Health Concerns of Youth, Who Age Out Of The System

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Abstract
This paper is about the failure of the child welfare system to provide adequate or proper medical care to foster children while under state jurisdiction. As a result, numerous health problems are confronted by former foster youth who no longer receive publicly funded medical care after emancipation.

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I. Introduction

“Aging out of the system” or “being emancipated” are terms used to describe foster youth who are released from the foster care system when they become a certain age, usually 18 years old. Nationally, approximately 20,000 teens age 16 or older, exit the foster care system each year,¹ and face the intimidating challenge of independent living. But regretfully, many of these teens lack the resources and training that are essential for a successful transition. Support for teens aging out of the system is generally very limited and fails to address their basic needs, particularly with respect to their health status and access to health care.

The failure of the system begins while the child is in foster care. It is well known among professionals in the child welfare system that foster youth are especially susceptible to health problems. Yet these youth continue to be overlooked and fall short of receiving services to address and reduce the risks they face while in care. On one hand, it seems as if the system is so focused on the safety of the child that it disregards important details – such as the physical and mental health needs of the foster child. This is so, despite the fact that most of these children enter the system with multiple health issues, have intense medical needs while in care, and few resources for securing such crucial health care once they age out. On the other hand, it may be that the current laws and policies in place insufficiently address these important health issues facing foster youth. In any event, if the health of foster children is not being treated adequately while they are under the jurisdiction of the state, it is no wonder that the health of former foster

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Youth is extraordinarily poor, exacerbated by their lack of access to health care once emancipated.

Though current laws and policies provide opportunities that, if fully realized, would significantly enhance health care access for former foster youth, challenges remain in determining how best to ensure full implementation of these existing laws and policies and to expand them if necessary to safeguard health care access for these emancipated youth. In order to improve the likelihood that youth making the transition out of foster care will become healthy members of society the child welfare system must provide considerably more guidance, adequate resources, and consistency in its services to them. Furthermore, such health care improvements must apply not only to emancipating foster youth, but must begin while they are in foster care.

The objective of this paper is to identify the health needs of foster youths generally under current foster care policies and to expose any deficiencies within the system, primarily concentrating on the health care concerns among emancipated foster youth in California. Part II of this paper introduces the relevant health care issues in the child welfare system as well as the demographics of both current and former foster youth, and reviews the known data about their health status. Additionally, Part II analyzes the range of barriers that prevents this population from accessing necessary health care, including lack of health insurance coverage and limited funding for safety net programs that could provide appropriate health services. Lastly, it specifically addresses health issues plaguing emancipated foster youth in California.

The next part of this paper analyzes federal and state law requirements, primarily focusing on California law, in light of the troubling statistics reflecting the health
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problems afflicting current and former foster youth. It analyzes whether the existing legal requirements are adequate but not enforced, or whether they are inadequate and in need of change, or both. Part IV evaluates alternative approaches that attempt to ensure essential health care for current and former foster youth. It examines various programs and policies, particularly in California, that try to address gaps in federal law. In concluding this paper, Part V offers policy recommendations, arguing for policy change in California for former foster youth, and the need for additional training and new or improved programs.

II. Issues Presented and Health Data on Foster Youth

The serious health problems that affect youth leaving foster care are of major social concern for several reasons: they threaten the health of the individual adolescents affected; they jeopardize the public health, and they place foster alumni at long-term risk for poor health, chronic homelessness, and inability to wholly integrate into society through education, employment, and other means. While there are countless issues to be discussed in connection with the child welfare system and its detrimental impact on current and former foster youth, this paper focuses primarily on the health concerns that face these youth. It discusses the failure of the child welfare system to provide sufficient medical care to foster youth as well as the barriers to proper health care that further contribute to and result in numerous health problems confronted by foster alumni who no longer enjoy access to health care.
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A. Background: Health Problems Suffered by Foster Youth

Children are placed in foster care through no fault of their own. Most end up in the system because of neglect or abuse by their parents or guardian and are given no choice as to where and how they should live. In spite of the fact that nothing they have done is the cause for their sad and debilitating circumstance, this vulnerable group is basically institutionalized. As a result, many of their fundamental needs are unmet, especially in regards to basic health care maintenance and medical conditions.

By the very nature of the system, those who are placed in foster care usually enter with some kind of physical or mental health issue. Numerous youths entering the system have health problems stemming from poverty, such as low birth weight and malnutrition. They suffer from issues resulting from parental neglect, maternal substance abuse, and physical or sexual abuse. Many foster youth suffer from a variety of health problems related to their experience in foster care. Such health related issues are due to frequent placement changes, inadequate supervision, careless foster families, and lack of communication between social workers, foster parents and physicians.

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3 By definition, foster care youths have experienced trauma; they were removed from the homes of their biological parents due to abuse or neglect and often placed with strangers or in group homes. Children who survive abuse are more likely to have problems in forming positive interpersonal relationships, physical and mental health problems, impaired cognitive development, reduced educational attainment increased delinquency, and a greater likelihood to engage in high-risk behaviors. Melinda Atkinson, Aging Out of Foster Care: Towards A Universal Safety Net for Former Foster Care Youth, 43 Harv. C.R.-C.L. L. Rev. 183, 183-184 (2008).
5 Atkinson, supra note 3, at 184. Many of the problems facing former foster youths stem in part from the treatment they received while in state care. Id.
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Accordingly, foster youth experience a higher incidence of mental and physical disabilities than youth in the general population. Children with disabilities are between 1.6 and 3.4 times more likely to be abused, compared to youth without disabilities, and therefore, more likely to enter the foster care system. Between 20-60% of youth entering foster care have developmental disabilities or delays, compared with about 10% of the general population. In addition, youth in foster care are more likely than non foster youth to experience developmental delays while in foster care. More than 80% of foster children have developmental, emotional, or behavioral problems. Nearly 50% suffer from chronic health conditions, elevated lead blood levels, and diseases such as asthma, requiring ongoing medical treatment. Moreover, dental problems are widespread; one-third to one-half of children in foster care is reported to have dental decay. Also, children in foster care are more likely than kids in the general population to suffer from sensitive health problems such as tuberculosis and sexually transmitted diseases.

As a consequence of changed providers and caseworkers that accompany numerous shifts in foster placement, children in the system are subjected to lack of

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8 Id. Foster care youth experience an overall developmental delay more than 6 times greater than the general population. Id. Among children in foster care, nearly 40% are born low birth weight and/or premature, two factor which increase the likelihood of medical problems and developmental delays. Fostering Perspective, supra note 4, at Vol. 10, No. 2.
9 Fostering Perspective, supra note 4, at Vol. 10, No. 2. Additionally, 21% of children in the child welfare system had a history of learning disabilities, 14% exhibited emotional disturbances, and 12% had speech impairment. Honoring Emancipated Youth, supra note 7, at 1.
10 Fostering Perspective, supra note 4, at Vol. 10, No. 2. At least 25% have three or more health issues (e.g., asthma, failure to thrive, obesity, anemia, and HIV). CATCH Resident Grants, Foster Parents and Physicians for Kids 267 (2002), available at www.aap.org/catch/residentgrants.htm.
11 Fostering Perspective, supra note 4, at Vol. 10, No. 2.
12 Id.
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continuity of health care. A large-scale study by the U.S. General Accounting Office, found that brought to light that a significant percentage of foster children do not receive basic health care, such as immunizations, dental services, hearing and vision screening, and testing for exposure to lead and transmissible diseases. The study found that interruption of needed medical care, resulting in missed appointments and uncompleted treatment regimes, in addition to failure to receive routine laboratory tests or needed referrals to specialized services, and increased risk of over and under immunizations was the main cause of poor health in foster youth.

Likewise, mental health problems burden foster youth at a higher rate than children from similarly deprived backgrounds who have remained in parental or informal family care. Thirty-eight percent of children entering foster care have severe mental health problems. Foster youth are more likely than other children on Medicaid to have a mental health or substance abuse condition, and the majority of foster children have moderate to severe mental health problems. One California study reported that while

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13 Fostering Perspective, supra note 3, at Vol. 10, No. 2. In 1995 the General Accounting Office studied the health of young children in foster care in New York City, Los Angeles County, and Philadelphia County (these areas are responsible for 50% of the foster children in the U.S.). It found that among foster children: 12% received no routine health care, 34% received no immunization, 32% continued to have at least one unmet health need after placement, 78% were at high risk for HIV, but only 9% had been tested for the virus, less than 10% received services for developmental delays, and children placed with relatives received fewer health-related services of all kinds than children placed with non-relative foster parents. Id.

14 Id. This explains why there is such a high percentage of foster youth suffering from those particular health problems mentioned in the previous paragraph.


16 Allen, supra note 6, at 20-21.

17 Honoring Emancipated Youth, supra note 7, at 1.

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children in foster care make up only 4% of the Medicaid eligible population, they consume 41% of the Medicaid mental health services.¹⁹

Since youth who have physical or mental disabilities or other health problems which make them more likely to enter the foster care system, they are likely to suffer from health problems while in care and likely to experience health problems after emancipation. As a result, foster youth require extensively more physical and mental health treatment compared to that of their non-foster peers nationwide. ²⁰ And because many of these health issues are not addressed while these children are living in care, emancipated foster youth suffer disproportionately more from physical and mental health problems compared to their counterparts. Their problems are further aggravated by a lack of transition planning and skill training in essential areas such as education, employment, and most importantly health care, that should be provided while they are living as dependents of the state.

B. Health Problems Faced by Foster Alumni

Whether they are prepared or not, at age 18 most foster youth emancipate from the foster care system. They are forced to navigate life on their own usually without family or a support system to help guide them. The anguish of losing their homes, friends, and communities, their limited access to personal resources, and the multiple placements and disruptions in their education and health maintenance, leave many

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¹⁹ Allen, supra note 6, at 21.
²⁰ Honoring Emancipated Youth, supra note 7, at 1.
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emancipating youth unprepared for independence at 18 years old.\textsuperscript{21} As a result, youth who “age out” of the foster care system are more likely than their peers to face homelessness, incarceration, poor education outcomes, unemployment, and poverty, and to lack proper health care.\textsuperscript{22}

Data suggests that the inferior health status of many foster youth may persist or worsen upon leaving foster care due to reasons such as unstable housing, increased risk-taking behaviors and limited health care access.\textsuperscript{23} The health issues experienced by emancipated foster youth cover a full range of behavioral, psychosocial, and medical conditions. Overall, many suffer from malnourishment and compromised health on top of specific health problems associated with drug use and sexual activity.\textsuperscript{24} One study discovered that 24\% of youth who exited the system had supported themselves by selling

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\textsuperscript{21} Research suggests that an 18-year-old’s inability to attain self-sufficiency may be rooted in biology. The National Institute on Mental Health, the Society for Adolescent Medicine, and the World Health Organization believe the brain remains immature at age 18 and continues to develop into early adulthood. The biological age of maturity may be as late as 26. This age may even be later for foster youth, as stressors such as physical and sexual abuse or neglect can lead to developmental and psychological delays. Melanie Delgado, et al., The Cal. Wellness Found., \textit{Expanding Transitional Services for Emancipated Foster Youth: an Investment in California’s Tomorrow} 2 (2007), available at http://www.caichildlaw.org/TransServices/Transitional_Services_for_Emanipated_Foster_Youth_FinalReport.pdf.
\textsuperscript{22} Atkinson, \textit{supra} note at 3, 3.
\textsuperscript{23} Mark E. Courtney & Amy Dworsky, \textit{Midwest Evaluation of the Adult Functioning of Former Foster Youth: Outcomes at Age 19} 35-38 (2005), available at http://www.chapinhall.org/sites/default/files/ChapinHallDocument_2.pdf. (noting that the higher rate at which exited youth reported experiencing particular symptoms was “concerning” and may reflect “the stress associated with the transition to independent living, especially in the absence of sufficient social supports”. This report also noted that, when compared to youth remaining in foster care, former foster youth reported higher incidences of hospitalization due to drug use and emotional problems and higher rates of inability to access needed medical and dental care due to the cost of care and lack of insurance). \textit{Id.} at 39-44.
\textsuperscript{24} Courtney & Dworsky, \textit{supra} note 23, 41-44. \textit{See also} Abigail English, Madlyn C. Morreale & Judith Larsen, \textit{Access to Health Care for Youth Leaving Foster Care: Medicaid and SCHIP}, 32, J. ADOLESCENT HEALTH (June suppl) 53, 57 (2003) (stating that a large number of foster alumni are also physically and/or sexually victimized or involved in dangerous or illegal activities such as using or selling drugs).
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drugs and 11% received money for sex.\textsuperscript{25} Many experience mental health disorders often
associated with physical and sexual abuse and victimization from which they have
suffered.\textsuperscript{26} Another study found that one in five of young adults discharged from foster
care reported experiencing some kind of serious physical victimization since discharge
and one in ten women reported being raped.\textsuperscript{27}

Growing up in foster care leaves psychological scars. Thus, upon exiting the
system, emancipating youth continue to experience high incidence of mental health
issues.\textsuperscript{28} Although 47\% of foster children receive mental health services while in foster
care, only 21\% receive those services after leaving care.\textsuperscript{29} In fact 54.4\% of foster alumni
have mental health problems as compared to 22.1\% of the general population.\textsuperscript{30} In a
shocking report by Casey Family Programs, panic disorder among foster alumni was
three times that of the general population, drug dependence was seven times more
prevalent among alumni, and alcohol dependence was twice as high.\textsuperscript{31} Another startling
study found that 100\% of former foster youth had either a depression score above the

\textsuperscript{25} Thom Reilly, \textit{Transition from Care: Status and Outcomes of Youth Who Age Out of Foster Care}, 82
CHILD WELFARE 727, 733 (2003).
\textsuperscript{26} Casey Family Programs, \textit{Improving Foster Care: Findings from the Northwest Foster Care Alumni Study}
22, 32 (2005), available at \url{http://www.nxtbook.com/nxtbooks/casey/alumnistudies/},
(charting and analyzing types and incidences of maltreatment suffered by children later placed in foster
care and noting disparate incidences of mental health problems among foster care alumni); e.g., Ruth
Massinga & Peter J. Pecora, \textit{Providing Better Opportunities for Older Children in the Child Welfare
System}, 151, 153-54 (2004), available at
\url{http://www.eric.ed.gov/ERICDocs/data/ericdocs2sql/content_storage_01/0000019b/80/3d/cf/bb.pdf},
discussing studies finding disproportionately high rates of mental health problems among foster care
alumni); Reilly, \textit{supra} note 24, 740-42 (finding many foster care alumni in one study were surviving but
had suffered physical or sexual abuse).
\textsuperscript{27} Youth Advocacy Center, \textit{The Future for Teens in Foster Care} 18 (2001), available at
\url{www.youthadvocacycenter.org/pdf/FutureforTeens.pdf}.
\textsuperscript{28} Courtney & Dworsky, \textit{supra} note 23, at 41 (describing high susceptibility to mental health problems for
those transitioning out of foster care, especially for individuals who lack sufficient social support following
discharge).
\textsuperscript{29} Allen, \textit{supra} note 6, at 21.
\textsuperscript{30} Youth Advocacy Center, \textit{supra} note 26, at 18
\textsuperscript{31} Delgado, et al., \textit{supra} note 21, at 18.
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clinical level or had been admitted to a mental hospital, and in general experienced more psychological distress than their peers in the same age group.\textsuperscript{32} Additionally, 25.2\% of former foster youth have been diagnosed with Post Traumatic Stress Disorder (PTSD).\textsuperscript{33} This rate is six times higher than war veterans and eight times higher than the general population.

In general, foster youth suffer from a disproportionate share of mental and physical disabilities.\textsuperscript{34} As a consequence, these disabilities present an added obstacle to youth aging out of foster care. Disabled youth face not only the challenge of independence, but also how to handle their disability and overcome the hurdles and limitations posed by it.\textsuperscript{35} Such disability may result in discrimination, educational hardships, emotional stress and financial burdens ensuing from the need for continuous medical care.

Further compounding the problem, some studies uncover the direct and indirect connections between the unstable living situations of foster alumni and their access to health care.\textsuperscript{36} Once youth age out of foster care, they are unlikely to find safe, affordable housing, resulting in high rates of homelessness.\textsuperscript{37} Homelessness can be attributed to many factors, and chief among them is health; i.e. physical health, trauma, developmental

\textsuperscript{32} Youth Advocacy Center, \textit{supra} note 26, at 18 (one researcher found that being exposed to long-term foster care had a primarily negative impact on adolescent identity development). \textit{Id.}

\textsuperscript{33} \textit{Id.}

\textsuperscript{34} Allen, \textit{supra} note 6, at 57.

\textsuperscript{35} Atkinson, \textit{supra} note 3, 197.

\textsuperscript{36} Yvette Leung, et al., \textit{Alameda County Health Needs Assessment of Emancipating and Emancipated Foster Youth} 4 (2007), available at \url{http://www.alamedasocialservices.org/public/community/funding_opportunities/ILSP_REPORT_public.pdf}.

\textsuperscript{37} See Allen, \textit{supra} note 6, at 16 (reporting 25\% will be homeless for at least one night).
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delays, disabilities, addictions and mental health. Since emancipating foster youth are particularly susceptible to mental health problems involving a great need of treatment and healing, these youth tend to be less capable of finding and sustaining permanent housing. With no stable housing, youth are less likely to complete their education, find employment, and retain access to health care, all of which jeopardize their ability to make a successful transition to independence. In view of such data, health problems experienced by foster alumni may either contribute to homelessness, or homelessness may exasperate their health problems.

Forty percent of former foster youth are a cost to the community. The cost to the community occurs within two to fours years of emancipation because the emancipated youth have been on public assistance or incarcerated by that time. For instance, approximately 50% of females in the California foster care system receive TANF Medi-Cal within one to six years of emancipation, in contrast to approximately 6% of all females age 19-29 in California who receive TANF. Twenty-seven percent of foster males and 10% of females will be incarcerated at least once. Moreover, several studies disclose that girls who exit foster care are far more likely (approximately three times more likely) than their peers to have a child by age 19. In fact, the majority of females will have given birth and a quarter of males will have fathered a child within 4

39 Everychild Foundation, supra note 1, at 1.
40 Everychild Foundation, supra note 1, at 1. E.g., Allen, supra note 6, at 16 (reporting almost 40% of foster alumni will be dependent on some form of public assistance or Medicaid).
41 Everychild Foundation, supra note 1, at 1.
42 Allen, supra note 6, at 16.
43 Everychild Foundation, supra note 1, at 1.
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years of the transition out of foster care.\textsuperscript{44} In addition, only one-half of youth aging out of foster care will have completed high school, and most will be unemployed within 4 years of leaving the system.\textsuperscript{45} While some state and federal funding is available for independent living programs and health services for emancipating foster youth, data exposes the deficiency of the system to properly provide the support necessary to enable these youth to become self-sufficient.

C. Barriers to Health Care

To a great extent the health care barriers confronted by foster alumni originate while these youth are still in foster care. In spite of the fact that federal law mandates that youth in foster care receive appropriate medical care and ordinary health services, older foster youth rely increasingly on emergency rooms for their typical source of care.\textsuperscript{46} Much of this is due to the fact that their basic health essentials are often not satisfactorily fulfilled. In reality, the foster care system is made up of inconsistent care givers, fragmented medical histories, and lack of designated care providers.\textsuperscript{47} Consequently, there is no clear determination of whose responsibility it is to identify or discover any health care impediments in the foster system. While pediatricians have become proficient at identifying child abuse, they have done little to provide a medical home to

\begin{footnotes}
\footnotetext[44]{Allen, \textit{supra} note 6, at 16 (60\% of females will have given birth and 24\% of males will have fathered).}
\footnotetext[45]{Id. (50\% will have completed high school, and the 62\% will be unemployed).}
\footnotetext[46]{See Leung, \textit{supra} note 36, at 4 (emergency visits by older foster youth occur most often during periods around placement transitions, for injuries and mental health concerns. Part of this abundant reliance on emergency care is due to the child welfare system’s hesitance in the past to allocate resources to teens, instead focusing on younger children).}
\end{footnotes}
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follow these high-risk children. Of course, foster parents too, play a central role when it comes to protecting and promoting the health and development of foster children. While it is expected that foster parents will contribute to their health needs by taking foster children to medical appointments, staying in touch with medical providers, and providing hands-on care that keeps children in good health, foster parents have fallen short in delivering this aid. Notwithstanding the other adults who are answerable regarding the health care of foster children, the ultimate responsibility for inquiring into the health needs of these children and carrying out the actions that address such inquiries, almost always falls on the agency that has custody of the child. Yet, this group has also been unsuccessful in performing its duty toward the health foster children.

A study where the objective of learning why there are an unequal number of children with special health care needs in foster care compared to that of non-care youth, identified lack of cross system collaboration between the child welfare system, medical providers, foster parents, and case workers as a major barrier to sufficient health care.

Common issues and themes recognized in this study included: difficulty sharing information and obtaining consent, lack of efficient information transfer, professional jargon, and inadequate understanding of systems outside their own. Though the

49 Fostering Perspective, supra note 4, at Vol. 10, No. 2.
50 Id.
52 Id. Over 85% of medical providers experienced barriers contacting key people involved in a child’s care, most often due to incomplete contact list; 46% identified consent as a barrier to information sharing. Professional jargon was identified as a barrier to communication by 51% of foster parents, 47% of child welfare professionals and 20% of medical providers. Less than half (48%) of foster parents reported having sufficient training to navigate the medical, legal and child welfare systems. Id.
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primary barriers to health care are lack of funding and integrating services, the child welfare system’s incompetent execution of existing duties and obligations designed to ensure health care access to foster youth, are just as much as an obstruction to health care as the former. Nonetheless, all these barriers are reflected in the disruptions of on-going health care for foster youth, and follow them as they exit the system.

The existing system of health care financing and delivery, on top off all the other issues foster alumni encounter, presents numerous barriers that impede and further complicate their ability to gain access to essential health care. Many of these youth live in poverty, primarily because they are poorly educated and/or unemployed. These features coupled with behavioral issues, victimization and criminality, in addition to insufficient health care providers and unfamiliarity with the health care system, intensify the hurdles former foster youth face in trying to obtain healthcare.53

i. Lack of Health Insurance for Foster Alumni

As emancipating foster youth are likely to be ill-equipped to manage and cope with routine and serious health problems by themselves, there are many bureaucratic barriers that also prevent former foster youth from receiving proper health care. One significant barrier is lack of health insurance. The health insurance system is often an unfamiliar concept to youth. Figuring out how to navigate the system presents a substantial challenge, and besides, even if youth can navigate the system, eligibility requirements make it extremely difficult to acquire coverage.54

53 English, Morreale & Larsen, supra note 24, at 53.
54 Allen, supra note 6, at 20. There is more information on eligibility requirements for former foster youth in Part II of this paper.
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A study found that a third of foster alumni undergo serious health problems after leaving foster care. Yet, over half of the participants in the study had no health insurance. In another survey, nearly one-half of former foster youth confirmed that they had experienced difficulties in acquiring health care and referred to a lack of health insurance as one of the reasons. An additional report found that 44% of foster alumni had trouble acquiring needed medical care most or all of the time, with 50% having no health insurance at all. Finally, a report conducted by Casey Family Programs reported that 33% of all former foster youth have no form of health insurance.

Research indicates that with so many former foster youth uninsured there must be many obstacles, beyond just their lack of preparedness for independent living, that make access to health care nearly impracticable for many of these teens. In fact with almost half of emancipating youth having to deal with chronic health issues, a large portion of this group must potentially have to face enormous medical bills since many of them do not have health insurance. Such potential debt or financial burden of maintaining insurance may also be a deterrent to seeking treatment. Therefore, the lack of health insurance presents one of the most difficult problems for foster youth making the transition to adulthood.

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55 English, Morreale & Larsen, supra note 24, at 53.
56 See Id. (noting that one of the youths located for the study was discharged without health insurance and died because of lack of access to needed diabetes medication). Of those with health coverage, 25% were on Medicaid, 11% on another form public assistance, and only 9% had obtained private health insurance. Id.
57 Id. at 57.
58 Youth Advocacy Center, supra note 27, at 18. One study reveals among 19-year-olds, only 47% of those who exited foster care had health insurance compared to 78% of 19-year-olds in the general population. Leung, supra note 36, at 4.
59 Honoring Emancipated Youth, supra note 7, at 1.
60 Leung, supra note 36, at 3.
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ii. Limited Funding for Safety Net Programs

Another barrier is the lack of adequate funding for safety net programs that are needed to fill in the gaps left by health insurance, or lack thereof. The variety of health issues that threaten emancipated youth imply that their access to a wide range of different types of health services is crucial. Services needed by foster alumni typically include health assessments and treatments for injuries and chronic illnesses and conditions, and behavioral health services, involving both mental and substance abuse assessments, counseling and treatment.61 They also need as specific care related to sexual activity (i.e., prenatal care, family planning, testing and treatment for sexual transmitted diseases), and dental and optical examinations and treatment.62

Without health insurance, former foster youth must rely on receiving health care through other means, like free clinics and safety net programs that serve low-income populations regardless of their insurance status. There are several healthcare safety net programs that are funded in whole or in part by the federal government.63 These programs serve both insured and uninsured individuals and are designed to offer more wide-ranging services to former foster youth.64 Programs that could be particularly important to foster alumni are for example: Community Mental Health Services, Prevention and Treatment of Substance Abuse, the Maternal and Child Health Services,

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61 English, Morreale & Larsen, supra note 24, at 57.
62 English, Morreale & Larsen, supra note 24, at 57.
Health Concerns of Youth, Who Age Out of the System and the Title X Family Planning Services.\textsuperscript{65} However, funding for these programs is already limited, and is becoming more limited every year. With state level budgets under stress, (especially in California) and federal deficits growing, the fight for depleting funds is affecting safety net programs at a growing speed.\textsuperscript{66} Youth emancipating from foster care are a particularly vulnerable group for receiving no health care by any means.

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D. California Statistics

The state of California has the largest number of youth in foster care in the United States, with approximately 83,000 children in the system.\textsuperscript{67} Some have been dependents of the state since they were young and most have multiple foster homes. On average a foster child in California experiences six placements.\textsuperscript{68} Though all foster youth in California are entitled to continuous Medi-Cal coverage while a dependent of the state, studies have shown that with disruptions in foster placements, many foster youth also experience disruptions in their Medi-Cal coverage.\textsuperscript{69} Anytime they change placements, the address of their new residence must be registered with Medi-Cal to receive an

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\item \textsuperscript{65} See English, \textit{supra} note 63, at 453-54 (referencing : 42 U.S.C. §§ 300x to 300x-9; 300x -21 to -35; 701-710; and 300 to 300a-8 (2000): Community Mental Health Services provide comprehensive community health assistance, including substance abuse, medical and dental service, for children with serious emotional disturbances; Prevention and Treatment of Substance Abuse provides assistance to sufferers of AIDS, tuberculosis, and intravenous substance abuse, with additional requirement that at least twenty percent of funding be applied to prevention efforts; the Maternal and Child Health Services fund programs that provide access to preventive and primary health care for low income mothers and children; Title X provides broad family planning assistance, including particularized services for adolescents).
\item \textsuperscript{66} English, \textit{supra} note 63, at 456.
\item \textsuperscript{67} Cities Counties and School Partnership, \textit{supra} note 2, at 3.
\item \textsuperscript{68} \textit{Id.}
\item \textsuperscript{69} Leung, \textit{supra} note 36, at 3.
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updated Medi-Cal card resulting in an often lengthy bureaucratic process, which leaves them without health coverage for a period of time.\textsuperscript{70}

In a disturbing 2005 San Luis Obispo County semi-annual report on medical conditions of children in foster care 85\% of children in foster care enter the system with one or more physical or mental health conditions requiring treatment.\textsuperscript{71} Most common medical conditions among foster children in the report included: suffering from upper respiratory infection/bronchitis, mental, emotional, and behavioral disorders, ear infections, and vision, hearing, and speech impairments. Other health issues mentioned were: dental problems, attention deficit hyperactive disorder, bone fractures, dermatitis, drug/alcohol exposure and affliction with scabies or lice.\textsuperscript{72}

Another report revealed that most foster youth in California have a usual source of care, though this includes the emergency room for many.\textsuperscript{73} Since foster youth are mandated to have Medi-Cal coverage, the majority reportedly use Medi-Cal to pay for health care. However between 25\% and 32\% of those surveyed did not receive a variety of needed services in the past year, including general medical care, eye care treatment and counseling services.\textsuperscript{74} As a result of inconsistent access to health care, foster youth

\textsuperscript{70} Leung, supra note 36, at 10.
\textsuperscript{71} San Luis Obispo County Department of Social Services, A Snapshot of Children in Foster Care: Semi-Annual Report 15 (2005), (under Foster Care Snapshot Report link) available at www.slocounty.ca.gov/dss/Foster_care.htm. The data is based upon records of 341 children in foster care as of 11/30/2005. \textit{Id.}
\textsuperscript{72} San Luis Obispo County Department of Social Services, supra note 71, at 15. (42\% having upper respiratory infection/bronchitis, 26\% suffering from mental, emotional, and behavioral disorders, 18\% are ill with ear infections, and 16.4\% with vision, hearing, and speech impairments. In addition, 13\% experience dental problems, 10\% are diagnosed with attention deficit hyperactive disorder, 6\% have bone fractures, 6\% have dermatitis, and 9\% are subjected to drug/alcohol exposure and 2\% are afflicted with scabies or lice).
\textsuperscript{73} See Leung, supra note 36, at 9. (reporting 17\% of foster youth usually use the ER as their usual place to get health care; and nearly half (46\%) report using the ER at least once in the past year).
\textsuperscript{74} \textit{Id.} (51\% are unemployed and 65\% emancipate without a place to live).
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are deprived of basic health maintenance and must tolerate limited treatment of serious medical issues while under the state’s jurisdiction.\textsuperscript{75} As one might expect, such absence or irregularity of care experienced by foster youth in the system is inherited and reinforced by many as they emancipate or leave foster care.

Four thousand youth exit the California foster system once they turn 18 years old each year.\textsuperscript{76} Studies of California’s former foster youth found that 46% have not completed high school, less than 3% go to college and over half are unemployed and emancipate without a place to live.\textsuperscript{77} One shocking statistic best explains how the system has failed foster alumni: over 70% of all California State Penitentiary inmates have spent time in the foster care system according to the May 12, 2006 Select Committee Hearing of the California Legislature.\textsuperscript{78} Even though each of the 58 counties in California offers some sort of Independent Living services to foster youth, less than 50% of eligible foster youth actually receive Independent Living Program funding.\textsuperscript{79}

Additionally, one in four emancipated youth in California are homeless, and 40% of people living in homeless shelters are former foster youth.\textsuperscript{80} In fact one of the strongest predictors of future homelessness in California is past involvement in the foster

\textsuperscript{75} See Leung, supra note 36, at 9.
\textsuperscript{76} Cities Counties and School Partnership, supra note 2, at 3.
\textsuperscript{77} Delgado, et al., supra note 2, at 7.
\textsuperscript{78} Everychild Foundation, supra note 1, at 1.
\textsuperscript{80} HEY, supra note 38, at 1 (recognizing the longer the period of youth is homeless the higher the risk that the youth will end up as a chronically homeless adult). See also Everychild Foundation, supra note 1, at 2 (stating within 2-4 years of emancipation, 25% of emancipated youth have been homeless for at least one night). In California, 65% of youth leaving care do so without a place to live and nearly 40% of transitioning youth will be homeless within eighteen months of discharge. Id. In Los Angeles and Alameda counties, 50% of emancipated youth will be homeless within 6 months. Id.
A qualitative study of foster alumni in the California Bay Area found that even with Medi-Cal coverage, housing instability often disrupted proximity to and continuity of health care. This study also found a propensity in former foster youth to de-prioritize health issues; their focus was on attending to their imminent needs, such as food, shelter, and clothing.

Like former foster youth throughout the nation, foster alumni in California face higher rates of physical and mental health problems compared to young adults not in the system. Unfortunately however, many foster alumni do not extend their Medi-Cal coverage to age 21. This is usually because they do not know that they can, and/or do not know how to, or they simply are not eligible. In a California study, inconsistent and/or lack of Medi-Cal coverage and lack of knowledge of resources the most commonly cited barriers to health care for former foster youth. Other commonly cited barriers were limited access to transportation, securing stable housing and employment, and the fact that many foster alumni tend to avoid services until their problems become an emergency. Health care costs in California are excessive; a chronic or serious illness will cause severe financial strife for any uninsured individual. Thus, health care costs

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81 Leung, supra note 36, at 3 (acknowledging housing instability as opposed to outright homelessness as being more prevalent among this group).
82 Leung, supra note 36, at 4.
83 Leung, supra note 36, at 4.
84 Id.
85 See Id. (disclosing that lack of Medi-Cal coverage was reported by youth who had trouble getting basic medical care (33%), eye care (33%), and dental care (26%)).
86 See Id. (reporting that not knowing where to get care was the most common problem cited among youth that had problems getting needed counseling (42%), reproductive health care (36%), and eye care (33%)).
87 Id.
88 See Id. at 18 (for example, a 2003 study found that the estimated annual costs for asthma treatment were over $4,900).
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for California’s former foster youth may be a primary impediment to proper treatment of medical conditions.

**III. Legal Requirements**

**A. Background**

In 1965 Congress created Medicaid, using joint federal and state funding to provide health insurance for people with very low incomes, such as families with children, the elderly and the disabled. In the early 1990s, Congress modified Medicaid to include eligibility based on income rather than linkage to a cash assistance program. In 1997, Congress enacted SCHIP, which was designed to provide health insurance coverage based on family income for children and adolescents who had not been eligible for Medicaid. SCHIP also provided a financial incentive for states, in the form of higher federal funds matching rates, to accelerate Medicaid coverage for poor adolescents and to be generous with their eligibility in SCHIP programs. In addition, Congress gave states 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.

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91 Morreale & English, *supra* note 90, at 28.

92 *Id.* at 27.
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Both the Medicaid eligibility expansions and the enactment of SCHIP resulted in significant benefits for youth aging out of foster care. States expanded adolescents’ eligibility for coverage under Medicaid and SCHIP, and increased adolescents’ enrollment in both programs. Notwithstanding the improvements enjoyed by former foster youth through the enactment of these health programs, both programs were designed to include poor children and adolescents generally. At the same time, the need of further assistance continued to grow for emancipated foster youth.

In 1986, the federal government amended the Social Security Act to include the Title IV-E Independent Living Initiative (ILI), which provided financial support specifically for foster youth emancipating from foster care. Between 1986 and 1998, these funds were limited to current foster youth, primarily those ages 16-18 years of age. States had the option to continue services and support after the youth aged out, yet the federal government provided no additional funding. After abundant research was conducted and accompanied with Congressional testimony, it was officially concluded that the majority of former foster youth were clearly unprepared to live independently, despite the ILI program. Therefore, in 1999, Congress enacted FCIA, the Foster Care Independence Act (also known as the John H. Chafee Act), doubling federal funding for independent living programs from $70 million to $140 million. The most critical change was the federal mandate that states use a portion of the funds to assist former foster youth up to age 21.

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93 Abigail English, Elisha Dunn-Georgiou & Marika Johansson, Ctr. for Adolescent Health & the Law, Medicaid and SCHIP: Essential Programs for Adolescents 4-5 (Feb. 2007).
94 Delgado, et al., supra note 21, at 4.
95 Id.
96 Id.
B. FCIA Medicaid Expansion Option

The FCIA included a Medicaid eligibility expansion option, which gave states the option of making Medicaid coverage available to youth who leave foster care on or after their eighteenth birthday to age 21. Though Congress insisted that states implement the Medicaid option, the choice to provide coverage to emancipated youth is ultimately determined by states themselves. Indeed the initial version of the FCIA legislation contained a mandate for extending Medicaid to all former foster youth ages eighteen through twenty, nonetheless it was considered impracticable to enact it as a mandate. For that reason, the option was offered instead, as a more acceptable alternative.

The FCIA Medicaid option gives states the type of flexibility they desire, granting them wide discretion, allowing them to set their own criteria regarding which foster care youths receive services. Still, many have not succeeded in using such flexibility for the benefit of foster alumni. The federal eligibility prerequisites are merely (1) an age requirement and (2) having been in foster care on the eighteenth birthday, yet some states conversely, have imposed a complex eligibility determination process, consequently forfeiting the simplicity of the two threshold criteria.

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99 English & Grasso, supra note 98, at 225.
100 Atkinson, supra note 3, at 197.
101 English, Morreale, & Larsen, supra note 24, at 64-67.
i. States’ Role & FCIA Funds

Federal law plays a significant role in state child welfare programs through funding statutes, like FCIA, but states are given ample discretion in adopting these programs for emancipating youth, and are entirely responsible for establishing specific procedures and managing individual cases. In addition, federal subsidies account for approximately half of the funding spent on child welfare nationwide, but the portions received by individual states differ significantly. Under federal law, states must only maintain jurisdiction over dependent youths until they reach age eighteen. Thus, statutory law regulating when a youth ages out of the system coupled with disproportionate state funding, has led to disparities among services provided to foster care youth across the nation.

FCIA is managed by the Administration for Children and Families within the U.S. Department of Health and Human Services (HHS). States are required to use “objective criteria for determining eligibility for benefits and services under the programs, and for ensuring fair and equitable treatment of benefit recipients.” In order to receive FCIA funds, states must submit multi-year plans detailing how they will comply with and implement FCIA; how the funds will be spent, and how the program will be evaluated. HHS is required to develop outcome measures that track state performance with emancipated foster care, thus, states must also submit annual reports to ACF to determine the effectiveness of their program. Unfortunately ACF did not

102 Atkinson, supra note 3, at 197.
103 Id.
104 Delgado, et al., supra note 21, at 5.
105 Atkinson, supra note 3, at 197.
106 Atkinson, supra note 3, at 197.
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require states to establish baseline measures, use a uniform reporting format, or report youth outcomes. Hence, state information is varied in its usefulness to evaluate program progress and advocates are concerned that states do not accurately report the level of services they provide.

As of 2008, more than eight years after FCIA Medicaid expansion option was enacted by Congress, only one-half of states provided Medicaid coverage to former foster youth beyond age 18 through the FCIA option. Ohio passed legislation that allowed for, but did not mandate, use of the Medicaid expansion option. As for other states, some required that implementation of the option be evaluated, or legislation was initiated but never enacted. Although state officials from over a dozen additional states reported that they gave such legislation considerable thought, in nearly all instances, these state officials cited budgetary constraints as the primary reason for not introducing such measures. For example the state of Oregon has declined to provide per se

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107 Delgado, et al., supra note 21, at 5. For example, of 90 annual progress reports reviewed, 52 did not include data that could be used to evaluate program effectiveness. Id.
108 Atkinson, supra note 3, at 198. E.g., Delgado, et al., supra note 20, at 5 (stating since foster alumni are no longer dependents of the state, no one is required to maintain contact. Instead, states must depend on the youth to initiate contact. States also expressed concern that youth who are doing well are more likely to maintain contact and participate in evaluations, thus resulting in distorted favorable outcomes).
109 Adrienne L. Fernandes, Congressional Research Service Report RL34499, Youth Transitioning From Foster Care: Background, Federal Programs, and Issues for Congress 1 (Sept. 2008), available at http://www.club.cc.cmu.edu/pub/wikileaks/wikileaks-crs-reports/RL34499.pdf. See also English, supra note 63, at 450 (reporting as of July, 2006, merely twelve states had implemented the FCIA Medicaid option: Arizona, California, Indiana, Kansas, Mississippi, Nevada, New Jersey, Oklahoma, South Carolina, South Dakota, Texas, and Wyoming. Of these states, few have imposed any limitations on eligibility beyond the two federal requirements). E.g., According to the U.S. Government Accountability Office (GAO), as of 2007, thirty-one states provide Medicaid benefits to some former foster youth. Delgado, et al. supra note 21, at 5.
110 English, supra note 63, at 450 (citing Ohio Rev. Code Ann, §5111.0111 (LexisNexis 2004)).
112 Id. (citing S. 88, 57th Leg., Reg. Sess. (Mont. 2001); S. 5197, 224th Leg., Reg. Sess. (N.Y. 2001); H.r. 2984, 56th Leg., 2d Sess. (Wash. 1999)).
113 English, Morreale, & Larsen, supra note 24, at 63.
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eligibility for former foster youth up to age 21 due to costs.\footnote{Allen, supra note 5, at 21.} Foster youth may still enroll, however they must do so prior to discharge and must keep up to date on their payments or they will be dropped and lose the ability to re-enroll. Some states limit services to “specific subpopulations of emancipated youth.”\footnote{Atkinson, supra note 3, at 198.} For instance, Florida limits Medicaid coverage to emancipated youth meeting the minimum academic requirements that allow them to be eligible for the state’s independent living scholarship program.\footnote{Id.} In spite of these measures, the passage of FCIA has led to significant increase in services to foster alumni.

C. California Law

As mentioned previously, California is home to the largest foster care population in the nation, with more than one in five of the country’s foster care children residing in the state.\footnote{Everychild Foundation, supra note 1, at 2. From January 1, 2004 to December 31, 2004, 4,255 children emancipated from foster care in California. Id. Of these 4,255 emancipating youth 1,402 were located in Los Angeles. Id.} Like most states, it has statutes empowering dependency courts to maintain jurisdiction of foster children beyond age 18. California’s Welfare & Institutions Code Section 303 states that the child welfare system may continue foster care up to age 21.\footnote{CAL. WELF. & INST. CODE § 303 (West 2006).} Jurisdiction, however, does not automatically nor routinely extend to all children under the age of twenty-one. Under Section 391, jurisdiction may be terminated at age 18 where the county agency has provided the youth with personal documents and assistance
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with certain services. However, in some counties, merely providing brochures on services to a foster child constitutes “assistance”. Courts retain discretion as to whether care should extend beyond age 18. Generally, jurisdiction is only maintained for a specific purpose, and only then for the minimum amount of time necessary.

In regards to the majority of foster youth, those who age-out at age 18, the California Department of Social Services distributes FCIA funds to all 58 counties to operate and administer their own programs for former foster youth. However, actual practices vary widely from county to county and judge to judge. They also consist of different eligibility policies, program administration, program funding, and services. Lack of consistency between counties results in disparate treatment of emancipated foster youth depending on where the youth lives. For example, in Los Angeles County in 2002, former foster youth received the most generous program benefits in the State, including free laptop computers upon completion of an Independent Living Program and scholarships for college. However, participants in neighboring Riverside County received only a small monetary bonus upon graduation from high school. Essentially, a youth’s county of residence determines the amount of resources offered to them, and thus their potential for success. California programs for foster alumni are unsuccessful in

119 CAL. WELF. & INST. CODE § 391 (West 2006).
120 Benedetto, supra note 79, at 424.
121 Delgado, et al., supra note 21, at 8.
122 Benedetto, supra note 79, at 412. As a result, the efficacy of Independent Living Programs and their success rate with youth varies from county to county. Id.
123 Delgado, et al., supra note 21, at 5-6. Additionally, counties may choose to contract such services to a separate service provider, such as a nonprofit. Benedetto, supra note 79, at 412.
124 Benedetto, supra note 79, at 413. See also Delgado, et al., supra note 21, at 6 (noting this disparate system also causes significant problems for current and former foster youth moving across county borders).
125 Id.
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delivering comprehensive assistance and services to a considerable number of former
foster youth in a significant way.

With respect to Medi-Cal eligibility, the state of California has implemented a
federal Medicaid Option that provides Medi-Cal for youth who age out of foster care.
Under this Option known as Extended Medi-Cal Eligibility for Former Foster Care
Children (FFCC), youth in foster care on their 18th birthday are eligible for Medi-Cal
coverage with no share of cost until their 21st birthday, regardless of income, resources,
or living arrangement.126 The county must transition youth to the extended Medi-Cal
program without requiring completion of an application. Nevertheless, the state has
carved out exceptions to eligibility for former foster youth who, while they come from
similar circumstances, are in different groups. For example, Medi-Cal coverage until age
twenty-one is not as readily available to youth who emancipate from the system before
the age of eighteen or those who were in certain programs like Kin-GAP placement on
their eighteenth birthday.127 Additionally, Medi-Cal has been denied to youth who do not
return re-determination forms on time, fail to fill out forms correctly, or never receive the
papers because they were sent to the wrong address.128

During 2006, legislation was offered to increase the number of foster alumni
eligible for Medi-Cal coverage. AB 2284 (Jones) proposed to expand the definition of
eligible youth to incorporate all youth removed from their homes, including automatic

126 CABWHP, California Black Women’s Health Project June 2009 Issue Guide & Events: The Foster
Care Crisis: An Advocacy Priority for Black Women 1 (June, 2009), available at
127 Delgado, et al., supra note 21, at 18. E.g., CAWHP, supra note 126, 1. (explaining that the Kin-
GAP program exists to provide essential support for foster children who live with relative guardians).
128 CAWHP, supra note 126, 1. (also noting the current redetermination process interrupts health care
coverage for youth and also wastes valuable resources).
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Medi-Cal eligibility for early emancipated youth.\textsuperscript{129} This measure was rejected by the Legislature. Furthermore, the current budget cuts that went into effect on July 1, 2009 dramatically changed the care that used to be offered through Medi-Cal. Some changes include the elimination of dental, podiatry and psychological care among other benefits that will no longer be available to adults who qualify for Medi-Cal, including emancipated foster youth.\textsuperscript{130}

Despite the availability of foster care services until age twenty-one, more often than not, the state kicks foster youth out into the street at age eighteen with no home to go to, no income, no support system, and no health insurance. Instead, the state creates added hardships, by complicating or even defeating any public health care opportunities purportedly designated for foster alumni. As a parent, the state of California has failed.

D. Evaluation of Legal Requirements

The existing legal framework for Medicaid offers the potential to extend coverage to at least some significant segments of the population of emancipating and emancipated foster youth. Medicaid may be the most favorable program for these youth for the following reasons. First, Medicaid is guaranteed to all foster youth in foster care until age eighteen. Second, enrollment of former foster youth in the FCIA Medicaid eligibility expansion Option program would warrant them health insurance coverage at least up to age twenty-one. Third, given that most foster youth are already covered by Medicaid while in foster care, a state could easily transfer a youth’s Medicaid eligibility from one

\textsuperscript{129} Delgado, et al., \textit{supra} note 21, at 18.
\textsuperscript{130} CAWHP, \textit{supra} note 126, at 1
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category to another without any interruption in coverage. Finally, Medicaid in general, is
targeted to the lowest income individuals, and therefore available to qualifying foster
alumni beyond age 20. In this manner, these young people may have uninterrupted
coverage for a considerable period of their early adulthood. States could then make
certain that emancipating and emancipated foster youth, at the minimum, have access to
preventive care, family planning, and substance abuse and mental health treatment.\textsuperscript{131} By
this means, states could drastically increase the probability that these health needs would be met.

One of the best features of Medicaid expansion option is the simplicity in its
eligibility requirements. The two threshold criteria of age and having been in foster care
on the eighteenth birthday are the only federal law requirements. Another positive
characteristic of the FCIA Medicaid expansion option, from a state policy point of view,
is that it is less costly. Given that most uninsured foster alumni would otherwise receive
their health care in emergency rooms, often entirely at state or local expense, a critical
benefit of implementing the option is that the cost of services is paid in part by federal
Medicaid matching funds at the federal medical assistance percentage.\textsuperscript{132} Thus, granting
foster alumni access to health care in which the cost is shared by the federal government
would likely prove cost effective for states.

There are, on the other hand, disadvantages to this approach. Some former foster
youth could still face barriers to certain kinds of care they require. For example, foster
alumni may encounter problems locating Medicaid providers who are available and eager

\textsuperscript{131} English & Grasso, supra note 98, at 227.
\textsuperscript{132} English, supra note 63, at 449 (\textit{citing} Federal Financial Participation in State Assistance Expenditures,
64 Fed. Reg. 1805, 1807-08 (Jan. 12, 1999) providing, federal medical assistance percentages for the FY
2000, the first year Medicaid expansion provision was effective, varied between 50% and 76.8%).
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to provide care for them. Also, the Medicaid benefit package may not include the
special kind of care or treatment they require. More notably, most states have not
implemented the option at the state level. In fact, legislation of the FCIA Medicaid
option has been unsuccessful in recruiting a wide range of supporters, advocates and
sympathetic service providers. While the FCIA Medicaid option is adequate to meet
the health needs of former foster youth, it is not implemented. The failure of Congress to
achieve enactment of the federal statutory provision as a mandate, demonstrates the
insufficiency of the law to directly address the health needs of former foster youth.
Therefore, a call for change in law and policy is crucial.

The numerous former foster youth who lack health insurance must depend on
other publicly funded and private health programs that support safety net sites and
specific type of services. There are many health care programs that are funded in whole
or in part by the federal government and designed to offer more wide-ranging services to
former foster youth. However, unlike Medicaid, which is an entitlement program,
these other federal programs do not create an individual entitlement to services. This
lack of entitlement means that if annual allocations are exhausted, eligible individuals

133 English, supra note 63, at 449. (explaining the availability of accessible providers may be limited for
reasons related to the number and geographic distribution of providers and low reimbursement rates).
134 See English, Morreale, & Larsen, supra note 24, at 63 (referencing the Cong. Budget Office, Cost
Informing when FCIA was under consideration in Congress, the Congressional Budget Office estimated that if all states were to implement the Medicaid
Option included, the total number of youth who would be newly eligible for and enrolled in it in FY 2004
would be only 24,000. (Yet, in interviews with state officials from forty-three states, budgetary constraints
were cited as a reason for not implementing the option, which may reflect insufficient support from
advocates and the public).
135 English, supra note 63, at 454.
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may be denied services. As well, these other programs are not intended to serve youth exclusively and there is significant variation as to whether they do serve youth or not. Furthermore, while these programs present a great and perhaps unexploited potential to serve these vulnerable youth and to improve the likelihood of their obtaining health care through targeted outreach and other means, their ability to do so is continuously being prevented by severe funding restraints and extensive disproportionate funding amounts. In view of these significant limitations, health care safety net programs are inadequate to sufficiently serve foster alumni single handedly. Accordingly, in this area too, change is necessary.

At last, the health care needs of foster alumni may only be satisfactorily fulfilled if there is political motivation to completely adopt the existing policy options that could help them. New laws must be implemented. The lack of guaranteed health care for former foster youth means that they ultimately become a more burdensome and larger cost to society, than if a much smaller, upfront investment had been made (such as the implementation of the public option) to better assist their health needs and prepare them during transition and the years preceding it.

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136 Id. Extended delays and denials in providing service have already occurred in numerous states, particularly with regard to dental and mental health services. Id.
137 See Id. (stating many of the programs served smaller numbers of adolescents, that adolescents comprise a very small percentage of the population served).
138 English, Morreale, & Larsen, supra note 24, at 66.
139 Id. Total federal funding for all noninsurance programs combined is a fraction of SCHIP’s $6.28 billion and is drastically lower than Medicaid’s $134 billion. Id.
140 See Everychild Foundation, supra note 1, at 2 (consider and compare California’s annual costs cited for housing an emancipated youth in a program providing health services such as Hillsides in Pasadena, is $20,000 - $25,000. Incarceration for the same young adult is between $55,000 and $115,000 (depending on the type of facility) according to the State’s Safety and Welfare Plan filed in April, 2006. Residence in a mental health facility is $215,000).
IV. Alternative/Complementary Approaches

Even though the majority of states have not adopted the FCIA Medicaid Eligibility Expansion Option, there have been many program initiatives and state law attempts to compensate for the limitations in federal law, in order to safeguard the health of both current and former foster youth. This part reviews the policies and programs that could alter certain barriers to health care and the extent to which they have done so to date.

A. Improving the Health of Foster Youth

It has been recognized that barriers to health care occur while children are in foster care. As a result, some states have designed programs to help improve the health of these children during their time in care. Medical records are difficult to obtain at the time of the child’s entry into foster care, while youth are in foster care and especially once they are emancipated. As a consequence, states such as Utah have mandated use of computerized medical databases to generate medical passports and provide information to caregivers of children in foster care and to youths once they emancipate from care. In California, some organizations are also using new technology to help manage health and education records for youth in foster care. It is a secure, portable, internet-based system with the purpose of tracking immunizations, drug allergies, school admissions activity and other important information. The data is accessible 24 hours a day, seven

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days a week through an encrypted, password-protected smart card called a Foster Youth ePassport. According to the Community College Foundation, which has operated training and education programs for foster youth for more than 10 years, the Foster Youth ePassport program will significantly increase the quality of life for foster youth and save millions of dollars in duplicative services and manual processes. Most importantly, the smart card is designed to be available to foster youth once they age out of the system.

Additionally, some states, such as Rhode Island, have put into action projects that provide a permanent system of assessment, referral, and care coordination for foster care children that will assure all foster children have a “medical home.” The medical home is defined as a regular provider of pediatric primary care services in the community, consisting of preventive, diagnostic, and therapeutic care. It also includes appropriate referrals and follow-ups for special medical, developmental, mental health and impatient services, and referrals to qualified providers of comprehensive care coordination for medically indicated social and support services. Some counties have also introduced a type of “medical home” for their foster youth. Missoula County, Montana, for instance, developed a system that collects retrievable health information that enables health records to follow the child. Moreover, the medical home is the designated place where foster kids receive routine medical care, periodic developmental screening and assessment. The

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143 Newberger, supra note 142. Currently, the Statewide Automated Child Welfare Information Systems (SACWIS) tracks certain data on services to foster youth, but no data systems links children to their health and education records simply and efficiently as they move through this system. Id.

144 Id. The Foundation has estimated that $1.5 billion is spent annually on duplicate services for foster youth. Their incomplete records result in over immunization, poor follow-up for health problems, delayed enrollment in school and missed opportunities. Id.


program requires that foster parents be educated about their child’s actual or potential health problems. 147 Likewise, Ohio has put into practice a program for foster parents to receive organized training in health care. 148 The objective of the program is to create a health curriculum for foster parents emphasizing continuity of care, medical recordkeeping, immunizations, universal precautions, nutrition, and development. Hilo, Hawaii, on the other hand, has designed a program that provides educational sessions for social workers and pediatricians aimed at improving the understanding of special needs of foster children. 149 The program includes protocols for comprehensive health plans for children entering foster care, and promotes communication between physicians, social workers, parents and foster parents. A Los Angeles program called Health Care Partnership for Children focuses its resources specifically on the child. 150 It offers foster children access to quality, continuous medical care by removing legal barriers they confront in accessing care. The Partnership combines The Alliance for Children’s Rights’ legal expertise and work for foster children with health care providers willing to care for foster children on Medi-Cal. 151

Finally, the State of North Carolina’s Early Intervention Program was approved and applauded by the Department of Health and Human Services’ Child and Family Services Review of 2006. 152 The Early Intervention Program entitles children aged birth to three to a multidisciplinary evaluation that includes hearing and vision screening and

147 HTPCP, supra note 146, at 733.
151 Id.
152 Fostering Perspective, supra note 3, at Vol. 10, No. 2.
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treatment, occupational, speech, and physical therapy and support services, such as parent training, counseling, and respite care to enable caregivers to enhance the child’s development. North Carolina’s health-related child welfare policies also incorporate requiring children to be referred for a physical examination within one week of an initial placement. Children who are identified with a need for dental, developmental, or psychological assessment are to be referred within one week from the discovery of the need.153

Although Medicaid coverage should be sufficient to provide comprehensive health services to foster youth, it is not without help. The programs reviewed above indicate that supplementary safety net programs and policies are required to ensure that Medicaid, or at least some type of health program, is being provided to foster children. Furthermore, if the health of foster youth and their access to care are considerably improved while in the foster system, the benefits to them are likely to extend beyond emancipation. Emancipating youth would not only enter independence with the advantage of having good health, but would also take with them health management skills acquired in foster care. They would potentially possess a health standard consisting of regular doctor visits and would seek treatment for medical problems encountered after emancipation. Clearly, much can be gained by improving the health of foster youth.

153 Fostering Perspective, supra note 3, at Vol. 10, No. 2.
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B. **Improving Access to Health Care for Former Foster Youth in California**

The following are examples of programs, laws and policies that may address the gaps in Medi-Cal for California former foster youth. Alameda County’s Independent Living Skills Program (ILSP) established the Beyond Emancipation Teen Health Center in 2004. The Health Center started out offering basic medical services to older foster youth (primarily age 16 to 18 years old), emancipated foster youth (primarily age 18 to 21 years old), and former foster youth in this age range (15½ - 21). As of July 2006, the Health Center was perceived as a one-stop-shop providing a broad range of services by a team who understand the unique issues and troubles faced by these young people. Services cover drop-in medical advice, screening and treatment services (such as but not limited to hearing, vision, and transmitted infections), physical exams, health education, and mental health referrals. This is a program that offers the type of services and access to health care that adequately serves all former foster youth.

Another approach that potentially facilitates the health of former foster youth, is a program called Healthy Kids and Young Adults. Healthy Kids is a city and county funded program in San Francisco. The health plan offers all-inclusive coverage for low-income young adults ages 19-24 that are not covered by employer-based insurance and are not eligible for Medi-Cal. This approach seeks to provide coverage aimed directly

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154 Leung, *supra* note 36, at 5. In late 2006, the Health’s Center’s expanded service role resulted in a name change distinguishing it from the ILSP and reflecting the target population, i.e., Beyond Emancipation. *Id.*
155 Leung, *supra* note 36, at 5. Youth may petition to emancipate from care, beginning at 15 years old, which is prior to aging out at age 18, or may extend their stay in care up to 20 years old. *Id.* Hence the age ranges of current and former foster youth the program serves all former foster youth even those not eligible under the FCIA program.
156 Leung, *supra* note 36, at 5
158 *Id.* at 457.
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at older adolescents and young adults. Thus, emancipating and emancipated foster youth that meet the criteria could be covered by this program.

In addition, San Francisco currently provides over 26 trauma-focused prevention and early intervention services for foster youth. Home Within is just one example, providing long term pro-bono psychotherapy to current and former foster youth.159 Another San Francisco program is Jewish Vocation Services (JVS), which assists youth with disabilities to obtain employment and has a full time case manager dedicated to serving current and former foster youth.160 JVS trains former foster youth with disabilities to work in the healthcare field by providing them employment training and internships. Although this program does not directly provide health care to foster alumni, it indirectly tends to the mental and emotional health of these disabled youth by affording them an opportunity for a better future. Furthermore, San Francisco currently has two Full Service Partnerships for Transitional Age Youth.161 They provide individual/family/couple therapy, intensive case management, medication support, social outings and a drop-in center where the youth can “hang out” or attend workshops.

In 2004, California voters passed Proposition 63 – the Mental Health Services Act (MHSA).162 Funds generated by the tax imposed by the MHSA are to be used for mental health services. MHSA states as one of its purposes prevention and early intervention services and medical and supportive care.163 Given the high incidence of mental health issues among former foster youth, it is evident that both current and former foster youth

159 HEY, supra note 38, at 1.
160 Id.
161 HEY, supra note 38, at 1.
162 Delgado, supra note 21, at 18.
163 Id.
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should be a priority for this funding. As a general point, it is important for these youth to be aware of the services and funding, beyond Medi-Cal or Medicaid, available to them and how best to access them.

V. Recommendation

Even supposing there are numerous health programs in California that could potentially accommodate current and former foster youth, access to these services and knowledge of them by these youth is radically constrained, evidenced by this research. In short, quantity of health programs and services for this population has not resulted in improved health or increased access to care.

A number of strategies could be implemented to improve health care access for emancipated foster youth, but financial access is a superseding, vital issue. Health care that would meet the needs and improve the health of each and every emancipated foster youth, and at the same time utilize resources and employ services by fiscally conservative means, could be made available and paid for through the combination of publicly funded health insurance coverage and publicly funded safety net programs. Foremost, health insurance coverage under the Extended Medi-Cal eligibility for Former Foster Care Children (FFCC) (i.e., FCIA Medicaid option) must be a mandatory service for all emancipating foster youth, despite their age when they emancipate or other programs they participate in. Together with an opt out provision, child welfare agencies must adopt “automated” procedures to ensure that youth who leave or age out of foster care, are

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164 As demonstrated by the programs mentioned in Part IV of this paper.
165 The data and statistics provided in Part II of this paper not only demonstrates the lack of access both current and former foster youth have to health care, but also shows that their lack of knowledge of what is supposed to be or could be provided to them is a key reason why their health needs go unfulfilled.
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given the opportunity to be enrolled in Medi-Cal. Thus, upon termination of jurisdiction, youth will have the choice as to whether or not they would like to receive continuing health services from the state, giving the youth until age 21 to decide to access these services. Also, Medi-Cal health care professionals and advocacy groups should conduct direct outreach to emancipated foster youth to encourage them to enroll in Medi-Cal if eligible. Alternatively, California should give foster youth a choice at age 18 whether or not they would like to remain under jurisdiction of the court, therefore eligible for Medi-Cal as a foster child.

Concurrently, the state must provide policy-imposed publicly funded safety net health programs, designed specifically to safeguard basic health needs of foster alumni, and directed at assisting foster alumni not qualified under Medi-Cal.\textsuperscript{166} With respect to California’s Independent Living Program, all expanded transitional health services must be equally available in every county in California. This is due to the fact that each county offers different services at different levels, making it difficult for former foster youth to take advantage of what is offered. Information regarding any expanded transitional health services must be widely available and easily accessible by former foster youth. Any paperwork necessary to receive expanded transitional services must be minimal and easy to access, understand, complete, and submit for initiation and the renewal of services. Lastly, current funders and administrators of safety net health programs should evaluate their potential to serve emancipated foster youth, and if necessary, revise their programs to meet the needs of these young people.

\textsuperscript{166} Because the FFCC Medi-Cal program only offers coverage to former foster youth until age 21, foster alumni who are 21 and over and who do not qualify under any other Medi-Cal programs, will have access to basic health care (at the minimum) via safety net programs specifically established for them, despite their age or anything else for that matter.
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As a result, California would utilize federal funds to meet expenditures currently born by the state and counties. The state would realize proven savings from not having to cover costs of emergency visits by uninsured former foster youth, declines in unemployment and homelessness due to poor health, reduction in teen pregnancy and related public assistance expenses attributable to reproductive health education and consistent check-ups, and other costly outcomes for young adults who age out of foster care. The money and resources saved could then be redistributed toward the support of mandatory safety net programs. The funding per county should be based upon the need for the programs. But the services offered would be the same in each county. As a final point, funding should be practical and realistic, not symbolic. Hence, programs need to be funded on a realistic scale, taking into consideration the number of emancipating foster youth who need assistance and the amount of assistance they need. Advocates and supporters must find resourceful methods to make use of the funding provided to achieve the optimum results for the youth.

By ensuring that all eligible former foster youth are enrolled in Medi-Cal until age 21, and providing publicly funded health safety net programs available to alumni age 21 and over in every county, the population of former foster youth could obtain access to health care in California. These developments, taken together, could provide significant benefits for former foster youth.