



OCTOBER 2010

Realizing Health Reform's Potential: *Young Adults and the Affordable Care Act of 2010*

SARA R. COLLINS AND JENNIFER L. NICHOLSON
THE COMMONWEALTH FUND

The mission of The Commonwealth Fund is to promote a high performance health care system. The Fund carries out this mandate by supporting independent research on health care issues and making grants to improve health care practice and policy. Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and not necessarily those of The Commonwealth Fund or its directors, officers, or staff.

For more information about this study, please contact:

Sara R. Collins, Ph.D.
Vice President for Affordable Health Insurance
The Commonwealth Fund
src@cmwf.org

To learn more about new publications when they become available, visit the Fund's Web site and [register to receive e-mail alerts](#).

Commonwealth Fund pub. 1446
Vol. 101

Abstract: The Patient Protection and Affordable Care Act includes several provisions that promise to stem the rapidly rising tide of uninsured young adults, one of the largest uninsured segments of the population. These include the ability to enroll in a parent's health plan up to age 26, beginning in September 2010; significant expansion in eligibility for Medicaid, beginning in 2014; and the creation of health insurance exchanges with subsidized private insurance for people with low and moderate incomes, also beginning in 2014. Of the 14.8 million uninsured young adults, up to 12.1 million may gain subsidized insurance once all the law's provisions go into effect in 2014: 7.2 million may gain coverage under Medicaid and 4.9 million may gain subsidized private coverage through the insurance exchanges. In addition, about 1 million uninsured young adults are expected to join their parents' policies over the next three years.



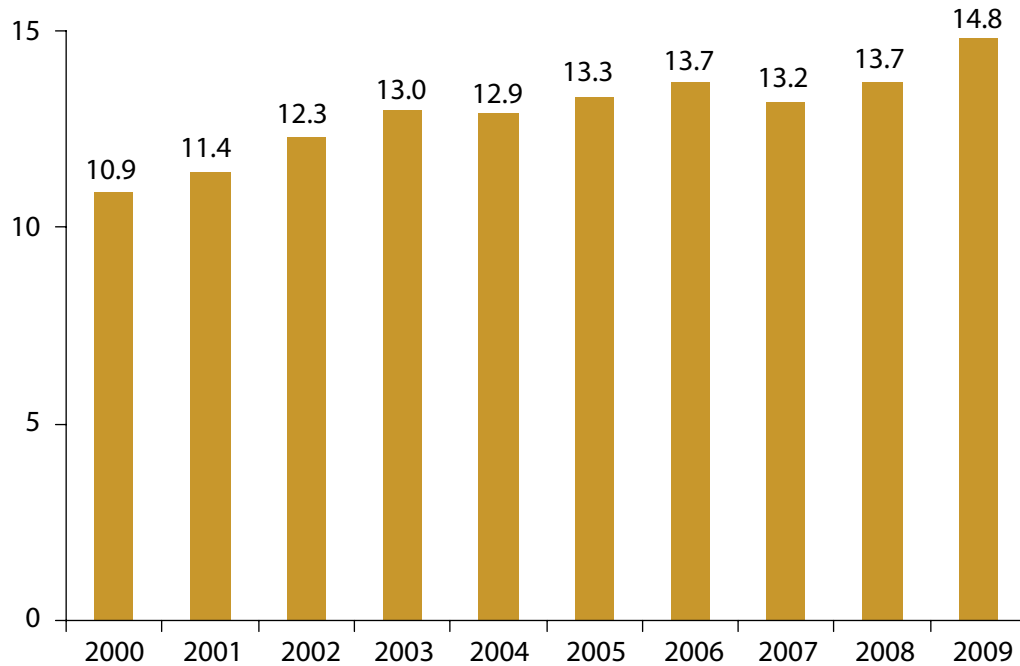
BACKGROUND

The number of uninsured young adults, ages 19 to 29, climbed to 14.8 million in 2009, an increase of more than 1 million over the prior year (Exhibit 1). These individuals represent one of the largest segments of the U.S. population without health insurance.¹ An additional 5 million insured young adults have such high out-of-pocket costs that they are effectively underinsured.² Insecurity is likely to have persisted into 2010, with unemployment soaring in this age group over the past year. As of August 2010, 14.9 percent of 20-to-24-year-olds were unemployed; certainly, many of these unemployed young adults are also uninsured.³

The high rates of uninsurance among young adults are linked to a loss of health insurance at two critical transition points: 19th birthdays or graduation from high school, and graduation from college. Young adults covered as dependents on their parents' employer policies often lose eligibility at age 19, particularly if they do not go on to college.⁴ The Commonwealth Fund Survey of Young Adults found that in 2009, of the young adults who were covered as dependents on their parents' employer plans during high school, 42 percent either lost or

Exhibit 1. 14.8 Million Uninsured Young Adults in 2009, Up by 1.1 Million in Past Year

Millions uninsured, adults ages 19–29



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.

switched coverage upon leaving or graduating from school (Exhibit 2). Of those with a gap in coverage, 23 percent went without insurance from one to two years, and 46 percent were uninsured for two years or more.

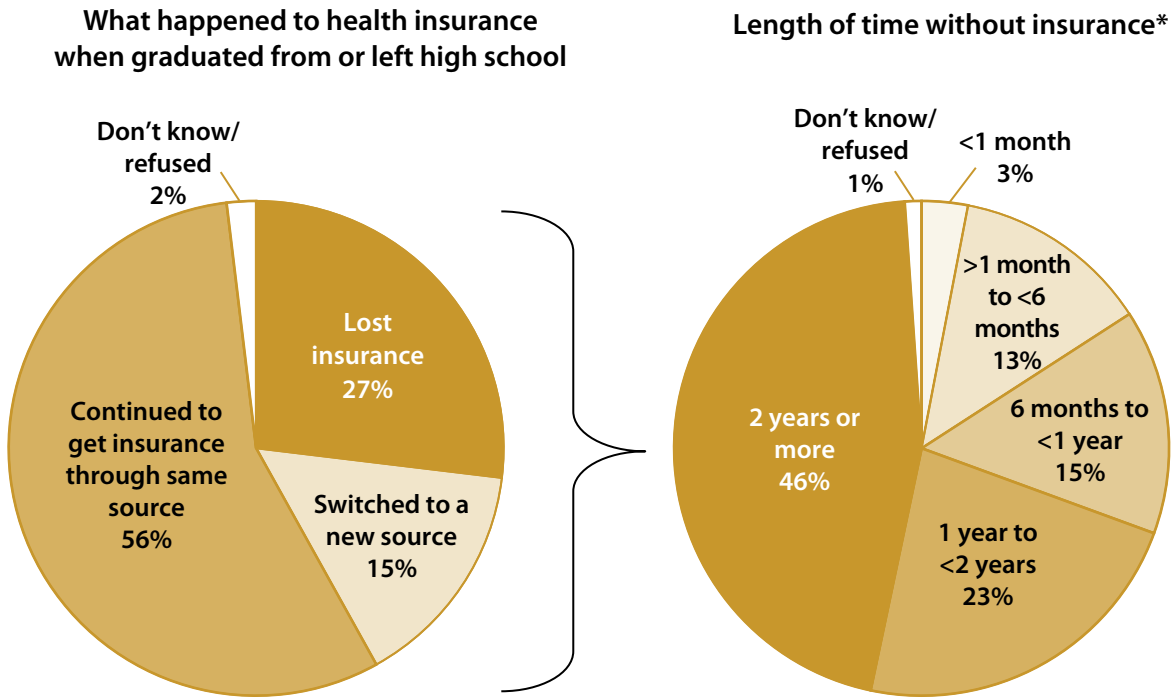
Similarly, Medicaid and the Children’s Health Insurance Program (CHIP) reclassify all teenagers as adults when they turn 19. As a result, a young adult who had been insured under Medicaid or CHIP generally does not have the option to stay covered unless he or she is able to qualify for Medicaid as an adult. In most states, eligibility for adults is generally restricted to very-low-income parents or disabled adults; therefore, most low-income young adults become ineligible for public programs. For this reason, many more poor young adults are uninsured than are children in low-income families (Exhibit 3).

Full-time college students are more likely to have health insurance than either nonstudents or part-time students, mainly because they can maintain coverage under their parents’ plans. But upon graduation, they confront challenges similar

to those facing high school graduates: difficulty in finding employment, health insurance waiting periods, temporary positions, lower-wage jobs, employment in small firms, and job turnover. All of these factors increase the risk that a young adult who leaves or graduates from college will go without health insurance. The 2009 Commonwealth Fund Survey of Young Adults found that among young adults who were covered under their parents’ employer plans during college, 75 percent either lost or switched coverage after college (Exhibit 4). Of those with a gap in coverage, 37 percent went without coverage for more than one year.

Despite the fact that young adults are generally healthy, going without health insurance—as so many young adults do—can have substantial health and financial consequences. For example, the 2009 Commonwealth Fund Survey of Young Adults found that more than three-quarters (76%) of young adults who were uninsured reported not getting needed care because of cost, more than twice the rate (37%)

Exhibit 2. Four of 10 Young Adults Who Had Insurance Through Their Parents' 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).

of young adults with coverage all year.⁵ In addition, an estimated 11.3 million young adults, both insured and uninsured, said they were paying off medical debt. Of those, 50 percent had asked parents or other family members for financial help, 31 percent delayed education or career plans, and 39 percent were unable to meet other debt obligations, such as school loans, because of their debt loads.

HOW WILL YOUNG ADULTS GAIN COVERAGE UNDER THE AFFORDABLE CARE ACT?

The newly enacted Patient Protection and Affordable Care Act of 2010 (ACA) promises to significantly reduce the number of uninsured young adults. There are several ways in which the legislation will help:

- by granting young adults the ability to remain on parents' health plans up to age 26, beginning September 2010;

- by instituting new insurance market regulations, including a ban of lifetime limits on insurance policies and offering new preexisting condition insurance plans, beginning in 2010;
- by significantly expanding Medicaid eligibility to cover all adults with incomes below 133 percent of the federal poverty level, beginning in 2014;
- by creating new state health insurance exchanges with subsidized private insurance for people with low and moderate incomes up to 400 percent of poverty, beginning in 2014; and
- by imposing shared responsibility payments for large employers that do not offer coverage or offer poor coverage (Exhibit 5).

Exhibit 3. Nineteenth Birthdays Are Critical Turning Points in Coverage for Young Adults

Percent uninsured	Children, age 18 and under	Young adults, ages 19–29
Total	10%	32%
<100% FPL	16	52
100%–199% FPL	14	42
≥200% FPL	7	17

Source: Analysis of the March 2010 Current Population Survey by N. Tilipman and B. Sampat of Columbia University for The Commonwealth Fund.

Of the 14.8 million young adults who were uninsured in 2010, 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 poverty would gain coverage under Medicaid and 4.9 million earning less than 400 percent of poverty would gain subsidized private coverage through the insurance exchanges (Exhibit 6). In addition, about 1 million young adults with incomes over 400 percent of poverty are expected to join their parents’ policies over the next 10 years. About 1.8 million are undocumented immigrants and would not be eligible for Medicaid or coverage through the insurance exchanges.⁶ The provisions of the law that will benefit young adults are analyzed in order of implementation.

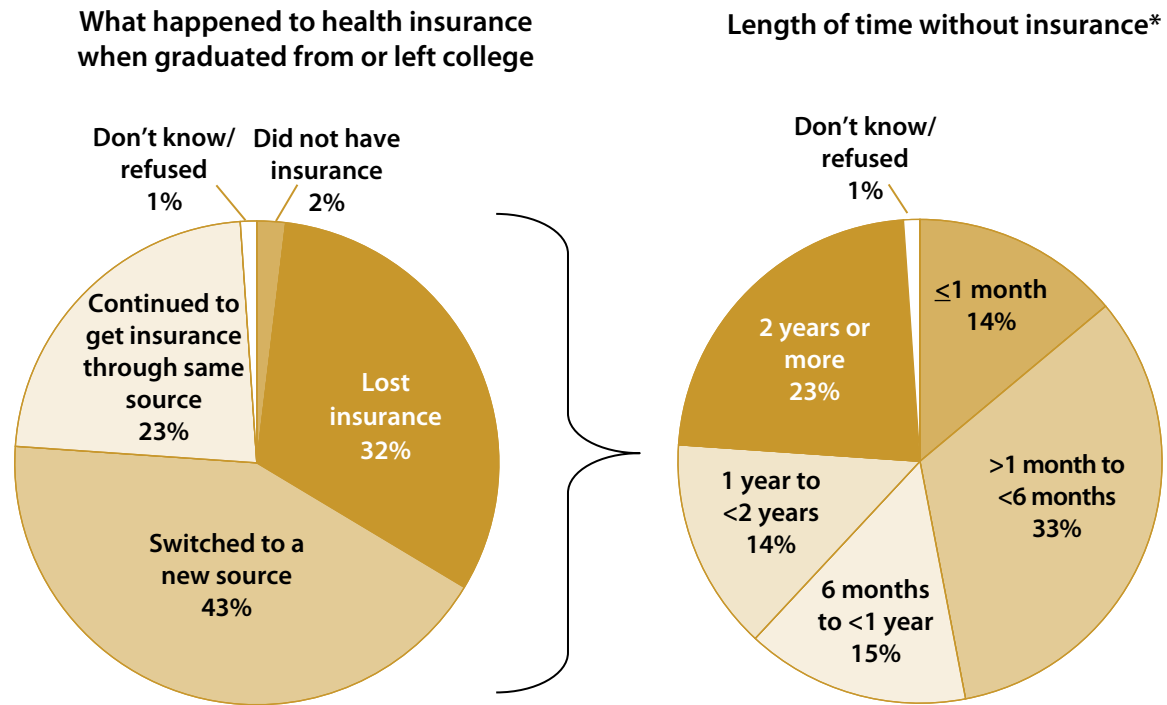
2010: Young Adults Can Remain on Parents’ Insurance Until Age 26

The major effects of the Affordable Care Act on young adult coverage will occur in 2014 and later, when the central insurance reforms go into effect. But beginning in September 2010, the legislation provides important transitional relief to many young adults and their families. The law requires 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.⁷ 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 self-insured (i.e., employers pay benefits directly to employees) or fully insured (i.e., employers purchase health insurance for employees from an insurance company). It will also include insurance plans that parents purchase on the individual insurance market. It applies to new health plans and so-called “grandfathered” health plans (i.e., those in existence when the ACA was signed into law in March 2010).⁸ There is one restriction: prior to 2014, young adults may only be covered by their parents’ grandfathered employer group health plans if they are not eligible to enroll in any other employer-sponsored plan (i.e., through their own employer or a spouse’s employer).⁹

How soon will young adults start to benefit from the new provision? Health plans and employers that offer dependent coverage are required on or after September 23, 2010, to hold an enrollment period of at least 30 days during which young adults can join their parents’ plans. They can, however, use their normal annual enrollment period to satisfy the requirement. Health plans and carriers are required to provide written notice about the enrollment period by the first day of the first plan or policy year beginning on or after September 23. While many firms and insurers have already made changes to allow young adults to join parents’ plans, many have announced they will wait for their normal enrollment period to fulfill the requirement. A survey of 800 large employers by Mercer, a human resources consulting firm, found that 75 percent planned to use their normal annual enrollment period to sign up newly eligible young adults.¹⁰

Exhibit 4. Three-Quarters of Young Adults Who Had Insurance Through Their Parents' Employer While in College Lost or Had to Switch Insurance After College



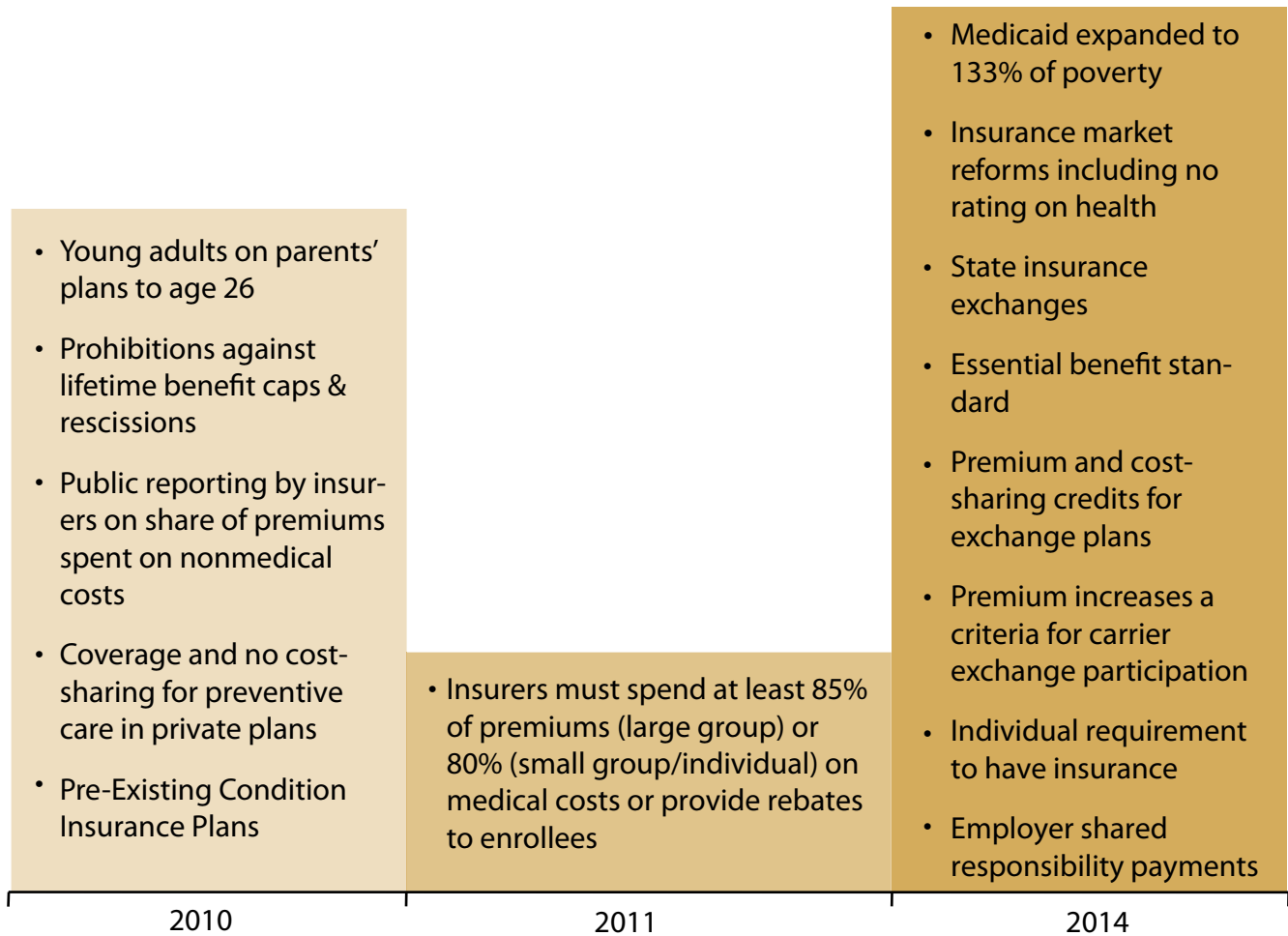
* Among those who had a gap between losing and gaining new insurance, or who went without insurance after graduating from or leaving college, or who did not have insurance when they graduated from or left college.
 Note: Numbers may not sum to 100% because of rounding.
 Source: The Commonwealth Fund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

Currently, 37 states have passed laws that increase the age of dependency for insurance purposes (Appendix Table 1). 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. In the case of Nevada, South Carolina, and Wyoming, the law extends only to parents covered by small-employer policies. But most important, none of the state laws apply to employers that provide health benefits directly to their employees (i.e., self-insured plans) rather than purchase insurance through a carrier (i.e., fully insured plans). Currently, 55 percent of the U.S. population covered by employer-based health insurance are in self-insured plans.¹¹ 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 standard in terms of age—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 ages 26 and older will still be able to qualify for dependent coverage under the provisions and definitions in their state laws.

This provision will help to reduce the number of uninsured young adults. In its interim final rules on this provision in the law, the Departments of Health and Human Services, Labor, and Treasury estimated that, in 2010, there will be about 6.6 million uninsured young adults between the ages of 19 and 26 and 2.7 million with coverage through the individual insurance market.¹² About 3.4 million of those uninsured and about 2.4 million of those with individual market coverage have parents with employer-based health insurance or an individual market policy. The agencies estimate that approximately 1.7 million young adults

Exhibit 5. Affordable Care Act: Provisions Affecting Young Adults



Source: SR Collins and JL Nicholson, *Rite of Passage: Young Adults and the Affordable Care Act of 2010*, (New York: The Commonwealth Fund, May 2010).

will become covered under parents' policies by 2013. Of those, nearly 1 million are estimated to be previously uninsured.¹³

The federal agencies also estimated the effect of this provision on premiums. Assuming that the number of young adults who enroll in their parents' employer plans is in the midrange of their estimates (i.e., 1.7 million in 2013), the agencies estimated 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 addition to providing a new source of coverage to many uninsured young adults, the provision has the potential to shorten or eliminate gaps in health insurance coverage experienced by young adults transitioning between high school or college and the job market. The provision will also potentially provide better coverage at lower cost to many young adults who are now purchasing coverage through the individual market or those enrolled in college plans. Currently, young adults who purchase on their own must pay the full premium for their coverage, regardless of income. In most states, they can be charged a higher premium for a preexisting condition, like asthma or a mental health problem, or have that condition excluded completely from their plan.

2010: Bans on Limits on Benefits and Requirements to Report Share of Premiums Spent on Medical Costs

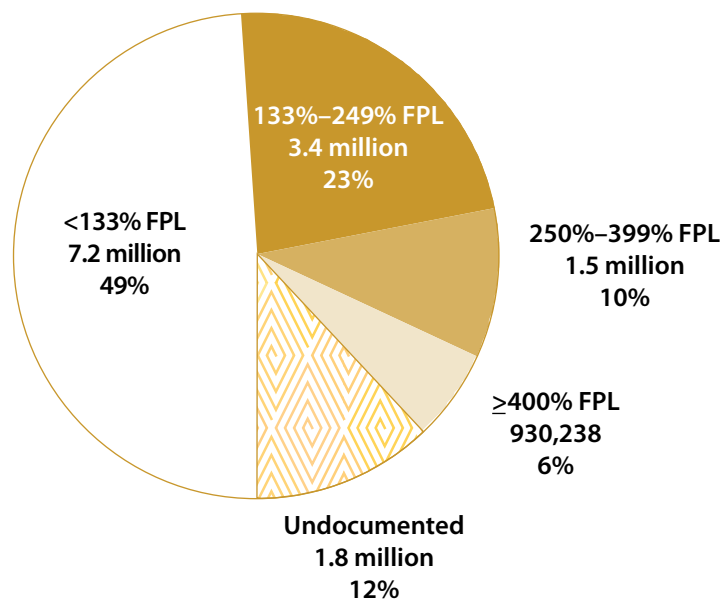
While college and university health plans provide some measure of protection for students, many plans offer only limited benefits and have low yearly or lifetime limits on the amounts the health plans will pay. A study by the Government Accountability Office of a sample of student health plans found that 96 percent had a maximum benefit amount.¹⁴ Among student insurance 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. Such limited plans put college students at risk of having high medical bills and medical debt if they experience a serious illness or injury. In fact, some college athletes have found themselves in debt after experiencing injuries during training that are not

covered by their private insurance plans or by their schools.¹⁵

Such benefit restrictions in some college plans have helped to decrease the benefits paid to students as a share of their premiums. The New York State attorney general is investigating student health plans that pay significantly less in benefits than they collect from students in premiums.¹⁶ 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.¹⁷

The Affordable Care Act includes several provisions going into effect this year and next that have the potential to eventually improve the quality of health plans offered to college students, including bans on lifetime benefit limits, phase-out of annual limits, and limits on nonmedical spending as a share of premiums. However, the American Council on Education

Exhibit 6. Distribution of 14.8 Million Uninsured Young Adults by Federal Poverty Level in 2009



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.

and several trade associations representing colleges have recently argued that some of the provisions, including those relating to annual limits and limits on nonmedical spending, do not apply to college plans.¹⁸ The secretary of the department of health and human services (HHS) will issue guidance soon on the ACA and college student health plans.

Lifetime limit ban. Starting on September 23, 2010, the ACA prohibits all health plans from imposing lifetime limits on what their plans will pay in benefits.¹⁹ The ban applies to all employer plans, including self-insured plans, and all plans sold in the individual insurance market. It applies to new plans and grandfathered plans. For people who exceed their lifetime limit before September 23, health plans must serve notice that the lifetime limit no longer applies and provide an enrollment period for people who have since disenrolled from the plan.

Phased-in restrictions on annual limits. The ACA will prohibit all health plans, except grandfathered plans sold on the individual market, from imposing annual limits in 2014. Restrictions on annual limits will increase gradually between 2010 and 2013, according to the following schedule:

- Between September 23, 2010, and September 23, 2011, plans cannot impose annual limits on health benefits of less than \$750,000.
- Between September 23, 2011, and September 23, 2012, plans cannot impose annual limits of less than \$1.25 million.
- Between September 23, 2012, and January 1, 2014, plans cannot impose annual limits of less than \$2 million.

The restrictions on annual limits apply to “essential health benefits” as they are broadly defined in the ACA and not benefits that fall outside that definition.

Limits on share of premiums insurers spend on nonmedical costs. The Affordable Care Act will place new standards

on what health plans must spend on medical care, as opposed to administration and profits. Beginning in 2010, health plans are required to report the proportion of premiums spent on items other than medical care. The secretary will make these reports available on the HHS Web site. Generally, medical care includes clinical services, activities to improve quality of care, and all other non-administrative costs. The secretary of HHS will issue regulations that explicitly define medical care, especially in the area of quality improvement activities, in addition to standardized methodologies for calculating the share of premiums spent on medical care. Beginning January 1, 2011, health plans in the large-group market that spend less than 85 percent of their premiums on medical care, as well as health plans in the small-group and individual market that spend less than 80 percent on medical care, will be required to offer rebates to enrollees. The rebates will be equal to the percentage difference between the minimum required by law and what a plan actually spends, multiplied by the total amount of premium revenue. As directed by the ACA, the National Association of Insurance Commissioners (NAIC) has drafted for public comment uniform definitions of medical care as well as a standardized method for insurers to calculate rebates.²⁰

2010: Preexisting Condition Insurance Plans Will Help Young Adults with Chronic Health Problems

While young adults are healthier on average than older adults, many have chronic health problems that can make it difficult, if not impossible, to buy a health insurance policy. An estimated 15 percent of adults between the ages of 18 and 29 have one of six health chronic health conditions: arthritis, asthma, cancer, diabetes, heart disease, or hypertension.²¹ These young adults, many of whom have been unable to buy health insurance because of their conditions, may benefit from new preexisting condition insurance plans (PCIPs).²² Now available in all 50 states and the District of Columbia, PCIPs are open to people who have been uninsured for at least six months and who have a

health problem that has made it difficult for them to gain health insurance. Premiums are set for a standard population in the individual insurance market and cannot vary by more than a factor of four, based on age (i.e., 4:1 age bands). The PCIPs are required to cover, on average, no less than 65 percent of medical costs and to limit out-of-pocket spending to the standards defined by health savings accounts—\$5,950 for individuals and \$11,900 for families. They also cannot impose preexisting condition exclusions.

The federal government invited states to submit applications to form their own PCIPs, supported by federal subsidies to cover the difference between premiums and the cost of claims. Twenty-seven states elected to run their own plans and are now accepting applications for enrollment.²³ States have some flexibility in setting the size of the deductible, the level of coinsurance or copayments and the scope of benefits, so there is variation in PCIPs from state to state. For example, while most plans have a deductible of \$2,500, 15 states offer plans with deductibles at or below \$1,000; Washington and Maryland set their out-of-pocket limits at \$1,500, well below the federal standard.²⁴

The federal government is operating PCIPs in the remaining 23 states and the District of Columbia. The plans in these states feature a \$2,500 deductible, \$25 copayment for doctor visits, 20 percent coinsurance for other covered in-network benefits, prescription drug coverage with \$4 to \$30 copayments for most drugs for the first two prescriptions and 50 percent of the cost of subsequent prescriptions, no cost-sharing for preventive services, no lifetime limit on benefits, and a \$5,950 out-of-pocket maximum for in-network services.²⁵

The HHS secretary will have \$5 billion to use to subsidize the gap between premiums collected for the PCIPs and claims costs between 2010 and 2013. The PCIPs are expected to cover between 175,000 and 400,000 people over their three-and-half years of operation.²⁶

2014: Medicaid Expansion to Adults with Incomes Up to 133 Percent of the Federal Poverty Level

Beginning in 2014, the Affordable Care Act expands eligibility for Medicaid to all legal residents with incomes up to 133 percent of the federal poverty level—about \$14,404 for a single adult or \$29,327 for a family of four. This is a substantial change in the Medicaid program in its coverage of adults, 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.²⁷ In addition, adults who do not have children are not currently eligible for Medicaid, regardless of income, in most states.

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. Of all uninsured young adults, about half (49%) are legal residents in families with incomes under 133 percent of poverty (Exhibit 7). The eligibility expansion has the potential to provide health insurance to up to 7.2 million uninsured young adults in that income range.²⁸ Approximately 1 million uninsured young adults in that income range are undocumented immigrants and would not be eligible for Medicaid.²⁹

2014: Insurance Exchanges and Tax Credits to Reduce Premiums and Out-of-Pocket Costs

The Affordable Care Act requires each state to establish a new health insurance exchange for individuals and another for small employers, or a single exchange for both individuals and small employers. States can set up their own exchanges or band with other states to establish regional exchanges. States can also decline to establish an exchange and the federal government will do it for them. The individual and small-group markets will continue to function outside the exchange, but new insurance market regulations will apply to plans sold inside and outside the exchanges. The new regulations include prohibition

of rating on the basis of health and gender, bans on preexisting condition exclusions, limits on the amount plans can vary premiums based on age, and eliminating the ability of plans to drop coverage if an enrollee becomes ill. Unlike today's individual insurance market, where young women can be charged premiums 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.³⁰

The exchanges will provide a new regulated marketplace in which people without access to employer coverage that meets certain affordability and coverage standards can purchase insurance. People with employer coverage who spend more than 9.5 percent of their income on premiums or those with a plan that covers less than 60 percent, on average, of their medical costs are eligible to purchase coverage through the exchange. Qualified health plans sold through the exchange and those sold in the individual and small-group markets will be required to provide a federally determined essential benefits package. The package will be similar to those offered in employer plans, including the provision of maternity services, a benefit rarely

covered in the current individual insurance market. People purchasing coverage through the exchanges can choose among four levels of cost-sharing: plans that cover an average 60 percent of medical costs (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. The essential benefits package and choice of cost-sharing level will provide consumers with far more information about benefits than they currently have in the individual market.

For the first time, young adults who must buy coverage on their own will be eligible for a federal subsidy to help pay for the cost of premiums for plans sold through the exchanges. Premium credits will be tied to the silver plan and will cap contributions for individuals and families from 2 percent of income up to 133 percent of poverty (\$14,404 for a single adult or \$29,327 for a family of four) and gradually increase to 9.5 percent at 300 percent to 400 percent of poverty (\$43,320 for a single person and \$88,200 for a family of four) (Exhibit 7).

Exhibit 7. Distribution of 14.8 Million Uninsured Young Adults by Federal Poverty Level in 2009 and Provisions in Affordable Care Act

Uninsured young adults ages 19–29

Federal poverty level	Percent	Number uninsured	Premium subsidy cap as share of income	Cost-sharing cap as share of medical costs
<133% FPL	49%	7,236,461	Medicaid	Medicaid
133%–149% FPL	5%	694,870	3.0%–4.0%	6%
150%–199% FPL	11%	1,630,967	4.0%–6.3%	13%
200%–249% FPL	7%	1,081,215	6.3%–8.05%	27%
250%–299% FPL	5%	766,004	8.05%–9.5%	30%
300%–399% FPL	5%	725,774	9.5%	30%
Subtotal (133%–399%FPL)	33%	4,898,830	3.0%–9.5%	6%–30%
≥400% FPL	6%	930,238	—	—
Undocumented	12%	1,781,663	—	—
Total	100%	14,847,191	—	—

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.

Young adults with low and moderate incomes will also benefit from cost-sharing credits that effectively reduce out-of-pocket spending under the silver plan to 6 percent, on average, of total costs for those with incomes up to 150 percent of poverty (\$16,245 for a single person and \$33,075 for a family of four). Costs will drop to 13 percent of total costs for those with incomes up to 200 percent of poverty (\$21,660 for a single person and \$44,100 for a family of four), and 27 percent for those with incomes up to 250 percent of poverty (\$27,075 for a single person and \$55,125 for a family of four) (Exhibit 7). In addition, out-of-pocket expenses will be capped for families earning between 100 percent and 400 percent of poverty (from \$1,983 for individuals and \$3,967 for families to up to \$3,967 for individuals and \$7,933 for families).

Subsidized private coverage has the potential to provide health insurance for up to 4.9 million uninsured young adults with incomes between 133 percent and 400 percent of poverty. (Exhibit 7).³¹ 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 ACA.³² There are fewer than 1 million uninsured young adults with incomes over 400 percent of poverty who would not be eligible for a premium subsidy through the exchanges but who would likely be eligible to join their parents' employer-sponsored health plan.

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 will be required to have the essential benefits package and include three primary care visits per year but could have cost-sharing similar to health savings account-eligible, high-deductible plans. 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.

2014: Employer Shared Responsibility Payments for Not Offering Health Insurance or for Offering Benefits of Low Quality

Currently, employed young adults are far less likely to have health insurance through their jobs than are older adults. The Commonwealth Fund Biennial Health Insurance Survey (2007) found that only slightly more than half (53%) of 19-to-29-year-olds who were working part-time or full-time were eligible for coverage offered by their employers, compared with three-quarters (74%) of 30-to-64-year-olds.³³ Only one-third of young adults were covered by employer plans. Twenty-eight percent of workers in this age group were uninsured, nearly three times the rate of older workers.

The Affordable Care Act does not include an employer mandate to provide insurance but it does require large employers that either do not offer health insurance to their employees or offer health insurance that is expensive to employees or of poor quality to make payments. If employers with 50 or more full-time equivalent workers do not offer health insurance, the legislation will require a payment of \$2,000 per full-time employee (those working more than 30 hours per week), if an employee becomes eligible for a premium subsidy through the exchanges. The payment does not apply to the first 30 full-time workers in a company.

Young adults who are enrolled in plans through their employers but spend a large share of their income on premiums or have health plans with substantial cost-sharing obligations may become eligible for subsidized coverage through the insurance exchanges, depending on income. In addition, their employers may have to make a payment to the federal government under such a scenario. Under the ACA, if a firm offers coverage and has 50 or more full-time workers and a full-time worker is determined to be eligible for premium subsidies through the exchange either because his premium contribution exceeds 9.5 percent of income or his coverage does not meet the minimum

creditable benefit standard (plan covers at least 60 percent of an enrollee's costs), the company must pay the lesser of \$3,000 for each full-time worker who receives such a premium subsidy through the exchange or \$2,000 for each full-time employee, not counting the first 30 employees.

A recent study by researchers at RAND estimated that the ACA would increase the number of workers covered by employer plans from 115.1 million to 128.7 million, covering nearly 95 percent of U.S. workers.³⁴ However, the researchers estimated that the increase in employer coverage will come less from employer requirements than from increased demand for health insurance from employees as a result of the individual requirement to have health insurance. They estimate that of the 13.6 million newly covered workers under the ACA, only 3.2 million will work in companies of 50 or more and thus subject to the shared responsibility payments.

2014: Individual Requirement to Have 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.³⁵ 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.³⁶ The experience of Massachusetts suggests that young adults will likely comply with the requirement to have health insurance. The state implemented a universal coverage law in 2007 that is similar to the ACA, including an insurance exchange with subsidized coverage, an individual requirement to have health insurance, and provisions targeted to young adults like 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 2007–2008.³⁷ In comparison, rates of uninsurance 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 the individual requirement to have health insurance in Massachusetts had the effect of increasing 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.³⁸ The RAND analysis predicts a similar effect of the ACA, with the individual mandate far more important in expanding employer-based coverage than the shared responsibility payments required of large employers.³⁹ Young adults in employer-based plans tend to take-up benefits at rates similar to those of older workers: in 2007, 78 percent of working young adults ages 24 to 29 took up coverage when it was offered by an employer, compared with 84 percent of workers age 30 and older.⁴⁰

CONCLUSION

The Affordable Care Act will bring sweeping change to the nation's health system—promising to cover at least 32 million more people, approximately 30 percent of whom are between the ages of 19 and 29. Young adults will benefit substantially from the ability to remain on their parents' health plans starting in 2010. Other changes will come into effect in 2014—an unprecedented expansion in the Medicaid program, new insurance market regulations, and subsidized private health insurance with a comprehensive benefits package through the new insurance exchanges. The combination of these provisions will substantially reduce both the share of young adults who are without health insurance (32 percent are currently uninsured) and the share who have health insurance but are underinsured (9 percent are estimated to be underinsured). Of the 14.8 million young adults who were uninsured in 2009, up 12.1 million may gain

subsidized coverage by 2014: 7.2 million may gain coverage through Medicaid and up to 4.9 million may gain subsidized private coverage through the insurance exchanges. In addition, about 1 million are expected to join their parents' policies. About 12 percent of uninsured young adults, or 1.8 million, are not legal residents and, therefore, not eligible for federally subsidized health insurance under the law. Further, by providing multiple insurance options for young adults at key life transition points, including graduation from high school and college, the law will significantly reduce both the short- and long-term gaps in health insurance that have historically plagued this age group at all income levels. When fully implemented, the ACA will allow young adults of all income levels to undergo a new rite of passage: establishing necessary ties with the health care system, without fear of accumulating medical debt, as they pursue their educational and career goals.

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).
- ² C. Schoen, S. R. Collins, J. L. Kriss, and M. M. Doty, “How Many Are Underinsured? Trends Among U.S. Adults, 2003 and 2007,” *Health Affairs* Web Exclusive, June 10, 2008, w298–w309.
- ³ U.S. Department of Labor, Bureau of Labor Statistics, The Employment Situation—August 2010, <http://www.bls.gov/news.release/pdf/empisit.pdf>.
- ⁴ According to a survey of employers, of those who offer coverage, nearly 60 percent do not insure dependent children over age 18 or 19 if they do not attend college. See S. R. Collins, C. Schoen, M. M. Doty, and A. L. Holmgren, *Job-Based Health Insurance in the Balance: Employer Views of Coverage in the Workplace* (New York: The Commonwealth Fund, March 2004).
- ⁵ 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). Avoided health care included not filling a prescription; skipping a medical test, treatment, or follow-up visit recommended by a doctor; not going to a doctor or clinic when sick; not seeing a specialist when a doctor or the respondent thought it was needed; or delaying or not getting needed dental care.
- ⁶ Estimate from Jonathan Gruber and Ian Perry of MIT using the Gruber Microsimulation Model for The Commonwealth Fund.
- ⁷ 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://www.hhs.gov/ociio/regulations/index.html-dependent_coverage; and Department of Health and Human Services, *Young Adults and the Affordable Care Act: Protecting Young Adults and Eliminating Burdens on Businesses and Families*, http://www.hhs.gov/ociio/regulations/adult_child_fact_sheet.html.
- ⁸ 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*, <http://www.hhs.gov/ociio/regulations/grandfather/index.html>.
- ⁹ Treasury, Labor, and Health and Human Services, *Interim Final Rules Relating to Dependent Coverage of Children to Age 26*, 2010; and Health and Human Services, *Young Adults and the Affordable Care Act*, http://www.hhs.gov/ociio/regulations/adult_child_fact_sheet.html.
- ¹⁰ J. Rovner, “Many Young Adults Will Wait for Health Coverage After All,” National Public Radio, May 20, 2010; and M. Andrews, “Graduates May See Coverage Gap After All,” *New York Times*, May 31, 2010.
- ¹¹ 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>.
- ¹² Treasury, Labor, and Health and Human Services, *Interim Final Rules Relating to Dependent Coverage of Children to Age 26*, 2010.
- ¹³ 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.
- ¹⁴ “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, U.S. Government Accountability Office, March 2008.
- ¹⁵ K. Peterson, “College Athletes Stuck with the Bill After Injuries,” *New York Times*, Jul. 16, 2009.
- ¹⁶ D. Hakim, “Colleges Skirt Rules on Health Plans, Cuomo Says,” *New York Times*, Apr. 8, 2010.

- ¹⁷ 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.
- ¹⁸ American Council on Education, Letter to the Honorable Kathleen Sebelius and Nancy-Ann Deparle, Aug. 20, 2010, http://www.acha.org/Topics/Health_Care_Reform/PPACA_Regulatory_Clarification_Request.pdf; and J. Appleby, “Colleges Say New Health Law May Imperil Student Policies,” *Kaiser Health News*, Aug. 20, 2010, <http://www.kaiserhealthnews.org/Stories/2010/August/19/college-health-plans-reform-law.aspx>.
- ¹⁹ Ibid.
- ²⁰ Public comments on the draft were due on October 4, 2010. See the National Association of Insurance Commissioners, Regulation for Uniform Definitions and Standardized Rebate Calculation Methodology for Plan Years 2011, 2012, and 2013 Per Section 2718(b) of the Public Health Service Act, http://www.naic.org/documents/ppaca_sub_draft_mlr_rebate_reg.pdf.
- ²¹ National Center for Health Statistics, *Health, United States, 2008* (Hyattsville, Md.: NCHS, 2009).
- ²² J. Hall and J. Moore, *Realizing Health Reform’s Potential: Pre-Existing Condition Insurance Plans Created by the Affordable Care Act of 2010* (New York: The Commonwealth Fund, Oct. 2010).
- ²³ These are: Alaska, Arkansas, California, Colorado, Connecticut, Illinois, Iowa, Kansas, Maine, Maryland, Michigan, Missouri, Montana, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Dakota, Utah, Washington, and Wisconsin. See <http://www.pcip.gov/StatePlans.html> for more information on state-run PCIPs.
- ²⁴ Hall and Moore, *Realizing Health Reform’s Potential: Pre-Existing Condition Insurance Plans*, 2010.
- ²⁵ These are: Alabama, Arizona, Delaware, Florida, Georgia, Hawaii, Idaho, Indiana, Kentucky, Louisiana, Massachusetts, Minnesota, Mississippi, Nebraska, Nevada, North Dakota, South Carolina, Tennessee, Texas, Vermont, Virginia, Washington, D.C., West Virginia and Wyoming. See <http://www.pcip.gov/StatePlans.html> for more information about the federal PCIP.
- ²⁶ Hall and Moore, *Realizing Health Reform’s Potential: Pre-Existing Condition Insurance Plans*, 2010; Department of Health and Human Services, *Preexisting Condition Insurance Plan Program, Interim Final Rule*, Federal Register July 30, 2010, <http://edocket.access.gpo.gov/2010/pdf/2010-18691.pdf>. Congressional Budget Office, Letter to the Honorable Michael B. Enzi, June 21, 2010.
- ²⁷ Collins and Nicholson, *Rite of Passage*, 2010.
- ²⁸ Analysis of the 2009 Current Population Survey by Nicholas Tilipman and Bhaven Sampat of Columbia University.
- ²⁹ Estimate from Jonathan Gruber and Ian Perry of MIT using the Gruber Microsimulation Model for The Commonwealth Fund.
- ³⁰ S. R. Collins, S. D. Rustgi, and M. M. Doty, *Realizing Health Reform’s Potential: Women and the Affordable Care Act of 2010* (New York: The Commonwealth Fund, July 2010); and National Women’s Law Center, *Still Nowhere to Turn: Insurance Companies Treat Women Like a Pre-Existing Condition* (Washington, D.C.: NWLC, Oct. 2009), <http://www.nwlc.org/pdf/stillnowhere-toturn.pdf>.
- ³¹ Analysis of the 2009 Current Population Survey by Nicholas Tilipman and Bhaven Sampat of Columbia University.
- ³² Estimate from Jonathan Gruber and Ian Perry of MIT using the Gruber Microsimulation Model for The Commonwealth Fund.
- ³³ J. L. Nicholson, S. R. Collins, B. Mahato, E. Gould, C. Schoen, and S. D. Rustgi, *Rite of Passage? Why Young Adults Become Uninsured and How New Policies Can Help, 2009 Update* (New York: The Commonwealth Fund, Aug. 2009).

- ³⁴ 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>.
- ³⁵ The tax filing threshold is the combination of the personal exemption amount plus the standard deduction amount. For 2010, the tax filing threshold is \$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*, Congressional Research Service, July 20, 2010.
- ³⁶ 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, pg. 19, http://www.cbo.gov/ftpdocs/108xx/doc10868/12-19-Reid_Letter_Managers.pdf.
- ³⁷ 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.
- ³⁸ 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.
- ³⁹ Eibner, Hussey, and Girosi, *Effect of the Affordable Care Act*, 2010.
- ⁴⁰ Nicholson, Collins, Mahato, Gould, Schoen, and Rustgi, *Rite of Passage?* 2009.

METHODOLOGY

Some of the data in the brief come from the Commonwealth Fund Survey of Young Adults (2009), a national telephone survey conducted May 12, 2009, through 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 25-minute telephone interviews were completed in both English and Spanish, according to the preference of the respondent.

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. A prescreened strata was 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 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 percent at the 95 percent confidence level.

Appendix Table 1. 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>.

ABOUT THE AUTHORS

[Sara R. Collins, Ph.D.](#), is vice president for Affordable Health Insurance at The Commonwealth Fund. An economist, Dr. Collins joined the Fund in 2002 and has led the Fund's national program on health insurance since 2005. Since joining the Fund, Dr. Collins has led several national surveys on health insurance and authored numerous reports, issue briefs and journal articles on health insurance coverage and policy. She has provided invited testimony before several Congressional committees and subcommittees. Prior to joining the Fund, Dr. Collins was associate director/senior research associate at the New York Academy of Medicine, Division of Health and Science Policy. Earlier in her career, she was an associate editor at *U.S. News & World Report*, a senior economist at Health Economics Research, and a senior health policy analyst in the New York City Office of the Public Advocate. She holds an A.B. in economics from Washington University and a Ph.D. in economics from George Washington University. She can be e-mailed at src@cmwf.org.

[Jennifer L. Nicholson, M.P.H.](#), formerly an associate program officer for the Affordable Health Insurance program at The Commonwealth Fund, is a first-year doctoral student in epidemiology at Emory University. While at the Fund, she was responsible for project development and grants management, and was also involved in researching emerging policy issues regarding the extent and quality of health insurance coverage and access to care in the United States, researching and writing reports and articles, and survey development and analysis. She holds a B.S. in public health from the University of North Carolina at Chapel Hill and an M.P.H. in epidemiology from Columbia University's Mailman School of Public Health.

ACKNOWLEDGMENTS

The authors thank Tracy Garber of The Commonwealth Fund for research assistance.

Editorial support was provided by Deborah Lorber.

