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Health Insurance Coverage and Use of Family Planning Services among Current and Former Foster Youth: Implications of the Health Care Reform Law

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Abstract

This research uses data from a longitudinal study to examine how two provisions in the Patient Protection and Affordable Care Act could affect health insurance coverage among young women who have aged out of foster care. It also explores how allowing young people to remain in foster care until age twenty-one affects their health insurance coverage, use of family planning services, and information about birth control. We find that young women are more likely to have health insurance if they remain in foster care until their twenty-first birthday and that having health insurance is associated with an increase in the likelihood of receiving family planning services. Our results also suggest that many young women who would otherwise lack health insurance after aging out of foster care will be eligible for Medicaid under the health care reform law. Because having health insurance is associated with use of family planning services, this increase in Medicaid eligibility may result in fewer unintended pregnancies among this high-risk population.

Impact of the PPACA

On June 28, 2012, the Supreme Court largely affirmed the constitutionality of the Patient Protection and Affordable Care Act (PPACA), including its individual mandate provision. This federal health care reform law will significantly change the US health care system over the next decade and dramatically reduce the number of Americans who are uninsured.[1] The purpose of the present study is to estimate the impact that two of the act's provisions could potentially have on one particular population—young women who have aged out of foster care. It also explores whether extending foster care until age twenty-one is associated with higher rates of health insurance coverage or increased access to family planning services.

Medicaid Eligibility for Youth in Foster Care

Thousands of young people exit foster care each year not because they are returned home to their families (reunification) or because another permanent connection has been established (adoption or legal guardianship) but because they become too old for the child welfare

[1]Although the Supreme Court largely affirmed the constitutionality of the 2010 PPACA, it did hold that withdrawing *all* Medicaid funds from states that failed to expand their Medicaid program under the PPACA violates the Tenth Amendment (*National Federation of Independent Business v. Sebelius*).

system. In federal fiscal year 2010, nearly twenty-eight thousand young people aged out of foster care (US Department of Health and Human Services 2012).

Youth in foster care are categorically covered by their state's Medicaid program (Geen, Sommers, and Cohen 2005). Whether this coverage continues after they age out depends in part on where they live. A provision in the 1999 Foster Care Independence Act allows but does not require states to extended eligibility for Medicaid coverage to former foster youth until their twenty-first birthday if they were still in foster care when they turned eighteen. In states that have taken advantage of this "Chafee option," young people remain categorically eligible for Medicaid for up to three additional years after aging out.[2] By 2008 at least twenty-eight states had exercised this option (Dworsky and Havlicek 2009).

In some of these states, youth automatically continue to receive medical benefits until their twenty-first birthday. In other states, however, continued receipt of medical benefits is not automatic. For example, youth may be required to complete an initial application (Connecticut, North Carolina, Tennessee, Wyoming, and Washington) or reapply on an annual basis (Arizona, Iowa, Nevada, Ohio, Oklahoma, South Dakota, and Texas). Similarly, youth may be eligible regardless of their income (California, New Jersey, New York, North Carolina, Rhode Island, and Wisconsin) or subject to an income test (Maryland and Michigan) (National Resource Center for Youth Development 2012). Although a majority of states have extended Medicaid to former foster youth through the Chafee option, youth in the states that have not done so will lose their Medicaid coverage on aging out unless they qualify based on some other status, such as having a disability, being pregnant, or being a very low-income parent (Golden and Fortuny 2011)

Relevant PPACA Provisions and Their Potential Impacts

Two provisions of the health care reform act, both of which are scheduled to be implemented in 2014, will affect this population's eligibility for Medicaid. One provision will require states to provide Medicaid coverage to all former foster youth until their twenty-sixth birthday if they were at least eighteen years old when they aged out of foster care (Klain, Kendall, and Pilnik 2010). The other will require states to extend Medicaid coverage to all nonelderly individuals with incomes below 133 percent of the federal poverty level (FPL). Prior research on the labor market outcomes and public assistance receipt among young people who aged out of foster care suggests that a large proportion of this population will be eligible for Medicaid under this income-based provision, even though it is not specifically aimed at former foster youth (Courtney et al. 2010; Dworsky 2005; Goerge et al. 2002).

Although these two provisions, if implemented in their current form, stand to increase Medicaid coverage among this population, the magnitude of the increase is difficult to predict and is likely to vary across states for several reasons. First, many states already extend Medicaid coverage to young people who aged out of foster care until their twenty-first birthday if they were still in foster care when they turned eighteen. Additional states may choose to do so before 2014. Conversely, it is also possible that some of the states that currently extend Medicaid coverage to former foster youth may choose to reverse that policy in response to budget shortfalls over the next few years.

Second, because of a provision in the Fostering Connections to Success and Increasing Adoptions Act of 2008, some states have increased or will soon increase the age at which young people age out of foster care from eighteen to twenty-one. These young people would

[2]The provision is called the Chafee option because the Foster Care Independence Act created the John H. Chafee Foster Care Independence Program.

continue to be categorically eligible for Medicaid.[3] Third, some of these young people already have health insurance through other sources, such as an employer or a spouse, but not much is known about the percentage covered or about cross-state variation in that percentage. Fourth, many young women who have aged out of foster care are either pregnant or parenting (Courtney et al. 2005, 2007; Courtney, Terao, and Bost 2004) and so may already be covered by Medicaid, depending on their income. Finally, the new provisions may prompt some young people to alter their behavior—for example, working fewer hours to reduce their income below the eligibility threshold.[4]

Relationship between Health Insurance Coverage and Contraceptive Use

Several studies have examined the relationship between health insurance coverage and contraceptive use. Culwell and Feinglass (2007) analyzed survey data collected from a nationally representative sample of 26,674 females aged 18–44 who participated in the 2002 Behavioral Risk Factor Surveillance System (BRFSS) to examine the relationship between prescription contraceptive use and health insurance coverage. Women who were insured were more likely to report that they used prescription contraceptives than women who lacked insurance (54 percent versus 45 percent). Conversely, women who lacked insurance were more likely to report using what the researchers characterized as less effective over-the-counter methods than women who were insured (25 percent versus 20 percent). Uninsured women were also more likely than those who had insurance to report using no method of contraception (20 percent versus 16 percent).

Health insurance coverage was related to prescription contraceptive use even after controlling for socioeconomic characteristics and self-reported ratings of overall health. Not having health insurance was associated with a 30 percent reduction in the relative risk of using prescription contraceptives. One limitation of the BRFSS data is that they do not distinguish between public and private insurance. Thus the researchers could not determine whether the reduction in the likelihood of using prescription contraceptives varied by insurance type.

Nearns (2009) also examined the relationships between health insurance coverage and prescription contraceptive use. Her analysis was based on data from a sample of 1,049 young women aged 18–24 who participated in the 2002 National Survey of Family Growth (NSFG). Being covered by either private insurance or Medicaid (but not other types of government insurance) tripled the odds of using prescription contraceptives, even after controlling for sociodemographic characteristics and sexual health factors known to be associated with prescription contraceptive use. Although Culwell and Feinglass (2007) had a much larger sample, the Nearns analysis may be more relevant to the present study for two reasons: all the women in her sample were under twenty-five years old, and the NSFG data do distinguish among different types of insurance.

More recently, Xu and colleagues (2011) examined the relationship between health insurance coverage and contraceptive use by analyzing data from two sources: a sample of 3,005 women aged 15–44 years old who participated in the 2006–2008 NSFG and a sample of 1,655 women aged to 18–44 years old who responded to a 2004 Guttmacher Institute survey. Although IUD users were more likely than users of injectable contraceptives to report being covered by private health insurance (59 percent versus 38 percent) and less likely to report being covered by Medicaid (16 percent versus 33 percent), these differences

[3]This provision allows states to claim federal reimbursement for foster care maintenance payments made on behalf of Title IV-E–eligible youth until their twenty-first birthday if they are in school, working, preparing for employment, or incapable of doing any of these activities because of a medical condition.

[4]We wish to acknowledge an anonymous reviewer for this suggestion.

were not statistically significant after controlling for demographic and family background characteristics. However, because all the women in the sample reported that they were currently using some type of reversible contraceptive method, the researchers could not examine the relationship between having health insurance and contraceptive use.

Unlike these studies, which looked at the relationship between health insurance coverage and contraceptive use at the individual level, other research has examined the effects of expanded eligibility for Medicaid or government-funded family planning services. Several studies have found that increasing Medicaid coverage among young women increases their use of family planning services and so reduces their risk for an unintended pregnancy (Dehlendorf et al. 2010; Glass, Kolko, and Evans 1971; Gold et al. 2009; Frost, Finer, and Tapales 2008; Luke et al. 1993).[5] More recently, Sonfield and colleagues estimated the potential impact of a provision in the health care reform law that will greatly simplify the waiver process to expand Medicaid eligibility for family planning services (Sonfield, Frost, and Gold 2011). They predicted that the twenty-eight states without a current waiver could avert a total of 960,000 unintended pregnancies, with savings of an estimated $19.7 million per year. They also predicted that further expanding Medicaid eligibility for family planning in eleven of the twenty-two states that currently have a waiver would avert at least 1,300 additional unintended pregnancies, for an additional annual savings of $1.7 million. All the predicted savings are due to short-term maternity (i.e., prenatal care, labor and delivery, postpartum care) and infant care costs related to a Medicaid birth that would not be incurred. These are the standard costs that the Centers for Medicare and Medicaid Services (CMS) requires states to use to evaluate existing waivers.

Another team of investigators from the Bixby Center for Global Reproductive Health compared the cost of providing family planning services through California's Family Planning, Access, Care, and Treatment (PACT) program with projected government expenditures that would have been incurred in the program's absence (Biggs, Foster, and Hulett 2010). Family PACT provides comprehensive family planning services to low-income (< 200 percent of FPL) residents. The researchers estimated that in 2007 the program prevented 286,700 unintended pregnancies and 128,800 live births among its female clients. The reductions in unintended pregnancies were credited with substantial savings in medical, welfare, and social service costs not incurred. Moreover, although adolescents accounted for 28 percent of the averted pregnancies and 31 percent of the averted births, those averted pregnancies and births accounted for 44 percent of the cost savings.

Relevance to Young Women in Foster Care

None of the studies cited above that looked at the relationship between health insurance coverage and contraceptive use or pregnancy prevention focused on young women who aged out of foster care. There is, however, no obvious reason why a similar relationship would not be observed among this population. This is important because young women in foster care are at high risk of becoming pregnant, both while they are under state supervision and after they age out. Although teenage pregnancy and birth rates are lower now than they have been in several decades (Kost and Henshaw 2012), young women in foster care do not appear to have benefited from this downward trend.

Several studies have found that young women in foster care are far more likely to become pregnant than their peers in the general population (Gotbaum 2005; Pecora et al. 2003;

[5]This is not to say that universal health insurance coverage would eliminate unintended pregnancies. Health insurance is only one of several factors that can influence contraceptive use (Culwell and Feinglass 2007; Frost and Darroch 2008; Shortridge and Miller 2007).

Dworsky and Courtney 2010; Courtney, Terao, and Bost 2004). For example, half of the young women who participated in one longitudinal study of youth aging out of foster care had been pregnant at least once by age nineteen, compared with only 20 percent of the nationally representative sample of young women who participated in the National Longitudinal Study of Adolescent Health (Dworsky and Courtney 2010). Some of this difference was accounted for by the fact that young women in foster care are disproportionately African American (Chibnall et al. 2003; Derezotes and Poertner 2005; Hill 2005, 2006; Hines et al. 2004; National Association of Public Child Welfare Administrators 2006; US Government Accountability Office 2007; Wulczyn and Lery 2007), and the rate of teenage pregnancy is higher among young African American women than among their peers who are non-Hispanic whites (Kost and Henshaw 2012). However, pregnancy rates were still significantly higher among young women in the foster care sample (51 percent) than among their peers (27 percent), even after controlling for race (Dworsky and Courtney 2010).

Research suggests that young women who have aged out of foster care continue to be at high risk of becoming pregnant (Singer 2006; Dworsky and Courtney 2010; Courtney et al. 2005, 2007, 2009). For example, Courtney and colleagues (2009) reported that nearly two-thirds of the twenty-three- and twenty-four-year-old females in their longitudinal study had been pregnant at least once since aging out of foster care.

This is important for two reasons. First, although the personal and social costs of teenage pregnancy are greater when children are born to younger (age seventeen and under) compared with older teens, childbearing prior to age twenty is associated with negative outcomes for both young mothers and their children, even when the young mothers are eighteen or nineteen years old (Hoffman 2006). Second, many young women who had been in foster care are not earning enough to support themselves, let alone a child, as many as five to eight years after aging out (Courtney et al. 2011; Dworsky 2005). Thus another potential benefit of the federal health care reform law is fewer unintended pregnancies among young women who do not achieve self-sufficiency after aging out of foster care.

Benefits of Extending Foster Care to Age Twenty-One

As alluded to above, an increasing number of states have raised or are in the process of raising the age at which youth become too old for foster care from eighteen to twenty-one. Although the full effects of this policy change remain to be seen, allowing youth to stay in foster care until their twenty-first birthday is associated with higher rates of college attendance (Dworsky and Courtney 2010; Peters et al. 2009). The present study examines whether the benefits of extending foster care apply to health insurance coverage or use of family planning services.

Data

The data for this study come from the Midwest Evaluation of the Adult Functioning of Former Foster Youth (hereafter Midwest Study), a longitudinal investigation that has been following a sample of young people from three Midwestern states (Illinois, Iowa, and Wisconsin) as they have transitioned out of foster care and into adulthood. Baseline interviews were conducted in 2002–2003 with 732 young people when they were seventeen or eighteen years old and still in foster care. Follow-up interviews were done at ages nineteen ($N = 603$), twenty-one ($N = 591$), and twenty-three or twenty-four ($N = 602$).[6] For the purpose of this study, we limited our analysis to the 378 young women in the baseline

[6]Additional information about the design of the study can be found at www.chapinhall.org/research/report/midwest-evaluation-adult-functioning-former-foster-youth.

sample.[7] Although young women composed 52 percent of the baseline sample, the attrition rate was lower for females than for males at each wave of follow-up data collection. Thus we have data for 326 females at age nineteen (87 percent of the baseline sample), 315 females at age twenty-one (83 percent), and 322 females at age twenty-three or twenty-four (85 percent).

An important feature of the Midwest Study that we take advantage of in our analysis is that at the time of data collection Illinois was one of only three jurisdictions in which young people could and routinely did remain in foster care until their twenty-first birthday.[8] By contrast, the age of emancipation in Iowa and Wisconsin was (and continues to be) eighteen years old. This between-state difference in child welfare policy explains why three-fourths of the young women from Illinois were still in foster care when they were interviewed at age nineteen, compared with only one woman from Iowa and none from Wisconsin. Because Iowa and Wisconsin had similar policies on age of emancipation and because the Iowa sample was particularly small ($N = 35$), we grouped the women from these two states together in our analyses.

Research Questions

We used the Midwest Study data to address four main research questions.

1. What was the relationship between being able to remain in foster care until age twenty-one and having health insurance?
2. What was the relationship between being able to remain in foster care until age twenty-one and use of family planning services?
3. What was the relationship between having health insurance and use of family planning services?
4. What impact are the two provisions of Medicaid coverage in the federal health care reform law likely to have on health insurance coverage among young women who age out of foster care?

Variables

Our analysis focuses on three dichotomous measures. The first is current health insurance status (does the respondent currently have health insurance?). This could include insurance provided by an employer, funded by the government (e.g., Medicaid or SCHIP), or obtained through some other source (e.g., spouse, parents, etc.). The second is use of family planning services (did the respondent use family planning services during the past year?). Our definition of family planning services includes information about birth control.

Our third dichotomous measure is Medicaid eligibility (would a respondent be eligible for Medicaid if states were required to extend coverage to individuals with incomes below 133 percent of the FPL?). To determine eligibility, we created a measure of household income for the past year that includes earnings from employment, child support received, and cash transfers from any of the following government programs: unemployment insurance, workers' compensation, Supplemental Security Income, and Temporary Assistance to Needy Families. Our household income measure included earnings from spousal employment if the young woman was married and living with her spouse.

[7]One study participant was mistakenly coded as a male in the baseline data. Because of the error, that participant was not asked any of the pregnancy history questions.

[8]The two other jurisdictions were New York State and the District of Columbia.

Results

Relationship between State and Health Insurance Coverage

Eighty-eight percent of the young women from Illinois had health insurance when they were interviewed at age nineteen, compared with only 57 percent of their peers from Iowa and Wisconsin, a statistically significant difference. That difference was entirely a function of the women from Illinois who were still in foster care; those who were no longer in foster care were no more likely to have health insurance than their Iowa and Wisconsin counterparts (table 1). No between-state difference was observed once all the young women from Illinois had aged out of foster care. Regardless of the state, two-thirds of the women had health insurance at age twenty-one, and three-fourths had health insurance at age twenty-three or twenty-four.

State was not related to the type of insurance the women had if they were insured. Medicaid and SCHIP covered a majority of the women at all three waves of data collection. However, the percentage of women whose employer provided insurance increased over time (table 2).

Relationship between State and Use of Family Planning Services

At age nineteen fewer than half of the young women reported that they had used family planning services since their baseline interview (table 3). They were even less likely to report that they had used such services since their last interview at age twenty-one. No between-state difference was observed at either wave.[9]

A different picture begins to emerge when the analysis is limited to the women from Illinois. Compared with those who were no longer in foster care, those who were still in foster care at age nineteen were significantly more likely to have used family planning services since their baseline interview (51 percent versus 30 percent).

Relationship between Health Insurance Coverage and Use of Family Planning Services

Compared with their uninsured peers, young women who had health insurance were more likely to report that they had used family planning services (table 4). The difference between those with and without health insurance was statistically significant both at age nineteen (47 percent versus 33 percent) and at age twenty-one (40 percent versus 23 percent).

This relationship explained some of the difference we observed in the use of family planning services in the Illinois sample between those who were still in foster care at age nineteen and those who had already left. The young women who were no longer in foster care were less likely to be insured, and hence less likely to have used family planning services, than those who were still in foster care, all of whom had health insurance (table 5).

Projected Increase in Health Insurance Coverage

Just over one-third of the young women in the Midwest Study did not have health insurance coverage when they were interviewed at age twenty-one. That had fallen to slightly below one-fourth by the time they were interviewed at age twenty-three or twenty-four (table 6). Implementation of the provision requiring states to provide Medicaid coverage until age twenty-six to all former foster youth who were at least eighteen years old when they aged out of foster care would result in nearly all of the young women being covered. It would be less than 100 percent because thirty-eight of the women exited foster care before their eighteenth birthday and so would not be categorically eligible for Medicaid.

[9]Comparable data were not available for wave 4 because study participants were not asked if they had received information about birth control when they were interviewed at age twenty-three or twenty-four.

Eighty-seven percent of the young women who did not have health insurance at age twenty-one had incomes below 133 percent of the FPL and would have been eligible for Medicaid under the PPACA's income-based provision. This would leave only 5 percent uninsured.

A similar pattern is observed at age twenty-three or twenty-four. Eighty-eight percent of the young women with no health insurance at those ages had incomes below 133 percent of the FPL and so would have been eligible for Medicaid under the income-based provision in the PPACA. Only 3 percent of the women would remain uninsured.

Limitations

Before discussing our findings, we briefly acknowledge the study's limitations. First, our sample is limited to young women from just three mid-western states. Although we have no reason to think our findings would have been substantively different had our sample been more geographically diverse, this does raise questions about their generalizability. Second, our analysis is primarily descriptive. A relatively small sample size precluded us from using multivariate statistical techniques to deal with the selection issues associated with state and foster care status at age nineteen. It also limited our statistical power to detect differences among groups. Third, all our measures are based on self-reported data. However, previous research suggests that most adolescents and young adults can accurately recall receiving health care services, including services related to sexual health and contraception, over the better part of a year (Klein et al. 1999).

Finally, although our follow-up response rate was consistently above 80 percent, which is considered adequate to achieve accurate estimates (Desmond et al. 1995), attrition is a perennial problem for longitudinal studies. To gauge how much of a problem this might be in our case, we compared baseline characteristics of the young women for whom we have data with baseline characteristics of those for whom data are missing at each of our four waves of data collection. We found no differences with respect to the race they identified with, whether they used family planning services, or whether they had ever been pregnant. The only statistically significant difference was between the women for whom we had data and those for whom data were missing at age twenty-one, when women from Illinois were more than twice as likely as those from Iowa and Wisconsin not to have been interviewed (21 percent versus 8 percent).

Discussion

We analyzed survey data collected from young women who had aged out of foster care in three midwestern states. Only one of those states allows youth to remain in foster care until their twenty-first birthday. We were interested in the relationship between this child welfare policy and two outcomes related to health care—health insurance status and family planning services use—as well as the relationship between those two outcomes.

At age nineteen, young women from Illinois were more likely than those from Iowa or Wisconsin to have health insurance. All this between-state difference was accounted for by the young women who were still in foster care; it had disappeared by age twenty-one. In addition, although we found no between-state difference in the percentage of young women who had used family planning services, those from Illinois who were still in foster care at age nineteen were more likely to have used these services than those who had already left care.

We have interpreted our results as evidence that allowing young people to remain in foster care until their twenty-first birthday is conducive to better outcomes. However, we recognize that this interpretation is not without problems. In particular, between-state

differences in foster care populations or Medicaid eligibility, rather than the extension of foster care to age twenty-one in Illinois, may have contributed to the difference we observed in the percentage of young women who were insured at age nineteen.

To test this hypothesis, we estimated two logistic regression models predicting health insurance status. Both models included state as well as an array of demographic, family background, or placement history characteristics as covariates. Consistent with our bivariate results, the estimated odds of having insurance were significantly higher for young Illinois women at age nineteen but not at twenty-one, all other things being equal. The latter is important because it would be difficult for any differences in Medicaid eligibility to account for these results.

Another possible objection to our interpretation stems from the fact that the young women who were still in foster care at age nineteen were a self-selected group. Any systematic differences between this group of young Illinois women and those who were no longer in foster care may have contributed to the difference we observed in family planning services use. However, when we compared their baseline characteristics, the only between-group difference we found is that those who were still in foster care were more likely to be African American (77 percent versus 54 percent) and less likely to be white (15 percent versus 30 percent). This reflects the fact that the foster care population in Cook County is more disproportionately African American than the foster care population elsewhere in the state, and Cook County youth are more likely to remain in foster care until age twenty-one (Peters et al. 2008).

We were also interested in how much two provisions in the PPACA are likely to affect the rate of health insurance coverage among young women who age out of foster care. Nearly 100 percent of the women in our study would be eligible for Medicaid until age twenty-six under the provision that requires states to extend coverage to young people who aged out of foster care when they were at least eighteen years old.[10] However, our analysis also suggests that almost all the women who did not have health insurance would be eligible for Medicaid under health care reform because their income is below 133 percent of the FPL.

Based on our analysis, we expect that substantially fewer young women will be uninsured when they age out of foster care, so the PPACA's impact may not be as large as our projections suggest. One reason is that a number of states, including Iowa and Wisconsin, have taken advantage of the Chafee option since the Midwest Study began. This means that young women who age out of foster care when they are eighteen will be eligible for Medicaid until their twenty-first birthday. Another reason is that an increasing number of states have responded to the Fostering Connections Act by extending foster care until age twenty-one (Schutte 2010). To date the US Department of Health and Human Services has approved seventeen state plans, and others are pending approval (National Resource Center for Youth Development 2012; Catherine Heath, Children's Bureau, pers. comm., January 17, 2013). This means there will be fewer youth 18–20 who age out of foster care and do not have health insurance.

Conclusion

The rate of pregnancy among young women aging out of foster care is high. Far too many of these women find themselves parenting alone and struggling to make ends meet. One potential benefit of health care reform may be a reduction in the number of unintended

[10]A small number of the young women in our study aged out of foster care just prior to their eighteenth birthday. They would not be eligible for Medicaid under this provision.

pregnancies among this population. Nearly all young women who age out of foster care will be eligible for Medicaid if they are not otherwise insured, and they are more likely to have used family planning services if they had health insurance than if they did not.[11] Given the relationship between use of family planning services and pregnancy prevention (Frost, Finer, and Tapales 2008), we expect that increasing the rate of health insurance coverage among young women aging out of foster care through a combination of existing mechanisms (e.g., the Chafee option and the extension of foster care to age twenty-one) and health care reform will turn out to be a prudent investment of public funds.

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Table 1

Health Insurance Coverage by State and Foster Care Status at Age 19

	Age 19[a,b]		Age 21		Age 23 or 24	
State	***N***	**Percentage**	***N***	**Percentage**	***N***	**Percentage**
Illinois	216	88	203	66	220	76
Still in foster care at age 19	162	98		NA		NA
No longer in foster care at age 19	54	57		NA		NA
Wisconsin and Iowa	110	57	112	65	102	74

[a] Difference between Illinois and Wisconsin/Iowa is statistically significant at $p < .001$

[b] Difference between still in care and no longer in care is statistically significant at $p < .001$

Table 2

Source of Health Insurance by Age and State (Only if Insured)

	Age 19		Age 21		Age 23 or 24	
	Illinois	**Iowa/Wisconsin**	**Illinois**	**Iowa/Wisconsin**	**Illinois**	**Iowa/Wisconsin**
N	189	63	134	73	168	75
Government:						
Medicaid, SCHIP	97%	73%	84%	71%	86%	72%
Employer	0%	6%	8%	16%	18%	19%
Other[a]	3%	21%	9%	13%	4%	9%

[a]Includes self, parents, spouse, school, and other

Table 3

Receipt of Family Planning Services by State and Foster Care Status at Age 19

	Received Family Planning Services			
	Age 19[a]		Age 21	
State	*N*	Percentage	*N*	Percentage
Illinois	216	46	203	36
Still in foster care at age 19	162	51		NA
No longer in foster care at age 19	54	30		NA
Wisconsin and Iowa	110	41	112	31

[a]Difference between still in care and no longer in care is statistically significant at $p < .01$

Table 4

Receipt of Family Planning Services by Health Insurance Status

	Received Family Planning Services			
	Age 19[a]		Age 21[a]	
Health insurance status	***N***	**Percentage**	***N***	**Percentage**
Health insurance	256	47	207	40
No health insurance	67	33	107	23

[a]Difference between insured and uninsured is statistically significant at $p < .05$

Table 5

Receipt of Family Planning Services by Health Insurance Status and Foster Care Status at Age 19

	Illinois[a]				Wisconsin and Iowa			
	Insured		Not insured		Insured		Not insured	
Foster care status at age 19	*N*	Percentage	*N*	Percentage	*N*	Percentage	*N*	Percentage
In care	162	51	NA		NA		NA	
Not in care	31	32	23	26	63	44	44	36
Total	193	48	23	26	63	44	44	36

[a]Difference between insured and uninsured is statistically significant at $p < .05$

Table 6

Projected Increase in Health Insurance Coverage under the Low-Income Provision of the PPACA

Age	*N*	No health insurance	Income below 133% of FPL (if uninsured)	Still uninsured if coverage extended to all individuals below 133% of FPL
Age 21	314	34.0%	86.5%	4.6%
Age 23 or 24	322	24.5%	88.3%	2.8%

Note: FPL = federal poverty level