



Implementing the Affordable Care Act for Young Invincibles

A STATE GUIDE TO HEALTH
CARE REFORM THAT WORKS
FOR MILLENNIALS

NOVEMBER 2011

EXECUTIVE SUMMARY

The Affordable Care Act greatly altered the ways in which Millennials will access health care and coverage. Among the many changes for young adults, we have identified five – the dependent coverage extension to age 26, reforms to college health care plans, the creation of catastrophic insurance plans directed at young adults, the establishment of insurance exchanges, and the expansion of Medicaid eligibility to all low-income Americans – that will have unique and far-reaching effects on young adults. Individual states will take a key role in implementing these provisions. This paper reviews the current state status quo, changes made by the Affordable Care Act and related regulatory decisions, and the role that states can take going forward in the implementation of these provisions.

We first review the dependent coverage extension. Prior to the Affordable Care Act, states used their discretion in setting how long dependents could stay on their parent's insurance plan. Many states did not extend coverage much past age 19, particularly for non-students, and even fewer extended coverage to or past age 26. The ACA extended coverage to age 26, with two notable exceptions: it does not require retiree-only plans to cover dependents, and until 2014, grandfathered plans are not required to cover a dependent if the dependent has employer-sponsored coverage. States, then, can help fill gaps left by those exemptions.

Second, we turn to college health insurance plans, which states have typically left unregulated. Proposed rules on the federal level clarify that college health insurance plans are subject to almost all of the regulations of individual plans. Exceptions are that college insurance plans will not be required to offer their plan to anyone not attending the school, and self-funded student health insurance plans will not be regulated. We recommend that states expand regulation to include self-funded student insurance plans, educate schools on the new requirements, clearly define student health plans in state code, and properly enforce ACA rules such as the requirement to provide adequate access to preventive care.

Next we discuss the role of catastrophic plans in ACA reforms. Catastrophic plans offer low monthly premiums but in exchange have high-deductibles. The ACA targets these plans at youth, but HHS has given little guidance on any implementation issues. In the absence of federal guidance, and to improve catastrophic plans, we recommend states further define the pre-deductible benefits required, and fully educate young people on their other affordable options.

Related to catastrophic plans are the Exchange and subsidy system. Because Exchanges will be new to most states, states will have to design an outreach strategy plan to educate all demographics – possibly one of the most important roles that states will play when it comes to connecting young adults to Exchanges. They will need to engage youth through online and mobile phone outreach methods. States can also issue clarifying guidelines around residency requirements for students moving for college, and facilitate easy alternate verification for subsidy eligibility, since tax returns may not be the most accurate portrayal of a young person's income.

Finally, states should prepare for a large influx of low-income young adults into their Medicaid systems. Medicaid, which previously only applied to certain low-income adults, will be expanded to include millions of childless low-income adults. Many, however, will be unaware of their new eligibility, and their added numbers could put a strain on the limited number of primary care physicians. To ensure a smooth transition, states should educate young adults through various channels about their eligibility for Medicaid, create multiple pathways and robust assistance for people applying for Medicaid, and invest in nurse practitioners and physician assistants to cover the shortage of doctors in the short-term.

Overall, the Affordable Care Act is a historic piece of legislation that will greatly increase many young people's access to affordable health insurance. While we laud the administration's effort to expand accessibility, much of the implementation will fall on the states' shoulders. The recommendations that we outline in this paper provide guidelines for successful implementation to ensure that the Affordable Care Act improves coverage for its intended target populations.

INTRODUCTION

The Affordable Care Act ("ACA") drastically changed the way the health care system in this country will function going forward, and its impact on young adults will be no exception. While numerous facets of the law will change the way that Millennials get their health coverage and receive health care, we identified five major pieces that both disproportionately impact young people, and that states have a significant role in implementing. These areas are:

- The dependent coverage extension up to age 26
- College health plan reforms
- Catastrophic plan offerings directed at young adults
- The establishment of Exchanges
- The expansion of Medicaid to childless low-income adults

In this report, we will first review the state-level status

of the health care system as it pertains to the provision at hand. Next, we give a brief overview of changes brought about by the Affordable Care Act at the federal level, particularly given the regulatory work done by HHS since the law's passage, and describe how those changes will alter the current way of doing things at the state level. Finally, we give recommendations on how best to implement these changes, making use of state flexibility allowed within the federal guidelines. We do not focus on more general issues that states face when implementing some of these provisions – for instance, whether to be an active purchasing exchange or not. Instead, we focus on youth-specific issues within each of these new areas, providing guidance to states to maximize health access and coverage for their young adult populations.

I. DEPENDENT COVERAGE

The ACA's extension of dependent coverage to the age of 26 is one of the most important provisions in the law for young people. It is comparatively comprehensive: unlike some previous state laws covering dependents, the federal law has few exceptions. However, states can still act to cover the minor gaps that still exist.

A. STATE STATUS QUO

Before the Affordable Care Act, most states did not have expansive coverage for children over the age of 19. States that did extend dependent coverage beyond the age of 19 often only covered them for a few more years, and included a litany of exemptions: they did not cover young people who were not financially dependent for tax purposes, married, not living at home, or not students for example. Few states covered dependents past the age of 26, and most of those also have exceptions.¹ All state extensions that go beyond the federal law are also preempted from applying to self-funded plans.²

¹ See "Covering Young Adults Through Their Parents' or Guardians' Health Policy," National Conference of State Legislators, <http://www.ncsl.org/default.aspx?tabid=14497>.

² Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406 § Sec. 514(b)(2)(B).

B. ACA CHANGES

The dependent coverage provision of the ACA requires all group and individual insurance issuers that offer family coverage to cover a dependent up to the age of 26. Few of the prior state exemptions are attached to this requirement: dependents can be married, financially independent, and live away from the house, but still be covered. Moreover, while prior state laws were limited in their coverage of self-funded plans due to ERISA preemption, the federal law covers self-funded plans.

There are still a few notable exceptions, however. First, the federal dependent coverage extension does not cover retiree-only plans.³ While it is unclear how many young adults under 26 have parents on retiree-only plans, some young adults have reported being denied coverage. Second, until 2014, grandfathered plans are not required to cover a dependent if the dependent is eligible for his or her own employer-sponsored coverage.⁴ The Department recently clarified that if a young adult is eligible for a so-called mini-med plan, this counts as an “eligible employer-sponsored plan,” meaning that their parent’s grandfathered plan is not required to cover them.

The implementation of the dependent coverage provision has been relatively smooth, as evidenced by the large take-up rate – about one million newly insured young adults in the beginning of 2011 alone.⁵ However, given the enormous potential for coverage access, states can still proactively implement this provision ways that further expand youth access to insurance.

C. RECOMMENDATIONS FOR STATE IMPLEMENTATION

Education. Over a million young adults have joined their parent’s plan, but there is still room for education to increase take-up of the provision even more. In particular, families should know 1) when their enrollment period comes up and how to enroll a young adult dependent;

2) what to do when children graduate from college and want to return to their parent’s insurance; and 3) the exceptions to the dependent coverage rules.

Mini-meds. While the federal law does not require employers to cover young adults if they have an offer of a mini-med plan, states can proactively assert that mini-meds do not count as employer-sponsored coverage at the state level, and implement an up-to-26 provision that requires plans to cover dependents who have an offer of mini-med coverage.

Coverage for Longer. The federal law creates a baseline, not a ceiling. In states where young adult unemployment levels are particularly high, states should consider extending coverage beyond 26. Several states already do this in some form.

II. COLLEGE HEALTH PLANS

Historically, state law has lacked clear rules for student health plans. The Affordable Care Act was similarly vague, but HHS promulgated more expansive regulations in February of 2011 that spell out a strong regulatory scheme for student health plans. While most of the work on the part of states will be in enforcing ACA provisions and educating local institutions, gaps remain where states should step in and provide oversight.

A. STATE STATUS QUO

College health plans are currently regulated under a vague patchwork of state law. Some state codes do not mention college health plans at all, while others call them “group plans” or “blanket insurance.” Finding data or state insurance filings can be difficult. Estimates vary on how many young people are actually enrolled in student health insurance plans, ranging from 2 million to 4.5 million. A recent poll conducted by Young Invincibles found 2.8 million young people between the ages of 18 and 34 enrolled in student health insurance plans.⁶

The quality of these insurance plans varies considerably. An investigation by then-Attorney General Andrew Cuomo found significant problems with many plans, includ-

³ 75 Fed. Reg. 34538 - 40.

⁴ Health Care and Education Affordability Reconciliation Act of 2010, Sec. 2301(a)4(B)(ii).

⁵ One Million Young Adults Gain Health Insurance in 2011 Because of the Affordable Care Act, ASPE Issue Brief, September 2011, available at <http://aspe.hhs.gov/health/reports/2011/DependentCoverage/ib.shtml>.

⁶ DEMOS AND YOUNG INVINCIBLES, STATE OF YOUNG AMERICA, November 2011, available at www.StateofYoungAmerica.org.

ing brokers with conflicts of interest, and denial of coverage for pre-existing conditions.⁷ Some plans also have low annual caps on coverage, particularly on benefits like prescription drugs.⁸ With such a sizable number of young people enrolling in these plans, state insurance offices should be well-versed on the existing regulation gap and the future changes.

B. ACA CHANGES

While the legislative text of the ACA did not say whether new consumer protections would apply to college health plans, later regulatory proposed rules clarified that insurance market reforms will reach student health plans. The final rules are pending and expected to be released in late fall of 2011. The proposed regulations clarify that student health insurance plans are individual plans and are subject to almost all of the protections as all other individual market plans, including a minimum 80 percent medical loss ratio, a ban on discrimination based on pre-existing conditions, the inclusion of essential health benefits, preventive care with no cost-sharing, a ban on lifetime limits, and a phase-out of annual limits.

HHS did, however, exempt student health insurance plans from providing guaranteed issue or guaranteed renewability – in other words, colleges are not required to offer their plan to anyone outside of their college walls. Additionally, HHS stated that it did not plan on regulating self-funded student health insurance plans.

i. Self-funded Student Health Insurance Plans Could be Exempt from ACA Reforms

In the proposed rule, the Department states that the federal government does not have the authority to make self-funded student health insurance plans subject to the ACA requirements that other student health plans would face.⁹ While some have disagreed with that as-

⁷ ANDREW M. CUOMO, OFFICE OF THE ATT'Y GEN. OF NEW YORK, LETTER TO SCHOOLS (2010) available at <http://www.nystudenthealth.com/pdfs/Letter%20to%20Schools%2004-06-10.pdf>.

⁸ *Id.*

⁹ Student Health Insurance Coverage, 76 Fed. Reg. 7,769, (Feb. 11, 2011). The ACA defines “individual health insurance coverage” as health insurance coverage offered to individuals in the individual market. It then defines “health insurance coverage” as “benefits consisting of medical care (provided directly, through insurance

assessment, HHS has not shown any indication that they will change their statement in the final rule.

Self-funded student health insurance plans do not seem to be a self-funded plan that falls under the jurisdiction of ERISA - because they are not employee benefit welfare plans.¹⁰ If, like the typical employer self-funded plan, they did fall within ERISA, this would give the federal government exclusive authority to regulate.¹¹ This may lead to confusion: it is possible that states may wrongly believe they do not have jurisdiction to regulate self-funded student insurance plans. HHS confirms this state authority, explicitly stating in the proposed regulations that “these self-funded student health plans may be regulated by the States.”¹² Thus, because self-funded student health insurance plans do not fall under ERISA for purposes of exemption from state regulation, states are left with authority to regulate these plans.

ii. Some Schools May Not Provide Adequate Access to Preventive Care

The preventive care requirements in the ACA¹³, which

or reimbursement, or otherwise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurance issuer.”

¹⁰ The statute defines “employee benefit welfare plan” and “welfare plan” as any plan, fund, or program established or maintained by an employer or by an employee organization, or by both, that is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, medical, surgical, or hospital care or benefits (among other things). § 1002. Employer means “any person acting directly as an employer, or indirectly in the interest of an employer, in relation to an employee benefit plan.” ERISA supersedes state law insofar as the state law relates to employee benefit plans, except that most insurance plans are “saved” from that preemption – except self-funded plans. 29 USC § 1144. Moreover, “self-insured health plans,” for the purposes of certain taxes imposed by the IRS include plans that have relationships between employers and employees, which does not include the relationship between and student and an institutes of higher education.

¹¹ 29 U.S.C. § 1144(b)(2)(B).

¹² Student Health Insurance Coverage, 76 Fed. Reg. 7,769, (Feb. 11, 2011).

¹³ Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, Fed. Reg. 46,621 (Aug. 3, 2011) (to be codi-

HHS recently provided guidance on, require all insurance plans to provide coverage for preventive care with no cost-sharing in-network. This provision is particularly important in the context of college health plans, given the high-usage of certain types of preventive care like contraception.¹⁴ The interim final rule on prevention would not prevent a plan or issuer from imposing cost-sharing requirements on preventive services administered by out-of-network providers.

But many student plans may not currently provide access to all preventive services in-network – which starting next year would effectively violate the spirit and letter of the ACA. Specifically, certain campus-based college health care providers and pharmacies may be unwilling to provide contraception or other services based on moral objections. Many schools proscribe their campus health centers from prescribing birth control, for example. But many student health plans also provide that only on-campus providers and pharmacies are “in-network.” Taken together, while insurers must provide a plan with coverage that includes in-network preventive care with no cost-sharing, universities might not provide physicians or pharmacies that offer preventive services at the sole in-network health center, forcing students to pay cost-sharing fees when they look out-of-network for those services. It is unclear whether HHS will clarify that all plans must provide access – i.e. providers in network - to required preventive services, in-network, without requiring cost-sharing.

C. RECOMMENDATIONS FOR STATE IMPLEMENTATION

Major changes will be coming to the college health plan landscape. It is unclear whether more students will enroll in student health plans due to the coming requirement to carry insurance, or whether fewer students will choose their campus plan when given an expanded list of coverage options to choose from. It is clear, however, that both state governments and university systems will need to prepare to fully implement these changes, and fill in any gaps in regulation that the federal rules have left. Proactive stakeholders should:

Properly regulate self-funded college health plans. States must ensure that self-funded plans are not left unregulated on the state level, given the gap in federal oversight left by the proposed student health plan regulations. Assuming the Department of Health and Human Services does not alter its proposed rule on the subject and begin regulating them on the federal level, states should update their insurance codes to explicitly state that student self-funded plans are not subject to ERISA preemption and are subject to state insurance regulation under their general insurance code. Moreover, state regulators should ensure that insurers and schools do not enter into contracts that look like fully-funded insurance but are called self-funded products for purposes of avoiding federal ACA regulation.

Enforce federal protections. State regulators should do their part to codify and enforce the ACA consumer protections required of student health plans. The increased medical loss ratios and low annual limits, in particular, will transform the current student health insurance market.

Educate schools on new requirements. Unfortunately, university insurance offices are at times run by administrators with little or no insurance or health background. At the same time, the changes coming to the health insurance system will be extensive and require education for even the most experienced health insurance expert. States and schools should take it upon themselves to educate their staff and students on new requirements.

Ensure that student health plans are defined properly in state code. While the federal government has clarified the insurance categorization of student health plans for purposes of federal law, state codes still often fail to adequately define the type of insurance that student health insurance falls under at the state level. States should proactively explicitly define plans in state code so that they are subject to the same state oversight as other plans.

Require student health plans to provide adequate access to preventive care. If HHS does not clarify that coverage of in-network preventive care means access to providers and pharmacies in-network to administer this care, it will be up to the states to protect access for their college students. They should require institutions within their

14 *Id.* at 45 C.F.R pt. 147).

14 *Id.*

boundaries to include access to preventive care, as defined by the ACA, at all campuses under student health insurance plans.

III. CATASTROPHIC PLANS

Young people typically have low incomes and often turn to low-cost plans. As a result, many young adults are enrolled in catastrophic plans, which have high deductibles but offer few benefits before that deductible is paid. Health care reform created a high-deductible catastrophic plan intended for young adults under 30 and low-income adults, but HHS has given little guidance in how they implement some of the legislative language around these plans. As such, states could have a significant role in ensuring that young adults enroll in plans that are right for them and offer the best coverage.

A. STATE STATUS QUO

Given the low-income of most young adults, they often turn to high-deductible plans that have lower monthly premiums. The deductibles can range from several hundred to several thousand dollars. However, young people who are strapped for cash may have difficulty paying for any required care out-of-pocket. Unsurprisingly, there is a difference between how high deductible plans affect people of different income levels. Lower income families with out-of-pocket expenditures in a HDHP plan were more likely than higher income families to forego or delay care.¹⁵

B. ACA CHANGES

Health care reform gave high-deductible plans a prominent role in the new health care system. Created with the fear that young people would not enroll due to cost, the catastrophic plan is intended to ensure that young people both have an affordable coverage option, and will participate in the health care system to keep the risk pool balanced. However, it is still unclear how risk adjustments will be calculated with catastrophic plans: HHS has raised the possibility that it will exclude cata-

strophic plans from risk adjustment calculations on Exchanges, which could defeat one of the intended consequences of their creation.¹⁶

The Catastrophic plan, by statute, must have a deductible of almost \$6,000.¹⁷ Before the deductible, enrollees can receive preventive care with no cost-sharing, and access 3 primary care visits.¹⁸ All other benefits – prescription drugs, emergency room visits, extra lab work, would be charged out of pocket until the \$6,000 sum is paid. HHS has given little guidance as to certain ambiguities in the law.

C. RECOMMENDATIONS FOR STATE IMPLEMENTATION

While catastrophic plans will offer minimal coverage for young adults, the restrictive legislative language in the Affordable Care Act leaves little room for state ingenuity to improve these plans. However, there are a few steps that states can take to ensure that young consumers are adequately informed about the type of coverage they will receive if they enroll in these plans, and about other affordable options.

Enhance federally-required sunshine provisions. States should require enhanced disclosure on state exchanges, with a clear listing of services not provided before paying the deductible. State exchanges should also include warnings for those with significant needs, with examples of the types of out-of-pocket expenses that enrollees could be expected to pay.

Educate enrollees about their options. The worst possible scenario is that young people enroll in seemingly inexpensive plans outside the exchange that provide little coverage, and lose the opportunity to obtain subsidies for their insurance plan. One could imagine a scenario where this might happen, particularly with the incentive to enroll young people in off-exchange plans. This would also undermine the goal of a robust exchange market, which would hurt consumers of all ages.

Explore further regulation of off-Exchange plans. States

¹⁵ Jeffrey T. Kullgren et al. Health Care Use and Decision Making Among Lower-Income Families in High-Deductible Health Plans. *Archives of Internal Medicine*, Nov. 2010(170(21)) pg. 1918-1924.

¹⁶ CENTER FOR CONSUMER INFORMATION AND INSURANCE OVERSIGHT, RISK ADJUSTMENT IMPLEMENTATION ISSUES (2011).

¹⁷ Patient Protection and Affordable Care Act, § 1302(e).

¹⁸ *Id.*

could explore the option of banning catastrophic plans from being offered off the Exchange. Barring that, they should, at least, provide extensive oversight of these plans so that insurers do not engage in discriminatory advertising practices.

Provide a broad definition of primary care in the absence of federal guidance. The Department of Health and Human Services has yet to describe exactly what the three primary care visits will entail. In the absence of any federal guidance, states should provide a robust definition of primary care that gives young adults access to needed care before they are forced to pay the enormous deductible.

Respond to Risk Adjustment: If the Department decides to exclude catastrophic plans from the general pool, it is likely that catastrophic plans will become even cheaper for potential enrollees – both because the risk pool will only be young people, and because insurers offering catastrophic plans will be incentivized to attract healthier individuals. If this happens, it will be even more important for states to adequately educate consumers on their other options.

IV. THE EXCHANGE AND SUBSIDY SYSTEM

The expensive individual health insurance market is one of the more direct causes of the high youth uninsurance rates in many states. In fact, while about 27% of young people say they are uninsured, only about 5% of young people are uninsured by choice.¹⁹ It is reasonable to assume, then, that given the low availability of employer-sponsored insurance, the related high uninsurance rates, and young adults' desire for coverage, that new Exchanges and attached subsidies will be very useful for this age group. Access to cheaper, standardized insurance marketplaces online could be a great option. However, the federal and state Exchange must be proactive in outreach to ensure that young adults understand their coverage options and can easily access these benefits.

A. STATE STATUS QUO

¹⁹ DEMOS AND YOUNG INVINCIBLES, STATE OF YOUNG AMERICA, November 2011, available at www.StateofYoungAmerica.org.

Access to employer-sponsored insurance for young people has fallen tremendously over the past decade alone. In 1999, 68% of 25 to 34 year-old workers had employer-sponsored health insurance. In 2009, that number dropped to 56%.²⁰ It's unsurprising, then, that a full 71% of uninsured 18 to 34 year-olds say that they are uninsured due to cost, lack of coverage from their job, or pre-existing conditions.²¹

However, state involvement in private insurance purchases is rare. Moreover, few young adults purchase insurance in the private market – in a recent poll, just 7% of insured young adults between the ages of 18 and 34 say they buy their own plan in the private market;²² given the price, that is unsurprising.

B. ACA CHANGES

One of the foremost reforms of the ACA is the creation of state and federally run insurance Exchanges, which will be marketplaces (primarily online) where consumers can easily compare and enroll in plans. Consumers can receive subsidies purchased through the Exchange, and all plans will have comparable benefits and baseline consumer protections.

While the differences between the current state individual market purchase are stark, it is important to narrow in on the differences that young people in particular will see. Young adults are generally more comfortable with online purchases, but have low insurance literacy rates. The act of purchasing private insurance will be new and confusing, but ultimately incredibly beneficial to young adults.

C. RECOMMENDATIONS FOR STATE IMPLEMENTATION

Given the enormous potential for young adult enrollment and coverage, states must engage in extensive youth education and outreach. State must also take steps to ease the cost and clarify eligibility requirements to maximize youth enrollment.

General Outreach. Design a statewide plan for enrollment,

²⁰ *Id.*

²¹ *Id.*

²² *Id.*

distributing materials to high schools seniors, college students, community clinics, community-based organizations, and at cultural events that attract various constituencies of hard-to-reach young adults. State Navigators and exchange consumer assistance programs should be integrated into those plans, and stakeholder consultation should specifically include youth advocates.²³

Navigators. HHS sought comment as to whether Navigators should be required to include at least one community-focused or non-profit organization. If HHS does not ultimately include this requirement, we encourage states to do so, in order to engage hard-to-reach younger audiences outside of places like college campuses.²⁴

Access for College Students. The federal exchange regulations currently do not clarify that a student moving for college – who may be moving within the state but outside of a prior service area – is eligible for a special enrollment period and can switch plans. States should clarify this point if the federal government fails to do so.

Online and Mobile Access. Web portals will serve as the primary access point to the Exchanges, but could prove less effective than anticipated if states do not pursue proper outreach and enrollment strategies. Perhaps surprisingly, young people, and particularly young people of color, may have a difficult time enrolling online. Communities of color have less reliable Internet access than whites, and young people of color disproportionately use smartphones such as Androids, Blackberries, and iPhones to access the Internet. People of color and young adults often use those phones as their primary mode for getting online. Yet mobile devices may not sync well with Exchange web portals, an additional barrier to access for the most frequently uninsured Americans. Removing that hurdle is important for successful implementation of the exchange system.

Although the traditional online option will work for many Exchange participants, creative alternatives can help enroll low-income consumers, communities of color, and young people. State Exchanges should look

²³ 76 Fed. Reg. 41,914 (July 15, 2011) (to be codified at 45 C.F.R. pt. 155.130).

²⁴ 76 Fed. Reg. 41,877 (July 15, 2011) (to be codified at 45 C.F.R. pt. 155.210(b)).

into developing a smart phone enrollment application, and at the very least a mobile integration plan, allowing exchanges to interact with mobile devices through actionable alerts, enrollment status updates, customer support services, and uploading documentation. Policymakers should incorporate mobile devices and social networking into their outreach plans. Kiosks in public places could provide information to those with limited Internet access. Finally, Exchanges should include a web-based consumer assistance tool.²⁵

Risk Adjustment and Age Rating. The Affordable Care Act limits age rating to 3:1, which means that insurers can only discriminate against older Americans by charging them as much as three times the premium of younger consumers, as opposed to the market rate which generally charges older consumers five or six times what a younger person gets charged. However, if Exchanges do not take that age rating out before calculating the required risk adjustment, insurers will likely not set rates at the 3:1 ratio, but instead increase premiums for young people and set it more like a community rate.²⁶ This higher price would potentially decrease participation in Exchanges on behalf of young adults.²⁷

Ease Alternative Income Verification. Young adults are unique when it comes to the employment world: they typically are mobile and more likely to take on temporary work,²⁸ and thus are more likely to see their incomes fluctuate throughout the year. In order to qualify for premium tax credits, applicants will need to file tax returns with the IRS.²⁹ The Exchange uses the tax returns to determine eligibility for premium tax credits. The Exchanges will also request data from other sourc-

²⁵ 76 Fed. Reg. 41,915, (to be codified at 45 C.F.R. pt.155.205(b))

²⁶ CENTER FOR CONSUMER INFORMATION AND INSURANCE OVERSIGHT, RISK ADJUSTMENT IMPLEMENTATION ISSUES (2011).

²⁷ Anthony T. Lo Sasso and Ithai Z. Lurie. Community Rating and the Market for Private Non-Group Health Insurance. *Journal of Public Economics*, 2009(93) pg. 264-279.

²⁸ See, e.g. Contingent Workers, Bureau of Labor Statistics, available at <http://www.bls.gov/news.release/conemp.t02.htm>; see also Jonathan R. Veum, Training and Job Mobility Among Young Workers in the United States, 10 *J. Population Econ.* 226 (1997).

²⁹ Health Insurance Premium Tax Credit, 76 Fed. Reg. 50,949 (Aug. 17, 2011) (to be codified at 26 CFR pt. 1.6011-8).

es, such as state agencies that collect wage data, to create a more accurate picture of an applicant's ability to pay premiums.³⁰ States can help young adults by ensuring that the methods of data collection are efficient and up-to-date, ensuring that any data collection is accurate, and easing communication between those agencies and Exchanges.

Clarify residency requirements. A person who is a resident in Arkansas may only use Exchanges in Arkansas. But for many young adults, where they reside or “intend to live” is fluid. A college student that is in a different state than his or her parents will usually provide two addresses, and typically maintain relationships in both states while in college. For example, some young people maintain their medical appointments and bank accounts in their parent's state, but spend most of the year in the college's state. The HHS proposed regulations allow young adults to choose their residence without regard to their parent's location if they are on the parent's family Exchange plan if they live elsewhere. But if they are college students – either dependent or independent – it may be unclear whether they are living in one state or another. If HHS does not clarify that a college student attending school out-of-state can enroll in the Exchange in his home state or the state of the institution that he/she attends, state Exchanges should be certain to make that clear.

V. EXPANDING MEDICAID

In addition to state exchanges, ACA will cover a significant portion of uninsured Americans through an expansion of Medicaid eligibility. Currently, the federal government only requires states to enroll certain low-income individuals and families, but those numbers will increase tremendously in 2014 when they begin covering a larger swath of low-income childless adults. The enormous number of new entrants could create challenges for states, particularly in its outreach and provider system.

A. STATE STATUS QUO

³⁰ Patient Protection and Affordable Care Act; Exchange Functions in the Individual Market: Eligibility Determinations; Exchange Standards for Employers, Fed. Reg. 51,232 (Aug. 17, 2011) (to be codified at 45 C.F.R pt. 155.320(c)(1)(ii)).

Federal law currently requires state Medicaid programs to cover certain members of low-income families with dependent children, blind or disabled people, and qualified pregnant women.³¹ The federal government sets a baseline level of income under which members of a certain group must be covered. It also mandates a basic package of benefits. Within these rules, states create eligible groups, types and ranges of services, payment levels for services, and administrative procedures.³² Presently, only seven states extend coverage further to childless adults.³³ As of last year, over 50 million individuals were enrolled in Medicaid.³⁴

B. ACA CHANGES

The ACA will expand the eligibility criteria for Medicaid. Beginning January 1, 2014, all children, parents, and childless adults who are not entitled to Medicare who have family incomes under 139% of the Federal poverty level³⁵ will become eligible for Medicaid. This will result in an estimated 18 million individuals gaining Medicaid coverage.³⁶ Over half of them will be under the age of 34.³⁷ The rapid addition of over 9 million young adults to Medicaid, almost 8 million of whom are cur-

³¹ 42 C.F.R. § 430.0

³² *Id.*

³³ “Income Eligibility- Low Income Adults - Kaiser State Health Facts .” Kaiser State Health Facts. <http://www.statehealthfacts.org/comparereport.jsp?rep=54&cat=4> (accessed October 17, 2011).

³⁴ Kaiser Family Foundation, *Medicaid Enrollment: June 2010 Data Snapshot*, at 4 (Feb. 2011), available at <http://www.kff.org/medicaid/upload/8050-03.pdf>.

³⁵ The ACA calls for coverage for people with incomes up to 133% of federal poverty level, but also adds a 5% disregard for the first percent of income. Kaiser Family Foundation, Focus on Health Reform, *Determining Income For Adults Applying for Medicaid and Exchange Coverage Subsidies* (March 2011).

³⁶ CMS, Office of the Actuary, *Estimated Financial Effects of the “Patient Protection and Affordable Care Act,” as Amended* (April 22, 2010), available at https://www.cms.gov/ActuarialStudies/Downloads/PPACA_2010-04-22.pdf. The CBO estimates that 17 million additional individuals will be added to the Medicaid and CHIP programs by 2021. Letter from Douglas Elmendorf to Henry Waxman (May 26, 2011), available at <http://www.cbo.gov/ftpdocs/121xx/doc12198/5-26-WaxmanLtr.pdf>.

³⁷ Kaiser Family Foundations. *Expanding Medicaid under Health Reform: A Look at Adults at or below 133% of Poverty*. 2010.

rently uninsured,³⁸ will create a variety of challenges for state governments. Two key ones relate to young adults:

i. Unfamiliar Consumers

Young adults may understand that coverage options have expanded, but their inexperience with purchasing insurance or signing up with a government program could hamper uptake. Typically, young people are insured at high rates until they finish school (either high school or college), which is when they must leave the government or student health plans they were on. Until the ACA's dependent coverage extension took effect, many often had to leave their parent's plans. At this point, the vast majority of young adults have never had to buy their own health insurance, and never had the option of enrolling in Medicaid.

ii. Limited Primary Care Physicians

The large influx of previously uninsured adults will also place additional strains on the Medicaid system. Millions will be able to afford medical care, but achieving access to that care could prove more difficult. Many states simply may not have enough doctors.³⁹ The problem arises from several factors including reimbursement rates, distribution of primary care physicians, and numbers of medical students entering the field in general. Some states pay less than others for medical care. Others have more doctors. The worrying sign is that the states with the greatest number of new Medicaid enrollees also have the proportionally least number of primary care physicians.⁴⁰

There has been less research into what kinds of specialists young people use; however, we do know what kinds of risks affect their population. In particularly young adults are more likely to use ambulatory care than other age groups.⁴¹ They face higher risks of acquiring sexu-

ally transmitted diseases.⁴² They also frequently need mental health care.⁴³ State Medicaid agencies should be aware that use of services in these areas could increase substantially as young people acquire coverage.

C. RECOMMENDATIONS

Outreach – States will have to spend significant resources to educate young adults about the availability of Medicaid and the methods for signing up. Creating a web portal will help, but as stated in the section above, it may not be enough to reach some low-income young adults. States can look to the Massachusetts health reform effort as an example of successful outreach to young people.⁴⁴

No wrong door – States will need to have one single, streamlined application to apply for all forms of coverage (including Medicaid, SCHIP, and premium tax credits to buy Exchange coverage). Many young adults fall on or near the cut-off between subsidies eligibility and Medicaid eligibility. Many more will switch between these during the year. In addition, a cumbersome administrative process could prevent many young adults from gaining coverage. In order to promote enrollment, applicants should be able to apply for coverage through multiple pathways, including online, in person, by phone, by mail, or by fax. States should provide in-person, online, and telephone application assistance to help young adults understand their coverage options, apply for coverage, and enroll in a program that is appropriate for them.

Nurse practitioners, physician assistants and doctors – States with too few primary care providers should invest in nurse practitioners and physician assistants to make

³⁸ DEMOS AND YOUNG INVINCIBLES, STATE OF YOUNG AMERICA, November 2011, available at www.StateofYoungAmerica.org.

³⁹ KU, et al., *The States' Next Challenge – Securing Primary Care for Expanded Medicaid Populations* (Jan. 26, 2010), available at <http://healthpolicyandreform.nejm.org/?p=13667&query=TOC>

⁴⁰ *Id.*

⁴¹ Robert Fortuna, et al, *Ambulatory Care Among Young Adults in the United States*, ANNALS OF INTERNAL MEDICINE, available at <http://www.annals.org/content/151/6/379.full.pdf+html>.

⁴² “Young Adults Visit Doctors Least at an Age When Risky Behavior Peaks,” UNIVERSITY OF ROCHESTER MEDICAL CENTER, Sept. 25, 2009, available at <http://www.urmc.rochester.edu/news/story/index.cfm?id=2628>

⁴³ “Study Ranks Mental Health as Young People's Main Health Problem,” U.S. NEWS AND WORLD REPORTS, available at <http://health.usnews.com/health-news/family-health/brain-and-behavior/articles/2011/06/07/study-ranks-mental-health-as-young-peoples-top-health-problem>.

⁴⁴ See e.g. Long, Stockley et. al, *Health Reform: The Remaining Uninsured*, Robert Wood Johnson Foundation, August 2010, available at www.rwjf.org/healthpolicy/product.jsp?id=67248.

up for the shortfall in the short-run. In the long-run, many states will need to train and attract more doctors so that the low-income adults on Medicaid can receive needed care.

Transitions from SCHIP – States should ensure that children who age off of SCHIP have a smooth transition into their state Medicaid program. Hundreds of thousands of young adults could transition off of SCHIP and onto Medicaid each year.⁴⁵

VI. CONCLUSION

The Affordable Care Act will bring enormous changes to private insurance markets. Expanded access to a parent's plan, better student health insurance coverage, private insurance options that are understandable and affordable, and public insurance that is more available means the potential for a huge coverage expansion in this population. Concentrating state implementation efforts on the recommendations provided above will help ensure that young adults see a smooth transition from the previous system to the new insurance landscape.

ABOUT YOUNG INVINCIBLES

Young Invincibles is a non-partisan, non-profit youth organization that seeks to expand opportunity for all Americans between the ages of 18 and 34. Young Invincibles engages in education, policy analysis, and advocacy around the issues that matter most to this demographic, focusing primarily on health care, education and economic opportunity for young adults, and working to ensure that the perspectives of young people are heard wherever decisions about our collective future are being made.

ACKNOWLEDGEMENTS

This report was written by Jennifer Mishory and Rory O'Sullivan. Maya Brod, Megan Cheney, Aaron Smith, Yuri Weigel, Brian Burrell and Justin Kasprisin also contributed to the report. Young Invincibles would like to thank the David and Lucile Packard Foundation, Atlantic Philanthropies, the California Endowment and the Nathan Cummings Foundation for their generous support of our health care work.

⁴⁵ State Children's Health Insurance Program At a Glance, KAISER FAMILY FOUNDATION (January 2007), available at <http://www.kff.org/medicaid/upload/7610.pdf>.