

The Supreme Court ACA Decision: What Happens Now for Adolescents and Young Adults?

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INTRODUCTION

On June 28, 2012, the United States Supreme Court affirmed the constitutionality of critically important components of the Patient Protection and Affordable Care Act of 2010 (ACA), allowing the vast majority of the Act to stand (“ACA decision”).^{1,2,3} In light of the 2012 election results, the ACA is now more likely to be implemented. This issue brief describes the implications of the Supreme Court’s ACA decision for adolescents and young adults.

The complex web of majority and dissenting opinions that comprised the Supreme Court’s ACA decision has important implications for future health insurance coverage and health care access for adolescents and young adults. Specifically, following the ACA decision, key elements of implementation will include provisions related to:

- the “individual mandate”;
- private health insurance;
- public health insurance—Medicaid and the Children’s Health Insurance Program (CHIP); and
- preventive health services.

This brief begins with a summary of the current health insurance status of adolescents and young adults. It continues with a discussion of implementation of the key elements of the ACA and what that will mean for these two age groups. Finally, the brief highlights implementation choices still to be made by the federal government and the states that will affect adolescents’ and young adults’ access to health insurance and health care services.

As enacted in 2010, the ACA contained numerous provisions relevant to adolescents and young adults that were scheduled to take effect beginning in 2010 and culminating in 2014.⁴ A more detailed description of these provisions, which are referred to throughout this brief, is available [here](#). Additional

resources analyzing the Supreme Court’s decision and its implications for implementation of the ACA are included in the references in this issue brief.

HEALTH INSURANCE STATUS OF ADOLESCENTS AND YOUNG ADULTS

In 2011, 89.3% of adolescents (ages 10-17) had continuous health insurance coverage for at least a year; for young adults (ages 18-25) this figure was only 66.7%. As shown in Table 1, a little more than half of adolescents and young adults are covered by private insurance. About a third of adolescents have public insurance, compared to only 15% of young adults. Two federal-state programs, Medicaid and CHIP, account for most public coverage of adolescents and younger children; Medicaid is the primary source of public insurance for young adults.^{5,6}

Table 1. Insurance status of Adolescents and Young Adults, by source and duration of coverage, 2011

	Adolescents 10-17	Young Adults 18-25
Insured for full year prior to interview		
• Private coverage	56.7%	51.5%
• Public coverage	32.6%	15.2%
Uninsured for all or part of year prior to interview		
• Full-year uninsured	5.1%	18.7%
• Partial-year uninsured	6.6%	14.5%

Source: Analysis of 2011 National Health Interview Survey

Note: Numbers total slightly more than 100% percent due to the 1-2% of adolescents and young adults with both private and public coverage.

INDIVIDUAL MANDATE

The ACA requires most individuals in the U.S., beginning in 2014, to have health insurance coverage that meets certain minimum criteria – a requirement known as the individual mandate. The Supreme Court upheld this provision. This means that the federal

government can impose a penalty on most individuals without health insurance.

The individual mandate applies to all age groups, including adolescents and young adults as well as other age groups.⁷ It can be satisfied by having coverage through an employer-based plan, Medicaid, Medicare, other public coverage that meets federal requirements, or an individual private plan, purchased in the private market or through the health insurance exchanges as explained in further detail below. Most individuals and families who already have health insurance will be able to satisfy the mandate with the coverage they already have. The financial penalty for those who do not have health insurance coverage will be assessed in connection with filing income tax returns. An individual whose income is too low to meet the tax filing requirements would not be subject to a penalty.

For most adolescents under age 18, their parents will be responsible for ensuring that they have the requisite coverage. Adolescents whose families have employer-based coverage will likely be included in the policy if dependent coverage is available. Some adolescents whose parents are uninsured will be eligible for Medicaid, although once the ACA is implemented, the number of uninsured families should diminish significantly.

Young adults age 18 and older are more likely to be responsible for their own health insurance. Some may have coverage through their employment and some may be eligible for Medicaid or coverage on a parent's plan. For the remaining young adults, the decision of whether to purchase coverage will likely involve their perceived need for insurance, as well as calculations based on the cost of health insurance options in their state, the amount of subsidies that might be available, and the amount of the penalty they would incur by not having coverage. The amount of the penalty will vary according to a formula based on household income, with the amount increasing over a three-year period. (See Box 1)

PRIVATE HEALTH INSURANCE

The ACA contains numerous provisions related to private health insurance that were left intact by the Supreme Court's ACA decision and are important for adolescents and young adults. They include:

- state health insurance exchanges;
- premium tax credits and cost-sharing subsidies;
- catastrophic coverage;
- dependent coverage to age 26;
- protection for pre-existing conditions; and
- "Essential Health Benefits".

Health Insurance Exchanges

State health insurance exchanges ("the exchanges") are a key feature of the ACA's approach for expanding health insurance coverage.^{8,9} States may choose to operate their own exchange, partner with the federal government to run an exchange, or allow the federal government to operate an exchange.¹⁰ In the exchanges, individuals and small businesses can shop for, compare, and purchase health insurance coverage beginning in January 2014. Important functions of the exchanges include determining eligibility and enrolling individuals in private market health

Box 1. ACA Math: What is the penalty for not having health insurance?

In 2014, the penalty will be the *greater* of \$95 or 1% of income; in 2015, \$325 or 2% of income; and in 2016 and thereafter, \$695 or 2.5% of income, adjusted for cost of living. In any year, the penalty cannot exceed the national average premium for the lowest cost for that year of a "Bronze" plan available through the exchanges.

A young adult earning \$20,000 per year (about 174% FPL or slightly more than the equivalent of full-time work at the federal minimum wage), who has no tax deductions or other factors affecting taxable income, and who chooses not to have health insurance, would likely pay a penalty of about \$200 in 2014, \$400 in 2015, and \$695 in 2016, but the penalty could not exceed the national average premium for a Bronze plan.

Source: Henry J. Kaiser Family Foundation. *Focus on Health Care Reform: A Guide to the Supreme Court's Affordable Care Act Decision*. July 2012. Available at: www.kff.org/healthreform/upload/8332.pdf.

plans – such as a Platinum, Gold, Silver, or Bronze “qualified health plan” – or in Medicaid or CHIP. Eligibility to enroll in a qualified health plan is available to individuals who are either citizens or noncitizens lawfully present in the U.S., are not incarcerated, and are residents of the state.

The eligibility and enrollment process is supposed to be seamless, so that individuals can fill out a single application and then be enrolled in the appropriate plan or program. This streamlined process could be particularly important for young adults obtaining their own health insurance for the first time; and for adolescents’ families who are unsure which type of coverage is most appropriate for their children.

Subsidies: Premium Tax Credits and Cost-Sharing Assistance

The exchanges also determine an individual’s eligibility for the subsidies established by the ACA. These subsidies include both premium tax credits and assistance with cost-sharing such as deductibles and co-payments. Individuals are eligible for these subsidies only if they are enrolled in a qualified “Silver” plan and meet other criteria.

Criteria for the premium tax credits include the source of insurance; specifically, eligibility is limited to those individuals eligible for coverage in the individual market – not the

group market – that would satisfy the individual mandate. Thus, young adults who have access to a plan through their employment usually would not be eligible for premium tax credits through the exchanges. To qualify for a premium tax credit, an individual generally must have household income between 100% and 400% of the Federal Poverty Level (FPL). Cost-sharing subsidies are available to those with incomes between 100% and 250% FPL. (See Box 2 for sample calculation of subsidies.) For a single person in 2012, 100% FPL is \$11,170; 250% FPL is \$27,925; and 400% FPL is \$44,680.

The two subsidies are structured to minimize impediments that would prevent young adults from having health insurance and seeking needed health care. First, the premium tax credits are payable in advance so that individuals do not have to wait until they file their income tax returns to receive the subsidy. Second, the cost-sharing subsidies for deductibles and co-payments are payable directly to the health plan, so that the out-of-pocket amount the individual actually pays is reduced. The combination of premium tax credits and cost-sharing assistance may be a major factor leading many low-income young adults to decide to purchase health insurance.

Catastrophic Coverage

Some young adults may conclude that even the cost of a Bronze plan, or a Silver plan with subsidies, is too expensive. For these young adults, if they are under age 30, the ACA offers the option of purchasing “Catastrophic” coverage, which may also be offered through the exchanges.¹¹ Catastrophic plans will be valued at less than the Bronze plan and will almost certainly have lower premiums. Similar plans have been available in the commercial market in some states for several years, aimed at young adults and sometimes referred to as “young invincibles” plans.

What makes the Catastrophic plans less expensive than the Platinum, Gold, Silver, and Bronze plans are their very high deductibles. (The deductible amount is to be determined by the tax code; according to 2012 rules, it would

Box 2. ACA Math: What calculations are involved in choosing a health plan?

A young adult age 22 living in a state in a medium cost region earning \$20,000 in 2014 dollars (roughly full-time at the federal minimum wage) would expect the annual premium cost for a “Silver” plan to be \$3391. The anticipated subsidy (in the form of a tax credit) would be \$2371, leaving the individual with a premium payment of \$1020, about 30% of the cost of the premium. As noted in Box 1, the penalty for this individual would be \$200 in 2014. Thus, the difference between the penalty and the estimated cost of a Silver plan in 2014 would be about \$820 per year. The cost-sharing assistance would reduce the overall out-of-pocket costs for this individual from 30% of the value of the plan’s benefits and services to 13% of that value.

Source: Henry J. Kaiser Family Foundation. *Health Reform Subsidy Calculator*.

<http://healthreform.kff.org/SubsidyCalculator.aspx#incomeAgeTables>

be \$6,050 for an individual, and presumably would be higher by 2014). Catastrophic plans must include coverage for at least three primary care visits and preventive health services that are not subject to the deductible, but any other benefits included in the Essential Health Benefits (described below) would be subject to this high deductible. For young adults who are healthy, these plans may seem appealing due to their low premium cost and the availability of some primary care and preventive services without additional out-of-pocket costs. However, the very high deductible for these plans means that any young adult who has an accident, who contracts a serious illness, or whose health status changes for the worse may quickly confront prohibitive medical costs in circumstances where the need for care is critical.

Dependent Coverage to Age 26

Effective September 2010, the ACA required most health plans to allow individuals to remain on a parent's policy up to age 26.¹² This coverage must be offered regardless of the young person's age, financial independence or dependent status, marriage, or educational enrollment. The premiums charged and the benefits covered must be the same as for younger children under the same policy.

In June 2012, the U.S. Department of Health & Human Services (HHS) announced that 3.1 million more young adults ages 19 to 25 had gained health insurance by the end of 2011 than would have been covered without the ACA.¹³ Research by HHS also shows that the ACA's expansion of dependent coverage benefits young adults of all races and ethnicities.¹⁴ This provision will continue to reach a significant proportion of previously uninsured young adults. It is not known at this time how many young people will remain on a parent's policy rather than purchase an individual policy once the exchanges are operating in 2014, but for now the dependent coverage requirement has had a major impact on health insurance coverage for young adults.

Protection for Pre-existing Conditions

The ACA eliminates the long-standing practices of health insurers that make it difficult for individuals with pre-existing conditions to obtain coverage in a timely manner or even to obtain coverage at all. Effective in 2010, the ACA prohibited health plans from imposing pre-existing condition exclusions for children, including adolescents who are minors. A similar provision will apply to all age groups beginning in 2014: health plans will no longer be able to refuse to issue a policy to individuals with pre-existing conditions or impose a waiting period for coverage of such conditions. Thus, when this provision is implemented in 2014, millions of young adults with chronic diseases or pre-existing conditions will no longer be prevented from obtaining health insurance as a result of their health status and will join the millions of adolescents under age 18 who have been protected in this way since 2010. Federal estimates of the percentage of children and young adults who will be affected range from 5% to 24% of children under age 18 and 9% to 35% of young adults ages 18-24.¹⁵

Essential Health Benefits

Plans that are offered through the exchanges must cover a set of comprehensive benefits, including at least the 10 "Essential Health Benefits" as specified by the ACA.^{16,17} (See Box 3) The ACA lists broad categories of services that comprise Essential Health Benefits (EHBs), but leaves it to HHS to define them further. HHS has delegated significant flexibility to the states to determine what constitutes Essential Health Benefits within the 10 categories.^{18,19} HHS set a "soft target" date of October 1, 2012 for states to determine their Essential Health

Box 3: Ten Essential Health Benefits

1. ambulatory patient services;	7. rehabilitative and habilitative services and devices;
2. emergency services;	8. laboratory services;
3. hospitalization;	9. preventive and wellness and chronic disease management; and
4. maternity and newborn care;	10. pediatric services, including oral and vision care.
5. mental health and substance abuse disorder services, including behavioral health treatment;	
6. prescription drugs;	

Benefits package by selecting a benchmark plan to base it on.²⁰ About a third of states had not identified a package by that targeted timeline.²¹ At the time of this writing, it is unclear precisely how the EHB packages will vary by state.²²

The inclusion of mental health and substance abuse disorder services is essential for some adolescents and young adults.²³ The adolescent and young adult years are critical for identifying and treating mental health and substance use problems, as symptoms of nearly half of lifetime diagnosable problems appear by age 14 and symptoms of nearly three quarters of these problems begin by age 24.²⁴ Among young adults (ages 18-25) in 2010, 15.8% had a substance use disorder and 8.2% had a major depressive episode (a widely measured disorder) in the past year; for adolescents, these figures were 4.6% and 8.0%, respectively.²⁵ Another welcome addition is the inclusion of dental and vision care for children. However, a serious omission is the lack of any requirement for dental or vision care for adults. Young adults face tremendous problems in access to dental care. Among 18- to 25-year-olds, 42% did not have a past-year dental visit and 17% had unmet dental needs in the past year; for uninsured young adults, these figures are much higher: 76% and 37%, respectively.²⁶

PUBLIC HEALTH INSURANCE: MEDICAID AND CHIP

In the original ACA legislation, the “Medicaid expansion,” described below, was a major vehicle for covering the uninsured, along with the individual mandate and the state health insurance exchanges. The ACA also included other provisions related to Medicaid and CHIP.

The Supreme Court’s Ruling on Medicaid

The Supreme Court’s ACA decision with respect to Medicaid was complex. Under the ACA statute, a state that did not implement the Medicaid expansion would have been penalized by losing *all* federal Medicaid support; that is, a non-compliant state would

lose not just the federal support for the expansion, but all federal funds that support the state’s Medicaid program in its entirety. The Supreme Court held that this enforcement mechanism was unconstitutional. However, it allowed the provision expanding Medicaid to individuals up to 133% FPL to stand, along with the increased federal support for that expansion.^{27, 28, 29, 30, 31}

Thus, as a result of the ACA decision, the Medicaid expansion is, in effect, optional for the states to implement.^{32, 33} All other Medicaid and CHIP related provisions of the ACA remain fully effective, including several more fully discussed below:

- maintenance of pre-ACA Medicaid and CHIP eligibility levels (“maintenance of effort”);
- mandatory increase in the eligibility level for children ages 6-18;
- requirement for continued Medicaid coverage up to age 26 for former foster youth;
- option for states to establish health homes for individuals with chronic conditions; and
- option for states to establish a Basic Health Program.

Medicaid Expansion

As a result of the ACA decision, states, in effect, have the option of adopting a new eligibility group for their Medicaid programs that includes all citizens and long-term legal residents in the U.S. who are under age 65, are not pregnant, do not have disabilities, and whose incomes are below 133% FPL (or 138% if income disregards are included). Medicaid already covers those who are pregnant and/or have disabilities at least up to this level and those over age 65 are eligible for Medicare.

The Medicaid expansion will reach both parents and childless adults, whose access to Medicaid in most states is extremely limited or nonexistent. As of January 2012, working parents were covered by Medicaid in 17 states only at income levels *below* 50% FPL, in 16 states at income levels from 50-99% FPL, and in only 18 states and DC at 100% FPL or a

higher level. Also in January 2012, childless non-disabled adults in 26 states had no access at all to Medicaid coverage.^{34, 35}

Young Adults

It is widely agreed that young adults will be among the leading beneficiaries of the Medicaid expansion. For example, one recent estimate, issued after the ACA decision, suggests that of the 15 million newly eligible (taking into consideration that all states may not implement the expansion) about half (7.8 million) will be under age 35.³⁶

Without the expansion, many young adults will continue to face the extremely low Medicaid eligibility levels that were in place in their states prior to the ACA. In these circumstances, their incomes might be too high to qualify for Medicaid under their state's old Medicaid eligibility levels, but too low to meet the low-end threshold of 100% FPL for enrolling in a subsidized plan through the exchanges. If this were to occur, one of the results of the Supreme Court's ACA decision could be to leave uninsured one of the most vulnerable groups the ACA was designed to help.

Certain vulnerable populations are especially likely to be among those who will benefit from the Medicaid expansion. These include, for example, homeless individuals and individuals who have been involved with the criminal justice system, among whom young adults are heavily represented.^{37, 38} Each of these groups is at high risk for having multiple serious health problems, including mental health and substance abuse disorders. They also frequently have encountered severe difficulties accessing needed medical care. States that have expanded Medicaid in the past to childless adults have experienced significant enrollment by these groups. A study of significant expansions of Medicaid in three states – Arizona, Maine, and New York – found numerous benefits resulting from the expansions.^{39, 40} These benefits included improved access to care and self-reported health, as well as decreased mortality. Thus, the decision by states of whether to expand

Medicaid or not is likely to have significant implications for the health of vulnerable low-income young adults.

Benefits for Newly Eligible

It will be challenging to ensure that adolescent and young adult Medicaid beneficiaries with complex medical needs not only have coverage, but actually receive needed care – this will be true for both the newly eligible and those who have been eligible under prior law. The ACA requires that newly eligible adult Medicaid beneficiaries have access to at least the minimum Essential Health Benefits, but the specific scope of these benefits, yet to be determined for each state, will affect young adults' ability to obtain needed care.

Costs of No Medicaid Expansion

Apart from the direct gains for the newly eligible beneficiaries themselves, there are many reasons for states to choose to implement the expansion.^{41, 42} Over the first nine years of the expansion, the federal government will bear 93% of the cost – 100% for the first three years and percentages declining to 90% thereafter.^{43, 44} If a state foregoes those funds to save its share of the expansion costs, the state may incur other costs when individuals who do not gain Medicaid coverage turn to emergency rooms and other local facilities for care. Many of those individuals will be young adults, who will continue to suffer, as they have in the past, from the obstacles that prevent the uninsured from seeking care or impel them to incur substantial burdens of medical debt for essential services.

Maintenance of Effort

The ACA contains important "maintenance of effort" requirements. Until at least 2014, states are required to maintain the Medicaid eligibility levels that were in place when the ACA was enacted. For adults, the Medicaid maintenance of effort provision will no longer apply in 2014, once the state health insurance exchanges are operational. For children and adolescents up to age 18, the maintenance of effort provisions for Medicaid and CHIP continue until 2019. Either rolling back

eligibility levels or instituting more burdensome enrollment procedures would result in fewer adolescents and young adults being able to qualify for Medicaid and CHIP.

Eligibility Increase for Children and Adolescents

A provision of the ACA, which is separate from the Medicaid expansion and thus is intact after the Supreme Court's decision, requires states to raise the Medicaid eligibility threshold for children ages 6-18 to 133% FPL effective in 2014. The minimum eligibility threshold for this age group was previously set at 100% FPL, so that states were required to offer coverage at least up to that level.⁴⁵ Although at least 10 states had already adopted more generous levels higher than 133% FPL by 2012, adolescents in most states will benefit from this higher eligibility threshold. Currently, these eligibility levels vary widely among the states for children ages 6-19 – from a low of 100% FPL in a large majority of states to a high of 275% FPL in one state.⁴⁶ Although some adolescents in a state where eligibility currently exceeds 133% FPL will lose Medicaid eligibility when maintenance of effort ends for children and adolescents in 2019, they should be able to receive subsidized coverage through the exchanges. However, an important question remains about whether the benefit package – which will be whatever their state adopts as its Essential Health Benefits – will be as broad as the package available from Medicaid.

Coverage to Age 26 for Former Foster Youth

Another important provision of the ACA requires states, beginning in 2014, to continue Medicaid coverage for youth aging out of foster care until they reach age 26.⁴⁷ These youth are among the most vulnerable, both because they are at risk for multiple health problems, and because they have extreme difficulty securing health insurance coverage. This ACA provision provides a safety net for these young people, who do not have families to support them, that is comparable to the one allowing other young adults to remain covered as a dependent on a parent's health insurance

plan to age 26. Even with this coverage requirement in place, numerous questions remain about how to implement it in ways that will ensure it reaches the eligible former foster youth.

Health Homes

One potential complement to the Essential Health Benefits for Medicaid eligible young people is the ACA's provision giving states a new option to create "Health Homes."⁴⁸ These Health Homes offer the possibility of providing coordinated care to Medicaid beneficiaries who have one or more chronic conditions, such as mental health or substance abuse disorders, asthma, diabetes, or severe obesity. The list of services is broad and includes care coordination, support, and referral services, which can be provided by a range of designated providers or various health teams. States receive a 90% federal match for the specific Health Home services (separate from funding for the underlying Medicaid services) provided to an individual for up to two years (or eight quarters). This option holds promise for increasing access to coordinated care for adolescent and young adult Medicaid beneficiaries who have complex medical needs or chronic conditions. As of August 2012, 20 states had expressed interest in this option and six had received approval to implement it.

Basic Health Program

The ACA made an additional option available to states to establish a Basic Health Program (BHP), an additional mechanism for insurance coverage that states can offer using federal tax subsidy dollars.^{49,50} Not technically part of Medicaid, the BHP option is intended as another way for states to increase continuity of coverage and care for low income populations by bridging potential eligibility gaps between Medicaid and the exchanges. In states choosing to establish a BHP, eligible individuals would include primarily those whose incomes are between 133% and 200% FPL; lawful immigrants with incomes up to 200% FPL, including those with incomes lower than 133% FPL, would also be eligible. The benefits would have to be at least equal to the

Essential Health Benefits package in the state. Individuals eligible for the BHP would not be eligible for subsidies through the exchanges, but their premiums and other cost-sharing could not be higher than they would be through the exchanges. It is unclear how many states will choose this option and many implementation details are yet to be determined, but in states that establish a BHP, many adolescents and young adults would be part of the eligible population.

PREVENTIVE HEALTH SERVICES

The Supreme Court decision left intact all of the ACA's provisions to increase access to and use of preventive services in both private and public insurance. These provisions will be, or already have been, beneficial for adolescents and young adults.

Of particular importance is the requirement that most private health insurance plans – including both employer-based and individual market plans – cover a specified set of preventive services without cost-sharing. These services include the evidence-based screening and counseling services rated highly by the U.S. Preventive Services Task Force; immunizations recommended by the Advisory Committee on Immunization Practices; the *Bright Futures* pediatric guidelines; and the services included in the Women's Preventive Health Services Guidelines.⁵¹ These preventive services must also be part of the Essential Health Benefits. The requirement for no-cost coverage of most of these preventive services became effective in 2010; the addition of services specified in the Women's Preventive Services Guidelines took effect in August 2012. HHS estimated in February 2012 that as a result of this requirement, 54 million individuals had received expanded coverage of at least some preventive services.⁵²

Several of the preventive services that must be covered without cost sharing for all adults includes several that are very important for young adults: immunizations; alcohol misuse screening and counseling; tobacco use screening and cessation interventions; depression screening; Type 2 Diabetes

screening; diet counseling for adults at higher risk for chronic disease; obesity screening and counseling; HIV screening; STI prevention counseling; and syphilis screening. Some of these services are specified only for individuals at increased risk. Most young adults will likely benefit from no-cost access to these preventive services.

In accordance with the Women's Preventive Services Guidelines,⁵³ private plans must offer additional services to women without cost-sharing, as well as the services that must be available to all adults.^{54, 55, 56, 57} A few of these additional services that are of particular importance for female adolescents and young adults include: contraception; domestic and interpersonal violence screening and counseling; and well-woman visits to obtain recommended preventive services. Most female adolescents and young adults will likely benefit from no-cost access to these preventive services. In particular, the inclusion of the full range of FDA-approved contraceptive methods is without question beneficial for adolescents and young adults.

FUTURE POLICY CHOICES

The federal government and states face major policy choices as implementation of the ACA moves forward in the wake of the Supreme Court's decision and the 2012 election. Opponents of the ACA will continue to challenge the entire ACA or key parts of it, and some states will resist implementation of specific parts of the law. HHS and other federal agencies will continue to issue and update regulations and guidance with respect to significant provisions of the ACA. Between now and 2014, particularly important choices must be made by the states. One major decision for each state is whether to operate its own health insurance exchange, partner with the federal government to run the exchange, or leave it entirely to the federal government to do so. Another key choice for each state is whether (and when) to implement the Medicaid expansion. HHS has offered flexibility to the states with some of the deadlines associated with these choices and with other requirements, so some aspects of

ACA implementation may continue to be a moving target.

As ACA implementation moves forward, key questions to monitor in order to determine how adolescents and young adults will be affected include:

- What specific content is included in the Essential Health Benefits package in each state?
- Which preventive services are included in each state's Essential Health Benefits package?
- Has the exchange in each state established a seamless process for applying for individual coverage and being approved for the appropriate plan?
- Is there an effective process for determining eligibility for premium tax credits and cost-sharing subsidies?
- Has each state opted to implement the Medicaid expansion?
- In states that do not implement the Medicaid expansion are some young adults left uninsured due to a gap between the eligibility level for Medicaid and for the exchange?
- Has each state increased its Medicaid eligibility level up to 133% FPL for children and adolescents ages 6-18?

- Has each state maintained its Medicaid and CHIP eligibility levels for children and adolescents until 2019?
- Has each state extended Medicaid coverage for former foster youth to age 26?

CONCLUSION

The Supreme Court's ACA decision and the recent election have given a green light to continued implementation of the ACA – signals that are welcome to those concerned about the health and health care access of adolescents and young adults. Many complex questions about eligibility, scope of benefits, subsidies, and access to care for these age groups remain unanswered. Many important decisions must still be made by the federal government and the states that will have a significant impact on adolescents and young adults – especially decisions about whether to implement the Medicaid expansion and which specific benefits to include in the Essential Health Benefits package. At this time, however, all the indications are that the Supreme Court's decision will allow that the ACA to be implemented in ways that will benefit millions of young people.



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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

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Past Issue Briefs in This Series

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