The Affordable Care Act and Youth Aging Out of Foster Care: New Opportunities and Strategies for Action

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Introduction

The Patient Protection and Affordable Care Act (ACA), enacted in March 2010 and fully implemented in January 2014, has powerful implications for families involved in the child welfare system, particularly youth who have aged out of foster care.[1] The ACA increases the number of individuals who have access to health insurance, simplifies insurance enrollment, requires that benefits include substance abuse and mental health coverage, as well as medical services, and promotes innovations to help coordinate the fragmented delivery of care. More specifically, the ACA includes a targeted provision to require health insurance coverage under Medicaid for youth ages up to age 26 previously in foster care and enrolled in Medicaid. The purpose of this brief is to explain this provision and to identify key steps towards effective implementation.

Effective January 1, 2014, all states must extend Medicaid coverage to age 26 for all youth who are enrolled in Medicaid and in foster care on their 18th birthday, or enrolled in Medicaid when they aged out of foster care if over age 18.[2] Youth who aged out in the past several years and are not yet age 26 are covered immediately, and youth currently in foster care are covered when they age out. This provision is intended to ensure these young people can have health insurance without interruption until they are age 26, and parallels the provision currently available to many youth of coverage to age 26 on a parent or guardian's health plan.

Because the new coverage became effective on January 1, 2014, state and federal child welfare advocates, policy experts, decision-makers, and practitioners must now work to support effective implementation. Key action steps include reaching out now to young people under age 26 who aged out in the last few years, building easy and automated linkages to Medicaid for youth who are about to age out, and considering the opportunities to improve health care in addition to health insurance coverage.

The Need for Health Coverage among Aging Out Foster Youth

The number of aging-out foster youth newly eligible for health insurance is not large compared to the total number of people newly eligible for health coverage under the ACA, likely tens of thousands of aging-out youth in the first year and perhaps close to one hundred thousand by 2017.[3] However, because aging-out foster youth have such disproportionately high rates of serious physical and behavioral health issues, ensuring they are covered immediately is especially urgent. Providing this vulnerable group with ongoing health care coverage could make a large difference in terms of their general health and well-being over time, and could potentially prevent damaging and high-cost long-run outcomes for the youth themselves, as well as their children.

There is a large evidence base that underscores the serious and widespread medical, mental health, and substance abuse challenges faced by aging out foster youth. For youth who enter into foster care, the Congressional Research Service reports that between 35 and 60 percent have at least one chronic or acute health condition that needs treatment, and 50 to 75 percent of foster youth exhibit behavioral or social competency issues that may require mental health treatment. Nearly half suffer from chronic conditions such as asthma, cognitive abnormalities, visual and auditory problems, dental decay, and malnutrition. They are also more likely to experience developmental delays or emotional and behavioral problems.[4] More than half of foster children require ongoing medical treatment, and an even larger proportion have moderate to severe mental health problems. Medicaid claims data suggest that as many as 57 percent of youth in foster care meet criteria for a mental disorder.[5] Young adults who were involved in out-of-home care during adolescence are more than twice as likely as their peers to have a current mental health problem and have higher rates of drug dependence than their peers.[6]

The chronic health issues that impact youth involved in the foster care system continue to be problematic for youth who ultimately age out of the foster care system. Youth who have aged out of foster care are more likely than their general peers to have a health condition that limits their daily activities, more likely to take part in psychological and substance abuse counseling, and less likely to be insured.[7]

The challenges that face youth who have aged out can increase their likelihood of various damaging experiences, such as economic and housing instability. For example, more than one-fifth (22.2 percent) of youth who aged out of foster care find themselves homeless at least once within a year of leaving foster care.[8] Many of these consequences are costly as well as deeply destructive. Consistent access to treatment has the potential not only to benefit youth, but also to avert costs to the community, including the cost of crisis response as well as unneeded hospitalization. More consistent treatment could also benefit the young children of aging-out foster youth by improving youth' capacity to offer a stable environment and nurturing parenting. Youth who have aged out of foster care have higher rates of childbirth at a young age, with a study finding they are twice as likely to have a child in the household by age 21.[9]

The prevalence of physical and behavioral health problems among aging out foster youth also has cost consequences. While foster youth may make up a small subset of the population, they have a

disproportionately high cost of care, and Medicaid expenditures are the highest for foster youth who receive behavioral health treatment. These youth are consistently two to three times more expensive than other Medicaid youth.[10] Using 2006 Medicaid data in selected states, 18-year-old foster youth with behavioral or development diagnoses consisted of 2.2 percent of all 18-year-olds on Medicaid, but accounted for 9.8 percent of Medicaid spending on this group. Additionally, the need for treatment for foster youth does not end when they age out of the foster system. They continue to require treatment, and research has shown that use of behavioral health services increases with age and the severity of the health issues increases over time.[11]

The Opportunity: ACA Provisions Affecting Aged-Out Foster Youth

The ACA guarantees these young people health insurance coverage, and it also includes provisions that strengthen their access to a more comprehensive benefit package that can meet their broader needs. Effective January 1, 2014, the ACA provides that foster care youth enrolled in Medicaid on their 18th birthday (or the date of aging out in a particular state if later than age 18) are eligible for Medicaid until they turn age 26. This provision is a mandatory expansion that is unaffected by the Supreme Court decision that gives states the option to implement the act's expansion to cover adults with an income up to 133 percent of the federal poverty level (FPL). Former foster youth who are eligible for Medicaid under this provision are eligible to receive full Medicaid benefits, as opposed to automatic enrollment in the "alternative benefit plan"[12] that states may define for newly eligible adults. Table 1 provides more detail on the specific ACA provisions that affect health insurance coverage and care for these youth.

Table 1: ACA Provisions that Affect Health Coverage and Care for Youth Aging Out of Foster Care

Coverage Provisions

- The ACA requires all states, starting on January 1, 2014, to extend Medicaid eligibility to former foster care children who were (1) in "foster care under the responsibility of the State" and receiving Medicaid when they turned 18 (or the applicable higher age in a state that provides foster care assistance to a later age), and (2) have not turned 26.[13] Income is irrelevant to eligibility for this category of Medicaid.

- Former foster youth are determined presumptively eligible for Medicaid, and current foster care children will not be placed in a new presumptive eligibility group.[14]

- The new eligibility group of former foster care children under age 26 is exempt from mandatory enrollment in an alternative benefit plan.

- Former foster care children must be treated as such, not as newly eligible adults, even if they seem to qualify as newly eligible adults (their income is at or below 133 percent of FPL and they would not have qualified for Medicaid before the ACA).[15] Accordingly, states receive standard federal matching payments for all former foster care children, not the greatly enhanced match that ACA provides to newly eligible adults.

- The ACA requires highly streamlined methods for eligibility determination, enrollment, and retention. For example, a single, simple application is used for all health coverage programs. Regardless of where the application is filed (e.g., with the insurance exchange or with the Medicaid agency), agencies cooperate behind the scenes to sort the applicant into the right program, eliminating any need for the family to go from program to program. Eligibility is determined by matches with third-party data, whenever possible, rather than documentation provided by the consumer, and applications and renewals can take place in person, by phone, online, or by mail.[16]

- States (1) are only required to extend Medicaid coverage to age 26 for those eligible youth who aged out of foster care in their state, but (2) may choose an option to include youth currently residing in the state but who aged out in another state.[17]

Care Provisions

- Young people receiving Medicaid as former foster care children receive, until age 26, full Medicaid benefits, as opposed to the alternative benefit plan that potentially applies to newly eligible adults under the ACA.[18]
    - Youth aging out of foster care are eligible for benefits from the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) provisions of Medicaid until age 21. EPSDT benefits include preventive, dental, mental health, and developmental services for youth, and states are required to provide all Medicaid-coverable, appropriate, and medically necessary services needed to these youth to improve their health conditions.
    - After age 21, youth will receive their state's full Medicaid benefit package for adults.

- While many of the specifics of the Medicaid service packages will vary by state, the ACA broadens access to mental health and behavioral health services, including substance abuse treatment, which has been included as part of the ACA's essential health benefits package. In addition, parity requirements mandate that Medicaid plans provide patients with services that are on par with those of other types of health care, and at comparable prices.

- The ACA includes a number of initiatives to promote integrated care and help improve access to appropriate and comprehensive care. For example:
    - Section 2703 of the ACA provides states with the opportunity to provide services through a "health home" model with a high rate of federal reimbursement. Health homes are very closely related to patient-centered medical homes in terms of care coordination, and have an increased emphasis on linkages between physical and behavioral health care.[19]
    - Section 2706 of the ACA authorizes Medicaid Pediatric Accountable Care Organization Demonstrations[20], which are administered by the Centers for Medicare & Medicaid Services (CMS).
    - Section 2402 of the ACA allows states to develop a state plan amendment to create an eligibility category to provide full Medicaid benefits to individuals eligible for home and community-based services.[21]

Youth will be covered by Medicaid's EPSDT benefit package for children until age 21, after which they will be covered by their state's benefit package for adults.[22] EPSDT includes regular screenings for health and developmental problems, and all treatment that is medically necessary to prevent or heal these problems.[23]

Another key feature of the ACA is its emphasis on delivering benefits through integrated care models. Youth aging out of foster care are a particularly high-need and high-cost group, and providing coordinated services can pay off in the long run by improving patient health and reducing potential health care and social service costs down the road. Health homes are a prime example; states can apply for health homes that are targeted towards serving specific groups of Medicaid patients. By providing integrated health and mental health services that are tailored to a specific sub-group, patients in health homes are able to receive more comprehensive care. States that do choose to implement health homes receive short-term access to 90 percent federal matching funds.

Other examples of integrated care models that may offer opportunities for case management and integrated health and mental health services that would help youth aging out of foster care include primary care medical homes, demonstration projects for integration of mental health and primary care, and accountable care organizations.[24, 25] In addition, Medicaid has long allowed states to cover targeted case management services, which provide for coordination of both health care and non-health care services.[26] Integrated approaches such as these may be especially useful to guide these youth because they emphasize care coordination, allowing for increased continuity over time and strong links between physical and behavioral health services.

Another opportunity the ACA offers complements the medical and behavioral health services for youth who are also parents. Section 2951 of the ACA allows states to apply for Maternal Infant Early Childhood Home Visiting Program (MIECHV) grants. MIECHV programs can focus on those involved in the child welfare system, or those with a history of child abuse and neglect.[27] Home visiting programs offer an opportunity to build a relationship with youth and their children, improve parenting, and engage youth with ongoing health and mental health care to address problems and improve continuity of care.[28, 29]

What Needs to Happen Now

The opportunities are great, but it will take careful, strategic, and prompt action to seize them. To ensure that former foster youth are taking advantage of the full benefits that health reform offers, federal and state officials, state child welfare policy experts and advocates, practitioners, and philanthropists all have a role. Immediate next steps include the following.

Immediately ensure that current foster youth are enrolled through automated systems as they age out, without having to take action or provide verification themselves. A recent study of ten Chafee programs, programs that allow former foster youth to retain Medicaid coverage until age 21, found that states with more automatic enrollment and redetermination processes were able to retain the largest number of youth on Medicaid in the year after they aged out. In states where higher levels of youth involvement were required in the enrollment and redetermination process, youth were less likely to be enrolled in the month before their 19th birthday.[30] Responding to this research evidence and the ACA's emphasis on easy and automatic enrollment, state policy-makers should ensure that enrollment and redetermination processes are as simple for youth as possible. At a minimum, the processes should include (1) a streamlined and automated approach for enrolling youth currently in foster care in Medicaid at the point when they age out, and (2) a

strategy for keeping them enrolled in Medicaid through age 26 that requires as little effort from the youth as possible.[31]

Because of the federal resources currently available for states to redo their Medicaid and human services eligibility systems in accordance with the ACA requirements, many states are now designing and performing major systems overhauls that should include this simplified enrollment and retention for foster youth. Necessary upgrades to information technology systems serving foster care programs can be funded with all Medicaid dollars, including 90 percent of funding from federal matching funds, as long as those upgrades take place by December 31, 2015. If states miss this opportunity and use a process that requires considerable intervention from the child welfare agency or the youth, they raise the risk of causing these youth to remain without health insurance. Among the specific requirements in the Medicaid regulations implementing the ACA changes are several that offer important opportunities for foster youth. For example:

- Eligibility must be granted, without asking for documentation, whenever data matches and applicant attestations are reasonably consistent.[32] This would include instances when former foster care children identify themselves as such, and state records establish that they were in the foster care system at age 18.

- Similarly, Medicaid regulations require eligibility to be continued automatically whenever information in state hands is sufficient to demonstrate continued eligibility,[33] which is very likely to be the case for former foster care children younger than age 26. Improvements should be included to ensure easy, automatic, and continuous eligibility without needing to provide paperwork or re-verify elements of eligibility that do not change.

Find and enroll youth who aged out before 2014, but are under age 26 as of January 1, 2014, and are still eligible for coverage. Child welfare officials will likely need to spearhead the work of identifying youth by drawing on their own administrative records and the networks and community partners that support youth. Given the high rates of housing instability and homelessness in this population, tracking these youth will likely be a challenge, and state leaders should consider informing their outreach strategies by conducting focus groups with foster youth to gain their insights and perspectives on effective strategies, as well as potentially implementing a broad public information campaign. No matter what door a youth enters, the agencies need to ensure that (1) there is a way to let them know about their eligibility and flag their applications during the enrollment process, (2) staff are trained to inquire after former foster youth status during Medicaid eligibility screenings, and (3) that enrollment is made as smooth as possible. Once enrolled, eligibility should be easy, automatic, and continuous until age 26, as indicated in the previous step. Philanthropic funders and the federal government should consider helping states share information on best practices about finding and enrolling these youth, and should also consider supporting data collection to track the effectiveness of enrollment and retention.

Train child welfare and Medicaid staff and relevant community partners in Medicaid enrollment and re-enrollment for aging-out youth. Enrollment for this population will not go smoothly if the social

workers, eligibility caseworkers, and community agency staff a youth interacts with do not themselves understand what he or she is eligible for. Research about the Chafee Medicaid extension, described earlier, found that child welfare staff were not consistently trained in the Medicaid enrollment process for youth aging out of foster care.[34]

Train child welfare staff and partners to help youth use their new health care coverage, not just enroll. Boosting training will not only help enrollment, but will allow child welfare staff and their partners to serve as supports for youth regarding how best to use their new health care benefits. As the system currently exists, the Fostering Connections Act requires child welfare agencies to inform youth about health care as part of a transition plan at least 90 days before they age out of foster care. In addition, some youth may receive guidance in connecting with health care providers through Chafee-funded transition providers, generally nonprofit organizations, while other youth may not have any help. In order to take advantage of the far greater opportunities under the ACA, key child welfare staff who work with youth will need to understand the Medicaid benefits and approach to care and, ideally, would introduce youth before they age out of foster care to their key health caregivers. The child welfare agency might also provide back-up support for youth as their lives change, offering them guidance in connecting back to the health care system, should they lose touch for some reason. In addition, the ACA requires child welfare agencies to discuss the idea of a health care power of attorney with youth as they transition out of care, potentially providing an opportunity for a broader discussion about the use of health care.[35]

Shape the benefit package to best meet the needs of youth aging out of foster care. As states begin to shape their benefit packages, child welfare officials, policy experts, and external stakeholders should provide solid information about the needs of these youth to their state Medicaid counterparts in order to design a system that can appropriately address their needs. Most important, state Medicaid officials need to understand the extent and nature of mental health and medical needs among the aging-out foster youth. Other information could be helpful as well, such as the share who are themselves parents raising young children, the extent of homelessness, and other aspects of their circumstances that might argue for more intensive coordination of services. This information could inform choices about special integrated services initiatives such as health homes, the specific services to be included in the benefit package, and given the high rates of childbirth among this population, how to meet the needs of highly vulnerable infants and toddlers and young adults. The data could also inform decisions about the design and quality standards for managed care. For example, if states serve youth aging out of foster care through managed care plans, they will need to consider how to match youth with plans that offer the right services for their needs, such as strong mental health, medical services and strong care coordination. In some states, when Medicaid beneficiaries do not select a managed care plan within specified time periods, the state selects the plan in which they will be enrolled. If such auto-assignment happens with former foster care youth, the state will need to consider whether these young people will be better served by some plans than by others and, if so, how to ensure auto-assignment to the appropriate plan.

Promote continuity of services, as well as enrollment, for these youth. As noted earlier, states should make continued enrollment in Medicaid until age 26 as automatic as possible. Enrollment is just the first step. States should also consider how to make health care as continuous as possible for these youth as well, a difficult task given the general levels of instability in their lives. For youth with more serious chronic health issues, ensuring continuity between providers who cared for them before they turned age 18 and those who see them as young adults may be important. Additionally, these youth move frequently, which may lead to continuity issues not only when they cross state lines, but also when managed care plans are limited to counties or other sub-state region.

Choose the policy option to cover youth who aged out in other states and develop partnerships with other states that are frequent destinations. As it currently stands, states are required to cover only those former foster youth who aged out of foster care in that same state. A state can choose as an option to cover youth who aged out of foster care elsewhere, but it is not mandated.[36] This poses considerable challenges for meeting the goal of making health and mental health coverage for former foster youth until age 26 on par with the coverage available to youth who are living with their parents. Former foster youth, like other young people in this age range, are extremely mobile. They could be moving across state lines for a multitude of reasons such as pursuing out-of-state education or employment opportunities, and reconnecting with family. States should strongly consider selecting the option to cover these youth regardless of where they aged out of foster care, and should develop partnerships with states that are frequent destinations for their former foster youth. To help other states that choose the option, states that do not choose it themselves should consider developing a streamlined method for confirming a youth's status as having aged out of foster care when it receives a request for information from the destination state.

An example of a state that has already taken action is California. Legislation was signed in June 2013 to allow youth who move to California, but aged out in a different state, to be covered under California's Medicaid plan through age 26.[37]

The federal government could potentially help states choose this option by enabling states to share information about their experience with it and potentially facilitating data sharing that would make it easier for states to confirm eligibility. Philanthropy and external partners can potentially contribute by supporting studies to understand the experiences of these youth and their mobility as they move into their mid-20s, and by helping youth tell their stories publicly.

Assess the health insurance options available to teenagers in the child welfare system who do not age out, but instead achieve a permanent home through guardianship before they turn 18; identify potential state and federal solutions. The opportunities for young people who enter guardianship situations in their teens require attention. This is a remaining policy challenge that needs attention but does not have simple solutions. From the child welfare perspective, subsidized guardianship is a better outcome for a young person than aging out of foster care because it provides a permanent family. However, there is a concern that potential guardians might face a disincentive because youth might not be eligible for Medicaid

upon turning age 18, and they may not be covered under a guardian's insurance plan.[38] It is unclear whether insurance companies are required to cover young adults under a guardian's plan. But, at a minimum, if an employer plan offers dependent coverage to youth under the care of guardians, it must extend such coverage until such youth's 26th birthdays, based on the ACA's statutory language.[39] This issue could potentially affect a considerable number of youth, given the greatly increased role of guardianships.[40] In 2012, 16,424 youth went from foster care to guardianship. State and federal agencies need to consider policy options to address this concern promptly to encourage kin and caregivers to provide permanent arrangements for children.

Conclusion

The ACA offers tremendous opportunities to increase the levels of health coverage and improve the quality of care for vulnerable populations across the country. When considering the implications of health reform on youth aging out of foster care, it is clear that these youth stand to benefit greatly from successful implementation and targeted and efficient outreach strategies. Achieving these objectives, however, will not happen without strategic and ongoing collaboration between health and child welfare leaders to ensure that policies are structured to prevent these youth from falling through the cracks. Federal agencies (CMS, the Administration for Children and Families, and the Substance Abuse and Mental Health Services Administration in particular) need to provide ongoing support to states and child welfare agencies by developing and disseminating technical assistance materials such as guidance, lists of frequently asked questions, or webinars. More intensive federal technical assistance activities such as consultations with state officials and peer learning meetings will also be important in helping states effectively implement health reform. Philanthropic organizations can also support this effort by amplifying federal technical assistance and public education efforts and convening stakeholders to identify and disseminate best practices as they emerge.

With ACA implementation currently underway, both child welfare and health officials are experiencing incredible pressure to ensure their respective systems operate smoothly, and will need to carve out time to make this a priority in order take advantage of opportunities for these youth. The important thing to bear in mind is this is both a marathon *and* a sprint. Ensuring that a system is developed to take advantage of the new opportunities offered to youth aging out of foster care will require urgent attention now to how systems are being designed for roll-out, but will also require continued collaboration in the long-run to ensure that child welfare and health officials are able to work together efficiently and effectively to improve outcomes for this vulnerable population over time.

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[1] This policy brief expands upon an Urban Institute policy paper that focuses on the implications of the ACA on families involved in the child welfare system more broadly. These families have high levels of health and mental health problems, yet before the ACA, they have often been unable to access care. For more information, please see: http://www.urban.org/publications/412842.html.

[2] States are only required to cover youth to age 26 who aged out in their state. States are encouraged to cover former foster youth who are eligible for Medicaid and moved to their state, but the final CMS regulation does not mandate states to do so.

[3] Initial estimates issued by CMS in their Notice of Proposed Rulemaking are that 55,000 former foster youth will actually take advantage of their new Medicaid eligibility in 2014, a number estimated to increase to 74,000 by 2017.

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[12] In its January 2013 Notice of Proposed Rulemaking, CMS replaced "benchmark and benchmark-equivalent plan" with "Alternative Benefit Plan" ("Medicaid, Children's Health Insurance Programs, and Exchanges," 78 Fed. Reg. 4594).

[13] This reflects CMS's interpretation in the Notice of Proposed Rulemaking of Social Security Act Section 1902(a)(10)(A)(i)(IX), added by ACA Section 2004 and amended by ACA Section 10201. The statute is less specific than the proposed regulation about whether the requirement of Medicaid coverage during foster care is tied to a youth's 18th birthday.

[14] Medicaid and Children's Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment; Final Rule. 42 CFR Parts 431, 435, 436, et al. July 15, 2013. Vol. 78 No. 135. Print.

[15] Social Security Act Section 1902(a)(10), clause (XVI) in the matter following subparagraph (G), as enacted by ACA Section 10201(a)(2).

[16] Patient Protection and Affordable Care Act. Pub.L. 111−148, 124 Stat. 119, H.R. 3590, enacted March 23, 2010. Section 1413. Web.

[17] This provision has not been clarified in the final rule, and is discussed by the authors later in the brief.

[18] Newly eligible adults have incomes no higher than 133 percent of FPL and would have been ineligible for their state's pre-ACA Medicaid program. Social Security Act Section 1937 (a)(2)(B)(viii), as amended by ACA Section 2004(c)(2). For the benefits they receive, See Social Security Act Sections 1902(k)(1), providing an alternative benefit plan to newly eligible adults, and 1937(b), describing the alternative benefits offered. Alternative benefit plans provided to newly eligible adults must include all essential health benefits. ACA Section 2001(a)(2).

[19] To qualify, beneficiaries must have two chronic conditions, one chronic condition and at risk for a second, or one serious and persistent mental health condition. States have some leeway in which conditions they choose to target. Thus the demonstrations could be serving mothers with depression or children with behavioral problems and who also have co-occurring physical problems such as diabetes, hypertension, or asthma (Howell et al. Forthcoming).

[20] Accountable Care Organizations (ACOs) are groups of providers who coordinate care for their patients across a range of medical services.

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[23] "Early and Periodic Screening, Diagnostic,-and-Treatment," http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Early-Periodic-Screening-Diagnosis-and-Treatment.html.

[24] Hanlon, Carrie. 2010. "Improving the Lives of Young Children: Opportunities for Care Coordination and Case Management for Children Receiving Services for developmental delay." Washington, DC: The Urban Institute. http://www.urban.org/ UploadedpdF/412289-improving-lives-young-children-3.pdf.

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[28] Howell, Embry, Olivia Golden, and William Beardslee. 2013."Emerging Opportunities for Addressing Maternal depression under Medicaid." Washington, DC: The Urban Institute. http://www.urban.org/publications/412758.html.

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[31] This assumes that the youth stays in the same state until age 26. If the youth moves out of state, a simple determination process should be put into place to check Medicaid eligibility in the new state, and easily enroll if eligible.

[32] See 42 CFR 435.952(b).

[33] See 42 CFR 435.916(a)(2) and (b).

[34] For more information on Chafee implementation, see Pergamit et al: http://www.urban.org/publications/412786.html.

[35] Baumrucker, Evelyne P., Adrienne L. Fernandes-Alcanatara, Emilie Stoltzfus, and Bernadette Fernandez. 2012. “Child Welfare: Health Care Needs of Children in Foster Care and Related Federal Issues.” R42378. Washington, DC: Congressional Research Service.

[36] “Medicaid, Children’s Health Insurance Programs, and Exchanges,” 78 Fed. Reg. 4594.

[37] "Affordable Care Act Expands Coverage for Former Foster Youth." Alliance for Children's Rights. http://kids-alliance.org/galleries/affordable-care-act-expands-coverage-for-former-foster-youth/(accessed January 24, 2014).

[38] There are also concerns about whether there would be disincentives for potential adoptive parents of teens in the foster care system. On the one hand, these concerns are less than those for potential guardians. The reason is that youth aged 18–26 must be included under an adoptive parent’s insurance just as they would be under a biological parent’s, although adding adult dependents to an insurance policy may increase the adoptive parents’ premiums. On the other hand, if adoptive parents are struggling economically themselves, and if they live in a state that does not take the Medicaid expansion, then they would not be able to guarantee health coverage for their adopted adult child. This will likely be particularly salient when low-income kin or foster parents are considering adopting a foster youth with major health needs.

[39] See Public Health Service Act Section 2714, added by ACA Sec 1001(5).

[40] The Fostering Connections Act increased the use of Kin Guardianship programs.