Adolescent Care Standards Provide Guidance for State CHIP Programs

Although widely thought of as a health insurance program for younger children, the State Children's Health Insurance Program (CHIP) also has enormous potential to expand insurance coverage, including coverage of reproductive health guidance and services, to millions of uninsured teenagers. The extent to which CHIP meets this potential will largely be determined by the individual states, which have considerable discretion in designing their own efforts and benefit packages. For guidance in making critical coverage decisions, states can look to several comprehensive guidelines for adolescent health care, including reproductive health services, developed in recent years.

By Rachel Benson Gold

Congress established the State Children's Health Insurance Program (CHIP) in 1997 in response to data indicating that there were over 10 million uninsured children in the United States that year—including 2.7 million teenagers between the ages of 13 and 18 (1.3 million females and 1.4 million males). With nearly $40 billion in federal funds available to them over 10 years, the states are charged with establishing CHIP programs, which may enroll children under age 19 in families with incomes up to 200% of the federal poverty level. The Health Care Financing Administration (HCFA), the federal agency that administers CHIP, reports that two million children were enrolled nationwide as of September 30, 1999.

According to the federal CHIP statute, a state may design its CHIP program in one of three ways: by expanding its Medicaid program, by creating or expanding a state-designed program not based on Medicaid or by using a combination of the two approaches ("The New Children's Health Insurance Program," *TGR,* April 1998, page 6). A 1999 review by The Alan Guttmacher Institute (AGI) of the initial state plans submitted to HCFA found that 21 states and the District of Columbia had opted to expand their Medicaid program, 16 states were developing an entirely separate program, and 13 states intended to take a combination approach ("State CHIP Programs Up and Running, but Enrollment Lagging," *TGR,* October 1999, page 6).

In the states choosing to expand their Medicaid program, CHIP enrollees are regular Medicaid enrollees; as such, they are entitled to the full range of Medicaid-covered services, including routine gynecologic examinations, Pap tests, diagnosis and treatment of sexually transmitted diseases (STDs) as well as family planning services and supplies. (The federal Medicaid statute specifically mandates coverage of family planning services for "minors who can be considered to be sexually active.")

In contrast, the states choosing to design programs of their own have wide latitude in crafting a benefit package. The CHIP statute itself requires coverage of only such basic services as physician and hospital care, laboratory and X-ray services, well-child care and immunizations. According to the AGI review, of the 29 approved state plans that had some state-designed component, 16 specifically indicated that family planning services and supplies would be covered, while most of the remaining plans indicated that the general category "prenatal care and prepregnancy family planning services" would be covered.

Teens' Reproductive Health Needs

Teens need a range of educational and medical services related to reproductive health. Half of all U.S. teens are sexually experienced. While sexual activity is rare among younger teens, it is common in the later teenage years; by age 19, over three-fourths of females and 85% of males have had intercourse. Yet, teens are less likely than older women to report consistent use of effective contraceptive methods. In addition, sexually active teens younger than 18 are less likely to use any method of contraception, compared with older women.

Contraceptive use is critical for sexually active teens to avoid unintended pregnancy and to protect themselves against STDs. A sexually active teenager who does not practice contraception has a 90% chance of becoming pregnant within one year. In fact, every year, some 900,000 American teens between the ages of 15 and 19 become pregnant, giving the United States one of the highest teenage pregnancy rates in the developed world.

The United States also has among the highest teen STD rates in the developed world. Each year, three million teens—about one in four sexually experienced teens—acquire an STD, which can compromise their ability to have children later in life or lead to life-threatening health problems, such as cancer or HIV infection. For example, recent studies indicate that up to 10–30% of sexually active teenage women tested for STDs are

infected with chlamydia, which, if left untreated, can lead to pelvic inflammatory disease, ectopic pregnancy and infertility. Additionally, teens have higher rates of gonorrhea than women older than 20, and some studies have found that up to 15% of sexually active teenage women are infected with human papillomavirus (HPV), many with a strain of the virus linked to cervical cancer.

Nonetheless, there are some disturbing indications that teenagers may not always be getting the full range of reproductive health care services they need. According to a study in the July 1999 issue of *Pediatrics,* only half of all physicians reported that they provided any counseling or education in their encounters with adolescents; fewer than 3% reported providing counseling or education on STDs or HIV. According to the 1997 Common-wealth Fund Survey of the Health of Adolescent Girls, only 15% of adolescent boys and 26% of adolescent girls reported that their provider had discussed pregnancy prevention with them. Similarly, only 24% of boys and 28% of girls reported that their doctor had discussed how to prevent STDs or HIV. And a study in the December 15, 1999, *Journal of the American Medical Association* reported that adolescents who are sexually active are more likely than other teens to forgo important health care, such as an annual physical exam. The study found that 25% of sexually active teens had forgone care, compared with only 15% of teens who are not sexually active.

Care Guidelines Remarkably Consistent

For guidance in making important decisions about the coverage for adolescents in their CHIP program, state policymakers may look to several widely accepted guidelines of care for preventive services to teens that have been developed by major health organizations. The three most comprehensive efforts are *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents,* which was sponsored by the Department of Health and Human Services; *Guidelines for Adolescent Preventive Services (GAPS),* which was developed by the American Medical Association; and *Primary and Preventive Health Care for Female Adolescents,* which was published by the American College of Obstetricians and Gynecologists (ACOG). These national guidelines strongly emphasize that comprehensive reproductive health services for teens, including both health guidance and medical care, are an integral component of preventive health services for this population. In fact, despite subtle differences, these recommendations, which are summarized below, are remarkably consistent (see table).

• *Routine, preventive service visits*

Routine visits are the mainstay of comprehensive and coordinated preventive care for teens. *Health Care for Female Adolescents* recommends that the initial visit for health guidance, screening and preventive care take place between the ages of 13 and 15. This initial visit should be followed by annual preventive health visits. The American Medical Association's *GAPS* recommends that all teens between the ages of 11 and 21 receive annual, routine visits, including three complete physical examinations—one each during early (11–14), middle (15–17) and late (18–21) adolescence.

All three sets of guidelines stress the importance of integrating medical care with education and counseling on responsible sexual decision-making. Annual preventive visits that promote routine and predictable screening, counseling and intervention are vital to this integrated approach. Since participation in risky behaviors can begin at any age, regular visits provide the opportunity to identify teens who have recently initiated, or are considering engaging in, such behaviors. They also offer an opportunity to identify teens who have recently become sexually active and to provide them with information concerning unintended pregnancy and STD prevention.

The various guidelines recommend that all teens should be screened during routine, preventive visits to determine their sexual history and practices. A comprehensive sexual history can be used to identify risk and evaluate the need for services as well as additional counseling and education. *GAPS* recommends that sexually active teens be asked about "their use and motivation to use condoms and contraceptive methods, their sexual orientation, the number of sexual partners they have had in the past six months, if they exchanged sex for money or drugs, and their history of prior pregnancy or STDs. Adolescents at risk for pregnancy, STDs (including HIV), or sexual exploitation should be counseled on how to reduce this risk." *GAPS* adds that both teens and their parents and other adult caregivers should receive guidance on the use of "tobacco products, alcohol and other drugs" in conjunction with sexual activity.

• *Cancer screening*

The guidelines all recommend that sexually active female teens receive a Pap test annually to screen for cervical cancer. In addition, *GAPS* and *Health Care for Female Adolescents* recommend that females 18 or older receive annual Pap tests, regardless of whether they are sexually active.

Bright Futures also recommends that instruction in breast and testicular self-examination be a part of routine physical examinations; the other practice guidelines do not address the issue.

• *STD/HIV screening*

The various guidelines also recommend that all sexually active teens be screened for gonorrhea and chlamydia.

Major Guidelines for Reproductive Health Services to Teenagers

Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents was developed by a special commission and a set of expert panels sponsored by the Health Resources and Services Administration and the Health Care Financing Administration of the Department of Health and Human Services. The second edition of the report, released in 2000, includes recommendations for preventive services from infancy through adolescence.

Guidelines for Adolescent Preventive Services (GAPS) was developed by the American Medical Association and released in 1992. *GAPS* was written with the assistance of a national scientific advisory board, which consisted of experts in medicine, social and behavioral science and health insurance.

Primary and Preventive Health Care for Female Adolescents was released by the American College of Obstetricians and Gynecologists (ACOG) in November 1999. The guidelines were developed under the direction of the Committee on Adolescent Health Care and were based in part on the American Medical Association's *GAPS,* which itself was developed with representation from ACOG.

	BRIGHT FUTURES: GUIDELINES FOR HEALTH SUPERVISION OF INFANTS, CHILDREN, AND ADOLESCENTS	GUIDELINES FOR ADOLESCENT PREVENTIVE SERVICES (GAPS)	PRIMARY AND PREVENTIVE HEALTH CARE FOR FEMALE ADOLESCENTS
Developed by	Department of Health and Human Services	American Medical Association	American College of Obstetricians and Gynecologists
Target Ages	11–21 years	11–21 years	13–20 years
Periodicity of Visits	Annual	Annual	Annual
Suggested Components of Health Guidance			
Sexual Development	X	X	X
Breast/Testicular Self-Exam	X		
Unintended Pregnancy Prevention	X	X	X
STD Prevention	X	X	X
Screening/Tests			
Pap Test	Sexually active teens, annually	Sexually active or age 18, annually	Sexually active teens or age 18, annually
STD Screening			
Gonorrhea	Sexually active teens, annually	Sexually active teens*	Sexually active teens, annually
Chlamydia	Sexually active teens, annually	Sexually active teens*	Sexually active teens, annually
Syphilis	High-risk teens	High-risk teens	High-risk teens
Human Papillomavirus	Sexually active teens, annually	Sexually active teens*	Sexually active teens, annually
HIV	High-risk teens	High-risk teens	High-risk teens

*Frequency of screening depends on the individual's sexual practices and history of STDs. *Note:* High risk is generally defined as a history of STDs, multiple sexual partners, having had a sexual partner who is at risk of STDs, history of having sex in exchange for money or drugs. Most of the standards also include living in a geographic area with a high incidence of syphilis as a risk factor for syphilis and a history of intravenous drug use or having had a blood transfusion before 1985 as a risk factor for HIV.

Health Care for Female Adolescents and *Bright Futures* recommend that these tests be performed annually, while *GAPS* suggests that the frequency of the screening should depend on the individual's sexual history.

For teens at risk for HIV, the guidelines recommend that testing be confidential and that it occur only after the teen gives informed consent and in conjunction with pretest and posttest counseling.

GAPS makes additional recommendations regarding follow-up for positive STD tests: Positive results should be followed by additional tests, as appropriate to make a definitive diagnosis, and a treatment plan should be instituted and the use of condoms encouraged.

• *Health guidance on sexual development*
The guidelines all recommend that as a part of routine health visits, teens receive health guidance—information, counseling and anticipatory guidance—about puberty and sexual development. In the context of health guidance on sexual development, *Bright Futures* suggests that health professionals ask young adolescents such questions as "Has anyone talked with you about what to expect as your body develops? Do you think you are developing pretty much like the rest of your friends? Have you started your period? Is it regular?" Health professionals can use the answers to these queries to provide information and counseling about sexual development appropriate to the individual patient.

Both *Health Care for Female Adolescents* and *GAPS* additionally recommend that parents or other adult caregivers be given periodic guidance regarding sexual development.

• *Health guidance on responsible sexual behavior and decision-making*
The various guidelines recommend that all teens receive information and counseling—as part of routine, preventive service visits—about sexual decision-making, including information about abstinence, contraceptive methods, and STD transmission and prevention. According to all the major guidelines, teens should be given information on the importance of pregnancy and STD prevention, the role of abstinence as an effective way to prevent unintended pregnancy and STDs, ways to prevent HIV transmission and basic facts about protection from sexual exploitation. Adolescents should also be given counseling to reinforce responsible sexual behavior, both among those who are not currently sexually active and among those using birth control and condoms effectively.

Health Care for Female Adolescents specifically urges that teens be informed that the most effective protection against unintended pregnancy and STDs, other than abstinence, is a combination of latex condoms and hormonal methods of contraception. *GAPS* recommends that all adolescents should receive annual counseling on responsible sexual behaviors, including abstinence. "Latex condoms to prevent STDs, including HIV infection, and appropriate methods of birth control should be made available, as should instructions on how to use them effectively."

Health Care for Female Adolescents specifically recommends that teens be counseled about emergency contraception.

Bright Futures suggests that health professionals question teens about the information they have learned from their family, friends, school and other sources, and supplement that information in the course of responding to their specific questions, problems or concerns. *Bright Futures* also suggests that the handouts that health professionals give adolescents to review at home should include, among other things, statements such as "Recognize that sexual feelings are normal, but having sex should be a well-thought-out decision. Delay having sex until you are mature enough to assume responsibility for sexual relations. If you are sexually active, discuss contraceptive methods and STD prevention with the health professional and your partner. Learn about and practice safer sex."

The Critical Role of Confidentiality

While routine guidance and care may play a vital role in preventing myriad serious health and social consequences, teens face substantial barriers to accessing care, including, among other things, deep-seated concerns about confidentiality. These concerns may prevent teens from seeking care in a timely fashion, or at all. As a result, the various guidelines stress the importance of confidentiality as a basic underpinning of the relationship between teenage patients and their health care providers. For some long-standing patients, this can mean recasting an ongoing relationship that had included parents as equal partners. For newer patients, it may mean developing a relationship that is built from the start on the premise of confidentiality. According to the various guidelines, health professionals should establish office policies regarding confidential care for teenagers, and both teens and their parents should be informed of these policies from the outset. According to *Health Care for Female Adolescents,* confidentiality is frequently identified as a major obstacle to the delivery of care to teens. As a result, the guidelines recommend that rather than wait until a problem arises, physicians should initiate discussion of the subject with both the teenager and her parents, and at the same time stress the importance of open communication among all parties.

The research on which this article is based was supported in part by a grant from The Annie E. Casey Foundation. The conclusions and opinions expressed in this article, however, are those of the author and The Alan Guttmacher Institute.