Limited Impact on Health and Access to Care for 19- to 25-Year-Olds Following the Patient Protection and Affordable Care Act

Meera Kotagal, MD, MPH; Adam C. Carle, MA, PhD; Larry G. Kessler, ScD; David R. Flum, MD, MPH

IMPORTANCE The Patient Protection and Affordable Care Act (PPACA) allowed young adults to remain on their parents’ insurance until 26 years of age. Reports indicate that this has expanded health coverage.

OBJECTIVE To evaluate coverage, access to care, and health care use among 19- to 25-year-olds compared with 26- to 34-year-olds following PPACA implementation.

DESIGN, SETTING, AND PARTICIPANTS Data from the Behavior Risk Factor Surveillance System and the National Health Interview Survey, which provide nationally representative measures of coverage, access to care, and health care use, were used to conduct the study among participants aged 19 to 25 years (young adults) and 26 to 34 years (adults) in 2009 and 2012.

EXPOSURE Self-reported health insurance coverage.

MAIN OUTCOMES AND MEASURES Health status, presence of a usual source of care, and ability to afford medications, dental care, or physician visits.

RESULTS Health coverage increased between 2009 and 2012 for 19- to 25-year-olds (68.3% to 71.7%). Using a difference-in-differences (DID) approach, after adjustment, the likelihood of having a usual source of care decreased in both groups but more significantly for 26- to 34-year-olds (DID, 2.8%; 95% CI, 0.45 to 5.15). There was no significant change in health status for 19- to 25-year-olds compared with 26- to 34-year-olds (DID, –0.5%; 95% CI, 1.87 to 0.87). There was no significant change for 19- to 25-year-olds compared with 26- to 34-year-olds in the percentage who reported receiving a routine checkup in the past year (DID, 0.3%; 95% CI, –2.25 to 2.85) or in the ability to afford prescription medications (DID, –0.4%; 95% CI, –2.93 to 1.93), dental care (DID, –2.6%; 95% CI, –5.61 to 0.61), or physician visits (DID, –1.7%; 95% CI, –3.66 to 0.26). There was also no change in the percentage who reported receiving a flu shot (DID, 1.9%; 95% CI, –1.93 to 4.93). Insured individuals were more likely to report having a usual source of care and a recent routine checkup and were more likely to be able to afford health care than uninsured individuals.

CONCLUSIONS AND RELEVANCE Implementation of the PPACA was associated with increased health insurance coverage for 19- to 25-year-olds without significant changes in perceived health care affordability or health status. Although the likelihood of having a usual source of care declined between 2009 and 2012 for all, this decrease was smaller among 19- to 25-year-olds, and younger adults were more likely than 26- to 34-year-olds to have a usual source of care.
Y
ing adults aged 19 to 25 years have the lowest rates of
health insurance coverage nationally, with nearly 1 in
3 lacking health insurance in 2009.1 An early provision
of the Patient Protection and Affordable Care Act (PPACA),
implemented in September 2010, mandated that insurance
companies allow adults younger than 26 years to remain ben-
eficiaries on their parents’ insurance. This provision was de-
dsigned to expand coverage for young adults, who often may
not have a source of insurance through an employer or other-
wise. Reports from the Centers for Disease Control and Pre-
vention, US Census Bureau, and Commonwealth Fund showed
that the percentage of uninsured Americans decreased in 2011
for the first time in 4 years, a drop attributed partly to the docu-
mented coverage expansion among 19- to 25-year-olds.2-4

While increased insurance coverage is presumed to be good
for this population, the PPACA’s impact on young adults’ health,
access to care, and health care use remains unknown. It is un-
clear whether expansion of coverage alone is sufficient to im-
prove health and access to care among young adults. One year
after implementation, the expansion of coverage for 19- to 25-
year-olds was associated with significant decreases in the num-
ber of young adults who delayed or did not receive care be-
cause of cost, but changes in having a usual source of care were
not found.5 In many settings, lack of insurance has been as-
associated with worse access to and quality of health care.6-9
However, expansion of coverage has not always been associ-
ated with improved health, as demonstrated through the RAND
Health Insurance Experiment,10 in which having coverage did
not affect health except for the poorest and sickest patients.
Persons aged 19 to 25 may also interact with the health
care system differently than older patients because they are
generally healthier.

To better understand the impact of health care coverage
expansion among 19- to 25-year-olds, we evaluated health, ac-
to care, and health care use before and after implemen-
tation of the PPACA provision using data from 2 national health
surveys.

Methods

Data
Data from 2 publicly available surveys—the Behavioral Risk Fac-
tor Surveillance System (BRFSS) and the National Health In-
terview Survey (NHIS)—were used to conduct the study. Data
from 2009 (before PPACA implementation) and 2012 (2 years
after implementation) were compared. The BRFSS is a tele-
phone survey of noninstitutionalized adults 18 years or older
that collects information on health status, behaviors, and ac-
to care. The survey uses a stratified probability sampling
design to allow for estimation of state-specific data and to cre-
ate a nationally representative sample. In 2009, the BRFSS in-
cluded more than 400,000 interviews, and response rates var-
ied by state from 37% to 72%.11 In 2012, response rates varied
by state from 27.7% to 60.4%.11 The NHIS is an in-person sur-
vey conducted by the Centers for Disease Control and Preven-
tion and the National Center for Health Statistics that in-
cludes approximately 100,000 participants per year in the

family core portion of the survey.12 Both surveys use com-
plex survey designs and design weights to create representa-
tive samples of the noninstitutionalized US adult population.
Ethical approval was not required for this study because the
study used publicly available, deidentified data.

Study Population
We selected 2 cohorts of individuals: young adults (19-25 years)
and adults (26-34 years) from both surveys. Young adults were
the primary cohort of interest, and adults were selected as the
comparison group, consistent with Sommers et al,5 because
an ideal comparison group of 19- to 25-year-olds who were not
affected by the PPACA provision does not exist.

Statistical Analysis
Demographic data, as well as data regarding health status, ac-
to care, and health care use, were compared for 2009 and
2012. In a univariate analysis, variables were compared using
the Pearson χ2 test for proportions and t tests for continuous
variables. We used an α level of P < .05 to determine statistical
significance. All our analyses properly subsetted the data (ie, used
subpopulation functions), used the survey design weights, and
accounted for each survey’s complex survey design.

To examine whether the PPACA improved the health, ac-
to care, and health care use for young adults, we used a dif-
ference-in-differences (DID) approach to help account for coun-
tervailing trends. We compared young adults (19-25 years) with
their slightly older counterparts (26-34 years). The DID ap-
proach allowed us to examine whether changes occurred across
time and whether any change (positive or negative) was more
pronounced for one group compared with the other. Compari-
sions were adjusted for race and ethnicity, sex, income, employ-
ment status, and educational level. Sensitivity analyses were
conducted based on insurance coverage status. We conducted
all analyses in Stata, version 12.1 (StataCorp).

Results
Demographic characteristics were compared between the
young adult (19-25 years) and older adult (26-34 years) popu-
lations (Table 1 and Table 2). The mean age for young adults
was approximately 22 years in both survey years and cohorts,
and the mean age for the older adults was approximately 30
years in both survey years and cohorts. There was an increase
in the percentage of individuals living in poverty in both age
groups between 2009 and 2012 (annual household income
< $15,000 increased from 17.7% to 22.1% for 19- to 25-year-olds
and from 10.0% to 13.8% for 26- to 34-year-olds according to
BRFSS data). Older adults were much more likely to have
graduated from college in both surveys. The proportion of the
population in each race was approximately the same across
surveys, cohorts, and survey years (approximately 58% non-
Hispanic white, 13% non-Hispanic black, 5% Asian, 3% non-
Hispanic other, and 20% Hispanic). There were slightly lower
numbers of non-Hispanic other respondents in the NHIS co-
horts (approximately 1%). Male and female sex was equally
represented in both age groups and survey cohorts.
### Table 1. Behavioral Risk Factor Surveillance System Cohort Demographic Information

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Persons Aged 19-25 y</th>
<th>Persons Aged 26-34 y</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2009</td>
<td>2012</td>
</tr>
<tr>
<td>Total participants, weighted, No.</td>
<td>24 483 817</td>
<td>29 532 874</td>
</tr>
<tr>
<td>Age, mean (SD), y</td>
<td>21.9</td>
<td>21.9</td>
</tr>
<tr>
<td>Sex, %</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>52.1</td>
<td>51.6</td>
</tr>
<tr>
<td>Female</td>
<td>47.9</td>
<td>48.4</td>
</tr>
<tr>
<td>Race/ethnicity, %</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Hispanic white</td>
<td>58.2</td>
<td>57.2</td>
</tr>
<tr>
<td>Non-Hispanic black</td>
<td>11.7</td>
<td>14.0</td>
</tr>
<tr>
<td>Asian</td>
<td>5.0</td>
<td>6.1</td>
</tr>
<tr>
<td>Non-Hispanic other</td>
<td>3.4</td>
<td>2.9</td>
</tr>
<tr>
<td>Hispanic</td>
<td>21.6</td>
<td>19.8</td>
</tr>
<tr>
<td>Current employment status, %</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employed</td>
<td>50.8</td>
<td>52.6</td>
</tr>
<tr>
<td>Not employed</td>
<td>16.3</td>
<td>12.5</td>
</tr>
<tr>
<td>Other (eg, student, retired)</td>
<td>32.9</td>
<td>34.9</td>
</tr>
<tr>
<td>Annual household income of &lt;$15 000, %a</td>
<td>17.7</td>
<td>22.1</td>
</tr>
<tr>
<td>Educational level, %</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High school or less</td>
<td>43.5</td>
<td>42.4</td>
</tr>
<tr>
<td>Some college</td>
<td>39.0</td>
<td>42.8</td>
</tr>
<tr>
<td>Graduated from college</td>
<td>17.4</td>
<td>14.7</td>
</tr>
<tr>
<td>Insurance type, %</td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>32.7</td>
<td>25.3</td>
</tr>
<tr>
<td>Medicaid only</td>
<td>8.7</td>
<td>9.5</td>
</tr>
<tr>
<td>Private only</td>
<td>49.5</td>
<td>53.0</td>
</tr>
<tr>
<td>Other</td>
<td>9.1</td>
<td>12.2</td>
</tr>
</tbody>
</table>

*a Approximately 133% of federal poverty level.

### Table 2. National Health Interview Survey Cohort Demographic Information

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Persons Aged 19-25 y</th>
<th>Persons Aged 26-34 y</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2009</td>
<td>2012</td>
</tr>
<tr>
<td>Total participants, unweighted, No.</td>
<td>28 723 061</td>
<td>30 542 129</td>
</tr>
<tr>
<td>Age, mean (SD), y</td>
<td>22.0</td>
<td>21.9</td>
</tr>
<tr>
<td>Sex, %</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>49.9</td>
<td>49.5</td>
</tr>
<tr>
<td>Female</td>
<td>50.1</td>
<td>50.5</td>
</tr>
<tr>
<td>Race/ethnicity, %</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Hispanic white</td>
<td>61.7</td>
<td>59.3</td>
</tr>
<tr>
<td>Non-Hispanic black</td>
<td>13.8</td>
<td>14.1</td>
</tr>
<tr>
<td>Asian</td>
<td>4.8</td>
<td>5.3</td>
</tr>
<tr>
<td>Non-Hispanic other</td>
<td>1.1</td>
<td>1.0</td>
</tr>
<tr>
<td>Hispanic</td>
<td>18.5</td>
<td>20.2</td>
</tr>
<tr>
<td>Current employment status, %</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employed</td>
<td>63.7</td>
<td>60.8</td>
</tr>
<tr>
<td>Not employed</td>
<td>12.5</td>
<td>14.7</td>
</tr>
<tr>
<td>Other (eg, student, retired)</td>
<td>23.9</td>
<td>24.5</td>
</tr>
<tr>
<td>Annual household income of &lt;100% FPL</td>
<td>24.8</td>
<td>27.6</td>
</tr>
<tr>
<td>Educational level, %</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High school or less</td>
<td>40.8</td>
<td>38.8</td>
</tr>
<tr>
<td>Some college</td>
<td>44.9</td>
<td>46.2</td>
</tr>
<tr>
<td>Graduated from college</td>
<td>14.3</td>
<td>15.0</td>
</tr>
</tbody>
</table>

Abbreviation: FPL, federal poverty level.
Health care coverage increased for 19- to 25-year-olds during the study period, as anticipated (68.3% to 71.7%; difference, 3.4%; 95% CI, 1.5 to 5.1), and declined significantly for 26- to 34-year-olds (77.8% to 70.3%; difference, –7.5%; 95% CI, –8.7 to –6.3) (Table 3). Self-reported overall health status did not change significantly from 2009 to 2012 for young adults (fair or poor health status decreased from 9.3% to 8.9%; difference, –0.4%; 95% CI, –1.5 to 0.7) (Table 3). We found a small but significant decline in the percentage of young adults with a usual source of care (62.0% to 58.8%; difference, –3.2%; 95% CI, –5.2 to –1.4). There was no significant difference in the percentage of young adults who reported a visit to a physician for a routine checkup in the past year (56.8% vs 56.3%; difference, –0.5%; 95% CI, –2.4 to 1.3) or in the percentage who reported being unable to see a physician because of cost (21.5% vs 20.5%; difference, –1.0%; 95% CI, –2.5 to 0.6). The percentage of 19- to 25-year-olds who reported being unable to afford prescription medications or dental care declined between 2009 and 2012 (11.0% to 7.9%; difference, –3.1%; 95% CI, –5.1 to –1.2 and 18.7% to 14.1%; difference, –4.6%; 95% CI, –7.1 to –2.1, respectively). Young adults were also more likely to report obtaining a flu shot (16.5% vs 21.1%; difference, 4.6%; 95% CI, 2.1 to 7.2). In sensitivity analyses comparing those with and without coverage, those with insurance were more likely than their uninsured counterparts to have a usual source of care (Table 3). Insured individuals were also more likely to report visiting a physician for a routine checkup, obtaining a flu shot, and being able to afford physician visits, prescription medications, and dental care than uninsured individuals.

Univariate Analyses

Health care coverage increased for 19- to 25-year-olds during the study period, as anticipated (68.3% to 71.7%; difference, 3.4%; 95% CI, 1.5 to 5.1), and declined significantly for 26- to 34-year-olds (77.8% to 70.3%; difference, –7.5%; 95% CI, –8.7 to –6.3) (Table 3). Self-reported overall health status did not change significantly from 2009 to 2012 for young adults (fair or poor health status decreased from 9.3% to 8.9%; difference, –0.4%; 95% CI, –1.5 to 0.7) (Table 3). We found a small but significant decline in the percentage of young adults with a usual source of care (62.0% to 58.8%; difference, –3.2%; 95% CI, –5.2 to –1.4). There was no significant difference in the percentage of young adults who reported a visit to a physician for a routine checkup in the past year (56.8% vs 56.3%; difference, –0.5%; 95% CI, –2.4 to 1.3) or in the percentage who reported being unable to see a physician because of cost (21.5% vs 20.5%; difference, –1.0%; 95% CI, –2.5 to 0.6). The percentage of 19- to 25-year-olds who reported being unable to afford prescription medications or dental care declined between 2009 and 2012 (11.0% to 7.9%; difference, –3.1%; 95% CI, –5.1 to –1.2 and 18.7% to 14.1%; difference, –4.6%; 95% CI, –7.1 to –2.1, respectively). Young adults were also more likely to report obtaining a flu shot (16.5% vs 21.1%; difference, 4.6%; 95% CI, 2.1 to 7.2). In sensitivity analyses comparing those with and without coverage, those with insurance were more likely than their uninsured counterparts to have a usual source of care (Table 3). Insured individuals were also more likely to report visiting a physician for a routine checkup, obtaining a flu shot, and being able to afford physician visits, prescription medications, and dental care than uninsured individuals.

Multivariable Analyses

Analyses using a DID approach, adjusting for race and ethnicity, sex, income, employment status, and educational level, found a significant increase in health care coverage for 19- to 25-year-olds when compared with their older counterparts (DID between age groups between 2009 and 2012, 7.7%; 95% CI, 5.4 to 9.86) (Table 4). While the likelihood of having a usual source of care decreased for 19- to 25-year-olds and 26- to 34-year-olds between 2009 and 2012, it did so more substantially for the older age group (~6.4% change vs ~3.3% change; DID, 2.8%; 95% CI, 0.4 to 5.1). There was no significant change during the study period in self-reported overall health status for 19- to 25-year-olds compared with 26- to 34-year-olds (DID, –0.5%
Discussion

The PPACA included a specific provision, implemented in 2010, to expand insurance coverage to young adults (19- to 25-years) through their parents’ insurance. In this study, we found an increase in coverage among young adults after implementation of the PPACA (2012), as expected, without significant changes in health status compared with the preimplementation period (2009). Despite increased coverage of an estimated 3 million people, the proportion of respondents with a usual source of care declined significantly among 19- to 25-year-olds. This decline, however, was less steep than that of 26- to 34-year-olds during the same time. The ability to afford prescription medications improved for 19- to 25-year-olds and 26- to 34-year-olds during the same time, but the percentage of 19- to 25-year-olds with a usual source of care decreased significantly between 2009 and 2012. When compared with 26- to 34-year-olds, this decline was less significant for 19- to 25-year-olds, but it remains that young adults, regardless of age, were significantly less likely to have a usual source of care in 2012 compared with 2009. We did not find significant improvements in the ability of 19- to 25-year-olds to afford health care coverage during the study period when compared with 26- to 34-year-olds.

There is evidence indicating a positive impact of insurance on health outcomes with increased use of preventive services, including Pap smears, and increased likelihood of having a usual source of care. While our findings reinforce this conclusion, with insured individuals faring better than those who were uninsured, the overall decline in having a usual source of care for both age cohorts suggests that the link between coverage and health care use is complicated depend-

Table 4. Changes in Health Care Coverage, Access to Care, and Health Care Usea

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Persons Aged 19-25 y (Baseline)</th>
<th>Change Before and After PPACA Implementation</th>
<th>DID Between Age Groups (95% CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health care coverage, %b</td>
<td>56.7</td>
<td>3.1</td>
<td>-4.6</td>
</tr>
<tr>
<td>Overall health fair or poor, %b</td>
<td>17.5</td>
<td>-0.3</td>
<td>0.3</td>
</tr>
<tr>
<td>With health care coverage</td>
<td>15.9</td>
<td>-0.6</td>
<td>0.3</td>
</tr>
<tr>
<td>Without health care coverage</td>
<td>19.4</td>
<td>0.6</td>
<td>-0.6</td>
</tr>
<tr>
<td>Have a usual source of care, %b</td>
<td>46.3</td>
<td>-3.7</td>
<td>-6.1</td>
</tr>
<tr>
<td>With health care coverage</td>
<td>60.4</td>
<td>-4.0</td>
<td>-4.8</td>
</tr>
<tr>
<td>Without health care coverage</td>
<td>30.1</td>
<td>-5.5</td>
<td>-3.3</td>
</tr>
<tr>
<td>Unable to see physician in past year because of cost, %b</td>
<td>28.5</td>
<td>-0.9</td>
<td>0.7</td>
</tr>
<tr>
<td>With health care coverage</td>
<td>15.7</td>
<td>-0.7</td>
<td>-0.1</td>
</tr>
<tr>
<td>Without health care coverage</td>
<td>44.8</td>
<td>1.5</td>
<td>-2.6</td>
</tr>
<tr>
<td>Unable to afford prescription medications in past year, %c</td>
<td>11.1</td>
<td>-3.1</td>
<td>-2.7</td>
</tr>
<tr>
<td>With health care coverage</td>
<td>5.5</td>
<td>-1.0</td>
<td>-1.6</td>
</tr>
<tr>
<td>Without health care coverage</td>
<td>23.7</td>
<td>-4.1</td>
<td>-7.0</td>
</tr>
<tr>
<td>Unable to afford dental care in the past year, %c</td>
<td>18.7</td>
<td>-4.6</td>
<td>-2.0</td>
</tr>
<tr>
<td>With health care coverage</td>
<td>12.2</td>
<td>-1.3</td>
<td>-0.9</td>
</tr>
<tr>
<td>Without health care coverage</td>
<td>39.4</td>
<td>-5.3</td>
<td>-7.3</td>
</tr>
<tr>
<td>Flu shot in the past year, %c</td>
<td>16.5</td>
<td>4.6</td>
<td>2.7</td>
</tr>
<tr>
<td>With health care coverage</td>
<td>11.7</td>
<td>5.4</td>
<td>4.1</td>
</tr>
<tr>
<td>Without health care coverage</td>
<td>5.4</td>
<td>0.5</td>
<td>1.8</td>
</tr>
</tbody>
</table>

Abbreviations: DID, difference-in-differences; PPACA, Patient Protection and Affordable Care Act.

a For persons aged 19 to 25 years compared with those aged 26 to 34 years, using a difference-in-differences approach adjusted for covariates.

b Behavioral Risk Factor Surveillance System data.

c National Health Interview Survey data.

95% CI, -1.87 to 0.87). There was no significant difference between 2009 and 2012 for 19- to 25-year-olds compared with 26- to 34-year-olds in the percentage who reported having a routine checkup in the past year; being able to afford to see a physician, obtain prescription medications, or receive dental care; and receiving a flu shot (Table 4). Although space constraints prevent their presentation, we observed these same patterns across several sociodemographic variables (eg, race, ethnicity, and educational level).
ing on interest and ability to obtain health care. The impact of interest (or lack thereof) on the ability to obtain health care may be more pronounced in young adults, as they are generally healthy and may have very little need to access health care. In addition, many 19- to 25-year-olds may be newly insured as a result of the PPACA provision, and the short duration for which they have had insurance may play a role in whether they have a usual source of care.

It is also important to note that, because this population is, overall, quite healthy, self-perceived health status may not be a useful metric among young adults. Other studies have found that, in general, young adults are healthy, with more than 96% reporting being in excellent, very good, or good health. Assessment of health in young adults may need to focus more on specific behaviors, such as sexual health, alcohol and drug use, and exercise, to better determine trends in health in young adults. In addition, a focus on young adult populations with special health needs, including chronic disease and disability, may better elucidate the impact of health care coverage.

While no prior interventions have expanded coverage to young adults specifically that would allow us to study the impact, 2 randomized trials have evaluated the impact on health of expanding insurance coverage and decreasing barriers to accessing health care. The RAND Health Insurance Experiment found that eliminating barriers to health care increased both necessary and unnecessary care but did not affect health (except for the poorest and most sick). The Oregon Health Insurance Experiment found improved self-reported health among insured participants as well as lower out-of-pocket medical expenditures and medical debt. Recent findings from this study demonstrate that coverage alone may not be sufficient to improve patterns of use. Individuals with Medicaid coverage were found to have significantly higher rates of emergency department use than their uninsured counterparts despite the fact that emergency department visits have often been thought to serve as a marker of lack of access to other sources of health care. The high emergency department rates among those with coverage may represent severity of illness, a preference for emergency department care over primary care, or an inability to find an available primary care provider. In our study, respondents in both age groups reported a decrease in having a usual source of care. This outcome may reflect difficulty accessing care or reluctance to establish care and could represent a broader trend. Young adults, given their overall healthy status, may not desire regular primary care, and thus an expansion in coverage may not lead these individuals to have a usual source.

The proportion of young adults who reported a recent physician’s visit, although more common among insured respondents, has declined yearly since 2003; this trend continued after implementation of the PPACA. We attempted to address this by using a DID approach (expecting that 19- to 25-year-olds and 26- to 34-year-olds would face similar economic pressures) and by controlling for relevant demographic characteristics, such as employment status and income. However, studies suggest that use of health care services may have decreased during the economic downturn regardless of coverage. Fifth, young adults may be some of the least frequent users of the health care system, and assessing changes in their overall use may be challenging. In addition, changes in health status likely require a longer duration than 1 year to manifest. Sixth, perceptions of health and well-being may relate to many things other than health care coverage, and the relationship between health care coverage and use is not a direct link. Last, one of the unique limitations of studying this legislation is that there are a number of factors not revealed in this national survey that may affect the insurance status of young adults, including whether their parents remain employed, whether employers shift from policies that cover dependents to those that do not, and whether employers shift to policies that only provide catastrophic coverage. These factors must be evaluated over time to fully understand the nature of insurance coverage for young adults.

Conclusions

This study evaluating nationally representative data surrounding the implementation of the PPACA confirms that health care coverage for young adults has increased but that young adults do not report improved health status, affordability of health care, or use of flu vaccination compared with their older counterparts. Persons aged 19 to 25 years were more likely to have a usual source of care than those aged 26 to 34 years, but both age groups saw declines in this measure of access to care. Understanding the PPACA’s full impact on young adults may require a focus on those who consume more health care, such as those with chronic disease. Insured patients fared better than their uninsured counterparts on all metrics of access to care, affordability, and health care use, however, and these results underscore the idea that insurance may be necessary, but not sufficient, to alter health care use and overall health. Health policy must continue to address access and quality in addition to coverage.
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