

A Crisis in Coverage

Falling Adolescent Health Insurance: Its Impact on Youth and Their Health Care Providers

Health insurance coverage, both public and private, has a profound influence on the ability of adolescents to obtain the health care they need. In New York State, the proportion of adolescents, particularly older adolescents aged 15-21, with no health insurance has continued to rise for more than a decade. Since older adolescents comprise a growing share of the uninsured, health care facilities that provide services to this population are experiencing the health care crisis far more intensely than those that serve other age groups.

A combination of declining private insurance, falling Medicaid coverage and rising Medicaid churning, as well as the shift towards managed care, have sharply reduced reimbursement for adolescent health care services, making it increasingly difficult for health care providers to deliver primary, preventive and reproductive care to the growing numbers of uninsured patients who seek their services. Many facilities have cut back services to the uninsured or closed their doors altogether. The result is that the remaining institutions that do continue to serve the uninsured experience an ever more rapid growth in their uninsured caseloads. Ultimately, without additional public funding to cover the growing costs of the uninsured, these trends inevitably lead to either cuts in the quality of care or the denial of care to older adolescents that are likely to need it most.

The rising rates of uninsurance among patients attending the Mount Sinai Adolescent Health Center, which serves a primarily low income population of inner-city adolescents, provides a clear example of the pressures that declining rates of health care coverage have created for providers of adolescent services.

But the decline in access to adolescent specific services and rising uninsurance among older adolescents has far broader repercussions on the health care system. When older adolescents are denied access to primary, preventive and/or reproductive care, they often end up as uninsured patients in emergency departments, where they comprise a growing share of uninsured patients. The rate of emergency department use among older adolescents is far higher than for the population as a whole. And since emergency department care is sporadic and has little follow-up, many adolescents who lack access to primary and reproductive care end up hospitalized for preventable ailments. Since 1994, the rate of uninsurance among hospitalized adolescents in New York State has increased, particularly within NYC.

Though rising rates of uninsurance in New York State reflect broader national trends, the ballooning share of adolescents with no health insurance coverage in the region is growing more rapidly than elsewhere in the country.

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When older adolescent populations (ages 15-21) are denied access to confidential comprehensive health care, there are inevitable health consequences, such as high prevalence of unintended teen pregnancy and sexually transmitted diseases. While public policy debate regarding poor teen health outcomes typically revolves around issues of declining morality and a loss of family values, evidence clearly shows that they are more closely linked to adolescent access to care. When adolescent populations have access to high quality adolescent specific care and support services, they lead healthier and more productive lives¹.

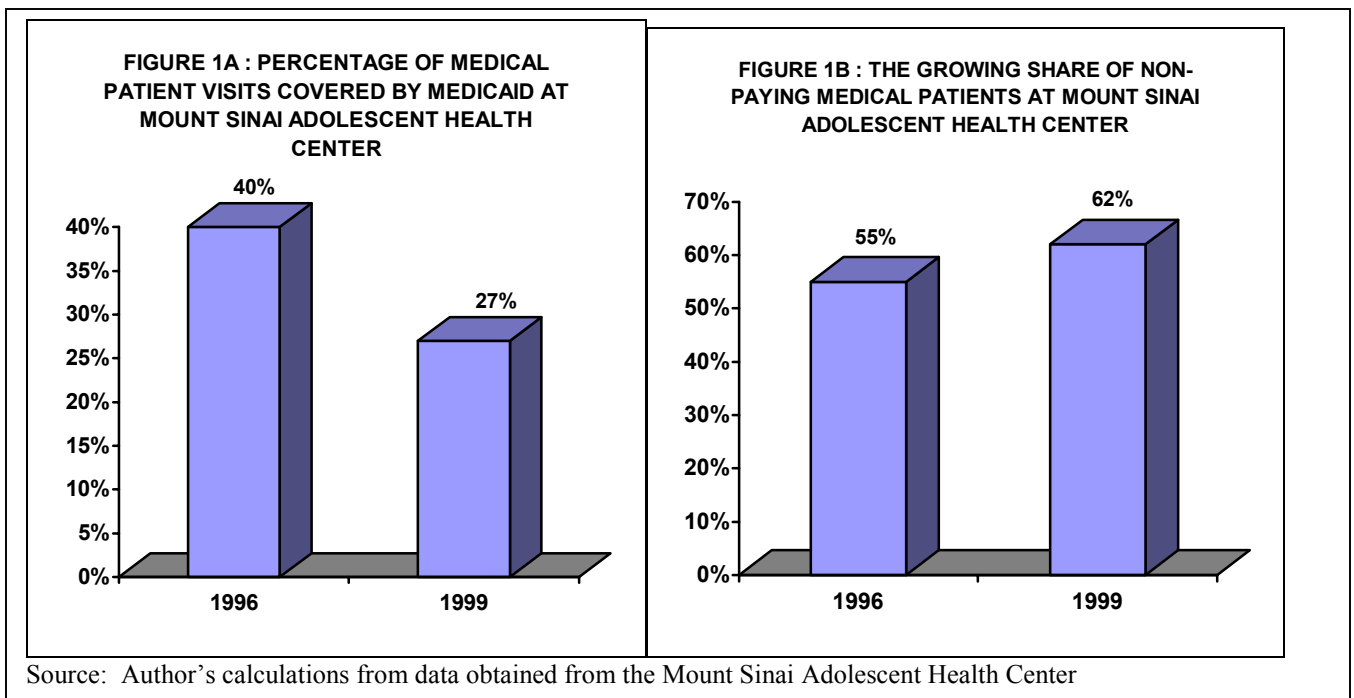
Unfortunately, high levels of uninsurance and other barriers to care mean that much of the care that adults often take for granted is unavailable to adolescents. In fact, the lack of access to health care has reached crisis level for older adolescents in New York State, particularly in New York City.

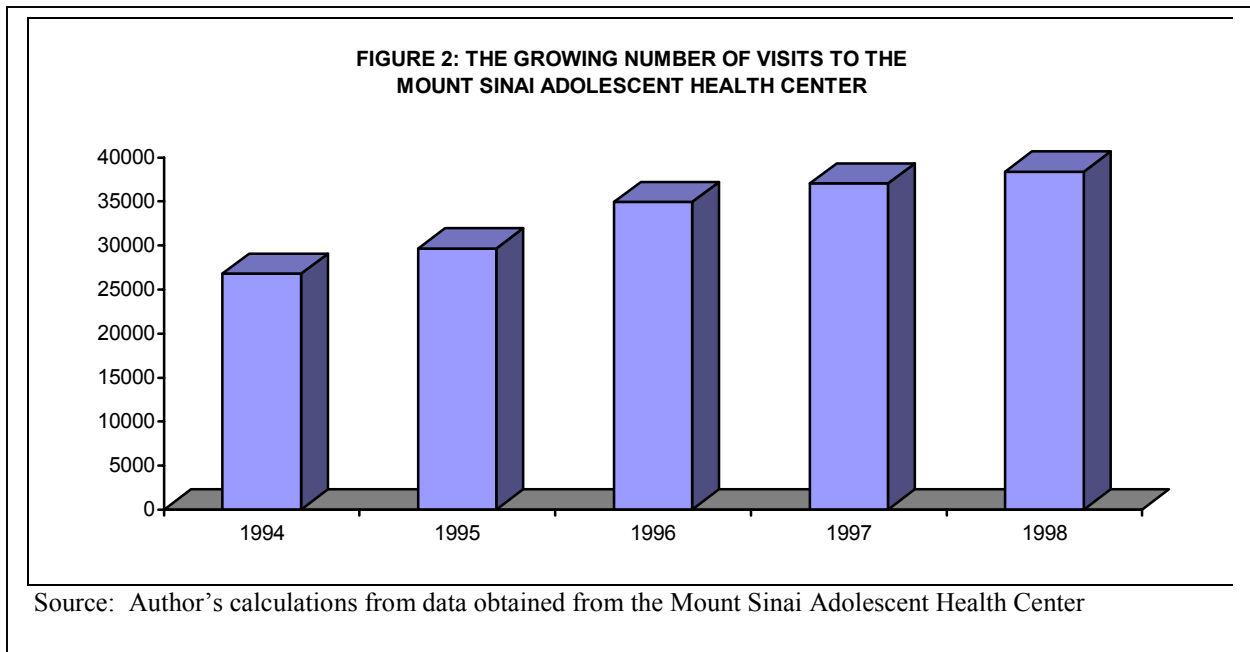
This report presents new

evidence demonstrating a growing lack of health care coverage, or uninsurance, among adolescents seeking services at health care facilities in the United States and New York. It also attempts to explain these trends by exploring changes in rates of health insurance coverage across all adolescents in the general population. Documentation of rising uninsurance among adolescents in the United States and New York State/City, as well as their declining access to private health insurance and falling Medicaid enrollments, is provided.

I DECLINING REIMBURSEMENT FOR ADOLESCENT PRIMARY, PREVENTIVE, & REPRODUCTIVE CARE

At the Mount Sinai Adolescent Health Center, where over 90% of patients are adolescents between the ages of 15 and 21, there has been a decline in the percentage of medical visits covered by Medicaid from 40% to 27% between 1996 and the year 1999.

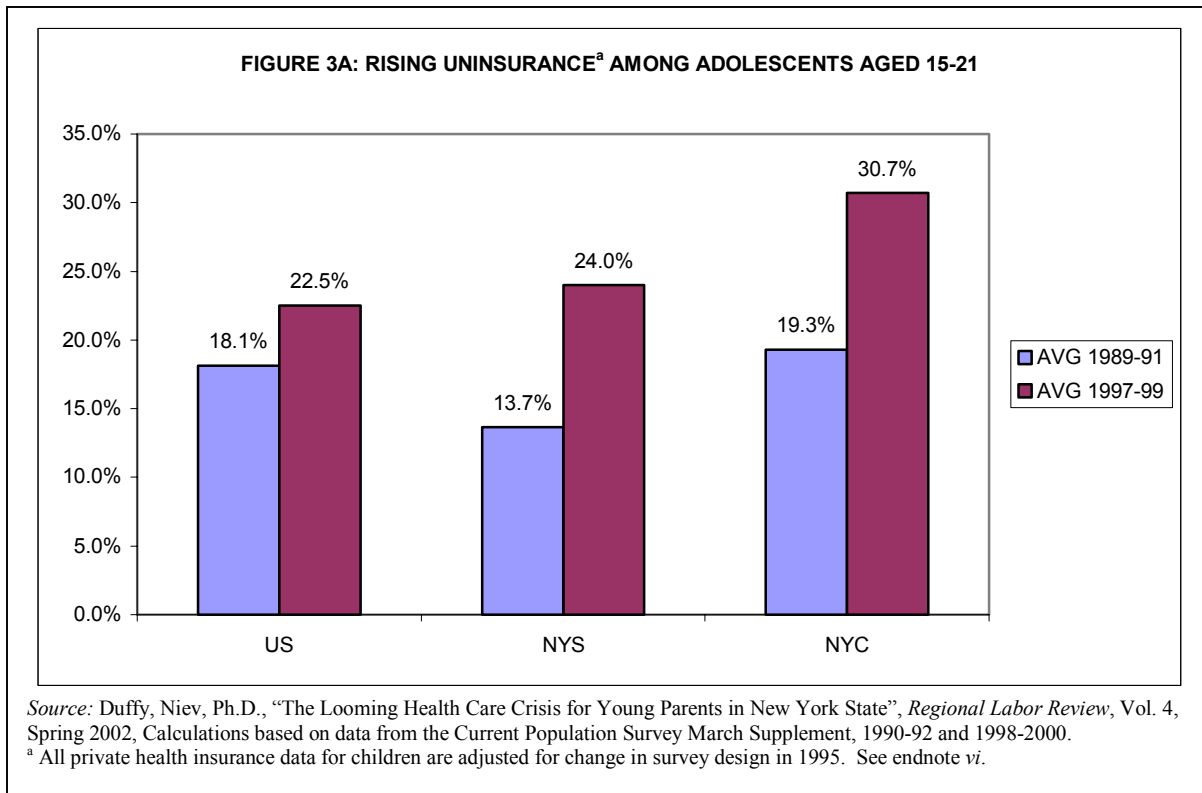




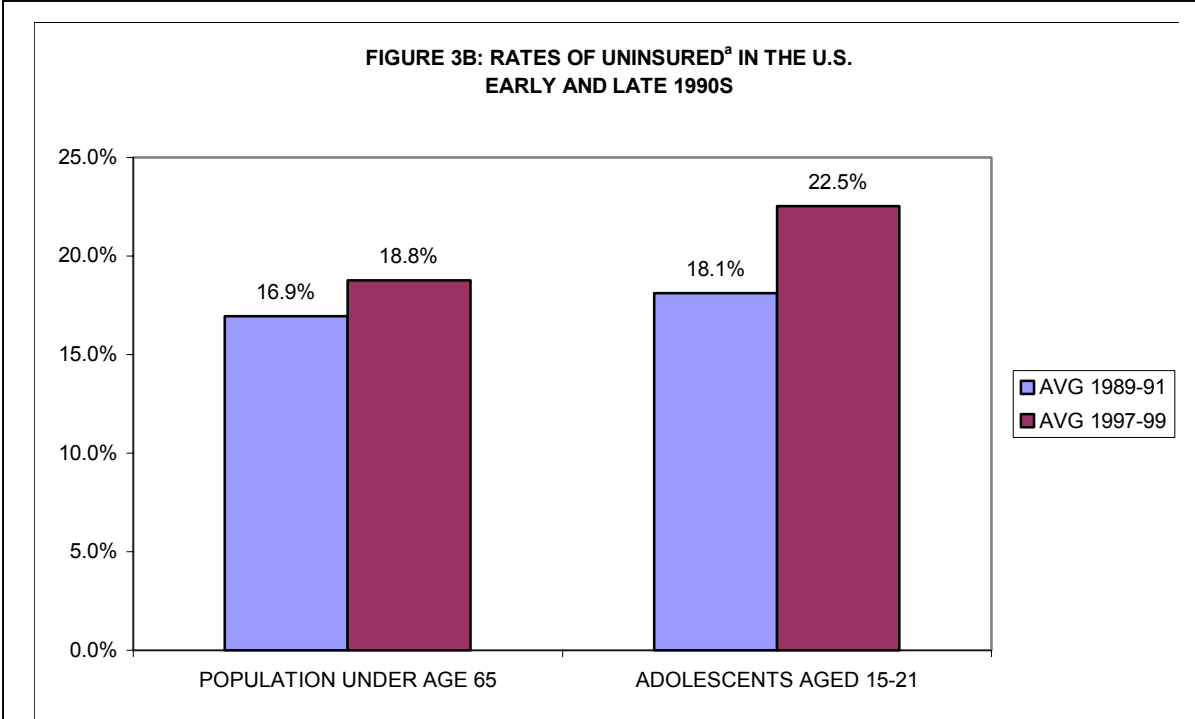
The decline has been accompanied by a rise in “self-pay” visits from 55% to 62%, for which the Center receives no reimbursement (See **Figures 1A and B**).

At the same time, the demand for all services at the Center is increasing, possibly because young people that have been dropped from the Medicaid rolls or

lost their private health insurance coverage are now being denied access to services elsewhere. Between 1994 and 1998, the number of visits to the Adolescent Health Center grew by 43%, and to date, the growing cost of non-billable visits has been absorbed by the Center (See **Figure 2**).

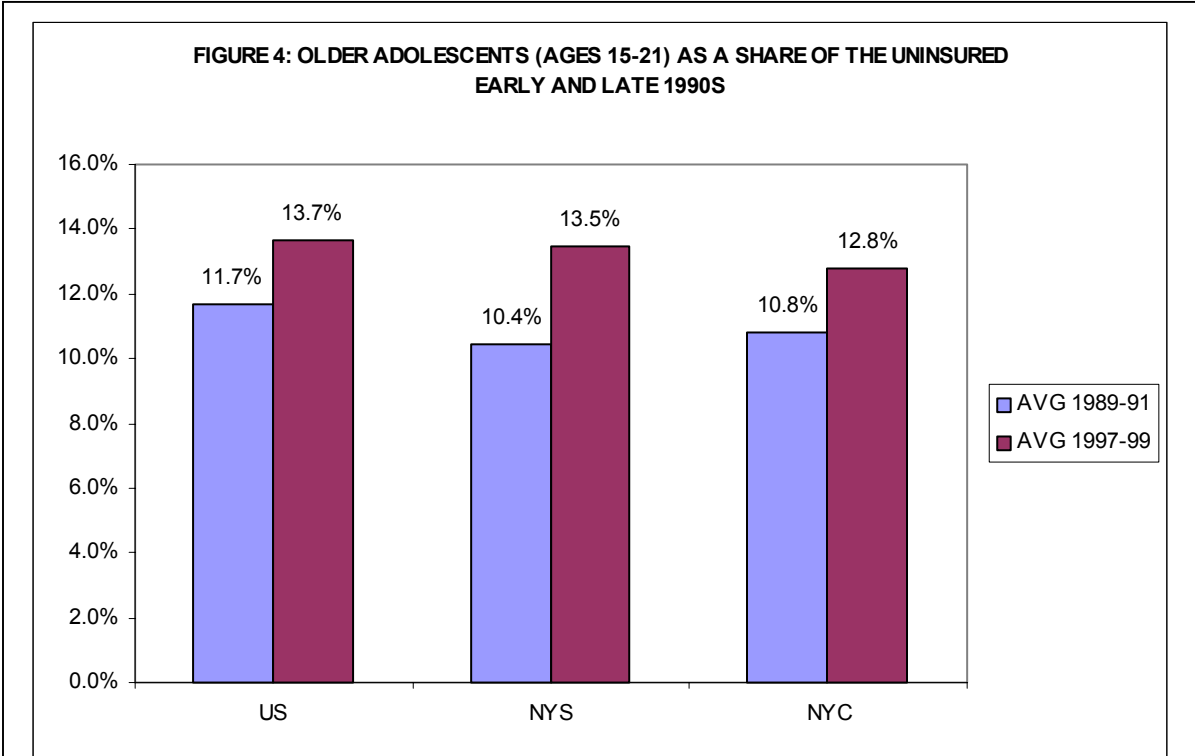


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Source: Duffy, Niev, Ph.D., “The Looming Health Care Crisis for Young Parents in New York State”, *Regional Labor Review*, Vol. 4, Spring 2002, Calculations based on data from the Current Population Survey March Supplement, 1990-92 and 1998-2000.

^a All private health insurance data for children are adjusted for change in survey design in 1995. See endnote vi.



Source: Duffy, Niev, Ph.D., “The Looming Health Care Crisis for Young Parents in New York State”, *Regional Labor Review*, Vol. 4, Spring 2002, Calculations based on data from the Current Population Survey March Supplement, 1990-92 and 1998-2000

EXPLAINING THE GROWTH IN UNINSURED PATIENTS

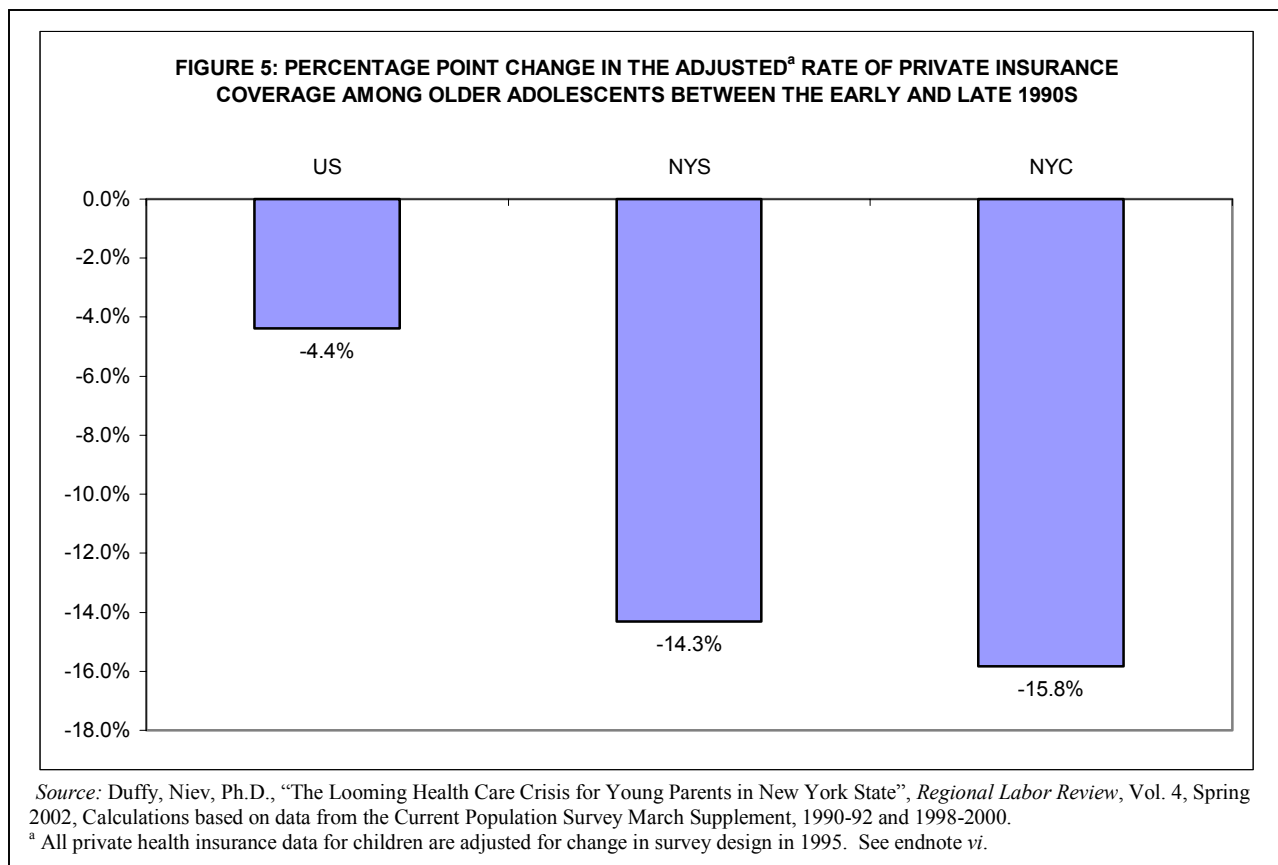
The recent decline in billable patients at AHC has coincided with a dramatic rise in rates of uninsurance among older adolescents in New York City and State (See **Figure 3A**). Because rates of uninsurance have been rising more rapidly among older adolescents than other age groups since the early 1990s (See **Figure 3B**), they represent a growing share of the uninsured (See **Figure 4**).

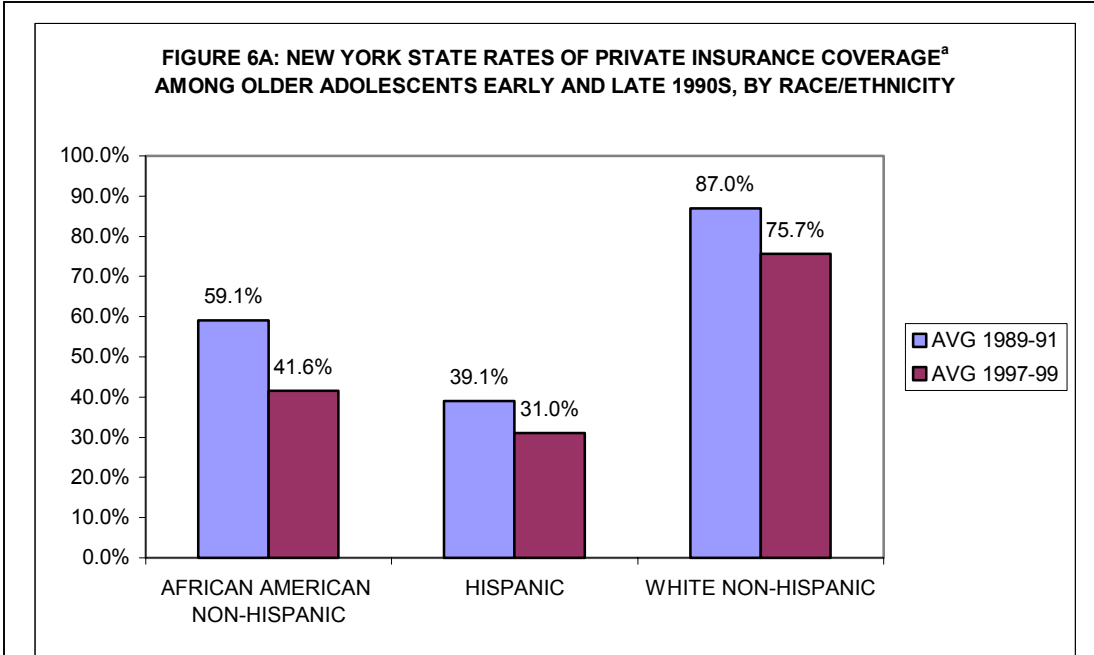
The rapid drop in health insurance coverage was largely due to declining rates of private health insurance among older adolescents (See **Figure 5**). In New York State and City, rates of private health insurance coverage have fallen far more rapidly

than on the national level, and all racial groups appear to have experienced sharp declines in coverage (See **Figures 6A and 6B**).

Declines in Medicaid coverage, starting in 1996 (See **Figure 7**), resulting from the economic recovery of the 1990s and following the passage of welfare reform, also helped to boost the share of adolescents with no health insurance, particularly in New York City.

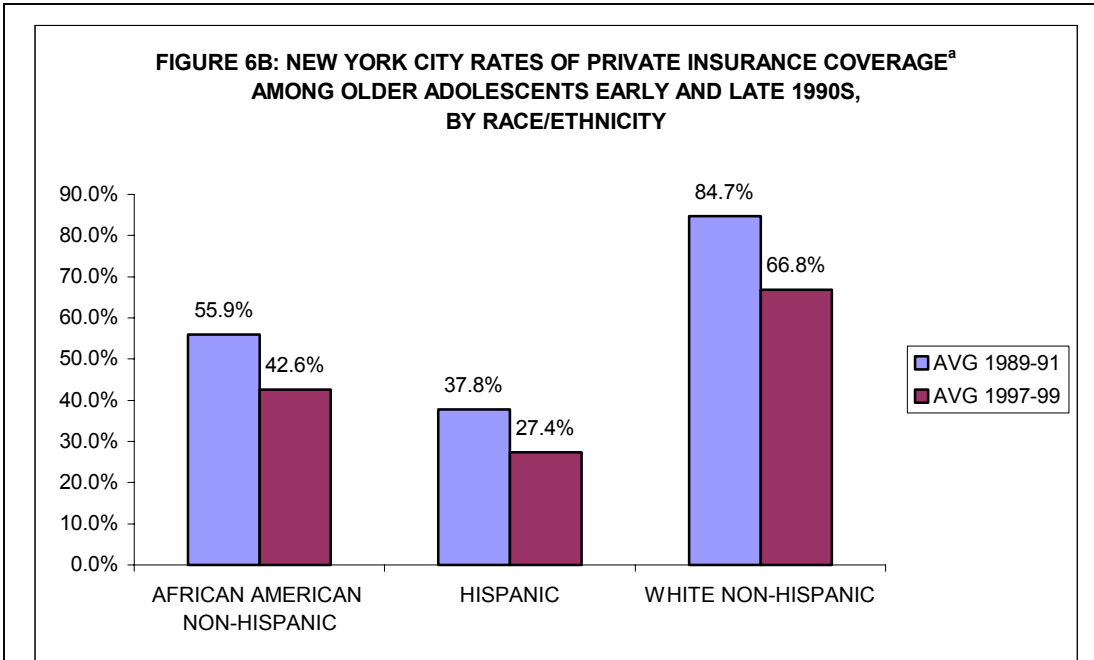
The decline in Medicaid coverage has resulted from both declining eligibility of adolescents and Medicaid churning due to increasingly stringent eligibility criteria and lengthy re-enrollment processes. Those dropped from the Medicaid rolls lose coverage either because they no longer meet the





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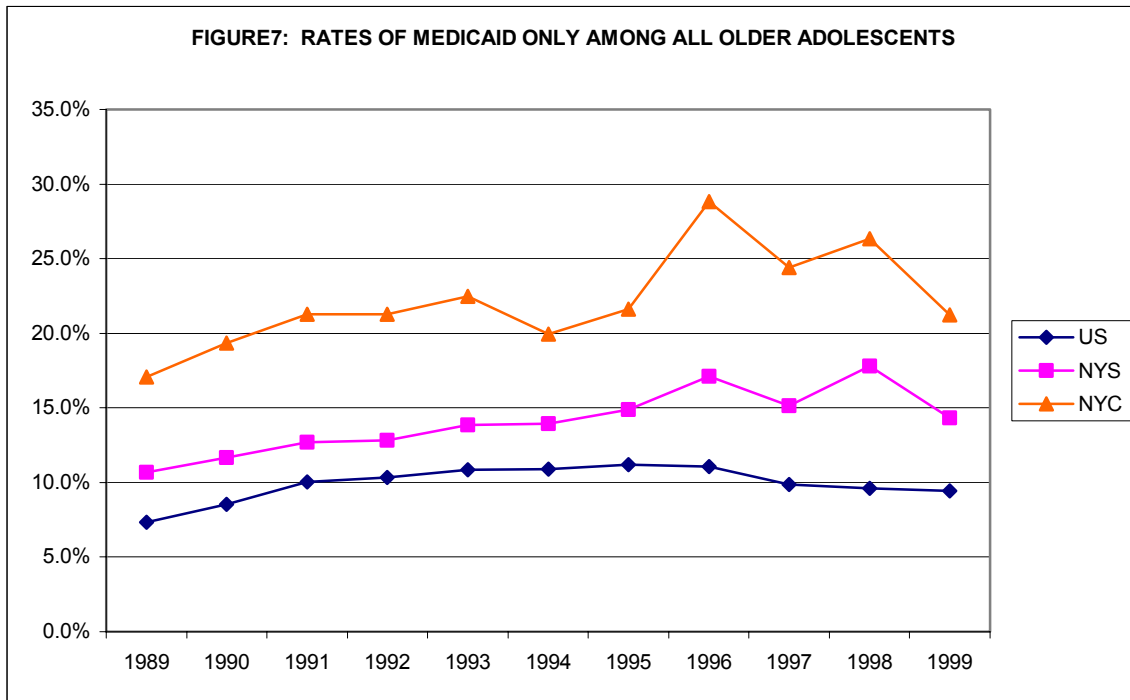
^a All private health insurance data for children are adjusted for change in survey design in 1995. See endnote vi.



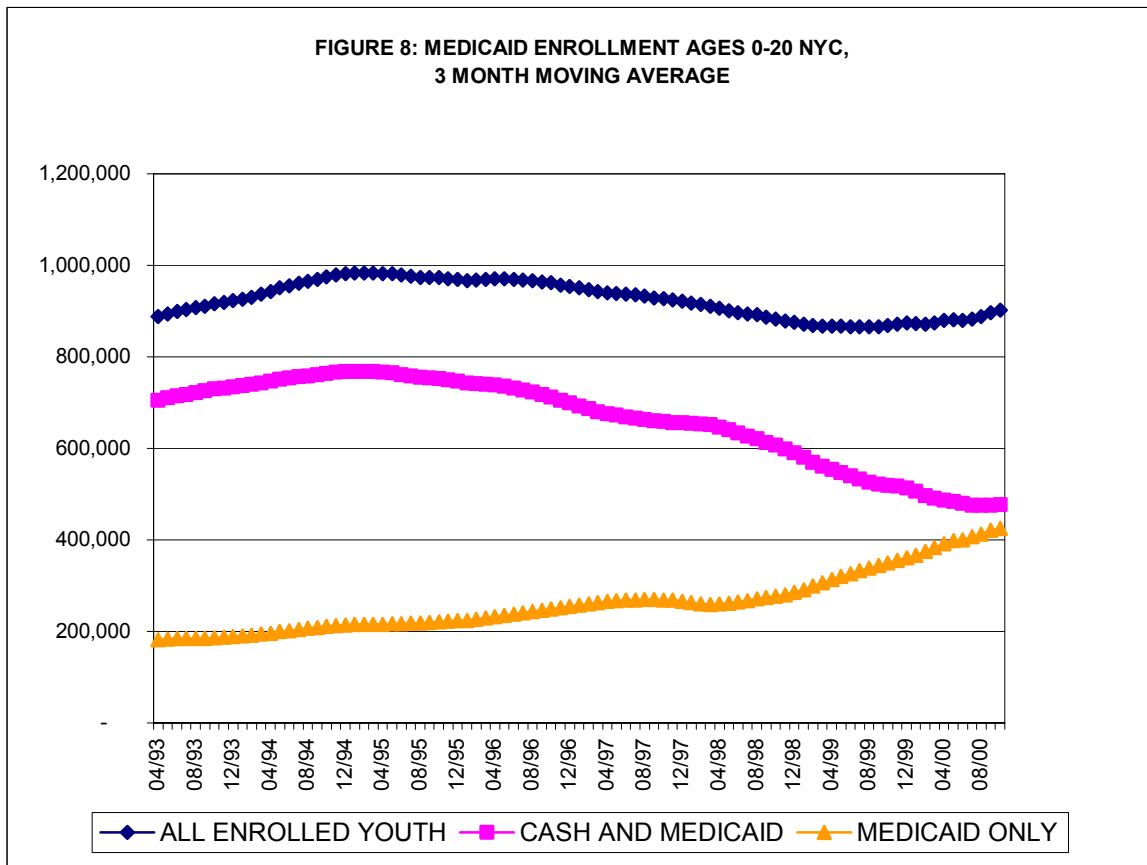
Source: Duffy, Niev, Ph.D., “The Looming Health Care Crisis for Young Parents in New York State”, *Regional Labor Review*, Vol. 4, Spring 2002, Calculations based on data from the Current Population Survey March Supplement, 1990-92 and 1998-2000.

^a All private health insurance data for children are adjusted for change in survey design in 1995. See endnote vi.

Rising Adolescent Uninsurance and Its Impact on Youth and Their Health Care Providers



Source: Duffy, Niev, Ph.D., "The Looming Health Care Crisis for Young Parents in New York State", *Regional Labor Review*, Vol. 4, Spring 2002, Calculations based on data from the Current Population Survey March Supplement, 1990-2000.



Source: Tabulations by Kenneth E. Thorpe

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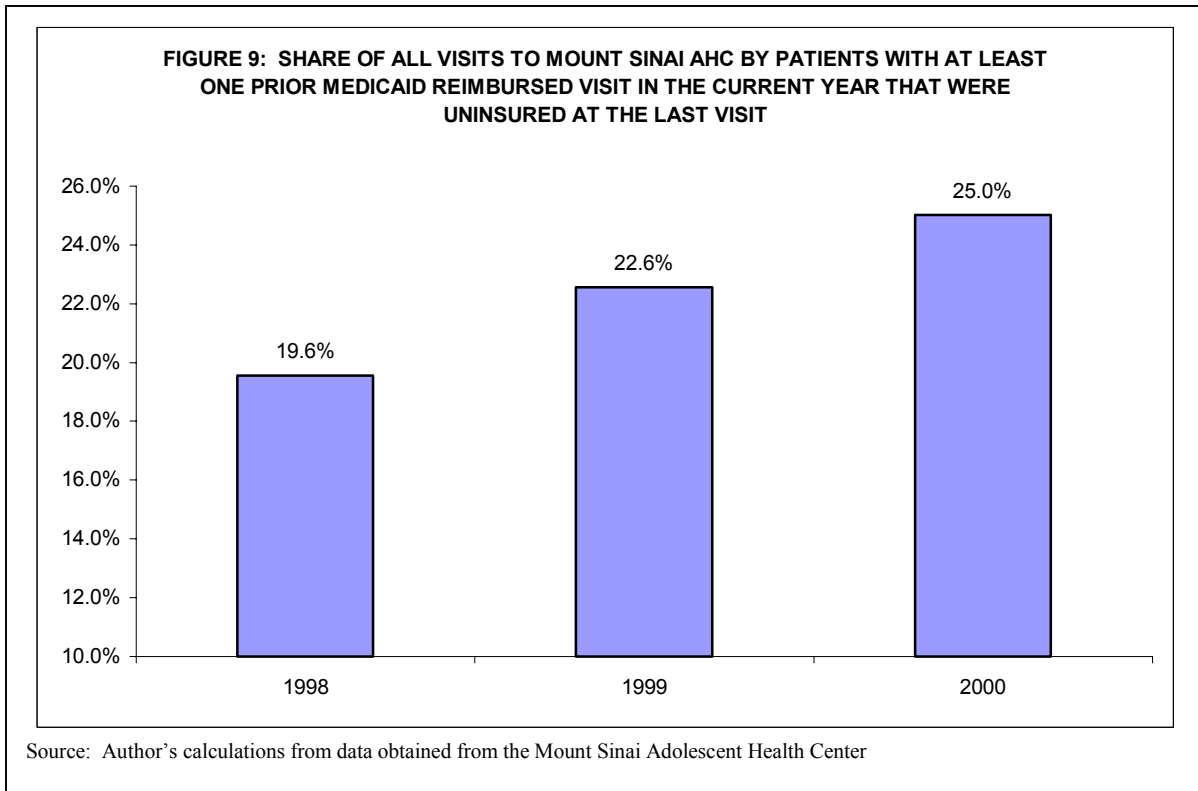
criteria for eligibility or because they fail to produce all the proper paperwork by a particular deadline.

Though recent “facilitated enrollment” efforts to increase CHIP and Medicaid enrollment among young people have helped to stem the decline in insurance coverage somewhat, evidence suggests that coverage continues to decline for the neediest adolescents, those that were formerly on public assistance.

Studies show that nearly 35% of adolescents aged 15 to 21 that are eligible for Medicaid remain uninsuredⁱⁱ. According to a report of The New York State Coalition of PHSPs, each month between June 1998 and January 2000, 4% of a managed care company’s members were involuntarily dis-enrolledⁱⁱⁱ. The CHIP program has similar problems. Approximately 50% of the children up for CHIP re-certification

each month are dis-enrolled and must reapply in order to qualify for coverage. **Figure 8** shows the rapid decline in Medicaid enrollment among those who receive both cash and Medicaid benefits. At the same time, facilitated enrollment programs led to a rise in enrollment among Medicaid Only enrollees, though at a somewhat slower rate. The net result has been a decline in total enrollment among young people aged 0-20, followed by a modest turnaround in late 1999. CHIP enrollment also rose during this time, but is now restricted to those that are not otherwise eligible for Medicaid.

The trends displayed in **Figure 8** do not capture the full impact of churning. In addition to declining enrollments, churning also ensures that many adolescents are without health care coverage during some portion of each year.



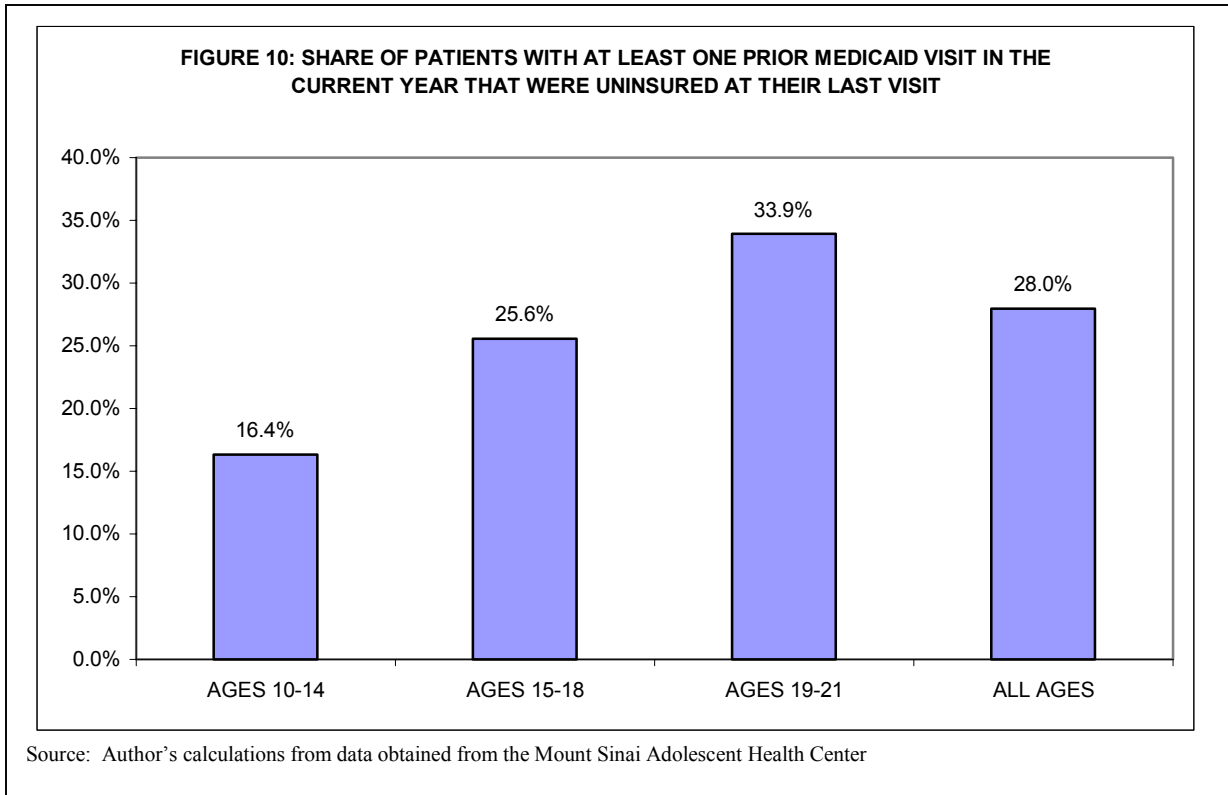


Figure 9 shows that at the Mount Sinai Adolescent Health Center a high and rising proportion of adolescents receiving primary and reproductive health care, who had at least one prior Medicaid reimbursed visit in that year, were uninsured at their last visit. The proportion rises with age, and is highest for adolescents between the ages of 19 and 21 who are most likely to have lost their eligibility for Medicaid (See **Figure 10**).

The overall impact of churning is that, at any given time, each patient is less likely to be enrolled in Medicaid. The consequence is often that adolescents have difficulty in obtaining needed care and that health care providers serving the uninsured face intensified financial difficulties. The loss of Medicaid coverage may accelerate as recipients of public

assistance reach the 5 year lifetime welfare limit.

The financial problems of public and not-for-profit private health care facilities that provide services to the uninsured are worsened by the fact that they must accommodate the growing numbers of the uninsured turned away by other not-for-profit and private hospitals. As a consequence, facilities that provide services regardless of a patient's ability to pay are shouldering a growing share of the costs of the uninsured at a time when public monies for health care are stagnating or even shrinking in real terms. The strain on health care providers that provide health care services to uninsured adolescents will continue to increase as the restructuring of health care markets continues and the proportion of adolescents with no health insurance continues to increase.

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But the repercussions of rising uninsurance among adolescents will be felt well beyond those institutions providing free primary, preventive, and reproductive care. When adolescents are denied access to primary, preventive and/or reproductive care, they often end up seeking care in emergency departments. And when chronic illnesses remain untreated for an extended period of time, adolescents are more likely to require hospitalization for preventable diagnoses.

II REPERCUSSIONS OF RISING UNINSURANCE IN THE BROADER HEALTH CARE SYSTEM

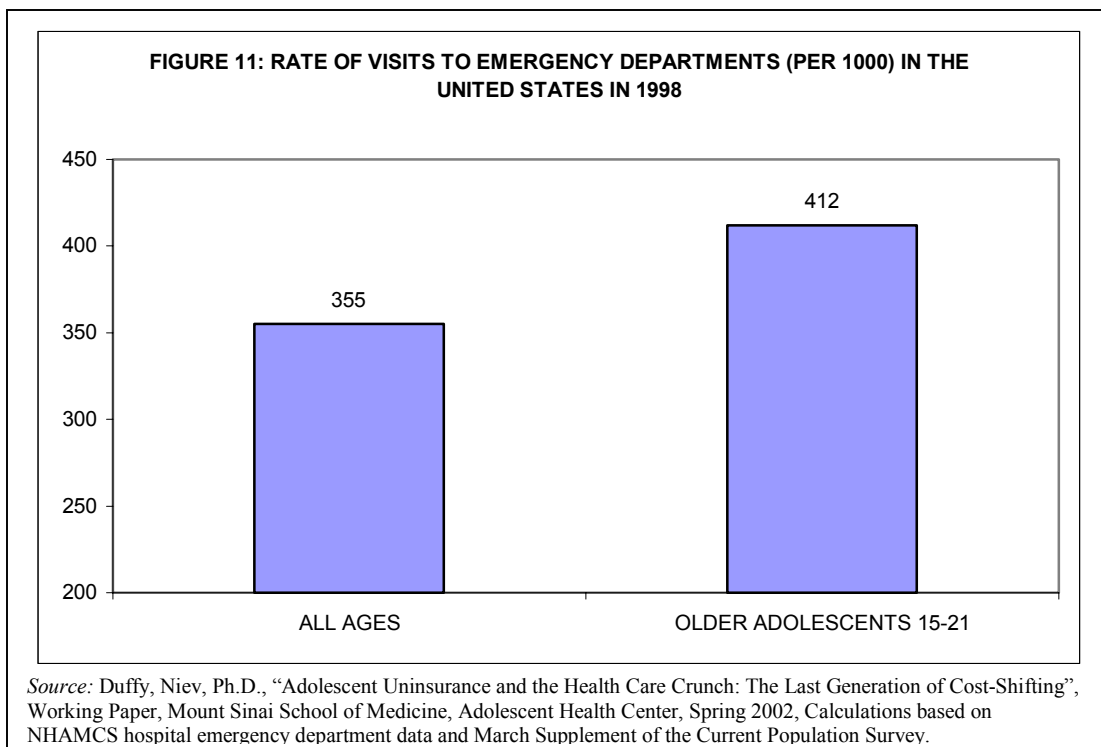
EMERGENCY DEPARTMENTS

The rate of emergency department use among older adolescents is 16% higher than that for the population as a whole, a fact which is likely to reflect, in part, their relative lack of access to health care services (See **Figure 11**).

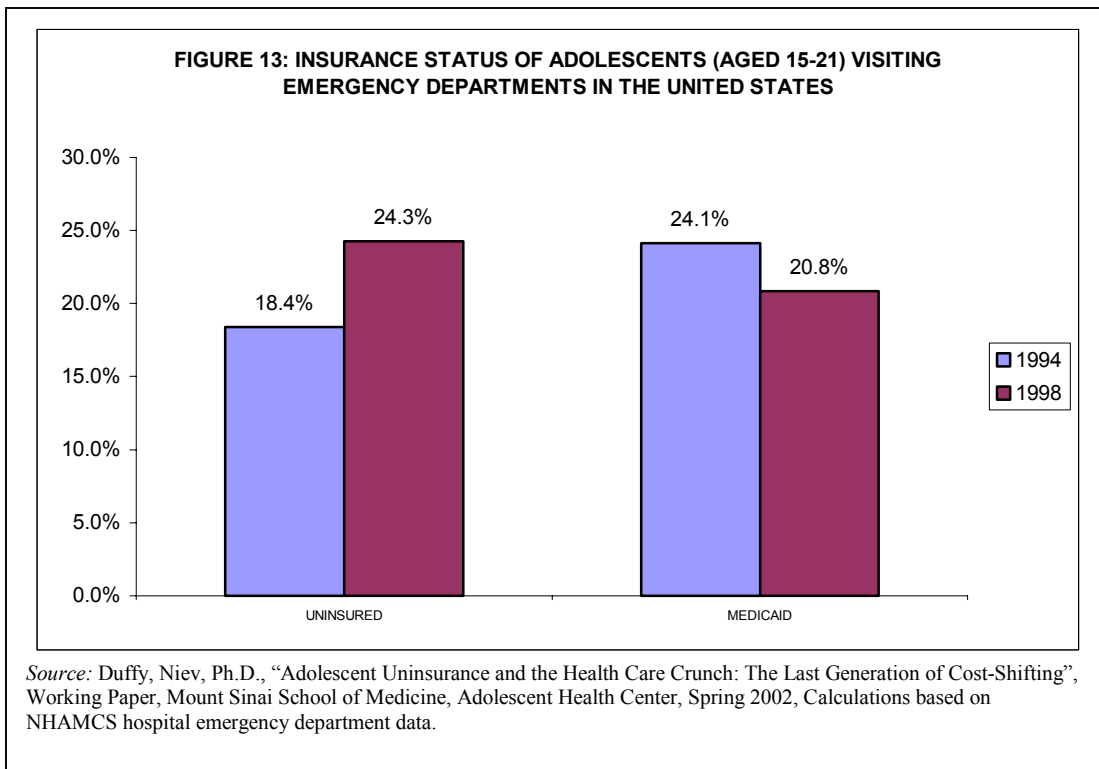
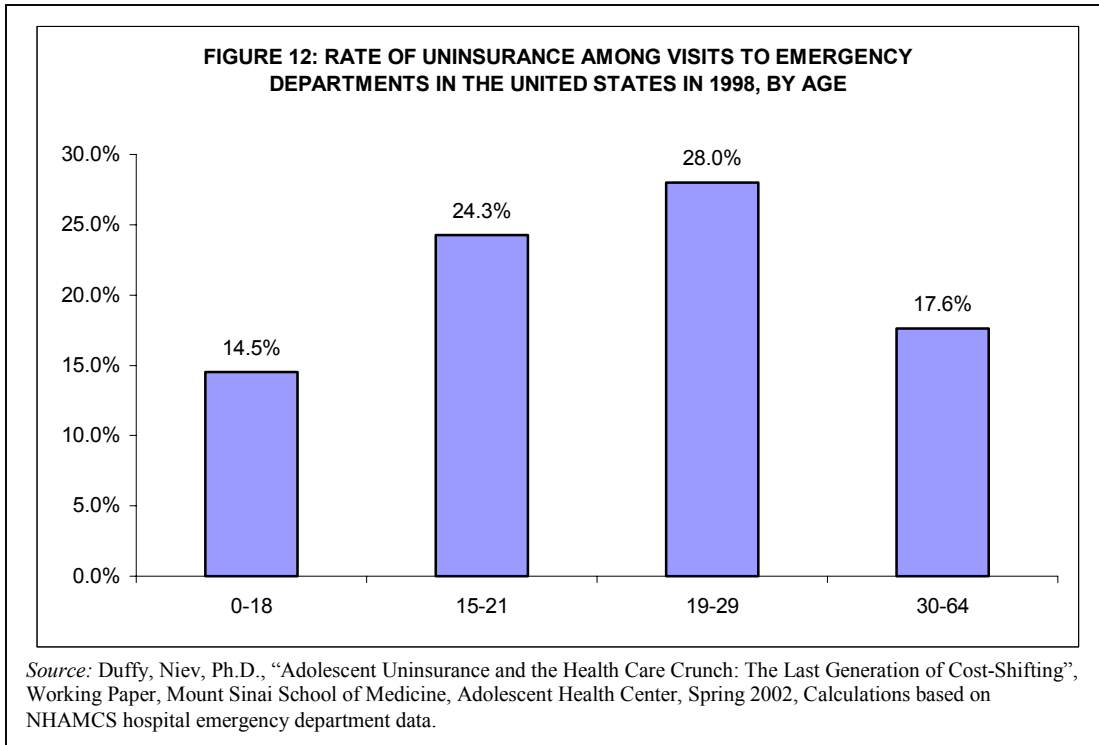
Older adolescents comprise a disproportionate share of the uninsured visiting emergency rooms. Next to young adults aged 19-29, older adolescents have the highest rates of uninsurance among those visiting emergency rooms (See **Figure 12**). Though adolescents between the ages of 15 and 21 make up only 11.4% of the national population, they represent over 17% of uninsured emergency department visits.

A rise in rates of uninsurance among adolescent emergency department visits between 1994 and 1998 coincided with a decline in Medicaid coverage of such visits (See **Figure 13**).

In the future, use of emergency departments by older adolescents is likely to rise as a result of declining funding for primary and reproductive health care, and as private health insurance declines with the economic downturn. The rising share of uninsured among youth seeking health services through emergency departments imposes a growing strain on the resources of hospitals that provide services to this population.



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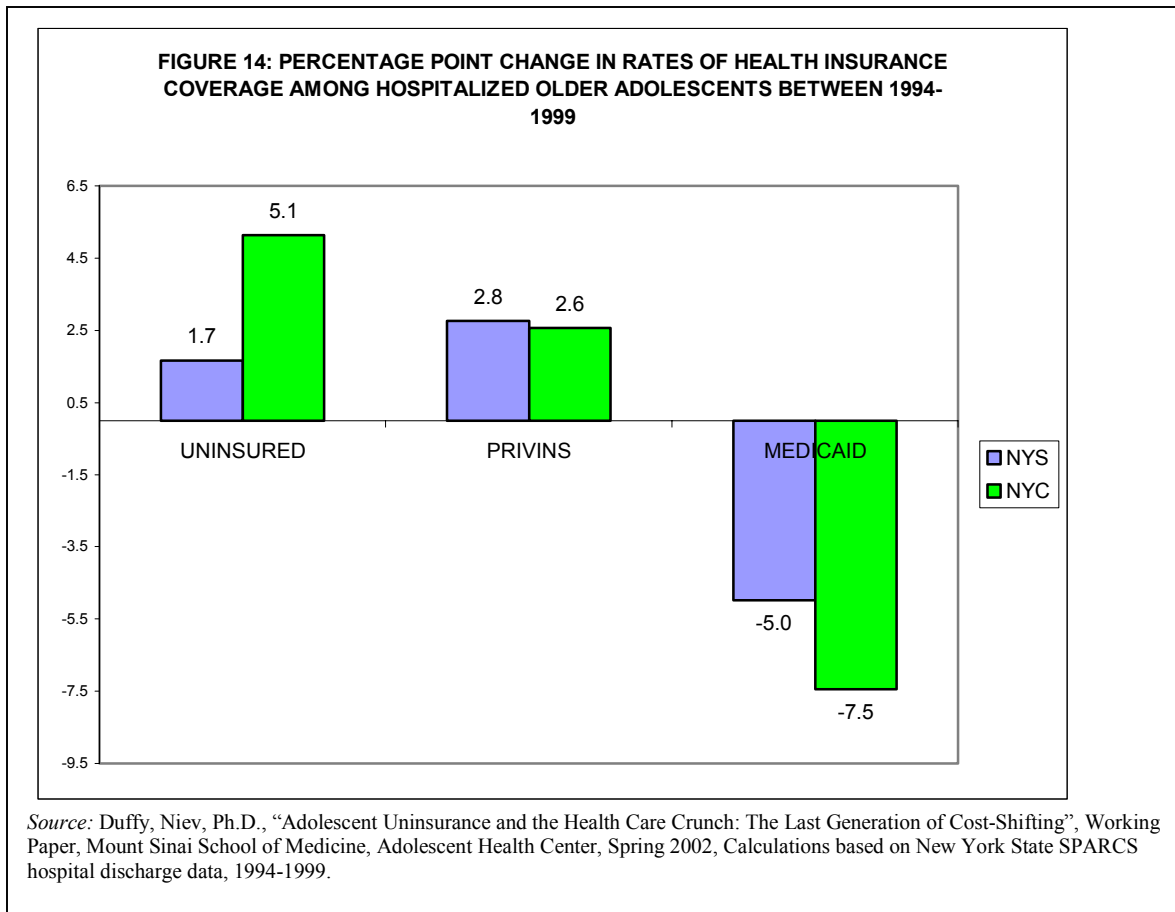


HOSPITALIZATIONS

Since 1994, the rate of uninsurance among hospitalizations of older adolescents aged 15 to 21 in New York State has increased, particularly within NYC. According to SPARCS hospital discharge data, there was a 5.1 percentage point rise in the share of older adolescents hospitalized in New York City between 1994 and 1999, who had no health insurance. This trend resulted from a 7.5 percentage point decline in Medicaid coverage during the same period, which was only partially offset by a much smaller increase in private insurance of 2.6 percentage points^{iv} (See **Figure 14**). A similar pattern emerges for hospitalizations in New York State, though it is somewhat less pronounced. Rising rates of

uninsurance are likely to explain much of this trend.

However, evidence also suggests that declining access to health care among the uninsured may contribute to rising rates of uninsurance among hospitalized adolescents. When adolescents lack access to primary and reproductive care, and their only contact with medical professionals is through sporadic visits to the emergency room, they are more likely to be hospitalized for preventable ailments. As a consequence, rates of uninsured hospitalizations appear to have grown most rapidly for some preventable illnesses that are more common among those with little or no access to primary health care.



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FIGURE 15A: RATE OF UNINSURED AMONG HOSPITAL DISCHARGES OF OLDER ADOLESCENTS FOR GENITO-URINARY ILLNESSES

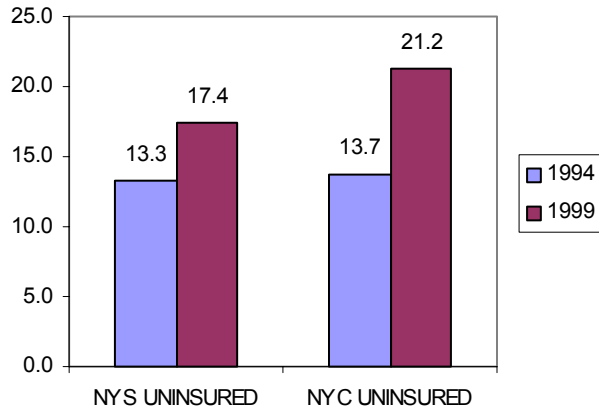


FIGURE 15B: RATE OF MEDICAID COVERAGE OF HOSPITAL DISCHARGES AMONG OLDER ADOLESCENTS WITH GENITO-URINARY ILLNESSES

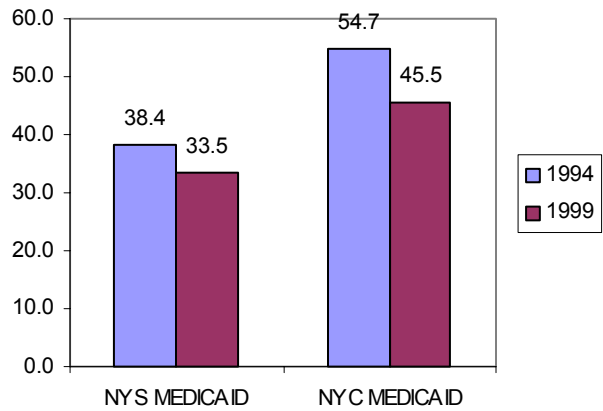


FIGURE 15C: RISE IN UNINSURED AMONG HOSPITAL DISCHARGES OF OLDER ADOLESCENTS WITH PID

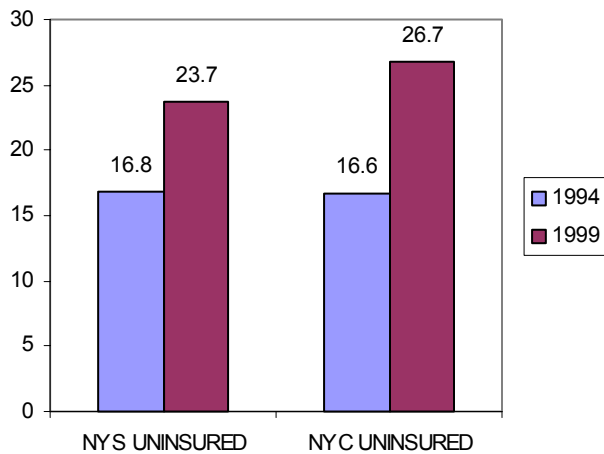
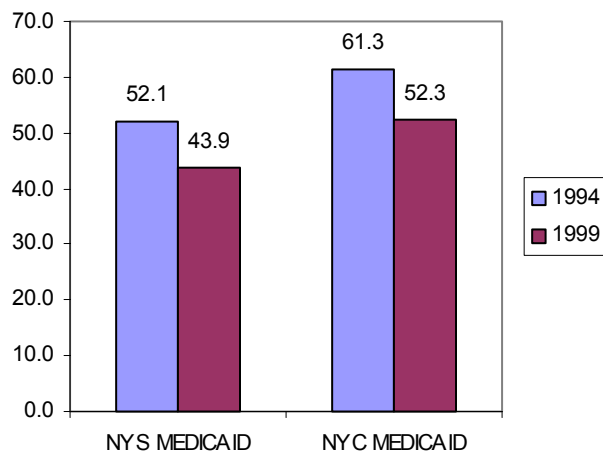


FIGURE 15D: RATE OF MEDICAID COVERAGE AMONG HOSPITAL DISCHARGES OF OLDER ADOLESCENTS FOR PID

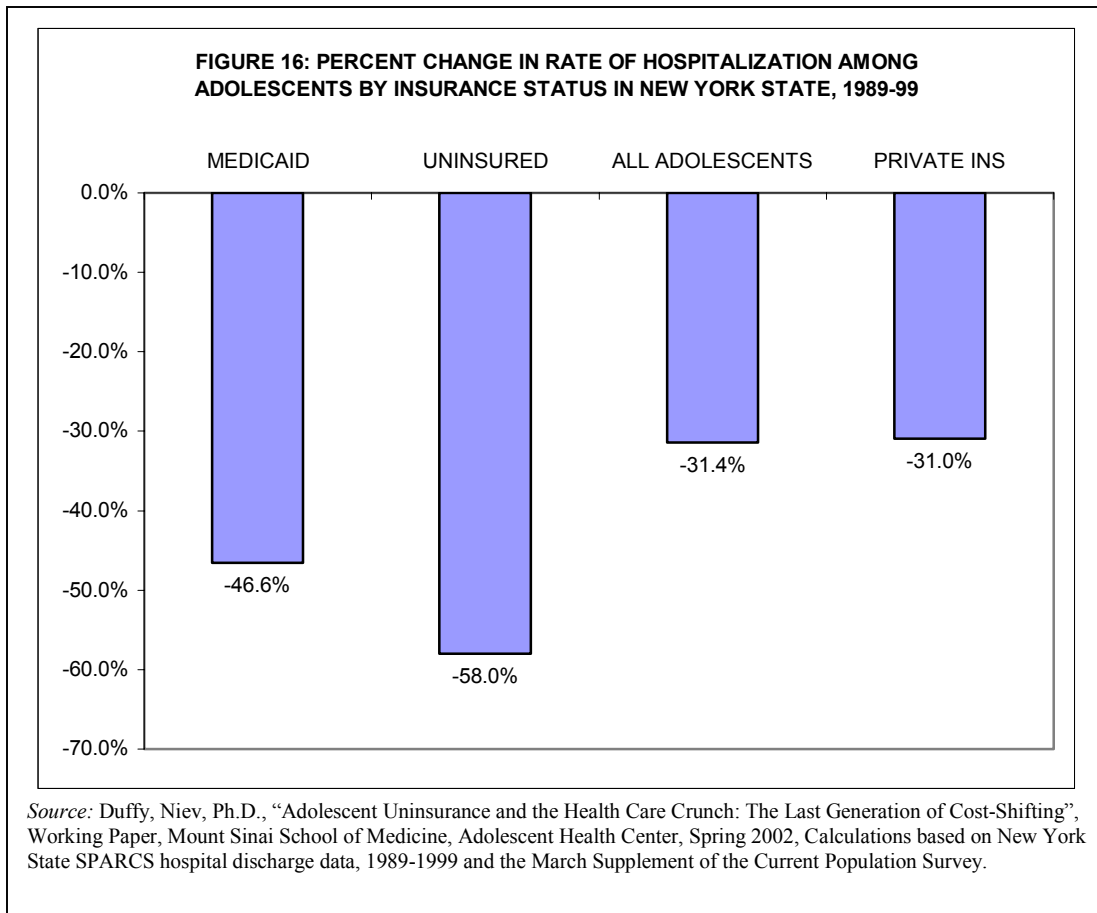


Source: Duffy, Niev, Ph.D., "Adolescent Uninsurance and the Health Care Crunch: The Last Generation of Cost-Shifting", Working Paper, Mount Sinai School of Medicine, Adolescent Health Center, Spring 2002, Calculations based on New York State SPARCS hospital discharge data, 1988-99.

For example, **Figure 15A** shows that the rate of self-pay among adolescents aged 15 to 21 hospitalized for genito-urinary illnesses rose dramatically from 13.7% in 1994 to 21.2% in 1999, in New York City hospitals. This coincided with a somewhat larger percentage point decline in Medicaid coverage of such hospitalizations (See **Figure 15B**). Similarly, uninsurance among adolescent patients hospitalized with pelvic inflammatory disease in New York City rose even faster from 16.6% in 1994 to 26.7% in 1999 (See **Figures 15C and 15D**). Self-pay among adolescent mental health discharges rose by 91%, between 1990 and 1999, so that hospitals must now absorb the cost of caring for one out of six of such patients. These increases were also accompanied by sharp declines in rates of Medicaid

coverage.

Though it would seem reasonable to assume that the expansion of managed care plans and their lower rates of hospitalization among those enrolled, would help to explain the decline in the share of insured patients hospitalized for preventable illnesses, this does not appear to be the case. In fact, as **Figure 16** demonstrates, the rate of hospitalization among uninsured adolescents fell faster than for any other group. In fact, the rising share of hospitalizations comprised of uninsured patients is more likely to arise from the rapidly growing rate of uninsurance among adolescents.



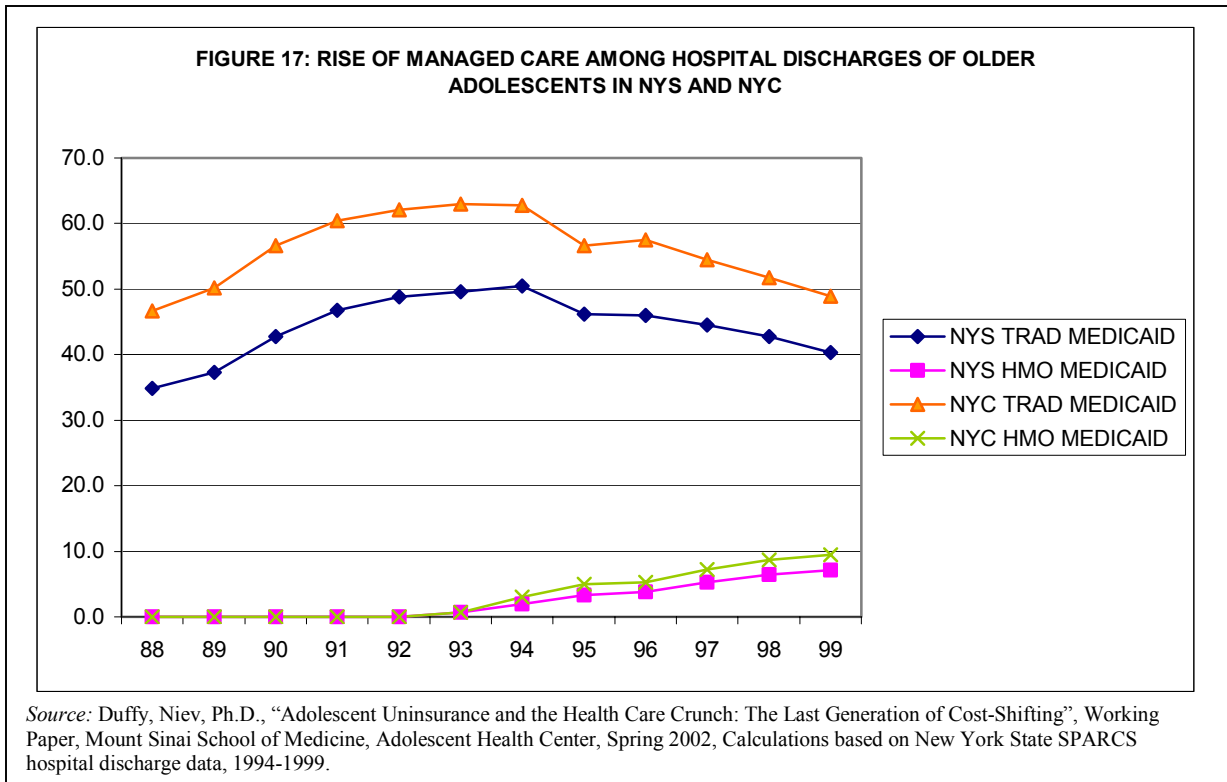
COST-SHIFTING TO COVER THE UNINSURED DURING THE TRANSITION TO MANAGED CARE

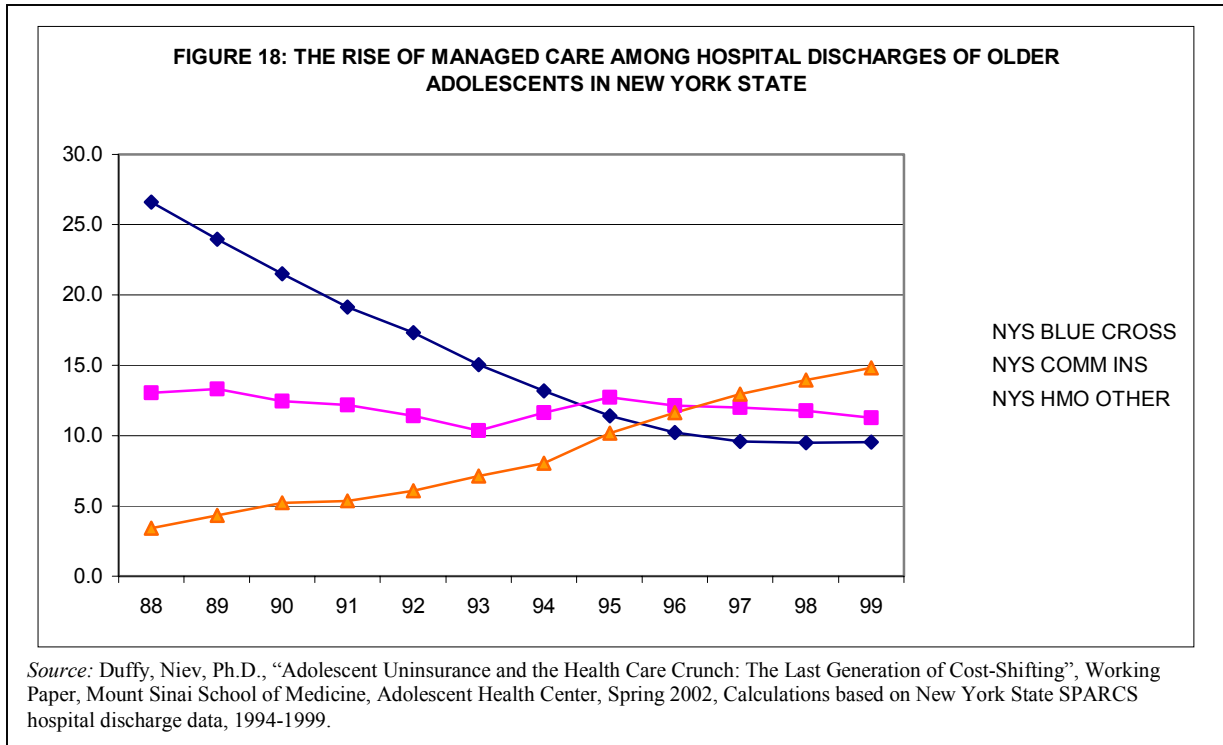
In order to provide services to the uninsured, health care providers have traditionally shifted revenues from insured patients to cover the costs of the uninsured, a practice called “cost-shifting”. However, the restructuring of health care markets is making this practice increasingly difficult.

At the same time that hospitals have experienced a sharp decline in the proportion of adolescent patients that are covered by Medicaid, they have also witnessed a strong shift among those that do have Medicaid coverage into Medicaid HMOs, which often impose more stringent reimbursement levels and restrictions (See **Figure 17**). A similar

shift has occurred for those that are privately insured, among whom a growing share are enrolled in managed care companies/HMOs that set strict caps on the fees charged by hospitals. The dramatic rise in managed care enrollment in NYC has been accompanied by a precipitous fall in more traditional, and relatively lucrative forms of coverage, in particular, fee for service Blue Cross/Blue Shield (See **Figure 18**).

As mentioned previously, the transition to managed care has led to dramatic declines in rates of hospitalization among both publicly and privately insured populations. This trend has also greatly reduced hospital revenues and further limited the ability of facilities to perform cost-shifting to cover the care of the uninsured. The fact that the rate of hospitalizations has





declined far more sharply for the uninsured raises serious concerns about the welfare of the uninsured, who may be going without badly needed medical care.

Health care providers shoulder a large and growing share of the cost of health care services for older adolescents. The resulting financial burden has forced many facilities to scale back services provided to uninsured adolescents.

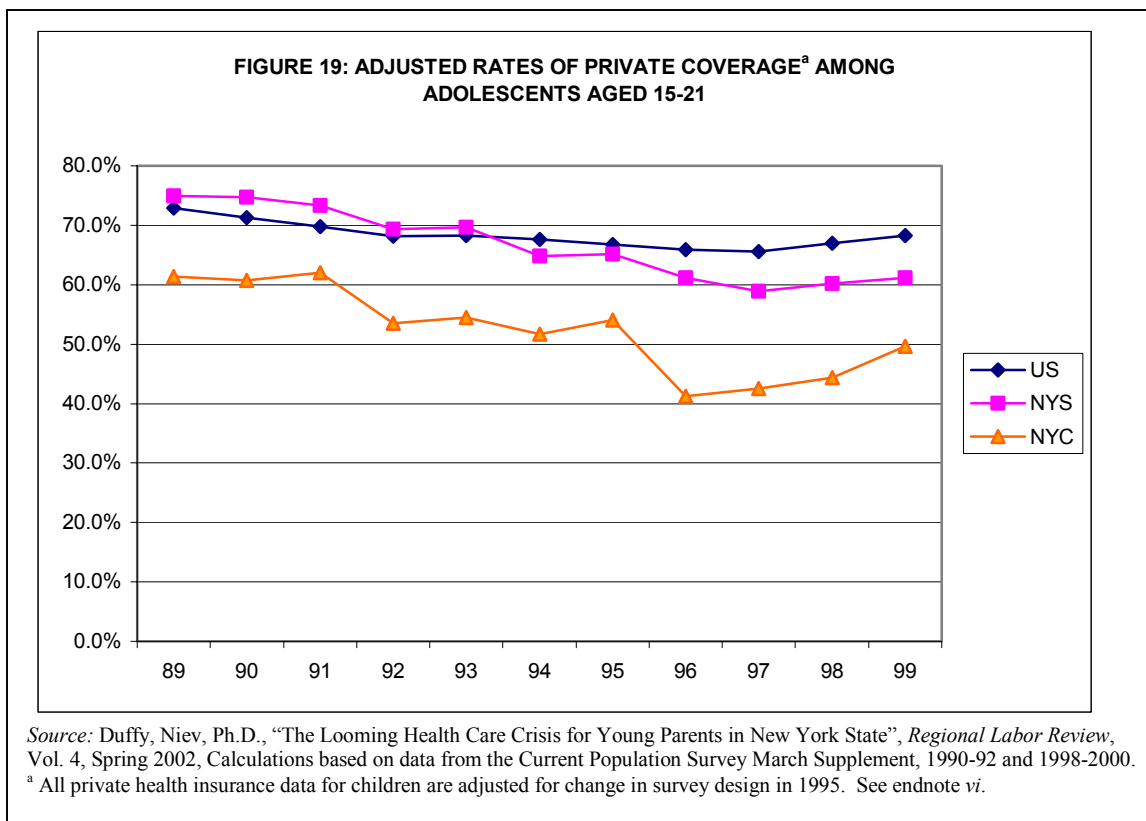
THE FUTURE OF HEALTH INSURANCE COVERAGE AMONG ADOLESCENTS

During the 1990s, rates of private health care coverage among young Americans tumbled. Even during much of the economic boom of the 1990s, the erosion of this critical source of health care coverage among older adolescents was still well under way. Thus far, two

groups, dependents and young adults, have been most affected by the decline in private health insurance, though for somewhat different reasons. While dependents typically lose private health coverage when a young parent loses their employer-provided health insurance, the rate of coverage among adolescents aged 18 to 21 is often determined by their direct access to health care coverage through an employer. Both pathways for obtaining coverage are in strong decline among older adolescents. For reasons discussed below, the loss of private coverage is likely to continue in the future.

DECLINING PRIVATE HEALTH INSURANCE COVERAGE AMONG DEPENDENTS

Disturbingly, the loss of private health insurance since the early 1990s has been most rapid among dependents^v. Young working parents in New York are



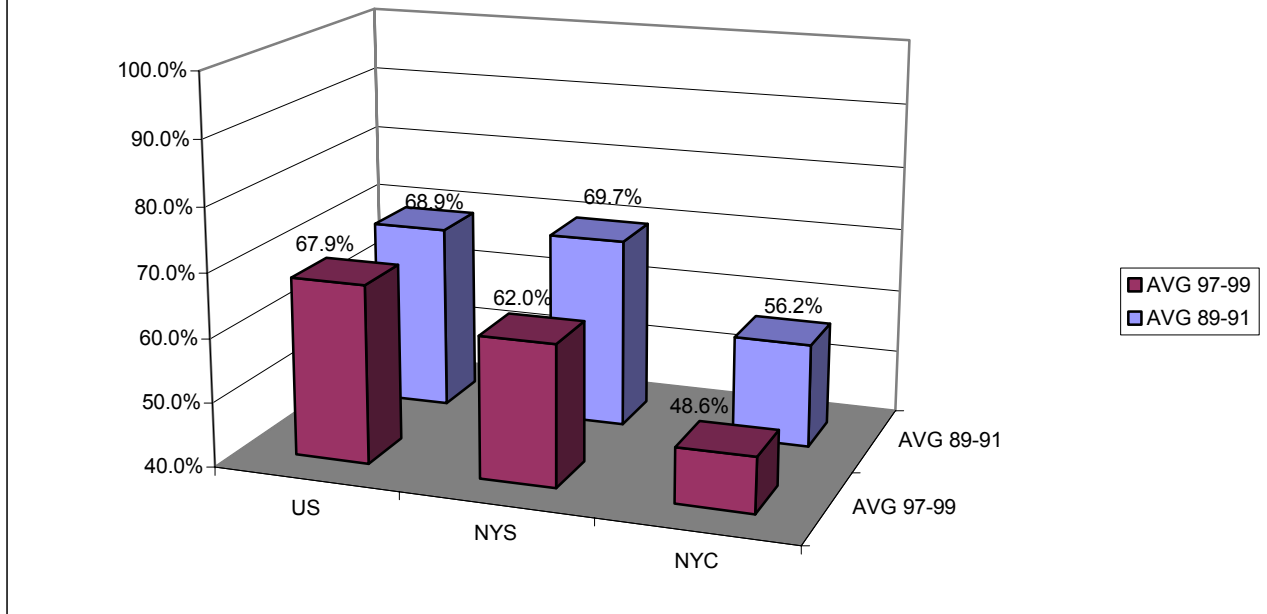
finding it increasingly hard to provide health care coverage for themselves and their families. While the decline in private coverage in the region reflects a much broader national decline, the drop in rates has been far sharper in New York, particularly among young workers.

During the recession of the early 1990s, rates of private health insurance coverage among children fell sharply in the United States. The economic upswing that followed fueled only a partial recovery of coverage among children, as labor force participation and the share of families with two working parents rose rapidly. However, from **Figure 19** it is clear that, despite the longest period of economic growth in the history of the United States, rates of private health insurance coverage among children never regained their 1989 levels^{vi}. The recovery in New York State was particularly lackluster, and as

a consequence, the decline in health insurance coverage at the state level over the last decade was sharper than the decline for the nation as a whole (See **Figure 20**). And though at the beginning of the 1990s children in New York State were more likely to have insurance than their national counterparts, by the end of the decade they were far less likely to have coverage. The picture is particularly bleak for children in New York City, where the precipitous fall in private health insurance among children started from a level already far below that at the state and national levels.

Though the scenario illustrated by **Figure 19** is a disturbing one, it does not fully reflect the erosion of health insurance coverage over the last decade. The rise in labor force participation of parents hides the diminishing access of working parents to private family coverage for their children. For this

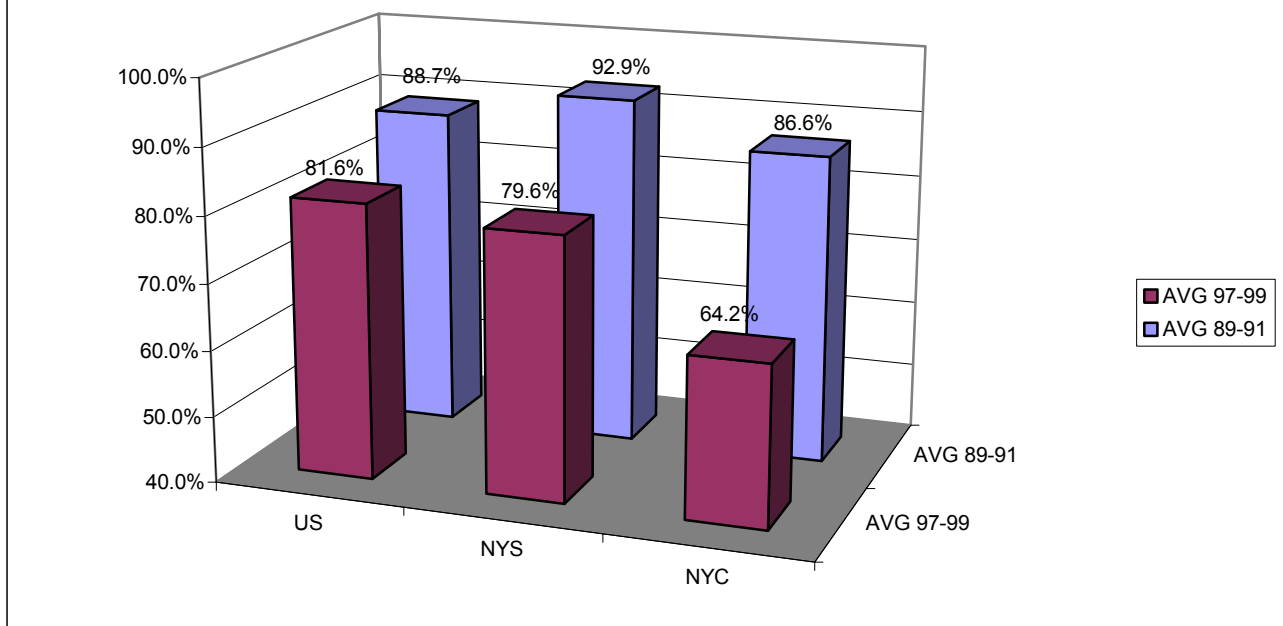
FIGURE 20: RATES OF PRIVATE HEALTH INSURANCE COVERAGE AMONG CHILDREN^a BY REGION, EARLY AND LATE 1990S



Source: Duffy, Niev, Ph.D., "The Looming Health Care Crisis for Young Parents in New York State", *Regional Labor Review*, Vol. 4, Spring 2002
 Calculations based on data from the Current Population Survey March Supplement, 1990-92 and 1998-2000.

^a All private health insurance data for children are adjusted for change in survey design in 1995. For details see endnote vi.

FIGURE 21: RATES OF PRIVATE HEALTH INSURANCE COVERAGE AMONG CHILDREN^a WITH A RESIDENT FULL-TIME YEAR-ROUND WORKING FATHER^b EARLY AND LATE 1990S



Source: Duffy, Niev, Ph.D., "The Looming Health Care Crisis for Young Parents in New York State", *Regional Labor Review*, Vol. 4, Spring 2002
 Calculations based on data from the Current Population Survey March Supplement, 1990-92 and 1998-2000.

^a All private health insurance data for children are adjusted for change in survey design in 1995. See endnote vi.

^b Includes households with only one full-time year-round working parent.

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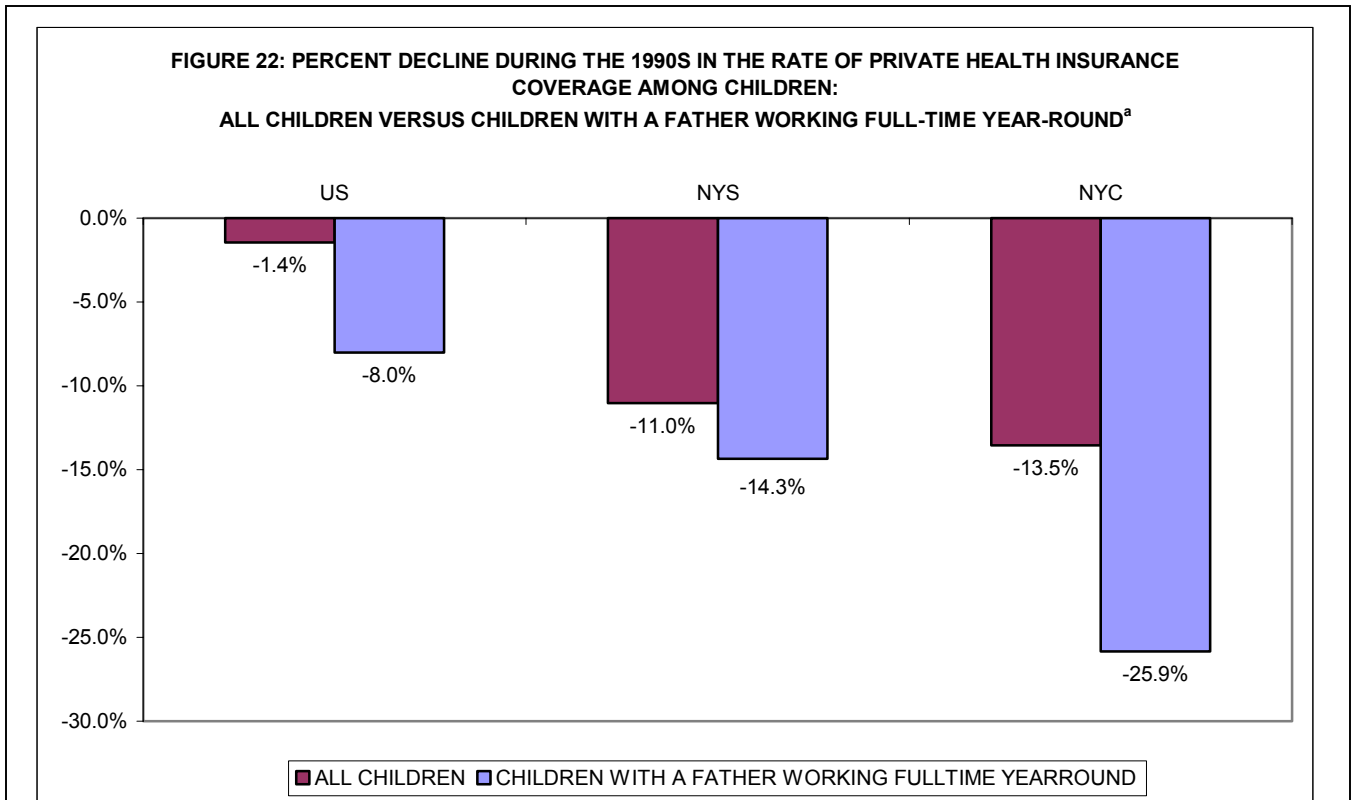
reason, the erosion of private health insurance coverage is better demonstrated by looking at coverage among children whose parents already work full-time year-round. **Figure 21** shows the more rapid decline in coverage among children with a resident full-time year-round working father^{vii}. Though the probability of having health insurance is higher, on average, among this group, their rate of coverage fell far faster than it did for children overall. **Figure 22** directly compares the rate of decline in coverage among all children, with the rate of decline among children with a full-time year-round working father. The fact that the fastest declines in coverage have occurred among children with working parents undermines hopes that any future strengthening of the economy will

reverse recent declines in private health insurance coverage among children.

Unfortunately, the recent economic recession has dashed hopes that a strong economy will lead to a solid recovery of employer-provided benefits. As employment levels slide with the current economic downturn, the full erosion of health care benefits experienced by working Americans will become clearer.

DECLINING OWN EMPLOYER-PROVIDED HEALTH INSURANCE COVERAGE AMONG OLDER ADOLESCENTS

Young people between the ages of 18 and 21 comprise a unique and vulnerable group in a number of ways.



Source: Duffy, Niev, Ph.D., "The Looming Health Care Crisis for Young Parents in New York State", *Regional Labor Review*, Vol. 4, Spring 2002
Calculations based on data from the Current Population Survey March Supplement.

^a Includes households with only one full-time year-round working parent.

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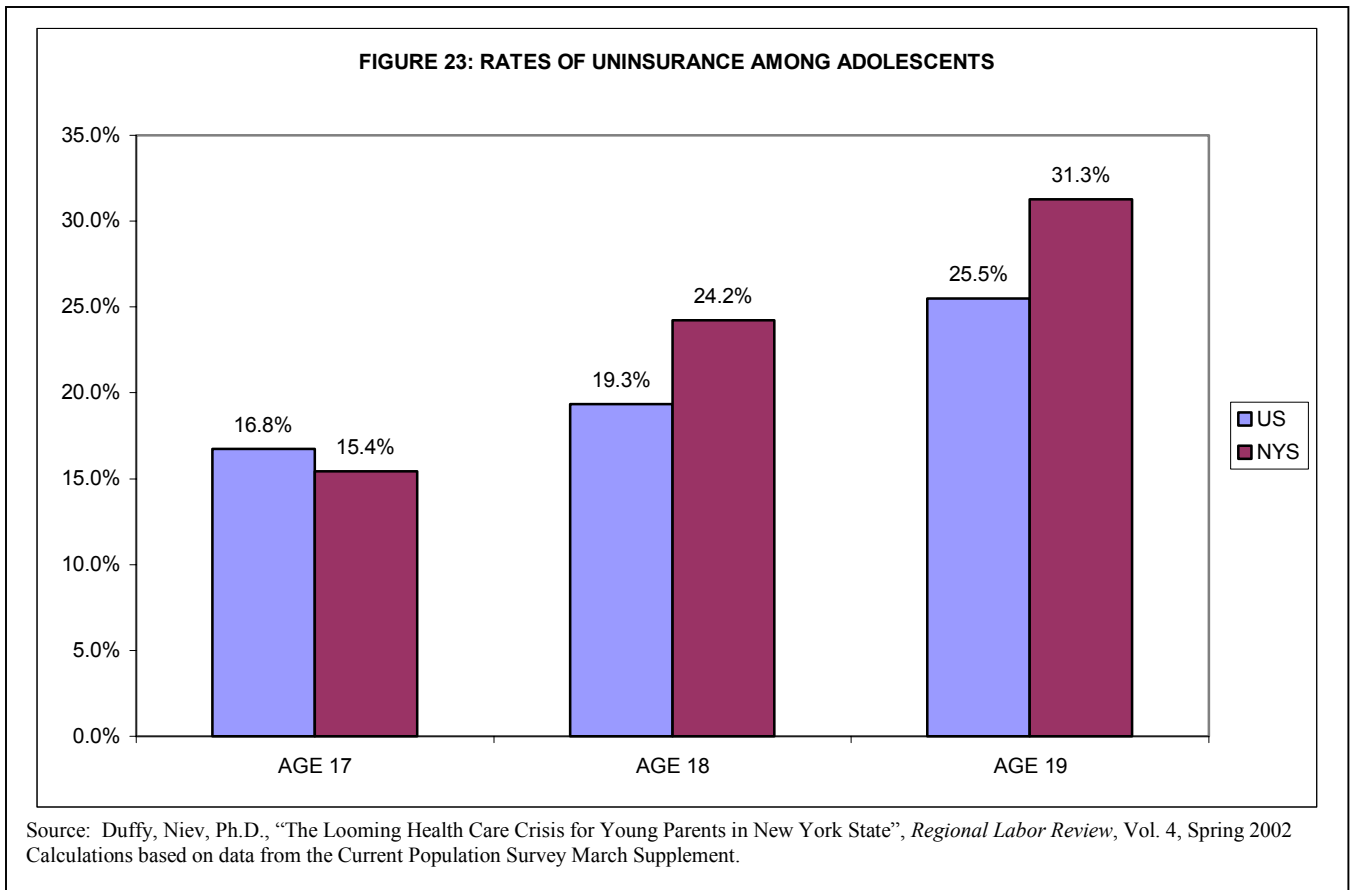
They are beginning the process of establishing independence from their parents both psychologically and financially at a time when they are just learning the skills needed to do so.

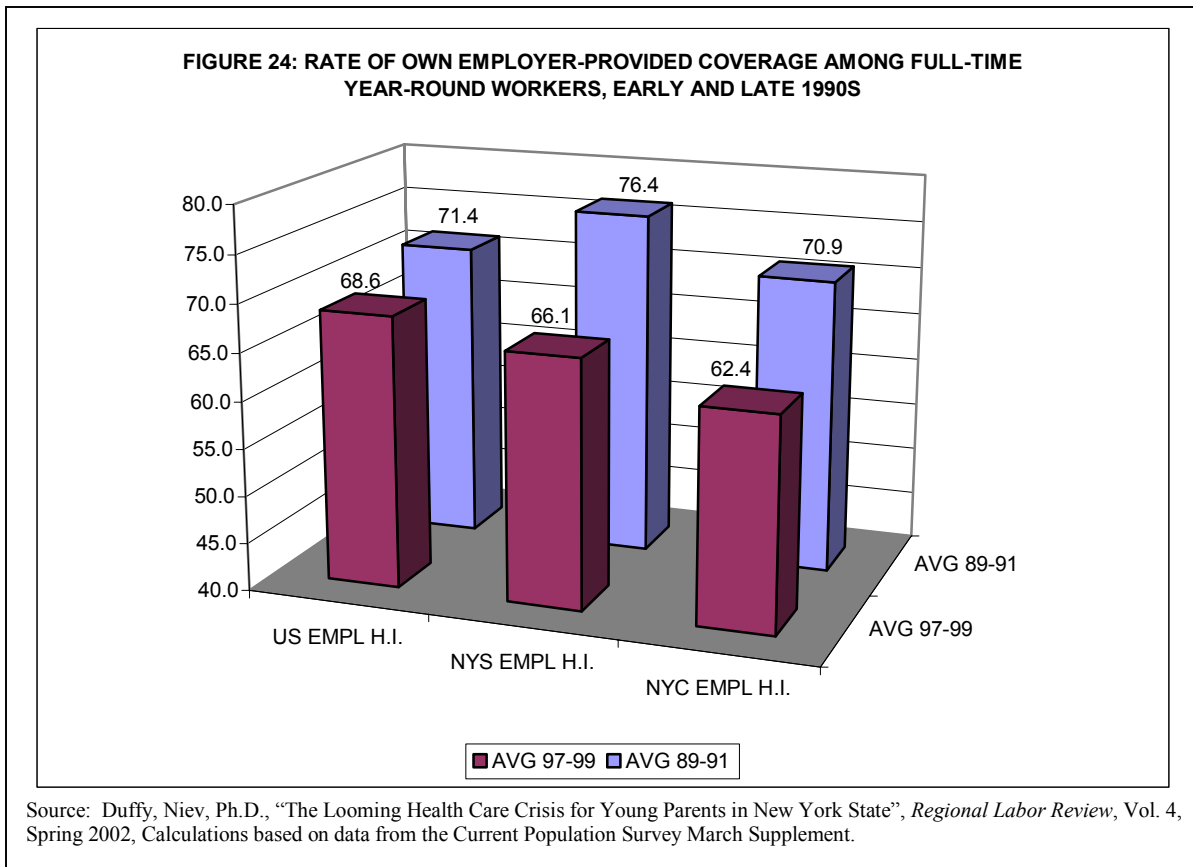
On their 19th birthday, or even earlier if they leave home, many adolescents lose eligibility for coverage under their parents' health insurance plans. Yet, very few have access to employer provided health benefits since they have little or no job experience or training. The lack of access to employer provided health benefits is worsened by high rates of unemployment, low skill levels, and the fact that young people are far more likely to be limited to part-time employment, involuntarily. The result is that, in New York State, the rate of

uninsurance doubles from 15.4% to 31.3% between the ages of 17 and 19 (See **Figure 23**).

In fact, the loss of *own employer-provided health insurance coverage*, (the health insurance that workers obtain directly through their employer or union), was responsible for the vast majority of the decline in overall private health insurance among older adolescents and young adults in the U.S during the 1990s.

Since 1989, own employer-provided health care coverage has declined dramatically for young working adults, particularly for those under the age of 25. Though the decline in employer-provided coverage is often

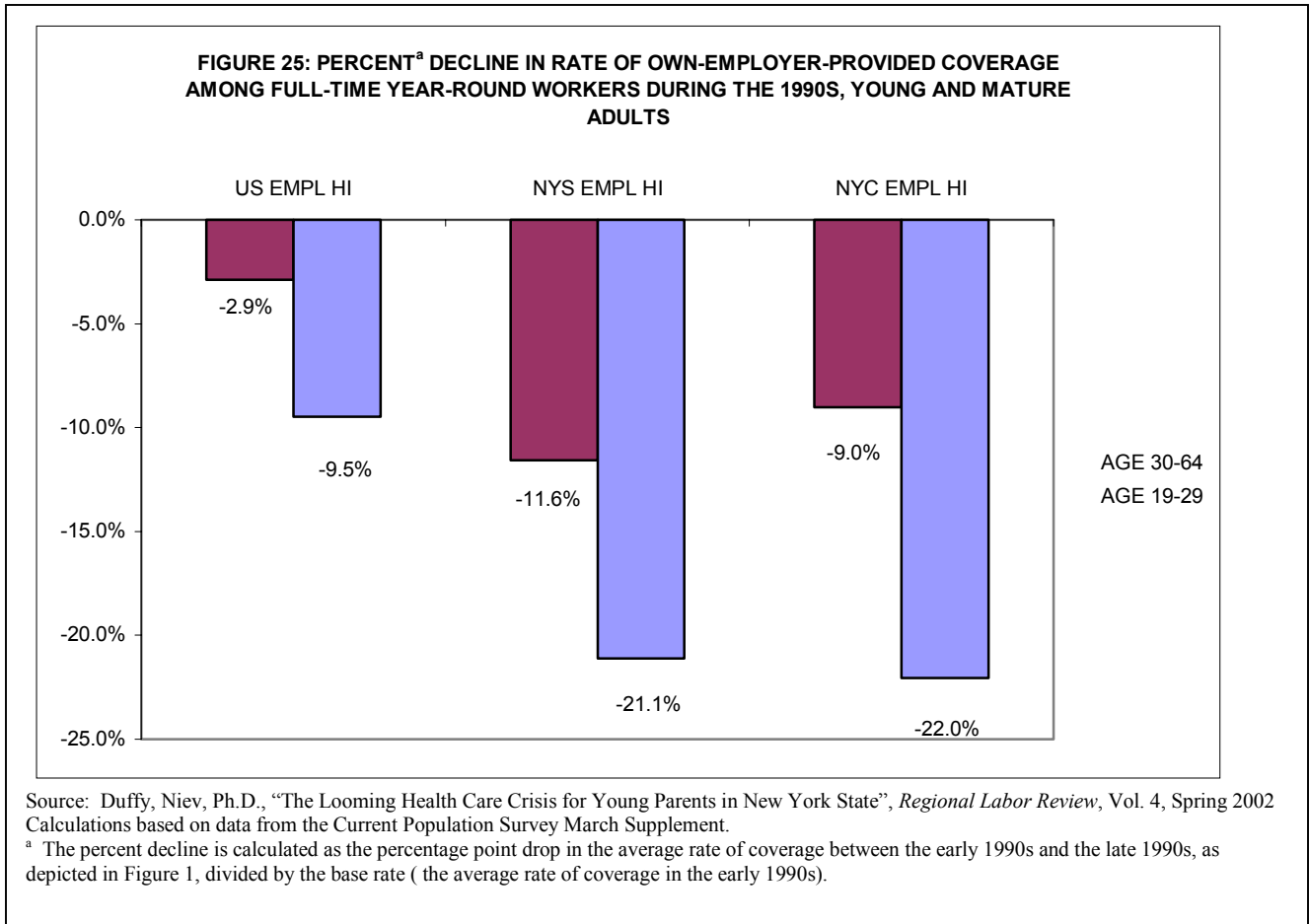




blamed on a rise in part-time and temporary employment, particularly among young people, the bulk of the decline in health insurance benefits among young adult workers has resulted from **declining coverage among full time year-round workers**. **Figure 24** compares the rate of own employer-provided coverage among full-time year-round workers in the early 1990s with the rate of coverage in the late 1990s^{viii}, demonstrating strong declines, particularly in New York State and City. **Figure 25** compares the percent decline for young workers aged 19-29, with older workers 30-64. The percent decline is calculated as the percentage point drop in the rate of coverage between the early 1990s and the late 1990s, (as depicted in **Figure 24**), divided by the base rate (the average rate of coverage in the early 1990s). As

Figure 25 clearly shows, this drop was far sharper for younger workers.

The current economic downturn is likely to substantially lower employment rates among adolescents, further decreasing their access to employer-provided health insurance benefits. The far lower rates of coverage among full-time year-round workers suggests that simply returning to 1989 levels of employment (a year of strong economic growth) would lead to precipitous declines in private insurance coverage among parents and their children. Worse yet, if we were to experience an economic recession similar to that of the early 1990s, the slide in coverage could be far greater, bringing down the rate of health insurance coverage well below levels experienced in 1993.



DISCUSSION

The rising share of patients with no health insurance and the growing financial constraints facing health care facilities have led many health care providers to reduce capacity, cut staff, eliminate community services, and/or deny services to the uninsured. Some have been forced to close their doors altogether. Community services for the underserved are often the first programs to be cut. The remaining institutions that continue to serve the uninsured experience ballooning deficits and an ever more rapid growth in the rate of referral of uninsured patients from other facilities. Ultimately, without additional public funding to cover the growing costs of the uninsured, these trends will

inevitably lead to the denial of services to those adolescents who are likely to need them the most.

Yet the declining availability of adolescent health care services has expensive consequences, both short-term and long-term. Health risks rise dramatically during late adolescence, an age when the probability of having health insurance coverage plummets. The result is often a lack of appropriate preventive and reproductive health care for this age group. Studies clearly show that the uninsured, particularly those among the working poor, are more likely to sacrifice needed care and have less access to services^{ix}. The lack of adolescent services leads to long-term social and economic problems that

detract from regional prosperity and create thorny political issues for policy makers. Politically, it is easier and cheaper to prevent poor adolescent health outcomes than to address the inevitable consequences when adolescents are denied access to comprehensive care.

For example, due to the lack of access to reproductive health care services for adolescents, including screening and treatment for STDs, the prevalence of treatable diseases such as Chlamydia Trachomatis among young people persists at epidemic levels^x. Left untreated, STDs can lead to more serious illnesses, such as Pelvic Inflammatory Disease, that require far more expensive treatment and/or hospitalization. Adolescents are also far more likely to experience unwanted pregnancies. Without health insurance and/or providers that ensure patient confidentiality, it is difficult for many adolescents to afford the reproductive health services that permit them to avoid unwanted pregnancies, leading to long-term public costs in terms of social services, lower individual earning potential, and the perpetuation of poverty. Young people are more likely than adults or children to experience physical and sexual abuse, now at epidemic proportions, resulting in physical and emotional trauma. Without consistent high quality counseling and preventive services, victims of abuse often experience ongoing personal victimization, diminished personal productivity, and high risk behaviors such as drug and alcohol abuse.

Studies have shown that comprehensive adolescent health care, including health education and mental

health counseling, can greatly reduce public outlays for social support programs^{xi}. Relatively small current expenditures on such programs provide both short-term and long-term savings. By reducing teen parenting, increasing school retention and attendance, and helping to limit high risk behaviors, adolescent health services foster individual independence and productivity. The ongoing decline in funding for adolescent services is therefore likely to lead to larger and longer-term increases in public outlays elsewhere.

FUTURE POLICY IMPLICATIONS

Given the very low and declining rates of private insurance among older adolescents in New York City, (43% for African Americans and 27% for Hispanics), Medicaid, CHIP and a patchwork of public funds for charitable care will continue to provide the vast bulk of funding for primary, preventive and reproductive health services for “at risk” adolescents.

Declining access to Medicaid/CHIP among older adolescents, as documented above, leaves a gap in funding that severely undermines the financial viability of facilities that serve uninsured adolescents. Unfortunately, new “facilitated enrollment” programs designed to provide Medicaid/CHIP coverage to the uninsured, are only of very limited value with respect to adolescent health services. Since facilitated enrollment programs require documentation of parental income, they breach the patient confidentiality that is a critical component of adolescent care. New legislation to permit adolescent

self-enrollment for confidential services, independent of parental income, is a necessary first step in broadening Medicaid/CHIP coverage of comprehensive adolescent health care services.

By expanding the CHIP program to provide coverage to many young parents and their families, New York State has established itself as a leader in addressing the lack of health insurance among young working people. Unfortunately, this program does not extend benefits to young people who seek reproductive health services that would enable them to delay child-bearing until they are financially independent. It would seem natural, therefore, to expand such legislation to permit adolescent self-enrollment for reproductive health services and pregnancy prevention programs, whether or not they have already started child-bearing.

Without new Medicaid/CHIP legislation, the gap in funding resulting from declining Medicaid/CHIP coverage can only be filled by alternative sources of public funds. While public monies for charity care, such as CHIP DIP, have the potential to help offset the costs of uninsured adolescent care, unless it is specifically earmarked for outpatient adolescent services, it is often used for other programs by institutions experiencing budgetary shortfalls. As a consequence, there is a critical and growing need for the direct public funding of comprehensive adolescent health care services in New York State.

The burgeoning numbers of uninsured has led to growing pressure for public funding of programs that

provide health care services and/or health care coverage to the uninsured. Recently, the A.F.L.-C.I.O. joined a broad coalition, including the United States Chamber of Commerce, the American Medical Association, as well as insurers and consumer groups, in advocating for new public policies designed to reduce the number of uninsured^{xii}. The long term erosion of employer-provided health care, always the mainstay of American health insurance coverage, is helping to fuel the renewed popularity of universal health care, which had enormous public support in the early 1990s, and played a pivotal role in the 1992 presidential election. Similarly, popular support for programs that serve uninsured adolescents is likely to grow in the future as the negative health consequences of declining access to services becomes clearer.

ⁱ “Adolescent Health Services: Improving Health and Lowering Health Care Costs”, Policy Report #1, Mount Sinai Adolescent Health Center, Mount Sinai School of Medicine, March 2002

ⁱⁱ Thorpe, KE, Florence, C, “Medicaid Eligible, But Uninsured: The New York State Experience”, United Hospital Fund, New York, October 2000

ⁱⁱⁱ Bachrach D, Tassi, A, “Coverage Gaps: The Problem of Enrollee Churning in Medicaid Manged Care and Child Health Plus”, A Report of the New York State Coalition of PHSPs, Kalkines, Arky, Zall and Bernstein LLP, June 2000

^{iv} A slight discrepancy in the numbers is due to other types of insurance coverage not listed here.

^v Holahan, J., Kim, J., “Why does the number of uninsured Americans continue to grow?”, Health Affairs, Vol. 19, No. 4, July/Aug 2000

^{vi} In order to adjust for a change in survey design that led to a sharp upward shift in reporting of private health insurance among children starting with the 1995 Current Population Survey March Supplement, the data prior to that year is compensated by using predicted values that include an adjustment factor estimated using eleven years of survey data. For a more detailed description of the estimation technique see Duffy, Niev, Ph.D., “Recent Trends in Insurance Rates among Parents and Their Children”, Working Paper, JFK Jr. Institute for Worker Education, CUNY, 2002

^{vii} Rates shown in Figure 4 include households with only one full-time year-round working parent, the father. Households with a mother also working full-time year-round were excluded since the share of households with two working parents has increased considerably over the last decade, and would skew the figures upward. Similar results were obtained, however, when analysis was performed exploring rates of coverage in all households with a full-time year-round working father, though declines in coverage were slightly less pronounced. These results are available upon request.

^{viii} Comparing an average of the years 1989-1991 with an average of the years 1997-1999.

^{ix} Guendelman, S., Pearl, M., “Access to care for children of the working poor”, Archives of Adolescent Medicine, Vol. 155, June 2001: 651-658, Holl JL, Szilagyi PG, Rodewald LE, Byrd RS, Weitzman ML. Profile of uninsured children in the United States. *Arch Pediatr Adolesc Med.* 1995;149:398-406, Klein JD, Wilson KM, McNulty M, Kappahn C, Collins KS. Access to medical care for adolescents: Results from the 1997 Commonwealth Fund Survey of the Health of Adolescent Girls. *J Adolesc Health.* 1999;25:120-130, McCormick MC, Kass B, Elixhauser A, Thompson J, Simpson L. Annual review of child health care access and utilization. *Pediatrics.* 2000;105:219-230, Newacheck PW, Brindis CD, Cart CU, Marchi K, Irwin CE. Adolescent health insurance coverage: Recent changes and access to care. *Pediatrics.* 1999;104:195-202, Newacheck PW, Stoddard JJ, Hughes DC, Pearl, M. Health insurance and access to primary care for children. *N Engl J Med.* 1998;338:513-9, Weinick, RM, Weigers ME, Cohen, JW. Children’s health insurance, access to care, and health status: New findings. *Health Affairs.* 1998;17:127-136

^x Diaz, Angela and Niev Duffy, “Declining Prevalence of Chlamydia Trachomatis among a

“High Risk” Population Attending an Urban Adolescent Health Center”, Working Paper, Mount Sinai Adolescent Health Center, Mount Sinai School of Medicine, New York, March 2002

^{xi} “Adolescent Health Services: Improving Health and Lowering Health Care Costs”, Policy Report #1, Mount Sinai Adolescent Health Center, Mount Sinai School of Medicine, March 2002

^{xii} Milt Freudenheim, “Coalition Forms to Reverse Trend of Fast-Rising Ranks of Uninsured Americans”, *New York Times*, (February 9, 2002): A12