

# The Patient Protection and Affordable Care Act of 2010: How Does it Help Adolescents and Young Adults?

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## BACKGROUND

Adolescents and young adults have health care needs that are significant and distinct from the needs of younger children and older adults. They are uninsured at high rates – especially young adults living in poverty. They are involved in behaviors that put their health at risk, which means that they need access to comprehensive prevention and other health services to address issues like mental health concerns, substance abuse, sexual activity, obesity, and injuries. Specific groups – like racial and ethnic minorities, homeless youth, youth in foster care or juvenile justice systems, and immigrant youth – are especially vulnerable and have heightened needs. Adolescents and young adults also require access to diverse health care sites capable of meeting the needs of young people, as well as access to health care professionals with appropriate training and experience.

Major health care reform legislation was enacted this year that will bring about profound changes in the health care system in the United States. Many aspects of this new law will affect adolescents and young adults, with implications for their access to health care and, ultimately, their health. This issue brief reviews major provisions of the new legislation – the Patient Protection and Affordable Care Act (PPACA) – highlighting those of greatest significance for adolescents and young adults.

## CONTEXT

The PPACA was signed into law in March 2010. Its enactment resulted from years of public debate and intense negotiation among members of Congress and the Administration. Numerous alternative versions of health care reform legislation had been introduced and debated prior to passage of the ultimate version of the Act.

The final version contains many provisions that were sought by groups concerned about the needs of adolescents and young adults. For example, in July 2009, the Society for Adolescent Health and Medicine (SAHM) issued a statement of five key principles that should guide health care reform to meet the needs of this age group. The SAHM principles urged that health care reform legislation should assure financial access, establish a comprehensive benefit package, expand the workforce prepared to serve adolescents through training and reimbursement, ensure confidentiality protection, and address the needs of special populations of adolescents and young adults.

An earlier fact sheet, published by the Center for Adolescent Health & the Law and the National Health Information and

Innovation Center during final debates over the health care reform legislation in late 2009, identified provisions of the major bills under consideration that could either enhance or limit adolescents' and young adults' access to health care services. This issue brief sets forth a similar analysis of the PPACA, including questions that remain to be answered during implementation at state and federal levels.

## TIMELINE

The requirements of the PPACA are phased in over several years, beginning in 2010 and extending until 2014 and beyond. Several key provisions that are important for adolescents and young adults are scheduled for immediate implementation in 2010. Others are spread over the four year implementation period. The general timeline for implementation of some requirements with particular significance for adolescents and young adults is set forth here, with more detailed explanations later in this issue brief.

### 2010

- In private insurance:
  - Provide dependent coverage for adult children up to age 26
  - Prohibit pre-existing condition exclusions for children
  - Require coverage of preventive services without cost-sharing
- In Medicaid:
  - Create a state option to cover childless adults through a Medicaid state plan amendment
  - Create a state option to expand coverage for family planning through a Medicaid state plan amendment
- Provide scholarships and loans for health care professionals

### 2011

- Increase funding for community health centers and the National Health Service Corps
- Establish new programs to support school-based health centers
- Establish teaching health centers to support community-based primary care residency programs

## TIMELINE (CONT'D)

### 2012

- Expand collection and reporting of data on race, ethnicity, sex, primary language, disability status, and underserved rural populations

### 2013

- Increase federal matching funds rate (Federal Medical Assistance Percentage or FMAP) for states that offer Medicaid coverage of preventive services without cost sharing
- Increase Medicaid payments for primary care physicians

### 2014

- In private health insurance:
  - Create state health insurance exchanges for individuals and small businesses to purchase coverage
  - Create essential health benefits package with coverage of at least 60% of actuarial value
  - Provide premium credits and cost sharing subsidies for those with incomes between 133% and 400% of the Federal Poverty Level (FPL)
  - Require guaranteed issue and renewability
  - Reduce out of pocket limits for those with incomes up to 400% FPL
  - Limit deductibles
  - Limit waiting periods
- In Medicaid:
  - Expand Medicaid to all non-Medicare eligible individuals under age 65 with incomes no greater than 133% FPL with enhanced federal subsidies to states for new eligibles
  - Continue Medicaid coverage to age 26 for youth aging out of foster care

## EXPANDING HEALTH INSURANCE COVERAGE FOR ADOLESCENTS AND YOUNG ADULTS

The Congressional Budget Office has estimated that PPACA will result in extension of coverage to 32 million uninsured individuals by 2019, about half through Medicaid expansions and the other half through private insurance. PPACA contains numerous provisions that would expand financial access to essential health care for adolescents and young adults by increasing the opportunities for them to receive health insurance coverage, either through Medicaid and the Children's Health Insurance Program (CHIP) or through individual or group coverage in private plans. Some of the most significant expansions are due to take effect immediately, in 2010. Others will be phased in between now and 2014.

### *Medicaid and CHIP*

PPACA contains several provisions of critical importance in extending Medicaid coverage to individuals who were previously ineligible. Many of the newly eligible will be young adults who are currently uninsured because they either cannot qualify for Medicaid or cannot afford private insurance. PPACA also contains important protections for adolescents and young adults who qualify for Medicaid or CHIP under current eligibility criteria.

- Beginning in 2014, PPACA creates a new mandatory Medicaid eligibility category requiring states to cover additional individuals with incomes no greater than 133% FPL. (In 2010, 100% FPL is \$10,830 for an individual.) These individuals must be under age 65 and must not be pregnant, disabled, or eligible for or enrolled in Medicare. This enables low-income childless adults who would previously have been ineligible to qualify for Medicaid and will help reach many currently uninsured young adults who are poor or near-poor. Increased federal matching funds are available for those who are newly eligible.
- PPACA gives states the option of implementing the above provision beginning in 2010. They can do so simply by amending their state Medicaid plans rather than seeking a waiver. Thus it would be possible that young adults with incomes no greater than 133% FPL could begin benefitting from expanded coverage immediately if their state chose this option. However, the current fiscal situation may limit the number of states that choose to do so.

### *Medicaid and CHIP (cont'd)*

- Beginning in 2014, PPACA requires states to continue Medicaid coverage for youth who age out of foster care until they reach age 26. These youth must have been the responsibility of the state on their 18th birthday. They must also have been enrolled in Medicaid while they were in foster care. Former foster youth are extraordinarily likely to be homeless, unemployed, and without health insurance, so this provision fills an important need.
- PPACA does not alter the current eligibility rules for immigrants to enroll in Medicaid or CHIP. Undocumented immigrants, including adolescents and young adults, are prohibited from enrolling. Non-citizen legal immigrants are barred from enrolling during their first five years in the United States, although states are permitted to lift this prohibition for pregnant women and children.
- PPACA requires states to provide Medicaid coverage for all children and adolescents through age 18 with family incomes no greater than 133% FPL.
- PPACA requires states to maintain current Medicaid and CHIP eligibility levels for those with incomes over 133% FPL until 2019. This means that adolescents and young adults who are currently eligible for Medicaid or CHIP even at those higher income levels will not lose coverage. The incentive for states to comply is significant because failure to do so would result in a loss of all Medicaid funding. If states have insufficient funds to cover all children and adolescents who are eligible for CHIP, they must be evaluated for eligibility for Medicaid or referred to the state health insurance exchange (described below under Private Insurance) for coverage. Protections with respect to benefit levels for those referred to the exchanges are included, as discussed below.
- Beginning in 2015 and continuing until 2019, PPACA provides for states to receive a 23 percentage point increase in the federal matching rate (not to exceed a total matching rate of 100%) that they receive in their CHIP programs.

### *Private Insurance*

Key provisions of PPACA are related to private health insurance, including both employer-based group plans and individual policies. Many of these are specific to adolescents and young adults, while others are relevant for them, but also pertain to other age groups. Taken together the requirements are designed to reduce the number of individuals without

insurance and, because so many young adults are currently uninsured, they are among those most likely to benefit, if the law is implemented effectively. Key provisions also include significant health insurance market reforms intended to increase protections for individuals who have insurance, particularly those who have or acquire a serious illness.

- Beginning in 2014, PPACA requires individuals to have insurance coverage or pay a penalty. Premium subsidies will be available for individuals with incomes up to 400% FPL. One hundred percent of FPL for a single individual in 2010 is \$10,830, so young adults with incomes below approximately \$43,000 would be eligible to receive a subsidy. This would potentially benefit the vast majority of young adults who are currently uninsured. Families are also required to have insurance coverage for their dependents and penalties apply for failure to do so. It is unclear to what extent the level established for the penalties will provide a sufficient incentive for individuals and families to purchase care, especially for young adults who view themselves as healthy.
- Beginning in 2014, PPACA requires the creation of state health insurance exchanges where individuals, families, and small businesses will be able to purchase insurance. Families of adolescents, as well as young adults, who do not have access to employer-based group coverage would be able to purchase individual policies through the exchanges.
- PPACA allows legal immigrants who are not citizens, including adolescents and young adults, to purchase coverage in the state health insurance exchanges and to receive subsidies to do so if their incomes are below 400% FPL. Undocumented immigrants are prohibited from doing so.
- Beginning in 2010, group health plans and health insurers issuing group or individual policies that include dependent coverage are required to extend coverage until dependents reach age 26. In order to qualify for this coverage it is not necessary for a young adult to be living with his or her parents, to be a full time student, or to be listed as a dependent on the parents' tax return. The benefit package, premiums, and co-payments must be the same as for younger dependents covered under the same policy or health plan.

### *Private Insurance (cont'd)*

- Beginning in 2010, group and individual private health insurance plans cannot impose pre-existing condition exclusions for children. This will enable families to purchase health insurance for their adolescents (as well as younger children) who have been or would be excluded due to their health status. Although this provision is effective beginning in September 2010, recent guidance from HHS indicates that health plans may restrict the opportunity to apply for such coverage to “open enrollment” periods.
- Beginning in 2014, PPACA establishes a variety of private health insurance market reforms including guaranteed issue, no pre-existing condition exclusions (for all ages, not just children), lower deductibles, lower maximum out of pocket expenditure levels, shorter waiting periods, and no annual or lifetime limits on coverage. These patient protections would be valuable to adolescents and young adults as well as young children and older adults.

### **IMPROVING ACCESS TO COMPREHENSIVE BENEFITS FOR ADOLESCENTS AND YOUNG ADULTS**

PPACA contains a number of provisions that should help to make it possible for adolescents and young adults to receive comprehensive benefits, whether they are enrolled in Medicaid or CHIP or covered by private insurance. It also contains provisions of some concern that will require monitoring of the effects of implementation.

#### *Medicaid and CHIP*

PPACA does not alter the Medicaid or CHIP benefit packages, but does contain some provisions designed to preserve CHIP benefits, at least temporarily. It also will make it possible for newly eligible adolescents and young adults under age 21 to receive the broad benefit package available in Medicaid.

- PPACA extends Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services to all “children” gaining coverage via Medicaid. Under existing law, for this purpose, children include Medicaid beneficiaries who are younger than age 21. Thus young adults who are age 19 or 20 who would previously have been ineligible for Medicaid, but who now will be able to qualify should be able to receive the full range of EPSDT services. Historically, EPSDT has represented one of the most

generous benefit packages available, and is designed to meet the needs of children and adolescents.

- Young adults age 21 or older, who are newly eligible for Medicaid, but who do not qualify as children, will most likely receive a package of Medicaid benefits referred to as “benchmark-equivalent coverage.” Benchmark coverage is an option that Congress has given states over the past few years, allowing them to provide some populations with a benefit package that is more limited than the full range of Medicaid benefits which states are required to provide to children and individuals with disabilities. Such coverage must have an actuarial value equivalent to one of several “benchmark” plans (e.g., the standard Blue Cross/Blue Shield plan for federal employees in the state, a health plan generally available to state employees, or coverage in the largest commercial non-Medicaid HMO in the state). Benchmark-equivalent coverage must at least include hospital, physician, and preventive services, and for additional services included in the benchmark plan, at least 75% of the actuarial value of those services. While the availability of even this package of services will be an improvement for young adults who were previously uninsured, significant benefits needed by this age group (e.g., certain mental health, substance abuse, or dental services) may not be covered, or may be covered at a more limited level (e.g., 75% of their actuarial value in the benchmark plan).
- PPACA requires states to continue the current benefit package and keep in place current cost-sharing protections in their CHIP programs through 2019. To the extent that states do not have sufficient funds to cover all children and adolescents who are eligible for CHIP, those who are not enrolled must be evaluated for eligibility for Medicaid or referred to the state health insurance exchange as indicated above. In a provision designed to protect children and adolescents from being harmed by a loss of CHIP coverage as a result of the health care reform legislation, the Act also requires HHS to conduct a review of benefits and cost sharing in the exchanges and to certify that they are equivalent to the benefits and cost sharing in CHIP.
- Beginning in 2010, PPACA creates an option for states to expand Medicaid coverage for family planning by means of the (simpler) state plan amendment process, rather than via a Medicaid waiver. This could extend family planning services to many additional adolescents and young adults.



## Private Insurance

PPACA requires the creation of a minimum essential benefit package and, although the details of what this package will contain remain to be determined by regulation, it contains several elements of great importance for adolescents and young adults, including a special emphasis on preventive services. It also contains some provisions that risk creating a group of young adults with “second tier” coverage.

- Beginning in 2010, PPACA requires private health plans and insurers issuing group or individual policies to provide coverage without cost-sharing for an important array of preventive services including services recommended by the US Preventive Services Task Force; immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC); preventive care for infants, children, and adolescents recommended by the Health Resources and Services Administration (HRSA) (Bright Futures); and additional preventive care and screenings for women to be determined by HRSA in 2011.
- PPACA requires the establishment of an “essential benefit package.” Although the details of what must be included will be determined by regulation, PPACA does provide that the essential benefit package must include at least: ambulatory services; emergency services; hospitalization; rehabilitative & habilitative services and devices; laboratory services; maternity & newborn care; mental health & substance use disorder services, including behavioral health treatment; prescription drugs; preventive & wellness services; chronic disease management; and pediatric services, including oral and vision care. Beyond the requirement to cover preventive services with no cost sharing, the inclusion of mental health and substance use services, as well as dental and vision care, is of great significance for adolescents and young adults.
- The inclusion in the essential benefit package of maternity care currently offered by only about 13% of health plans in the private sector, is a major advance for adolescents and young adults. PPACA does not specify in detail the sexual and reproductive health services to be included in the essential benefit package. However, critically important services, such as contraceptive services and supplies, could be mandated for inclusion by regulation.
- Exchange plans are required to offer a range of plans with different levels of cost-sharing: 90% (for Platinum plans),

80% (for Gold plans), 70% (for Silver plans), and 60% (for Bronze plans). Thus, in a Bronze plan, a beneficiary would be responsible for 40% of the costs. Although each plan must offer at least the essential benefit package, the differences for covered individuals and families are in the premiums charged and the level of cost-sharing.

- In addition to the standard Platinum, Gold, Silver, and Bronze plans, PPACA allows for the creation of catastrophic plans (with a more limited benefit package) for young adults under age 30, who have been referred to as “young invincibles.” Prevention benefits and three primary care visits would be exempt from the deductibles, which would be set at a very high level to keep premium costs lower. These high deductibles might discourage young adults purchasing these plans from seeking health care that is important, but for which they would have to pay out of pocket, in order to satisfy the deductible.

## IMPROVING TRAINING AND COMPENSATION OF PROVIDERS WHO SERVE ADOLESCENTS AND YOUNG ADULTS

PPACA provides for improvements in the training and compensation of health care providers, including those who take care of adolescents and young adults, in several important ways.

- In 2013 and 2014 PPACA provides for increasing Medicaid payments to 100% of Medicare rates for primary care physicians. This could help increase the willingness/capacity of physicians who care for adolescents and young adults to continue to serve the low-income Medicaid population in this age group.
- Beginning in 2011, PPACA will increase the number of Graduate Medical Education positions, with priority given to primary care and general surgery and to states with the lowest resident physician-to-population ratios, and will establish Teaching Health Centers defined as community-based ambulatory patient care centers and provide funding for them.
- Beginning in 2010, PPACA will increase flexibility in the requirements for GME to promote training in outpatient settings.
- PPACA will support training of health care professionals through scholarships and loans, support primary care training, establish a loan repayment program for the public

health workforce, promote cultural competence of health care professionals, support development of interdisciplinary mental and behavioral health training programs, and establish a training program for oral health professionals.

- Beginning in 2010, PPACA will support training programs, provide loan repayment and retention grants, and create a career ladder for nursing and, beginning in 2011, will provide grants to employ and train nurse practitioners who provide primary care in federally qualified health centers and nurse-managed clinics.
- Beginning in 2010, PPACA will support development of training programs that focus on primary care models such as medical homes, team management of chronic disease, and integration of physical and mental health services.

## INCREASING EMPHASIS ON PREVENTION AND WELLNESS

One of the significant advances that PPACA represents is a greatly increased emphasis on prevention and wellness. The prevention and wellness provisions are diverse, ranging from major policy initiatives such as the creation of a Prevention and Wellness Trust Fund to specific measures, such as requirements for nutritional content labeling in vending machines. Many of the prevention and wellness provisions of PPACA will affect adolescents and young adults either directly or indirectly in positive ways.

- As noted above, beginning in 2010, PPACA requires coverage in private health plans without cost-sharing for preventive services recommended by the US Preventive Services Task Force; immunizations recommended by ACIP; preventive care for infants, children, and adolescents; and additional preventive care and screenings for women recommended by HRSA.
- Beginning in 2012, PPACA provides for increased federal Medicaid matching funds for states that provide coverage for preventive services in Medicaid without cost sharing.
- PPACA creates a Prevention and Public Health Trust Fund with \$7 billion in funding over 5 years and \$2 billion per year thereafter, for a total of \$15 billion.
- Beginning in 2010, PPACA establishes a grant program to support the delivery of evidence-based and community-based prevention and wellness services aimed at strengthening prevention activities, reducing chronic disease rates and addressing health disparities, especially in rural and frontier areas.

- PPACA provides \$75 million per year for grants to states to educate adolescents on abstinence and contraception to prevent pregnancy, STDs, and HIV. It also reinstates \$50 million for abstinence education previously eliminated by Congress.
- PPACA requires chain restaurants and vending machines to disclose nutritional content.
- PPACA appropriates \$25 million to implement a Program to Combat Childhood Obesity that was authorized in 2009 in the CHIP Reauthorization Act.

## INCREASING ACCESS FOR VULNERABLE ADOLESCENTS AND YOUNG ADULTS

A critical concern with respect to the treatment of adolescents and young adults in any health care reform measures has been whether the needs of vulnerable populations would be sufficiently well addressed. PPACA contains numerous provisions that address the needs of vulnerable groups, at least in part, while leaving the needs of others unattended.

- As noted above, beginning in 2014, PPACA requires states to continue Medicaid coverage for youth who age out of foster care until they reach age 26. These youth must have been the responsibility of the state when on their 18<sup>th</sup> birthday. They must also have been enrolled in Medicaid while they were in foster care.
- Beginning in 2014, PPACA requires states to conduct outreach to, and enroll in Medicaid and CHIP, several vulnerable and underserved populations, including unaccompanied homeless youth, children with special health care needs, pregnant women, racial and ethnic minorities, rural populations and individuals with HIV/AIDS. A failure to do so can result in a loss of all Medicaid funding. This could extend Medicaid or CHIP to extremely needy adolescents and young adults who have previously lacked insurance and have significant health concerns and medical needs.
- Beginning in 2011, PPACA creates new programs to support school-based health centers. Separate provisions appropriate funds for infrastructure and authorize funds for operations. Most school-based health center are located in underserved areas and serve vulnerable adolescents.
- Beginning in 2011, PPACA provides for an increase of \$11 billion in funding for Community Health Centers, many of

which serve adolescents and young adults, particularly those with low-incomes, Medicaid and CHIP beneficiaries, and the uninsured, including those who are homeless.

- PPACA allows legal immigrants to purchase coverage through the state health insurance exchanges and to receive subsidies to do so if their incomes are below 400% FPL. It does not, however, address in a positive way the ongoing problem of health care access for undocumented immigrants, many of whom are adolescents and young adults. Nor does it alter the existing rules that limit enrollment in Medicaid and CHIP by legal immigrants during their first five years of residence, unless they live in a state that has waived that limit for pregnant women and children.
- PPACA does not alter the current situation in which incarcerated adolescents and young adults are unable to receive Medicaid coverage while they are in juvenile justice or correctional facilities. However, the PPACA provisions that expand Medicaid eligibility for young adults and the new avenues for private insurance coverage through the state health insurance exchanges will provide opportunities for additional young people who have been incarcerated to secure health insurance coverage upon re-entry into the community.
- Beginning in 2012, the PPACA requires expanded collection and reporting of data on race, ethnicity, sex, primary language, disability status, and underserved rural populations. In light of the anticipated increase in the percentage of the adolescent and young adult population who will be members of racial and ethnic minorities, this provision will be of great importance in monitoring the effects of health care reform for these two age groups.

Health care reform unquestionably presents an extraordinary opportunity, both in the policy arena and in the realm of service delivery, to advance the health and well-being of adolescents and young adults. This will only happen with significant vigilance and concerted advocacy by those who are concerned about the needs of this age group. Over the next few months and several years an extensive implementation process will take place at the federal and state levels. The issuance of numerous sets of federal regulations interpreting the law has already begun and more will follow rapidly. Each of these proposed regulations is subject to public comment by individuals and organizations, health care professionals, and policy experts who want to ensure that PPACA meets the needs of adolescents and young adults to the maximum extent possible. Further actions will be needed at the state level – including both statutes enacted by state legislatures and regulations promulgated by state agencies. Careful monitoring of these actions also can help to ensure that adolescents and young adults are well served by the landmark health care reform legislation enacted in 2010.

## HEALTH CARE REFORM IMPLICATIONS—ACTIONS AND CHALLENGES

The health care reform law enacted in 2010 is an ambitious and complex piece of legislation. The requirements of PPACA are scheduled to be phased in over a period of several years, beginning immediately in 2010, phasing in most elements by 2014, but with full implementation extending well beyond that. If successful, the law will result in an increase of 32 million additional insured individuals in the United States, many of whom will be adolescents and young adults. In addition to the expansion of health insurance coverage, the potential for young people to access comprehensive benefits, especially preventive services, is a key aspect of the new law.

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

### *National Adolescent Health Information Center*



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The National Adolescent Health Information and Innovation Center (NAHIIC) was established in 1993 with funding from the Maternal and Child Health Bureau. The overall goal of NAHIIC is to improve the health of adolescents by serving as a national resource for adolescent and young adult health information and research, and to assure the integration, synthesis, coordination and dissemination of adolescent and young adult health-related information. Throughout its activities, NAHIIC emphasizes the needs of special populations who are more adversely affected by the current changes in the social environment of young people and their families.

#### **Suggested Citation:**

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