# Health Care for Homeless Youth: Policy Options for Improving Access

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## BACKGROUND

Homeless youth represent a vulnerable population with serious health concerns and limited access to health care. Youth become homeless for complex reasons, with some choosing to leave home in search of adventure and autonomy, others fleeing severe domestic abuse, and still others being forced from their homes by conflict with parents over lifestyle or sexual orientation.[1] After leaving home, some youth may live with relatives or in shelters and return home after a short period of time, but others become trapped in a pattern of chronic homelessness, remaining on the streets or separated from their families for long periods of time or permanently.[2]

Youth experiencing chronic homelessness have particularly high rates of physical and mental illness, and these conditions are exacerbated by the multiple barriers they face to accessing health care.[1] These barriers are similar to those facing the general homeless populations, including limited financial resources and social disconnectedness, but homeless youth under age 18 also face additional barriers due to their status as minors and lack of an adult caregiver. Addressing these compounding barriers requires recognition of the unique characteristics of this vulnerable population.

### Financial Barriers

Although many homeless youth under age 19 likely do meet income eligibility criteria for Medicaid[3] or the State Children's Health Insurance Program (SCHIP)[4], many lack health insurance. In 1992 an estimated 43% of homeless youth were uninsured[5] and it is likely that a very significant proportion remain so, although more recent data are not available. Uninsured homeless youth rarely apply for coverage in part because of the perception of ineligibility,[6] and also because complex enrollment forms and an inability or hesitancy to provide proper identification or contact information act as additional barriers.[7] Once homeless youth reach age 19, they are no longer eligible for Medicaid or SCHIP in most states (unless they are pregnant or disabled), thus joining the 46.5% of all poor young adults ages 19-24 who lack health insurance.[8,9]

Additionally, there are publicly funded programs designed to address the health care needs of the uninsured and medically underserved, including the Health Care for the Homeless Program[10] and the Runaway and Homeless Youth Act[11] programs, but these programs suffer from chronic underfunding and cannot adequately serve the specific health care needs of homeless youth. Nevertheless, they do provide important services and supports. Addressing the financial barriers to health care faced by homeless youth requires both improving their access to insurance and strengthening safety-net programs that serve them.

***Addressing the multiple barriers homeless youth face to accessing health care requires recognition of the unique characteristics of this vulnerable population.***

### Consent & Confidentiality Barriers

When unaccompanied youth do find their way to a health care provider or site and can overcome the financial barriers, additional obstacles associated with consent and confidentiality may impede their access to comprehensive services. Depending on their age, unaccompanied youth may or may not be legally authorized to give consent for their own care, and limitations on the confidentiality of that care often exist. Due to the nature of the reasons why youth become homeless, it may be particularly problematic for them to obtain the consent of a parent whey they need health care; and they may also have particularly pressing concerns about protecting their privacy and preventing disclosure of confidential information. Therefore, understanding the laws that allow homeless youth to consent for their own care and that provide confidentiality protection, and expanding those laws if necessary, has special importance for this population.

## Overcoming Financial Barriers

Although homeless youth face significant financial barriers to health care access, some of these barriers may be addressed within the existing legal and policy framework, while others will require changes in the law. In order to significantly improve access to care for this small but vulnerable population, policy makers, program administrators, and service providers must recognize the particular needs of homes youth and include provisions specifically targeting their needs within both Medicaid and SCHIP and programs for the medically underserved.

### Improved Access to Medicaid and SCHIP

Although Medicaid and SCHIP programs already do much to provide health insurance for adolescents in need, there is still potential in the existing policy framework to cover even more adolescents, including homeless youth. However, further expansion beyond existing policies will also ultimately be necessary to ensure that all youth in need of health care have access to insurance.

***Many homeless youth should already be eligible for Medicaid or SCHIP, particularly if they are under age 19.***

Under current law, at minimum, all youth up to age 19 living at or below the federal poverty level are eligible for Medicaid in all states.[12] Moreover, in every state, youth up to age 19 are eligible for either Medicaid or SCHIP up to higher income levels.[13] Thus many, but not all, homeless youth should already be eligible for Medicaid or SCHIP, particularly if they are under age 19. For older youth, however, eligibility is more problematic overall, and even for the younger ones there are many barriers to enrollment.

### *Federal Expansion of Eligibility*

In both Medicaid and SCHIP, eligibility options are significantly restricted by federal law once a youth reaches age 19. Originally enacted in 1997, SCHIP was due for reauthorization in 2007 and attempts were made during the reauthorization process, albeit unsuccessfully, to expand eligibility for older youth. An early version of the SCHIP reauthorization bill, passed by U.S. House of Representatives in the summer of 2007, contained an option for states to expand Medicaid and SCHIP eligibility to include individuals up to age 25 on a phased in basis,[14] but subsequent SCHIP reauthorization bills passed by both the House of Representatives and the Senate did not contain this option, and were ultimately vetoed by the President.[15]

### *State Expansion of Eligibility*

Even without a change in federal policy, states do have options for increasing age eligibility for Medicaid and SCHIP, at least for some populations of older youth. These include the Foster Care Independence Act (FCIA) Medicaid expansion option, HIFA waivers, and the option to cover certain young people with very low incomes known as "Ribicoff" youth.

#### Foster Care Independence Act

First, one critically important option exists for states to expand eligibility to improve access to health insurance for some homeless youth. The Foster Care Independence Act (FCIA), enacted in 1999, provides states with the option of expanding Medicaid eligibility in a targeted way to cover all youth aging out of foster care up to age 21.[16,17] This option allows states to offer virtually automatic Medicaid eligibility to these young people—a group at high risk for homelessness—and thereby to improve their health care access. However, despite its significant potential, as of January 2008 only twenty-six states had implemented the FCIA expansion option, resulting in limited efficacy thus far.[13]

#### HIFA Waivers

Second, the Health Insurance Flexibility and Accountability (HIFA) demonstration initiative, established in 2001 as part of the Section 1115 Research and Demonstration projects, gives states the opportunity to expand health insurance coverage to the uninsured within currently available Medicaid and SCHIP resources.[18] This includes the option to expand eligibility to cover non-disabled childless adults, a group which would include older unaccompanied youth.[18] States may apply for a HIFA waiver to expand health insurance coverage for poor youth over the current age eligibility levels regardless of federal age limits otherwise imposed on Medicaid and SCHIP eligibility.

### Ribicoff Youth

Third, states also have the option to provide coverage for youth up to age 21 with very low incomes. Known as "Ribicoff" youth, these individuals are defined as those who would have met financial eligibility requirements for the Aid to Families with Dependent Children program in effect in 1996. These eligibility levels were very low, and therefore individuals qualifying as Ribicoff youth are living in extreme poverty.[17,19] Because most homeless youth have very little or no income, this option could be used to expand their eligibility for Medicaid up to age 21.

Pending a general federal expansion of Medicaid and SCHIP eligibility for older youth, states may utilize these three options to cover more young people with low incomes, including unaccompanied minors and homeless youth.

## *Barriers to Enrollment in Medicaid and SCHIP*

Application and enrollment procedures vary widely among states in the extent to which they enable homeless youth to establish eligibility for Medicaid or SCHIP. States' guidelines and procedures generally are designed for low-income families with children. Thus the guidelines often fail to acknowledge the possibility that unaccompanied minors may need to apply on their own, even though there is no real legal impediment to their doing so and federal law requires states to allow all individuals to apply for Medicaid.[20] However, potentially problematic requirements in many states include: the signature of a parent/guardian or responsible adult on a minor's application; documentation of parents' income; and a permanent address for contact the applicant—all requirements which homeless youth may be unable to meet.

A small number of states directly address the unique circumstances of unaccompanied minors in their eligibility and application guidelines. For example, both Wisconsin and Arizona specify that the parents' income[21,22,23,24] and state of residence[25,26] do not need to be considered; and Arizona also explicitly allows the young person to sign his or her own application[27,28] and does not require a fixed or permanent address be provided.[29] If state guidelines do not explicitly allow unaccompanied minors to apply independently, they may effectively render many homeless youth ineligible for public health insurance. To facilitate enrollment of homeless youth in public health insurance programs, guidelines should specifically allow youth living apart from their parents to enroll as independent individuals, without the need for parental involvement or consideration of their parents' income or residence.[30,31]

Other states specifically allow "emancipated minors" to apply for public insurance (e.g. Delaware,[32] Kansas[33]). Although a judicial declaration of emancipation may be required in some state, in other (e.g. Pennsylvania[34]) meeting common law criteria for emancipation may be sufficient. It is important to note that although providing specific guidelines regarding the eligibility and enrollment of emancipated minors in public health insurance may be beneficial to a small number of youth, the complications of obtaining emancipated status may limit the applicability of these guidelines for most homeless youth, who usually are not judicially emancipated.

To facilitate enrollment and renewal of eligibility for youth who meet eligibility criteria for public insurance, states also may adopt options such as presumptive eligibility[35] and 12-month continuous eligibility.[36] The presumptive eligibility option allows states to authorize certain "qualified entities" (including organizations receiving federal money to provide emergency food aid and shelter to the homeless) to enroll youth under 19 to begin receiving coverage immediately if the youth appears eligible based on information provided on a preliminary application.[37] Presumptive eligibility would allow homeless youth to receive coverage under Medicaid or SCHIP (depending on which program they appear eligible for) immediately upon seeking medical care without the required waiting period and follow-up.[38] But as of January 2008, only nine states had adopted the presumptive eligibility option, and three had not yet implemented the option.[13]

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The continuous eligibility option allows states to grant youth under age 19 who have been determined eligible for Medicaid to remain enrolled for 12 months without undergoing renewal procedures.[37] Because homeless youth lack a permanent address and are therefore difficult to recontact for renewal of eli-

gibility and re-enrollment,[7] continuous eligibility would ensure that once they are enrolled they will remain enrolled for an extended period. As of January 2008, though, only 29 states had adopted the 12-month continuous eligibility option; and of these, 12 states did so only in their SCHIP programs.[13]

Additionally, simplifying the enrollment process by limiting the documentation required can help to increase utilization of both Medicaid and SCHIP by all eligible individuals, including homeless youth. States do not have the authority to bypass the citizenship identification requirements of the 2005 Deficit Reduction Act.[39,40] However, they can minimize the other official documentation that applicants are required to submit with their application by allowing an applicant's signed declaration as proof of income, assets, residency, age, and family composition without requiring applications to provide further documentation.[7,41,42,43] In addition, although an applicant is required to provide a social security number, the state or local agency with which the application is filed is also required to assist the applicant in obtaining necessary identification.[44]

***To be fully effective, any policy changes must be coupled with rigorous outreach efforts to identify and assist eligible and needy homeless youth in accessing public insurance.***

States also may modify other aspects of the application process, including interview procedures and complex application forms, which may be difficult or impossible for a homeless youth to complete. State have the option to eliminate the in-person interview requirement for both enrollment and renewal, an option which most (but not all) states have chosen to adopt.[13] Additionally, state may choose to shorten their application forms for Medicaid and SCHIP or utilize a joing application, allowing applicants to complete only one application for both programs, after which program administrators determine the specific program for which the individual qualifies.[13] Though these options are not specifically targeted to homeless youth, they would address barriers that homeless youth face when applying for insurance.

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## Increased Funding for Programs Serving Homeless Youth

### *Health Care for the Homeless*

The Health Care for the Homeless program, established in 1988 by the McKinney-Vento Homeless Assistance Act, is administered through a system of Federally Qualified Health Centers providing comprehensive primary care, mental health and substance abuse services, case management, and client advocacy, regardless of patients' ability to pay.[45] Although these services are designed to reach underserved populations, including the homeless, they are not specifically targeted to youth.[46] In 2006, only 5.6% (39,304) of the total 701,623 patients served by clinics funded by HCH grants were between the ages of 13 and 19.[47] Numerous factors contribute4 to the small number of homeless youth served in HCH funded sites, including both insufficient attention to making sure the serves are "youth friendly" and insufficient HCH funding overall. In FY 2006, Congress appropriated $155 million for the HCH program, which funded 182 projects.[48] Although there would be advantages to requiring that youth-targeted programs be funded and operated with HCH funds, this would only make sense with increased funding for the program overall.

### *Runaway and Homeless Youth Act*

The Runaway and Homeless Youth Act (RHYA) is the only large federal program to specifically target homeless youth. Although the program does not directly fund or deliver health care services, some of it components are or could be important elements in facilitating access to health care for homeless youth. RHYA provides funds to administer three programs: the Basic Center Program (BCP), the Transitional Living Program (TLP), and the Street Outreach Program (SPO).[49,50] These programs provide shelter and other services for youth under age 18 and their families, including outreach to bring youth to facilities, emergency residential care, help with family reunification, counseling and referrals to other health services, and assistance with the transition to independent living.[45,49] Despite evaluations supporting the efficacy of RHYA programming in restoring family connections and supporting educational progress and economic independence,[51] the program remains underfunded. Although a reauthorization bill introduced in the House of Representatives in 2008[52] would have provided increased funding for the program, this attempt was unsuccessful.

## Overcoming Consent & Confidentiality Barriers

### Consent

Homeless youth who are age 18 or older are legally adults and are generally able to give consent for their own care on the same basis as other adults. However, homeless or unaccompanied youth who are under age 18 are legally minors. They may or may not be able to give their own consent for care, depending on specific provisions of state and federal law and the services they are seeking. Generally the consent of a parent is required for health care that is provided to a minor child, including an adolescent under age 18. However, every state has numerous laws that allow minors to give their own consent for care in specific circumstances. These laws are based either on the status of the minor or the services sought. They are often referred to as "state minor consent laws."[53]

Every state has laws that allow *one or more* of the following groups of minors to consent for their own health care: emancipated minors, minors living apart from their parents, married minors, minors in the armed services, pregnant minors, minor parents, high school graduates, or minors who have attained a certain age. Minors who meet the legal criteria for emancipation would almost always be recognized as having the right to consent for their own health care, whether or not they have a legal declaration of emancipation issued pursuant to a formal state procedure.

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Of particular importance for homeless youth, slightly less than one half of states have enacted statutes that enable minors who are living apart from their parents to consent for their own health care.[53] Of these, about one third permit minors to consent for their own care based on a characteristic such as age, the unavailability of a parent, or having sufficient intelligence to comprehend the risks and benefits of the care.[53] The other two thirds expressly authorize minors who are "living apart from their parents," "separated from parents," or "homeless" to consent for their own care.[53] Some of these states limit the authority to consent based on the length of time the minor has been living apart from parents (e.g. 30 or 60 days, or four months) or require the minor to be "managing his or her own financial affairs."[53]

Recently, Hawaii has enacted a new law providing consent and confidentiality protections for minors who are "without support."[54] This law allows minors who are at least age 14, and who are "not under the care, supervision, or control of a parent, custodian, or legal guardian,"[55] to give their own consent for "primary medical care and services" if certain criteria are met.[56] The definition of primary medical care is broad enough to include many of the services unaccompanied or homeless youth would need, including preventive services, but does exclude most surgery.[55] The law specifies that the minor is financially responsible for the care.[57] It also provides certain confidentiality protections when claims are filed for health insurance coverage of the care.[58]

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In addition, every state has laws that allow minors of varying ages to give their own consent for *one or more* of the following types of health care: general medical care, emergency care, family planning or contraceptive services, pregnancy related care, diagnosis and treatment for sexually transmitted disease, HIV/AIDS care, diagnosis and treatment for reportable infectious or communicable disease, care for sexual assault, counseling or treatment for drug and alcohol problems, and outpatient mental health services.[53] Even if a state's laws do not allow unaccompanied or homeless minors to consent to all of their own health care, they would be able to consent to specific services on the same basis as other minors. These laws can be very helpful for homeless youth, in light of the particular types of services that are generally covered, and the health problems that are common in this population.

Unfortunately, these laws are variable and sometimes not well understood by adolescents or their providers. The resulting confusion may deter or prevent adolescents from seeking care even when they have the legal right to consent without a parent, or may discourage some providers from offering care even when it would be legal for them to do so.

## Confidentiality

With respect to confidentiality of health care, unaccompanied youth who are age 18 or older are generally entitled to the same confidentiality protections as other adults. The confidentiality of care for those who are under age 18 is generally governed by different rules.

Numerous state and federal laws affect the confidentiality of patients' health care information and records.[53] These include the state minor consent laws, which sometimes address confidentiality and disclosure issues; other medical records laws; the confidentiality regulations for the federal Title X Family Planning Program;[59] and the federal drug and alcohol confidentiality regulations.[60] In particular, the federal medical privacy regulations issued pursuant to the Health Insurance Portability and Accountability Act (the HIPAA Privacy Rule) contain important provisions that affect medical privacy for both adults and minors.[61]

The HIPAA Privacy Rule and other federal and state laws determine the confidentiality of health care that is provided to an adolescent who is a minor based *in part* on whether the minor can give consent for his or her own care. Thus there is an important link between the minor consent laws and confidentiality protections. It is important to note, however, that even when the law authorizes a minor to give consent for care, it may also grant discretion to a physician to share information with the minor's parents. The specifics in this regard vary significantly from state to state.

# Policy Recommendations

## Recommendations for Financial Access

Financial access to care for homeless youth may be improved both through the existing policy framework and through changes in state and federal policy, including:

- Expand eligibility for public insurance to homeless youth over age 19 at the federal level by raising the age to which states are permitted or required to provide eligibility for Medicaid or SCHIP.
- Expand eligibility for Medicaid at the state level through implementation of the FCIA Medicaid expansion option, a HIFA waiver, or use of the option to cover "Ribicoff" youth.
- Ensure that all states' Medicaid and SCHIP guidelines specifically allow youth living apart from their parents to enroll as independent individuals, without the need for parental involvement or consideration of their parents' income or residence.
- Adopt optional procedures to facilitate and maintain enrollment including presumptive and continuous eligibility procedures.
- Simplify application procedures both through elimination of unnecessary documentation requirements and in-person interview requirements, and through utilization of simplified or joint applications for Medicaid and SCHIP.
- Strengthen outreach efforts through street-based outreach and outstationed enrollment assistance in health clinics.
- Increase funding for safety-net programs, including the Health Care for the Homeless Program and the Runaway and Homeless Youth Act programs, and encourage thse programs to design services that specifically address the needs of homeless youth.

## Recommendations for Consent and Confidentiality

Many of the health services needed by unaccompanied youth fall within the scope of states' minor consent laws. Also, many unaccompanied youth fall within the groups of minors who are authorized to give consent for their own care. However, health care providers, and young people themselves, are often unaware of the different ways in which laws may allow these youth to give their own consent for care and receive it on a confidential basis.

At least two specific steps could play an important role in overcoming the consent barriers to health care for homeless youth:

- Enact statutes in states that have not done so already that authorize minors living apart from their parents to consent for their own health care.
- Disseminate information and train health care professionals and health care administrators on the scope of state minor consent laws.

## CONCLUSION

Homeless youth represent a small but highly vulnerable population with significant health care needs who experience substantial barriers to accessing health care services. Homeless youth share with the general homeless population many of the same challenges in accessing health care, but for homeless youth these significant challenges are intensified by their status as youth. Improving access to care for homeless youth requires shaping policies, programs, and services that address the unique needs and challenges facing homeless youth. Many essential improvements can be made within the existing legal and policy framework, while others will require adoption of new laws and policies. Although homeless youth face significant health challenges, implementation of the above recommendations could improve their access to care and, ultimately, their overall health status.

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

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

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