



The ACA and Former Foster Youth: Opportunities and Challenges for States

Introduction

Foster youth face many challenges throughout their lives, with one particularly difficult period being the transition to independent living after reaching the maximum age for foster care, which varies by state. During this time, one of their biggest challenges is maintaining good health. Former foster youth face significantly higher rates of mental and physical illness than their non-foster youth peers. They are also much more likely to be uninsured.¹ Consequently, many former foster youth go without the health care they need. To address this issue, the Affordable Care Act (ACA) extended Medicaid eligibility for former foster youth up to age 26.

This paper reviews the health challenges facing youth in foster care and summarize the ACA's former foster youth Medicaid eligibility provision. Additionally, it addresses the issue of eligibility for youth who move to a different state after aging out of foster care, as well as approaches to outreach and enrollment. The paper concludes with lessons learned from advocates and state officials who are working to expand coverage among former foster youth.

Scope of Challenges to Former Foster Youth

Nationwide, 640,000 youth were in foster care at some point in 2012, with 400,000 in foster care at any given time.² Children may be placed in multiple foster homes, and placements can occur across state lines, due to a 50 state agreement known as the Interstate Compact for the Placement of Children (ICPC).^{3,4} Each year, 10 percent of foster youth are emancipated from or "age out" of foster care when they reach their program's maximum age and must begin living independently. The maximum age for foster care is typically 18 years; however, through the Fostering Connections to Success and Increasing Adoption Act of 2008, some states have taken up the option to expand their program up to 21.

Former foster youth are at elevated risk for chronic mental and physical illnesses as a result of their stressful upbringing. Post-traumatic stress disorder (PTSD) is twice as common among foster care youth as it is among Iraq combat veterans.^{5,6} Compared to those with no foster care background, foster youth have twice the risk of depression, are more likely to suffer from anxiety or attention hyperactivity disorder, and are more likely to attempt suicide.⁷ Nearly 60 percent of foster youth are on antidepressants.⁸ In addition to mental illness, common physical ailments include growth failure, asthma, anemia, and neurodevelopmental delay.⁹ Most of these conditions are chronic and require ongoing care.

While in foster care, youth are categorically eligible for Medicaid, which provides comprehensive physical and mental health coverage. Since passage of the Foster Care

Independence Act of 1999, some states have accepted federal matching funds to expand Medicaid to former foster youth up to age 21, an arrangement known as the Chafee Option. Despite the availability of this option, former foster youth go without health insurance at twice the rate of their peers who were not in foster care.^{10,11,12} Former foster youth struggle to find and retain work; employment rates for those in their early 20s hover around 60 percent, and poverty is common in the former foster youth population.¹³ Among Illinois, Iowa, and Wisconsin foster care alumni aged 23 to 24, 30 percent had been homeless for at least one night, and 45 percent of males and 18 percent of females had been incarcerated.¹⁴ Altogether, former foster youth comprise a high risk but often overlooked population that faces considerable past and present stressors that negatively affect their health and their ability to obtain health coverage.

Medicaid Eligibility Extension under the ACA

Section 2004 of the ACA extends Medicaid eligibility to youth who aged out of foster care, regardless of income, up to age 26. This provision is analogous to the provision allowing young people to remain on a parent's insurance up to age 26. All states are required to implement this provision regardless of their decision to expand their Medicaid program to cover adults under 138 percent of the federal poverty level (FPL).

To qualify for coverage under this provision, former foster youth must have turned 18 while in foster care or, in states that have extended their foster care programs beyond 18, aged out at that program's maximum allowed age; they are also required to have been enrolled in Medicaid upon aging out. Approximately 180,000 former foster youth are currently eligible nationally, and an estimated 25,000 more will become eligible each year.¹⁵

Eligibility is guaranteed for youth meeting the criteria described above, provided that they remain in the state where they were in foster care. Eligibility is less straightforward for those who move across state lines after emancipation, because it is optional for states to extend Medicaid eligibility to youths who aged out in a different state. For this group, eligibility is left as a state option because of a nuance in the language of the provision, which defines eligible youth as having been in the custody of "the state." The Centers for Medicare and Medicaid Services (CMS) interprets "the state" to be distinct from "a state" and concludes that the ACA only mandates states to extend Medicaid eligibility to former foster youth who aged out of foster care in the same state in which Medicaid coverage is sought.¹⁶ CMS accepted comments on the interpretation of this provision; however, officials did not address the issue in the final rule.^{17,18}

At present, 11 states have moved to provide Medicaid to former foster youth from out of state.¹⁹

- California
- Georgia
- Kentucky
- Louisiana
- Massachusetts
- Michigan
- Montana
- New York
- Pennsylvania
- South Dakota
- Wisconsin

Consequently, former foster youth who move after emancipation to one of the other 39 states will be ineligible to receive Medicaid under the former foster youth provision, unless these states

act to change course in the future. Of youth who reside in a state where they can obtain coverage, few are doing so.²⁰ Low enrollment suggests that many remain unaware that the benefit even exists, creating an opportunity for outreach, education, and enrollment efforts targeting this population.

Expanding Medicaid to Cover Former Foster Youth from Out of State

While many states have done little more to implement this ACA provision than the minimum required by law, some states have been quick to provide Medicaid for all former foster youth, regardless of where they aged out.

Massachusetts has submitted a State Plan Amendment (SPA) to CMS to extend eligibility to all former foster youth, regardless of where they aged out. The state has a longstanding goal of minimizing the number of uninsured residents, and covering all former foster youth advances this goal. The state plans to use self-attestation of former foster youth status, which lessens the administrative burden of verification for both the applicant and the state's Medicaid agency. Massachusetts administrators estimate the cost of expanding coverage to all former foster youth will be insignificant; as a result, they did not perform a cost analysis.²¹

While Massachusetts used a SPA to implement this policy, California's legislature passed legislation extending Medicaid eligibility to former foster youth emancipated in other states.²² Through the Chafee Option, California already provides Medicaid to youth who aged out of any state's foster care program up to the age of 21. Advocates cite this policy as the rationale for the legislation, which effectively extends the existing policy up to the age of 26.^{23,24} Stories from former foster youth highlighting their challenges enrolling in health insurance helped advocates convince legislators to pass the legislation.

There are several reasons states may not yet have acted to implement the eligibility expansion for youth who aged out of foster care out of state. In some states, administrators are preoccupied with other ACA implementation projects and may conclude that, because the population of former foster youth from out of state is small, other matters take precedence over this issue.²⁵ Awareness of this option is also low, dampening efforts to expand coverage. Moreover, the perception of high costs may be an issue in some states, as federal matching for individuals in the former foster youth eligibility group is provided based on the state's existing match rate, rather than the enhanced match for newly eligible adults.²⁶ However, education and outreach to policymakers—and particularly effective use of stories and personal testimony—may be effective in overcoming these hurdles.

Outreach and Enrollment

Mechanics of Enrollment and Retention

For individuals who are still participating in foster care or related services through the Chafee Option, enrollment is straightforward. Youth can fill out Medicaid application forms with a case worker as part of the transition planning process. Alternately, since the child welfare department has up-to-date personal information, a young person can be enrolled automatically when he or she turns 18. In California, for example, youth are automatically enrolled in Medicaid at their

birthday and are reenrolled at every birthday thereafter until they reach the age of 26. Automatic reenrollment up to the age of 26 will also begin for former foster youth who previously left Medicaid coverage and now return under extended eligibility. In each case, recipients will only be contacted by the department during re-enrollment if the recipient's information is no longer accurate or is incomplete.

A 2012 study found automatic re-enrollment to be the most successful strategy to maintain health insurance coverage for former foster youth.²⁷ However, the study also found poor utilization rates among populations that were auto-enrolled without significant concurrent outreach. The report concluded that auto-enrollment must go hand-in-hand with education for enrollees on the benefits of coverage. As such, outreach should be targeted to fulfill two distinct but parallel goals: identifying and enrolling youth who are not covered and also educating youth about the benefits they receive and how to use their coverage to gain access to services.

One potential hazard of automatic renewal also is that it could lead to the state having out-of-date information if the youth moves, potentially causing a gap in benefits. Additionally, reassessment might be necessary if the youth becomes eligible for Medicaid through another category, although states are at liberty to determine whether to conduct reassessments proactively. Administrators in California determined this type of reexamination to be unnecessary.²⁸ The state has adopted a policy to automatically re-enroll former foster youth without re-examining beneficiaries' eligibility, unless they are presented with information leading them to suspect a reassessment is necessary.

Mechanics for Youth Who Aged Out in a Different State

Those who move to a new state after emancipation face additional challenges. If the new state has expanded eligibility to youth who aged out elsewhere, the state's Medicaid application process may prove more difficult compared to those who remained in the same state after foster care. This is true in New York, for example, where out of state former foster youth who apply for Medicaid receive notice following submission of their application that they must contact customer service at the state's health insurance Marketplace, New York State of Health (NYSOH) to move their application forward. Once contacted, NYSOH representatives attempt to verify the applicant's foster care history and Medicaid status with his or her former state of residence. Coverage does not begin until verification is complete.²⁹ This additional burden on applicants may have a chilling effect on the number of former foster youth who complete the application process, decreasing the impact of the state's decision to cover these individuals.

In California, the application process is simplified so that it is the same regardless of where the applicant was in foster care. The application initially relies upon self-attestation of foster care emancipation and Medicaid history; the state verifies applicants' foster care history and begins coverage while the verification is in process.³⁰ Since counties administer child welfare services in California, child welfare officials at the county level first attempt to verify former foster youth status. If unsuccessful, the verification process moves to the state level. Advocates, along with the California government, are working to establish contacts in every state able to verify alumni from their foster care program. Using these nationwide contacts, California hopes to create an efficient method for verification that does not burden the applicant, streamlines the administrative process on the county and state levels, and ultimately maximizes enrollment.

Ultimately, states that are looking to reduce application requirements on out-of-state former foster youth may use California's application process as a model.

Outreach to Eligible and Future Eligible Youth

As noted previously, outreach is important both for publicizing the eligibility extension and also for educating youth about how to use their coverage. Outreach and enrollment may be particularly challenging for youth who have left foster care but are still under the age of 26, as these individuals are no longer necessarily connected to the state's services.

Many states and advocacy groups have used outreach approaches designed to overcome outdated contact information. In Maine, for example, advocates have distributed flyers to health care providers, homeless shelters, and caseworkers in order to reach former foster youth where they are and through services the youth are already using.³¹ In New Hampshire, the Department of Children, Youth, and Families (DCYF) has posted information on their webpage and Facebook page and has sent flyers detailing the new benefit to foster and adoptive parents, residential facilities, and court appointed special advocates. DCYF has also mailed letters to former foster youth who are a part of the National Youth in Transition Database or to those whom DCYF has a current address, and has promoted the benefit at youth advisory board meetings, at the state's annual teen conference, and at other major statewide events. The department has also been active with local media and has had articles published highlighting former foster youth Medicaid eligibility.³²

Administrators in New Hampshire have faced challenges reaching youth who left foster care several years ago, since the contact information for this group is often outdated. Interagency collaboration can prove a valuable strategy for outreach to this group. Former foster youth older than 21 years of age have high rates of enrollment in Supplemental Nutrition Assistance Program (SNAP), Temporary Assistance for Needy Families (TANF), and other social programs.³³ Collaboration among state departments that manage these programs is crucial to ensure that outreach efforts successfully reach those who are eligible. For example, New Hampshire uses a shared database that combines foster care history as well as enrollment data from TANF, SNAP, Medicaid, and Child Care for verifying foster care and Medicaid history among Medicaid applicants.³⁴ This data could prove an effective and efficient resource to ensure that eligible youth receive outreach and education on Medicaid eligibility.

Collaboration between state agencies can prove valuable in the effort to maximize enrollment, as exemplified by the surge in Medicaid enrollees in states that used SNAP data to enhance their enrollment efforts during the first ACA open enrollment period. In California alone, collaboration among the Department of Social Services, which oversees SNAP, and the Department of Health Services resulted in 550,000 previously uninsured adults and 153,000 previously uninsured children enrolled in Medi-Cal, California's Medicaid program.³⁵ Similar outreach and enrollment successes can be realized with former foster youth Medicaid enrollment in states across the country if state agencies work together.

While California is a leader in implementation of the ACA's former foster youth provision, it has nonetheless encountered challenges in managing outreach and enrollment efforts targeting former foster youth. Because California social programs are county-administered, there are

different enrollment services and supports depending on an individual's county of residence. The county system creates issues with youth who move to a different county after enrolling in services. Because Medi-Cal managed care organizations are based in the county of residence, it can be difficult for youth to access services if they move to a different county. A solution proposed by advocates is for counties to work together to conduct efficient interagency transfers to allow former foster youth seamless access to care after a move. California also offers former foster youth an option to enroll in a fee-for-service Medi-Cal plan. Since it is less geographically restrictive, advocates, eligibility councilors, and navigators recommend youth to sign up for this option if the youth is expecting to move.

Conclusion

Former foster youth constitute a high risk population whose access to health care often ends when they age out of foster care. To support this population's health needs, the ACA makes former foster youth eligible for Medicaid up to age 26. Implementation of this benefit will progress over the coming years, requiring state policymakers and administrators to make key decisions on who is eligible, how outreach is performed, and what is to be done to keep former foster youth covered. Because the former foster youth population is relatively small—and the population of youth who move to a new state after aging out is smaller still—implementation of this provision may not be a priority for policymakers. Advocates in states that do not yet cover youth who aged out elsewhere will be integral to securing coverage for these young adults. In particular, collecting information about this population—both data on the number of youths and stories about what coverage would mean for these individuals—is an important first step in building a compelling case for changing state policy. Moreover, advocates can recommend multiple tactics—including SPAs, budget amendments, or legislation—to policymakers as vehicles to secure coverage for former foster youth. Finally, advocates can point to the successes of other states in implementing this provision and encourage their policymakers to follow the examples of the 11 states that have thus far elected to provide coverage to this population.

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