FACT SHEET- NO.4
April 2007

# The Public Health Insurance Cliff for Older Adolescents

*By Harriette B. Fox, Stephanie J. Link, and Margaret A. McManus*

Adolescents have higher rates of uninsurance than their younger peers. Moreover, uninsurance rates increase among adolescents as they get older. Data from the National Health Interview Survey show that 12% of children from birth through age 11 are uninsured compared with 22% of adolescents ages 12 through 21. Older adolescents -- those ages 19 through 21 -- are particularly likely to be uninsured, with 35% having no public or private health insurance coverage, a rate nearly three times that of younger children.[1]

The effects of uninsurance on health care access have been well documented and include unmet needs for dental, vision, and mental health care as well as medical care and prescription drugs. Free or reduced-cost care may be available to uninsured older adolescents at community health centers and family planning clinics, but this care is often not comprehensive. Research has shown, for example, that many community health centers are limited in their ability to provide or make referrals for mental health and other specialty care for patients without insurance.[2,3]

Although a significant proportion of uninsured adolescents are eligible for Medicaid or SCHIP coverage, older adolescents -- those with particularly high rates of uninsurance – are the least likely to have the option of public coverage. According to researchers from the Urban Institute, 65% of uninsured adolescents ages 10 through 16 and 70% of adolescents ages 17 through 18 are eligible for public coverage -- either through Medicaid or SCHIP -- but are not enrolled. Among uninsured adolescents ages 19 through 21, however, the proportion who are eligible but not enrolled in public coverage is only 20%.[4]

These differences in insurance coverage among adolescent age groups, and in particular the "insurance cliff" experienced by older adolescents, are largely attributable to federal policies governing Medicaid and SCHIP eligibility. For adolescents ages 12 through 18, Medicaid requires coverage for those in families with incomes at or below 100% of the federal poverty level. By obtaining federal approval for an 1115 research and demonstration waiver or by using the 1902(r)(2) option, which allows states to adopt more liberal income and resource methodologies than would otherwise apply, coverage can be extended to those in families with incomes above the federally required minimum. SCHIP, an optional program operating in all states, permits coverage of adolescents through age 18 in families with incomes up to 200% of poverty, and higher in some situations.

The National Alliance
To Advance Adolescent Health

For older adolescents ages 19 and 20 who are not disabled, Medicaid is required only for those who are pregnant and those who are parents. There are a number of optional Medicaid eligibility groups that permit coverage for older adolescents, but most of these are linked to welfare eligibility levels, unless the 1902(r)(2) option is used, or are for individuals in specific high-risk groups or with special health needs. SCHIP permits coverage without an 1115 research and demonstration waiver only for older adolescents who are pregnant. With a waiver, SCHIP can be available to those who would qualify as childless adults[5] or as parents.

Moreover, not all states have adopted the coverage options for older adolescents that are available under Medicaid and SCHIP. Only 19 states, for example, use one of the two Medicaid eligibility options to extend coverage to all 19- and 20-year olds in families that meet the state's established income eligibility levels, most of which are below 100% of the federal poverty level. By comparison, all but eight states offer public coverage to adolescents ages 12 through 18 in families with incomes at 200% of the federal poverty level or higher. In fact, the average income eligibility level for adolescents 12 through 18 is 219% of poverty, while for older adolescents ages 19 and 20, the average is 78% of poverty, as shown in Table 1.

This fact sheet reviews the mandatory and optional pathways for extending Medicaid or SCHIP eligibility to 19- and 20-year olds and presents 2006 information on the number of states that have adopted each of the options. It includes eligibility policies through which older adolescents can be targeted specifically for public coverage as well as policies under which they can be covered as part of a larger group by virtue of their family circumstances or health status. Since there is no single source of information on adolescents' eligibility, we drew on published reports and the CMS website, in addition to our own review of state plan documents and communications with state Medicaid and SCHIP agency staff.

## Optional Coverage of Older Adolescents

Of the various eligibility policies that enable adolescents ages 19 and 20 to qualify for public health insurance coverage, only two target all adolescents who meet state-established income levels, and both are optional coverage groups under Medicaid. One is the "Ribicoff children" option and the other is the children's medically needy option. Coverage for older adolescents under these options is provided in 19 states.

### *Older Adolescents Who Qualify as "Ribicoff Children"*

For more than two decades, states have had the option to cover "Ribicoff children," those through age 18, 19, or 20 who meet the financial criteria but not the categorical criteria for Medicaid eligibility.[6] Today, with mandatory Medicaid coverage at 100% percent of poverty for all children through 18, the "Ribicoff children" category gives states the option to extend Medicaid coverage to all older adolescents ages 19 and 20 who meet the AFDC income and resource standards in effect in July of 1996. States can adjust the income standard for inflation, provided that the percent increase is not greater than the annual increases in the Consumer Price Index (CPI) for urban consumers. More importantly, they can raise income eligibility by using the 1902(r)(2) option that permits them to apply more liberal income disregards than those in effect in 1996.[7]

We found that only 15 states use the "Ribicoff children" option to cover adolescents through age 20. The income standards in these 15 states vary widely, ranging from 23% to 150% of the federal poverty level, but the income standard is below 100% of poverty in nine of the 15 states and below 50% of poverty in four states.

### *Older Adolescents Who Qualify as Medically Needy*

By adopting the medically needy program option for children through age 20, states are able to extend Medicaid coverage to older adolescents in families that meet a state income eligibility standard set anywhere between 100% and 133$^{1}/_{3}$% of the state's AFDC payment level in effect in July 1996, although by using the 1902(r)(2) option they can set their income eligibility standards higher.[8] Under a medically needy program, states must also provide coverage to children who "spend down" to the medically needy level on the basis of their incurred medical expenses. States have the option, however, to provide children who qualify as medically needy a more limited benefit package that does not include EPSDT.

Currently, only 16 of the 34 states that operate a medically needy program for children have elected to include 19- and 20-year olds. Medically needy income levels in these 16 states range from 22% of poverty to 102% of poverty. In more than half of the states medically needy income levels are below 50% of the federal poverty level, since they are not adjusted annually. Importantly, though, EPSDT is a covered benefit in all but one of the 16 states.

### Mandatory and Optional Coverage That Includes Older Adolescents in Specific Family Circumstances

Eligibility for public coverage is also available to 3 subgroups of adolescents who may qualify under adult categories on the basis of their family circumstances as well as their income. For two of these groups -- parents and pregnant women -- coverage under Medicaid is mandatory. For the third group, childless adults, Medicaid and SCHIP coverage is available only through a federally approved 1115 waiver. Fifteen states have received waiver approval to cover childless adults.

### *Older Adolescents Who Qualify as Pregnant Women*

Federal law requires states to provide Medicaid coverage to pregnant women who live in families with incomes up to 133% of poverty[9] and also gives them several mechanisms under Medicaid and SCHIP to increase income eligibility above the federally required minimum. Since the passage of the Omnibus Budget Reconciliation Act of 1987, states have had the option of extending Medicaid coverage to pregnant women in families with incomes up to a state-established income standard as high as 185% of poverty.[10] States may also use the 1902(r)(2) option, discussed above, to extend eligibility to pregnant women with higher incomes. A third option, available under SCHIP since 2002, is to cover pregnant women by making the "unborn child" eligible for SCHIP at the same income level as other eligible children, which can be set anywhere up to 200% of poverty and higher in some states.[11] This controversial option allows states to provide pregnancy-related services that "demonstrate a connection between the benefits and the health of the unborn child" rather than cover the pregnant woman herself. A fourth option requires a federally approved SCHIP 1115 waiver that enables states to use unspent SCHIP funds to cover pregnant women directly and continue their coverage through the postpartum period. Income eligibility under the waiver may be set at any level up to the level used for eligible children.

All older adolescents who are pregnant and live in families with incomes up to 133% of poverty are eligible for public coverage, and in 44 states they are eligible at higher income levels. In 38 states they are eligible at 185% of poverty, and in 19 of these they are eligible at 200% of poverty or higher. However, in 10 of the 44 states, older adolescents who are pregnant would not receive the full array of otherwise covered services.

### *Older Adolescents Who Qualify as Parents*

Under Medicaid, individuals who are older than 18 and are parents are a mandatory covered group. Section 1931 of the Social Security Act, authorized by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, provides that states must establish Medicaid eligibility for parents who meet the income and resource standards of the AFDC program in place in July 1996 and may cover higher income parents by applying more generous methodologies for counting income.[12] In addition, states have the option to obtain federal approval for an 1115 waiver to cover parents under SCHIP. Beginning in 2000, CMS has allowed states that cover children up to 200% of poverty in their SCHIP programs and have no waiting lists to use their unspent SCHIP funds to cover low-income parents up to a state-established income level at or below the level used for children.

In all states older adolescents who are parents and meet the state's financial eligibility criteria have access to public coverage. However, income eligibility levels for parents vary widely. In 30 states income eligibility standards for parents are below 100% of the federal poverty level, and in 26 of these states they are below 50% of poverty. By contrast, in eight states parents with incomes up to 200% of poverty qualify for public coverage.

### *Older Adolescents Who Qualify As Childless Adults Living Independently*

Only by obtaining federal approval for an 1115 research and demonstration waiver are states able to offer coverage to childless adults under either Medicaid or SCHIP. This waiver authority permits states to cover individuals who live independently (that is, are not dependent children) and who have no dependent children of their own. Income eligibility under Medicaid may be set at any level and under SCHIP up to any income level below the level used for children. Under both programs, however, states may impose significant cost-sharing requirements and also cap enrollment. What limits states' use of the waiver is the requirement for budget neutrality, meaning that federal expenditures cannot be greater than they would be without the waiver. Since the enactment of the Deficit Reduction Act of 2005, CMS has been prohibited from approving any new 1115 waivers that use SCHIP funds to cover childless adults.[13]

Older adolescents without children and who are living independently are eligible for public coverage in fifteen states. (Another state uses this option but gives older adolescents coverage under a different option.) Depending on the state, they qualify for coverage at substantially different income levels. Income eligibility is set as low as 35% of poverty in one state and as high as 275% of poverty in another. The remaining states set their income eligibility levels for older adolescents between 100% and 200% of poverty.

### Mandatory and Optional Coverage That Includes Older Adolescents With Special Needs

Several subgroups of older adolescents can be made eligible for Medicaid coverage on the basis of their special health care needs or high-risk status. These subgroups include older adolescents who meet the SSI disability criteria but are able to work, those who are in psychiatric facilities or other institutional care, those who were previously in foster care, and those who require family planning services. Except for those requiring family planning services, all are optional Medicaid groups. Medicaid eligibility can be extended to those requiring family planning services only through an 1115 waiver. All but five states use at least one of these options. Only one state uses all four. The group most likely to be covered is employed adults with disabilities.

***Older Adolescents Who Qualify as Reasonable Categories of "Ribicoff Children"***

States that elect not to cover all "Ribicoff children" (discussed previously) still have the option of providing Medicaid coverage to reasonable categories of these children through age 18, 19, or 20.[14] Federal regulations identify several reasonable subgroups. These include children in foster care or adoption whose care is financed through state, local, or private funds: children in publicly subsidized foster care or institutional care; children in privately subsidized foster care or institutional care, if the publicly subsidized optional group is covered; and children in publicly subsidized adoption. They also include disabled children in institutional care: children in a skilled nursing facility or intermediate care facility for the mentally retarded, and children receiving care in a psychiatric facility. Coverage for this last group may be extended through age 21. As with the "Ribicoff children" category generally, income eligibility for the foster care-related categories can be set at the AFDC payment level in effect in July of 1996 or raised by adjusting for inflation or applying the 1902(r)(2) option. For the remaining groups, which are SSI-related and pertain to adolescents in institutional care, income eligibility would essentially be unlimited, since parental income deeming rules would not apply.

In 26 states older adolescents who fall into one or more of these reasonable categories of "Ribicoff children" have coverage under Medicaid, as shown in Table 2. Those who would be most commonly covered are older adolescents in foster homes subsidized by a public agency: 22 states provide eligibility to these individuals. Those in psychiatric facilities would have coverage in 18 states.

***Older Adolescents Who Qualify Because They Were Formerly in Foster Care***

States have the option to continue providing Medicaid coverage to older adolescents who have "aged out" of the foster care system and are no longer receiving federal cash assistance under Title IV-E, known as the Chafee group.[15] Except for certain groups of children in foster care who are determined to have special needs because of a physical, mental, or emotional disability, Title IV-E assistance is available only to children through age 17.[16] Since 1999, with the passage of Title I of the Foster Care Independence Act, which established the Chafee Foster Care Independence Program, states have been able to cover all adolescents through age 20 who were formerly in the federally subsidized foster care system. States can set their own income eligibility levels for this group, but they may not use an income standard that is more restrictive than the one in effect for low-income parents covered under Section 1931.[17]

There are only 18 states, however, in which Medicaid eligibility is extended to older adolescents formerly in foster care. One provides coverage through age 19, but the remainder provide coverage through age 20. In 14 of the 18 states, income eligibility is unlimited. In the remaining four states, eligibility is set at 185% of poverty, 200% (two states), and 400%. An additional state is awaiting approval of a state plan amendment to cover this population.

***Older Adolescents Who Qualify Because They Receive SSI Cash Payments***

Federal Medicaid law requires states to provide Medicaid coverage to those who meet the income, resource, and disability criteria of the Supplemental Security Income (SSI) program and gives states the option of using state assistance eligibility criteria in place in 1972 instead of SSI criteria.[18] Because SSI eligibility for children ends

when a child reaches 18, unless he or she is a full-time student, an 18-, 19-, or 20-year old adolescent must meet the disability criteria established for adults: be unable to engage in any "substantial gainful activity" because of a physical or mental impairment

that is expected to result in death or to continue for at least 12 months. An older adolescent who is a full-time student may qualify for SSI by meeting the more generous children's definition of disability until the age of 22.[19] The SSI income standard in 2006 is $603 per month, or 74% of the federal poverty level, and assets may not exceed $2,000.

In 40 states, older adolescents who qualify for SSI cash payments are eligible for Medicaid. In 11 other states, referred to as "209(b)" states, older adolescents with disabilities must meet state-established disability, income, and resource standards.[20] Three of these 11 states set income eligibility below the federal SSI standard, and two also use disability criteria stricter than used for SSI.

### *Older Adolescents Who Qualify as Employed Individuals with Disabilities*

Since 1997, states have had the option of extending Medicaid eligibility to individuals with disabilities who are employed and therefore no longer eligible for SSI cash payments.[21] This option, authorized by the Balanced Budget Act of 1997 (BBA) and the Ticket to Work and Work Incentives Improvement Act of 1999, benefits adolescents age 16 and older. This option enables states to cover employed individuals who meet SSI disability criteria and would qualify for SSI were it not for their earnings. The Ticket to Work option also enables states to cover those whose medical conditions have improved and who would no longer meet the SSI disability criteria but still have a "severe or medically determinable impairment."[22] Under the BBA option, income eligibility is capped at 250% of poverty and resources can be no more than those allowed under the SSI program,[23] but under the Ticket to Work option, states are able to set their own limits on assets and income. Under both options, states can elect to charge premiums and establish other cost-sharing requirements.

Older adolescents who are disabled but able to work are covered under the buy-in option in 33 states.[24] Five of these states also cover those whose medical conditions have improved. Income eligibility is usually set at 250% of poverty but is as high as 765% of poverty in one state and unlimited in two others. Monthly premiums are charged in all but two of the states but not usually for individuals with incomes below 150% of poverty, and copayments are only required in one state.

### *Adolescents Who Qualify Because of Their Need for Family Planning Services*

States have the option to expand eligibility through a Section 1115 waiver for Medicaid-covered family planning services to adolescents who are not otherwise Medicaid eligible. Covered services vary by state but generally include sexually transmitted infection services, contraceptive services and supplies, and gynecological exams. Primary care, mental health, and substance abuse services are not covered, although all states are required to establish formal arrangements with community health centers that serve the uninsured in order to facilitate access to primary care.

Older adolescents are an eligible target population for Medicaid family planning services in all 17 of the states with approved federal family planning waivers.[25,26] In 15 of these states, income eligibility for older adolescents is essentially unlimited, since older adolescents may apply as an individual with parental income not taken into account. Income eligibility in the other two states is set at 185% of the federal poverty level. However, not all of the states have elected to cover males. Older adolescent males have access to Medicaid coverage for family planning services in only seven states.

## Conclusions

Low-income older adolescents ages 19 and 20 are more likely than other adolescents to be uninsured due in large

part to federal Medicaid and SCHIP eligibility policies. Medicaid permits coverage for older adolescents but does not mandate it, and most states have not adopted the broad eligibility options available, while SCHIP is intended only for adolescents through age 18. As a result, in the majority of states, older adolescents who do not qualify as pregnant, parents, or disabled only have access to public insurance if they meet the criteria for working adults with disabilities. Moreover, in states that do cover all older adolescents as a group, income eligibility levels are usually well below those of younger adolescents.

Older adolescents have not benefited from the two significant public program expansions that have taken place since 1990. In 1990, Congress required a gradual phase in of Medicaid coverage for children and adolescents through age 18 so that by 2002, all adolescents with family incomes up to 100% of the federal poverty level were eligible. Coupled with the enactment of SCHIP in 1997, access to public coverage for children and adolescents through age 18 with family incomes at or below 200% of poverty vastly improved. Both of these historic expansions, however, stopped short of covering adolescents over the age of 18.

Two major policy improvements would have a significant impact on the uninsurance rate for older adolescents and extend access to needed health care at a critical point in their development. The first is continuing to phase in Medicaid coverage of all adolescents through age 20 in families with incomes up to 100% of the federal poverty level. The second is extending SCHIP eligibility to targeted low-income adolescents through age 20. Enacting these changes would provide the necessary health insurance support for improving access among low-income older adolescents for health promotion and risk reduction services, the early identification of health problems, management of acute and chronic conditions, and effective transition to adulthood.

**Acknowledgements**

We appreciate the assistance of state Medicaid and SCHIP staff who responded to our many requests for information. We also gratefully acknowledge generous gifts from several individuals who provided support for this fact sheet.

**Endnotes**

[1] Estimates prepared by Amy Cassedy at Cincinnati Children's Hospital Medical Center based on data from the 2004-2005 National Health Interview Survey.
[2] Park MK, Fairbrother G, Park H. Exploring the limits of the safety net: community health centers and care for the uninsured. *Health Affairs*. 2002; 21: 188-94.
[3] Rosenblatt RA, Andrilla CH, Curtin T, Hart LG. Shortages of medical personnel at community health centers: implications for planned expansions. *Journal of the American Medical Association*. 2006; 295: 1042-9.
[4] Estimates prepared by Genevieve Kenney and Allison Cook of the Urban Institute based on a simulation model for Medicaid and SCHIP that adjusts for underreporting of public coverage and immigration status. From the Urban Institute's Tabulations of the 2005 Current Population Survey.
[5] The Deficit Reduction Act of 2005 prohibits CMS from approving any new SCHIP waivers to cover childless adults after October 1, 2005; states that already had waivers may continue to provide coverage.
[6] Section 1902(a)(10)(A)(ii)(I) and Section 1905(a)(i) of the Social Security Act.
[7] A final rule issued by CMS in January 2001 made the 1902(r)(2) option available for the Ribicoff and medically needy populations. Dear State Medicaid Director Letter #01-007, January 10, 2001.
[8] Section 1902(a)(10)(C) of the Social Security Act.

[9] Section 1902(a)(10)(A)(i)(IV) and Section 1902(1)(1)(A) of the Social Security Act.
[10] Section 1902(a)(10)(A)(ii)(IX) of the Social Security Act.
[11] State Children's Health Insurance Program; Eligibility for Prenatal Care and Other Health Services for Unborn Children, Final Rule, 67 Fed. Reg. 61956 (October 2, 2002), available online at www.access.gpo.gov/su_docs/fedreg/a021002c.html.
[12] Section 1931(b)(1) and Section 1931(b)(2) of the Social Security Act.
[13] Section 2107(a)(f) of the Social Security Act.
[14] Section 1902(a)(10)(A)(ii) of the Social Security Act.
[15] Section 1902(a)(10)(A)(ii)(XVII) and Section 1905(w)(1) of the Social Security Act.
[16] All children and adolescents who receive federal assistance under Title IV-E are considered a mandatory eligibility group under Medicaid.
[17] Section 1905(w)(2) of the Social Security Act.
[18] Section 1902(f) of the Social Security Act.
[19] The disability criterion used for children's SSI eligibility is "a medically determinable physical or mental impairment which results in marked and severe functional limitations and which can be expected to last for a continuous period of not less than 12 months."
[20] These 11 states are Connecticut, Hawaii, Illinois, Indiana, Minnesota, Missouri, New Hampshire, North Dakota, Ohio, Oklahoma, and Virginia.
[21] Section 1902(a)(10)(A)(ii)(XIII) and Section 1902(a)(10)(A)(ii)(XV) of the Social Security Act.
[22] Section 1902(a)(10)(A)(ii)(XVI) of the Social Security Act.
[23] Resources for an individual are limited to $2,000.
[24] Two other states -- Massachusetts and Oklahoma -- extend eligibility to the working disabled through section 1115 waivers.
[25] Alan Guttmacher Institute. *State Medicaid Family Planning Eligibility Expansions*. New York: AGI, 2007.
[26] Individuals in 6 other states are eligible for family planning services but only during the postpartum period, and individuals in 2 other states who lose Medicaid eligibility for any reason are eligible for family planning services.

## TABLE 1. STATES' MEDICAID AND SCHIP INCOME ELIGIBILITY LEVELS AS A PERCENT OF POVERTY FOR ADOLESCENTS AGES 12 THROUGH 20, 2006

| States | Adolescents Ages 12 through 18 | Adolescents Ages 19 through 20 | | | | |
|---|---|---|---|---|---|---|
| | | Covered as Ribicoff Children | Covered as Medically Needy[1] | Covered as Pregnant Women | Covered as Parents | Covered as Childless Adults Living Independently |
| Alabama | 200% | - | - | 133% | 12% or 26%[2] | - |
| Alaska | 175 | 156% | - | 175 | 76 or 81 | - |
| Arizona | 200 | - | - | 133 | 200 | 100% |
| Arkansas | 200 | - | - | 200 | 15 or 200 | 200 |
| California | 250 | 73 | 73% | 300 | 100 or 107 | - |
| Colorado | 200 | - | - | 200 | 60 or 67 | - |
| Connecticut | 300 | 66 | 66 | 185 | 150 or 157 | - |
| Delaware | 200 | - | - | 200 | 100 | 100 |
| District of Columbia | 200 | - | 68 | 200 | 200 or 207 | - |
| Florida | 200 | - | 22 | 185 | 22 or 58 | - |
| Georgia | 235 | - | - | 200 | 31 or 55 | - |
| Hawaii | 300 | - | - | 185 | 100 | 100 |
| Idaho | 185 | - | - | 185 | 185 | 185 |
| Illinois | 200 | - | - | 200 | 185 | 200 |
| Indiana | 200 | - | - | 150 | 21 or 27 | - |
| Iowa | 200 | 31 | 59 | 200 | 31 or 77 | 200 |
| Kansas | 200 | - | - | 150 | 29 or 36 | - |
| Kentucky | 200 | - | - | 185 | 38 or 66 | - |
| Louisiana | 200 | - | - | 200 | 14 or 20 | - |
| Maine | 200 | 150 | 39 | 200 | 200 or 207 | -[3] |
| Maryland | 300 | 53 | 43 | 250 | 31 or 38 | 116 |
| Massachusetts | 300 | - | - | 200 | 133 | - |
| Michigan | 200 | - | 50 | 185 | 38 or 61 | 35 |
| Minnesota | 275 | 100 (275)[4] | - | 275 | 275 | 275 |
| Mississippi | 200 | - | - | 185 | 27 or 33 | - |
| Missouri | 300 | - | - | 185 | 21 or 40 | - |
| Montana | 150 | - | - | 133 | 35 or 62 | - |
| Nebraska | 185 | - | 48 | 185 | 46 or 58 | - |
| Nevada | 200 | - | - | 200 | 200 | - |
| New Hampshire | 300 | - | - | 185 | 45 or 56 | - |
| New Jersey | 350 | 115 | 40 | 200 | 115[5] | - |
| New Mexico | 235 | - | - | 185 | 200 | 200 |
| New York | 250 | 74 (150)[6] | 85 | 200 | 150 | 100 |
| North Carolina | 200 | 44 | 30 | 185 | 39 or 54 | - |
| North Dakota | 140 | 38 | 61 | 133 | 38 or 65 | - |
| Ohio | 200 | 50 | - | 150 | 90 | - |
| Oklahoma | 185 | - | - | 185 | 34 or 43 | - |
| Oregon | 185 | - | - | 185 | 200 | 185 |
| Pennsylvania | 200 | 30 | 50 | 185 | 30 or 61 | - |
| Rhode Island | 250 | - | - | 250 | 185 | - |
| South Carolina | 150 | - | - | 185 | 48 or 97 | - |
| South Dakota | 200 | - | - | 133 | 58 | - |
| Tennessee | 250 | 147 | 30 | 250 | 70 or 80 | - |
| Texas | 200 | - | - | 185[7] | 14 or 29 | - |
| Utah | 200 | - | - | 133 | 150 | 150 |
| Vermont | 300 | 100 | 102 | 200 | 185 | 150 |
| Virginia | 200 | - | - | 166 | 24 or 31 | - |
| Washington | 250 | - | - | 185 | 39 or 79 | - |
| West Virginia | 200 | - | - | 150 | 18 or 36 | - |
| Wisconsin | 185 | - | - | 200 | 200 | - |
| Wyoming | 200 | - | - | 133 | 43 or 57 | - |
| **Total** | 51 (100%) | 15 (29%) | 16 (31%) | 51 (100%) | 51 (100%) | 15 (29%) |

[1] The EPSDT benefit is not required for the medically needy population.
[2] Where 2 income thresholds are indicated, the first applies to non-working parents and the second applies to working parents.
[3] In Maine, eligibility for childless adults is for individuals age 21 and older.
[4] In Minnesota, all children and adolescents through age 20 with incomes up to 275% of poverty are eligible for public coverage. The "Ribicoff children" option covers older adolescents up to 100% of poverty.
[5] In New Jersey, parents with incomes up to 200% of poverty who were enrolled in the program prior to September 2002 may remain in the program but new enrollees are eligible only with incomes up to 115% of poverty. The state intends to increase the income eligibility standard in September 2007 -- to 133% of poverty.
[6] In New York, adolescents ages 19 and 20 who live with their parents are eligible for public coverage at the same income eligibility level as their parents, 150% of poverty. Adolescents ages 19 and 20 who live independently are eligible at a lower income level, 100% of poverty. The "Ribicoff children" option covers older adolescents up to 74% of poverty.
[7] In Texas, starting on January 1, 2007, the state uses the SCHIP option to cover "unborn children" to increase eligibility for pregnant women to 200% of poverty.

**Source**: Information obtained by The National Alliance To Advance Adolescent Health through communication with state Medicaid and SCHIP agency staff, an analysis of state Medicaid and SCHIP plan documents and from the Centers for Medicare and Medicaid Services website (www.cms.gov). Information on parents' eligibility comes from Ross DC, Cox L, and Marks C. *Resuming the Path to Health Coverage for Children and Parents: A 50-State Update on Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and SCHIP in 2006*. Washington, DC: Kaiser Commission on Medicaid and the Uninsured, 2007.

**TABLE 2. STATES' USE OF MEDICAID OPTIONS FOR EXPANDING ELIGIBILITY TO SPECIAL GROUPS OF OLDER ADOLESCENTS AGES 19 AND 20, 2006**

| States | Reasonable Categories of Ribicoff Children | Adolescents Formerly in Foster Care | Working Disabled Adolescents | Adolescents Covered under Family Planning Waivers |
|---|---|---|---|---|
| Alabama | X | | | X |
| Alaska | | | X | |
| Arizona | | X | X | |
| Arkansas | X | | X | X |
| California | | X | X | X |
| Colorado | | | | |
| Connecticut | | X | X | |
| Delaware | X | | | |
| District of Columbia | X | | | |
| Florida | X | X | | |
| Georgia | | | | |
| Hawaii | X | | | |
| Idaho | X | | | |
| Illinois | X | | X | |
| Indiana | X | X | X | |
| Iowa | | X | X | X |
| Kansas | X | X | X | |
| Kentucky | | | | |
| Louisiana | X | | X | X |
| Maine | | | X | |
| Maryland | | | X | |
| Massachusetts | | X | | |
| Michigan | | | X | X |
| Minnesota | | | X | X |
| Mississippi | X | X | X | X |
| Missouri | X | | | |
| Montana | X | | | |
| Nebraska | X | | X | |
| Nevada | | X | X | |
| New Hampshire | X | | X | |
| New Jersey | | X | X | |
| New Mexico | X | | X | X |
| New York | | | X | X |
| North Carolina | | | | X |
| North Dakota | | | X | |
| Ohio | | | | |
| Oklahoma | X | X | | X |
| Oregon | X | | X | X |
| Pennsylvania | | | X | |
| Rhode Island | X | X | X | |
| South Carolina | | X | X | X |
| South Dakota | X | X | | |
| Tennessee | | | | |
| Texas | | X | X | |
| Utah | | X | X | |
| Vermont | | | X | |
| Virginia | X | | | |
| Washington | X | | X | X |
| West Virginia | | | X | |
| Wisconsin | X | | X | X |
| Wyoming | X | X | X | |
| **Total** | 25 (49%) | 18 (35%) | 33 (65%) | 17 (33%) |

**Source**: Information obtained by The National Alliance To Advance Adolescent Health through communication with state Medicaid agency staff and analysis of Medicaid state plan documents and state Medicaid policy documents. Information on adolescents formerly in foster care comes from state eligibility policy manuals and regulations and Patel S. and Roherty MA. *Medicaid Access for Youth Aging out of Foster Care*. Washington, DC: American Public Human Services Association, 2007. Information on adolescents covered under family planning waivers comes from Alan Gutmacher Institute. State *Medicaid Family Planning Eligibility Expansions*. New York: Alan Guttmacher Institute, 2007.

The National Alliance to Advance Adolescent Health provides education, research, policy analysis, and technical assistance to achieve fundamental improvements in the way that adolescent health care is structured and delivered in the United States. Its mission is to enhance the physical and emotional well-being of adolescents, especially those who are low-income and minority, by improving the health care delivery model for adolescents and achieving the infrastructure changes needed to support it. The National Alliance seeks to promote comprehensive, interdisciplinary models of physical, mental, behavioral, and reproductive health care that incorporate a youth development philosophy and operate in collaboration with schools and other community-based programs. It also seeks to ensure that all adolescents have health insurance coverage for the services they require.

For more information about our work and available publications, contact Corinne Dreskin at The National Alliance to Advance Adolescent Health: cdreskin@TheNationalAlliance.org. Also visit our website: www.TheNationalAlliance.org.



THE NATIONAL ALLIANCE TO ADVANCE ADOLESCENT HEALTH
750 17th Street, NW, Suite 1100, Washington DC 20006
p: 202.223.1500 f: 202.496.9067