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The Importance of the Young Invincibles to the Success of the Affordable Care

Ethel K. Ishimwe
Wright State University - Main Campus

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The Importance of the Young Invincibles to the Success of the Affordable Care

Ethel K. Ishimwe

Wright State University
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Abstract

Health care reform in the United States, as codified in the Affordable Care Act (ACA), includes an individual mandate to insure that all citizens are participants in public or privately funded health insurance programs. Universal participation insures that the national risk pool of insured persons will include the broadest spectrum of patient utilizers from the very healthy, who are low utilizers, to the very sick who are high utilizers of health care services. It is only through this high level of participation that the increased services and cost savings of health care reform can be realized. Key to this comprehensive risk pool is the category of potential patients referred to as the young invincibles (YI), typically healthy, low utilizers of services who will in the long run benefit most from prevention and screening services. Additionally, comprehensive health care services earlier in life result in healthier middle aged and older people which has the potential of further reducing health care costs overall. This study reviews the participation of YI in the ACA market place. The first objective of this study was to look at the projected and desired number of YI anticipated to enroll in the ACA health insurance market in the first open enrollment period that ran from November 15, 2013 to March 31, 2014. The second objective was to evaluate the extent to which these critical goals were met. Lastly, the study focuses on describing outreach methods used to enroll YI in a health insurance plan under the ACA.

Keywords: Health Insurance, ACA Marketplace, Risk Pool, Healthy Utilizers, One on One Encounters
The Importance of the Young Invincibles to the Success of the Affordable Care

The passing of the Affordable Care Act into law on March 23, 2010 marked a dramatic change in the United States of America’s healthcare system (Rosenbaum, 2011). In fact, this law’s intent was to make significant alterations to the financing structure of the health care industry such that a large proportion of Americans could access health care services (Rosenbaum, 2011). For many years healthcare has not been accessible to many Americans and a big portion of the population has had no health insurance, such that 50 million Americans were uninsured in 2013 (Schoen, Osborn, Squires, & Doty, 2013). This system has also been known to focus on treatment instead of prevention (American Public Health Association, 2013).

Moreover, the healthcare system in the United States of America (USA) suffers from inefficiency and poor quality of patient care while the expenditure in this sector is high. In 2011 the USA spent as much as $8,508 per person on health care (Barker 2013). Even with high expenditures healthcare outcomes are often poorer in the USA than in other countries that spend far less (Barker, 2013). Therefore the ACA has just been instituted to help achieve universal coverage and make healthcare more affordable providing coverage to more than 95% of Americans and reducing the budget deficit by $138 billion in a ten years’ timeframe (House Committees, 2010).

In order for the system to work under the ACA nearly universal participation in health insurance plans is required to insure a national risk pool with a broad spectrum of both healthy and unhealthy individuals. Of particular interest is a portion of the population referred to as young invincibles. Young Invincibles are those individuals who are in the age group 18 to 34 years old. While it is widely believed that these YI expect to stay healthy and do not feel motivated to purchase health insurance, it is hoped that provisions of the ACA including the
individual mandate will compel YI to buy health insurance. The challenge becomes how to get them motivated to enroll (Kliff, 2013; Barker, 2010).

An expectation of insurance companies participating in the federal health insurance exchange or market place is that about 40% of enrollees will need to be YI in order to sufficiently offset the more expensive patients. If such cross-subsidization can be realized insurance premiums can be kept low and under control (Levitt, Claxton, & Damico 2013). Historically YI have opted out of health insurance as they perceive themselves to be healthy and not need health insurance. However, the participation of YI in insurance plans offered through the ACA Marketplace is so important that a number of targeted outreach strategies were developed during the first year of the project.

**Statement of Purpose**

This study will review the projected and desired number of YI anticipated to enroll in the ACA health insurance Marketplace in the first open enrollment that started from November 15, 2013 and ended on March 31, 2014 period. Secondly this study will evaluate the extent to which these goals were met. Lastly, the study will focus on the evaluation of outreach methods to enroll YI in a health insurance plan under the ACA.

**Literature Review**

**Healthcare in the USA before the ACA**

Before the passing of the ACA in March of 2010 the health system in the USA was such that individuals had to purchase private health insurance either through their employer or individually on the private market. Those who were older than 65 years, the poorest and the children benefitted from government issued health insurance plans. In the 1970s and 1980s, with advancements in medical care, the rise of successful biomedical research and the introduction of
highly effective diagnostic and therapeutic procedures, most patients in America had access to optimal healthcare (Dalen, 2000). However, in the 1980s and 1990s these advancements in medical care made the cost of healthcare rise extremely high, such that premiums for private health insurance rose significantly and the government funded health care became more limited. No one could afford to pay for care and the number of uninsured residents increased. Thus, many Americans were left without health insurance and access to affordable care became a big issue.

As of 2012 the number of uninsured in America had risen to about 50 million people (Schoen et al., 2014; Dalen, 2000). In addition 31.7 million people who had insurance were considered underinsured often carrying only catastrophic care insurance and forgoing routine medical care to avoid the costs of high deductible plans (Schoen et al., 2014; Schoen et al. 2013). These two groups of people added up to at least 82 million people living in the USA who were not able to afford needed medical care (Schoen et al., 2014). Of particular concern were the working poor who made too much money to qualify for publicly funded programs like Medicaid, yet could not afford to pay for private health insurance. Typically the working poor were employed full-time but the companies they worked for did not offer insurance or did not pay their workers enough for them to be able to purchase individual health insurance plans in the private marketplace. Lacking access to primary care and preventive services often led to seeking medical care in hospital emergency departments where the cost of care was twice as much as a visit at a primary care facility (Dalen, 2000).

In short, the cost of healthcare was very high in the USA before the ACA. The country as a whole spent a lot of money on healthcare. However a lot of people were uninsured and could not afford to pay for primary and preventive care. In the wake of the healthcare reform, it
is of value to compare healthcare in the USA to other countries in the world to point out
differences and similarities that could help explain overall outcomes.

**Comparison of the Healthcare in the USA Before the ACA to Other Countries in the World**

Although the USA has the most expensive health system in the world, the performance
and outcomes of this system are poorer than in other industrialized countries. As a measure of
performance the quality of medical care in the USA ranks lower than in countries such as
Germany, New Zealand and the UK, because of poorer chronic care management in the USA and
safe, coordinated, and patient-centered care in other countries (Davis & Fund, 2007). Looking at
expenditures, the USA comes in first place spending $3,000 more per person than what Norway
spends as the second-highest spender on healthcare (Schoen et al., 2013).

While most of the other industrialized countries have tried to extend access to healthcare
to all their populations through universal healthcare, the USA stands out with a complex health
insurance industry consisting of public and private insurance products with few regulations
(Schoen et al., 2013). The numerous residents who cannot afford to pay for private insurance
premiums, co-pays and deductibles opt to forgo needed care in the USA. In fact more than two-
fifths of lower income adults went without needed medical care due to cost, demonstrating that
healthcare is more equitable in countries where there is universal access to healthcare coverage
(Davis & Fund, 2007).

Additionally, the USA ranks poorly as far as the rate of death from conditions that could
be prevented if timely medical care were received, with rates 25 to 50 percent higher than in
Canada and Australia (Davis & Fund, 2007). In the USA the top five causes of death are heart
disease, cancer, chronic lower respiratory diseases, stroke and unintentional injuries. The risk
factors to these conditions can be increased if access and affordability to healthcare services is
limited. With near universal access to healthcare services these risks can get reduced, screening and early intervention is possible and successful treatment of a particular condition is more feasible. In fact, a study has found that countries such as Australia and Canada that have a universal health insurance system have overall lower mortality rates amenable to health care rates, and lower infant mortality rates than in the USA (Davis & Fund, 2007).

It is evident that that although expenditure on healthcare in the USA is high, other nations that spend much less outperform the USA. In order to attempt to resolve all these issues that have been present in the health system, the ACA was enacted.

**What is the ACA and What is its Importance?**

The Patient Protection and Affordable Care Act, which is also referred to as the Affordable Care Act (ACA), was enacted into law on March 23rd, 2010. This law marked a turning point in the history of healthcare policy in the USA, where millions of Americans were uninsured and while healthcare spending was significantly higher than elsewhere in the world, health outcomes were still not the best. In fact, the ACA marks the beginning of a move towards near-universal health insurance coverage, the improvement of quality, fairness, affordability and efficiency, the strengthening of primary care and preventive services access, and the strategic investment in the public’s health (Rosenbaum, 2011; Barker, 2013).

Before the ACA there were about fifty million uninsured people in the USA (Schoen et al. 2013). In order to achieve near universal-coverage the ACA will bring about fundamental reform in the health insurance market. This is achievable by requiring everyone to participate. This law’s individual mandate requires everyone living in the USA to have insurance or face a penalty (Barker, 2013). Broader health insurance policy reforms generally consist of requiring insurance companies to offer same rate policies which do not exclude preexisting conditions, and
regulating rate increases while preventing arbitrary cancelation policies (Silvers, 2013). Additionally, the working poor will benefit from major subsidies that will increase their purchasing power in the private health insurance market (Silvers, 2013). On the newly created health insurance Marketplace, competition among insurers will lead to lower premiums and more pressure on providers to make care better and more efficient (Silvers, 2013). Also, young people will be able to stay on their parents’ insurance up to the age of 26 years. Moreover, the expansion of Medicaid to the working poor making less than 133 percent of the poverty level is a way to increase coverage and increase access to care for poor people and the elderly (House Committees, 2010).

More specifically, in order to improve quality of life and health care the ACA wants to see the reduction of costs of care by abandoning the fee-for-service system and opting to “fairly pay for quality and value” (House Committees, 2010). Incentives will be paid to providers of care in order to improve the quality of their work. In addition to this quality of health and care aspect, the ACA intends to improve people’s lives by making them healthier and thus reducing the need to pay for hospitalization. This can be achieved by promoting and increasing access to preventive services, wellness programs and other public health services. In fact, this law will get rid of co-pays and deductibles for preventive services and will also provide needed information for people to stay healthy and there will be increased investment in education on disease prevention (Obama Care Facts, 2014; & House of Committees, 2010).

The ACA also aims at increasing the healthcare workforce by making provisions to increase funds for scholarships and loans to help those young people who are going into health related fields of study. The ACA seeks to increase access to care for underserved communities by giving incentives to primary care practitioners and providers who will serve in those areas.
More funds will also be allocated to expand primary care practices and community health centers (Obama Care Facts, 2014; House of Committees, 2010). Moreover, it is the ACA intent to move family practice into a central role to manage patient care in deciding where and how treatment occurs.

Therefore the healthcare reform is intended to make health insurance coverage nearly universal while improving access and quality of care and giving priority to primary and preventive care. The ACA is of great importance and it is essential to uncover and understand the functionality of the new healthcare reform.

The Functionality of the Health Insurance under the ACA

The ACA’s aim was to achieve near universal health care coverage in the USA by instituting the individual mandate, the insurance market reforms, the Medicaid Expansion and the Health Insurance Marketplace. In order to avoid paying a penalty each citizen and legal resident must have a qualifying health plan (QHP) that offers the defined ten essential health benefits (EHS). For the first enrollment period, the penalty for not enrolling was equal to $95 or 1% of the individual’s income and is paid when individuals file their income taxes (Health Policy Institute of Ohio, 2014; Blumenthal & Collins, 2014). This mandate is accompanied by a provision that those individuals with earnings between 100% and 400% of the federal poverty level (FPL) are eligible to receive premium assistance and those with incomes between 100% and 250% of the FPL qualify for cost-sharing deductions in the purchase of these QHP (Health Policy Institute of Ohio, 2014; Blumenthal & Collins, 2014).

Secondly, the insurance market had to be reformed in order to expand coverage. Under the new law anyone who applies for or renews a policy must be issued insurance. Pre-existing conditions cannot be grounds for denying coverage to an individual. While insurers will not
charge people at higher risk more than healthier ones, they will be allowed limited variation in premiums rates based on a few factors such as smoking, age, geographic location and family size. Moreover, people with mental and physical disabilities cannot be discriminated against. Also, young adults will be permitted to remain on their parents’ health insurance until they turn 26, if they desire to do so (HPIO, 2014).

Thirdly, Medicaid coverage was expanded to all people who have incomes up to 138% of the FPL and who are under 65 and are not eligible for Medicare including children, pregnant women, parents and adults without dependent children. The federal government left it up to the States to opt for this expansion or not. Ohio is one of the States that instituted this expansion and did therefore receive federal government financing of the program. This large expansion will contribute to reducing the number of uninsured Americans (Blumenthal & Collins, 2014; HPIO, 2014).

Fourthly, Health Insurance Marketplaces were created to make the buying and selling of QHP easier for the individual with different vendors and plans all right there in one place, where price and quality control are feasible and visible. In the same way small businesses that employ one to fifty people are able to purchase QHP through the Small Business Health Options Program. Marketplaces are expected to increase the number of the insured, increase transparency, educate consumers and assist anyone in need to the right coverage (HPIO, 2014).

All aspects of the ACA are predicated on the assumption that the individual mandate will work, that a large risk pool of insured individuals will be created. It is critical that all demographic groups- young, old, rich, poor- participate in the national insurance risk pool so that insurance companies can remain viable and will choose to offer plans in the ACA Marketplace.

“Health insurance risk pools are large groups of individual entities (either individuals or
employers) whose medical costs are combined in order to calculate premiums” (American Academy of Actuaries, 2009, p. 1). The higher the enrollment the better for any given insurance company, because it is more likely to have both the healthy and those not so healthy sign up. While a small pool may be comprised of the sick and the elderly who really need insurance, a larger pool is more likely to include healthier and younger populations who cost less to the insurance companies. Therefore, the low risk individual covers the costs of the higher risk people. Higher enrollment would also mean a possibility in lowering health insurance premiums. In an event where mainly high risk people make up a risk pool adverse selection can occur and lead to an increase in premiums. Therefore, the ACA policy makers instituted grounds that would increase population participation such as the individual mandate and the provision of subsidies to low-to-middle income individuals who cannot afford to pay the premiums in order to insure the largest risk pool possible (http://www.vox.com, 2014; American Academy of Actuaries, 2009).

In the end, the institution of the individual mandate, the insurance market reforms, the Medicaid expansion and the creation of the ACA marketplace are essential in bringing about reform in healthcare in the USA. Moreover the creation of strong risk pool is vital. In these regards the enrollment of young and healthier adults, specifically the YI, in the ACA marketplace has to be consistent in order to keep premiums affordable. Therefore campaigning and outreaching to them was of great importance during the first enrollment period of the ACA.

**Who are the Young Invincibles?**

The young invincibles are those individuals who are in the age group 18 to 34 years old. They are described as such by the insurance industry, because they expect to stay healthy and thus live without health care coverage (Kliff, 2013). Before the Affordable Care Act (ACA) was
enacted in March 2014, they were the largest group of uninsured people with about 27% of YI being without health insurance (Block, 2006; Durand, 2012). In addition to not purchasing health insurance because they are the healthiest demographic group, the YI were more likely to be uninsured after losing coverage under their parents because they were unemployed or had a job that did not offer health insurance (Block, 2006). Moreover, even when YI were employed, they often chose not to spend money on health insurance.

However invincible this group may be believed to be, reports have shown that they also have health issues and have always needed medical care. A big number of young adults (15%) are affected by chronic diseases which commonly include asthma, arthritis and hypertension. Also, some young adults live with chronic conditions mainly affecting older individuals such as diabetes, cancer and cardiovascular disease. This invincibility is moreover challenged by the number of young adults that receive care in emergency rooms for no-injury-related illnesses. In fact one in five health care visits among this group occurs in an emergency room (Bibbins-Domingo et al., 2010). Moreover, the lack of coverage and access to health services in YI led to health and economic problems in later adulthood since their issues related to obesity and alcohol and tobacco use were frequently left unaddressed (Cantor Monheit, DeLia, & Lloyd, 2012).

Consequently, not only is enrolling the YI a critical part of health care reform, insuring their access to health care will improve American health overall.

**The ACA and the Young Invincibles**

The ACA was designed to provide health insurance to groups of uninsured populations, especially the young invincibles. In the age group of 18-34 year olds 31.4% were uninsured before the ACA-dependent coverage expansion, which is close to double the national rate (Cantor et al., 2012). After the ACA with the opportunity for young adults to remain insured
with their parents until age 26, there was a 25 percent rise in the number of YI with insurance and a 10 percent drop in their uninsured rate (Cantor et al., 2012).

In addition to expanding dependent coverage, the ACA has other provisions that will increase the number of insured YI. These provisions include creating equality among enrollees in college health plans as in any other health insurance plan, covering preexisting conditions and preventive care and expanding Medicaid (Durand, 2012).

In the new insurance marketplace, young and healthy people are needed to buy into the new plans. These YI are a vital part of the good functionality of the ACA marketplaces, because they will offset the costs to cover the higher risk, older, sicker residents of the USA (Stawicki, 2013). The participation of YI that is critical for the system to work in the first year was estimated to be 2.7 million 18-35 year olds (Cappellanti, 2013). This group should make up about 40% of all enrollees on the marketplace in order to reach an optimum premium level (Pace, 2014; Landler & Shear, 2014).

From these facts it is evident that the ACA marketplace system would fail if the YI did not participate as needed. In order to have a strong risk pool, healthier, young adults have to enroll. If they do not participate, the insurance marketplace will mainly be comprised of the sick and elderly who require high cost medical care. By draining money in an unbalanced pool premiums will rise and the taxpayers will have to pay more (Pauly, 2014; Levitt et al., 2013; Landler & Shear, 2014).

After reviewing what the literature presents of the importance of the historically new health care reform under the ACA and why YI are important for the functionality of the new insurance market place, this study will move on to answering the questions raised earlier in the study. This study will provide information about the targeted number of YI to enroll in a plan
under the ACA, the actual number of YI enrolled in the first open enrollment period and the outreach methods used to get them to enroll.

**Methods**

In order to gather data related to best practices of outreach to YI to enroll in health insurance plans offered through the ACA market place, an extensive literature review was conducted. Services explored included internal industry reports, online databases, peer reviewed journals, national and state reports, print media, personal interviews and attending public meetings and seminars. Internal industry reports were obtained from Get Covered America (GCA). The choice for GCA rests on its national recognition as an important player in the outreach and enrollment in the first year of enrollment in insurance plans under the ACA. Academic Search Complete (2014) was the main database that was used to obtain data and information for the study. Peer reviewed journals and articles and state reports obtained in print or online are cited throughout this document. Lastly, based on the literature reviewed questions were developed to be answered by the front workers such as GCA workers.

**Results**

The first objective of this study was to look at the projected and desired number of YI anticipated to enroll in the ACA health insurance market in the first open enrollment period that ran from November 15, 2013 to March 31, 2014. The second objective was to evaluate the extent to which these critical goals were met. Lastly, the study will focus on describing outreach methods used to get people enrolled in general in health insurance plans under the ACA as well as specific outreach methods to young invincibles.

As previously reviewed in the literature, the targeted number of YI to enroll in the insurance plans under the ACA was 40% of all enrollees. If such a level of enrollment were
reached, the new insurance market would be very successful, since the YI help to strengthen the risk pool and to maintain premiums at a minimum.

This study found that 8 million people in the USA enrolled on the ACA market place during the first enrollment period. Among those 8 million enrollees, 28% or 2.7 million people were the YI. These numbers reveal that the initial goal was not met and that the number of YI enrolled in a plan under the ACA was short by 12% (Capellanti, 2014; Department of Health and Human Services [DHHS], 2014). Two main issues that are blamed for this shortage are the dysfunctional website in the first two months of enrollment and the fact that some young people would rather pay the penalty they consider to be cheaper than the expensive coverage (Pace, 2014).

It is worth noting that the total number of YI that enrolled varied over time during the first enrollment period. In fact the proportion of YI rose by four percentage points in the last month of the enrollment period, which confirms the expected trend of this age group to wait for the last minute to enroll (DHHS, 2014). Financial assistance was provided to 85 percent of enrollees and it was a strong force that led to a strong YI enrollment (Young Invincibles, 2014). Moreover, some facts are important to mention about the YI who enrolled in the Marketplace. Among the 18 to 34 age group who signed up for coverage accounted for 29% of all males and 28% of all females. Also, the majority of YI (68%) who signed up through the Marketplace opted for the Silver plan. The Silver plan also happens to be the most popular plan for all individuals who signed up on the Marketplace with 65% of the persons having opted for it (DHHS, 2014).
After looking at numbers of the ACA enrollees, it is of importance to present outreach methods that this study found to have been used to get the general public and the YI enrolled in a health insurance plan during the first enrollment period.

**Outreach Methods to get the General Population Enrolled**

In order to make the American population enroll in a plan on the ACA marketplace, the government used different means to reach out to them. The total number of first year enrollees is high (8million) due to groundbreaking outreach and campaigning efforts (Pallarito, 2014). The White House’s biggest challenge was to convince people that health insurance was a good deal. Unfortunately the campaigning for the ACA by the government was up to a rocky start with the malfunction of the website which had been designed for providing education and for proving that the ACA was a good deal. In fact people who tried to use healthcare.gov during the first weeks of the enrollment period in the fall of 2013 received error messages, had long waiting time, had to make several attempts to enroll or lost their applications. Fortunately, the Federal government relied on outreach groups such as Enroll America, Families USA and other supporters of the ACA to do their best in outreaching, informing, educating and campaigning without this website (Kliff, 2014).

While the government website was getting fixed a survey revealed to federal government officials that another challenging situation was that people were ignorant about the availability of health insurance. This was a big task for the last months of enrollment to convince the uninsured that the new insurance was affordable and that financial help was available for the low and middle income residents. Thus the White House increased events and campaigning opportunities to let the people know about subsidies. There were over 300 radio interviews done and appearances by upper echelons of the White House who increased their public appearances to
increase awareness efforts. Also, all advertisement done by the federal government had a tagline meant to tell people that enrollment was ending soon and to urge them to sign up. Awareness efforts and all outreach activities by all entities involved is reported to have had a remarkable impact on increasing the number of enrollees, especially the YI. For instance 95% of YI were reached by radio and television ads; two-thirds of them visited the government website and half of them bought an insurance plan there. Also enrollment activities doubled from February to March due to all these efforts to reach out to people (Kliff, 2014).

As the government’s largest outreach organization, Enroll America was founded as an outreach group which had as mission of maximizing enrollment of Americans in the ACA insurance programs. The role of Enroll America was crucial especially in the early months of the enrollment period (in the fall of 2013), because the government website designed to do outreach was dysfunctional. Enroll America used grassroots efforts to identify key consumers, educate them and help them sign up for coverage by connecting them with opportunities to enroll on the ACA marketplace.

These efforts consisted of building on existing partnerships in local communities, working with enrollment assistors such as navigators and community health centers, recruiting and training volunteers in outreach and creating new partnerships with key institutions such as colleges, faith communities and small businesses. Partnerships were essential in outreaching to the uninsured. Campaigning efforts included public outreach events, phone banks and door-to-door canvassing which enabled Enroll America to collect information of interested consumers so that there could be a follow up from staff or partners by phone or email. The objective of this grassroots campaign was to make people aware of new coverage options, to identify the uninsured and connect them to opportunities to enroll.
A key factor that made Enroll America’s campaign successful was the provision of face-to-face educational encounters with consumers and the consistency and accessibility of enrollment events. In fact, a report from this organization mentions that the people who met a navigator, a Certified Application Counselor, or other in-person helper were twice more likely to enroll successfully than those that visited the website only. Moreover, the likelihood of buying health insurance increased, even in the hard to reach groups, if follow-ups were done. Enrollment is reported to have increased by 33% when individuals were contacted four times.

Young invincibles are hard to reach and Enroll America knew that they had to reach them given the importance of their participation in the ACA market place. Therefore, outreach efforts were made to find them where they were (Livio, 2014; Al-Faruque, 2014; Kliff, 2014; Warren, 2014).

**How were the young invincibles reached?**

In particular, it took specific outreach methods to target the YI and increase their participation in the new insurance program. States and local partners, volunteers and health navigators put efforts together to win YI who were uninsured to enroll. The most important step to take was to try to convince them of the two main reasons that should make them enroll which were the provision of subsidies to make insurance affordable under the ACA, and the value of having health insurance even when one is young and healthy (Stawicki, 2013; Pallarito, 2014; Pace, 2014; Cunningham & Bond, 2013).

It was no easy task to convince uninsured young people, who do not have immediate medical needs, that they need insurance and that it is currently affordable (Cunningham & Bond, 2013). Another convincing factor that was used was the penalty to those who would forgo insurance under the ACA’s individual mandate. Therefore targeted messages were used and they
had to be powerful to accomplish this task. The social media, television ads, personal
testimonies, sporting events, billboards, ads on buses, skyways and newspapers were all channels
used to convey these messages in an appealing manner to the YI and they were tailored to lure
them into enrolling (Stawicki, 2013).

Another important outreach method was to meet the uninsured YI where they were at. It
was essential to find the uninsured and then get them to enroll. Efforts to find them included
going to universities and colleges on a regular basis and carrying out informational sessions and
handing out flyers (Pace, 2014). Once those YI that needed insurance were identified, they were
helped to enroll or their information was taken and volunteers made follow up calls to them to
make sure that they were able to sign up for coverage (Pace, 2014). All these outreach efforts
required a lot of patience, hard work and collaboration among different partnerships as
previously named. As an example, locally in Montgomery County, OH, state and local officials,
non-governmental organizations, certified counselors, navigators and volunteers all worked hand
in hand to put in place a network that reached out to the YI living in the area.

In the end this study accomplished the task of reviewing the targeted number of young
invincibles to enroll in the ACA marketplace, the unveiling of how many young invincibles
enrolled in the first open enrollment period and the reporting of outreach efforts used to get the
young invincibles enrolled. This new reform in healthcare was remarkably successful with eight
million people enrolled, but some lessons can be learned and recommendations can be made in
order to have future successful enrollments.

Discussion and Recommendations

Overall numbers reveal that the goal that was set to enroll for 40% of enrollees to be YI
was not exactly reached. However the difference of about 12 % less YI enrolled is not likely to
affect premiums for the second enrollment period. Considering that this law was all new, the slow start, the adverse political climate, innovative outreach methods were being tried and that the general population lacked enough information about the ACA, this first enrollment period was remarkably successful. However, given that YI’s participation in ACA is crucial, it is essential to boost enrollment numbers by reaching out to them more effectively.

This study was limited by the fact that the ACA was all new and that not a lot of data, facts and evaluation of activities have been made available to the public yet.

A lot of lessons were learned as days went by. Now that the importance of outreach to YI has been demonstrated, efforts that proved effective should start early in the coming enrollment periods. For instance it would be of benefit to increase personal contact with YI in order to inform them and work with them through the enrollment process. All the grassroots methods were proven effective and should be intensified. Talking about the individual mandate, the financial assistance and the penalty seemed to motivate many to enroll.

After all things considered, YI ought to be convinced that health insurance is vital if they are to really be and stay invincible. There is no greater wealth than to have a healthy lifestyle and to regularly seek preventive care in order to avoid and manage possible chronic illness that face the YI who in reality are not spared by sicknesses. In the long run, keeping the YI insured and cared for will keep health insurance affordable and available to many. Moreover, healthy YI will mean an improvement in public health and a decrease in health care costs in the USA, since prevention will have overridden treating chronic illnesses.
References


Appendix 1

Questions about Outreach to Young Invincibles in the First Enrolment Period of the ACA.

1. In the first enrollment period of the ACA, how many people enrolled in Ohio; in the Montgomery County, OH?
2. How many young adults (18-34 years old) enrolled in the ACA in Ohio; in Montgomery County, OH?
3. What outreach methods were used by your organization? How did these young adults hear about the ACA?
4. Was there an evaluation done by your organization about outreach to young adults?
5. Do you know what made young adults who enrolled enroll in Ohio; Montgomery County, OH?
6. Is there any demographic group that was recruited better in Ohio; Montgomery County, OH? Why?
7. Any characteristic of the young adults who enrolled in Ohio; Montgomery County, OH? (Gender, race, employment status, health status?)
Appendix 2 – List of Competencies Met in CE

### Tier 1 Core Public Health Competencies

<table>
<thead>
<tr>
<th>Domain #1: Analytic/Assessment Skills</th>
</tr>
</thead>
<tbody>
<tr>
<td>Describes factors affecting the health of a community (e.g., equity, income, education, environment)</td>
</tr>
<tr>
<td>Applies ethical principles in accessing, collecting, analyzing, using, maintaining, and disseminating data and information</td>
</tr>
<tr>
<td>Selects valid and reliable data</td>
</tr>
<tr>
<td>Identifies gaps in data</td>
</tr>
<tr>
<td>Describes public health applications of quantitative and qualitative data</td>
</tr>
<tr>
<td>Contributes to assessments of community health status and factors influencing health in a community (e.g., quality, availability, accessibility, and use of health services; access to affordable housing)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Domain #2: Policy Development/Program Planning Skills</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identifies current trends (e.g., health, fiscal, social, political, environmental) affecting the health of a community</td>
</tr>
<tr>
<td>Describes implications of policies, programs, and services</td>
</tr>
<tr>
<td>Gathers information for evaluating policies, programs, and services (e.g., outputs, outcomes, processes, procedures, return on investment)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Domain #3: Communication Skills</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identifies the literacy of populations served (e.g., ability to obtain, interpret, and use health and other information; social media literacy)</td>
</tr>
<tr>
<td>Communicates in writing and orally with linguistic and cultural proficiency (e.g., using age-appropriate materials, incorporating images)</td>
</tr>
<tr>
<td>Suggests approaches for disseminating public health data and information (e.g., social media, newspapers, newsletters, journals, town hall meetings, libraries, neighborhood gatherings)</td>
</tr>
<tr>
<td>Conveys data and information to professionals and the public using a variety of approaches (e.g., reports, presentations, email, letters)</td>
</tr>
<tr>
<td>Facilitates communication among individuals, groups, and organizations</td>
</tr>
<tr>
<td>Describes the roles of governmental public health, health care, and other partners in improving the health of a community</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Domain #4: Cultural Competency Skills</th>
</tr>
</thead>
<tbody>
<tr>
<td>Describes the concept of diversity as it applies to individuals and populations (e.g., language, culture, values, socioeconomic status, geography, education, race, gender, age, ethnicity, sexual orientation, profession, religious affiliation, mental and physical abilities, historical experiences)</td>
</tr>
<tr>
<td>Describes the diversity of individuals and populations in a community</td>
</tr>
<tr>
<td>Describes the ways diversity may influence policies, programs, services, and the health of a community</td>
</tr>
<tr>
<td>Recognizes the contribution of diverse perspectives in developing, implementing, and evaluating policies, programs, and services that affect the health of a community</td>
</tr>
<tr>
<td>Addresses the diversity of individuals and populations when implementing policies, programs, and services that affect the health of a community</td>
</tr>
<tr>
<td>Describes the effects of policies, programs, and services on different populations in a community</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Domain #5: Community Dimensions of Practice Skills</th>
</tr>
</thead>
<tbody>
<tr>
<td>Describes the programs and services provided by governmental and non-governmental organizations to improve the health of a community</td>
</tr>
<tr>
<td>Recognizes relationships that are affecting health in a community (e.g., relationships among health departments, hospitals, community health centers, primary care providers, schools, community-based organizations, and other types of organizations)</td>
</tr>
<tr>
<td>Suggests relationships that may be needed to improve health in a community</td>
</tr>
<tr>
<td>Collaborates with community partners to improve health in a community (e.g., participates in committees, shares data and information, connects people to resources)</td>
</tr>
<tr>
<td>Provides input for developing, implementing, evaluating, and improving policies, programs, and services</td>
</tr>
<tr>
<td>Informs the public about policies, programs, and resources that improve health in a community</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Domain #6: Public Health Sciences Skills</th>
</tr>
</thead>
<tbody>
<tr>
<td>Describes the scientific foundation of the field of public health</td>
</tr>
<tr>
<td>Identifies prominent events in the history of public health (e.g., smallpox eradication, development of vaccinations, infectious disease control, safe drinking water, emphasis on hygiene and hand washing, access to health care for people with disabilities)</td>
</tr>
<tr>
<td>Retrieves evidence (e.g., research findings, case reports, community surveys) from print and electronic sources (e.g., PubMed, Journal of Public Health Management and Practice, Morbidity and Mortality Weekly Report, The World Health Report) to support decision making</td>
</tr>
</tbody>
</table>
### Domain #6: Public Health Sciences Skills (Cont'd)

<table>
<thead>
<tr>
<th>Skill</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recognizes limitations of evidence</td>
<td>(e.g., validity, reliability, sample size, bias, generalizability)</td>
</tr>
<tr>
<td>Describes evidence used in developing, implementing, evaluating,</td>
<td>and improving policies, programs, and services</td>
</tr>
<tr>
<td>Describes the laws, regulations, policies, and procedures for the</td>
<td>ethical conduct of research (e.g., patient confidentiality, protection of human subjects, Americans with Disabilities Act)</td>
</tr>
<tr>
<td>Contributes to the public health evidence base</td>
<td>(e.g., participating in Public Health Practice-Based Research Networks, community-based participatory research, and academic health departments; authoring articles; making data available to researchers)</td>
</tr>
<tr>
<td>Suggests partnerships that may increase use of evidence</td>
<td>in public health practice (e.g., between practice and academic organizations, with health sciences libraries)</td>
</tr>
</tbody>
</table>

### Domain #7: Financial Planning and Management Skills

<table>
<thead>
<tr>
<th>Skill</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Describes the structures, functions, and authorizations of</td>
<td>governmental public health programs and organizations</td>
</tr>
<tr>
<td>Describes government agencies with authority to impact the</td>
<td>health of a community</td>
</tr>
<tr>
<td>Describes public health funding mechanisms (e.g., categorical</td>
<td>grants, fees, third-party reimbursement, tobacco taxes)</td>
</tr>
<tr>
<td>Describes financial analysis methods used</td>
<td>in making decisions about policies, programs, and services (e.g., cost-effectiveness, cost-benefit, cost-utility analysis, return on investment)</td>
</tr>
<tr>
<td>Describes how teams help achieve</td>
<td>program and organizational goals (e.g., the value of different disciplines, sectors, skills, experiences, and perspectives; scope of work and timeline)</td>
</tr>
<tr>
<td>Describes program performance standards and measures</td>
<td></td>
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</tbody>
</table>

### Domain #8: Leadership and Systems Thinking Skills

<table>
<thead>
<tr>
<th>Skill</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Describes public health as part of a larger inter-related system</td>
<td>of organizations that influence the health of populations at local, national, and global levels</td>
</tr>
<tr>
<td>Describes the ways public health, health care, and other</td>
<td>organizations can work together or individually to impact the health of a community</td>
</tr>
<tr>
<td>Contributes to development of a vision</td>
<td>for a healthy community (e.g., emphasis on prevention, health equity for all, excellence and innovation)</td>
</tr>
<tr>
<td>Identifies internal and external facilitators and barriers that</td>
<td>may affect the delivery of the 10 Essential Public Health Services (e.g., using root cause analysis and other quality improvement methods and tools, problem solving)</td>
</tr>
<tr>
<td>Describes needs for professional development (e.g., training,</td>
<td>mentoring, peer advising, coaching)</td>
</tr>
<tr>
<td>Describes the impact of changes (e.g., social, political, economic,</td>
<td>scientific) on organizational practices</td>
</tr>
<tr>
<td>Describes ways to improve individual and program performance</td>
<td></td>
</tr>
</tbody>
</table>

### Public Health Management Concentration Competencies

<table>
<thead>
<tr>
<th>Skill</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Have a knowledge of strategy and management principles related to</td>
<td>public health and health care settings</td>
</tr>
<tr>
<td>Know effective communication strategies used by health service</td>
<td>organizations</td>
</tr>
<tr>
<td>Have an understanding of organizational theory and how it can be</td>
<td>utilized to enhance organizational effectiveness</td>
</tr>
<tr>
<td>Know change management principles</td>
<td></td>
</tr>
<tr>
<td>Have a knowledge of successful program implementation principles</td>
<td></td>
</tr>
<tr>
<td>Have a knowledge of strategies used for monitoring, evaluating, and</td>
<td>continuously improving program performance</td>
</tr>
<tr>
<td>Have a knowledge of systems thinking principles</td>
<td></td>
</tr>
<tr>
<td>Have an awareness of strategies for working with stakeholders to</td>
<td>determine common and key values to achieve organizational and community goals</td>
</tr>
<tr>
<td>Have a knowledge of human resource principles to enhance</td>
<td>organizational management, motivate personnel and resolve conflict</td>
</tr>
<tr>
<td>Be able to determine how public health challenges can be addressed</td>
<td>by applying strategic principles and management-based solutions</td>
</tr>
<tr>
<td>An understanding of marketing principles and strategies</td>
<td></td>
</tr>
<tr>
<td>A knowledge of ethical standards for program development</td>
<td></td>
</tr>
<tr>
<td>Detailed knowledge of public health laws and regulations</td>
<td></td>
</tr>
</tbody>
</table>