Health Care for Adolescents and Young Adults Leaving Foster Care: Policy Options for Improving Access

Prepared by: Abigail English, JD, Amy J. Stinnett, MPA, Elisha Dunn-Georgiou, MS, Center for Adolescent Health & the Law

Overview

The young people who leave or "age out" of foster care each year are a vulnerable population with multiple health concerns, intense health care needs, and few resources for securing health care.[1] These youth entered foster care—a system of out-of-home care for children under the supervision of child welfare or juvenile justice agencies—at varying ages and for different reasons. Some were abused or neglected by their parents and removed from their homes at an early age; some were abandoned or forced out of their homes in adolescence; and others were placed into foster care through the juvenile justice system.

Addressing the health concerns of youth leaving foster care by providing them with appropriate and timely health care is a critical component of their successful transition to adulthood. Ensuring their access to health care requires overcoming significant policy and service delivery challenges. Providing these adolescents and young adults with health insurance coverage is one important element in meeting the challenges.

The existing policy framework for Medicaid and the State Children's Health Insurance Program (SCHIP) includes options for making health insurance available to many of these young people.[1,2] Taking full advantage of the existing options would require additional specific action by most states; and ensuring that all young people leaving foster care have access to health insurance would require expansion of existing policy options at the federal or state level or both. Such actions are both necessary and appropriate to meet the compelling needs of young people for whom public governmental agencies have had responsibility throughout much of their lives.

This issue brief describes the young people who are aging out of foster care, their health status, and the barriers to health care they face when leaving foster care. It explains how health care access can be improved for this population, by first describing how Medicaid and SCHIP currently reach adolescents and young adults, and how these two programs can be used to help former foster youth. The brief emphasizes, in particular, the important opportunity presented by the Medicaid Expansion Option contained in the Foster Care Independence Act of 1999, and summarizes the policy options that can best improve access to health care for former foster youth.

Who are the youth leaving foster care?

Young people aged 16 years or older represent about one-fifth of the more than one-half million children and youth in foster care.[3] At any time, more than 100,000 youth aged 16 years or older are in the foster care system, and nearly 62,000 of them leave care each year (Figure 1).[3] More than 20,000 foster youth are "emancipated" each year and expected to live independently after exiting care (Figure 1).[3] Others are reunited with parents or principal caretakers, adopted, placed in guardianship, transferred to another agency, or die or run away.[3] Depending on their specific circumstances, many of these young people encounter significant barriers in accessing health care. Those who are emancipated from care are especially likely to do so, as are those who are members of racial and ethnic minority groups, who comprise nearly half of the children and youth exiting care in 2003.[3]

Figure 1

- *Foster youth aged ≥ 16 years in care on 9/30/2003 = 103,500*
- *Foster youth aged ≥ 16 years exiting care in FY 2003 = 61,990*
- *Foster youth exiting care to emancipation in FY 2003 = 21,720*

Source: HHS, FY 2003 AFCARS Report [3]

There is wide variation among states with respect to the number of youth in their foster care systems who are older adolescent or young adults and also with respect to the numbers who exit to emancipation. Numbers of older youth in foster care in 2002 ranged from a high of 19,889 in California to a low of 172 in South Dakota (Table A). Numbers of youth exiting foster care to emancipation in 2002 varied from a high of 4,011 in California to a low of 2 in Nebraska (Table B). These variations have financial implications with respect to the cost of ensuring access to care for these young people.

Table A

Older youth (≥ 16 years) in foster care on September 30, 2002

National = 101,515

States with highest number:		States with lowest number:	
California	19,889	South Dakota	172
New York	8,680	Idaho	179
Illinois	6,208	Alaska	207
Pennsylvania	4,823	New Hampshire	244
Ohio	4,123	Delaware	245

Source: HHS, Child Welfare Outcomes 2002: Annual Report [4]

Table B

Youth exiting foster care to emancipation in FY 2002

National = 19,548

States with highest number:		States with lowest number:	
California	4,011	Nebraska	2
New York	1,498	New Mexico	11
Illinois	1,250	Alaska	26
Ohio	1,161	Connecticut	32
Florida	939	Maine	33

Source: HHS, Child Welfare Outcomes 2002: Annual Report [4]

How and when do youth "age out" of foster care?

The term "age out" of foster care is sometimes applied when a youth has reached an age when he or she no long automatically qualifies for such care under the jurisdiction of the court and/or the supervision of the state's child welfare agency.[1] Each state sets its own age for automatic discharge from foster care, which may vary between 18 and 21 years, although youth may leave care at an earlier age or they may be offered the possibility of remaining in care voluntarily beyond age 18 years or the usual discharge age.[1]

Youth leaving foster care as adolescents or young adults may or may not receive supportive transition services from their foster care case worker or the child welfare agency responsible for their placement; and even when they do, those transition services often do not include any assistance with accessing health care.

Depending on state policies, some youth have the opportunity to enter or to continue in a residential independent living program when they age out of foster care. These independent living arrangements generally would not be considered foster care, unless they met specific legal criteria. Given the variety of arrangements that exist in different states however, a youth may remain in some version of foster care even after reaching the age at which youth normally age out.[1]

Ultimately, with very few exceptions, most youth will age out or exit from foster care no later than their 21st birthday. During the period between age 16 and 21 years, a significant number of foster youth may be in a transitional status. These youth may no longer be in "foster care" or state custody in the traditional sense but also are not living entirely on their own. Their status during this transitional period may significantly affect both their eligibility for health insurance coverage and their access to health care.[1]

What is the health status of youth aging out of foster care?

High rates of physical and mental health problems have been extensively documented among children and youth as they enter foster care and while they are in care, revealing that many youth in placement under the supervision of child welfare systems have, or are at risk for having, acute, chronic, disabling, and potentially life-threatening illnesses or conditions.[5-8] Many of them could be considered "children with special health care needs" based upon their chronic medical and mental health conditions. There is strong reason to believe, and the available data suggest, that when youth exit foster care their poor health status may persist or even worsen, due to both increased risk-taking behaviors and more limited health care access.[9]

The health problems of former foster youth encompass the full range of behavioral, psychosocial, and medical concerns, including, among others: generally compromised health; mental disorders; substance abuse; sexual risk behaviors; pregnancy; physical and sexual abuse; and malnourishment.[9-13] Consequently, these youth need access to a wide range of health care and services to address these issues (Figure 2).

Figure 2

Health Services Needed by Youth Exiting Foster Care

- Comprehensive health assessments and treatment of identified conditions
- Dental examinations and treatment
- Family planning and other reproductive health services
- Pregnancy related care
- STD and HIV testing and treatment
- Mental health services
- Substance abuse assessment, counseling, and treatment
- Treatment of injuries
- Treatment for acute and chronic illnesses and conditions
- Case management and coordination of care

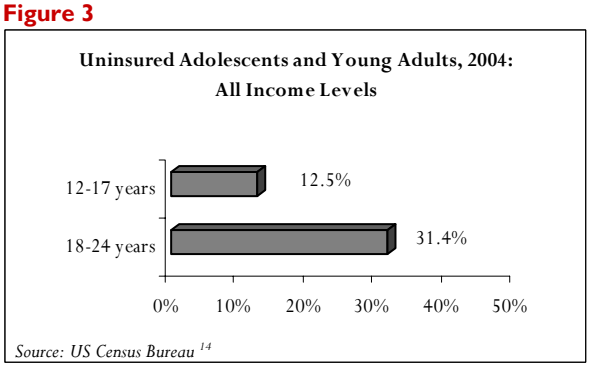
Source: English A, Morreale MC, Larsen J. J Adolesc Health, 2003 [1]

What barriers to health care do youth face when they leave foster care?

Many youth exiting foster care spend at least some period of time living in perilous circumstances. Large numbers of former foster youth are poorly educated, unemployed, and/or homeless: consequently, many are living in poverty.[9-13] Many also are physically or sexually victimized or involved in dangerous or illegal activities such as using or selling drugs.[1] These characteristics, combined with the young people's lack of familiarity with the health care system and a dearth of appropriate providers available to care for them, all contribute to the difficulty they experience in accessing the health care they need. One significant barrier that could be addressed in the policy arena is lack of health insurance: between one-third and one-half of former foster youth in several studies confirmed that they experienced difficulties in accessing health care, with many citing lack of health insurance as a major reason, although not the only barrier.[1] The lack of health insurance characterizing former foster youth is entirely consistent with the overall pattern of uninsurance among older adolescents and young adults, which is the age group in the population that is uninsured at the highest rates, especially for those in poverty.

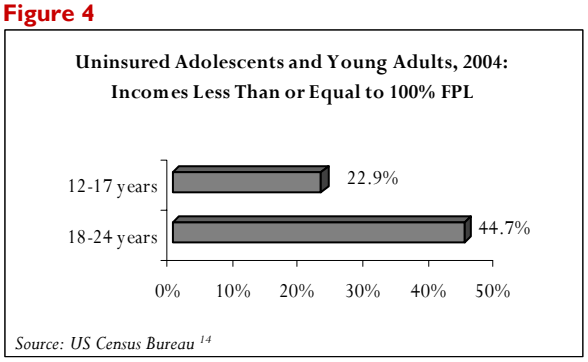
Overall, in 2004, a total of 3.2 million adolescents ages 12-17 years (12.5%) and 8.8 million young adults ages 18-24 years (31.4%) lacked health insurance (Figure 3); and a total of 0.9 million adolescents ages 12-17 years with incomes less than or equal to 100 percent of the federal poverty level (FPL) (22.9%) and 2.3 million young adults ages 18-24 years with incomes less than or equal to 100% FPL (44.7%) lacked health insurance (Figure 4).[14]

Figure 3



Source: US Census Bureau [14]

Figure 4



Source: US Census Bureau [14]

How can health care access be improved for youth who have aged out of foster care?

Many strategies could be used to improve health care access for former foster youth, but financial access is an overriding, critical issue. These young people's health care could be provided and paid for in a variety of ways, including, among many others, both health insurance coverage and publicly funded service delivery programs tailored to the needs of this population. From the perspective of individual adolescents and young adults, the health insurance component is a necessary, if not sufficient, element in assuring their access to care.

Making sure that all former foster youth have health insurance coverage could be assured by way of different strategies, including:

- Universal health insurance coverage for the entire population
- Universal health insurance coverage for children, adolescents and young adults
- Expanded health insurance coverage for older adolescents and young adults
- Targeted health insurance coverage for former foster youth
- Comprehensive enrollment of all eligible adolescents and young adults in existing programs

Significant progress could be made in implementing one or more of these strategies by building on the existing policy framework for Medicaid and SCHIP.

How well do Medicaid and SCHIP currently reach adolescents and young adults?

Until relatively recently, Medicaid eligibility for adolescents generally was limited to "categories" of individuals who received cash assistance from the former welfare program for families with children (AFDC), the Supplemental Security Income (SSI) program for individuals who are blind or disabled, or the federal foster care or adoption assistance program under Title IV-E of the Social Security Act. By the early 1990s, however, states were required to provide Medicaid eligibility independent of cash assistance for certain groups of children and adolescents. In particular, states were required to phase in, one year at a time, eligibility for all poor adolescents through age 18 years (or up to the 19th birthday), until they were all covered by 2002.[2]

Medicaid coverage has the potential to meet the multiple and serious health problems of youth making the transition out of foster care.

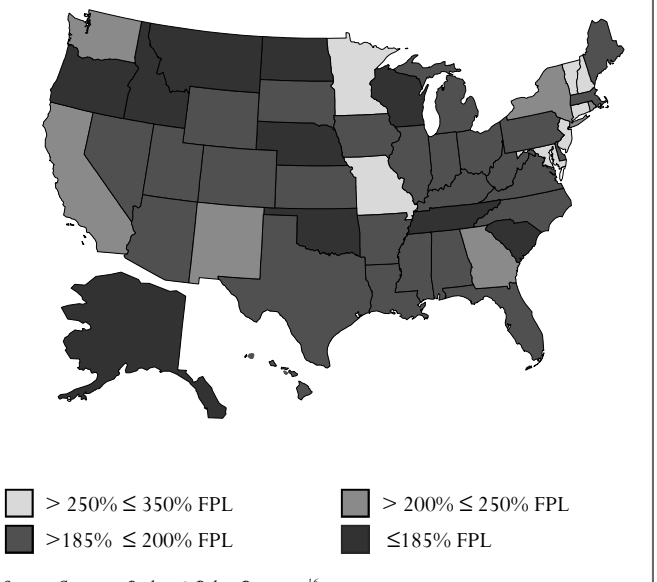
In 1997, Congress created the State Children's Health Insurance Program (SCHIP) and authorized approximately $40 billion in federal funds over 10 years to assist states to provide health insurance to children and adolescents on the basis of family income. States were given the option of using the funds to expand Medicaid, to implement a separate state-designed SCHIP program, or to do a combination of the two, and about one-third of states chose each of these options. States were also offered some fiscal incentives—in the form of higher federal funds matching rates—to accelerate their Medicaid coverage of poor adolescents and to be generous with their eligibility in SCHIP programs. The enactment of SCHIP, and the financial incentives it offered to states, acted as a catalyst to expand adolescents' eligibility for public health insurance through Medicaid and the new SCHIP programs. In the five years following SCHIP enactment, states made significant progress in expanding eligibility and increasing adolescents' enrollment in the two programs.[2] These improvements could be used to benefit youth exiting foster care.[1]

Table C illustrates the upper eligibility limits in Medicaid and in separate state SCHIP programs as reported to the Center on Budget and Policy Priorities in a 2005 survey conducted for the Kaiser Family Foundation. In each state, children and adolescents whose family incomes are at or below the specified level would be eligible either for Medicaid or for SCHIP, as indicated. It is important to note that SCHIP eligibility is limited to youth who do not qualify for Medicaid and who are younger than age 19 years. Youth applying for SCHIP must be evaluated for Medicaid eligibility and enrolled in that program if they qualify. Thus, in any particular state, a child or adolescent younger than age 19 years, whose family income does not exceed either of the levels specified in Table C for their state, would be eligible for either Medicaid or SCHIP.

According to the data in Table C, and looking at the highest eligibility income level provided for either in Medicaid or SCHIP, in 2005, seven states (CT, MD, MN, MO, NH, NJ, VT) provided eligibility for all youth aged younger than 19 years with family incomes at or below a specified level between 250% and 350% FPL (Figure 5). Six states (CA, GA, NM, NY, RI, WA) provided eligibility for youth under age 19 years with family incomes at or below a specified level between 200% and 250% FPL (Figure 5). Twenty-seven states (AL, AR, AZ, CO, DE, FL, HI, IL, IN, IA, KS, KY, LA, ME, MA, MI, MS, NV, NC, OH, PA, SD, TX, UT, VA, WV, WY) and the District of Columbia (DC) provided eligibility for all youth under age 19 years with family incomes at or below 200% FPL (Figure 5). Ten states (AK, ID, MT, NE, ND, OK, OR, SC, TN, WI) provided eligibility to youth under age 19 years with family incomes at or below a specified level less than or equal to 185% FPL (Figure 5).[16]

Figure 5

Maximum Eligibility Level for Youth < Age 19 in Medicaid and/or SCHIP, 2005



Source: Center on Budget & Policy Priorities [16]

What is the potential of Medicaid and SCHIP to meet the needs of former foster youth?

Medicaid coverage has the potential to meet the multiple and serious health problems of youth making the transition out of foster care because the Medicaid benefit package is comprehensive. Specifically, Medicaid includes the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) requirements for Medicaid recipients who are younger than age 21 years. States are required to make available to these children and adolescents periodic comprehensive assessments of their health, inter-periodic health screens, and follow-up diagnosis and treatment. The SCHIP benefit package is potentially as broad as Medicaid, although states have greater discretion in determining which services to offer.

Table C

Medicaid & SCHIP Eligibility Limits < Age 19, 2005

State	Medicaid [a] %FPL	Separate SCHIP %FPL
Alabama	100	200
Alaska	175	
Arizona	100	200
Arkansas	200	
California	100	250
Colorado	100	200
Connecticut	185	300
Delaware	100	200
Dist. of Columbia	200	
Florida	100	200
Georgia	100	235
Hawaii	200	
Idaho	150	185
Illinois	133	200
Indiana	150	200
Iowa	133	200
Kansas	100	200
Kentucky	150	200
Louisiana	200	
Maine	150	200
Maryland	200	300
Massachusetts	150	200
Michigan	150	200
Minnesota	275	
Mississippi	100	200
Missouri	300	
Montana	100	150
Nebraska	185	
Nevada	100	200
New Hampshire	185	300
New Jersey	133	350
New Mexico	235	
New York	100	250
North Carolina	100	200
North Dakota	100	140
Ohio	200	
Oklahoma	185	
Oregon	100	185
Pennsylvania	100	200
Rhode Island	250	
South Carolina	150	
South Dakota	140	200
Tennessee	100	
Texas	100	200
Utah	100	200
Vermont [b]	225 (300)	300
Virginia	133	200
Washington	200	250
West Virginia	100	200
Wisconsin	185	
Wyoming	100	200

Source: Center on Budget & Policy Priorities [16]

a. Includes regular Medicaid and SCHIP-funded Medicaid expansions.
b. Medicaid covers uninsured children with incomes at or below 225% FPL and underinsured children with incomes at or below 300% FPL.

How can Medicaid and SCHIP be used to help former foster youth?

Most youth in foster care qualify for Medicaid based on a patchwork of coverage deriving from several different eligibility categories.[1,17] Federal law requires all states to provide Medicaid for youth receiving federal foster care payments under Title IV-E of the Social Security Act. Even those without "IV-E linkage" are often eligible on another basis, because most states have implemented one or more optional Medicaid eligibility categories that allow them specifically to cover foster children and youth whether or not they are receiving IV-E foster care payments.[1]

Thirty states and the District of Columbia have opted to provide coverage for a special category of children and adolescents with very low family incomes who are known as "Ribicoff" children or youth (Table D). Ribicoff youth are individuals younger than age 21 years (or at state option age 20, 19, or 18 years) who would have met financial eligibility requirements for AFDC based on rules in effect on April 16, 1996. Because those financial eligibility levels were extraordinarily low, many Ribicoff youth are living in extreme poverty.[1] Nevertheless, if they are beyond the usual age cutoff for Medicaid or SCHIP eligibility in their state they probably would not be covered unless their state had chosen to cover them as Ribicoff youth. In the 12 states where the age cutoff for Ribicoff youth is age 18 or 19 years, the Ribicoff option would have little or no practical significance because virtually all Ribicoff-eligible youth would already qualify based on having family incomes at or below 100 percent FPL. Twenty-six states have used the Ribicoff option to cover youth in foster care up to age 18, 19, 20, or 21 years (Table D). Of these, eight states also cover Ribicoff youth generally, but to a lower age limit (Table D).

Only those foster children who do not receive IV-E payments and who cannot qualify under any of the options their state has implemented would be ineligible for Medicaid. The net result of the policies states have adopted has been that most children and youth in foster care are eligible for Medicaid, at least until they reach age 18 or 19 years, and in many states up to age 21 years.[1]

The contrary appears to be true for young people after they leave foster care. Comprehensive national or state-by-state data are not available, but data that do exist suggest many of these youth lack coverage after they leave foster care between ages 16 and 21 years.[1] This could be changed within the framework of existing laws and policies: Medicaid and SCHIP offer the potential to provide health insurance coverage for virtually all youth exiting foster care. If states were to adopt many of the optional eligibility categories in Medicaid and extend SCHIP eligibility as broadly as allowed, most young people exiting foster care could be covered between ages 16 and 21 years.[1]

In every state, youth up to age 19 years with family incomes at or below 100 percent FPL, or even higher in most states, are eligible for Medicaid or SCHIP (Table C). Moreover, very low-income youth who do not qualify for Medicaid or SCHIP on some other basis may be eligible for Medicaid as Ribicoff youth. In addition, in at least ten states former foster youth may be able to receive Medicaid coverage almost automatically under the Medicaid Expansion Option of the Foster Care Independence Act (FCIA) (Table D, Figure 7). Other bases for eligibility would include pregnancy or disability.[1]

Table D

Medicaid Coverage of Ribicoff Youth and Former Foster Youth, 2005

State	Ribicoff Youth	Ribicoff Youth in Foster Care	FCIA Medicaid Expansion Option
Alabama	<19	<21	
Alaska	<20		
Arizona	<18		Yes
Arkansas	<18	<21	
California*	<21		Yes
Colorado	<20	<21	
Connecticut	<21		
Delaware		<21	
Dist. of Columbia	<21		
Florida		<21	
Georgia	<18	<21	
Hawaii		<21	
Idaho		<21	
Illinois	<18	<21	
Indiana			
Iowa	<21		
Kansas		<21	Yes
Kentucky	<19		
Louisiana		<21	
Maine	<21		
Maryland	<21		
Massachusetts	<18		
Michigan			
Minnesota	<21		
Mississippi	<18	<21	Yes
Missouri		<21	
Montana		<21	
Nebraska	<21		
Nevada		<19	
New Hampshire		<19	
New Jersey	<21		Yes
New Mexico		<18	
New York	<21		
North Carolina	<21		
North Dakota	<21		
Ohio	<21		
Oklahoma	<18		Yes
Oregon		<21	
Pennsylvania	<21		
Rhode Island		<21	
South Carolina	<19	<21	Yes
South Dakota		<21	Yes
Tennessee	<21		
Texas*		<20	Yes
Utah	<18		
Vermont	<21		
Virginia*		<21	
Washington	<19	<21	
West Virginia		<21	
Wisconsin	<18		
Wyoming		<21	Yes
TOTALS	31	26	10

Source: State Medicaid Plans and Amendments as of June 15, 2005, www.cms.hhs.gov/medicaid/stateplans

* CCH Medicare and Medicaid Guide ¶ 15,560 (California, as of 7/1/03; Texas, as of 2/7/04; Virginia, as of 6/20/02).

How can the Foster Care Independence Act (FCIA) make a difference?

The Foster Care Independence Act of 1999 (FCIA) increased from $70 million to $140 million federally authorized annual appropriations to the states for independent living services for former foster youth, including housing, education and employment assistance.[18] If fully implemented, the FCIA could enhance significantly the provision of transitional support services, including health care benefits, to young people leaving foster care.

If fully implemented, the Foster Care Independence Act could enhance significantly the provision of transitional support services, including health care benefits, to young people leaving foster care.

FCIA Medicaid Expansion Option

A specific provision of the FCIA known as the "FCIA Medicaid Expansion Option," gave states the option to extend Medicaid eligibility to all youth who were in state-supervised foster care on their 18th birthday (Figure 6). Medicaid coverage under the FCIA Medicaid Expansion Option can be extended until the 21st birthday. Because most youth in foster care are covered by Medicaid, under the FCIA Medicaid Expansion Option, a state could readily facilitate the transfer of a youth's Medicaid eligibility from one category to another without any gap in coverage, as long as the transfer occurred before or simultaneous with the youth's exit from care. Despite its advantages, as of July 2005, only ten states had implemented the FCIA Medicaid Expansion Option: AZ, CA, MS, NJ, OK, SC, SD, TX, and WY[19-28] (Figure 7).

Figure 6

FCIA Medicaid Expansion Option at a Glance

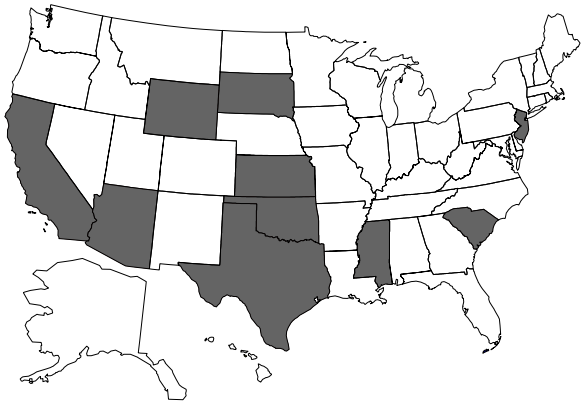
FCIA created a new optional Medicaid eligibility category: "independent foster care adolescents"

- *States may offer Medicaid to youth who were in foster care under state supervision on their 18th birthday*
- *States may continue coverage until youth reach their 21st birthday*
- *States may limit eligibility based on income or other financial criteria*
- *States may limit eligibility to reasonable subgroups of independent foster care adolescents*
- *States must make available to independent foster care adolescents the full range of Medicaid benefits, including EPSDT*
- *As of July 2005, ten states had implemented the FCIA Medicaid Expansion Option*

The FCIA Medicaid Expansion Option created a new eligibility group specifically for youth making the transition out of foster care: "independent foster care adolescents." This group includes anyone who is younger than age 21, who was in foster care on his or her 18th birthday, and whose income and other financial resources do not exceed whatever level, if any, the state establishes. States may choose to cover all 18, 19 and 20 year-olds who were in foster care when they reached age 18 years without any financial or other restrictions. If states elect that approach, only two criteria must be satisfied to establish eligibility: first, the young person must be younger than age 21 years and second, the young person must have been in foster care under the responsibility of the state on his or her 18th birthday.[29]

Figure 7

States Implementing the FCIA Medicaid Expansion Option, 2005



Although they are not required to do so, states may limit eligibility to narrower groups of young people.[29] Specifically, a state may limit eligibility to any "reasonable categories" of independent foster care adolescents based, for example, on age or on prior receipt of federal foster care payments or independent living services. Also, a state may limit eligibility by establishing financial tests, within certain limitations.[29]

One of the most positive aspects of the FCIA Medicaid Expansion Option is its simplicity and, if a state were to place limits on eligibility beyond the threshold criteria, much of this simplicity would be lost. Among the states that have implemented the FCIA Medicaid Expansion Option, only four imposed any limitations beyond the eligibility criteria required by federal law and only two of these imposed any income limitation.[1]

In addition to simplicity, one of the distinct advantages of the FCIA Medicaid Expansion Option is that once enrolled, youth exiting foster care would be entitled to the full range of benefits offered under Medicaid, including EPSDT. This means that youth would be able to obtain any preventive health services, dental care, family planning and reproductive health care, mental health and substance abuse services that are part of the Medicaid benefit package.

Health Care Access Provisions in FCIA State Plans

In addition to allowing states to implement the Medicaid Expansion Option, the FCIA required states to submit 5-year plans to the federal government describing the ways in which they intended to use the new "independent living" funds they would receive under the FCIA. These plans contain descriptions of some steps– other than implementation of the Medicaid Expansion Option—that states were intending to take to improve health care access for former foster youth. Although many of these state plans did not address health care issues in any detail, a few states included innovative approaches in their plans that would facilitate health care access. For example, one state is blending a variety of federal and state funds to create tools like health "passports" and stipends that can be used for medical expenses and insurance. Another state is blending funds to create wraparound services for seriously emotionally disturbed youth.[1]

In addition to the states' 5-year plans, state officials ("independent living coordinators") in a number of states who were interviewed in 2001 and 2002 identified creative approaches for improving health care access for former foster youth. These approaches included ideas for ensuring enrollment in states implementing the Medicaid Expansion Option; mechanisms for increasing Medicaid and SCHIP enrollment generally for these youth; ideas for outreach to youth themselves; methods for increasing access to other health insurance; and ways to facilitate access to other health services and sites.[1]

What policy options can best improve access to health care for former foster youth?

Within the existing policy framework, states can go a long way toward ensuring that former foster youth have access to health care. One of the barriers that stands in the way of doing so is the fiscal pressure that is currently making it difficult at both the state and federal level even to maintain, much less expand, current programs. Medicaid is particularly at risk in this regard. Nevertheless, the fact that the number of youth who exit foster care each year is small (Figure 1, Tables A, B) means that the added cost of providing them with health insurance and health care is limited in scale.

One of the most effective strategies to improve health care access for former foster youth is for every state to implement the Medicaid Expansion Option created by the FCIA. Even doing so, however, will not reach all former foster youth. To reach the others—who were not in foster care on their 18th birthday for example—states can establish a mechanism for evaluating the circumstances of each individual foster youth when he or she leaves care to determine which, if any, of the Medicaid or SCHIP eligibility categories is available as a basis for providing health insurance, and ensuring that the youth is enrolled in one of the programs if eligible. For those youth who cannot currently be reached either through existing Medicaid or SCHIP eligibility or through implementation of the FCIA Medicaid Expansion Option, modest further expansion of those programs at the federal or state level could fill the gaps. In light of the fact that foster youth have been the responsibility of the government for a significant portion of their lives, providing them with the access to the health care that is an important element of the successful transition to adulthood is a well-founded use of public authority.

References

1. English A, Moreale MC, Larsen J. Access to health care for youth leaving foster care: Medicaid and SCHIP. J Adolesc Health 2003;32S:53-69.
2. Morreale MC, English A. Eligibility and enrollment of adolescents in Medicaid and SCHIP: Recent progress, current challenges. J Adolesc Health 2003;32S:25-39.
3. U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau. The AFCARS Report: Preliminary FY 2003 Estimates as of April 2005. Available at: http://www.acf.hhs.gov/programs/cb/publications/afcars/report10.htm Accessed November 7, 2005.
4. U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau. Child Welfare Outcomes 2002: Annual Report. 2005. Available at: http://www.acf.hhs.gov/programs/cb/publications/cwo02/cwo02.pdf. Accessed November 7, 2005.
5. Rosenfeld AA, Pilowsky DJ, Fine P, et al. Foster care: An update. J Am Acad Child Adolesc Psychiatry 1997;36:448-57.
6. Chernoff R, Combs-Orme T, Risley-Curtiss C, et al. Assessing the health status of children entering foster care. Pediatrics 1994;93:594-601.
7. Takayama JI, Wolfe E, Coulter KP. Relationship between reason for placement and medical findings among children in foster care. Pediatrics 1998;101:201-7.
8. Halfon N, Nerkowitz G, Klee L. Mental health service utilization by children in foster care in California. Pediatrics 1992;89:1238-44.
9. Courtney ME, Dworsky A, Ruth G, Keller T, Havlicek J, Bost N. Midwest Evaluation of the Adult Functioning of Former Foster Youth: Outcomes at Age 19. Chicago: Chapin Hall Center for Children, University of Chicago, May 2005.
10. Courtney M, Terao S, Bost N. Midwest Evaluation of the Adult Functioning of Former Foster Youth: Conditions of Youth Preparing to Leave State Care. Chicago: Chapin Hall Center for Children, University of Chicago, February 2004.
11. Pecora PJ et al. (compilers). Improving Family Foster Care: Findings from the Northwest Foster Care Alumni Study. Seattle: Casey Family Programs, March 2005.
12. Massinga R, Pecora PJ. Providing better opportunities for older children in the child welfare system. Future Child 2004 Winter;14(1):150-173.
13. Reilly T. Transition from care: Status and outcomes of youth who age out of foster care. Child Welfare 2003 Nov-Dec;82:727-46.
14. U.S. Census Bureau, Current Population Survey, Annual Demographic Survey, March Supplement, 2004, Table HI02.
15. U.S. Census Bureau, Current Population Survey, Annual Demographic Survey, March Supplement, 2004, Table HI03.
16. Ross DC, Cox L. In a Time of Growing Need: State Choices Influence Health Coverage Access for Children and Families. Menlo Park, CA: Kaiser Commission on Medicaid and the Uninsured, 2005. Available at: http://www.kff.org/medicaid/upload/In-a-Time-of-Growing-Need-State-Choices-Influence-Health-Coverage-Access-for-Children-and-Families-Report.pdf. Accessed January 12, 2006.
17. Schneider A, Fennel K. Medicaid Eligibility Policy for Children in Foster Care. Portland, ME: National Academy for State Health Policy, 1999.
18. Allen M, Nixon R. The Foster Care Independence Act and John H. Chafee Foster Care Independence Program: New catalysts for reform for young people aging out of foster care. J Poverty Law 2000;34:197-216.
19. Ariz. Rev. Stat. §36-2901(6)(a)(iii).
20. Cal. Welf. & Inst. Code §14005.28.
21. Kan. Medicaid State Plan Attachment 2.2A, p. 23a, Eff. Oct. 1, 2003.
22. Miss. Code Ann. § 43-13-115(23).
23. A.B. 49, 209th Leg., § 7 (N.J. 2000).
24. H.B. 1298 (Okla. 2001).
25. S.C. Medicaid State Plan Attachment 2.2A, p.23d, Eff. Apr. 1, 2000.
26. S.D. Admin. R. 67:46:01:02 (2005).
27. Tex. Hum. Res. Code §32.0247.
28. Wy. Medicaid State Plan Attachment 2.2-A, p.23d. Eff. Jul. 1, 2000.
29. 42 U.S.C. § 1396a(a)(10)(a)(ii)(XVII); 42 U.S.C. § 1396d(w); Foster Care Independence Act § 101(e), 113 Stat. 1822, 1829 (1999).

Center for Adolescent Health & the Law
310 Kildaire Road, Suite 100
Chapel Hill, NC 27516-4407
ph. 919.968.8850
f. 919.968.8851
e-mail: info@cahl.org
http://www.cahl.org

Public Policy Analysis and Education Center for Middle Childhood, Adolescent and Young Adult Health
University of California, San Francisco
UCSF Box 0503
San Francisco, CA 94143-0503
ph. 415.502.4856
f. 415.502.4858
email: policycenter@ucsf.edu
http://policy.ucsf.edu

The Center for Adolescent Health & the Law is a unique organization that works exclusively to promote the health of adolescents and their access to comprehensive health care. Established in 1999, the Center is a non-profit, 501(c)(3) organization. Working nationally, the Center clarifies the complex legal and policy issues that affect access to health care for the most vulnerable youth in the United States. The Center provides information and analysis, publications, consultation, and training to health professionals, policy makers, researchers, and advocates who are working to protect the health of adolescents.

The Public Policy Analysis and Education Center for Middle Childhood, Adolescent and Young Adult Health (Policy Center) was established in 1996 with funding from the Maternal and Child Health Bureau. The overall goal of the Policy Center is to identify and analyze the effects of public policies on the health and well-being of young people and their families. Its efforts focus on examining (1) the relationship between the health status of young people and service delivery systems and (2) the environmental determinants of health and development.

Suggested Citation:

English A, Stinnett AJ, Dunn-Georgiou E, Center for Adolescent Health & the Law. Health Care for Adolescents and Young Adults Leaving Foster Care: Policy Options for Improving Access. Chapel Hill, NC: Center for Adolescent Health & the Law; and San Francisco, CA: Public Policy Analysis and Education Center for Middle Childhood, Adolescent and Young Adult Health, 2006.

Acknowledgements:

This issue brief was an outgrowth of a project on "Access to Health Care for Youth Leaving State Custody," initiated in 2000 by the Center for Adolescent Health & the Law and the ABA Center on Children and the Law with support from the William T. Grant Foundation. Work on the project was conducted primarily during 2000-2003 by Abigail English, J.D., and Madlyn C. Morreale, M.P.H., of the Center for Adolescent Health & the Law, Kathi Grasso, J.D., of the ABA Center on Children and the Law, and Judith Larsen, J.D., a consultant to the ABA. The project resulted in several publications related to youth who have been under the jurisdiction of the child welfare system and are exiting foster care, with additional attention to youth who have been under the jurisdiction of the juvenile justice system. Those publications include:

- English A, Morreale MC, Larsen J. Health Care Access for Youth Leaving Foster Care: Understanding Federal and State Policy Options. Chapel Hill, NC: Center for Adolescent Health & the Law, forthcoming 2006.
- English A, Morreale MC, Larsen J. Access to health care for youth leaving foster care: Medicaid and SCHIP. J Adolesc Health 2003;32S:53-69.
- Morreale MC, English A. Eligibility and enrollment of adolescents in Medicaid and SCHIP: Recent progress, current challenges. J Adolesc Health 2003;32S:25-39.
- English A, Grasso K. The Foster Care Independence Act of 1999: Enhancing youth access to health care. Clearinghouse Review/J Poverty Law 2000;34:217-232.

The issue brief also was the result of a collaboration between the Center for Adolescent Health & the Law and the Public Policy Analysis and Education Center for Middle Childhood, Adolescent and Young Adult Health (Policy Center) at the University of California San Francisco (UCSF). The authors gratefully acknowledge the contributions of their colleagues at the Center for Adolescent Health & the Law, the ABA Center on Children and the Law, and the Policy Center at UCSF.

Support:

Support for the preparation of this document was provided in part under MCHB Grant No. U45 MC00023. Additional support was provided by the William T. Grant Foundation and The California Wellness Foundation. The views expressed are those of the authors alone.