Health Insurance for Older Adolescents and Young Adults: Policy Options to Expand Coverage

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Health Status

Adolescents and young adults are generally perceived to be healthy. Nevertheless, they have numerous health concerns including injuries, homicide, suicide, mental and emotional illness, substance use, poor nutrition, eating disorders, dental problems, pregnancy, sexually transmitted infections (STIs), HIV, and chronic illnesses and disabilities.

Health Care Needs

To address these concerns, adolescents and young adults require access to comprehensive health assessments and treatment of identified conditions; immunizations; family planning and other reproductive health services; pregnancy related care; STI and HIV testing and treatment; dental examinations and treatment; substance abuse assessment, counseling, and treatment; treatment for acute and chronic illnesses and conditions; and case management and coordination of care.

Key Policy Issues

Understanding health insurance coverage for older adolescents and young adults involves several interrelated policy questions:

- To what extent do older adolescents and young adults lack health insurance?
- Who is covered under existing public and private health insurance?
- What are the options for extending coverage to those who are uninsured?
- What obstacles might prevent expanding health insurance for this age group?

Health Insurance Status of Older Adolescents and Young Adults

In August 2005, the U.S. Census Bureau released its most recent figures showing that the number of uninsured reached nearly 46 million in 2004, 15.7% of the population.[5] These numbers would be even higher if they included all individuals who were uninsured at any time during the year.[15, 17]

Older adolescents and young adults are among those most likely to lack health insurance coverage, private or public. Those who are living in poverty or members of racial or ethnic minority groups are even more likely to be uninsured.

Older adolescents are at significantly greater risk than younger adolescents for going without health insurance, with 13.7% of 15-18 year olds uninsured in 2002, compared with 11% of 10-14 year olds.[14] Young adults are in even worse straits than older adolescents. The Robert Wood Johnson Foundation reported that in 2002 nearly 34% of young adults ages 21-24 were uninsured.[4] The U.S. Census Bureau reported for 2004 that 31.4% of those ages 18-24 were without insurance: 8.8 million young adults.[5] An estimate published in 2004 suggested that nearly two-thirds of young adults ages 19-23 are likely to lack insurance at some point during the next four years.[3]

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Race and ethnicity play a major role both for adolescents and for the population as a whole. In 2002, 27.7% of Hispanic, 12% of Black, and 8.4% of White adolescents ages 10-18 were uninsured.[14] In 2004, for all age groups, 32.7% of Hispanics, 19.7% of Blacks, 16.8% of Asians, and 11.3% of Non-Hispanic Whites were uninsured.[5] Once again the risks for young adults who are members of racial or ethnic minority groups are substantial. For example, three-fourths of Hispanic 19-23 year olds were uninsured at some time during 1996-2000 and half were uninsured for 13 months or more during that time.[3]

Income is also highly significant for adolescents and young adults. In 2002, 19.7% of adolescents ages 10-18 with family incomes below 100% FPL, 19.2% with family incomes between 100% and 200%, and only 6.3% with family incomes at or above 200% FPL were uninsured.[14] In 2004, 44.7% of young adults ages 18-24 who were living in poverty and 22.9% of poor adolescents ages 12-17 lacked insurance.[20]

There is no doubt at the present time that the age group most affected is the young adult population. There are numerous reasons for this, which affect all income categories, although young adults living in poverty are most vulnerable. In the private insurance arena, most employers who offer dependent coverage do not extend it beyond age 18 or 19 unless the young person is in college full time.[3] In the public insurance world, Medicaid and State Children's Health Insurance Program (SCHIP) coverage is usually lost at age 19, unless the young person is pregnant, a parent, or disabled. Overall, reaching the 19th birthday and high school or college graduation often lead to uninsurance: 3 in 10 high school graduates, and half of those who do not go to college, are uninsured at some time during the year following high school graduation.[3] The reasons why older adolescents and young adults lack health insurance must inform the policy options for how to address this problem.

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Current Health Insurance Coverage of Older Adolescents and Young Adults

Although older adolescents are worse off than younger adolescents and young children, they have fared better under existing policies than young adults. In particular the expansion of health insurance coverage for older adolescents in Medicaid and SCHIP since the late 1990s has made a significant difference for this age group.[13]

Overall the role of government health insurance programs such as Medicaid and SCHIP has been an increasingly important one.[14] Between 2003 and 2004, employer-based coverage continued to shrink, while public health insurance coverage increased, largely in Medicaid.[5] Nevertheless, older adolescents have benefited from this more than young adults, although not as much as younger children. In 2004, 24.6% of adolescents ages 12-17 were covered by a government insurance plan, but only 14.4% of young adults ages 18-24 had government health insurance.[19]

Significant numbers of older adolescents remain eligible for, but not enrolled in, Medicaid and SCHIP

Medicaid and SCHIP have provided a significant benefit to older adolescents by increasing the proportion of this age group who are eligible for the programs and who are actually enrolled in them.[13] For example, between 1997 and 2001, the number of states that provided Medicaid coverage for all poor adolescents under age 19 doubled from 23 to 46.[13] In addition, some especially vulnerable young people have benefited from optional coverage through Medicaid: such as the option to cover very low income 18-20 year olds who would have qualified for AFDC welfare under 1996 rules; or the option enacted by Congress in 1999 for states to provide Medicaid coverage for young people aging out of foster care at age 18.[6] Nevertheless, significant numbers of older adolescents remain eligible for, but not enrolled in, Medicaid and SCHIP.[13] Although adolescent-specific data is lacking, it was estimated that, in 2002, 70% of uninsured children and adolescents ages 0-18 were eligible for but not enrolled in Medicaid or SCHIP.[1]

Options for Extending Coverage to Uninsured Older Adolescents and Young Adults

Numerous options exist for reducing or eliminating the number of older adolescents and young adults who lack health insurance. These include:

- Adopting policies to achieve universal health insurance coverage for the entire population.
- Providing a mechanism for universal coverage for children, adolescents, and young adults.
- Making sure that all who are eligible for Medicaid and SCHIP are enrolled.
- Expanding eligibility in Medicaid and SCHIP to cover young adults.
- Increasing the upper age limit for dependent coverage in private insurance.
- Increasing the likelihood that students in colleges and universities have health insurance.

Universal health insurance coverage for all age groups has proved elusive at the federal and state levels. Some states have proposed or begun to implement policies that would move in that direction. So far, however, none stands out as particularly successful in reducing the number of uninsured older adolescents and young adults.

Federal legislation has been introduced that would provide coverage for all children and adolescents to age 23. Known as MediKids, and supported by the American Academy of Pediatrics, this legislation is designed to ensure that all children, adolescents, and young adults would be enrolled in a public or private health insurance plan from birth until age 23. MediKids has been introduced in Congress but not enacted.[12] State states have also adopted policies designed to reduce or eliminate the number of uninsured children and adolescents.

One specific proposal targeting low-income young adults has been introduced, although not enacted, in the 109th Congress: the Health Care for Young Adults Act of 2005.[9] This legislation would permit states to cover low-income youth up to age 23 in Medicaid and SCHIP, with an enhanced federal matching rate offered as an incentive to implement the option. Recent estimates have suggested that extending Medicaid and SCHIP could cover 2.7 million uninsured adults ages 19-23 with incomes under 100% FPL.[3]

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A few targeted initiatives to insure young adults have already been implemented in the public and private sectors. Although the cost of such initiatives is not readily available, estimates have suggested that annual per capita expenditures for 19-23 year olds is $1,468, the lowest of any age group.[3]

One way of targeting coverage is to ensure that in employer-based plans coverage for dependents is extended to a higher age limit. Another is to eliminate the restriction, common in many policies, that limits coverage for dependents over age 18 to only those who are in college full time. The Federal Employee Health Benefit Program offers dependent coverage for all unmarried dependents under age 22;[8] and at least one state, Utah, has a state mandate that when dependent coverage is offered in private health insurance policies it must be available for unmarried dependents under age 26.[21] Estimates have suggested that extending eligibility for dependent coverage to age 23 could result in covering 800,000 unmarried dependent young adults, with an average rise in premiums of 3% to 5%.[3] Measures to ensure coverage for college and university students could cover up to 2 million uninsured part and full time students who are currently uninsured.[3]

Another very different approach that has appeared in the private sector is TONIK, a group of health plans offered by Blue Cross of California, which are designed for young adults and offer low monthly premiums, limited benefits, and high deductibles. The TONIK plans have names like "thrill-seeker," "part-time daredevil," and "calculated risk-taker," and the premiums start at $69 per month.[18]

Most relevant for low-income young adults is a city and county funded initiative recently implemented as a pilot program in San Francisco. The San Francisco Health Plan is offering comprehensive coverage for low-income young adults ages 19-24 who are not covered by employer-based insurance and are not eligible for Medi-Cal, California's Medicaid program. Unable initially to cover all 27,000 uninsured young adults in San Francisco or even all 14,000 low-income uninsured young adults, the program has begun offering coverage to two groups of low-income uninsured adults ages 19-24: those who are aging out of California's Medi-Cal or SCHIP programs or San Francisco's Healthy Kids program; and those who are parents of a child enrolled in Medi-Cal, SCHIP, or Healthy Kids. The San Francisco plan covers legal and undocumented immigrants as well as U.S. citizens.[16]

Obstacles to Expanding Health Insurance for Older Adolescents and Young Adults

Many obstacles must be overcome to achieve meaningful expansion or ensure continuation of existing health insurance coverage for older adolescents and young adults. Of great significance is the fiscal situation at both the federal and state levels. In addition, the current burden that health care costs represent for employers will make them reluctant to implement expansions that represent added costs. A major threat to Medicaid is that the program might be restructured as a block grant, which would do away with the entitlement feature of Medicaid that has provided very important protection for adolescents, especially by guaranteeing access to the EPSDT benefit package. Finally, recent changes made to Medicaid, and other changes being proposed and discussed for both Medicaid and SCHIP, not only could hamper the expansion of those programs to encompass young adults but also could undermine their integrity in ways that would threaten the gains that have been made for older adolescents over the past several years.

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State fiscal crises have led states to modify their Medicaid and SCHIP programs over the past few years, by limiting eligibility, benefits, and provider reimbursement, as well as increasing cost sharing.[7] At least six states (AL, CO, FL, MD, MT, UT) enacted or continued enrollment caps in their SCHIP programs in 2004.[2] Even more radical plans to transform Medicaid have been proposed in some states (e.g., FL).[11] Several states have used Health Insurance Flexibility and Accountability (HIFA) waivers to significantly change the makeup of their Medicaid and SCHIP programs for certain groups.[2] Although these HIFA waivers can be, and in some cases have been, used to extend coverage to new groups (e.g., very low income childless adults ages 18-64 <35% FPL in WA), they also allow states to restrict eligibility and benefits and increase cost sharing for others.[2]

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Recent budget activity at the federal level has also threatened the ongoing capacity of Medicaid and SCHIP to meet the needs of low-income older adolescents and young adults. Although Congress did not fully accede to the deep cuts in the federal budget for health programs, including Medicaid, that were proposed by the President in 2005, and may not do so in 2006, it has nevertheless acted to modify the Medicaid program in ways that could harm older adolescents and young adults. Recently, Congress enacted and the President signed the Deficit Reduction Act of 2005(DRA). The DRA permits states to modify their Medicaid programs in two ways of great significance for beneficiaries, particularly adolescents and young adults. First, the DRA allows states to reduce benefits; and second, the DRA allows states to increase cost sharing for beneficiaries.[8a,10] Both approaches, if implemented by the states, would restrict access to essential services for adolescents and young adults.

Conclusion

Reaching more of the uninsured population of older adolescents and young adults is a logical next step after the gains that have been made in health insurance for children and adolescents over the past several years. However, taking this step will require significant effort by health care professionals and advocates and significant political will on the part of policy makers. Particularly in the current environment with the obvious concerns about federal deficits, state budgets, and escalating health care costs, this task presents a major challenge. Policies that would meet that challenge have already been proposed. The task now is to be sure that they are implemented.

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Suggested Citation

English A. *Health Insurance for Older Adolescents and Young Adults: Policy Options to Expand Coverage*. Chapel Hill, NC: Center for Adolescent Health & the Law, June 2006.

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Additional Resources

For a policy issue brief on a related topic, see English A, Stinnett AJ, Dunn-Georgiou E. *Health Care for Adolescents and Young Adults Leaving Foster Care: Policy Options for Improving Access*. Chapel Hill, NC: Center for Adolescent Health & the Law, February 2006. www.cahl.org/FCIssueBrief.htm.

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Support

Support for the preparation of this document was provided in part by the William T. Grant Foundation, the California Wellness Foundation, and the Ittleson Foundation. The views expressed are those of the author alone.