigrant and migrant youth; gay, lesbian, and bisexual adolescents; homeless, runaway, and street youth; and adolescents living in state custody or out-of-home care. Adolescents who are members of these vulnerable groups are likely to need more intensive health services than other adolescents and to have greater difficulty accessing traditional sources of care. Health insurance coverage affects an individual's access to health care and utilization of health services, which has serious implications for adolescents, who lack health insurance coverage with greater frequency than most other age groups in the United States. Lack of insurance is more prevalent among certain groups of adolescents, often those with the greatest need for health care. Over the past decade, the rate at which adolescents are insured—or not insured—has remained relatively steady but the patterns in their source of insurance coverage have shifted. In 1995, slightly more than fourteen percent of adolescents—one in seven—lacked any health insurance coverage. Certain groups of adolescents are more likely to lack insurance, such as older adolescents, members of racial and ethnic minority groups, and those with lower family incomes. Notably, the proportion of adolescents without insurance did not change significantly over the decade from the mid-1980s to the mid-1990s. What did change was the source of adolescents' health insurance, with private and employer-based coverage dropping and public insurance coverage, particularly Medicaid, increasing.

By 2000, while both the number and percentage of adolescents without health insurance remained high, a much higher proportion

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17 See ENGLISH ET AL., MEDICAID AND CHIP, supra note 16, at 21-22 ( tbl. 3) (providing detailed documentation of the demographics and health care needs of these special populations of adolescents).

18 Id.


20 Nervacheck et al., supra note 19, at 197 ( tbl. 1).


22 Nervacheck et al., supra note 19, at 209.
of that group were eligible for but not enrolled in a public health insurance program.20 Although beyond much of the discussion in this article, young adults ages eighteen through twenty-four are uninsured at even higher rates, almost twice the rate of adolescents, presenting a daunting challenge for health care policymaking in the new century.24

Lack of health insurance coverage limits adolescents' access to care and utilization of health services, affecting whether or not they have a "usual source of care" and their average number of annual physician contacts.25 There are, of course, numerous other factors that affect adolescents' access to necessary health care.26 One factor that looms particularly large on the horizon is the degree to which adolescents can receive confidential care. Many adolescents will only seek some important services if they can do so on a confidential basis.27 Generally, adolescents are more likely to seek health care, particularly for such issues as sexuality or substance use, if they can do so without their parents' knowledge.28 One 1997 study found that seventeen percent of surveyed adolescents had forgone health care in the past at least in part because of privacy concerns, and that assurances of physician confidentiality increased adolescents' willingness to disclose general information, report truthfully, and consider a return visit.29

Awareness of all of these issues did not develop until well into the second half of the twentieth century. In the early years of adolescent health care, neither the knowledge base regarding adolescents' health concerns, the service delivery models for their care, the financing of needed services, or the awareness of the importance of confidentiality were yet developed.

II. The Early Years

Only very recently has adolescent health care been considered a field of its own. Indeed, the idea of adolescence itself—as a concept for a distinct period of human development—barely spans more than a century. The early years of contemporary adolescent health care, or adolescent medicine, were those following World War II.30 They also witnessed a proliferation of writings in psychology and sociology about adolescence as a stage of life. During this period, both legislatures and courts recognized that some adolescents who are legally minors should be allowed, in some circumstances, to provide their own consent for health care, thus laying the foundation for confidentiality in adolescent health care as we know it today. At the same time, private employer-based health insurance was growing as a means of financing health care for workers and their families. Not long after, publicly-funded programs—such as Medicare, Medicaid, and numerous categorical programs—were created to help pay for health care for the poor, the elderly, and the disabled. Many of these programs have had long-term significance for adolescents and their access to health care.

20 According to projections by the American Academy of Pediatrics, there were 3.7 million uninsured adolescents ages thirteen through eighteen in 2000, 2.4 million were eligible for but not enrolled in Medicaid or the Child Health Insurance Program.


22 Overall, twenty-nine percent of young adults ages eighteen through twenty-four were without insurance in 1999; and of those living below the poverty level, nearly one-half (45.4 percent) lacked health insurance in 1999. U.S. Census Bureau, supra note 19, at 2 (Feb. 4, 2001). A)

23 Noveshek et al., supra note 19, at 200 (Feb. 4, 26).


25 See, e.g., AMERICAN MEDICAL ASSOCIATION (AMA), POLICY COMMITTEE ON CONFIDENTIAL HEALTH SERVICES FOR ADOLESCENTS (JANET CARR ed., 1994); American Medical Association (AMA), Council on Scientific Affairs, Confidential Health Services for Adolescents, 260 JAMA 1420 (1993); Society for Adolescent Medicine, Confidentiality for Adolescents: Positive Paper of the Society for Adolescent Medicine, 21 J. ADOLESCENT HEALTH 408 (1997).

26 Council on Scientific Affairs, supra note 27.


28 The term adolescent medicine refers to the care of adolescents by physicians. However, because of the diverse health care needs of adolescents, which require care from health care professionals in many disciplines in addition to medicine, the term adolescent health care will be used throughout this article, except when referring specifically to care by physicians.
A. Establishing Adolescent Medicine

Recognition of adolescence as a distinct period of human development provided the necessary foundation for the establishment of adolescent medicine. Although the term “adolescence” had been used for centuries, it often referred to a broad age group that spanned as far as from age seven to age thirty. The term “adolescence” did not come into use until the late nineteenth and early twentieth century, and its recognition represented the acknowledgment of diverse social, cultural, economic, and psychological changes that occurred in the late nineteenth century. Understanding of adolescence increased throughout the twentieth century, with numerous milestones along the way.

Although the creation of adolescent medicine followed the recognition of adolescence, it did not do so immediately. Recommendations for the establishment of a specific field of medical practice to address the needs of adolescents date back to the beginning of the twentieth century, but the field of adolescent medicine was not created in its contemporary form until mid-century. Just as the medical specialty was supported in the early decades of the twentieth century by the expanded understanding of child development, and of the differences between children and adults, so too was the development of adolescent medicine supported by the increased understanding of how adolescents differ developmentally from both younger children and adults.

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A landmark event in the creation of adolescent medicine was J. Roswell Gallagher’s establishment in 1951 of the Adolescent Unit at Boston Children’s Hospital, the first such service at a United States hospital. While developments internal to pediatrics as a profession played a significant role in the establishment of adolescent medicine, Gallagher’s recognition of the widespread misconception that adolescents are generally healthy and need little beyond basic health care also played an important part. This misperception persists to the present day.

Widely credited as the founder of adolescent medicine, Gallagher was a pioneer. Not only did he recognize the diverse and serious health care needs of adolescents, he also identified the integral relationship between physical and mental or emotional issues in the health of adolescents, as well as the critical role to be played by research in further expanding understanding of their health care needs and appropriate prevention and treatment approaches. These themes have continued as important ones in the field of adolescent medicine and adolescent health care throughout the past half century.

B. Allowing Mature Minors to Consent for Health Care

One of the earliest laws in the United States that permitted minors to give their own consent for health care was a statute enacted in California in 1953 that allowed married minors to give their own consent for pregnancy-related care. Amended numerous times thereafter, the statute remains on the books today, allowing minors in California to consent to the full range of pregnancy-related care

39 Priscott, supra note 32, at 37-38 (summarizing the career of J. Roswell Gallagher, founder of the unit, often considered the founder of adolescent medicine).
40 Priscott, supra note 32, at 35, 39 (detailing his discovery that even many adolescents from higher income families suffered from a wide variety of illnesses and conditions that were not discovered prior to their entering a boarding school).
41 For details regarding adolescents’ myriad health concerns, see supra notes 5-15, and accompanying text.
43 Priscott, supra note 32, at 42-44.
and a categorical program designed for younger children or adults also may not target adolescents' needs. Moreover, the connection between the nature of some of the health care problems of adolescents and their need for confidentiality presents unique issues. For the most part, however, these issues did not emerge in the early years of health insurance or public financing of health care.

1. Private Health Insurance

Although the antecedents date back at least to the mid-nineteenth century, health insurance policies as we know them today did not really begin to proliferate in the United States until almost a hundred years later. During the Great Depression, Blue Cross emerged as a leading provider of policies to cover the costs of hospitalization, with one of the driving forces being fears about the long-term financial viability of voluntary hospitals. Shortly thereafter, Blue Shield was created to cover physician expenses. Some of the issues that arose in the early years, such as whether the insured would have a "free choice" of provider, find their echoes in the present day and have important implications for adolescents.

As the century progressed, employer-based health insurance became the dominant mode of financing health care costs throughout the United States. Many of the features of employer-based health insurance have had significant implications for adolescent health care. For example, employers, as payers, and the unions that represent large numbers of workers, have determined which health care benefits and services would be covered by health insurance, a

45 However, they were reflected in the enactment of some of the earliest laws allowing minors to give their own consent for health care. See infra notes 94-96 and accompanying text.


47 EMERICK, supra note 50, at 205-96.

48 Arrowsmith et al., supra note 50, at 704.

49 See infra Part V.

50 Employer-sponsored health insurance financed health care for 62.8 percent of the U.S. population in 1999. U.S. HEALTH INSURANCE情况 1999, supra note 19, at 1 (fig.1). That dominance may be attributable largely to the favorable tax treatment it receives both from the perspective of the employer and the employee. Arrowsmith et al., supra note 50, at 705. Whatever the reason for its popularity in comparison to other types of private health insurance, employer-sponsored health insurance covers not only more workers, but also more children, including the adolescents who are the dependents of workers, than other types of health insurance.
fact that has had major implications later in the century for adolescents’ access to the health care benefits they need.  

2. Public Health Insurance

Several decades elapsed between the emergence of private employer-based health insurance and the advent of publicly-funded health insurance as we know them today. The creation of Medicare and Medicaid in the 1960s was a major milestone in the financing of health care, particularly for vulnerable population groups such as low-income seniors, women, children, and individuals with disabilities.

Medicaid, in particular, has had far-reaching implications for health care coverage and access for adolescents from low-income families and other vulnerable teens. Enacted in 1965 as Title XIX of the Social Security Act, Medicaid is a program in which the federal government establishes minimum standards for eligibility, services, and administration, and the states administer the program within those parameters. Medicaid is financed jointly by the states and the federal government. The joint federal-state nature of the program laid the groundwork for a situation in which, through a combination of federal requirements and state discretion, Medicaid has slowly moved in a positive direction for adolescents over its three and one-half decades of existence.

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3. Other Publicly-Funded Health Care Programs

Despite the overriding importance of Medicaid, other publicly-funded health care programs at the federal and state levels have also played significant roles in the financing of health care for adolescents. While many such programs have made a contribution, three have been of particular importance, each for different reasons. These are the Maternal and Child Health (MCH) Services Block Grant under Title V of the Public Health Service Act (known as Title V), the Voluntary Family Planning and Population Services Program under Title X of the Public Health Service Act (known as Title X), and the Ryan White Comprehensive AIDS Resources Emergency (CARE) Act of 1990 (known as the Ryan White CARE Act or Ryan White).

In the early years of adolescent health care, however, only one of these federal programs—the Title V MCH program—was available to provide any assistance for adolescent health care. Title V was not enacted until 1970, when adolescent health care had begun to mature, and the Ryan White CARE Act was not enacted until two decades later during the rapid spread of the HIV epidemic.

III. The Middle Years

From the late 1960s through the late 1980s, numerous legal and policy developments improved the potential for health care access for adolescents. For example, adolescent medicine as a field matured, with public funding for training programs and new models
of service delivery; the United States Supreme Court recognized that minors as well as adults have Constitutional rights; states enacted a broad range of statutes allowing minors to consent to health care; Medicaid improved in ways that benefited adolescents; and other federally-funded health care programs provided critically important services for this age group.

A. Maturing of Adolescent Health Care

Adolescent health care began to mature as a field during the 1960s and 1970s with the expansion of the number of adolescent medicine and adolescent health training programs. In addition, the Society for Adolescent Medicine was established, providing a forum for adolescent health care professionals to share research and to network professionally across disciplines. Other key advances in adolescent health care during this period included the development of educational curricula, the expansion of clinical services and sites tailored to adolescents' needs, and the interest and involvement of national foundations in adolescent health.

On the service delivery front, the implementation of comprehensive adolescent health clinics and the establishment of school-based health centers made a major contribution to the understanding of how adolescents' health care needs could best be met. "Comprehensive adolescent health clinic" is an umbrella term for service sites that have been developed over the past two decades in an effort to focus on adolescents' special health care needs, including easy access, multi-disciplinary care, integration of psychosocial and medical services, and coordination with other health care resources.

The most complete survey to date of such programs identified six types: school-based health centers (forty-five percent of responding sites); hospital-based clinics (twenty-two percent); community or neighborhood health centers (eleven percent); health centers (nine percent); public health departments (eight percent), and other models (five percent). While the number of comprehensive adolescent programs has grown since 1990, these services still reach only a fraction of the youth who need them.

One of the particular attractions of comprehensive adolescent health care clinics has been protection of adolescent patients' confidentiality. While private physicians in office-based practices also may assure and protect confidentiality, comprehensive adolescent health care clinics are perceived (often correctly) by adolescent patients as having better systems for preventing disclosure of sensitive information, and many adolescents choose these sites for that reason. As a result of the confidentiality protections and other access benefits, adolescents who have the option often seek care from community-based comprehensive adolescent health care clinics even if they are insured for care elsewhere.

School-based health centers (SBHCs) are the most common model of comprehensive adolescent health services; along with school-linked health centers (SLHCs), both centers have experienced tremendous growth in recent years. Both kinds of clinics have formal ties to schools and are usually sponsored by a county or city health department, by an affiliated hospital, or by another commu-

47The first two such training programs were funded in the 1960s by the federal Children's Bureau (later the Maternal and Child Health Bureau) at Boston's Children's Hospital and at the Division of Adolescent Medicine at the Children's Hospital in the District of Columbia. Health, supra note 36, at 4. In 1979 the Maternal and Child Health Bureau of the U.S. Department of Health & Human Services funded eight training centers for multi-disciplinary adolescent health care. Id.


49 See, e.g., Health, supra note 36, at 4 (describing development by the American Academy of Pediatrics in 1977 of a core curriculum in pediatrics that encompassed adolescent medicine and a 1982 initiative in adolescent health care funded by the Robert Wood Johnson Foundation to link health services in academic centers and local health agencies).
nity-based organization. As with all comprehensive adolescent sites, SBHCs and SLHCS are most common in urban areas; rural youth have fewer opportunities to use them.

Services provided most frequently in SBHCs are acute care, preventive care, and reproductive health services.

The overall number of SBHCs has increased rapidly, to more than 1,300 in 2000. Most of these are in middle and high schools. SBHCs are financed heavily through state funds, although federal funds from the MCH Block Grant, and the Healthy Schools, Healthy Communities grant program, administered by the Bureau of Primary Health Care, in the United States Department of Health and Human Services also support SBHCs. SBHCs serve poor youth disproportionately: during the 1991-1992 school year, thirty-nine percent of students using school-based health centers were uninsured and twenty-eight percent were covered by Medicaid.

B. Evolving Law and Policy

During the late 1960s, the 1970s, and the 1980s, changes in the legal and policy framework had great significance for adolescents and their access to health care. A series of decisions by the United States Supreme Court as well as the lower federal and state courts

recognized that adolescents had Constitutional rights. While not all of these decisions related to health care, many of the most important ones focused on reproductive health care and the constitutional privacy rights of minors.

During the same period, virtually all states enacted minor consent laws that allow adolescents who are under the age of majority to give their own consent for health care in some cases. These laws were fundamental to the ability of adolescents who are minors to receive care on a confidential basis.

While the Constitutional privacy rights and the consent and confidentiality rights of adolescents were being defined, the publicly-funded programs that financed health care for this age group also were evolving. Several aspects of these programs strengthened their ability to serve the adolescent age group, but there were also significant limitations.

1. Adolescents and the Constitution

The concept that minors have Constitutional rights as individuals is a recent one. Only in 1967 did the United States Supreme Court decide that minors as well as adults are entitled to a broad range of due process protections when they are arrested and tried for criminal misbehavior and it was only very shortly thereafter, in 1969, that the Court acknowledged students' Constitutional rights of free speech and free expression.

Within the next decade the Supreme Court also decided that the privacy of minors as well as adults is protected under the Constitution. In two landmark cases, Planned Parenthood of Central Missouri v. Danforth and Carey v. Population Services International, the Supreme Court limited the power of states to block access to reproductive health care for minors. In Danforth, the Supreme Court
held that parents do not have an arbitrary veto power over the abortion decision of a minor daughter who is mature enough to become pregnant.\textsuperscript{67} In\textit{ Carey}, the Court held that a state may not ban the sale of nonprescription contraceptives to minors.\textsuperscript{68} These cases became landmarks in both the effort to expand access to health care, including reproductive health care, for adolescents and in the ongoing debate over the scope of minors' Constitutional rights and the relationships among children, parents, and the government.

Since the\textit{ Carey} decision in 1977, the Supreme Court has not decided a case concerning minors' access to contraceptive services.\textsuperscript{69} The\textit{ Danforth} decision in 1976, however, was only the beginning in a long line of decisions addressing the scope of minors and parents' rights with respect to abortion, and the permissible degree to which the state may delimit and limit those rights.\textsuperscript{70} The net effect of these cases has been to permit states to enact laws requiring the involvement of parents when minors seek abortions, but only if they provide for an alternative that allows a minor to obtain an abortion without first going to her parents.\textsuperscript{71} The landscape of recognition for Constitutional rights of minors was not smooth terrain, however, and became rockier as the century progressed. This was true in health care and in other arenas. For example, at the same time that the Supreme Court held that a mature minor must be able to make the abortion decision for herself, albeit after her maturity was determined by a court,\textsuperscript{72} the Supreme Court also held that commitment of a minor to an inpatient psychiatric hospital did not require the full panoply of Constitutional Due Process protections such as a pre-commitment hearing.\textsuperscript{73}

2. The Minor Consent Laws

From mid-century through the 1980s, even before courts began to recognize that minors have Constitutional rights that affect their access to health care, states enacted a series of statutes that allow minors to give their own consent for health care. These statutes fell generally into two broad classifications: laws based on the status of the minor; and laws based on the services the minor is seeking.\textsuperscript{74} The categories of minors who are most commonly authorized to give their own consent for a broad range of services are: mature minors; legally emancipated minors; married minors; minors in the armed forces; minors living apart from their parents; minors over a certain age; high school graduates; pregnant minors; and minor parents.\textsuperscript{75} The types of services for which minors are most often authorized to give their own consent (or to obtain care without prior parental consent) are: emergency care; pregnancy-related care (sometimes including abortion); contraceptive services; diagnosis or treatment of venereal or sexually transmitted diseases; diagnosis or treatment of reportable, infectious, contagious, or communicable diseases; HIV/AIDS testing and/or treatment; treatment or counsel-


\textsuperscript{68} See\textit{ Parham v. J.R.}, 44 U.S. 669 (1979) (stating that a child, in common with adults, has a substantial liberty interest in not being confined unnecessarily for medical treatment. . . . We conclude that the risk of error inherent in the parental decision to have a child institutionalized for mental health care is sufficiently great that some kind of inquiry should be made by a "neutral factfinder" to determine whether the statutory requirements for admission are satisfied. . . . It is not necessary that the deciding physician conduct a formal or quasi-formal hearing." (emphasis added)). See also\textit{ Schall v. Martin}, 467 U.S. 253, 265, 268 (1984) (holding nearly two decades after\textit{ Babbit v. Baird}, that prospective preventive detention of juveniles did not violate their Constitutional Due Process rights and pointing out that while the "juvenile's . . . interest in freedom from institutional restraints . . . is undoubtedly substantial] . . . that interest must be qualified by the recognition that juveniles, unlike adults, are always in some form of custody." (citations omitted)).

\textsuperscript{69} See State Minor Consent Statutes, supra note 46 (compiling states' minor consent statutes);\textit{ Boonastra}, supra note 46, at 6-7;\textit{ Morrisey et al.}, supra note 46, at 20-22;\textit{ Holcer}, supra note 46, at 129-33.
ing for drug or alcohol problems; collection of medical evidence or treatment for sexual assault; or outpatient mental health services. Although EPsDT technically appears in the Medicaid statute among the list of mandatory benefits that states are required to provide, 42 U.S.C. § 1396d(d) (Supp. IV 1998), it is often referred to as a program.

a. Medicaid

Originally established in 1965, Medicaid was modified in 1967 to include Early and Periodic Screening, Diagnosis and Treatment (EPsDT). Ultimately, as amended more than two decades later in 1989, EPsDT has been the legal mechanism for ensuring that, at least on paper, children and adolescents have access to the full package of benefits that is federally reimbursable under the Medicaid statute. This mechanism, combined with the expansions in Medicaid eligibility enacted by Congress during the 1980s, serves to make the legal framework for the Medicaid program increasingly responsive to the needs of adolescents.

In administration of Medicaid, states may vary program guidelines as long as they adhere to federal standards or receive federal permission (in the form of a “waiver”) to depart from those standards. Thus significant variation among states exists in coverage of optional eligibility groups, coverage of optional services, and provider reimbursement, among many other issues. Some of these variations have specific importance for adolescents.

Eligibility for Medicaid is determined by each state according to its specific guidelines. However, the federal government specifies the mandatory eligibility categories (groups that must be covered in every state) and the optional eligibility categories (groups that may be covered if the state chooses to do so). Several of the mandatory and optional eligibility categories have particular significance for Medicaid coverage of adolescents.
During the 1970s and early 1980s, however, the primary way in which an adolescent could qualify for Medicaid was by being linked through eligibility for a cash assistance program such as Aid to Families with Dependent Children (AFDC), Supplemental Security Income (SSI), or Title IV-E foster care benefits.106 For these programs, particularly AFDC, the income limits were set so low in many states that an adolescent had to be living in a family with income no higher than a fraction of the federal poverty level in order to qualify for Medicaid.107

Congress moved initially in the 1980s to separate Medicaid eligibility from eligibility for cash assistance programs. The initial congressional focus was on expanding eligibility for young children and for pregnant women. For the most part, adolescents benefited from these early expansions only if they were pregnant females.108

The federal government specifies not only eligibility criteria but also mandatory services that must be covered for all Medicaid beneficiaries and optional services that may be covered at the state’s discretion. The combined set of mandatory and optional Medicaid benefits, while not without some gaps and deficiencies, includes a long and relatively comprehensive list of services.109 When the EPSDT provision of the Medicaid statute was amended in OBRA-89, it required that a state make available to all beneficiaries up to age twenty-one the full range of mandatory or optional services necessary to “correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services,” whether or not the state covered the optional benefits for adults.110 This amendment rendered the Medicaid benefit package one of the

106 See English et al., Medicaid and CHIP, supra note 16, at 29.
108 While this policy may have been designed to assure that pregnant women and adolescents would obtain prenatal care, it had an ironic aspect in limiting benefits for adolescents to those who were pregnant at the same time that other policy-related efforts were being made to discourage teen pregnancy. See, e.g., Raising the Future: Adolescent Sexuality, Pregnancy, and Childbearing 141 (Cheryl D. Hayes ed., 1987) (hereinafter Raising the Future) (referring to fifteen years of interventions to reduce teen pregnancy).
b. Title V

The Maternal and Child Health (MCH) Services Block Grant, embodied in Title V of the Social Security Act is directed at improving the health of all mothers and children.\textsuperscript{117} The program is one of the oldest federally-funded health programs and dates back to 1935 when the Social Security Act was originally passed, although it has been restructured and revised many times since then.\textsuperscript{118} The Title V program includes many diverse components, but one of its most important roles has been the funding of adolescent health training programs.\textsuperscript{119}

Wide variation exists in the way that Title V programs are implemented at the state level, but Title V provides an opportunity for states to address the health care needs of adolescents in several ways.\textsuperscript{120} Title V MCH programs have been an important source of funds for family planning services (representing approximately ten percent of federal dollars spent on family planning) and have worked to improve prenatal care for adolescents as well as older women.\textsuperscript{121} Additionally, Title V programs for Children with Special Health Care Needs (C SHCN) are focused on meeting the needs of children, including adolescents, with special health care needs.\textsuperscript{122} Although Title V programs have not uniformly made adolescents a high priority for their services,\textsuperscript{123} many states have used their Title V funds creatively for improving adolescents’ care and health.\textsuperscript{124}

Medicaid has long required EPSDT program coordination with Title V.\textsuperscript{125} More recently, with the enactment of the State Children’s Health Insurance Program (SCHIP) in 1997,\textsuperscript{126} there is an opportunity for coordination between Title V and public insurance programs to provide expanded health insurance coverage for adolescents. The role of Title V programs often is a salutary one in a number of states. As a result, states have taken the lead in designing the SCHIP program, provided leadership with respect to outreach, and spearheaded a focus on special services within SCHIP for children and adolescents with disabilities.\textsuperscript{127} Work that Title V agencies have done with respect to performance measurement and data reporting regarding adolescents in the public health arena offers one model that could be used or adapted by SCHIP programs.\textsuperscript{128}

Adolescents provide an excellent illustration of both the advantages and disadvantages of the degree of discretion that is vested in the states in the operation of their Title V programs. Some states have used this flexibility to design innovative programs and to target services to reduce risk behaviors and provide needed services for adolescents, while others have allowed adolescents to remain in their customary shadows. The success of a program like Title V, from the perspective of adolescents, depends upon the pres-

\textsuperscript{117} 42 U.S.C. §§701-710 (2000). Title V funds are awarded to states pursuant to state plans for maternal, child, and adolescent health. States are required to match three dollars in state funds for every four dollars in federal funds they receive and many states provide funds beyond their required match. Health Resources and Services Administration, U.S. Department of Health and Human Services, Block Grant Program, available at http://www.mchdata.net/ LEARN_More/Block_Grant_Program/ block_grant_program.html (last visited May 5, 2001) [hereinafter Title V Block Grant Program]. Funds are used for maternal and child health (MCH) programs and programs for children with special health care needs (C SHCN). Id.

\textsuperscript{118} Title V History, supra note 63.

\textsuperscript{119} See, e.g., Heald, supra note 36, at 4.

\textsuperscript{120} Title V Block Grant Program, supra note 118. See, e.g., Health Resources and Services Administration, U.S. Department of Health and Human Services, Title V Today, at http:// www.mchdata.net/ LEARN_More/Title_V_History/ title_v_history.html (last visited May 5, 2001).


\textsuperscript{122} See, e.g., National Center for Youth with Disabilities, Teenagers at Risk: A National Perspective of State Level Services for Adolescents with a Chronic Illness or Disability III (1993).

\textsuperscript{123} Id. at 11.


\textsuperscript{125} Health Care Financing Admin., U.S. Department of Health and Human Services, State Medicaid Manual § 5123.

\textsuperscript{126} See, e.g., Brindis et al., Adolescents and the State Children’s Health Insurance Program (CHIP): Healthy Options for Meeting the Needs of Adolescents 7 (1999) [hereinafter NAHCRC/AMCHP Report].

\textsuperscript{127} Id. at 55-56.

ence of a community of state public health officials, health care providers, and community advocates who are committed to the agenda of improving adolescents' health and their access to health care. When such a state community exists, there are almost limitless ways in which the program, within the boundaries of its financial resources, can benefit adolescents.

c. Title X

Since 1970, the family planning clinics funded under Title X of the Public Health Service Act have been a major source of family planning services for low-income adolescents in the United States. Title X funds appropriated by Congress provide direct grants to health care facilities and to state and local agencies. No federal program apart from Title X has the sole purpose of supporting family planning and related reproductive health services for low-income women and teens.

From the beginning, Title X programs have provided access to confidential family planning services for adolescents. They have done so in accordance with federal law, but not without ongoing controversy. The Title X statute and regulations require that services be provided "without regard to age," and that confidentiality be protected. This dual requirement has served, in effect, as a lightning rod for two decades, resulting in litigation, as well as legislative and regulatory attempts to limit adolescents' access to Title X services. Efforts to include parental consent or notification requirements in the Title X statute have thus far not succeeded, but they are ongoing.

In 1983, after the statute was amended to require Title X grantees to "encourage where practicable" family involvement, the Department of Health and Human Services issued proposed regulations that would have required prior notification of parents


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by registered mail when minors received prescription contraceptives from Title X-funded clinics. This "squeal rule," as it was known, drew tens of thousands of comments and was ultimately held to conflict with the statute, with the court in Heckler finding that "encourage" does not mean the same thing as "require."

In the 1998 Fiscal Year appropriations bill (Pub. L. 105-178) for the Departments of Labor and Health and Human Services, which included Title X appropriations, Congress added the following language: "None of the funds appropriated . . . may be made available to any entity under Title X . . . unless the applicant . . . certifies . . . that it encourages family participation in the decision of minors to seek family planning services and that it provides counseling to minors on how to resist attempts to coerce minors into engaging in sexual activities." Pursuant to this legislation, the Office of Population Affairs required programs to submit an updated Title X Certification of Compliance that they encourage family participation and counsel minors on resisting coercive sexual activity.

The experience with the Title X program offers at least two lessons that are difficult to reconcile. First, the presence of a strong federal program that recognizes and protects the ability of large numbers of adolescents to obtain essential health care services on a confidential and independent basis is a key element of the infrastructure of adolescent health care service delivery. Second, such a program serves as a focal point for the efforts of individuals and groups who are opposed to adolescents having access to confidential health care.

125 Planned Parenthood Fed'n of New York v. Heckler, 712 F.2d 600 (D.C. Cir. 1983); National Family Planning and Reproductive Health Act of 1992, Pub. L. No. 102-55, § 212, 111 Stat. 1467, 1485 (Nov. 13, 1995). In 1998, additional legislation in the same vein was introduced. H.R. 3230 contained the "Title X Parental Notification Act of 1998," which would have modified the substantive Title X statute to require actual written notice to a parent or legal guardian or the written consent of a parent or guardian for a minor to receive any prescription contraceptive drugs or devices from a Title X program unless the minor were emancipated or had obtained a court order. H.R. 3230, 105th Cong., 2d Sess. (1998).
d. Ryan White CARE Act

The Ryan White Comprehensive AIDS Resources Emergency (CARE) Act of 1990 offers equally important, but distinctly different, lessons with respect to the financing of adolescent health care services. Enacted by Congress to provide comprehensive federal support for a continuum of services for people with HIV, including children, adolescents, and families, the Ryan White CARE Act provided support for the development and evaluation of innovative projects targeted at adolescents. Although the total amount of funding for adolescents under the Ryan White CARE Act has not been large, and the services targeted at a very small segment of the adolescent population, the Ryan White CARE Act nevertheless provides legal, policy, and financial support for innovations that may provide lessons of significance beyond the AIDS epidemic and the high-risk youth affected by it.

In its original form, the Ryan White CARE Act contained several distinct programs: an emergency relief grant program for metropolitan areas (Title I); HIV Care Grants (Title II); funds for comprehensive outpatient Early Intervention Services (Title III); and other provisions such as those related to pediatric demonstration grants and national research projects (Title IV). Title II contained a provision permitting a set aside of up to ten percent of the funds for special projects of national significance (SPNS) to provide for the care and treatment of individuals with HIV disease. Several of the categories of projects targeted for SPNS funding could be important for adolescents affected by HIV, including those who use drugs, minorities, those with hemophilia, Native Americans, rural youth, homeless youth, and incarcerated youth. Most importantly, in 1993 the SPNS Program issued a competitive grant announcement focused exclusively on adolescents, pursuant to which ten adolescent-focused projects were funded in Fiscal Year 1993-1994 for three years; nine of these projects were renewed for an additional two-year period in 1997.

Even though the Ryan White CARE Act does contain some key legal provisions that are important to adolescents, such as protection of confidentiality and requirements of informed consent, the program has not drawn the same fire as Title X. It also has not affected comparable numbers of adolescents in nearly as visible a way as Title X has done and its adolescent-focused services have been limited to a small number of communities. Nevertheless, the adolescent-focused SPNS projects emphasize a variety of diverse and important elements that are often not well-developed or included at all in other programs that serve adolescents, including youth involvement (San Francisco), outreach (Bridgeport, Alabama), case management and linkage to service (Indiana; Seattle; Minnesota), and a comprehensive continuum of care (Boston; Los Angeles; San Francisco). The effectiveness of these programs was evaluated, and the evaluation data could and should be used to guide program and policy development for other settings and issues affecting high-risk teens or youth in general.

IV. THE END OF THE TWENTIETH CENTURY

Following the significant legal and policy developments of the previous three decades, the last decade of the twentieth century saw more consolidation of knowledge, growing awareness among policymakers and researchers of adolescent health issues, and rising problems in access to care. It was a time of shifting focus, with key innovations in adolescent health care access occurring in the public insurance arena more than in the categorical programs. It was also a time of increased tension over confidentiality in adolescent health care. The last decade of the twentieth century clearly set the stage with the challenges that will need to be addressed in the early years of the twenty-first century to maintain and expand adolescents' access to essential health services.
A. Policymakers and Researchers Paying Attention to Adolescents

In the late 1980s and early 1990s, numerous commissions, advisory groups, and governmental agencies issued dozens of reports addressing policy issues in adolescent health. In addition, many reports and textbooks summarized the state of scientific knowledge about adolescent health and included recommendations for further research. Three entities in particular issued a series of noteworthy studies and reports: the Office of Technology Assessment (OTA); the Carnegie Council on Adolescent Development; and the Institute of Medicine. In addition, several agencies within the federal government collaborated in funding the landmark National Longitudinal Study of Adolescent Health.19

In the late 1980s Congress asked the Office of Technology Assessment (OTA) to undertake a study of adolescent health.199 Pursuant to that request, OTA conducted a three-year study examining a broad range of issues, such as the health status of adolescents, the service delivery system for adolescent health-related services, legal issues affecting adolescents’ care, the insurance status of adolescents, and the financing of their health care.200 The massive three-volume report that resulted from the OTA study contained detailed documentation for each of these issues together with a lengthy series of policy options for Congress to consider.201 The leading policy option for Congress identified by OTA pertained to adolescents’ access to health care and suggested that: “Congress Could Take Steps to Improve Adolescents’ Access to Appropriate Health and Related Services.”202

In 1987 the Carnegie Corporation of New York established a Council on Adolescent Development.203 Over a ten year life span, this Council issued a series of reports on issues of critical import.

199 See NIH Revitalization Act of 1993, Pub. L. No. 103-43, § 1001, 107 Stat. 122 (1993) (requiring the National Institutes of Health to develop a prospective longitudinal study of adolescent health, including information about the health and well-being of adolescents in our country, the behaviors that promote adolescent health or that put health at risk, and how communities influence the health of adolescents).


204 Id. at 8-81 (identifying a group of five recommendations designed to further that goal: (1) assure delivery of high quality services; (2) provide access to comprehensive health services; (3) improve financial access to comprehensive health services; (4) assure the legal right to health care and confidentiality of care; (5) provide adolescent-focused and adolescent acceptable health services).

199 Id. at 151-53 (noting the publications of the Carnegie Council on Adolescent Development).

200 Id. at 63. See also English, THE ADOLESCENT ALONE, supra note 97, at 3.

201 For example, the Carnegie Council supported OTA’s study of adolescent health by funding many of the background papers. OTA, Vol. I, supra note 2, at iii.


204 See, e.g., HANDLE HIGH RISK Jugend, NATIONAL RESEARCH COUNCIL, LOSING GENERATIONS: ADOLESCENTS AT HIGH-RISK SETTINGS (1993); RISING THE FUTURE, supra note 10.


206 Id. at 8-81 (identifying a group of five recommendations designed to further that goal: (1) assure delivery of high quality services; (2) provide access to comprehensive health services; (3) improve financial access to comprehensive health services; (4) assure the legal right to health care and confidentiality of care; (5) provide adolescent-focused and adolescent acceptable health services).
search recommendations. Many of the research recommendations also addressed the need for research related to health care systems and policies.

Conducting adolescent health research could contribute in significant ways to the implementation of many of the policy recommendations designed to improve access to care for adolescents. For a comprehensive range of such research studies to be conducted, however, several impediments must be overcome. In 1995, the Society for Adolescent Medicine took the lead in developing a set of guidelines for adolescent health research designed to help overcome some of these impediments and to facilitate the conduct of such research.

B. Clinicians Focusing on Prevention

Focus on prevention of health problems for adolescents increased during the 1990s. National professional organizations and governmental agencies issued clinical practice guidelines regarding preventive services for children and adolescents. The guidelines contained recommendations for the frequency or periodicity of services, as well as the content of services. They closely paralleled the EPSDT requirements of the Medicaid statute. In addition, clinical preventive services for adolescents were included in monitoring tools for managed care and in performance measures for Medicaid and the State Children’s Health Insurance Program.

The national guidelines were consistent in recommending that adolescents receive preventive health visits at frequent intervals, with some of the groups recommending that the visits be annual. In addition, the guidelines spelled out in detail what the content of preventive visits should include.

Implementation of these clinical preventive services guidelines is not mandated by statute. However, some states have incorporated them into state policy either by including them in their state plans under the State Children’s Health Insurance Program or by incorporating them into managed care contracts for public programs. In addition, the statutory requirements for EPSDT in Medicaid reflect the same general goals and many of the same specific elements as the clinical preventive services guidelines. Several key elements of clinical preventive services also have been incorporated into monitoring tools for managed care. In spite of the encouraging level of activity regarding clinical preventive services that occurred during the past decade, few adolescents are likely to benefit from receiving these services on a regular basis unless they have health insurance coverage.


164 Id. at 4 (identifying two priority areas for research on health care systems and policies: adolescents’ health services needs and the organization of health services; as well as clusters of recommendations related to the relationship between adolescents and health care providers and how health policies affect adolescents). The guidelines and background papers were collected in a special issue of the Journal of Adolescent Health. See generally 17 J. Adolescent Health 259-330 (1995). See also Abigail English, Guidelines for Adolescent Health Research: Legal Perspectives, 17 J. Adolescent Health Care 277 (1995).


167 AAP GUIDELINES, supra note 166, at 225 (supp. A); GAPS, supra note 166, at 179 (6th ed.16); BRIGHT FUTURES, supra note 166, at 205 (supp. A).

168 AAP GUIDELINES, supra note 166, at 225 (supp. A); GAPS, supra note 166, at 179 (6th ed.16); BRIGHT FUTURES, supra note 166, at 205-17, 224-53.

169 Nevertheless, implementation has taken place in a number of locations around the United States. See, e.g., MEYER FELDMAN ET AL., LESSONS LEARNED: NATIONAL DEVELOPMENT TO LOCAL IMPLEMENTATION OF GUIDELINES FOR ADOLESCENT PREVENTIVE SERVICES (2001).

170 ENGLISH ET AL., MEDICAID AND CHIP, supra note 16, at 67; NAHIC/AMCHP REPORT, supra note 127, at 48 (8th ed.)

171 Kibler Olson & Jane Perkins, Medicaid Managed Care Contracts and Agreements For Preventive Services For Adolescent Health Care, In Adolescent Health Care In Transition: Medicaid, Managed Care, and Health Care Reform (A. English et al. eds. forthcoming, 2001).


C. Expanding Health Insurance Coverage

Fortunately, the 1990s was also a decade in which health insurance coverage expanded for adolescents, at least in the public sector. While private insurance coverage of adolescents declined from the mid-1980s through the mid-1990s, public health insurance coverage, primarily Medicaid, increased as a result of mandates and options for the states enacted by Congress. In 1997, Congress enacted the State Children's Health Insurance Program (SCHIP), which accelerated the expansion of adolescents' eligibility for publicly-funded health insurance.

In the 1980s and early 1990s, Congress had taken significant steps to separate Medicaid eligibility from cash assistance and expanded Medicaid eligibility for pregnant women, children, and adolescents based on their family income in relation to the federal poverty level (FPL).

As a result of these successive actions by Congress, several mandatory eligibility categories emerged that are significant for adolescents. Particularly noteworthy was the requirement that states cover adolescents under age nineteen with family incomes at or below 100 percent of the FPL on a phase-in basis, one year at a time. Also as a result of these successive actions by Congress, several optional eligibility categories emerged that are particularly significant for adolescents. The very complexity of these categories serves to emphasize the challenges involved in making sure that all eligible adolescents are enrolled in the Medicaid program. Nevertheless, the importance of meeting this challenge is paramount because of the large numbers of adolescents who are eligible for Medicaid but not enrolled.

The SCHIP statute, enacted in the Balanced Budget Act of 1997 (BBA) as a new Title XXI of the Social Security Act, made available to states a total of forty-eight billion dollars over ten years to expand health insurance for low-income children and adolescents. SCHIP allows states to expand Medicaid, create separate, non-Medicaid state programs, or to combine these approaches. States with federally approved state plans receive Title XXI funds at a higher matching rate than the Medicaid matching rate; SCHIP "enhanced" matching rates vary from sixty-five to eighty-three percent. In Medicaid expansion programs, federal Medicaid requirements apply unless the state has obtained a waiver of those requirements, while in non-Medicaid SCHIP programs, states have considerable discretion to design and administer their own programs within some broad federal parameters.

As of late 1999, all states and the District of Columbia had submitted plans and had received approval for at least an initial plan from the Health Care Financing Administration. Because states can submit amendments to their state plans at any time, the SCHIP plans are "work in progress" and changes may be sought to improve the programs' effectiveness in meeting adolescents' needs. By March 31, 2001, plans had been approved for Medicaid expansion programs in sixteen states (the District of Columbia), for non-Medicaid, state-designed programs in sixteen states, and for combination programs in nineteen states.

In both Medicaid expansions and non-Medicaid SCHIP plans, states may cover uninsured children and adolescents who are younger than age nineteen and who live in families with incomes up to either 200 percent FPL or a higher level. This expanded cover-
age occurs in states that, prior to SCHIP, had raised their maximum Medicaid eligibility level above 150 percent of the FPL.\(^{184}\)

The combined effect of states’ implementation of the Medicaid expansions enacted by Congress during the early 1990s and the SCHIP program enacted in 1997 has been, on paper, to significantly expand health insurance for low-income adolescents. By February 2001, forty-five states including the District of Columbia had exceeded the federal phase-in requirement by age and/or income for Medicaid coverage of adolescents,\(^{185}\) whereas prior to the enactment of SCHIP, only twenty-one states had done so.\(^{186}\) This occurred in part because SCHIP provided a financial incentive for states to “accelerate” the mandatory Medicaid phase-in of adolescents with family incomes at or below 100 percent FPL by allowing them to do so immediately and then claim the enhanced SCHIP matching rate.\(^{187}\)

Additional states used SCHIP funds to raise eligibility for adolescents through a non-Medicaid, state-designed SCHIP program. The combined effect of the Medicaid and non-Medicaid, state-designed SCHIP programs is encouraging. By February 2001, for children ages six through eighteen, twelve states had set a maximum family income level that was less than 200 percent of the FPL.\(^{188}\) In thirty-two states, including the District of Columbia, the maximum family income level was between 200 and 300 percent of the FPL; and in seven states, the maximum family income level was equal to or greater than 300 percent of the FPL.\(^{189}\)

D. Ensuring Appropriate and Comprehensive Benefits

The Medicaid benefit package is among the broadest, if not the broadest, of any public or private insurance package. In particular, it includes coverage both for preventive services and for “wrap around” services and ancillary therapies needed by adolescents with a chronic illness or disability.

As with eligibility, the federal government determines a basic framework of mandatory and optional Medicaid benefits. However, the entire set of mandatory and optional Medicaid benefits must be available to eligible children and adolescents under age twenty-one if they are determined to be medically necessary. Changes enacted by Congress in 1989 to Medicaid’s EPSDT program require states to provide “necessary health care, diagnostic service, treatment, and other measures described [in the Medicaid Act] to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services.”\(^{190}\) This requirement (sometimes referred to as the “T” in EPSDT) is not only widely misunderstood but also has been the source of considerable controversy and even opposition from states with concerns—realistic or otherwise—about the potential impact on state budgets.\(^{191}\) The breadth of the Medicaid benefit package, combined with the fact that Medicaid is an entitlement program for its beneficiaries, means that it has the potential to meet adolescents’ needs more fully than some other public and private insurance plans.

SCHIP varies from Medicaid in that, by federal statute, the non-Medicaid component of the program is not an entitlement for eligible children and adolescents,\(^{192}\) although states are free to create an entitlement to services within their state-designed programs.\(^{193}\) In a non-Medicaid, state-designed SCHIP program, the scope of benefits is determined by the state within very broad federal parameters.\(^{194}\) States do have the option of offering a very generous package of benefits, as generous as the Medicaid program.\(^{195}\) Virtually every state opted to offer a benefit package that goes well beyond the minimum. In fact, some states offer a “Medicaid look-alike” package or include an expanded benefit package for children and adolescents with a chronic illness or disability.\(^{196}\) However, some


\(^{186}\) English et al., MEDICAID AND CHIP, supra note 16, at 48.

\(^{187}\) English et al., MEDICAID AND CHIP, supra note 16, at 48.


\(^{189}\) AAP GUIDELINES, supra note 166.

\(^{190}\) Id.


\(^{193}\) See Rossbraugh, supra note 98.

\(^{194}\) See English et al., MEDICAID AND CHIP, supra note 16, at 65.

\(^{195}\) See English et al., MEDICAID AND CHIP, supra note 16, at 65.

\(^{196}\) See English et al., MEDICAID AND CHIP, supra note 16, at 65 ( tbl. 15).

\(^{197}\) See English et al., MEDICAID AND CHIP, supra note 16, at 70.
non-Medicaid, state-designed SCHIP programs have failed to provide some benefits that are important for adolescents.283

E. Managing with Managed Care

The advent of managed care in both the private and public sectors has brought about extraordinary changes in the financing and delivery of health care to all age groups, including adolescents.284 In Medicaid, while enrollment of beneficiaries in managed care has occurred for more than two decades, the pace of this process has accelerated dramatically in the past ten years.285 Not only have states continued to enroll Medicaid beneficiaries in managed care plans on a voluntary basis, they also seek federal waivers under Section 1115 and Section 1915 of the Social Security Act to allow them to mandate beneficiaries enrollment in managed care arrangements that limit their freedom of choice of provider.286 Many states also choose to use managed care arrangements including risk-based capitated plans to deliver the services to SCHIP enrollees.287

Managed care enrollment has considerable significance for many aspects of the financing of adolescents’ health care, but it has particularly strong implications for inclusion and participation of health care providers with interest, training, and experience in serving the adolescent age group.288 Many adolescent-oriented providers work in traditional settings such as private physicians’ offices and


284 See, e.g., SAM Managed Care Background Papers, supra note 26.


288 Managed care has had an impact on many other aspects of adolescents’ care, although extensive documentation of the effects is not readily available at this time. Other important issues include: coverage of specific benefits such as reproductive health services; the bifurcation of physical and mental health services into separate plans in a number of Medicaid programs and managed care organizations. See Robert Lapin et al., Reproductive Health: A State-by-State Examination of Family Planning Under Medicaid Managed Care (2000); U.S. General Accounting Office, Medicaid Care, Four States’ Experiences with Mental Health Care Out Programs (1999) (GAO/HEHS-99-118). The carve-out of behavioral health programs is most problematic in respect to treatment of problems common to adolescents, such as eating disorders, which

require care from a multi-disciplinary team that cuts across the divisions between physical and mental health treatment. See Fisher, supra note 9.

289 See, e.g., Children Now, Partners in Transition: Adolescents in Managed Care (2000).

290 See, e.g., Kline et al., supra note 70.

291 See, e.g., Christel Breloch et al., School-Based Primary Care in a Managed Care Environment: Options and Issues, 7 ADOLESCENT MEDICINE: STATE OF THE ART REVIEWS 197 (1996).

292 A Survey of Adolescent Health Experts: Managed Care Issues, in Adolescent Health Care in Transition: Medicaid, Managed Care, and Health Care Reform (Abigail English et al. eds. forthcoming 2001) [hereinafter Survey of Experts].


294 Breloch et al., supra note 206.
providers is the level of payment they receive. Two recent reports, one on capitation rates in Medicaid managed care and the other on Medicaid reimbursement rates, contain significant information, although further research and analysis is needed to fully understand the implications of this information for the providers who care for adolescents.

The average fee-for-service Medicaid reimbursement rates for certain services that are commonly provided to adolescents appear to be low. The information about capitation rates in Medicaid managed care is not as readily available for the adolescent age group specifically; however, the rates do vary by age group and by state. Without further information and research it is not possible to draw firm conclusions about whether current rates are too high or low, or about their impact on access, but widespread anecdotal evidence suggests that this is an important area for further study.

V. ADOLESCENT HEALTH IN THE NEW CENTURY: CHALLENGES FOR THE FUTURE

As we move into the new century, major challenges confront us with respect to each of the essential elements that must be in place to assure adolescents’ access to health care. At minimum, these challenges include: ensuring the accessibility of providers with the training, experience, and interest in caring for this age group; providing an opportunity for adolescents’ individual needs to be accurately assessed and identified; maintaining the protection of confidentiality; and assuring the availability of a source of financing for the comprehensive range of necessary services.

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212 For example, the average rate nationally for a thirty minute counseling visit is $37.07 dollars, for an EPSDT preventive visit for an established patient age twelve through seventeen is $47.01 dollars, and for Hepatitis B immunization for an adolescent over age eleven is $37.74 dollars (with at least one-third of states not providing the vaccines through a state-purchasing program). Id. at 5, 6, 11.

213 For 1998, the average statewide adjusted per-member-per-month Medicaid managed care rate, which varied among states, fell between $22.75 and $22.92 dollars. Holahan et al., supra note 210, at 221 (no. 7).

214 CHILDREN NOW, supra note 204, at 31.
B. Assessing Adolescents’ Individual Needs

Our ability to assess and identify adolescents’ individual needs accurately has been informed and improved over the past half century and particularly over the past decade. The training of a cadre of adolescent health care professionals, with their ability to conduct research and inform clinical practice, has helped to sharpen and hone the capacity of the health care system overall to address adolescents’ needs appropriately. Moreover, laws and policies are beginning to be put in place that support the professional consensus that exists regarding what needs to be done to accurately assess and identify adolescents’ needs and prevent future health problems.

Several features of the current health care system threaten this important goal. They include: (1) lack of full implementation of the participation and screening requirements of EPDD for adolescents;220 (2) failure to include, or maintain, enough adolescent-specific performance measures in the quality assessment and monitoring tools used for managed care plans and individual providers;221 (3) insufficient enforcement or oversight by public and private purchasers of the provisions in their managed care contracts that require coverage of annual (or periodic) well-adolescent exams;222 (4) lack of training for health care providers and managed care plans regarding the needs of adolescents and the appropriate clinical methods for identifying those needs;223 and (5) inadequate reimbursement of adolescent health care professionals for the time needed to complete a comprehensive health assessment.224

A renewed commitment to the importance of prevention and comprehensive services for adolescents is needed in order to promote full implementation as well as expansion of the laws and policies already in place that support them.

C. Protecting Confidentiality

Few issues in adolescent health care have been the subject of as much consensus or of as much controversy as the confidentiality of adolescents’ care. Experts in adolescent medicine and adolescent health care agree that the ability to provide confidential care is one of the cornerstones of the field. Adolescents’ need for confidentiality has also been reflected in state and federal law: the state minor consent statutes; the confidentiality protections in programs like the Title X family planning program; and the recognition by the courts of the privacy rights of minors.

Numerous threats have already arisen to the continuation of the existing legal framework that makes possible confidentiality in adolescent health care. These include: (1) continuing efforts to require parental notification or consent in Title X-funded or other family planning clinics;225 (2) intensification of efforts to prevent minors from obtaining abortions without parental consent or notification;226 (3) focus on the schools and school-based health centers as a target for limiting minors’ access to confidential care;227 (4) efforts to repeal state minor consent statutes in whole or in part;228 and (5)

\[\text{See, e.g., } \text{AARP MEDICAID REIMBURSEMENT SURVEY, supra note 211, at 5-6; CHILDREN NOW, supra note 204, at 31; SAM Managed Care Background Paper, supra note 26, at 207.}\]

\[\text{See supra notes 50-91, and accompanying text.}\]

\[\text{For example, efforts have been made to amend state constitutions for the purpose of overturning state court decisions that have held unconstitutional parental consent or notification requirements for minors’ seeking abortions. See, e.g., Planned Parenthood of Cent. N.Y. v. Farmer, 762 A.2d 620 (N.J. 2000); Am. Acad. of Pediatrics v. Largent, 16 Cal. 3d 307 (4th Ct. 1977); Author's telephone interview with Margaret C. Crosby, Staff Counsel with the ACLU Foundation of Northern California (May 9, 2001).}\]

\[\text{See, e.g., Alan Guttmacher Institute, School-Based Health Centers and the Birth Control Debate (2009); H.R. 1203, General Assembly Sess., H. 1 (N.C. 2001) (prohibiting school districts from providing or contracting for psychological or reproductive health services to students and from referring student for such services without prior written parental consent).}\]

\[\text{See, e.g., H.B. 1336, General Assembly Sess. (N.C. 2001) (requiring physicians to notify parents within twenty-four hours after treating a minor for venereal disease, pregnancy, substance abuse, or emotional disturbance); S.B. 562, Reg. Sess. ( Ala. 1998) (which would}\]
possible repeal or modification of the confidentiality protection for minors included in the federal medical privacy regulations that recently took effect.220

In addressing the laws and policies related to confidentiality in adolescent health care, debate should focus less on viewing minors’ rights as being in conflict with the rights of parents and more on understanding how the pressing health care needs of adolescents can best be met.

D. Assuring an Available Source of Financing

Never has the need for a source of financing for the health care of adolescents been more urgent than it is today. Health care is more expensive than ever: few families and even fewer adolescents can afford to pay out-of-pocket for all the health care they need. Between the categorical health programs that have been developing over several decades, and the publicly-funded health insurance programs that have increased the percentage of adolescents who are eligible for coverage, the potential exists for paying for a significant proportion of the care needed by most adolescents.

Conclusion

Over the past fifty years, laws and policies in the United States have evolved in a way that has made it more likely for adolescents to be able to obtain the health care they need. This has occurred

taining Medicaid Spending, supra note 192, at 1490 (discussing the imprecision of Medicaid becoming a block grant program).

223 By September 30, 2000, the date by which states were required to have spent their FY 1998 SCHIP allotments, only ten states had met the deadline, a pattern that could lead Congress to reauthorize the amount of federal funds appropriated for SCHIP. Robert Pezz, 40 States Forfeit Health Care Funds for Poor Children, N.Y. Times, Sept. 24, 2000.

224 Mental health needs are among the most pressing unmet health needs for adolescents. See ELLIS ET AL., MEDICAID AND CHIP, supra note 16, at 69. This problem is exacerbated by the lack of parity in health insurance coverage between coverage for physical illness and coverage for mental illness. On March 15, 2001, Senators Domenici and Wellstone introduced “A bill to provide for equal coverage of mental health benefits with respect to health insurance coverage unless comparable limitations are imposed on medical and surgical benefits.” S. 543, 107th Cong. 1st Sess. (2001). See also American Psychiatric Association, State of the States: Parity Laws (Sept. 2000), at http://www.psych.org/pub/pol_adv/ stateparity/2000/dm (last visited May 13, 2001).

225 See, e.g., DiLiddo, supra note 135, at 8 (discussing such challenges for the Title X program).

against a backdrop of increased understanding of adolescence as a distinct period of human development, establishment of adolescent medicine within the health care professions, and growing knowledge about the health status and health care needs of adolescents. Legal and policy changes have helped, to a greater or lesser degree, to establish an infrastructure of providers with the training, experience, and interest in caring for adolescents; to provide opportunities for the health care needs of individual adolescents to be assessed and identified; to allow adolescents to receive confidential health care; and to make available a source of financing for the care adolescents need. These are the minimum elements necessary for adolescents health care needs to be met, but they are within our grasp. For them to be in place for all adolescents, however, it will be necessary for the legal and policy changes that have supported these elements to be maintained and for law and policy to continue evolving in a similar direction. This will only occur if numerous challenges on the horizon can be overcome.

INTRODUCTION

On April 17, 2001, Colorado Governor Bill Owens signed a law that prohibits rebirthing. The rebirthing procedure, which simulates emergence from the womb, was fatally employed by two psychologists treating a ten-year-old girl with reactive attachment disorder: the child apparently had difficulty forming a loving bond with her adoptive mother. Commenting on the case, Dr. Arthur Caplan suggested the futility of legislating against health care treatments because enforcement can be impossible. According to Caplan:

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"CAM is an abbreviation for complementary and alternative medicine."

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"Janowsky, supra note 1."

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