Targeted Reforms in Health Care Financing to Improve the Care of Adolescents and Young Adults

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Significant changes have occurred in the commercial and government insurance marketplace after the passage of 2 federal legislation acts, the Patient Protection and Affordable Care Act of 2010 and the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. Despite the potential these 2 acts held to improve the health care of adolescents and young adults (AYAs), including the financing of care, there are barriers to achieving this goal. In the first quarter of 2016, 13.7% of individuals 18 to 24 years of age still lacked health insurance. Limitations in the scope of benefits coverage and inadequate provider payment can curtail access to health care for AYAs, particularly care related to sexual and reproductive health and mental and behavioral health. Some health plans impose financial barriers to access because they require families to absorb high cost-sharing expenses (eg, deductibles, copayments, and coinsurance). Finally, challenges of confidentiality inherent in the billing and insurance claim practices of some health insurance plans can discourage access to health care in the absence of other obstacles and interfere with provision of confidential care. This policy statement summarizes the current state of impediments that AYA, including those with special health care needs, face in accessing timely and appropriate health care and that providers face in serving these patients. These impediments include limited scope of benefits, high cost sharing, inadequate provider payment, and insufficient confidentiality protections. With this statement, we aim to improve both access to health care by AYAs and providers’ delivery of developmentally appropriate health care for these patients through the presentation of an overview of the issues, specific recommendations for reform of health care financing for AYAs, and practical actions that pediatricians and other providers can take to advocate for appropriate payments for providing health care to AYAs.
Provider-initiated screening for physical and mental health conditions, early disease identification and prevention, health promotion, and anticipatory guidance are critical components of routine care for AYAs. The cornerstone of clinical prevention is the periodic health supervision visit, the elements of which are detailed by Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, Fourth Edition. The National Committee for Quality Assurance, through its Health Employer Data and Information System, continues to affirm the importance of well-care visits for patients 12 to 21 years of age in its 2019 metrics. Delivery of routine clinical preventive services to all AYAs, including those with special health care needs, encompasses screening for physical and mental health conditions and risk behaviors and has been shown to identify individuals who are more likely to engage in high-risk behaviors. Payment reform can eliminate barriers to providers’ delivery of such care by paying fairly for services provided and by covering benefits that are critical for AYAs. In addition, payers should eliminate patient barriers to seeking care, such as concerns about breaches of confidentiality or excessive cost sharing for preventive services.

There have been significant changes in the commercial and government insurance marketplace after the passage of 2 important pieces of federal legislation. The Patient Protection and Affordable Care Act of 2010 (ACA) (Pub L No. 111-148) created substantial improvements in insurance coverage for AYAs by allowing parents to extend coverage for their dependent children until their 26th birthday, precluding denials for preexisting conditions, eliminating copays and deductibles for certain preventive health maintenance services, and setting a framework for extending Medicaid to thousands of previously uninsured individuals. The ACA exempted some health plans from some key ACA reforms, including certain governmental plans and many individual and group plans that were in effect before the law was enacted on March 23, 2010 (so-called “grandfathered” plans), as long as specific features of these plans did not change. The Paul Wellstone * The ACA treated “grandfathered” plans differently than any new individual or group plan that became effective after March 23, 2010. The ACA required grandfathered plans to cover adult children up to the age of 26 but did not require free preventive care, coverage of all the essential health benefits outlined in the ACA, or coverage of preexisting conditions. New plans that became effective after March 23, 2010, but before October 1, 2013 (so-called “grandmothered” plans), were required to provide preventive care without cost sharing but still had no mandate to cover all essential health benefits or to insure preexisting conditions. Grandmothered plans initially were required to terminate by December 31, 2013, with a pathway to transition to a fully compliant ACA plan. This date was later extended by 4 years to December 31, 2017. Enrollment in grandfathered plans has been decreasing over time. By 2015, only 25% of workers with employee-sponsored insurance were enrolled in a grandfathered plan. By 1 estimate, only 400,000 enrollees will continue to be covered by grandfathered non-ACA individual plans. Some insurance carriers have terminated grandfathered plans in various states. and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Part C of Pub L No. 110-343) implemented parity in payments for medical and behavioral health services, the latter of which has often been covered at lower payment rates. This policy statement discusses improvements in health care financing for AYAs aimed at mitigating the following existing barriers: (1) continued uninsurance; (2) variability in benefit structures across insurance plans; (3) adverse impact of cost sharing; (4) inadequate provider payment for health care services; and (5) insufficient confidentiality protections for billing and insurance claims.

CONTINUED UNINSURANCE AMONG AYAs

Comprehensive and affordable health insurance for AYAs is vital. According to data reported by the Centers for Disease Control and Prevention, in 2015, the rate of uninsurance among children and adolescents from birth to 18 years of age was 5%, and the rate of uninsurance among young adults between 18 and 24 years of age was 14.1%. Although these rates are an improvement over the previous 3-year period, a significant number of AYAs remain uninsured. Uninsurance rates also vary from state to state, with substantially higher rates for individuals 18 to 64 years of age in states that have not accepted Medicaid expansion under the ACA. As of February 2016, 19 states had chosen not to take advantage of the ACA Medicaid expansion, thereby excluding many eligible uninsured adults 18 to 64 years of age from Medicaid coverage, after the 2012 Supreme Court’s ruling that allowed states to opt out of this federally funded opportunity. As a result, the percentage of uninsured adults fell by ~50% (from 18.4% to 9.4%) between 2013 and the first half of 2016 in Medicaid expansion states, whereas a more modest decline from 22.7% to 17.5% ensued in nonexpansion states.
are more likely to be uninsured than young women.10
In states that have opted to expand Medicaid, many uninsured young adults obtained their initial health insurance in this program. A recent study has revealed that children in families in which young adult parents have enrolled in Medicaid are 29% more likely to receive preventive annual well-child visits.11

**VARIABILITY IN BENEFIT STRUCTURES ACROSS INSURANCE PLANS**

Provisions to improve preventive and other health care benefits for AYAs are vital, especially with mandates that employer-based plans insure dependents up to 26 years of age (variably interpreted to mean the 26th birthday or the end of the calendar year in which the 26th birthday falls). The latter provision addressed the phenomenon of “aging out” of coverage after age 18 or 19 that was a primary reason for lack of insurance coverage during the young adult years before passage of the ACA.12 The ACA also states that all nonexempt health plans (ie, grandfathered and grandmothered plans) cover 10 essential health benefit classes for all enrollees:

1. ambulatory services;
2. emergency services;
3. hospitalization;
4. maternity and newborn care;
5. mental health and substance use disorder services, including behavioral health treatment;
6. prescription drugs;
7. rehabilitative and habilitative services and devices;
8. laboratory services;
9. preventive and wellness services and chronic disease management; and
10. pediatric services.

The last category of pediatrics services is incompletely defined but does include a prescription to cover oral and vision care.13

The ACA mandates coverage of clinical preventive services for AYAs on the basis of recommendations in Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, including immunizations for children younger than 18 years and, as recommended by the US Preventive Services Task Force, for young adults 18 years and older. The ACA also mandates coverage for women’s reproductive services, including contraception, without copays or deductibles, as recommended by the Institute of Medicine (now the National Academy of Medicine) in its report “Clinical Preventive Services for Women: Closing the Gaps”14 and adopted by the US Health Resources and Services Administration.15

Despite recommendations to adopt a single, comprehensive, preemptive federal standard in implementing the essential health benefit statute,16 the US Department of Health and Human Services elected to use a variation of the Children’s Health Insurance Program (CHIP) benchmark strategy.17 The authors of 1 study reported that no state specified a distinct pediatric services benefit class.18 Although some benchmark plans explicitly included multiple pediatric conditions, many plans also exclude services on which children with special health care needs may rely, thereby leading to a state-by-state patchwork of coverage with exclusions.18

Although the ACA offered the potential to reduce barriers to the delivery and receipt of clinical preventive services if screening were to be incorporated into health supervision visits,19 disparities in coverage across all health care plans persist and contribute to disparities in access to care as well as care delivery. In addition, some states legally offer only a “minimal health benefit” (excluding benefits available in Medicaid and some commercial health care plans) through their own ACA exchanges. For behavioral health services, use of carve-out arrangements continues to limit access to and thus receipt of behavioral health services because of insufficient numbers of appropriate providers in the contracted networks (see discussion of behavioral health services, below, for more details).

**ADVERSE IMPACT OF COST SHARING**

The ACA established rules regarding cost sharing and the actuarial value of health plans (the percent of medical costs an average person can expect the plan to cover versus the percent of costs the patient must cover through a combination of deductibles, copayments, and coinsurance); however, it can still be difficult for patients to predict how much they are expected to pay for health supervision visits (ie, well-child visits). Although all ACA-compliant plans must provide certain preventive care services at no cost to the beneficiary, ACA-exempt plans may require substantial cost sharing for preventive care,19 thereby discouraging access to these services.

Although health care use highly correlates with insurance coverage,20 having insurance does not necessarily guarantee use of health care services.21 Publicly and privately insured AYAs may not have certain benefits in categories that the ACA labels as “essential” (including behavioral health benefits) or may have difficulty paying deductible, copay, and coinsurance costs. As an extreme example, “catastrophic” health insurance plans that are available on the federal healthcare.gov marketplace exchanges can be purchased at low premiums but carry a high individual out-of-pocket maximum (currently $6850). These catastrophic plans were selected by almost 30,000 AYAs during the enrollment period of November 2015 through February 2016, thereby
leaving these AYAs or their parents with almost complete financial responsibility beyond certain preventive services and 3 primary care visits per year.\textsuperscript{22}

Over the last decade, the number of high-deductible health plans (HDHPs) has also steadily increased. HDHPs decrease the insurance policy premium costs for purchasers and shift the risk of further payments to the individual subscriber. The high deductibles and other out-of-pocket expenses associated with these plans result in the inability to access care or delays in needed care because of a prohibitive cost to the insured and generate high medical debt for families when care has been accessed.\textsuperscript{23} Although HDHPs are designed to reduce use and total medical costs in the short-term, out-of-pocket costs for primary care and other outpatient services may increase total health care costs in the long-term.\textsuperscript{24}

**INADEQUATE PROVIDER PAYMENT FOR AYA SERVICES**

Despite the fact that Medicaid, CHIP, and ACA plans are now mandated to pay for the full Current Procedural Terminology (CPT) expense of some number of preventive visits per year with no cost sharing, they are not required to pay separately for other potential components of the visit. Indeed, a plan may require that these separate components are bundled with the visit code, thereby not paying the provider/practice for the expenses of these additional services. Grandfathered non-ACA plans may impose deductibles and copays for well visits and all of their components (including vaccines) and can still charge copays for any individual component (such as vaccines) or even exclude specific components from coverage. In addition, payments to different providers for the same services by a given payer will vary depending on the leverage the provider can bring to bear during contract negotiations. Providers with smaller patient panels, with higher cost attribution, or with lower quality metrics are disadvantaged with respect to payment schedules.

Payment levels by many governmental and private health care plans do not appropriately pay for the time and effort providers need to deliver services to AYAs.\textsuperscript{25} For example, Medicaid payments for evaluation and management services average less than 80% of Medicare’s payment.\textsuperscript{26} An increase in Medicaid payment to office-based primary care pediatricians to Medicare levels, as was transiently achieved as mandated by the ACA in 2013–2014, did increase physician participation.\textsuperscript{27} The American Academy of Pediatrics (AAP) Committee on Coding and Nomenclature recommends that the Resource-Based Relative Value Scale, a system of valuing physician services by using relative value units, should accurately reflect the resources expended in providing recommended care, including consideration of the complexity of both cognitive and procedural physician work, comprehensive practice expense, and professional liability insurance expense.\textsuperscript{28} Policy makers and payers need to ensure that payment for AYA preventive care services are appropriately covered and paid for adequately.

Other issues further complicate payment for providers’ delivery of preventive services. Some plans do not adhere to CPT guidelines, do not pay individually for specific services (eg, they may bundle separate procedure codes into 1), do not cover CPT billing codes for health education or chronic care management, may restrict coverage of certain diagnostic codes, or have complex and variable coding requirements. Payment for non–face-to-face services, such as telephone calls and e-mails, for nonchronic conditions is also variable or nonexistent.

Providers should become familiar, if not already, with best billing and coding practices for adolescent care.\textsuperscript{29} Importantly, providers may choose to bill for added time spent on specific identified problems (eg, an acute condition or a condition identified during a screening) during a health maintenance visit using a –25 modifier and the pertinent diagnostic codes as part of the billing process. However, this may subject patients to unexpected copays and higher out-of-pocket costs.

At some point, providers face the challenge of transitioning some or all aspects of the care of AYA to other providers who care for adults. Recommendations for best coding and payment procedures for these activities are available at http://www.gottransition.org/resourceGet.cfm?id=352.

Specific challenges to the delivery of behavioral health and sexual and reproductive health services remain for providers of care to AYAs. These specific aspects of care merit in-depth discussion, including the delivery of behavioral health services (including care for mental health problems, eating disorders, and substance use disorder) and the delivery of sexual and reproductive health services.

For behavioral health services, the Paul Wellstone and Pete Dominici Mental Health Parity and Addiction Equity Act of 2008 (Pub L No. 110-343), further expanded in 2013, requires that qualifying financial requirements and coverage limitations be no more restrictive for mental health benefits than any other health benefits, that no separate qualifying criteria may be applied, and that the same level of out-of-network coverage must be available for mental health, substance use, and medical or surgical benefits. As of yet, not all states have implemented full
parity of coverage for mental health disorders or only require limited parity linked to severity of illness or a limited range of disorders, thereby allowing discrepancies in the form of visit limits, copays, deductibles, annual and lifetime limits, treatment caps, or more stringent medical necessity standards to be placed on mental health than on other aspects of health care.30 Plans are often not clear about which inpatient and outpatient mental health services are covered. Patients may not learn that a service is not covered until a submitted charge is denied after initiation of treatment.30

Eligibility for new enrollees under Medicaid expansion may not be equivalent to traditional Medicaid benefits, yet it can include a lower level of “benchmark-equivalent” coverage, which translates to gaps in coverage for newly insured individuals with mental illness conditions and substance use disorders.31 Low payment rates and service carve-out arrangements further limit mental health and substance use disorder treatment access and care. People with mental health disorders have been more likely to be covered by public than private insurance.32 However, inadequate payment for these services by many Medicaid and CHIP plans reduces the number of mental health clinicians who participate.33

Insurers also “carve out” services that are included in the benefit package to a contracted third party, especially in the area of behavioral health. Plans may carve out specific diagnoses (eg, depression, substance use disorder) or a class of patients (eg, patients with “serious mental illness”). This can occur at the payer (primary carve-out) or health plan (secondary carve-out) level. Patients may be placed under highly restrictive, managed care programs for behavioral health. These arrangements can limit access to appropriate care, both because members may have difficulty in understanding how to achieve access and because the number of appropriate contracted providers may be insufficient. According to a report published online by Open Minds in 2014, 14 states contracted with managed care organizations (MCOs) for fully integrated behavioral and physical health benefits; 11 states contracted with MCOs for fully integrated behavioral and physical health benefits but carved out 1 behavioral health benefit category, such as substance use disorder or psychiatric inpatient care; 16 states carved out all behavioral health benefits from their MCO contracts or fee-for-service systems; and 10 states operated primarily fee-for-service systems of coverage with minimal managed care or primary care case management.34

Children and youth with special health care needs enrolled in state Medicaid plans that carve out behavioral health coverage experienced greater unmet behavioral health care needs than children in plans that did not.33 In recognition of the need for primary care clinicians’ expanded role in the identification and management of behavioral health disorders, the AAP published extensive guidance in a supplement to Pediatrics in 2010.35 The AAP has developed recommendations that help practices to overcome the significant administrative and financial barriers to providing behavioral health care in the primary care setting.36 The AAP has also issued a call to action for the payer community for all children and AYAs to have access to mental health services, insurance coverage for mental health care, and payment systems that ensure appropriate payment to pediatricians.37

For sexual and reproductive health services, after passage of the ACA, women’s access to a full range of contraceptive methods has improved and expenses related to cost-sharing have decreased. Many female AYAs now have increased access to preventive sexual and reproductive health services under the ACA, which should include provision of the full range of contraceptive methods without cost sharing. Initial data indicate that after ACA implementation, the mean and median per prescription out-of-pocket expenses have decreased for almost all reversible contraceptive methods on the market.37 Out-of-pocket spending for oral contraceptive pill prescriptions and intrauterine device insertions by women using those methods has decreased by 20%.39

Even after implementation of the ACA’s coverage expansions, safety-net family planning clinics continue to see millions of women, men, and adolescents.40 Research by the National Women’s Law Center has reported that insurance companies are (1) not providing coverage for methods of birth control approved by the Food and Drug Administration or are imposing out-of-pocket costs for them; (2) providing payment only for generic oral contraceptives; and (3) failing to cover the services associated with birth control without out-of-pocket costs, including counseling or follow-up visits.41 Other violations of the ACA’s birth control benefit included plans not having a required waiver process, failing to cover sterilization for dependents, imposing age limits on coverage, and adopting other policies that in effect deny or restrict coverage of birth control.

Finally, contraceptive methods used by males, especially condoms, were excluded from the ACA’s guarantee of contraceptive coverage without out-of-pocket costs, despite their proven health benefits.42
INSUFFICIENT CONFIDENTIALITY PROTECTIONS FOR BILLING AND INSURANCE CLAIMS PRACTICES

Few insurers have adjusted their administrative and billing systems to protect adolescent confidentiality. Regulations governing those systems may vary from state to state, with some states now mandating changes in explanations of benefits (EOBs) to protect confidentiality.44,45 Historically, a number of barriers prevent or limit confidentiality in billing practices of insured adolescents.44,45 With ACA insurance expansion covering dependents through the age of 26 years, issues regarding confidential care now affect young adults 18 years and older, who have traditionally been protected by Health Insurance Portability and Accountability Act privacy laws.44,46

Inadvertent breaches of confidentiality for AYAs covered by their parents’ private insurance plans occurs commonly because of information available via patient portals that link with electronic medical records, EOBs sent to the primary policy holder (including parents), requests for additional information about a claim, actual payment of claims, and claims made in cases of divorce and child custody disputes.46 Some of the issues contributing to these breaches include (1) use of protected health information under the Health Insurance Portability and Accountability Act to secure payment, even in the absence of specific authorization from the patient; (2) disclosures contained in EOBs that make it impossible for an individual covered as a dependent to obtain care confidentially; and (3) the standard industry practice for insurers to communicate solely, or primarily, with the designated policy holder, thereby permitting access to all information about claims filed via the insurer’s Web site.

Some states have fee-for-service payment mechanisms or carve-outs to reimburse providers for confidential care, although most do not.41 Use of such an approach can allow for compensation of providers of care to AYAs seeking services, including services related to sexual and reproductive health, behavioral health, substance use, pregnancy, and abortion.

CONCLUSIONS

Significant health care needs of all AYAs, including those with disabilities, may not be met because of a number of factors, including continued uninsurance, deficiencies in scope of benefits, high cost sharing, inadequate provider payments, and insufficient confidentiality protections despite passage of 2 important pieces of federal legislation, the Paul Wellstone and Pete Dominici Mental Health Parity and Addictions Equity Act and the ACA. Clear definition of broader essential health benefits for AYAs and better alignment of provider payments with the cost of services will catalyze increased availability of key clinical care and preventive services that may improve the overall current and future health and well-being of AYAs. Reducing cost sharing for key services other than an annual preventive visit, as well as implementation of effective billing and claims procedures that maintain confidentiality, will encourage AYAs to obtain needed care. These interventions work to improve financing for health care that can lead to improving AYAs’ access to and receipt of health care, to achieving better compliance and lessen financial challenges for providers delivering recommended AAP care guidelines, and to alleviating the hardship of high out-of-pocket expenses that may ration essential care.54–50

RECOMMENDATIONS

The AAP recommends the following strategies targeted at improving financing for the health care of AYAs:

1. Federal and state agencies should increase their efforts to further reduce the number of AYAs who are not insured or who lack comprehensive and affordable health insurance. An important fact that AAP members can use during advocacy activities with policy makers is that states that have adopted Medicaid expansion have witnessed, on average, a greater reduction in uninsurance rates for young adults ages 19 to 26 years than have states that have chosen not to participate.

2. The Centers for Medicare and Medicaid Services should implement its regulatory authority to update its standards for essential health benefits, as defined in the ACA, in the 2 categories of mental and behavioral health services and pediatric services. These essential health benefits should be consistent with the full scope of benefits outlined in *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, Fourth Edition* (including health supervision visits, nationally recommended immunizations, screening for high-risk conditions, and adequate counseling and treatment of conditions related to sexual and reproductive health, mental and behavioral health, and substance use disorders). In this way, all AYAs can access the full range of services needed during this developmentally critical period to secure optimal physical and mental health as they enter middle adulthood.

3. All health plans should provide preventive services without member cost sharing. In addition, to reduce financial barriers to care for AYAs, payers should limit the
burden on families by reducing or eliminating copayments and eliminating coinsurance for visits related to anticipatory guidance and/or treatment of sexual and reproductive health, behavioral health, and immunization visits.

4. To provide sufficient payment to physicians and other health care providers for medical services to AYAs, insurers’ claims systems should recognize and pay for all preventive medicine CPT codes related to services for health and behavior assessment, counseling, risk screening, and/or appropriate interventions as recommended in *Bright Futures*. These services should not be bundled under a single health maintenance CPT code.

5. Government and private insurance payers should increase the relative value unit allocation and level of payment for practitioners delivering care and clinical preventive services to AYAs to a level that is commensurate with the time and effort expended, including health maintenance services, screening, and counseling.

6. The Centers for Medicare and Medicaid Services should mandate that payers provide enhanced access to cost effective and clinically sound behavioral health services for AYAs, ensure that payment for all mental health services is more equitable with payment provided for medical or surgical services, and ensure that primary care providers are paid for mental health services provided during health maintenance and follow-up visits.

7. There is an ethical and regulatory imperative that private and government insurance plans develop and implement unique billing and claims strategies that ensure AYAs can obtain care with full protection of their confidentiality for appropriate services.

8. The Centers for Medicare and Medicaid Services, together with state agencies, should invest in tracking the impact of the ACA on care of AYAs by monitoring insurance rates, access and delivery of services, coverage, costs, payment, and confidentiality protections, especially those related to billing and insurance claims practices for medically sensitive services.

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**ABBREVIATIONS**
AAP: American Academy of Pediatrics
ACA: Patient Protection and Affordable Care Act of 2010
AYA: adolescent and young adult
CHIP: Children’s Health Insurance Program
EOB: explanation of benefits
HDHP: high-deductible health plan
MCO: managed care organization
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