Implementing the Affordable Care Act: How Much Will It Help Vulnerable Adolescents & Young Adults?

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Introduction

Many important provisions of the Patient Protection and Affordable Care Act of 2010 (ACA) are being implemented beginning in January 2014. The ACA will affect most individuals and businesses in the United States, expanding health insurance coverage to the uninsured and offering important protections for many who already have or will gain insurance. Although much of the ACA remains poorly understood by the general population, its effects for vulnerable populations of young people, sometimes called "disconnected youth,"[1] are even less well known. The ACA has great potential to benefit adolescents and young adults in general. It will also have major implications for vulnerable adolescents and young adults, helping many but leaving others without essential coverage.

This issue brief explores the implications of the ACA for three groups of vulnerable adolescents and young adults at special risk of being disconnected from supportive adults and social institutions: youth in or aging out of foster care; youth involved in juvenile and criminal justice systems; and homeless youth.* For each group, the brief provides an overview of demographic characteristics and health status, and discusses access to health care and health insurance prior to and post-ACA. It ends with a discussion of common themes and upcoming challenges for the three populations. An accompanying fact sheet summarizes the ACA's implications for these three groups.

Youth in Foster Care and Aging Out

Highlights

Hundreds of thousands of children and youth are in foster care in the United States and tens of thousands of adolescents and young adults age out of foster care each year. Young people in foster care are disproportionately members of racial and ethnic minority groups and experience serious health problems at higher rates than adolescents and young adults in the general population. While in foster care, they are generally eligible for and enrolled in Medicaid, but historically health insurance coverage has been severely limited once they age out. The ACA will reverse that trend by requiring states to provide Medicaid coverage for most youth as they age out of foster care up to age 26.

Demographics

In 2012, an estimated 400,000 children, adolescents, and young adults were in foster care in the United States.[3] Nearly 40% of youth in foster care, or slightly under 150,000, were adolescents and young adults ages 12-20.[3] A significant number were in the older adolescent/young adult age group: 56,000 were ages 16 or 17; and nearly 17,000 were ages 18-20.[3] A few of these youth entered foster care as very young children; others entered as older children or as adolescents. The total population was slightly more than half male, and almost half female.[3] Generally, foster youth are in a variety of placements, including foster family homes (with relatives or unrelated families), pre-adoptive homes, group homes, institutions, and supervised independent living. Overall, the vast majority of youth in foster care live in foster family homes, but a much larger proportion of adolescents and young adults live in group homes or institutions.[3] Youth in foster care are disproportionately from racial and ethnic minority groups, with 26% of the total Black and 21% Hispanic.[3]

Table 1: Foster Care Population by Race and Ethnicity, 2012		
White	42%	164,990
Black or African American	26%	101,915
Hispanic (of any race)	21%	84,186
American Indian/Alaskan Native; Asian; or Native Hawaiian/Other Pacific Islander	3%	11,332
Two or more Races	6%	22,883
Unknown/Unable to Determine	3%	11,155

Adapted from "The AFCARS Report."[3]

Turnover in the foster care population is high, with approximately 250,000 children and youth entering care in 2012 and almost as many leaving in the same year.[3] Of those who exited foster care in 2012, an estimated 23,396 or 10% left by "emancipation," or "aging out."[3] Prior to 2008, the age to exit foster care was usually 18, with exceptions in some states. In 2008, the federal Fostering Connections to Success and Increasing Adoption Act was signed into law. The Act provides additional support for older youth to remain in foster care, in the form of continued federal foster care payments for those ages 18 or older who meet certain placement conditions and are engaged in activities designed to lead to independence, including educational programs, employment, and certain programs related to gaining employment.[4] Continuation of support past age 18 can be critical to the safe survival of former foster youth. As they transition into adulthood, youth in foster care face major challenges,

* Undocumented immigrant youth, who are also at risk of being disconnected, are not eligible for insurance under any ACA provisions.[2]

including lack of family support; employment and income problems; inadequate or inappropriate living arrangements; medical, dental, and mental health problems; and lack of health insurance.[5]

Health Status

Youth in and aging out of foster care experience many physical and mental health problems at high rates, significantly higher than the general population.[5, 6] When compared with other youth from the same socioeconomic backgrounds, those in foster care have higher rates of physical and mental health issues, including birth defects, developmental delays, emotional adjustment problems, chronic physical disabilities such as asthma and seizure disorders, malnutrition, dental caries, and substance abuse.[7, 8, 9, 10]

Although estimates vary widely, all suggest that chronic illness, disability, and mental health problems among foster youth are prevalent at high rates. Estimates of the proportion of foster youth who have mental health problems when entering care, while in care, or in their lifetimes range from 30% to 80%; more than 30% of older adolescents in foster care have a chronic illness or disability.[5, 11] Some of their health problems are directly related to factors, such as physical or sexual abuse, which led to their placement in foster care; others arise during placement.

Health Care Access

Health Care Access Highlights

Youth in foster care and aging out often encounter significant problems gaining access to health care, and frequently lack access to health care providers experienced in caring for a population with their particular needs. While in foster care, virtually all adolescents are eligible for Medicaid. Once they age out, however, the picture changes significantly, with studies finding that only about half of foster youth had health insurance after they exited care.[5] Beginning in 2014, the ACA requires all states to provide Medicaid coverage for most youth aging out of foster care until the age of 26, although challenges in accessing this coverage will remain for this vulnerable population.[12]

Pre-ACA

Historically, children and adolescents in foster care have been eligible for Medicaid, removing at least one of many obstacles to receiving the health care they need. However, most of these young people lost their Medicaid coverage as soon as they "aged out" of foster care, usually at age 18, with some states allowing voluntary continuation in care until age 21. After losing the Medicaid coverage they were eligible for by virtue of being in foster care, many former foster youth were unable to secure health insurance by other means, such as through Medicaid or private insurance. Medicaid income eligibility levels for single adults who were neither pregnant nor disabled have persistently been extremely low in most states;[13] and because many former foster youth experience difficulty in gaining employment, especially with benefits, employer-based coverage is also often unavailable to them. A major longitudinal study of former foster youth in 2010 found that nearly one-half lacked health insurance at age 23 or 24,[14] consistent with the findings of earlier studies.[15] The federal Foster Care Independence Act enacted in 1999 included a "Medicaid expansion option," that allowed states to continue Medicaid coverage for former foster youth to age 21.[16] As of January 2011, 33 states had implemented this option.[17]

Post-ACA

The ACA offers an important opportunity to improve this situation by requiring all states to provide continued Medicaid coverage for former foster youth to age 26.[18] This parallels the ACA provision allowing young adults to remain on a parent's health insurance policy to age 26, which has resulted in millions of additional young adults gaining private health insurance since it went into effect in 2010.[19, 20] In January 2013, HHS issued a proposed regulation to implement this ACA provision for former foster youth;[21] as of January 1, 2014 this regulation for former foster youth had not yet become final.

According to the proposed regulation, states must provide Medicaid coverage to individuals who are under age 26, are not otherwise eligible for and enrolled under Medicaid's mandatory categories, and were in foster care and enrolled in Medicaid when they reached age 18 (or a later age for aging out of foster care, as specified by their state). As written, the coverage would be limited to former foster youth applying for Medicaid in the state in which they had been in foster care. However, the proposed regulation would provide states with the option of offering the coverage to youth who had been in foster care in any state, but would not require them to do so. There are no financial eligibility ("income or resources") requirements for a former foster youth to qualify for this Medicaid coverage, and a former foster youth who meets the other requirements may apply at any time up to age 26. The Centers for Medicare and Medicaid Services has estimated that by 2017 an additional 74,000 former foster youth will be enrolled in Medicaid under this provision.[22]

Youth in Juvenile and Criminal Justice Systems

Highlights

Millions of adolescents and young adults in the United States have some contact with either the juvenile justice system or the criminal justice system. For some the contact is limited to an arrest, or a prosecution that leads to no conviction or to release on probation, but many are detained or incarcerated in juvenile or adult facilities for brief or prolonged periods of time. These youth experience high rates of numerous health concerns, especially mental health and substance abuse problems, and widely varying access to the health care they need. The implications of the ACA for this vulnerable population depend on the specifics of their individual circumstances and the state in which they live.

Demographics

In 2010, 1.6 million individuals under age 18 were arrested in the United States.[23] These youth include both juvenile delinquents who have committed offenses that would be crimes for adults and status offenders who have committed offenses "for children only," such as school truancy or running away from home. According to an FBI crime report, there were 2.8 million arrests of young adults ages 18-24 in 2011.[24]

The cases of most juveniles who are arrested do not go to trial, and most cases result in probation without incarceration or confinement.[25] Nevertheless, in 2010, there were over 70,000 juveniles ages 20 and younger in residential placements in the juvenile justice system, including such sites as detention centers, shelters, reception/diagnostic centers, group homes, and boot camps.[26] Juvenile males outnumber females almost seven to one in these residential placements.[26] Large numbers of young adults also are in federal or state prisons or local jails; in 2010, for example, 73,000 young adults ages 18-19 were incarcerated in one of these settings.[27] Minorities are vastly overrepresented, with African Americans making up 41% of juveniles in the residential placements and 39% of young adults ages 20-24 in state and federal prisons and local jails.[26, 27]

Adolescents and Young Adults in Juvenile Residential Placement by Race, 2011

	White	Black	Hispanic	Other	Total
12 or younger	41.6%	36.8%	14.0%	7.6%	100%
13-17	32.5%	39.9%	22.8%	4.8%	100%
18-20	15.6%	20.6%	11.5%	52.3%	100%
Total	28.3%	35.0%	19.9%	16.8%	100%

Adapted from "Easy Access to the Census of Juveniles in Residential Placement."[26] Note: Does not include juveniles or young adults held in adult jails or prisons.

Health Status

Adolescents entering the juvenile justice system who are detained or incarcerated generally have pre-existing health problems.[28 pp112-113] Mental health issues, including suicide, are of particular concern.[29, 30] An estimated 60-65% of adolescents in the juvenile justice system have a mental disorder, and among those with mental disorders, 20% of mental disorders are considered "serious."[31, 32] In addition, they may also experience problems associated with sexual activity, substance abuse, and violence at higher rates than their peers in the general population.[33] Although little information is available specific to the young adult population within the justice system, incarcerated adults generally experience many of the same health problems as youth in the juvenile justice system.[34] Additionally, HIV is a concern among adult inmates, with a prevalence rate higher than the general US population.[34]

Health Care Access

Health Care Access Highlights

Multiple factors determine access to health care for youth while they are in the juvenile and criminal justice systems and after they exit those systems. These include their individual socio-economic circumstances, which state they live in, and what part of the system they are involved in. Many young people involved in the juvenile and criminal justice systems are living in poverty or have very low family incomes. Responsibility for providing health care to detained or incarcerated adolescents and young adults rests mostly with the states and local communities in which the facilities are located, with significant variations in quality. Many youth involved in these systems are not confined in secure facilities, even if adjudicated or convicted. Some of these, who are living in non-secure residential placements or in the community on probation or parole, have Medicaid or private health insurance coverage, but many do not. In the future, the effects of the ACA for the poor and low-income youth involved the juvenile or criminal justice system will turn largely on whether or not they live in a state that implements the Medicaid expansion for adults ages 19 and older.

Pre-ACA

Some young people involved in the juvenile and criminal justice systems are eligible for (and may be enrolled in) Medicaid prior to their entry into the system based on their financial circumstances and other factors, but many – especially the young adults – are not.[35, 36] States have been required to cover children and adolescents through age 18 up to 100% of the federal poverty level (FPL), but young adults have been far less likely to qualify for Medicaid unless they were pregnant or disabled, due to extremely low Medicaid eligibility income thresholds for adults in most states prior to the ACA.[13]

Most of those who are enrolled in Medicaid lose their Medicaid coverage during incarceration due to a long-standing provision of Medicaid law. Federal law prohibits use of federal Medicaid funds to pay for services to "inmates of public institutions."[36, 37, 38] Despite this provision, several options exist for maintaining Medicaid eligibility for youth who are detained on only a temporary basis, or for making sure that their eligibility is reinstated immediately upon release.[35, 36, 39] Possibilities include suspending rather than terminating eligibility while a youth is in a public institution, using presumptive eligibility to allow services to begin immediately after a youth returns to the community while an application is being processed, and requiring case managers or probation officers to fill out Medicaid applications for youth leaving juvenile residential placements.[39]

If a youth is in temporary detention, Medicaid eligibility may be suspended rather than terminated, allowing coverage to resume upon exit from detention without renewed application and re-enrollment.[35] Many facilities and state and local authorities have not implemented policies to make this possible, however. Thus, many otherwise eligible youth have not been able to benefit from Medicaid coverage to receive health care services essential to treating their multiple physical and mental health problems. As states update their computer systems to facilitate compliance with the ACA, more states may adopt a policy of suspending rather than terminating Medicaid eligibility.

Consistent with these structural barriers to obtaining public or private insurance, research has demonstrated that these young people are medically underserved, and are less likely than other young people to have medical homes.[40] The National Center on Correctional Health Care has detailed standards for the provision of health care in juvenile facilities, and in adult jails and prisons.[41, 32, 43] However, youth confined in juvenile justice settings, in both short-term detention and longer-term correctional placements, and young adults in jails and prisons receive health care of widely varying quality and consistency.[44] This is true in spite of the fact that incarcerated individuals have a constitutional right to health care.[45] In a 2010 survey of youth in residential placement, two-thirds reported a need for health care, but more than one-third said they did not receive needed care.[46]

Post-ACA

Access to health insurance and necessary health care for young adults age 19 and older leaving the juvenile and criminal justice systems is likely to depend largely on whether they live in a state that chooses to implement the ACA Medicaid expansion, because so many are living in poverty or have very low incomes.[47] The ACA gives states the option of expanding Medicaid to most individuals under age 65 with incomes below 133% FPL. Medicaid eligibility for young adults age 19 and older who are involved in the criminal justice system will depend not only on whether they are incarcerated in a public institution but also on whether they live in a state that implements the Medicaid expansion.

Adolescents under age 19 will fare better than their older counterparts, even in states that do not expand Medicaid for adults, because the ACA requires all states to provide Medicaid coverage for all children and adolescents through age 18 up to 133% FPL beginning in 2014. Thus, young people under age 19 involved in the juvenile justice system will be eligible for Medicaid if their family incomes are below 133% FPL, as long as they are not confined in secure facilities that meet the definition of "public institution."

Both adolescents and young adults with incomes too high to qualify for Medicaid may be able to access health insurance either on a parent's employer-based policy (if they are under age 26) or through the policies available through the health insurance exchanges being implemented under the ACA. Subsidies may be available – in the form of premium tax credits for those with incomes between 100% and 400% FPL and cost-sharing assistance for those with incomes between 100% and 250% FPL – that make these policies more affordable. Agencies and facilities in the juvenile and criminal justice systems can play an important role in ensuring that eligible youth do not fall through the cracks but are enrolled in insurance coverage for which they are eligible, particularly as they are leaving those systems.[35, 48] Having health insurance in place so that health care appointments can proceed immediately following return to the community is vital for preventing recidivism, especially for young people with mental disorders and substance abuse problems.

Homeless Youth

Highlights

Homeless youth are among those most disconnected from social and adult support and thus are among the most vulnerable young people. The actual size of the homeless population is unknown. However, there is little doubt that many thousands of youth are homeless for either short or long periods of time; some of them are still minors, others are young adults. These young people experience very high rates of serious health problems and great difficulty accessing needed health care. Although the ACA theoretically could improve their health insurance coverage and access to care, many challenges will exist to make the promise a reality, particularly in states that do not expand Medicaid.

Demographics

The total number of adolescents and young adults who are homeless in the United States is difficult to estimate, and existing estimates vary widely. Whereas the foster care and juvenile justice systems are structured systems and better suited to accounting for the populations they serve, homelessness is unique in that its population consists of transient individuals who are underserved, and are not found or identified within any single system.

Unaccompanied Homeless Youth Under the Age of 18*		
Category	Percent	Estimated Number of Youth
Temporarily Disconnected	86%	327,000
Unstably Connected	8%	29,000
Chronically Disconnected	6%	24,000
Total	100%	380,000
*Adapted from "An Emerging Framework for Ending Unaccompanied Youth Homelessness."[49, 54] *Note: no date specified for year of estimates, but based on a 2011 study.*		

One estimate suggests that there are nearly 1.7 million unaccompanied homeless youth under age 18, with approximately 380,000 of these remaining homeless for more than one week, and about 130,000 for more than one month, with the remainder returning home quickly.[49] These homeless youth include those who have run away from home ("runaway youth") as well as those who have been forced out. Additional adolescents are homeless as part of a family, but not counted here. The number of homeless young adults ages 18-24 is even more difficult to estimate, and reliable estimates are not available. These young people share many characteristics and health care needs with their younger counterparts.[49] One 2013 report identified more than 61,000 homeless young adults ages 18-24 who were either single or parents of at least one child.[50]

Of note are the different minority populations among the homeless, and the specific challenges they face. A 23-city survey estimated that 42% of the general homeless population is African American, 39% is white, 13% is Hispanic, 4% is Native-American, and 2% is Asian.[51] Another important minority population is LGBT youth, or lesbian, gay, bisexual, and transgender persons. Studies estimate that nearly 40% of homeless youth are LGBT.[52, 53]

Unaccompanied Homeless Single Young Adults Ages 18-24*		
Category	Percent	Estimated Number of Young Adults
Transitional	81%	122,000
Episodic	9%	13,000
Chronic	10%	15,000
Total	100%	150,000
*Adapted From "An Emerging Framework for Ending Unaccompanied Youth Homelessness."[49, 54] *Note: no date specified for year of estimates, but based on a 2011 study.*		

Substantial variations exist among those who remain homeless for more than one week: some are "low-risk" and "transient" youth who retain relationships with their families; others are "high-risk" youth who have highly unstable or nonexistent family ties.[49] Factors contributing to homelessness among adolescents include sexual orientation other than heterosexual and a history of foster care placement and school expulsion.[55] A major longitudinal study found that by age 19, 13.8% of youth reported ever being homeless after leaving foster care, and by age 23-24, as many as 36.5% of former foster youth have reported being homeless or "couch surfing" after leaving foster care.[14, 56]

Health Status

Homeless and runaway youth generally lack primary health care and may have increased health problems because of factors that influenced their being homeless as well as the increased risk and exposure that result from living on the street.[57] Consequently they have extensive health care needs, which are insufficiently met.[58, 59] The health problems they experience are similar to those affecting youth in foster care and juvenile justice settings. These problems are often exacerbated by their living conditions, with exposure to the elements and limited sanitation. Areas of particular concern for

homeless youth include physical and sexual abuse and exploitation, sexual activity, drug and alcohol use, and mental health problems.[28 pp99-105]

Homeless youth face special challenges in sexual and reproductive health, as they often have been sexually abused,[60, 61, 62] initiate sexual activity earlier than the general population, and exhibit sexual risk behaviors.[63, 64] They are at increased risk for being sexually exploited and trafficked.[55] Nine percent of runaway youth in a non-random sample of over 1600 youth reported engaging in survival sex (the exchange of sex for food, shelter, or other necessities) at some point in their lives.[65] A large national study found that 28% of youth living on the street and 10% of youth living in shelters engaged in survival sex.[66]

Health Care Access

Health Care Access Highlights

Homeless youth experience multiple obstacles in securing necessary health care. The transient status of those who are homeless for extended periods of time makes it difficult for them to establish a relationship with a usual source of care and complicates the process of enrolling in Medicaid or securing other health insurance. Similar to young people involved in the juvenile or criminal justice system, homeless youth are heavily dependent on Medicaid as a potential source of health insurance, and many have remained uninsured. The ACA could change that but is likely to do so only in states that opt to expand Medicaid.

Pre-ACA

Although reliable data are not available, a strong likelihood exists that many, perhaps most, homeless youth are uninsured, especially if they are disconnected from families for prolonged periods of time. In the past, youth who are away from home for only a few days have been in a similar position to other adolescents living at home: eligible for Medicaid if family income is below 100% FPL (or a higher limit set by their state) and they are age 18 or younger; otherwise they might be covered on a family's employer-based policy. Most homeless youth disconnected from their families – both adolescents and young adults – would be financially eligible for Medicaid, even under the very low income thresholds prevalent in many states for single adults. However, many obstacles exist that have made it difficult for them to enroll even if eligible, especially if they are unaccompanied minors.[59] These barriers include complex application and enrollment procedures that include requirements for a parent's signature and documentation of parents' income in the case of minors, as well as a permanent address for contacting an applicant of any age.[59] Allowing a signed declaration in lieu of other documentation of such matters as age, residency, family composition, and income could facilitate the process significantly.[59] The difficulties associated with enrolling in Medicaid have meant that many homeless youth have relied on emergency rooms or sites offering free care funded by such programs as Health Care for the Homeless to obtain whatever health care they were able to access.[59]

Post-ACA

Whether the ACA helps homeless young adults join the ranks of those with health insurance will depend to a great degree on whether they are in a state that has chosen to expand Medicaid up to 133% FPL. Homeless adolescents under age 19 will be eligible in every state up to 133% FPL beginning in 2014. Also important – both for homeless adolescents and young adults – will be whether the application and enrollment obstacles that have stood in the way in the past are removed. Even though some homeless young adults are employed, the vast majority have very low incomes or none at all and would almost certainly be eligible for Medicaid in states that implement the Medicaid expansion for individuals with incomes up to 133% FPL. Even in the states that do not, and continue to have very low eligibility levels for single adults in Medicaid, homeless young adults might be able to qualify. But either way, the application and enrollment procedures, particularly the requirement of a permanent address, as well as documentation requirements, can still stand in the way of securing coverage. In addition, many homeless youth will not have any means of knowing what they are eligible for and how to go about applying for it. As discussed below, the ACA requires states to conduct outreach in Medicaid to vulnerable populations and also to have streamlined application procedures, both of which might be helpful to homeless youth.[67, 68, 69] One obstacle that has been a problem in some states for homeless youth under age 18 is that they have not been able to apply independently of a parent. Recently, however, the federal agency responsible for Medicaid has made clear that in any state where an unaccompanied homeless youth is too young under state rules to file a Medicaid application, any responsible adult (not necessarily a parent or guardian) may do so on behalf of the youth.[70]

Common Themes and Major Challenges

Review of the health status, health care access, and health insurance coverage of youth in and aging out of foster care, youth involved in the juvenile and criminal justice systems, and homeless youth identifies numerous common themes among the three populations, both pre- and post-ACA implementation. It also serves as a stark illustration that many important challenges must be overcome to ensure that as many of these vulnerable young people as possible have health insurance coverage and improved health care access as the ACA is implemented.

Common Themes

The demographic characteristics, health status, health care access, and health insurance coverage of the three vulnerable groups of young people discussed in this issue brief are characterized by many common themes. Several of the most salient are:

- *Significant overlap and intersection among the three groups.* Many youth become homeless or are arrested after exiting foster care. Many foster youth are at risk for being arrested as juveniles. Many youth who are arrested and processed through the juvenile justice system are placed in foster care facilities such as group homes or residential treatment center. Many homeless youth were either in foster care or have been arrested or involved in the juvenile or criminal justice system.

- *Overrepresentation of racial and ethnic minorities.* Without exception, all three vulnerable populations comprise members of racial and ethnic minority groups at disproportionately high rates, with African American young people especially heavily represented among all three populations.

- *Higher rates of serious health problems than the general population.* The three groups' health problems extend across the full spectrum of health concerns of adolescents and young adults, but mental health, substance abuse, and sexual health issues are of particular concern.

- *High rates of being uninsured and heavy reliance on Medicaid.* With the exception of adolescents in foster care, who are mostly covered by Medicaid, substantial proportions of young people in these vulnerable groups are either uninsured at high rates, sometimes approaching 50%, or are at high risk for losing insurance. All are more likely to secure health insurance coverage through Medicaid than private health insurance.

- *Disconnection from familial, adult, and social support.* Many of the vulnerable youth in all three groups, especially those who are homeless, are seriously lacking in connections to and support from parents, family members, other adults, and social institutions. Even those with a connection to the child welfare or juvenile or criminal justice system often lack meaningful supportive adult connections.

Major Challenges

Although numerous challenges impede access to health care and health insurance coverage for youth exiting foster care, youth involved in the juvenile or criminal justice system, and homeless youth, two areas of challenge are particularly critical: Medicaid eligibility and expansion; and outreach and enrollment procedures.

Medicaid Eligibility and Expansion

As originally enacted, the ACA would have required all states to expand Medicaid coverage for all individuals under age 65 who are citizens or long term legal residents, are not pregnant or disabled, and whose incomes are below 133% FPL. In June 2012, the Supreme Court decided that states were not required to expand Medicaid in this way, but have the option of doing so.[12] As of December 11, 2013, 25 states and the District of Columbia had decided to implement the option in 2014, and 25 states were not moving forward at this time, although two of those are seeking to implement the option after 2014.[71]

The implications for vulnerable groups of young people in states that choose not to implement the ACA Medicaid expansion will be severe. Among the states that are not expanding Medicaid, all but one do not offer any Medicaid coverage to single adults unless they are pregnant, parents of dependent children, or have a disability, with the exception of some extremely limited coverage through a waiver in a small handful of states.[72, 73, 74] Even young adults who are parents of dependent children do not fare well in the states not expanding Medicaid: the median income eligibility level for parents of dependent children is 47% FPL (e.g., less than $10,000 per year in a family of three).[74] Comparison of the states that have decided to expand Medicaid with those that have not indicates that states not moving forward with expansion have more limited Medicaid eligibility than those moving forward, leaving large coverage gaps that will affect millions of individuals who are disproportionately people of color.[75, 76]

The failure of states to expand Medicaid eligibility has seriously adverse implications for young adults involved in the criminal justice system and for homeless young adults. These

two groups are very unlikely to have access either to employer-based health insurance or to individual policies through the health insurance exchanges. Homeless young adults are unemployed at extremely high rates[77] and have little or no income with which to purchase health insurance. Young adults who have been involved in the criminal justice system similarly have great difficulty gaining employment[78] and thus have very limited ability to purchase health insurance, unless they have the possibility of being on a parent's policy. Further, the lowest-income young adults in states not expanding Medicaid – those with incomes under 100% FPL – will not be eligible for subsidies in the health insurance exchanges. Thus, in half the states, these two vulnerable groups are likely to fall between the cracks and unlikely to gain health insurance as a result of the ACA. This consequence provides an additional important reason for states to expand Medicaid as, without insurance, these young people are likely to seek care from emergency rooms and local sources of free care, which place additional burdens on state and local budgets.

Outreach and Enrollment

These three groups of vulnerable youth may be eligible for Medicaid in several circumstances: for young adults ages 19 and older in states that are moving forward with the Medicaid expansion; in all states for youth up through age 18 up to 133% FPL; and for youth aging out of foster care up to age 26. Even for the youth who are eligible, the complexities associated with enrolling in Medicaid may prevent some from gaining coverage. Under the current proposed regulation, youth exiting foster care may not be eligible for Medicaid if they were not in care and enrolled on their 18th birthday, or if they move to a state other than the one where they were in care. Even if eligible, former foster youth may not know about their Medicaid eligibility or how to enroll. The same may be true for all of the other vulnerable youth who are eligible for Medicaid, either currently, or once the ACA is implemented.

The ACA includes two requirements that could be important in this regard. First, states are required to "…conduct outreach to and enroll in Medicaid/CHIP vulnerable and underserved populations, including unaccompanied homeless youth . . .."[67] Also, states are required to have streamlined application procedures.[68] In addition, agencies that have contact with these young people – including child welfare agencies, juvenile justice agencies, adult jails and prisons, homeless shelters, and other agencies serving homeless people – could easily establish procedures to help overcome the barriers and streamline the application and enrollment process.

Conclusion

The ACA offers both the promise of important benefits and the risk of continued disadvantage for three populations of vulnerable youth. Most youth in and aging out of foster care will be eligible for Medicaid up to age 26. Many young people involved in the juvenile justice system will also be eligible for Medicaid, at least up to age 19, unless they are confined in public institutions; but young adults involved in the criminal justice system will only qualify for Medicaid if their state implements the Medicaid expansion option. Homeless youth under age 19 are likely to be financially eligible for Medicaid but may encounter significant obstacles in the application and enrollment process. Homeless young adults, like those involved in the justice system, are likely to have insurance coverage only in states that expand Medicaid. Young people in any of the three groups who are not eligible for Medicaid can qualify for subsidies to purchase coverage through the exchanges if their incomes are at least 100% FPL; otherwise they will have no option available to them. Ensuring that vulnerable populations of young people benefit from the full promise of the ACA will depend on providing assistance to individuals to secure health insurance they are eligible for as well as advocacy to promote policies that will allow them to gain the coverage they need.

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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.

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The National Adolescent and Young Adult Health Information Center (NAHIC) was first established as the National Adolescent Health Information Center in 1993 with funding from the Maternal and Child Health Bureau. The overall goal of NAHIC is to improve the health of adolescents and young adults 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, NAHIC 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

English A, Scott J, Park MJ. Implementing the Affordable Care Act: How Much Will It Help Vulnerable Adolescents and Young Adults? Chapel Hill, NC: Center for Adolescent Health & the Law; and San Francisco, CA: National Adolescent and Young Adult Health Information Center, 2014.

Past Issue Briefs in This Series

English A, Park MJ. The Supreme Court ACA Decision: What Happens Now for Adolescents and Young Adults. Chapel Hill, NC: Center for Adolescent Health & the Law; and San Francisco, CA: National Adolescent and Young Adult Health Information Center, 2012.

English A, Park MJ. Access to Health Care for Young Adults: The Affordable Care Act is Making a Difference. Chapel Hill, NC: Center for Adolescent Health & the Law; and San Francisco, CA: National Adolescent Health Information and Innovation Center, 2012.

English A. The Patient Protection and Affordable Care Act of 2010: How Does It Help Adolescents and Young Adults. Chapel Hill, NC: Center for Adolescent Health & the Law; and San Francisco, CA: National Adolescent Health Information and Innovation Center, 2010.

Acknowledgments

The authors gratefully acknowledge the contributions of their colleagues Claire D. Brindis and Charles E. Irwin, Jr. at NAHIC, and Trina Anglin at the Maternal and Child Health Bureau for their thoughtful review of this brief.

Support

Support for the preparation of this document was provided in part by funding from the Maternal and Child Health Bureau, Health Resources and Services Administration, U.S. Department of Health and Human Services (U45MC 00002 and U45MC 00023). Additional support was provided by the Brush Foundation and by individual donors to the Center for Adolescent Health & the Law.

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