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Realizing Health Reform's Potential

How the Affordable Care Act Is Helping Young Adults Stay Covered

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Abstract: The Affordable Care Act is making a difference for young adults, among the groups most at risk for lacking health insurance in the United States. Young adults up to age 26 may now stay on or join their parent's health plans if they include dependent coverage, and early reports indicate that at least 600,000 have done so. Starting in 2014, of the 14.8 million uninsured adults ages 19 to 29, an estimated 12.1 million could gain subsidized coverage once all the law's provisions go into effect: 7.2 million may gain coverage under Medicaid and 4.9 million may gain subsidized private coverage through state insurance exchanges. New findings from the 2010 Commonwealth Fund Biennial Health Insurance Survey indicate the need for these reforms: 45 percent of young adults reported delaying needed care because of costs in 2010, up from 32 percent in 2001, and 39 percent reported problems paying medical bills.

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OVERVIEW

In the United States it is young adults who are among those most at risk of going without health insurance. According to the most recent U.S. Census data, during 2009 nearly 15 million people ages 19 to 29 (one-third of the people in that age group) were not covered. During the last decade, the number of uninsured young adults climbed by 4 million (Exhibit 1). These high uninsured rates are caused in part by young adults being excluded from their parents' policies when they graduated from high school or college.[1] Or, if they were insured under Medicaid or the Children's Health Insurance Program (CHIP), they generally aged off this insurance at age 19. As new entrants to the labor market, young adults face significant challenges finding full-time employment that carries health benefits.

But new surveys and health plan enrollment numbers suggest the Affordable Care Act is already turning the tide for many young adults, providing new protections to the 2011 graduating class. The law's requirement that health plans that offer dependent coverage allow children under the age of 26 to remain on or join their parents' policies has led to an increase of 600,000 young adult enrollees in five health plans.[2] In addition, a new Gallup Poll shows that uninsured rates among 18-to-29-year-olds fell in the early part of this year.[3] By

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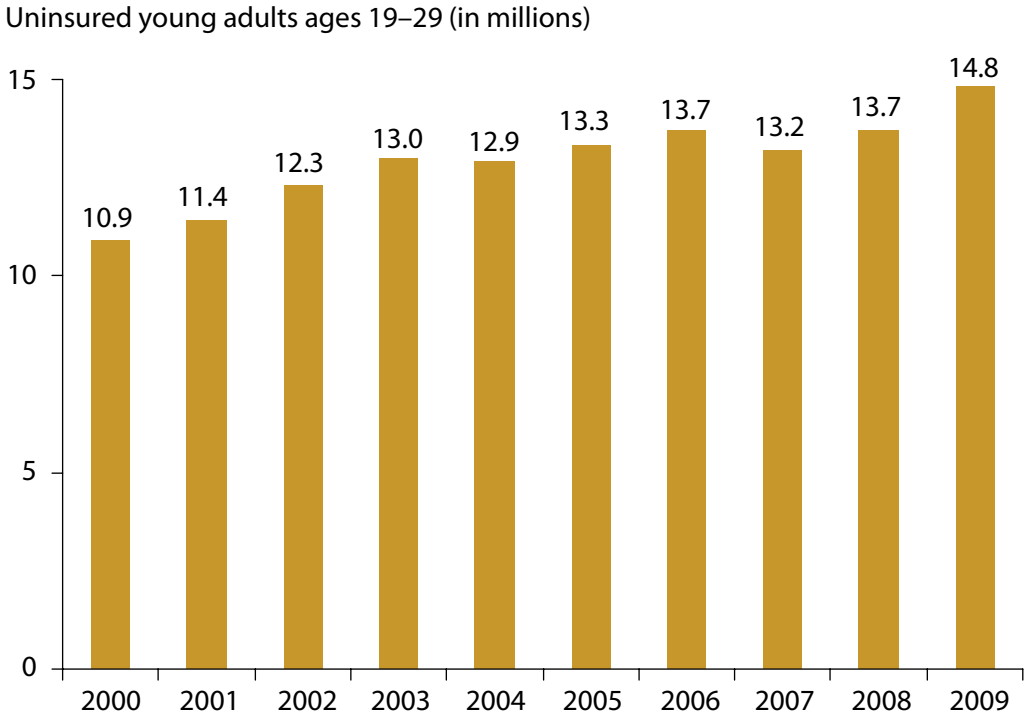
September 2011, when all health plans and employers with dependent coverage will include young adults, the number of them who will be newly covered is certain to climb.

Still, most young adults who are uninsured now will gain coverage only when the central provisions of the law go into effect in 2014. Nearly half of uninsured young adults, or 7.2 million who are legal residents, are in families with incomes under 133 percent of the federal poverty level, or FPL ($14,404 for a single person), and most of them will become eligible for newly expanded coverage under the Medicaid program (Exhibit 2).[4] An additional 4.9 million have incomes from 133 percent to 399 percent of the FPL ($14,404 and $43,320 for a single person) and will qualify for subsidized private coverage under the law.

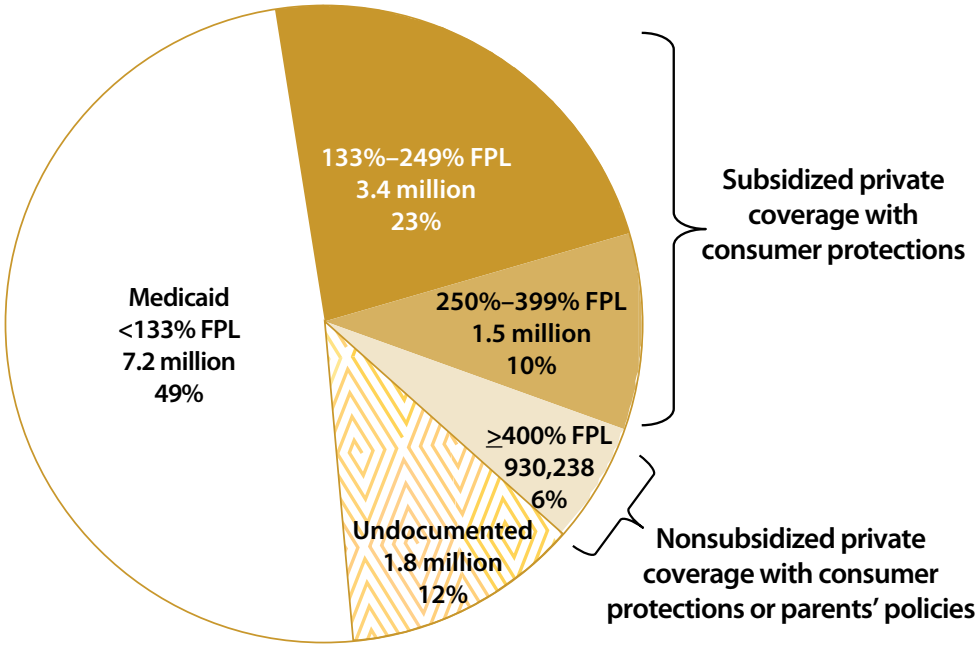
New findings from the Commonwealth Fund Biennial Health Insurance Survey of 2010 underscore why health reform has become so important for those in this age group. As the numbers of young adults without health insurance climbed over the last decade, they became more exposed to the rapidly rising costs of health care, complicating their ability to get medical attention. Forty-five percent of young adults reported that cost considerations caused them to forgo needed treatment in 2010, up from 32 percent in 2001 (Exhibit 3). Young adults reported problems at higher rates than adults ages 50 to 64 (36%) in 2010 (Table 3). Forgoing care included, because of cost, not filling prescriptions, not going to the doctor when sick or seeing a specialist when necessary, and not getting follow-up treatment recommended by a doctor. Young adults in low- and moderate-income families experienced the greatest deterioration in their ability to gain timely health care over the past decade. More than half (53%) of young adults with incomes of less than 100 percent of the FPL ($10,830 for a single person) delayed needed health care because of the cost, up from one-third (32%) in 2001. In the next-higher income group, 100 percent to 199 percent of the FPL (up to $21,660 for a single person), the share of young adults reporting cost-related problems also rose to more than half (52%).

Exhibit 1. There Were 14.8 Million Uninsured Young Adults in 2009, Up by 4 Million in the Past Decade



Source: Analysis of the 2001–2010 Current Population Surveys by N. Tilipman, B. Sampat, S. Glied, and B. Mahato of Columbia University for The Commonwealth Fund.

Exhibit 2. Distribution of 14.8 Million Uninsured Young Adults in 2009, by Income Level

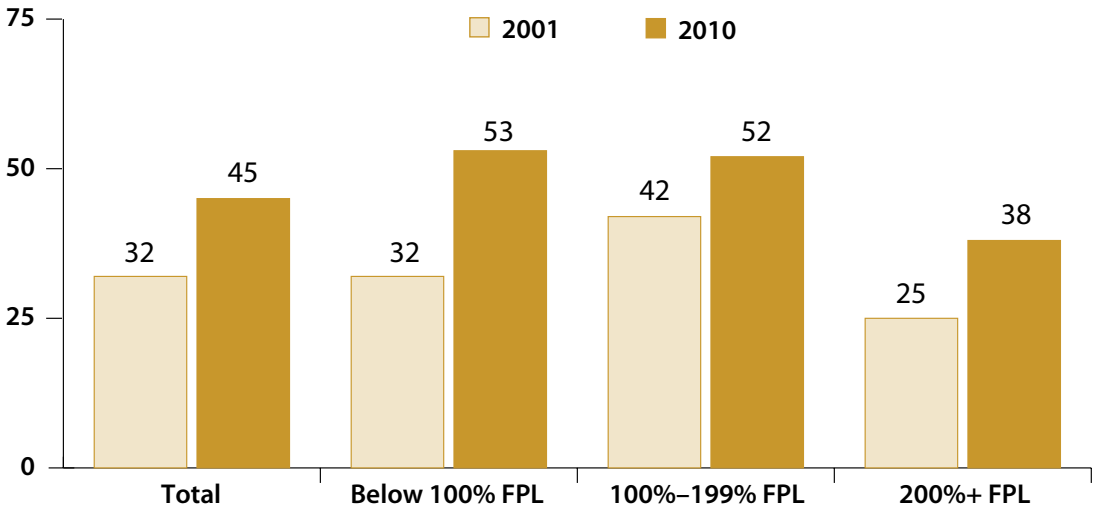


14.8 million uninsured young adults ages 19–29

Note: FPL refers to Federal Poverty Level.
Source: Analysis of the March 2010 Current Population Survey by N. Tilipman and B. Sampat of Columbia University for The Commonwealth Fund; estimates of undocumented uninsured young adults by Jonathan Gruber and Ian Perry of MIT using the Gruber Microsimulation Model for The Commonwealth Fund.

Exhibit 3. Half of Young Adults with Low and Moderate Incomes Went Without Needed Care Because of Its Cost in 2010

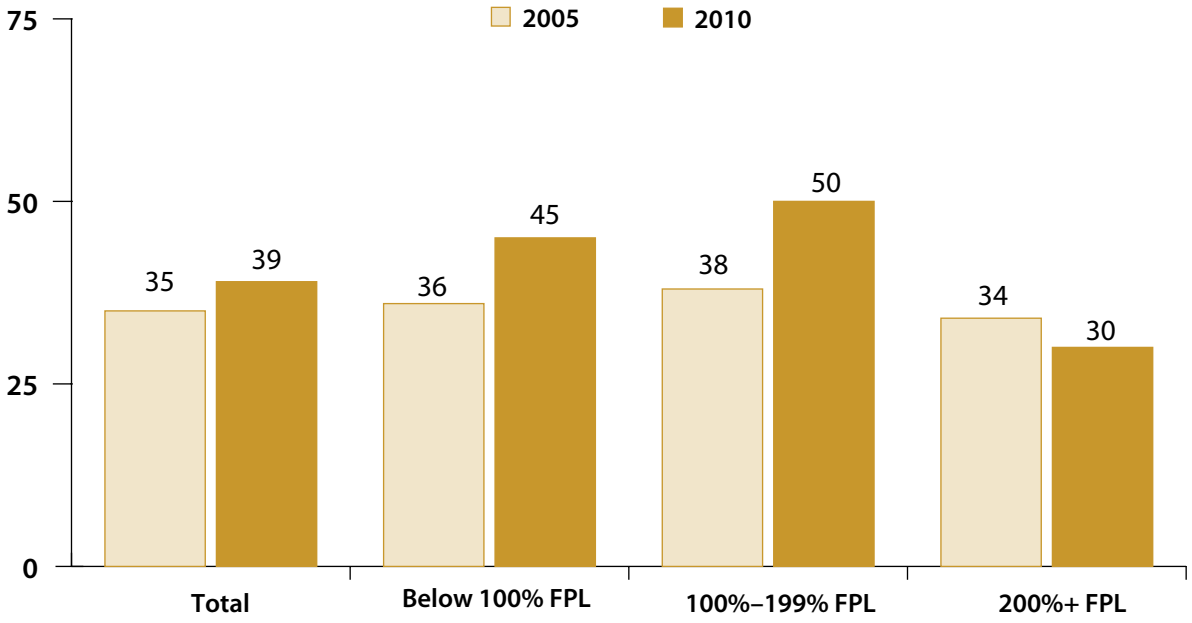
Percent of young adults ages 19–29 who had any of four access problems* in past year because of cost, by income level



Note: FPL refers to Federal Poverty Level.
* Did not fill a prescription; did not see a specialist when needed; skipped recommended medical test, treatment, or follow-up; had a medical problem but did not visit doctor or clinic.
Source: The Commonwealth Fund Biennial Health Insurance Surveys (2001 and 2010).

Exhibit 4. Medical Debt and Bill Problems Worsened for Young Adults with Low and Moderate Incomes

Percent of young adults ages 19–29 with medical bill problems or accrued medical debt,* by income level



Note: FPL refers to Federal Poverty Level.
* Had problems paying medical bills, contacted by a collection agency for unpaid bills, had to change way of life in order to pay medical bills, or has outstanding medical debt.
Source: The Commonwealth Fund Biennial Health Insurance Surveys (2005 and 2010).

And even young adults with somewhat higher incomes (200% of the FPL or higher) reported cost-related delays in obtaining needed care; those numbers rose from 25 percent in 2001 to 38 percent in 2010.

The survey also found that young adults have been struggling to pay their medical bills. Nearly 40 percent reported that they had not been able to pay their bills, had been contacted by a collection agency about unpaid bills, had to change their way of life to pay their bills, or were paying off medical debt over time (Exhibit 4). Young adults with low and moderate incomes reported problems at the highest rates: 45 percent of those with incomes of less than 100 percent of the FPL and half of those with incomes from 100 percent to 199 percent of the FPL reported problems paying medical bills, up from just over one-third (36% and 38%) in 2005.[5] Of those young adults struggling with medical bills, one-third had depleted their savings to pay their bills and nearly one of five (18%) took on credit card debt (Table 4).

Young adults who lacked health insurance had the greatest difficulty obtaining needed care and paying medical bills. Nearly six of 10 (58%) uninsured young adults reported delaying care because of cost compared with one-third (34%) of those who had health insurance all year (Table 3). Half of uninsured adults reported difficulties paying their medical bills, twice the rate of insured young adults (Table 4).

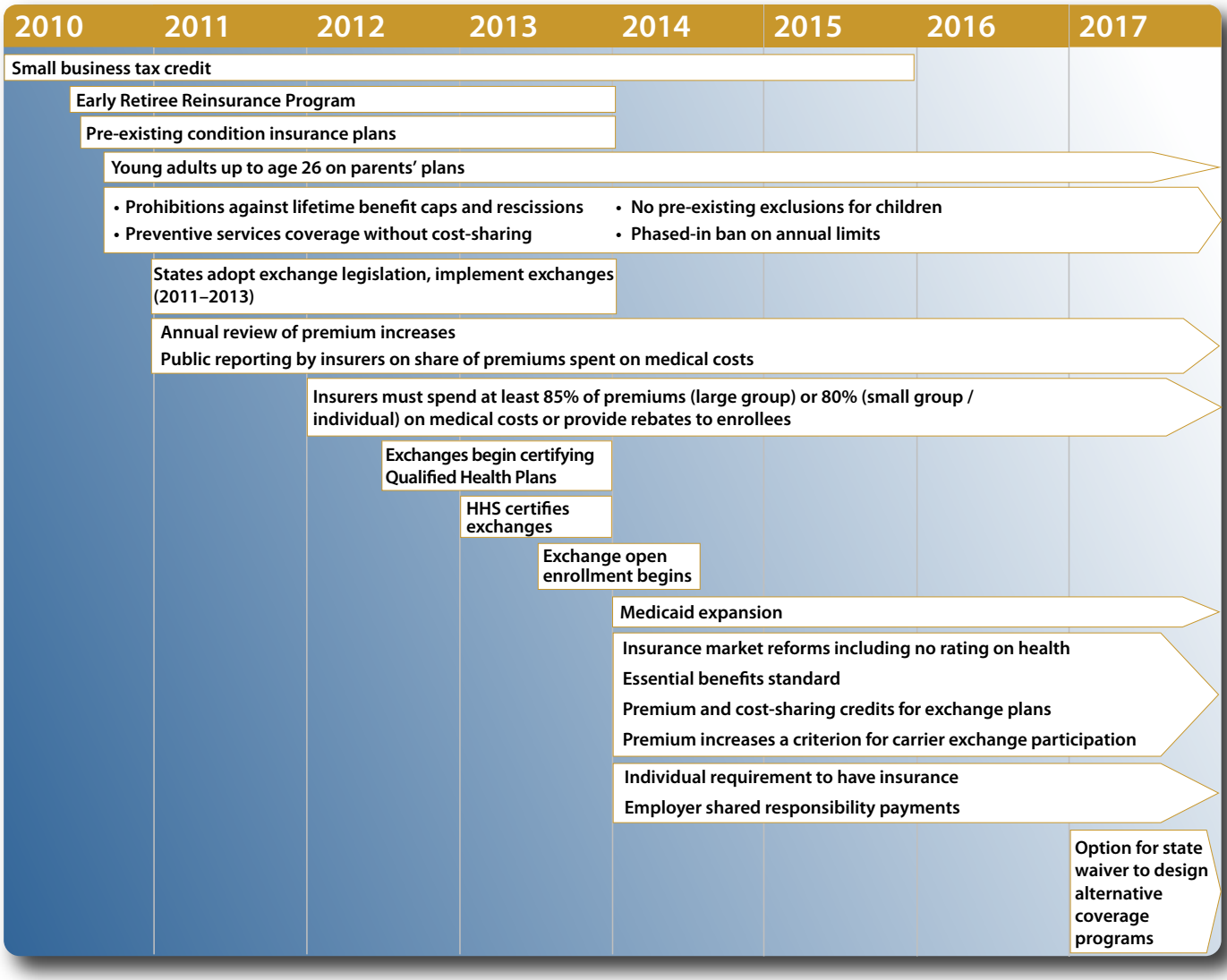
And women in this age group, with their greater reproductive and preventive health care needs, reported problems at higher rates than men.[6] Half (51%) of women ages 19 to 29 reported delays in obtaining needed care because of cost, compared with 39 percent of men (Table 3). And 44 percent of women had problems paying medical bills, compared with 34 percent of men (Table 4).

HOW THE AFFORDABLE CARE ACT WILL INSURE NEARLY ALL YOUNG ADULTS AND PROTECT THEIR HEALTH AND FINANCIAL SECURITY

The Affordable Care Act will provide near universal coverage to young adults, allowing them to pursue educational and career goals without incurring the risk of catastrophic health care costs (Exhibit 5).[7] There are several ways in which the law will help:

- It lets young adults remain on or join their parents' health plans up to age 26 (this provision went into effect in 2010);
- It requires college health plans to meet new standards, starting in 2012;
- It significantly expands Medicaid eligibility to cover all adults with incomes below 133 percent of the federal poverty level, beginning in 2014; and
- It creates new state health insurance exchanges with subsidized private insurance for people with low and moderate incomes up to 399 percent of the FPL, beginning in 2014.

Exhibit 5. Timeline for Health Reform Implementation: Coverage Provisions



Source: National Association of Insurance Commissioners; Commonwealth Fund Health Reform Resource Center: What's in the Affordable Care Act? (PL 111–148 and 111–152), http://www.commonwealthfund.org/Health-Reform/Health-Reform-Resource.aspx.

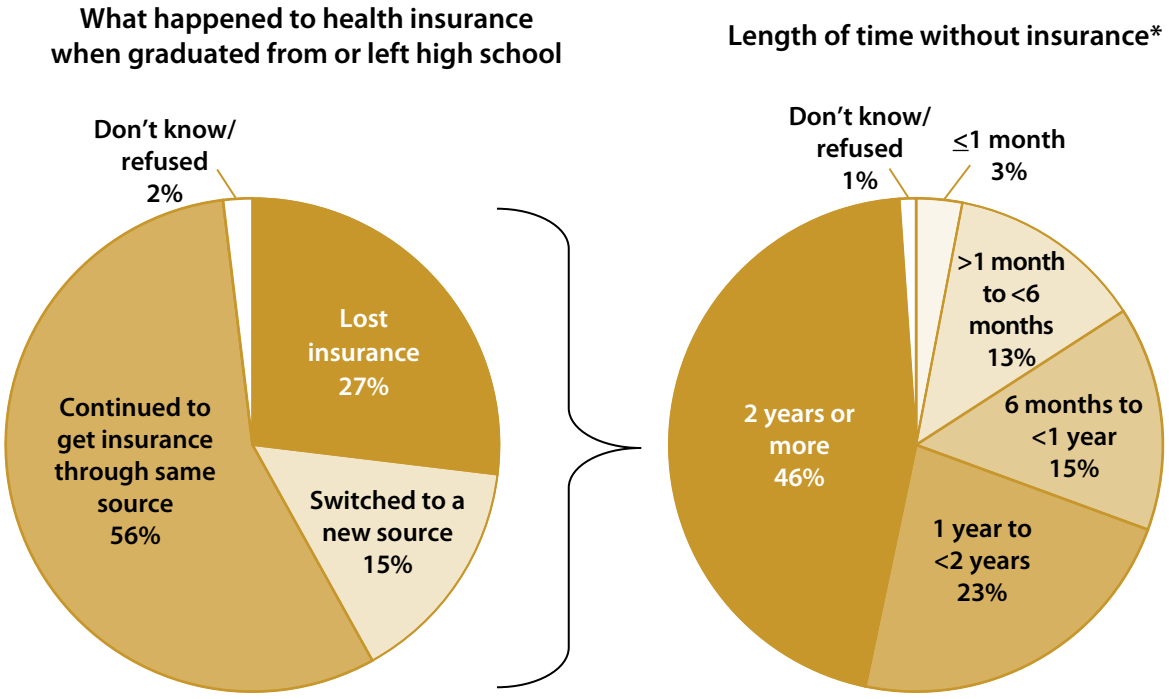
Of the 14.8 million young adults who were uninsured in 2009, up to 12.1 million could gain subsidized coverage once all the law's provisions go into effect in 2014: 7.2 million in families earning less than 133 percent of the FPL ($14,404 for a single person) would gain coverage under Medicaid and 4.9 million earning from 133 percent to 399 percent of the FPL ($43,320 for a single person) would gain subsidized private coverage through the insurance exchanges (Exhibit 2). In addition, about 1 million uninsured young adults with incomes of 400 percent of the FPL or higher are expected to either join their parents' health plans or purchase policies through the exchanges, gaining greater protections than is the case today. About 1.8 million uninsured young adults are undocumented immigrants and would not be eligible for Medicaid or coverage through the insurance exchanges.[8] The provisions of the law that will benefit young adults are analyzed in order of implementation.

Young Adults Can Remain on Parents' Insurance Until Age 26: 2010

Graduation from both high school and college historically has been associated with a loss of health insurance, often for extended periods of time. In the past, high school graduates who were covered as children on their parents' employers' plans who did not go on to college generally became uninsured. The Commonwealth Fund Survey of Young Adults found that in 2009, of young adults who were covered as dependents on their parents' employers' plans during high school, 42 percent either lost or switched coverage on leaving or graduating from school (Exhibit 6).[9] Of those with a gap in coverage, 46 percent were uninsured for two years or more.

Similarly, college graduates generally have lost eligibility for dependent coverage shortly after graduation. As new entrants to the labor market, graduates are often eligible for the types of jobs that tend not

Exhibit 6. Four of 10 Young Adults Ages 19–29 Who Had Insurance Through Their Parent's Employer While in High School Lost or Had to Switch Insurance After High School; Almost Half Went Without Insurance for Two Years or More



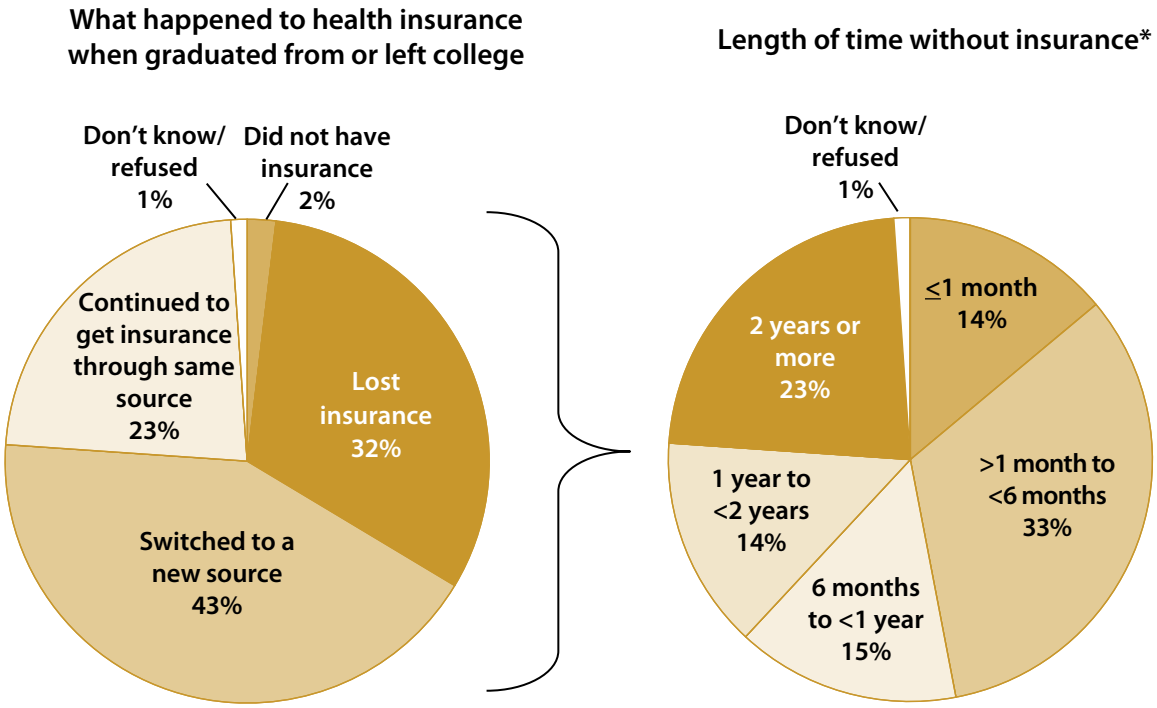
* Among those who had a gap between losing and gaining new insurance, or who went without insurance after graduating from or leaving high school, or who did not have insurance when they graduated from or left high school.
Note: Numbers may not sum to 100% because of rounding.
Source: The Commonwealth Fund Survey of Young Adults (2009).

to come with health benefits: temporary, part-time, low-wage, or in small businesses. And many young adults are unemployed: the unemployment rate among 20-to-24-year-olds is currently 14.9 percent, the highest of any group above 20 years of age, and well above the national average of 9 percent.[10] The survey found that among young adults who were covered under their parents' employers' plans during college in 2009, 75 percent either lost or switched coverage after college (Exhibit 7). Of those with a gap in coverage, 37 percent went without coverage for more than one year.

The Affordable Care Act is now addressing these graduation-related insurance gaps by requiring all insurance plans that offer dependent coverage to offer the same level of coverage at the same price to their enrollees' adult children up to their 26th birthdays.[11] The law applies to all adult children, regardless of living situation, degree of financial independence, or marital or student status. Health plans cannot charge adult children a higher premium or offer fewer benefits than they do for young children. In addition, the employer premium contribution is tax exempt, no matter the child's age or dependent status.

The law applies to all forms of health insurance, including coverage offered by employers, whether they are self-insured (employers pay benefits directly to employees) or fully insured (employers purchase health insurance for employees from an insurance company). It also includes insurance plans that parents purchase on the individual insurance market. It applies to new health plans and "grandfathered" health plans—those in existence when the law was signed in March 2010.[12] There is one restriction: prior to 2014, young adults may be covered by their parents' grandfathered employer group health plans only if they are not eligible to enroll in any other employer-sponsored plan, whether their own employer's plan or their spouse's plan.

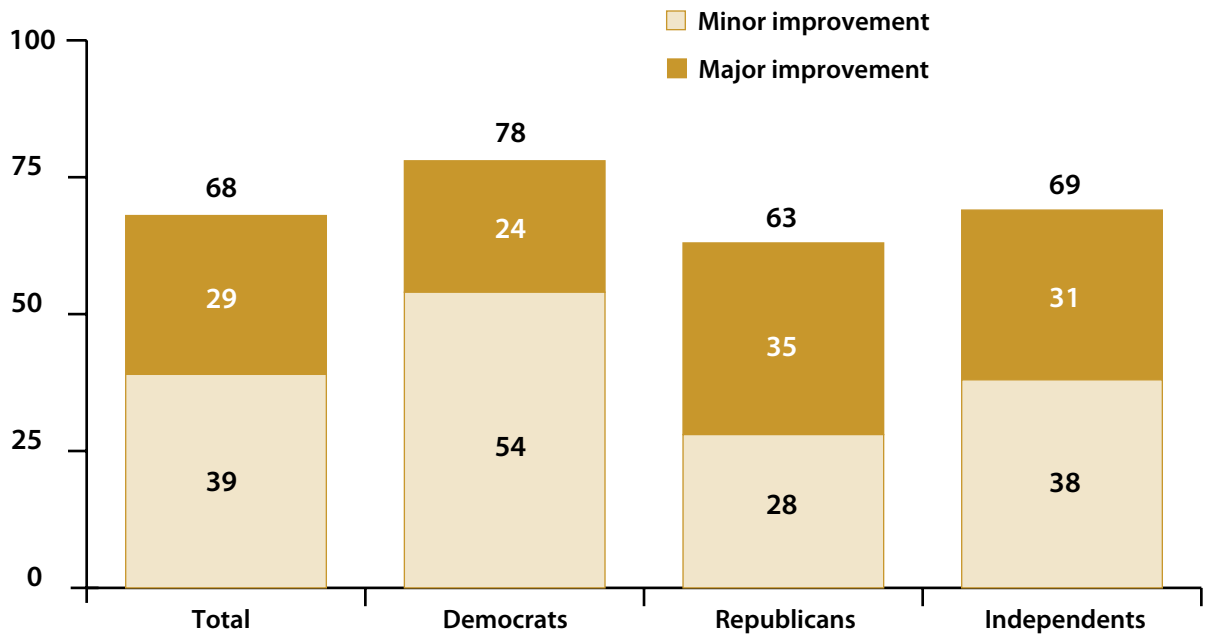
Exhibit 7. Three-Quarters of Young Adults Ages 19–29 Who Had Insurance Through Their Parent's Employer While in College Lost or Had to Switch Insurance After College



* Among those who had a gap between losing and gaining new insurance, or who went without insurance after graduating from or leaving college, or who did not have insurance when they graduated from or left college.
Note: Numbers may not sum to 100% because of rounding.
Source: The Commonwealth Fund Survey of Young Adults (2009).

Exhibit 8. Under the health reform law, many provisions will make it easier for young adults to remain covered after they graduate. Do you think this is a major improvement in the health care system, a minor improvement, not an improvement, do you think it makes things worse, or do you not know enough to say?

Young adults ages 19–29, by political affiliation



Note: FPL refers to Federal Poverty Level.
Source: The Commonwealth Fund Biennial Health Insurance Survey (2010).

State Laws

When the Affordable Care Act was signed into law, 37 states already had laws on their books that increased the age of dependency for insurance purposes (Table 5). The laws vary considerably by age, ranging from age 23 in Oregon and Wyoming to age 31 in New Jersey. The laws also vary by how they define dependent young adults. Some laws are restricted to full-time students, financially dependent young adults, young adults residing in the same state as their parents, or unmarried young adults. But most important, none of the state laws apply to self-insured plans, which enroll 55 percent of the U.S. population covered by employer insurance.[13] Thus, substantially more young adults and their families can potentially benefit under the new federal law than under the state laws. In addition, the federal law will create a minimum-age standard—young adults up to age 26 will be eligible for coverage on their parents' plans. But in states that have higher age limits, like New Jersey and New York, young adults age 26 and older will still be able to qualify for dependent coverage under the provisions and definitions in their state laws.

Enrollment

The Departments of Health and Human Services, Labor, and Treasury estimate that approximately 1.7 million young adults will become covered under parents' policies by 2013.[14] Of those, nearly 1 million are estimated to be previously uninsured.[15] Based on this enrollment estimate, the agencies project that the average annual premium cost would be about $3,380 in 2011, $3,500 in 2012, and $3,690 in 2013. If this cost is spread across all employer family policies, family premiums—shared by employers and employees—would increase by 0.7 percent in 2011, 1 percent in 2012, and 1 percent in 2013.

In May, five large insurance companies reported substantial increases in enrollment of young adults, mostly for self-insured employer plans. Wellpoint, which has 34 million subscribers, reported an increase of 280,000 young adults in the first three months of the year, accounting for about one-third of its total enrollment growth.[16] Aetna, Kaiser Permanente, Highmark, and Health Care Service together added about 344,000 new enrollees in this age group.

The greater than expected enrollment growth may help explain the public's broad familiarity with and approval of the new benefit. The Commonwealth Fund Biennial Health Insurance Survey asked young adults about their view of this new provision. More than two-thirds (68%) of adults ages 19 to 29 thought that being able to maintain their health insurance upon graduation from high school or college was a major or minor improvement in the health system (Exhibit 8). This view was held by large majorities of young adults regardless of party affiliation: 78 percent of Democrats, 69 percent of Independents, and 63 percent of Republicans thought the provision was a major or minor improvement in the health system.

New Rules for College Health Plans: 2012

College and university health insurance plans have long provided some measure of protection for students who do not have access to other forms of coverage. The 2009 Commonwealth Fund Survey of Young Adults found that in that year 11 percent of 19-to-29-year-olds, or an estimated 1.6 million young adults, were enrolled in a health plan offered through their college or university. An additional 18 percent of that age group who were no longer in college, or about 2.2 million young people, said that they had been enrolled in such a plan while in school. But many plans offered by universities and colleges offer only limited benefits and have low annual or lifetime limits on benefit payments. A study by the Government Accountability Office of a sample of student health plans found that 96 percent had a maximum benefit amount.[17] Among plans with a maximum benefit amount on a per-condition, per-lifetime basis, more than one-quarter (27%) had a maximum benefit of less than $20,000. Another 25 percent had a maximum benefit of $20,000 to $29,000.

> Of all the provisions in the Affordable Care Act, the Medicaid expansion will potentially have the largest impact on reducing the number of uninsured young adults.

Such limited plans put college students and their families at risk of catastrophic medical bills if they experience a serious illness or injury. The Commonwealth Fund Survey of Young Adults found that 15 percent of young adults ages 19 to 29 who had been enrolled in a student plan said that they had had expensive medical bills not covered by their plan. Nearly one-quarter (23%) said that their doctor had charged them a lot more than their plan would pay and they had to pay the difference.

The Affordable Care Act includes several new consumer protections—many of which have already gone into effect—that will greatly improve the quality of health insurance policies offered in the individual and employer group markets. Such protections include bans on lifetime benefit limits and rescissions of insurance policies when someone becomes ill; phasing out, and eventually banning, annual limits; and restricting the share of premiums that can go to administrative costs or profit. But the law states that some provisions should not apply to student plans if they prohibit colleges and universities from being able to offer the plans at all.

In February, the Department of Health and Human Services (HHS) proposed regulations that clarify how the Affordable Care Act applies to student health plans offered at colleges and universities for policy years beginning on or after January 1, 2012.[18] The department explicitly defines student plans as individual health insurance coverage, excepting plans that are self-insured by colleges and universities. This means

that student health plans under the Affordable Care Act would follow the same requirements that apply to other individual market policies, such as the bans on lifetime benefit limits.

In addition, HHS requires student health plans to:

- Offer coverage to all students and dependents, regardless of their health status, medical conditions (both physical and mental illnesses), claims experience, receipt of health care, medical history, genetic information, evidence of insurability, and disability.
- Provide coverage only to students who are enrolled at an institution of higher education and their dependents. Coverage that is extended to students on break between academic terms or on temporary leaves of absence, or recent graduates, would also be considered a student health plan.
- Provide insurance through a written agreement between an institution of higher education and a health insurance issuer.

The regulations also make it less likely that colleges will be able to sell short-term health insurance policies that would not be subject to the new regulations. Insurance policies that are provided for less than 12 months fall under the definition of short-term, limited-duration insurance. These plans are not considered individual market insurance by law, and the Affordable Care Act and other laws do not protect people covered by them. However, HHS notes in its rule that some of these policies sold to college students expire just a day, or even hours, short of the 12-month limit, even though students often renew at 12 months, or universities automatically reenroll them. The proposed regulations state that if limited-duration policies offered to students are renewable each year at the option of the student, the coverage would not meet the definition of limited-duration insurance and would thus be defined as individual market coverage, subject to the protections of the Affordable Care Act.

The Affordable Care Act will provide near-universal coverage to young adults, allowing them to pursue educational and career goals without incurring the risk of catastrophic health care costs.

The proposed regulations provide some flexibility to health plans so that they continue to offer coverage to students. Under the law, all health plans must phase out annual limits on what they will pay in a year. Until September 2011, annual limits may be no less than $750,000; no less than $1.25 million until September 2012; and no less than $2 million until January 2014, after which they are banned completely. There is a transition period for student health plans that allows them to have annual limits of no less than $100,000 for policy years beginning on or after January 2012 until September 23, 2012. They must meet the general requirements for the phase out after that.

Under the Affordable Care Act, plans sold in the individual insurance market must spend at least 80 percent of their premium dollars on medical care and quality improvement as opposed to administration and profits. A recent study by the state of Massachusetts of 13 insurance carriers selling college plans in the state found that the plans spent from 46 percent to 89 percent of their premiums on medical care, with the average around 69 percent.[19] The proposed regulations do not exempt student health plans from this requirement, but call for comments on whether the requirement would make it difficult for health plans to continue offering coverage. It will be important, however, that the premiums students pay for their health insurance provide sufficient value in health benefits to justify their costs.

Universal Coverage: 2014

New Coverage Under Medicaid

Currently, Medicaid and the Children's Health Insurance Program (CHIP) reclassify all teenagers as adults when they turn 19. As a result, a young adult who had been insured under Medicaid or CHIP generally does not have the option to stay covered unless he or she is able to qualify for Medicaid as an adult. In most states, Medicaid eligibility is restricted to very-low-income parents of dependent children, pregnant women, and elderly or disabled adults; therefore, most low-income young adults become ineligible. Even teenagers with disabilities who qualified for Medicaid before their 19th birthdays must go through a new set of screening tests to determine whether they are still eligible for benefits as disabled adults.[20] For this reason, many more poor young adults are uninsured than are children in low-income families (Exhibit 9).

Beginning in 2014, the Affordable Care Act increases eligibility for Medicaid to all legal residents with incomes under 133 percent of the federal poverty level—$14,404 for a single adult or $29,327 for a family of four. This is a substantial change in Medicaid's adult coverage, and a change that will particularly benefit young adults. Although several states have expanded eligibility for parents of dependent children, in most states, income eligibility thresholds are well below the federal poverty level.[21] In addition, adults without disabilities who do not have children are not currently eligible for Medicaid, regardless of income, in most states.

What it means for young adults. Of all the provisions in the Affordable Care Act, the Medicaid expansion will potentially have the largest impact on reducing the number of uninsured young adults. More than half (51%) of young adults in families with incomes under 133 percent of the FPL are uninsured (Exhibit 10). And, of the total number of uninsured young adults nationwide, half (49%) are legal residents in families with incomes under 133 percent of the FPL (Exhibit 2). The eligibility expansion has the potential to provide health insurance to as many as 7.2 million uninsured young adults in that income range.[22] Approximately 1 million uninsured young adults with incomes under 133 percent of the FPL are undocumented immigrants and would not be eligible for Medicaid.[23]

In addition, because there will be little or no premium contribution or cost-sharing under Medicaid, the expansion in eligibility will substantially reduce the costs of health insurance and health care for young adults in this income range, improve their ability to access health care, and reduce their incidence of burdensome medical bill and debt problems. In the 2010 Commonwealth Fund Biennial Health Insurance Survey, 44 percent of young adults with incomes below 133 percent of the FPL spent 10 percent or more of their income on premiums and out-of-pocket costs (Exhibit 10). More than half (52%) said they had delayed or avoided needed care because of costs, and 45 percent reported a problem paying medical bills or that they were paying off medical debt over time.

Exhibit 9. Percentage of Uninsured Young Adults Ages 19–29 Is Triple the Rate of Children Age 18 and Under

Income level	Percent uninsured, children age 18 and under	Percent uninsured, young adults ages 19–29
Total	10%	32%
<100% FPL	17	52
100%–199% FPL	14	42
≥200% FPL	7	17

Note: FPL refers to Federal Poverty Level.
Source: Analysis of the March 2010 Current Population Survey by N. Tilipman and B. Sampat of Columbia University for The Commonwealth Fund.

Exhibit 10. Under the Affordable Care Act, Young Adults Will Benefit from Newly Subsidized Sources of Health Insurance

Percent of young adults ages 19–29

	Total	<133% FPL <$14,404	133%–249% FPL $14,404–<$27,075	250%–399% FPL $27,075–<$43,320	≥400% FPL ≥$43,320
Uninsured in 2009^	32%	51%	36%	19%	9%
In the past 12 months (2010):^^				250%+ FPL ≥$27,075	
Any bill problem or medical debt*	39%	45%	53%	25%	
Any cost-related access problem**	45%	52%	50%	36%	
Spent 10% or more of household income on premiums and total out-of-pocket costs***	31%	44%	28%	14%	

Note: FPL refers to Federal Poverty Level.
^ Analysis of the March 2010 Current Population Survey by N. Tilipman and B. Sampat of Columbia University for The Commonwealth Fund.
^^ The Commonwealth Fund Biennial Health Insurance Survey (2010).
*Includes: Had problems paying or unable to pay medical bills, contacted by collection agency for unpaid medical bills, had to change way of life to pay bills, medical bills being paid off over time. **Includes any of the following because of cost: had a medical problem, did not visit doctor or clinic; did not fill a prescription; skipped recommended test, treatment, or follow-up; did not get needed specialist care. ***Base: Respondents who specified income level and premium/out-of-pocket costs for combined individual/family medical expenses.

New Subsidized Private Health Plans with Consumer Protections

The law requires that by 2014 each state establish new health insurance exchanges for both individuals and small businesses.[24] States can set up their own exchanges, or if they decline to, or have not made sufficient progress by 2013, the federal government will work with the state to establish an exchange in the state. The exchanges will create a regulated marketplace in which people without access to affordable and comprehensive employer coverage can purchase insurance. A person whose employer-supplied coverage costs more than 9.5 percent of his or her income or those with plans that cover less than 60 percent, on average, of their medical costs also will be eligible to purchase coverage through the exchanges. The individual and small-group markets will continue to function outside of the exchanges, but new insurance market regulations will apply to plans sold inside and outside the exchanges. The new regulations prohibit rating on the basis of health and gender, ban preexisting condition exclusions, limit the amount plans can vary premiums based on age, and prevent plans dropping coverage if an enrollee becomes ill. Unlike today's individual insurance market, where young women can be charged up to 84 percent more than men for the same insurance policy, female young adults will face the same premiums as men in their age group.[25]

All health plans sold in the exchange and in the individual and small-group markets will be required to provide benefits similar in scope to a typical employer plan. Maternity care, rarely covered in plans sold in the individual insurance market, will be included. Plans offered to individuals and small businesses will have the same essential benefit package but are allowed four different levels of cost-sharing: plans that cover an average 60 percent of an individual's total medical costs per year (bronze plan), 70 percent of medical costs (silver plan), 80 percent of medical costs (gold plan), and 90 percent of medical costs (platinum plan). Out-of-pocket costs are limited to $5,950 for single policies and $11,900 for family policies and are lower for people with lower incomes.

For the first time, young adults who must buy coverage on their own will be eligible for a federal tax credit to help them pay for plans sold through the

exchanges. Premium credits will be tied to the silver plan and will cap contributions for individuals and families at 2 percent of income for those with incomes under 133 percent of the federal poverty level ($14,404 for a single adult or $29,327 for a family of four), gradually increasing the cap to 9.5 percent of income for those with incomes from 300 percent to 399 percent of the FPL ($43,320 for a single person and $88,200 for a family of four).

Young adults with low and moderate incomes will also benefit from cost-sharing credits that reduce out-of-pocket spending under the silver plan to an average 6 percent of total costs for those with incomes up to 149 percent of the FPL ($16,245 for a single person and $33,075 for a family of four). Out-of-pocket costs will be reduced on average to a maximum of 13 percent of total costs for those with incomes up to 199 percent of the FPL ($21,660 for a single person and $44,100 for a family of four) and 27 percent for those with incomes up to 249 percent of the FPL ($27,075 for a single person and $55,125 for a family of four). In addition, out-of-pocket expenses will be capped for families earning from 100 percent to 399 percent of the FPL, at $1,983 for individuals and $3,967 for families (at the low end), and $3,967 for individuals and $7,933 for families (at the high end).

Under the law, adults under age 30 who are not eligible for subsidized coverage will have the option to purchase a catastrophic health plan. The plan must offer the essential benefits package and cover three primary care visits per year, but could have cost-sharing similar to high-deductible plans that are paired with health savings accounts. This would likely result in a lower premium for enrollees but higher cost-sharing than other plans sold through the exchanges. Preventive services will be excluded from the deductible and cost-sharing would be limited to the current health savings account out-of-pocket limits ($5,950 for single policies and $11,200 for families). People over age 30 who could not find a plan with a premium that is 8 percent or less of their income would be able to purchase the young adult plan, as well.

What it means for young adults. Subsidized private insurance could cover up to 4.9 million uninsured young adults with incomes from 133 percent to 399 percent of the FPL (Exhibit 2).[26] An estimated 800,000 uninsured young adults in that income range are undocumented immigrants and would not be eligible for the federal subsidies under the Affordable Care Act.[27] Just under 1 million uninsured young adults with incomes over 400 percent of the FPL would not be eligible for a premium subsidy through the exchanges, but many would likely be eligible to join their parents' employer-sponsored health plans. Or they could purchase private plans through the exchange, gaining greater protection than is the case today.

Under the new law, young adults earning from 133 percent to 249 percent of the FPL ($14,404 to $27,075 for a single person) will register large gains in insurance coverage and gain substantial new protections against the cost of premiums and out-of-pocket costs. More than one-third (36%) of young adults in this income range are uninsured (Exhibit 10). Up to 3.4 million young adults who are legal residents would gain coverage through the insurance exchanges (Exhibit 2), and receive tax credits that will cap premium costs at 3 to 8 percent of income. Young adults who are enrolled in employer-based health plans who spend more than 9.5 percent of their income on premiums will also be eligible to purchase health insurance in the exchanges and receive the tax credit. In addition, young adults in this income range will receive cost-sharing tax credits, and there are limits on out-of-pocket spending. These assurances and the coverage in the essential benefit package should reduce cost-related difficulties obtaining care (these affect 50% of young adults in this income range) and medical bill problems (53%).

Young adults earning from 250 to 399 percent of the FPL ($27,075 and $43,320 for a single person) will also make gains in coverage and cost protection. One in five (19%) young adults in this income range is uninsured (Exhibit 10). For as many as 1.5 million young adults who are legal residents and eligible for coverage through the exchanges, tax credits will cap their premium costs at 8 percent to 9.5 percent of their

The Congressional Budget Office estimates that the influx of young and healthy people into the exchanges and individual markets will lower premiums by 7 percent to 10 percent.

incomes; young adults in employer plans spending 9.5 percent or more of their incomes on premiums are also eligible for the tax credits for coverage through the exchange (Exhibit 2). There are limits on out-of-pocket spending for young adults in this income range, though no subsidies for cost-sharing. Such limits combined with the new consumer protections and the essential benefit package should help reduce the high rates of cost-related problems gaining needed care that young adults with incomes of 250 percent of the FPL or higher (36%) and lessen their medical bill burdens: one-quarter reported problems paying medical bills (Exhibit 10).

Requiring Health Insurance Will Help Bring Young Adults into Insurance Markets

Beginning in 2014, all U.S. citizens and legal residents will be required to maintain minimum essential health insurance coverage through the individual insurance market, insurance exchanges, public programs, or employers—or face a penalty. There are some exemptions: individuals who cannot find a health plan that costs less than 8 percent of their income, net of subsidies and employer contributions; people who have incomes below the tax-filing threshold ($9,350 for an individual and $18,700 for a family); people who have been without insurance for less than three months; and certain other circumstances.

People who are not exempt from the mandate and cannot demonstrate on a tax form that they have health insurance will be required to pay a penalty equal to the greater of $95 or 1 percent of applicable income (i.e., income in excess of the tax-filing threshold) in 2014, $325 or 2 percent of applicable income in 2015, and $695 or 2.5 percent of applicable income in 2016, up to a maximum of $2,085 per family.[28] The tax, which will be assessed through the tax code and applied as an additional amount of federal tax owed, will be prorated for partial years of noncompliance.

The compliance of young adults will be particularly important in terms of creating broad and diverse risk pools in the exchanges and individual markets. Indeed, the Congressional Budget Office estimates that the influx of young and healthy people into the exchanges and individual markets will lower premiums by 7 percent to 10 percent.[29] The experience of Massachusetts suggests that young adults will likely comply with the requirement. The state implemented a universal coverage law in 2007 that is similar to the Affordable Care Act, including an insurance exchange with subsidized coverage, an individual requirement to have health insurance, and provisions targeted to young adults (e.g., the ability to stay on parents' plans to age 26). Sharon Long and colleagues found that the uninsured rate among young adults ages 19 to 26 dropped by more than half post-reform, falling from 21.1 percent in 2005–2006 to 8.2 percent in 2007–2008.[30] In comparison, uninsured rates among young adults in New York, which did not have a similar program over that period, remained steady at 27 percent.

Other research has found that Massachusetts's health insurance requirement increased the number of people who were covered by employer-based health insurance, as employers met a new demand from their employees for health insurance so that they might comply with the individual mandate.[31] An analysis by Christine Eibner and colleagues at RAND predicts a similar effect for the Affordable Care Act, with the individual mandate far more important in expanding employer-based coverage than the shared responsibility payments required of large employers.[32] Young adults in employer-based plans tend to take up benefits at rates similar to those of older workers: in 2010, 75 percent of working young adults ages 19 to 29 took up coverage when it was offered by an employer, compared with 78 percent of 30-to-49-year-old workers and 83 percent of those ages 50 to 64 (Table 2).

CONCLUSION

In a rite of passage unique to the American experience, high school and college graduates in the United States have historically not only greeted the new freedoms and responsibilities of adulthood on graduation day, but a strong chance of going months or years without health insurance. If these young adults were covered by their parents' employers' health plans, that frequently ended with graduation. High school graduates with coverage through Medicaid or the Children's Health Insurance Program were nearly certain to lose it on their 19th birthdays. High rates of unemployment, job turnover, and part-time and temporary employment along with periods of time in graduate school kept employer-based health benefits beyond the reach of millions of young adults every year.

The Affordable Care Act is reversing this situation. Members of the 2011 graduating class will be able to remain covered on their parents' health plans as they look for jobs or prepare for graduate school. From 1 million to 2 million young adults are expected to benefit, and early reports by national insurers of new subscribers under age 26 suggest that enrollment may ultimately exceed initial estimates.

But the most significant change for young adults and their families is yet to come. Universal coverage under the Affordable Care Act will begin in 2014, and nearly all the 15 million currently uninsured young adults will gain affordable and comprehensive health insurance. Millions more who are spending substantial portions of their income on health plans that often provide little protection will also gain significantly, thanks to subsidies that improve benefits and offer relief from high out-of-pocket costs. Rather than spending their savings on medical bills—a situation revealed by last year's Commonwealth Fund Biennial Health Insurance Survey—young adults will be able to use their savings for higher education or to start families. To ensure a more stable future for graduates and their families, it is critical that federal and state policymakers continue implementing all provisions of the Affordable Care Act over the next three years.

Notes

1 S. R. Collins and J. L. Nicholson, *Rite of Passage: Young Adults and the Affordable Care Act of 2010* (New York: The Commonwealth Fund, May 2010); J. L. Nicholson and S. R. Collins, *Young, Uninsured, and Seeking Change: Health Coverage of Young Adults and Their Views on Health Reform—Findings from the Commonwealth Fund Survey of Young Adults, 2009* (New York: The Commonwealth Fund, Dec. 2009); *Rite of Passage? Why Young Adults Become Uninsured and How New Policies Can Help*, 2003–2009 updates (New York: The Commonwealth Fund).

2 P. Galewitz, "At Least 600,000 Young Adults Join Parents' Health Plans Under New Law," *Kaiser Health News*, May 1, 2011.

3 E. Mendes, "Fewer 18–26 Year Olds in U.S. Uninsured in 2011," Gallup, May 5, 2011, http://www.gallup.com/poll/147422/Fewer-Year-Olds-Uninsured-2011.aspx#1.

4 Analysis of the 2009 Current Population Survey by Nicholas Tilipman and Bhaven Sampat of Columbia University; estimates from Jonathan Gruber and Ian Perry of MIT using the Gruber Microsimulation Model for The Commonwealth Fund.

5 2005 was the first year that a comparable question was asked on the survey. The increase among young adults with incomes less than 100% of the FPL is not statistically significant.

6 R. Robertson and S. R. Collins, *Women at Risk: Why Increasing Numbers of Women Are Failing to Get the Health Care They Need and How the Affordable Care Act Will Help* (New York: The Commonwealth Fund, May 2011).

7 See The Commonwealth Fund Health Reform Resource Center: What's in the Affordable Care Act? (P.L. 111-148 and 111-152).

8 Estimate from Jonathan Gruber and Ian Perry of MIT using the Gruber Microsimulation Model for The Commonwealth Fund.

9 J. L. Nicholson and S. R. Collins, *Young, Uninsured, and Seeking Change* (New York: The Commonwealth Fund, Dec. 2009).

10 U.S. Department of Labor, Bureau of Labor Statistics, *The Employment Situation—May 2011,* http://www.bls.gov/news.release/pdf/empsit.pdf.

11 Department of the Treasury, Department of Labor, and Department of Health and Human Services, *Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Dependent Coverage of Children to Age 26 Under the Patient Protection and Affordable Care Act,* May 10, 2010, http://cciio.cms.gov/resources/regulations/index.html#cya.

12 See S. R. Collins, "Grandfathered vs. Non-Grandfathered Health Plans Under the Affordable Care Act: Striking the Right Balance," Commonwealth Fund Blog, June 22, 2010; and Department of the Treasury, Department of Labor, Department of Health and Human Services, *Interim Final Rules for Group Health Plans and Health Insurance Coverage Relating to Status As a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act,* June 17, 2010, http://cciio.cms.gov/resources/regulations/index.html#cya.

13 Employee Benefit Research Institute, *Health Plan Differences: Fully Insured vs. Self-Insured*, EBRI Fast Facts #114 (Washington, D.C.: EBRI, Feb. 11, 2009), http://www.ebri.org/pdf/FFE114.11Feb09.Final.pdf.

14 Department of the Treasury, Department of Labor, and Department of Health and Human Services, *Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Dependent Coverage of Children to Age 26 Under the Patient Protection and Affordable Care Act,* May 10, 2010, http://cciio.cms.gov/resources/regulations/index.html#cya.

15 The agencies estimate a range of 1 million to 2 million young adults being covered in 2013, with 330,000 to 1.2 million of those previously uninsured.

16 Galewitz, "At Least 600,000," 2011.

[17] U.S. Government Accountability Office, "Health Insurance: Most College Students Are Covered Through Employer-Sponsored Plans and Some Colleges and States Are Taking Steps to Increase Coverage," Report to the Committee on Health, Education, Labor, and Pensions, U.S. Senate (GAO, March 2008), http://www.gao.gov/new.items/d08389.pdf.

[18] Department of Health and Human Services, "Student Health Insurance Coverage, Proposed Rule," Feb. 9, 2010, http://www.ofr.gov/OFRUpload/OFRData/2011-03109_PI.pdf.

[19] Massachusetts Division of Health Care Finance and Policy, *Student Health Program, Academic Years 2005–2006 through 2007–2008*, Nov. 2009, http://www.mass.gov/Eeohhs2/docs/dhcfp/r/pubs/09/student_health_program_report_nov-2009.doc.

[20] E. Fishman, "Aging Out of Coverage: Young Adults with Special Health Needs," *Health Affairs*, Nov./Dec. 2001 20(6):254–66.

[21] Collins and Nicholson, *Rite of Passage 2010*, 2010.

[22] Analysis of the 2009 Current Population Survey by Nicholas Tilipman and Bhaven Sampat of Columbia University.

[23] Estimate from Jonathan Gruber and Ian Perry of MIT using the Gruber Microsimulation Model for The Commonwealth Fund.

[24] T. S. Jost, *Health Insurance Exchanges and the Affordable Care Act: Eight Difficult Issues* (New York: The Commonwealth Fund, Sept. 2010); T. S. Jost, *Health Insurance Exchanges and the Affordable Care Act: Key Policy Issues* (New York: The Commonwealth Fund, July 2010).

[25] Robertson and Collins, *Women at Risk*, 2011; National Women's Law Center, *Still Nowhere to Turn: Insurance Companies Treat Women Like a Pre-Existing Condition* (Washington, D.C.: NWLC, Oct. 2009).

[26] Analysis of the 2009 Current Population Survey by Nicholas Tilipman and Bhaven Sampat of Columbia University.

[27] Estimate from Jonathan Gruber and Ian Perry of MIT using the Gruber Microsimulation Model for The Commonwealth Fund.

[28] The tax-filing threshold is the combination of the personal exemption amount plus the standard deduction amount. For 2010, the tax-filing threshold was $9,350 for an individual, $18,700 for a married couple filing jointly, and $26,000 for a married couple with two children. See H. Chaikand and C. L. Peterson, *Individual Mandate and Related Information Requirements Under PPACA* (Washington, D.C.: Congressional Research Service, July 20, 2010).

[29] Congressional Budget Office, Letter to the Honorable Evan Bayh, Nov. 30, 2009; and Congressional Budget Office, Letter to the Honorable Harry Reid, Dec. 19, 2009, p. 19, http://www.cbo.gov/ftpdocs/108xx/doc10868/12-19-Reid_Letter_Managers.pdf.

[30] S. K. Long, A. Yemane, and K. Stockley, "Disentangling the Effects of Health Reform in Massachusetts: How Important Are the Special Provisions for Young Adults?" *American Economic Review,* May 2010 100(2):297–302.

[31] J. R. Gabel, H. Whitmore, J. Pickreign et al., "After the Mandates: Massachusetts Employers Continue to Support Health Reform as More Firms Offer Coverage," *Health Affairs* Web Exclusive, Nov./Dec. 2008 27(6):w566–w575.

[32] C. Eibner, P. S. Hussey, and F. Girosi, "The Effect of the Affordable Care Act on Workers' Health Insurance Coverage," *New England Journal of Medicine,* Sept. 1, 2010, Online First, available at http://www.nejm.org/doi/full/10.1056/NEJMp1008047.

Table 1. Demographics by Age (base: adults ages 19–64)

	Total (ages 19–64)	Ages 19–29	Ages 19–29		Ages 30–49	Ages 50–64
			Male	Female		
Total (millions)	183.6	43.6	22.0	21.5	80.0	60.1
Percent distribution	100%	24%	51%	49%	44%	33%
Unweighted n	3,033	563	276	287	1,231	1,239
Race/Ethnicity						
White	64	57	57	56	63	71
Black	12	14	11	17	12	12
Hispanic	16	20	22	18	18	9
Asian/Pacific Islander/Other	6	8	9	8	6	5
Income						
Less than $20,000	26	47	46	49	21	19
$20,000–$39,999	20	21	25	18	20	17
$40,000–$59,999	14	12	14	10	14	16
$60,000 or more	29	9	10	9	35	35
Poverty status						
Below 133% FPL	27	46	42	51	24	18
133%–249%	18	18	22	14	20	14
250%–399%	19	15	19	12	21	20
400% FPL or more	25	11	13	10	25	34
Below 200% FPL	38	58	54	61	37	26
200% FPL or more	51	33	40	25	54	60
Insurance status (base: insured all year)						
Employer	73	62	65	60	78	74
Medicare	7	3	3	3	6	9
Medicaid	8	14	12	16	8	5
Individual	6	9	11	6	4	7
Other	6	12	9	16	4	5
Insurance continuity						
Insured all year	72	56	53	59	72	83
Insured now, time uninsured in past year	8	15	16	15	7	5
Uninsured now	20	28	31	26	21	13
Any time uninsured*	28	44	47	41	28	17
Family status						
Married/LWP, no children	25	17	16	17	13	47
Married/LWP, children	37	23	17	29	55	23
Not married, no children	27	52	61	43	16	22
Not married, children	11	8	6	10	15	7
Adult work status						
Full-time	52	46	50	43	59	46
Part-time	12	18	19	17	11	11
Not currently employed	36	36	31	41	31	42
Employer size**						
Self-employed/1 employee	6	2	3	0	7	8
2–24 employees	20	25	26	23	19	19
25–99 employees	14	14	15	13	16	11
100–499 employees	15	14	13	14	17	15
500 or more employees	42	42	41	43	40	45

Notes: FPL refers to Federal Poverty Level; LWP refers to living with partner.
* Combines “Insured now, time uninsured in past year” and “Uninsured now.”
** Among full- and part-time employed adults ages 19–64.
Source: The Commonwealth Fund Biennial Health Insurance Survey (2010).

Table 2. Availability of and Workers' Eligibility for Employer Insurance (base: workers ages 19–64)

	Total	Ages 19–29	Ages 19–29 Male	Ages 19–29 Female	Ages 30–49	Ages 50–64
Total (millions)	183.6	43.6	22.0	21.5	80.0	60.1
Eligibility						
Employer offers a plan	84	77	75	79	84	90
Eligible for employer plan	76	63	63	63	78	85
Coverage						
Covered through own employer	38	30	31	28	39	43
Covered through someone else's employer	19	14	13	15	20	20
Covered through public program	14	14	12	16	13	14
Individual	5	6	7	4	4	6
Other	5	8	6	10	3	5
Uninsured	20	28	31	26	21	13
Take-up rate of own-employer insurance*	79	75	79	71	78	83

Note: Workers include full- and part-time workers.
* Base: Full- and part-time workers who were offered and eligible for employer insurance.
Source: The Commonwealth Fund Biennial Health Insurance Survey (2010).

Table 3. Access Problems and Preventive Care by Age, Insurance Continuity and Income (base: adults ages 19–64)

			Ages 19–29				Ages 19–29				
	Total (ages 19–64)	Ages 19–29	Male	Female	Ages 30–49	Ages 50–64	Below 133% FPL	133%–249% FPL	250% FPL or more	Insured all year	Uninsured anytime
Total (millions)	183.6	43.6	22.0	21.5	80.0	60.1	20.2	7.7	11.6	24.4	19.1
Percent distribution	100%	24%	51%	49%	44%	33%	46%	18%	27%	56%	44%
Unweighted n	3,033	563	276	287	1,231	1,239	262	101	143	316	247
Access Problems in Past Year											
Went without needed care in past year because of cost:											
Did not fill prescription	26	26	19	33	29	22	33	33	14	19	35
Skipped recommended test, treatment, or follow-up	25	25	22	29	26	24	32	30	16	18	34
Had a medical problem, did not visit doctor or clinic	26	31	27	34	28	21	35	38	26	22	42
Did not get needed specialist care	18	19	17	21	19	17	25	16	17	13	28
At least one of four access problems because of cost	41	45	39	51	42	36	52	50	36	34	58
Delayed or did not get preventive care screening because of cost	18	15	12	19	19	18	20	17	7	8	24
Delayed or did not get dental care because of cost	38	38	32	45	40	33	43	35	36	30	50
Preventive Care											
Regular source of care	89	76	69	83	90	95	74	76	82	87	63
Blood pressure checked (past year)	85	74	67	82	86	92	69	76	85	83	63
Dental exam (past year)	59	50	47	54	60	64	43	48	63	63	35
Received pap test in past year (females ages 19–29), in past three years (females age 30+)	74	66	NA	66	83	69	—	—	—	72	57
Cholesterol checked in past five years	70	48	43	53	71	85	39	55	59	54	40
Seasonal flu shot in past 12 months	38	30	25	35	36	46	25	25	40	34	25

Note: FPL refers to Federal Poverty Level.
— Sample size too small to report results.
Source: The Commonwealth Fund Biennial Health Insurance Survey (2010).

Table 4. Bill and Debt Problems by Age, Insurance Continuity and Income (base: adults ages 19–64)

	Total (ages 19–64)	Ages 19–29	Ages 19–29		Ages 30–49	Ages 50–64	Ages 19–29				
			Male	Female			Below 133% FPL	133%–249% FPL	250% FPL or more	Insured all year	Uninsured anytime
Total (millions)	183.6	43.6	22.0	21.5	80.0	60.1	20.2	7.7	11.6	24.4	19.1
Percent distribution	100%	24%	51%	49%	44%	33%	46%	18%	27%	56%	44%
Unweighted n	3,033	563	276	287	1,231	1,239	262	101	143	316	247
Medical Bill Problems in Past Year											
Had problems paying or unable to pay medical bills	29	29	23	35	32	24	35	41	14	17	41
Contacted by collection agency for unpaid medical bills	16	18	15	20	18	14	23	29	5	9	27
Had to change way of life to pay bills	17	11	9	13	19	19	14	14	6	6	15
Any bill problem^	34	33	28	39	37	29	41	48	16	20	46
Medical bills/debt being paid off over time	24	20	18	22	27	21	22	30	16	14	25
Any bill problem or medical debt	40	39	34	44	43	35	45	53	25	25	52
Base: Any Bill Problem or Medical Debt											
Percent reporting that the following happened in the past two years because of medical bills:											
Unable to pay for basic necessities (food, heat, or rent)	31	25	24	25	32	33	—	—	—	20	28
Used up all of savings	40	33	35	31	42	41	—	—	—	27	36
Took out a mortgage against your home or took out a loan	10	6	6	6	11	12	—	—	—	2	8
Took on credit card debt	24	18	21	16	26	25	—	—	—	19	18
Had to declare bankruptcy	6	2	1	2	7	8	—	—	—	1	2
Insurance status of person/s at time care was provided											
Insured at time care was provided	59	43	43	43	62	66	38	—	—	—	22
Uninsured at time care was provided	35	54	54	55	31	29	61	—	—	—	75
Other insurance combination	2	0	0	0	2	2	0	—	—	—	0

Note: FPL refers to Federal Poverty Level.
— Sample size too small to report results.
^ Problems paying or unable to pay medical bills, contacted by collection agency for inability to pay medical bills, or had to change way of life significantly in order to pay medical bills.
Source: The Commonwealth Fund Biennial Health Insurance Survey (2010).

Table 5. State Laws That Increase the Age Up to Which Young Adults Are Considered Dependents for Insurance Purposes

State	Year law passed or implemented	Limiting age of dependency status	Applies to non-students?
Colorado[1]	2006	25	Yes
Connecticut[2]	2007	26	Yes
Delaware[3]	2006	24	Yes
Florida[4]	2009	30	Yes
Georgia[5]	*	26	No
Idaho[6]	2007	25	No
Illinois[7]	2008	26	Yes
Indiana[8]	2007	24	Yes
Iowa[9]	2008	25	Yes
Kentucky[10]	2008	25	Yes
Louisiana[11]	2009	24	No
Maine[12]	2007	25	Yes
Maryland[13]	2007	25	Yes
Massachusetts[14]	2006	26	Yes
Minnesota[15]	2007	25	Yes
Missouri[16]	2009	26	Yes
Montana[17]	2007	25	Yes
Nevada[18]	*	24	No
New Hampshire[19]	2007	26	Yes
New Jersey[20]	2006	31	Yes
New Mexico[21]	2005	25	Yes
New York[22]	2009	30	Yes
North Dakota[23]	*	22	Yes
Ohio[24]	2009	28	Yes
Oregon[25]	2009	23	Yes
Pennsylvania[26]	2009	30	Yes
Rhode Island[27]	2006	25	No
South Carolina[28]	2009	22	No
South Dakota[29]	2005	30	No
Tennessee[30]	2008	24	Yes
Texas[31]	2003	25	Yes
Utah[32]	1994	26	Yes
Virginia[33]	2007	25	Yes
Washington[34]	2007	25	Yes
West Virginia[35]	2007	25	Yes
Wisconsin[36]	2010	27	Yes
Wyoming[37]	2009	23	No

1 Colorado Rev. Stat. § 10-16-104.3; Requires group and privately purchased individual health plans to cover unmarried dependents up to age 25. Dependents must be unmarried or financially dependent, or live at the same address as parents, but eligibility is not dependent on full-time enrollment in school.

2 Connecticut C.G.S.A. § 38a-497; Requires that group health insurance policies extend coverage to children up to age 26, as long as they are unmarried and either remain residents of Connecticut or are full-time students; effective January 1, 2009.

[3] Delaware Code Ann. Tit. 18, § 3354; Requires insurance providers to cover unmarried young adults under a pre-existing family policy up to age 24. Applicable as long as the young adult has no dependents and either lives in the state of Delaware or is a full-time student.

[4] Florida Chapter 627.6562; Allows unmarried young adults up to age 25 who are financially dependent on their parents and who either live with their parents or are full- or part-time students to remain on their parent's health insurance; health insurance plan must cover these young adults at least until the end of the calendar year in which the young adult turns 25. Unmarried young adults up to age 30 may remain on their parent's insurance as long as they have no dependents of their own and either reside in Florida or are full- or part-time students.

[5] Georgia Code § 33-30-4; Allows young adults who are financially dependent on their parents to remain on their parent's insurance up to and including age 25, as long as they are enrolled as a full-time student at least 5 months during the year or are prevented from enrolling as a full-time student due to illness or injury.

[6] Idaho Stat. § 41-2103; Allows unmarried financially dependent full-time students up to age 25 to remain on their parent's health insurance, and unmarried non-students up to age 21.

[7] Illinois 215 ILCS 5/356z.12; Allows parents to keep dependents on their health plan until their 26th birthday; parents with dependents who are veterans can keep them on their health plan until their 30th birthday.

[8] Indiana IC 27-8-5-2,28 and IC 27-13-7-3; Requires commercial health insurers and health maintenance organizations to cover dependents up to age 24 on their parent's insurance.

[9] Iowa Code § 509.3 and §514E.7; Requires health insurers to continue to cover dependents on their parent's coverage as long as the child is under the age of 25 and a resident of Iowa, a full-time student, or disabled. The dependent must be unmarried.

[10] Kentucky Rev. Stat. § 304.17A-256; Allows parents to keep their unmarried children on their health insurance plans up to age 25. Parents may have to pay extra premiums for their child's coverage.

[11] Louisiana Rev. Stat. Ann. § 22:1003; Allows unmarried, dependent children up to age 24 who are full-time students to remain on their parent's insurance.

[12] Maine 24-A MRSA § 2742-B; Requires individual and group health insurance policies to continue coverage for an unmarried dependent child up to age 25 if the child is financially dependent on the policyholder and has no dependents of his/her own.

[13] Maryland Code Insurance § 15-418; Allows young adults up to age 25 to receive coverage through their parent's health insurance as long as they live with the policyholder and are unmarried.

[14] Massachusetts Gen. Laws Ann. Ch. 175 § 108; As part of Massachusetts' April 2006 health insurance expansion law, young adults are considered dependents for insurance purposes up to age 26 or for two years after they are no longer claimed on their parent's tax returns, whichever comes first.

[15] Minnesota Chapter 62E.02; Effective January 1, 2008; Allows unmarried dependents up to age 25 to remain on their parent's private health insurance plans.

[16] Missouri Rev. Stat. § 354-536; Allows unmarried dependents up to age 26 to remain on their parent's health insurance plans as long as the child is a resident of Missouri.

[17] Montana MCA 33-22-140; Provides insurance coverage to unmarried children up to 25 years of age under a parent's policy; effective January 1, 2008.

[18] Nevada NRS 689C.055; Allows unmarried, dependent children who are full-time students to remain on their parent's insurance policy up to age 24 if parent is covered by a small group policy.

[19] New Hampshire Rev. Stat § 420-B:8-aa; Applies to unmarried dependents who are either under age 25 and a full-time student or under age 26, a resident of New Hampshire, and not provided coverage through another group or individual health plan. 2009 SB 115 allows young adults up to age 26 to purchase coverage through the New Hampshire CHIP program, Healthy Kids.

[20] New Jersey S.A. 17B:27-30.5; Requires most group health plans to cover unmarried adult dependents up to age 31, as long as they have no dependents of their own, are residents of New Jersey or are full-time students, and are not provided coverage through another group or individual health plan.

[21] New Mexico Stat. Ann. § 13-7-8; Requires that all insurance policies provide coverage for unmarried dependents up to age 25, regardless of school enrollment.

[22] New York 2009 Assembly Bill 9038; Allows unmarried young adults up to age 30 who are not eligible for employer sponsored insurance to be covered under their parent's health insurance, regardless of financial dependence, as long as they are a resident of New York; effective September 1, 2009.

[23] North Dakota Cent. Code § 26.1-36-22; Allows unmarried, financially dependent children up to age 22 who live with their parents to remain on parent's insurance; allows full-time students up to age 26 to remain on parent's insurance.

[24] Ohio Rev. Code § 1751.14, as amended by 2009 OH H 1; Allows unmarried dependent children up to age 28 to remain on their parent's insurance, as long as they are an Ohio resident or a full-time student.

[25] Oregon O.R.S. § 735.720; Defines dependent for insurance purposes as an unmarried child up to age 23, regardless of student status.

[26] Pennsylvania 2009 SB 189; Allows an unmarried child up to age 30 to remain on parent's insurance as long as they have no dependents themselves and are residents of Pennsylvania or a full-time student.

[27] Rhode Island Gen. Laws § 27-20-45 and Gen. Laws § 27-41-61; Requires health insurance plans to cover unmarried dependent children up to age 19, or age 25 for financially dependent students.

[28] South Carolina Code Ann. § 38-71-1330; Allows unmarried, financially dependent children up to age 22 who are full-time students to remain on parent's insurance if parent is covered by a small group policy.

[29] South Dakota Codified Laws Ann. 3-12A-1; Prohibits any insurance provider that offers dependent benefits from terminating coverage before age 19, or 23 if the dependent is a full-time student and financially dependent on his/her parents. South Dakota Codified Law § 58-17-2.3 allows dependents who remain full-time students upon reaching age 24 but not exceeding age 29 to remain on their parent's insurance.

[30] Tennessee Code Ann. 56-7-2302; Allows unmarried and financially dependent young adults up to age 24 to remain on their parent's health insurance plan.

[31] Texas V.T.C.A. Insurance Code § 846.260 and V.T.C.A. Insurance Code § 1201.059; Allows unmarried dependents up to age 25 to be covered by their parent's insurance plans.

[32] Utah Code Ann. Title 31A § 22-610.5; Requires insurance policies that include dependent coverage to cover unmarried dependents up to age 26, regardless of enrollment in school.

[33] Virginia Code Ann. 38.2-3525; Allows dependent children up to age 25 to remain on their parent's health insurance, as long as they reside with the parent or are full-time students.

[34] Washington RCWA 48.44.215; Requires all insurers to offer enrollees the opportunity to extend coverage to unmarried dependents up to age 25.

[35] West Virginia Code § 33-16-1a; Increases the dependent age for a child or stepchild to 25 for health insurance coverage.

[36] Wisconsin Stat. § 632.885; Requires insurers to cover unmarried dependents up to age 27 through their parent's insurance if they are not offered insurance through their employer. Effective January 1, 2010.

[37] Wyoming Stat. § 26-19-302; Allows unmarried full-time students to remain on their parent's insurance up to age 23 if parent is covered by a small group policy.

[*] Year law passed/implemented unknown.

Additional sources: National Conference of State Legislatures, *Covering Young Adults Through Their Parent's or Guardian's Health Policy*, http://www.ncsl.org/IssuesResearch/Health/HealthInsuranceDependentStatus/tabid/14497/Default.aspx.

Methodology

Most data in this issue brief are from three surveys: the March Annual Social and Economic Supplement to the Current Population Survey (CPS), 2010; the Commonwealth Fund Biennial Health Insurance Survey (2010); and the Commonwealth Fund Survey of Young Adults (2009). Bhaven Sampat and Nick Tilipman of Columbia University's Mailman School of Public Health provided analysis of the CPS. Jonathan Gruber and Ian Perry of the Massachusetts Institute of Technology provided estimates of undocumented uninsured young adults using the Gruber Microsimulation Model. Commonwealth Fund staff analyzed the Commonwealth Fund surveys.

The CPS is a federal survey sponsored by the U.S. Census Bureau. The CPS, the primary source of information on U.S. labor force characteristics, is conducted monthly on a sample of about 57,000 households representing approximately 140,000 people. The Annual Social and Economic Supplement to the CPS is conducted in March of each year with a sample of about 99,000 households.

The Commonwealth Fund Biennial Health Insurance Survey (2010), was conducted by Princeton Survey Research Associates International from July 14 to November 30, 2010. The survey consisted of 25-minute telephone interviews in either English or Spanish with a random, national sample of 4,005 adults, age 19 and older, living in the continental United States. Because relying on landline-only samples leads to undercoverage of American households, a combination of landline and cell phone random-digit dial (RDD) samples was used to reach people, regardless of the type of telephones they use.[1] This issue brief is based on the responses of 563 adults ages 19 to 29 in the sample. Data are weighted to correct for the stratified sample design, the overlapping landline and cellular phone sample frames, and disproportionate nonresponse that might bias results. The landline portion of the survey achieved a 29 percent response rate and the cellular phone component achieved a 25 percent response rate. The survey has an overall margin of sampling error of +/– 1.9 percentage points at the 95 percent confidence level. We also report estimates from the 2001 and 2005 Commonwealth Fund Biennial Health Insurance Surveys. These surveys were conducted by Princeton Survey Research Associates International using the same stratified sampling strategy as was used in 2010 except that they did not include a cellular phone random-digit dial sample.[2] In 2001, the survey was conducted from April to July 2001 and included 2,829 adults ages 19 to 64; in 2005, the survey was conducted from August 2005 to January 2006 among 3,353 adults ages 19 to 64.

The Commonwealth Fund Survey of Young Adults (2009) was a national telephone survey conducted from May 12, 2009, to July 2, 2009, among a nationally representative sample of 2,002 young adults ages 19 to 29 and living in the continental United States. The survey was conducted by Social Science Research Solutions (SSRS). Since many young adults use cell phones "mostly" or "exclusively," this survey employed a dual-frame landline and cell phone telephone design in which half (1,002) of the interviews were conducted by cell phone. The landline portion of the sample used a disproportionate, stratified random-digit dialing design to increase the potential of reaching young adult households overall, as well as those specifically low-income and African American and Hispanic. Prescreened strata were included, which supplemented the sample with additional interviews of households identified as having a 19-to-29-year-old in prior waves of SSRS's national omnibus survey. The cell phone portion of the sample was accomplished using a basic random-digit dialing methodology of working cell phone exchanges. Using this dual-frame stratified sampling design, this study obtained an oversample of low-income,

African American, and Hispanic adults. Survey data were weighted to: 1) correct for the fact that not all survey respondents were selected with the same probability, and 2) account for gaps in coverage and nonresponse biases in the survey frame. In the first stage, SSRS developed design weights to compensate for sample-frame biases and the number of telephones in the household/cell phone-only status. Population counts for telephone status were requested from the National Center for Health Statistics and drawn from their National Health Insurance Survey. In the second stage, the data were weighted by age, education, geographic region, gender, and race/ethnicity using the 2007 American Community Survey population exhibits. The resulting weighted sample is representative of the approximately 46 million adults ages 19 to 29. The survey achieved a 32 percent response rate (calculated according to the standards of the American Association for Public Opinion Research). The survey has an overall margin of sampling error of +/– 2 percentage points at the 95 percent confidence level.

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[1] According to the latest estimates from the 2008 National Health Interview Survey, 20 percent of U.S. households have only wireless telephones. S. J. Blumberg and J. V. Luke, "Wireless Substitution: Early Release of Estimates from the National Health Interview Survey, July–December 2008" (Atlanta, Ga.: National Center for Health Statistics. May 2009), http://www.cdc.gov/nchs/data/nhis/earlyrelease/wireless200905.htm.

[2] In 2005, only 7.2 percent of households in the United States did not have landline telephones. S. J. Blumberg and J. V. Luke, "Reevaluating the Need for Concern Regarding Noncoverage Bias in Landline Surveys," *American Journal of Public Health,* Oct. 2009 99(10):1806–10. Employing a landline-only sample in 2001 and 2005 did not result in undercoverage of American households.

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